Bundle Finance and Performance OPEN 18 September 2023

Agenda attachments

ITEM 0 Open F and P Agenda - 18 September 2023

0 09:30 - OPENING ITEMS

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

2 Declarations of Interest
Declarations of Interest

3 Minutes of last meeting - 17 July 2023
ITEM 3 OPEN F and P Minutes - 17 July 2023 - V3

4 Action log and matters arising
ITEM 4 Full F and P Action and Decisions Log
ITEM 4.1 Finance and Performance Committee Highlight Report July 2023

5 09:35 - Operations Quarterly Report
ITEM 5 Operations Quarterly Report for Committees 23-24 Q2
ITEM 5.1 Annex to Operations update

5.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

6 09:45 - Financial Position for Month 5

7 10:05 - Financial Sustainability Programme Report
ITEM 7 ES - FSP Governance
ITEM 7.1 Appendix B - August 2023 FSP Update

8 10:25 - Risk Management and Board Assurance Framework
ITEM 8 Executive Summary Risk Management Report FPC 180923

9 10:35 - Integrated Medium Term Plan 2023-2026 Q1/Q2 Delivery and Assurance
ITEM 9 Executive Summary - IMTP Q1Q2 Delivery & Assurance
ITEM 9.1 Appendix 1 - 2308 - IMTP Delivery Assurance Report (1)
ITEM 9.2 Appendix 2 - 230815 - STB Assurance Report - StratDev

10 10:50 - Monthly Integrated Quality and Performance Report - TO FOLLOW

11 11:05 - Digital Strategy Plan
ITEM 11 SBAR - Digital Strategy Update FPC Sept 2023
ITEM 11.1 Digital Reporting Sept 23_ Open FPC

11.1 11:20 - COMFORT BREAK

12 11:30 - Mobile Data Vehicle Solution Welsh Government Project Assurance Review
ITEM 12 FPC MDVS Exec Summary
ITEM 12.1 Gateway

13 11:40 - Environment, Decarbonisation and Sustainability Update August 2023
Note:
Item 13.3 DCR submission report and
Item 13.4 Quantitative report have been e mailed separately
ITEM 13 FPC Decarb and Sustainability Update
ITEM 13.1 Decarbonisation Programme Board TOR
ITEM 13.2 Decarbonisation Programme Board Risk Register
ITEM 13.5 Sustainability Report 2022-23 V.3
ITEM 13.6 Annual Utility, water and & waste report

14 12:00 - Manchester Arena Inquiry – Progress Update
ITEM 14 Executive Summary for FPC - MAI Recommendations 2

14.1 CONSENT ITEMS
The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.

15 12:10 - Cycle of Business Monitoring Report and Review of Committee Priorities
ITEM 15 Finance and Performance Committee Priorities and Cycle Monitoring Report
ITEM 15.1 FPC Cycle of Business Monitoring Report

15.1 CLOSING ITEMS

16 12:15 - Reflection & Summary of Decisions and Actions

17 Any Other Business
18 Date and Time of Next Meeting; 13 November 2023 09:30

MEETING OF THE OPEN FINANCE AND PERFORMANCE COMMITTEE
Held on 18 September 2023 from 09:30 to 12:25
Meeting held virtually via Microsoft Teams

AGENDA

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome, apologies, and confirmation of quorum	Information	Joga Singh	Verbal	5 Mins
2.	Declarations of Interest	Information	Joga Singh	Verbal	
3.	Minutes of last meeting – 17 July 2023	Approval	Joga Singh	Paper	
4.	Action Log and Matters Arising July Committee AAA Report	Review	Joga Singh	Paper	
5.	Operations Quarterly Report	Information	Judith Bryce	Paper	10 Mins
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
6.	Financial Position for Month 5	Assurance	Chris Turley	Presentation	20 Mins
7.	Financial Sustainability Programme Report	Assurance	Angie Lewis	Paper	20 Mins
8.	Risk Management and Board Assurance Framework	Assurance	Julie Boalch	Paper	10 Mins
9.	Integrated Medium Term Plan 2023 -2026 Q1/Q2 Delivery and Assurance	Assurance	Rachel Marsh	Paper	15 Mins
10.	Monthly Integrated Quality and Performance Report	Assurance	Rachel Marsh	Paper	15 Mins
11.	Digital Strategy Plan	Assurance	Aled Williams	Paper	15 Mins
COMFORT BREAK – 10 MINUTES					
12.	Mobile Data Vehicle Solution Welsh Government Project Assurance Review	Assurance	Keith Williams	Paper	10 Mins

No.	Agenda Item	Purpose	Lead	Format	Time
13.	Environment, Decarbonisation and Sustainability Update 13.1. Decarbonisation Programme Board Terms of Reference 13.2. Decarbonisation Programme Board Risk Register 13.3. DCR Submission report 13.4. Quantitative report 13.5. Sustainability report 2022/23 13.6. Utility, water and waste report	Assurance Endorsement	Chris Turley	Paper	20 Mins
14.	Manchester Arena Inquiry – Progress Update	Assurance	Judith Bryce	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.**					
15.	Cycle of Business Monitoring Report and Review of Committee Priorities	Information	Trish Mills	Paper	5 Mins
CLOSING ITEMS					
16.	Reflection & Summary of Decisions and Actions	Discussion	Joga Singh	Verbal	10 Mins
17.	Any Other Business	Discussion	Joga Singh	Verbal	
18.	Date and Time of Next Meeting; 13 November 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
Leanne Smith	Interim Director of Digital Services

Chris Turley	Executive Director of Finance and Corporate Resources
Keith Williams	Head of Operational Communications Programme

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 17 JULY 2023 VIA TEAMS

Meeting started at 09:30

PRESENT:

Kevin Davies	Non-Executive Director (Chaired meeting)
Bethan Evans	Non-Executive Director
Martin Turner	Non-Executive Director (Left meeting after item 49/23)

IN ATTENDANCE:

Hugh Bennett	Assistant Director, Commissioning and Performance
Lee Brooks	Executive Director of Operations (Item 50/23 only)
Judith Bryce	Assistant Director of Operations
Jason Fernard	HART Training Manager (Item 50/23 only)
Ross Hughes	Internal Audit
Fflur Jones	Audit Wales
Navin Kalia	Deputy Director of Finance and Corporate Resources
Jason Killens	Chief Executive Officer
Angela Lewis	Director of People and Culture
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Marinela Stoicheri	Risk Officer
Lisa Trounce	Business Manager, Corporate Services
Damon Turner	Trade Union Partner

APOLOGIES:

Rachel Marsh	Executive Director of Strategy and Planning
Joga Singh	Non-Executive Director and Chair of Committee
Leanne Smith	Interim Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources

44/23 PROCEDURAL MATTERS

The Chair welcomed all to the meeting and reminded attendees that the meeting was being audio recorded. Members noted that any declarations of interest were contained within the Trust's declarations of interest register. Professor Kevin Davies added that he was no longer a Trustee of St John and it was noted the register would be updated accordingly. Apologies were received from Lee Brooks, Rachel Marsh, Joga Singh, Leanne Smith and Chris Turley

Minutes

The minutes of the open session held on 17 July 2023 were considered by the Committee and confirmed as a correct record.

Action Log

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

Action 20/23a - Deep dive on 111 clinical call back times - To be included in MIQPR, further update at next meeting.
Action 28/33 - Update on actions following the Manchester Arena Inquiry – Action Closed.
Action 33/23 - Annual Review of Key Metrics, Circulate to Committee seeking comments in readiness for next meeting. Action Closed.
Action 38/23 - Provide Comms Team with information on the electronic Patient Care Record (ePCR) for circulation to staff. Action closed.

RESOLVED: The minutes of the meeting held on 17 July 2023 were confirmed as a correct record and the action log was considered and updated as described.

45/23 OPERATIONS QUARTERLY REPORT

Judith Bryce presented the Operations Directorate update for quarter one and drew attention to the following key points:

An update on the recommendations as a result of Manchester Arena Inquiry was given; the Trust was currently progressing 71 of the 149 recommendations within volume 2 of the report as these were relevant to WAST.

The extended time it took to transfer the care of patients at hospital emergency departments continued to be of concern. The Trust was focussing on several areas to minimise these delays.

In terms of the Emergency Medical Technician (EMT) role, the Committee were updated on the work to develop the EMT3 role.

Comments:

The Committee sought clarity on the terminology 'licensed for systematic care'. Judith Bryce explained this referred to the risk arrangements with the roles undertaken by the Trust which was predominantly pre-hospital care on hospital premises.

Members were keen to understand details of recruitment and retention within the EMS coordination team; and the percentage of vacancies the Trust was carrying. Judith Bryce agreed to feedback the details at the next meeting whilst acknowledging there was a reasonably high attrition rate. Notwithstanding this, performance across the control room was high.

The Committee expressed their concerns with the high number of outstanding coroner statements; noting that work was ongoing to address this. Liam Williams assured the Committee that work was ongoing to address this and provided further details. This included a request for additional resource.

Members queried whether it was feasible to have more than one patient in an ambulance (cohorting) and therefore freeing up the other ambulance to attend 999 calls. Judith Bryce explained that the practice did exist and it was often the case that crews would care for more than one patient, however it was not necessarily advocated by the Trust. Liam Williams explained further how this worked and stressed it was the exception as opposed to the norm; adding there were additional risks and responsibilities with caring for the patient. The challenge for the Trust was to ensure that crews were comfortable with this approach and that the safety of the patients were uppermost.

The Chair reiterated the fact that an ambulance was a temporary clinical environment and had stressed this at a recent Vice Chair's meeting.

Hugh Parry explained that cohorting had been tried and tested for several years and quite simply was not very effective.

RESOLVED: That the Committee noted the report.

46/23 FINANCIAL POSITION MONTH 3, 2023/24

The Committee received an update from Navin Kalia on the financial position for Month three, 2023/24, and an update from Angela Lewis on the Financial Savings Programme (FSP) Key highlights from the report included:

a) The cumulative year to date (M3) revenue financial position reported was a small overspend against budget of £0.033m.

b) The Capital plan was being progressed and planned expenditure of £32m was forecast to be fully spent by the end of the financial year.
c) Funding for the £6m 100 front-line Whole Time Equivalents (WTE) was still assumed with correspondence continuing with the Emergency Ambulance Services Committee (EASC).

d) An overview of the financial performance by each Directorate was provided and it demonstrated that the majority of Directorates were performing broadly in line with the current budget plan.

e) Savings to date had overachieved by £93k.

f) The overall financial risks were illustrated and these included the challenging savings targets for the 2023/24 financial year and the continuing increased costs in services due to inflation increases.

g) Details of capital expenditure were given. The Trust has, at month three, spent £0.387m against the current all Wales capital scheme budget of £27.863m, and £1.332m against the discretionary budget of £4.321m.

h) Members were updated on the timelines for submission of the Trust's Annual Accounts and Annual report. These were due approval at the Board on 27 July 2023; an unqualified audit opinion was expected in respect of the Accounts.

i) In terms of the Financial Savings Programme, Angela Lewis advised the Committee that the Support Services Review (administrative/Corporate type roles) was almost complete with a first draft of the report due for Executive sign off on 24 July 2023.

j) The report would consider high level themes focussing on, amongst others, consistency across ways of working and culminating in recommendations around cost saving/spend avoidance.

k) In respect of recruitment, members noted that the Recruitment Control Panel had met on 20 occasions and that 145 posts had been approved; this information was correct as at 30 June 2023.

l) The Operations Financial Savings Group had identified £2m in savings; partly related to overtime which helped the Trust to fully identify its savings plan.

m) Income generation group work continued and was progressing well, with several savings schemes being identified. The group continues work to generate additional income through innovative ideas.

Comments:

The Committee expressed concern around the assumption against agreed salary increases will be fully funded by Welsh Government (WG). Navin Kalia explained that WG had provided assurances as per previous financial years that WG would fully fund all pay rises for this financial. However, going forward for future financial years, it could be an issue.

The Committee recorded a note of thanks to everyone involved in achieving the position at the end of month 3 which was not without its significant challenges.

Members noted that from the point of risk this required a significant cultural shift in terms of how resources were viewed in the Trust which was emphasised by Angela Lewis. In respect of the risk around income generation, it was asked what the Trust's level of confidence was in terms of achieving its goal, and also its ability to attain the significant level of savings required. Navin Kalia assured the Committee the Trust should deliver on the £1m target in respect of income generation which will however fluctuate throughout the year. As far as achieving the savings needed, both Navin and Angela explained this was delicately balanced and were reasonably confident for this financial year; however, the future financial years would prove to be more challenging. The risk around this will continue to increase unless the Trust takes proactive action to identify recurrent sustainable savings, which it was doing.

The Committee were comfortable that the Trust would balance financially at the end of 2023/24, noting there was some reliance on no-recurring savings this year. Angela Lewis explained that the Trust shared its concerns and ideas reciprocally with Health Boards on the state of finances across the NHS. Liam Williams added that the Trust continued to increase its visibility particularly across all of the six goals. He further added that the Trust's clinical transformation model gave exposure to greater financial efficiency across Wales; and should the clinical strategy be implemented in full this would reduce overall conveyance numbers and subsequently offer a wider NHS benefit. Additionally, savings could also be made through digital means, such as providing remote consultation and assessment.

RESOLVED: The Committee:

(1) Noted and gained assurance in relation to the Month 3 revenue financial position and performance of the Trust as at 30 June 2023 along with current risks and mitigation plans;

(2) Noted the delivery of the 2023/24 savings plan as at Month 3, and the context of this within the overall financial position of the Trust;

(3) Noted a detailed paper on the financial position will be presented to Trust Board at the 27 July meeting; and

(4) Noted the audited accounts when approved by the Trust Board on 27 July will be submitted to Welsh Government by Audit Wales on 31 July 2023.

47/23 RISK MANAGEMENT AND CORPORATE RISK REGISTER

Trish Mills presented the revised report which contained details of the risks relevant to the Committee's remit with additional rationale relating to any movement in risk scores.

All of the nine the risks under the Committee's remit had been reviewed in July 2023 apart from Risks 100 and 283, which were due for review in August 2023. Details of any movement in scores was given. One of the risks- Risk 424 (Prioritisation or Availability of

Resources to Deliver the Trust's Integrated Medium Term Plan); which had had increased from a score of 12 to 16.

In respect of risks 260 (A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems) and 543 (Major disruptive incident resulting in a loss of critical IT systems), whilst the majority of mitigation actions had been completed, there were still further reviews to be undertaken to identify any more mitigations.

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) having reached its target, has been closed.

Comments:

Members recognised that the report had clearly illustrated dynamic evaluation of risks particularly for this year being set against the financial challenge.

RESOLVED: The Committee accepted the status of the nine corporate risks which it has been assigned to oversee the management of. The Committee received the relevant sections of the Board Assurance Framework and noted the ongoing mitigating controls.

48/23 INTEGRATED MEDIUM TERM PLAN (IMTP) 2023/24 QUARTER ONE UPDATE FOR 2023/24

Hugh Bennett presented the report and drew out the following key points for the Committee's attention:

a) Following Trust Board approval on 30 March 2023, the Trust's IMTP for 2023-26 was submitted to Welsh Government on 31 March 2023. The Trust was currently awaiting formal feedback and approval, including any accountability conditions.

b) The 150 actions within the IMTP were constantly being addressed to be streamlined and to avoid duplication and were being grouped into work packages.

c) The Committee were updated on the IMTP delivery programmes for 23/24 which included EMS Operations programme and the Ambulance care programme.

d) In addition to reviewing the IMTP assurance arrangements, the Trust has been developing project management guidance for all staff which aims to provide a practical guide to implementing business change.

e) Members noted that in determining the justification of funding for projects and programmes, a revenue business case process had been developed which will scope out projects and, in some instances, develop full business cases.

f) Work was also focussing on developing the lessons learned from projects and programmes.

g) In terms of the Ambulance Care Programme, the Committee noted that the Trust was not proceeding with the roster review in respect of re-prioritising the existing capacity.

h) A service review on financial sustainability was due to be undertaken, however there was an issue in earmarking a resource to conduct this.

i) The Committee were updated on progress in terms of inverting the triangle and this included change management training and EMS demand and capacity review.

Comments:

Trish Mills commented that the Datix risk module, which was not in the Trust's control in any event, has been removed from the risk transformation programme and therefore will no longer be an issue.

Following a query on staff attrition, Angela Lewis informed the Committee there was a steady decline in staff turnover rates; which was really positive.

RESOLVED: The Committee:

(1) Noted the update against WAST's IMTP delivery governance and assurance mechanisms; and

Noted the approach to project delivery and Post Implementation Review set out in this paper.

49/23 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Hugh Bennett presented the report which covered the month of May 2023 informing the Committee there had been a slight easing of pressure, although the operating positing remains extremely challenging.

In terms of key points from the report, the Committee were updated on the following:

a) 999 answering times have been on target for the last five months.

b) 111 call answering was improving with the call abandonment rate of 5% almost achieved in May with 42% of calls being answered within 60 seconds; whilst this remained off target, work was underway to improve this by recruiting more call handlers.

c) In respect of 111 clinical response, the clinical call back time for the highest priority continued to be on target, while lesser priority calls remained slightly below the performance target.

d) The Red 8-minute response target for ambulance response was at 54% and whilst this showed an improvement when compared to April 2023, however, further improvement was still required.

e) With regards to recruitment, confirmation had been received that no-recurrent funding in 2023/24 will be available to support the 100 Whole Time Equivalent (WTE) staff recruited in 2022/23.

f) In terms of the Clinical Support Desk (CSD), the Trust managed to increase its consult and close rate to 14.1%, with the ambition to reach 17% going forward.

g) Recruitment for the Cymru High Acuity Response Unit (CHARU) continues with alacrity, the aim being to have 153 Whole Time Equivalents (WTE) in post in the near future.

h) There were over 20k lost hours due to handover delays which was a decrease compared to the 23k lost in April 2023. Whilst this has led to improved quality and performance for EMS, Amber 1 performance with waits of over four hours remained unacceptable and the levels of lost hours to handover delays remained so extreme that all the actions within the Trust's control cannot mitigate and offset this level of loss.

i) Overall, Ambulance Care (formally knowns as Non-Emergency Patient Transfer Service) performance continued to be stable, notwithstanding that general demand for this service continued to increase.

Comments:

The Committee recognised that the vast number of hours lost due to handover delays and the associated risks continued to weigh heavily, also noting that the Trust persisted in in its efforts to mitigate this loss.

Liam Williams updated the Committee on the commitment of the Executive Teams from other Trusts to tackle the lost hours problem; noting that whilst improvements have started to be seen in other Health Boards, the Cardiff and Vale University Health Board area has shown a marked improvement.

Members held a discussion which reflected on the number of immediate release directives being declined; recognising that the significant number of Amber ones would result in patient harm.

The Committee noted the positive aspects of the report which included improvements in 111 call out and also the Return of Spontaneous Circulation rates at 20% had achieved the highest on record.

Existing and proposed Metrics for 2023/24

Hugh Bennett gave an overview of the existing and proposed metrics for 2023/24 which were being presented to the Committee for Board approval on 27 July 2023.

The Committee were fully supportive of the metrics and queried what was going to be measured in terms of the Duty of Candour. Liam Williams advised that work was ongoing on a national basis to determine what the consistent measures were likely to be. In the meantime, the Trust will be illustrating the number of events and those responded to in relation to the Duty of Candour.

Following a query in relation to how the Board and Committees receive information and level of assurance relevant to them; Hugh Bennett advised that going forward it was the intention for the Board and Committees to receive one integrated report.

RESOLVED: The Committee considered the May 2023 Integrated Quality and Performance Report and actions being taken and determined that:

(1) It provided sufficient assurance; and

(2) Agreed the new metrics for 2023/24 for onward approval at Trust Board.

50/23 EMERGENCY PREPAREDNESS, RESILIENCE, AND RESPONSE (EPPR) ANNUAL REPORTING

The Committee received a report and a presentation on the Emergency Preparedness, Resilience and Response (EPPR) which illustrated several areas and arrangements in place for their assurance.

The update included a review of the Civil Contingencies in Wales in which the Trust had been liaising with partners including Welsh Government to consider the future of Civil Contingencies in Wales.

Members were advised on the key areas of work being undertaken by the Trust's EPRR Team during 2023/24 and this included: Response to the Manchester Arena Inquiry (MAI), the Trust's Incident Response Plan, the review of Civil Contingencies in Wales, the UK Government Resilience Framework, the Welsh Government Annual Emergency Planning Report and the Annual Hazardous Area Response Team (HART)/Specialist Operations Response Team (SORT) Key Performance Indicators (KPI) report.

The Committee noted that the Trust's response to the 149 recommendations following the MAI, of which 71 were applicable to the Trust and work continued to monitor, review and address these. Members recognised that some of the recommendations would be closed off later as part of the Incident Response Plan (IRP) review.

In terms of the IRP this remained the Trust's overarching plan to determine its response to an incident. The IRP had been updated to included lessons learnt from several incidents and exercises. The IPR and was due for review in October 2023 and will include the new Joint Operating Procedures to respond to Marauding Terrorist Attacks.

Members were updated on Risk 594 (the Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death). As part of the mitigation of this risk the Trust was liaising with Welsh Government, who continue to provide support.

The Committee were advised that since the transfer of Powers in 2018 a first review of the Civil Contingencies within Wales had recently been completed. There were 15 recommendations within the report which the Trust continued to address going forward; the review confirmed that governance arrangements in place were fit for purpose.

Another key piece of legislation impacting on resilience was the UK Government Resilience Framework which sets out how the UK will strengthen collective resilience. It focused on how the UK will anticipate, assess, prevent, mitigate, and respond to civil contingency risks, known or unknown.

The Committee were updated on new Business Continuity (BC) plans being implemented to include plans on Information and Communication Technology (ICT) disruption and power outage.

The Welsh Government Annual Emergency Planning Report reports on the Trust's compliance and readiness to meet its obligations under the Civil Contingencies Act 2004. This included assurance that:

- Emergency plans were in place for the Trust to respond effectively to incidents of different types.
- Plans were reviewed and updated to reflect lessons identified internally and by external organisations.
- Training and exercises were carried out alongside partners, including seven tabletop exercise and over 20 multiagency counter terrorism tabletop exercises over the previous year, and participation in 12 multiagency live exercises over the previous three years.
- Processes were in place to train our commanders and refresher training has been provided at all levels of command.

The HART/SORT KPI report illustrated to the Committee an overview of the key activities these specialist teams had provided over the previous year. The Committee noted that whilst demand for HART had fallen during the pandemic, the number of deployments was now at pre-pandemic levels. In terms of the Enhanced SORT Business case, the Committee noted this had been resubmitted to Welsh Government at their request and the Trust was currently awaiting approval.

Comments:

It was questioned whether the Exercises conducted by the Trust had sufficient complexity. Judith Bryce commented that the exercises were fairly consistent with current events/incidents adding that the training scenarios were detailed and complex. However,

there was always the need to adapt and be familiar to developing scenarios going forward. Jason Fernard provided the Committee with details of the Trust's involvement in Exercise Dollhouse, a multi-agency exercise which focused on a scenario involving a terrorist attack at a music event. Lee Brooks added that exercises of this nature were invaluable to the Trust's learning.

RESOLVED: That the Committee:

(1) Received and discussed the annual report with a view to offering its confirmed assurance of the Trust's work in this area and to onward report to the Trust Board; and

(2) Received the Manchester Arena Inquiry Volume 2: Emergency Response report, the End of year summary report for 2022/23, the Health Emergency Planning Annual Report for 2022 and the UK Government Resilience Framework report.

51/23 INTERNAL AUDIT TRACKER REPORT AND INTERNAL AUDIT REPORTS

Trish Mills advised the Committee that the Audit Tracker was undergoing a revision and a recommendation on a revised process and format will be presented at the Audit Committee in September. Members noted that the Corporate Governance Team will liaise with both Internal Audit and Audit Wales on the production of the revised report.

In terms of the Tracker, there were 86 internal audit recommendations assigned to the Committee for oversight, with 33 having not met their agreed and revised completion dates.

There were 11 recommendations with no update, four were due in April, four were due in May and three in June. The Committee were assured that by the next meeting a more comprehensive update would be provided.

Advice had been sought from the Head of Internal Audit regarding historic recommendations resulting in a number of these being marked as closed rather than complete particularly where further reviews were due to take place and where actions have been subsumed into detailed work plans or superseded.
The Committee reviewed two internal audit reports, the Information Management & Technology (IM&T) Infrastructure which received a reasonable assurance, the objective being to provide assurance on the management and operation of the Trust's IM&T. The other report, the Savings and Efficiency report also receiving a reasonable assurance, looked at last year's financial year. The report noted the introduction of the Financial Sustainability Programme for the challenging year of 2023/24. A recommendation from the report highlighted the requirement for this Committee to clearly demonstrate its scrutiny of the savings programme.

Comments:

The Committee welcomed that the tracker was being reviewed particularly around the timing of closures.

RESOLVED: The Committee noted the update and acknowledged receipt of the Savings and efficiency Internal Audit review and the Information Management and Technology Infrastructure Internal Audit review.

52/23 TRUST POLICY REPORT

The Committee were updated on the status of Trust policies by Trish Mills.

Members noted that a number of policies had not been reviewed within the expected review date; and these levels had fallen during the Covid-19 pandemic where work on policies had been paused. This has resulted in a great deal of policies going beyond their review date.

A prioritisation exercise has taken place based on a risk assessment, and a revised governance process for policies and delegations for approvals was underway. Whilst only 14% of policies (13 of 93) were currently within their review date, the Committee noted that policies do not 'expire' and that extant but overdue for review policies have undergone rigorous review prior to their approval; as a result, these policies would be acceptable with minor amendments. The Audit Committee will monitor progress of improvement plans and will review the revised governance arrangements.

The Trust's policy governance process was being refreshed in partnership with Trade Union colleagues and included the review of the Policy on Policies and the process for other documents such as Standard Operating Procedures. It was expected that proposals will be submitted to the Executive Management Team (EMT) for endorsement in late August 2023, and a report submitted to Audit Committee and Trust Board in December 2023 for approval.

Comments

Members questioned whether the policies were Trust only policies or whether they included Welsh NHS policies. Trish Mills advised that the 93 referred to were Trust only. Additionally, there were 19 all Wales NHS policies, and only one was within its review date.

Members held a discussion in which they recognised the importance of reviewing policies in partnership with Trade Union colleagues.

It was questioned what the level of risk was in terms of reputational risk with regards to having a high number of policies awaiting review. Trish Mills added that the risk must be tempered with those influencing factors such as Covid-19, Industrial Action, and Winter pressures. She added that the policies were being reviewed in order of those that posed the highest risk.

Damon Turner added that from a trade union perspective and as an employee there was a robust governance structure in place for the review and monitoring of policies.

The Committee recognised the challenges involved with the effective use of capability and capacity when reviewing the policies against the backdrop of other priorities.

RESOLVED: The Committee considered the contents of the report and the programme of work in development to mitigate risk and bring policies in line with appropriate review dates.

53/23 MAY COMMITTEE AAA REPORT

The report was noted.

RESOLVED: The Committee noted the report.

54/23 CYCLE OF BUSINESS MONITORING REPORT AND REVIEW OF COMMITTEE PRIORITIES

The report was noted.

RESOLVED: The Committee noted the report.

REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

It was agreed that any reflections would be e mailed to chair after meeting and he would liaise with Trish Mills on any actions and/or decisions.

RESOLVED: Noted as above.

Meeting concluded at 12:24

Date of Next Meeting: 18 September 2023

ACTION LOG - FROM NOVEMBER 2021

FINANCE AND PERFORMANCE COMMITTEE

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
20/23a	21 March 2023	MIQPR	Deep dive on 111 clinical call back times - To be included in MIQPR	Rachel Marsh	18 September 2023	Update for 18 September 2023 Verbal Update	Open
45/23	17 July 2023	Operations Update	Percentage of vacancies to establishment	Judith Bryce	18 September 2023	Update for 18 September 2023 Update to be included in Operations Update See ITEM 5.1	Open

FINANCE AND PERFORMANCE COMMITTEE
HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report.

Trust Board Meeting Date	27 July 2023
Committee Meeting Date	17 July 2023
Chair	Kevin Davies

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Following the Trust's revised policy process being implemented in 2017 there was a significant improvement in the number of policies within their review date. However, the rate of review fell below reasonable levels during the pandemic as policy work was largely paused and efforts directed to support the response. This, coupled with a challenging Winter and prolonged industrial action has led to a significant number of **policies past their review date**. A prioritisation exercise has taken place on the basis of a risk assessment, and a revised governance process for policies and delegations for approvals is underway. The risk assessments were based on known risks, internal audits completed and those planned for 2023/24. Whilst only 14% of policies are currently within their review date, the Committee noted that policies do not 'expire' and that extant but overdue for review policies have undergone rigorous review prior to their approval and as a result would likely stand the test of time with minor amendments. The Audit Committee will monitor progress of improvement plans and will review the revised governance arrangements.

ADVISE

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

2. The proposed **Board and Committee Level Key Performance Indicators for 2023/24** were endorsed for Board approval at the July meeting. It was noted that some of the metrics will need further defining and therefore may not appear on the August MIQPR, including the measure for the Duty of Candour which may be subject to national measures.

3. The **Operational Update for Q1** was received. On the issue of WAST's facilitation of extended transfer of care, in particular portering, members sought to understand at a future meeting the risks of staff working in this way where they are not trained to so and where WAST is not commissioned to provide this service. The impacts on staff of handling a high number and increasing complexity of concerns was discussed, as was the high levels of attrition in Emergency Medical Services (EMS) Coordination. Both these issues will be reviewed in more detail in the Quality, Patient Experience

and Safety Committee and the People and Culture Committee at their next meetings. The cohorting of patients in ambulances was also discussed and noted that this was not an answer to the continued lengthy handover delays.

4. Members **reflected** that culture was discussed in terms of income generation and business continuity, and that this was a positive step that supports organisational cultural change more broadly.

ASSURE

(Detail here assurance items the Committee receives)

5. The Committee received a presentation on the **financial position for Month 3 2023/24** due to the date of this meeting coming close to end of month. The Board will have a detailed paper on the financial position before it for the July meeting. The cumulative year to date revenue position is a small overspend of £33K, with the year end forecast being one of break even. The capital plan is forecast to be fully spent by the end of the financial year. Key assumptions underpinning the year to date performance were discussed and assurance provided regarding the agreed salary increases being covered by Welsh Government. The Committee commended the finance and operations teams on the £6m of savings planned now being fully identified but noted the risk in delivery and the need to deliver more sustainable recurrent savings schemes.

6. Gross savings of £1.820m have been achieved against a year to date target of £1.727m. A **Financial Sustainability Programme** update was received against identified initiatives including the support services review; service review; recruitment control panel; operations savings group; and income generation group. Members recognised the good progress and were assured that there was momentum in the programme, with the support services review shortly coming to a close, and resources identified for the service review. It was recognised that income generation for transformative schemes was a slower programme of work, and that focus on sustainability across all reviews was key. Resourcing across all programmes to develop initiatives and to implement them is a continuing risk, however the support services review and the services review should highlight potential opportunities to mitigate this. Garnering external support and recognition for initiatives was raised given reliance on non-recurrent funding for the 100 WTE this year, and it was noted that WAST now has a seat on the Six Goals Programme Board.

   The Committee reviewed the **Saving and Efficiencies Internal Audit Report** which focused on the 2022/23 financial year and received reasonable assurance. The report noted the introduction of the financial sustainability programme for the challenging year of 2023/24 and this will be reviewed as part of the 2024/25 Internal Audit Plan. The Committee will continue to monitor the management actions which address the six medium level recommendations through the Audit Tracker.

7. The Audit Wales **unqualified opinion on the draft financial accounts** for 2022/23 and the timelines and next steps was noted and recognition of this was made by the Chair.

8. The **structure and governance for the Strategic Transformation Board** and its programmes was reviewed and the Committee was assured that these were appropriate and clear.

9. Whilst formal approval of the **Integrated Medium-Term Plan (IMTP) 2023-26** is awaited from Welsh Government along with any accountability conditions, the final year 2022/23 actions (c.150) have been reviewed and a single reporting line has been defined for actions continuing into 2023/24. The year end position, transitioning arrangements, and deep dive on the Inverting The Triangles Programme provided assurance to the Committee on progress and milestones.

10. A **Project Path Framework** has been developed to provide a guide to implementing business change, regardless of the scale of the project or the user's level of experience in project management. The Project Path will be accompanied by a variety of practical tools and templates that can be applied by change agents across the organisation. In particular, the framework seeks to strengthen our organisational approach to **benefits realisation** by promoting a benefits-led approach, with sections on evaluation and benefits realisation woven into each stage of the project lifecycle. This approach will be embedded in the IMTP delivery programmes.

11. The **MIQPR** for May 2023 was received and is before the Board at the July meeting. The Committee noted:

    - Over 20,000 hours were lost in May, a decrease compared to the 23,000 hours lost in April. Whilst this has led to improved quality and performance for EMS, Amber 1 performance with waits of over four hours remain unacceptable and the levels of lost hours to handover delays remain so extreme that all the actions within the Trust's control cannot mitigate and offset this level of loss.
    - There is improving 111 performance but resilience into the winter and the planned SALUS implementation in November are key areas of focus.
    - Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance is stable.
    - ROSC (return of spontaneous circulation) is at 20% - the highest on record.

    Overall, the picture remains one in which the Trust can demonstrate clear improvement over things it controls, but a more mixed picture where there are system dependencies e.g. handover lost hours.

12. The Committee received a number of reports on **Emergency Preparedness, Resilience and Response (EPRR)** and were assured as to EPRR arrangements and leadership. Content included the Review of the Civil Contingencies in Wales report where the team has been working with partners, including Welsh Government, to look at the future of Civil Contingencies within Wales. The UK Resilience Framework which describes the vision the UK government has for Civil Contingencies. The report highlights the annual HART/SORT Key Performance Indictors Report. The Trust's response to the recommendations following the Manchester Arena Inquiry were also reviewed and the Committee assured that dedicated resources are applied to ensuring the 71 relevant recommendations for the Trust are incorporated into programmes of work and implemented.

13. The **Welsh Government Annual Emergency Planning Report** reports on the Trust's compliance and readiness to meet its obligations under the Civil Contingencies Act 2004. This included assurance that:

    - Emergency plans are in place for the Trust to respond effectively to incidents of different types.

- Plans are reviewed and updated to reflect lessons identified internally and by external organisations.
- Training and exercises are carried out alongside partners, including seven tabletop exercise and over 20 multiagency counter terrorism tabletop exercises over the previous year, and participation in 12 multiagency live exercises over the previous three years. Using this data, the Trust was able to assure Welsh Government that the Trust has met the required standards. It was confirmed that exercises practices are in the main consistent with actual events the Trust has been involved in but that the SORT Business Case will provide scope for more complex training scenarios. The Committee will monitor this as there is risk should the Business Case not be approved by Welsh Government.
- Processes are in place to train our commanders and refresher training has been provided at all levels of command.

The WAST Incident Response Plan remains the overarching plan to determine the Trust's response to an incident. The plan was updated in October 2022 and will be reviewed in October 2023.

The Committee thanked the operations teams for the presentation and were assured at the significant amount of work that is ongoing and the preparedness and resilience evident in the annual report.

14. The Committee reviewed the **IM&T Infrastructure Internal Audit Report,** the overall objective of which was to provide assurance over the management and operation of the WAST Information Management and Technology (IM&T) Infrastructure. The report received reasonable assurance and the Committee will monitor the eight recommendations (three high, three medium and two low). In private session the Committee reviewed the Cyber Security Internal Audit Report.

15. The Committee was presented with the **audit tracker** and noted the revised dates on some recommendations and the need to provide further updates to actions due in April, May and June. The Audit Tracker will undergo a revision over the next quarter, with a recommendation to the September Audit Committee on a revised process and format. This will include an approach to the more historical recommendation and management action plans. The Corporate Governance Team will work in partnership with Internal Audit and Audit Wales in the production of this.

16. The **Committee priorities** for 2023/24 are on track.

RISKS

Risks Discussed: There are nine principal risks within the remit of this Committee. Seven risks remained static (noting that two were not due for review until August), one score increased, and one risk was closed. The Committee were assured that the mitigating actions were appropriate, and all relevant risks had been reviewed, with members welcoming the continued evolution of the BAF and inclusion of the rationale for changes in score which illustrates the work owners and the risk team put into these reviews.

Risk 424 (prioritisation or availability of resources to deliver the Trust's IMTP) has seen an increase in the likelihood score from 12 (3x4) to 16 (4x4) given the level of risk the organisation is experiencing in the current financial climate and with no further recurrent funding agreed to deliver the Trust's

transformational plans. This score is aligned to the Trust's financial Risk 139.

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

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

Risk 594 (the Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death) remains at 15 (3x5). While the Health Boards have responded to the original letter sent from the Chief Executive highlighting this risk the responses have provided limited assurance. The Trust's civil contingency response was also discussed during the review of the EPRR annual report.

Risk 245 (failure to have sufficient capacity at an alternative site for EMS CCCs which could cause a breach of statutory business continuity regulations) has reached its target score of 8 (2x4), having reduced from 16 (4x4), in particular due to the control room solution implementation.

New Risks Identified: No new risks identified.

COMMITTEE AGENDA FOR MEETING		
Operations Quarterly Report	Financial position for month 3 2023/24	Risk Management and Corporate Risk Register
Integrated Medium Term Plan 2023-26 and post implementation review process	Monthly Integrated Quality and Performance Report	Emergency Preparedness, Resilience and Response (EPRR) Annual Report
Internal audit tracker	Policy Report	Committee Priorities

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

[1] Lee Brooks in attendance for EPRR item

	Attended
	Deputy attended
	Apologies received
	No longer member

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2023-24 Q2 (July - Sept 2023)

National Operations & Support

Challenges

Manchester Arena Inquiry Report (MAI)

Work is progressing on the 71 recommendations that the Trust has determined as relevant to WAST, with 9 recommendations completed and 17 recommendations have been assessed as needing national guidance to complete. We have agreed the reporting and governance processes for the recommendations and WAST continues to work with colleagues from the blue light services within Wales and EPRR colleagues across the UK to assess and implement the recommendations.

General Update

EPRR - Exercise Dollhouse

Exercise Dollhouse was undertaken in July with representatives from across the Trust participating. This exercise tested our response to a Manchester Arena style attack and our collaboration with multiagency colleagues using JESIP. Overall, the exercise showed that our commanders have a robust understanding of the need to deploy front line staff quickly but safely in the event of a Marauding Terrorist Attack environment to save lives and narrow the care gap identified during the MAI.

EPRR - Mass Casualty Arrangement Exercise

The EPRR team is currently working with colleagues from the Health Boards across Wales and Welsh Government to develop and deliver an exercise to test the Casualty Dispersal Plan within Wales. This exercise is intended to test the capability of the Health Boards to accept patients within the first two hours of a mass casualty incident and the arrangements in place to efficiently disperse patients from a scene post the initial 2 hours.

Volunteering

We have recruited a replacement Operations Manager for the Volunteer Car Service who will plan to increase the number of active VCS volunteers from 100 to more than 200 by the end of the year. Q2 recruitment has already improved from 4 drivers across 22/23 to 19 drivers in Q2 of 23/24.

Our Operations Manager with a focus on alternative responders was appointed in Q2 and is focussed on the new Community Welfare Responder volunteer role which is currently under development as phase one of the Connected Support Cymru project.

A grant application of £315,000 has been awarded to the volunteering team through NHS Charities Together in support of the Community Welfare Responder project. This will fund the fixed term recruitment for new Support Officer roles which will commence in Q3.

Planning is underway for two volunteer conferences including recognition for volunteers demonstrating WAST behaviours (as provided to staff at CEO roadshows) to be held in Q3 in Llandudno and Swansea, hosted by the volunteer team and supported by colleagues across the Trust.

Operational Delivery Unit

During quarter 2 we welcomed a new National Delivery Manager to the team, completing our team with no current vacancies. The ODU team continue to support the implementation of the NHS Wales System Escalation Framework. We expect to see the first iteration of the new Urgent and Emergency Care Dashboard during Quarter 3 which will complement the escalation framework and build upon the live reporting tools available to inform situational awareness and decision making across the unscheduled care system.

Resourcing & EMS Coordination

Challenges

Concerns Team Outstanding Tasks

The workload for the Operations Quality (OQ) Concerns Team remains high at 200 outstanding tasks. This is however a reduction from 283 in 2022/23 Q4. The OQ Team continues to work closely with the Putting Things Right (PTR) Team to prioritise work to meet deadlines and requests. At the time of preparing this report, all concerns outstanding are now within PTR's Tier 1 target which is positive. The demand for coroner's statements across Wales continues to remain high with 18 statements currently with OQ that require completion. The due date has lapsed for 13 of these. The team has been supported by wider Operations team colleagues to complete these statements, which has resulted in an improved position from over 40 outstanding at the end of 2022/23 Q4.

Ineffective Breathing

During a levelling exercise delivered by the International Academy of Emergency Dispatch (IAED), it was identified that there is a widespread issue relating to the compliance of audits relating to breathing problems. Auditors have been over-auditing breathing problems and marking them as non-compliant due to ineffective breathing descriptors which is now recognised to be incorrect. An report is being constructed by the Service Manager, Operations Quality (SMOQ) to share the work and learning around ineffective breathing which will go to operational and clinical governance groups; Clinical Prioritisation Assessment Software Group (CPAS), Clinical Quality Governance Group (CQGG), Senior Operations Team (SOT) and Senior Leadership Team (SLT). Additionally, reviews of the audits of over half of the outstanding 38 Nationally Reportable Incidents (NRIs) sitting with OQ are required as they relate to ineffective breathing. An approach is being worked through with PTR to ensure transparency and accuracy.

Recruitment and Retention

Recruitment and retention within EMS Coordination remains a concern with the attrition rate for the rolling 12-month period (Aug 22 to July 23) improved to 16.84% peaking in September and December 22. This attrition figure only relates to external attrition and does not account for internal moves or staff who leave their FTE position but retain a bank contract.

Significant recruitment initiatives have been implemented since September 2022 with more than 100 staff being recruited in the same period (36% of the current establishment for EMSC). Despite this, we continue to see withdrawals during the recruitment process, during induction and during training which further impacts our establishment position. Workforce plans are in place for the year based on our attrition rate, however due to the 3-month lead in time for recruitment and one month notice period for these staff groups, we are often in an under-established position.

Intentions to recruit to levels above attrition rates have not been realised due to high levels of attrition, withdrawals from cohorts and new recruits being unable to meet the appropriate

standard leading to redeployment and/or resignation. This continues to be an area of focus but remains a risk and challenge.

The inability to identify funding streams for the EMSC restructure, retention plans and increased staffing levels to meet the aggregated demand means that this recruitment and retention challenge has a significant impact on the wellbeing of staff within the EMS Coordination environment. Sickness absence in July 23 increased to 9.2% above the stable position of 8% which had been maintained since February 23. This has been driven by an increase in Long Term Sickness absence with Anxiety/Stress/Depression remaining the number one cause of sickness absence in EMSC.

IMTP

EMS Coordination Culture Programme

The EMSC Culture Programme has commenced with meetings chaired by the Director of People and Culture. Senior Leaders in the EMSC team have met with Trade Union Partners to discuss culture, behaviours, and concerns to design an action plan for improvement. As part of this work a Staff Experience agenda item has been added to the EMSC Quality Meeting which will be Chaired by the Service Manager for Operations Quality from September 23 onwards. This forum gives a platform for EMSC staff to share their experiences of working in EMSC and the challenges this presents to the Senior Leadership Team as well as other key stakeholders. The Group has heard powerful presentations from the Carmarthen EMSC Culture Champion and a North 999 Call handler and hope to have a representative from Vantage Point House at the next meeting in September 23.

General Update

IAED Accreditation

All Trust activities required for submission to the Academy for reaccreditation have been completed. The Academy has fed back that WAST is leading nationally in its submission of the required evidence. The Trust obtained ACE in Good Standing for April/May/June 2023 which is the highest achievable level and bodes the Trust well in its application for reaccreditation as an Accredited Centre of Excellence with the IAED.

SOPs Review

EMS Coordination teams have undertaken a robust review of their Standard Operating Procedures, and these are now moving through governance processes for approval. Led by the Business Support Manager, the work involved EMSC teams as well as managers and operations quality colleagues reviewing all SOPs to absorb learning and guidance previously communicated via bulletin as well as to absorb the transformational changes impacting the operations directorate including CHARU, Falls Responders, Community Welfare Responders, and Immediate Release Guidelines.

Emergency Medical Service

Challenges

Continued System Pressures

Delayed handover of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service. 33,081 hours were lost in April 2023, 20,397 in May 2023, 18,543 in June 2023, and 19,118 in July 2023. The impacts of these pressures is regularly discussed at Committee and Trust Board.

Red performance and Amber response

While handover delays have seen a degree of improvement since April 2023, this has not fully translated into improved red performance. However, while it is recognised that there have been improvements in red response ,overall the red performance falls short of 65%. Significant focus is being applied by EMS and EMS Coordination to improve the response to our sickest patients.

Since April 2023, the amber median trend has seen improved community response times to these categories of patients. This would partly be due to the slight improvement in handover delays at hospitals.

Reduced overtime allocation due to Financial Savings Plan resulting in reduced UHP

As part of the financial savings plan EMS has controlled the level of overtime allocation. Original data identified predicted UHP levels because of controls. The reduced overtime allocation commenced on 1 July 2023 and the resultant UHP levels for the month of July were extremely close to the predicted levels with abstraction variation across the 7 Health Board areas between 30% to 39%, with a Trust average of 35.62%.

IMTP

An innovative process is being considered to combine a CHARU and EA rota for interested paramedics within the rural community. This will support paramedics to undertake a dual role working in both roles to support retention and provide this level of clinical response. This process will be reviewed and could pave the way for similar working practices in other areas.

Absence Trajectory

A considerable amount of work has been done by the team in collaboration with People Services and Occupational Health to reduce the sickness absence trajectory. In December 2022 the sickness level was at 11.05% which reduced to 10.08% by March 2023 and then to 8.57% in July 2023.

It is recognised that we are not where we need to be at this stage, but a lot of effort and scrutiny continues to improve the sickness absence trajectory and abstractions generally.

Managing Sexual Safety and Improving Culture

Following the Sexism and Sexual Safety at Work Survey and WAST Voices, action plans have been implemented across the four territories to raise awareness on the subject of sexual safety, and to positively influence behaviour and culture within the Trust. Local sessions have been conducted by the Trust's Organisational Development Team with locality managers and DOMs to support them to undertake appropriate local actions.

General Update

Delivering on Financial Savings Plan

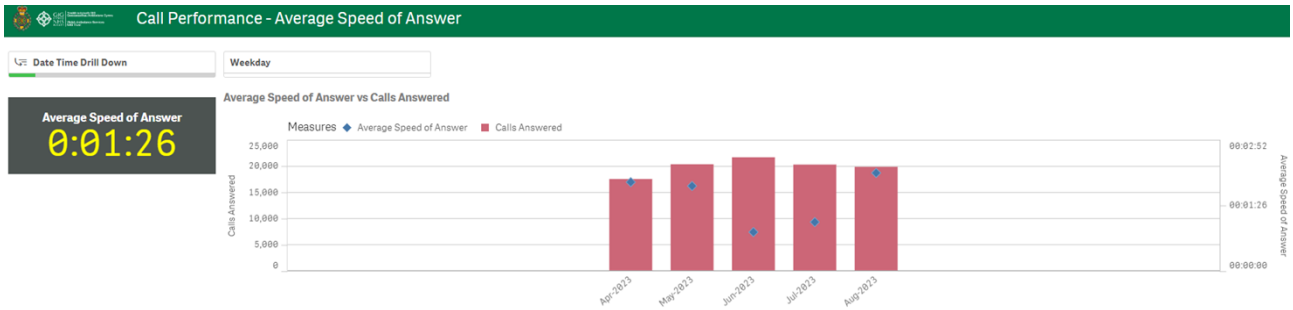
EMS continues to lead on the Operations Directorate's Financial Savings plan and are supporting the non-pay and non-patient facing pay savings. Each health board area has been allocated a daily/weekly overtime allowance that is allocated in line with demand forecasting, UHP, local events, and civil contingency requirements as examples. This is a robust process with all overtime allocated recorded in detail to support monitoring and review. As part of these plans a 'Reserve Allowance' has been established to ensure that we can meet the fluctuating demands, dips in UHP and significant events with associated risk.

Ambulance Care

Challenges

Net Centre

Call taking via the NET Centre continues to challenge. Although a really good period of stability and performance have been achieved through July and August, the small size of the national team is significantly impacted by any spikes in sickness and staff loses. August has seen a dip in performance but the national manager has been working on alternative solutions to mitigate the reductions in staff.



Demand

Demand continues to gradually move back towards pre pandemic levels but changes in health board service delivery through different journey/clinic destinations has increased demand on the resource availabilty. This has caused increases in late cancellation of journeys, in particalr in the Aneruin Bevan area where rosters need better alignment to the demand. Additionally, the focus on maintaining financial balance has restricted historic movement to costly additional provision to convey all, including ineligilbe patients.

General Update

CMP (Capacity Management Plan)

Following the introduction of the CMP to manage eligibility within Ambulance Care, the team have reviewed and implemented changes to improve the management of activity. This is allowing Ambulance Care to ensure eligible users are prioritised above ineligible. This is also enabling Ambulance Care to maintain focus on financial stability through the year. The changes were taken through the Delivery Assurance Group for information and consultation where it encompassed support and no resistance. Work continues to improve the NEPTS application of the eligibility criteria.

Vehicles development

The delivery and operational commencement of the new MAN B class Ambulances has been delayed. This was due to supplier issues but now following delivery in August WAST has been able to fit the relevant communication requirements/kit and they are now ready for service. A training plan will now be devised via the Educational and Development team and a roll out programme for both Barry and Bassaleg Station where these vehicles will be operationally based and evaluated. The evaluation will inform any future developments and procurement.

Integrated Care

Challenges

111 SALUS Operations Implementation

Despite some challenges within the wider implementation 111 operations have continued to work with colleagues across the Trust to prepare for implementation of the product. In particular, 23 new Standard Operating procedures have been developed in readiness for the commencement of train-the-trainer.

IMTP

ECNS Accreditation

All Trust activities required for submission to the Academy for Emergency Nurse Communications System Accreditation have now been completed. The Academy is undergoing due diligence in relation to the evidence we have provided in our submission. All 21 ACE points have been achieved and random audits are now being undertaken by the Academy as the final element of ratification. The Trust is aiming for Accreditation in September 2023.

111 Urgent Dental Development

During quarter two 111 operations and clinical colleagues have been heavily involved in the national review into access to urgent dental care. This work aims to expand the current dental services provided by 111 into one consistent pan-Wales model across all Health Boards. Through co-design a new model for one of the health boards for which 111 manages urgent dental access has been developed which will improve patient and staff experience and increase the number of patients booked directly into face to face care through 111. Work alongside the six goals team to develop this on a national scalable basis continues in Q3.

General Update

NHS 111 Wales Performance

During quarter two 23/24 111 have seen a sustained improvement in many areas of its service performance following work on rostering, system efficiencies and individual performance. 111 call abandonment has been below the KPI for June, July, and August both for the months and weeks. Across the quarter only 8 days have exceeded the 5% abandonment KPI and this includes the bank holidays and weekends which have historically been severely challenged. There has been similar improvement in the percentage of calls answered within 60 seconds with seven months of sustained improvement. Whilst further work is required to achieve the KPI the improvement is marked.

Time to triage performance has again seen an improving position with consistent achievement of the 90% KPI.

Police Pilot

During quarter 4 2022/23 CSD engaged in a small-scale pilot with South Wales Police within the Vale of Glamorgan. The purpose of the trial was to broaden the Remote Clinical Support offer to Police for circumstances where Officers on scene with a patient waiting for an ambulance response.

In its evaluation the report detailed that the pilot was not well utilised by police colleagues deemed partially due to the size of the geography covered and as such it has been agreed through the Joint Emergency Services Group (JESG) that CSD supports a further pilot with both South Wales and Gwent Police forces. This trial is due to commence mid-September 2023.

Connected Support Cymru

Known locally as the “Community Welfare Responder (CWR)”, this pilot has been supported by CSD since the beginning of May 2023 and to date over 313 calls attended with 173 resulting in non-conveyance. Consult and Close was 41.6% of all activity. 469 hours have been provided by CWR responses during the same period with a utilisation from 1st August-21st August utilisation being 54% (total time available v's committed to incidents). CSD will continue to support this activity into winter and continue the development of the service as it moves into phase 2 of the pilot.

Please find outlined below the current establishment with the vacancy rate for EMSC as September 2023.

Role	Funded	Total	Variance
Head of Service	1	1	0
Service Manager	3	3	0
Administrator	3	2	-1
DCM	20	20	0
Allocator	68	63.6452	-4.3548
HCP Allocator	7	3	-4
GUH Allocator	6	6	0
Dispatcher	67	59.78827	-7.21173
Call Taker	111.76	109.07306	-2.68694
CHS	18	18	0
CCC Systems Administrator	1	1	0
Total	305.76	286.50653	-19.25347

Overall vacancy rate - 6.3%
EMD's (call taker) – 1.8%
Dispatcher – 10.8%
Allocator – 11.2%

We currently have 28 either in training or planned for next few weeks with a further course of 12 now scheduled for November. This provides an additional 40 new recruits into the room over the next couple of months and before winter. There is a caveat of course that we do suffer from pre-join attrition on the journey, and we have 5 known leavers and a further 3 individuals who have secured vacancies but have yet to submit their resignations so we should be in a positive staffing position by early November. In addition, as noted in previous F&P updates, staff are only obliged to give 1 month notice and yet it takes more than 3 months to recruit, which is why we are trying to get as many staff into the centres as possible and hence the extra course in November.

We continually review and try to predict our vacancy levels, but at times the volume of staff leaving to take up positions in other departments or Health Boards outstrips our ability to recruit sufficient staff with the requisite skills.

AGENDA ITEM No	**7**
OPEN or CLOSED	**Closed**
No of ANNEXES ATTACHED	**3**

Audit Response – FSP Reporting Structure

MEETING	Finance and Performance Committee
DATE	18th September 2023
EXECUTIVE	Angela Lewis, Executive Director of People and Culture
AUTHOR	Gareth Taylor, Project Manager
CONTACT	Gareth.taylor3@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this report is to provide an overview of governance arrangements for the Financial Sustainability Programme and propose addition of an extra layer of scrutiny, via Finance and Performance Committee.

KEY ISSUES/IMPLICATIONS

Recommendation:

- In order to provide an additional layer of scrutiny and assurance, it is recommended that a progress update be provided to Finance and Performance Committee on a quarterly basis.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Appendix A: Scheme Process Map
Appendix B: Example STB Report
Appendix C: FSP Governance Group Membership

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	Yes	Financial Implications	Yes
Environmental/Sustainability	Yes	Legal Implications	NA

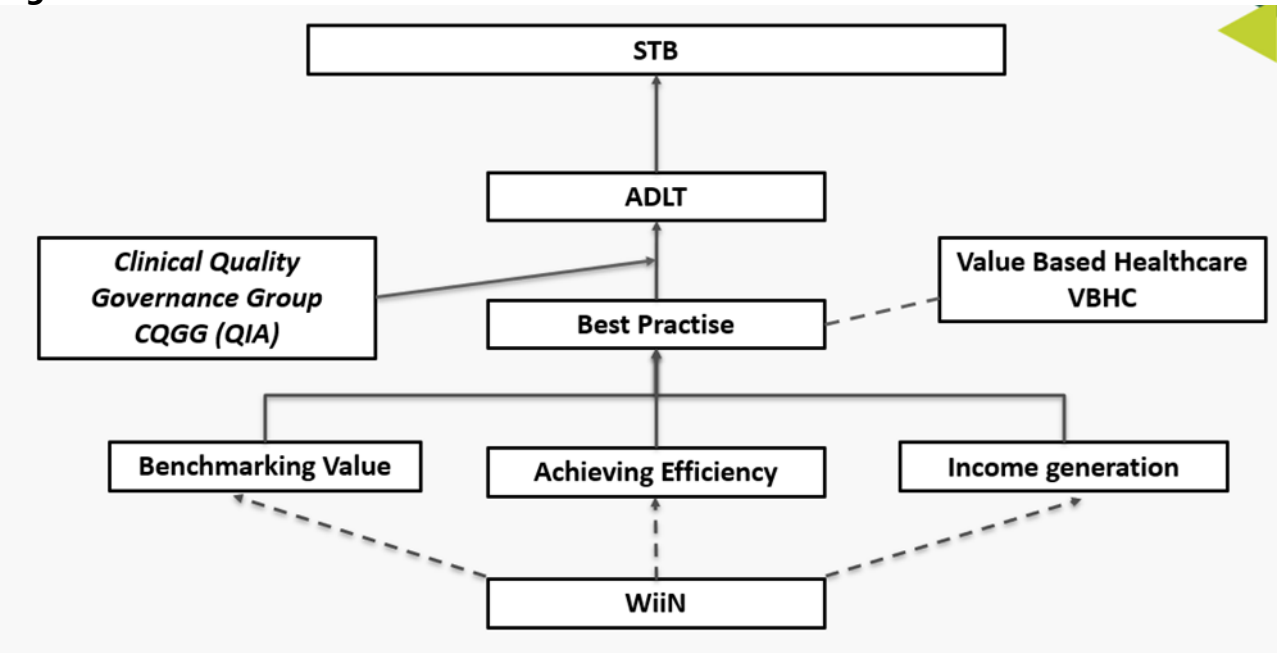
Estate	Yes	Patient Safety/Safeguarding	Yes
Ethical Matters	Yes	Risks (Inc. Reputational)	Yes
Health Improvement	NA	Socio Economic Duty	Yes
Health and Safety	NA	TU Partner Consultation	Yes

Summary

- The Financial Sustainability Programme was initially launched in May 2022 at Strategic Transformation Board, following a mandate provided by the Executive Director of Finance and Corporate Resource.

- At inception, the Programme consisted of four workstreams; Income Generation, Achieving Efficiency, Best Practise, and Benchmarking. The Governance process is outlined in **Fig. A**.

Fig. A:



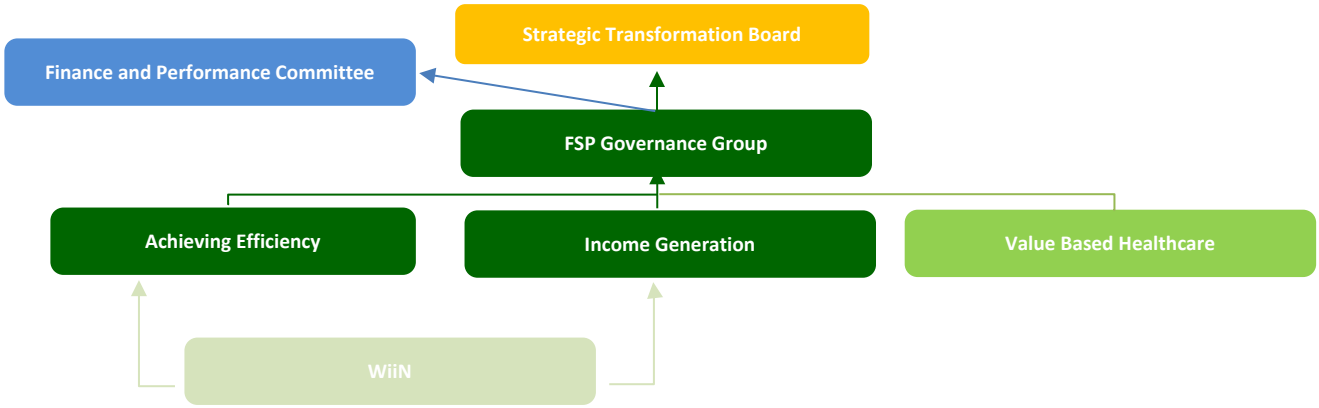
- In December 2022, the Programme underwent a structure and leadership change, in which four workstreams were condensed into two by removing Best Practise, and absorbing Benchmarking into Achieving Efficiency. The Director of People & Culture became the Senior Responsible Officer, taking over from the Executive Director of Finance and Corporate Resource.

- The resulting changes led to a proposed amendment to structure (as shown within **Fig. B**) with an overarching Programme Board. However, it was decided following discussion that the unique structure of the Financial Sustainability Programme, did not call for a formal Programme Board, instead focussing on the use of an overarching Governance Group, consisting of Executive Directors

and key stakeholders (**Fig. C**); details of membership of this group are contained within **Appendix C**.

Fig. B:

Fig. C:



- While the purpose of the Sustainability Programme was largely financial, the subsequent impact and role of the workforce in achieving the desired outcomes was the determining factor behind the change.

- Since the change, schemes have continued to be presented, scoped, discussed, and pursued if viable. Due to the range, scale, resource requirement, and impact of each scheme, an agile approach has been the desired approach. **Appendix A** displays a process map outlining the scheme scoping process implemented.

- Where applicable, a scoping exercise is undertaken for schemes proposed. This may be a detailed proposal complete with cost and risk analysis, or a shorter document that summarises evidence of risk, process of establishment, and other key information that may be relevant when determining viability.

- These documents are submitted to the relevant workstream for discussion. If the decision is to pursue, then additional documents such as a QIA or EQIA (where applicable) is completed, alongside other relevant project documentation.

- An FSP Delivery Framework is currently being re-written, with a first draft due to be circulated for comment by the end of September.

- A total of 94 schemes have been suggested as potential opportunities. Of those, around 55 schemes are in a scoping or delivery phase, while a further 34 have been rejected on viability grounds or have not yet been explored in any capacity. A further 5 are currently paused because of Industrial Action and resulting discussions.

- While most schemes aim to deliver identifiable cash-releasing savings, or income, there are schemes that aim to scope the current structures to identify future key lines of enquiry, such as the recent Administrative Review, and Service Review.

- Considering the current financial climate within the public sector in Wales, the FSP also aims to embed a foundational understanding of financial management across the organisation, upon which future financial sustainability can be achieved.

- Each scheme has a designated lead, responsible for reporting on progress, risks, issues, and timelines. This update is fed into the Income Generation and Achieving Efficiency Workstreams.

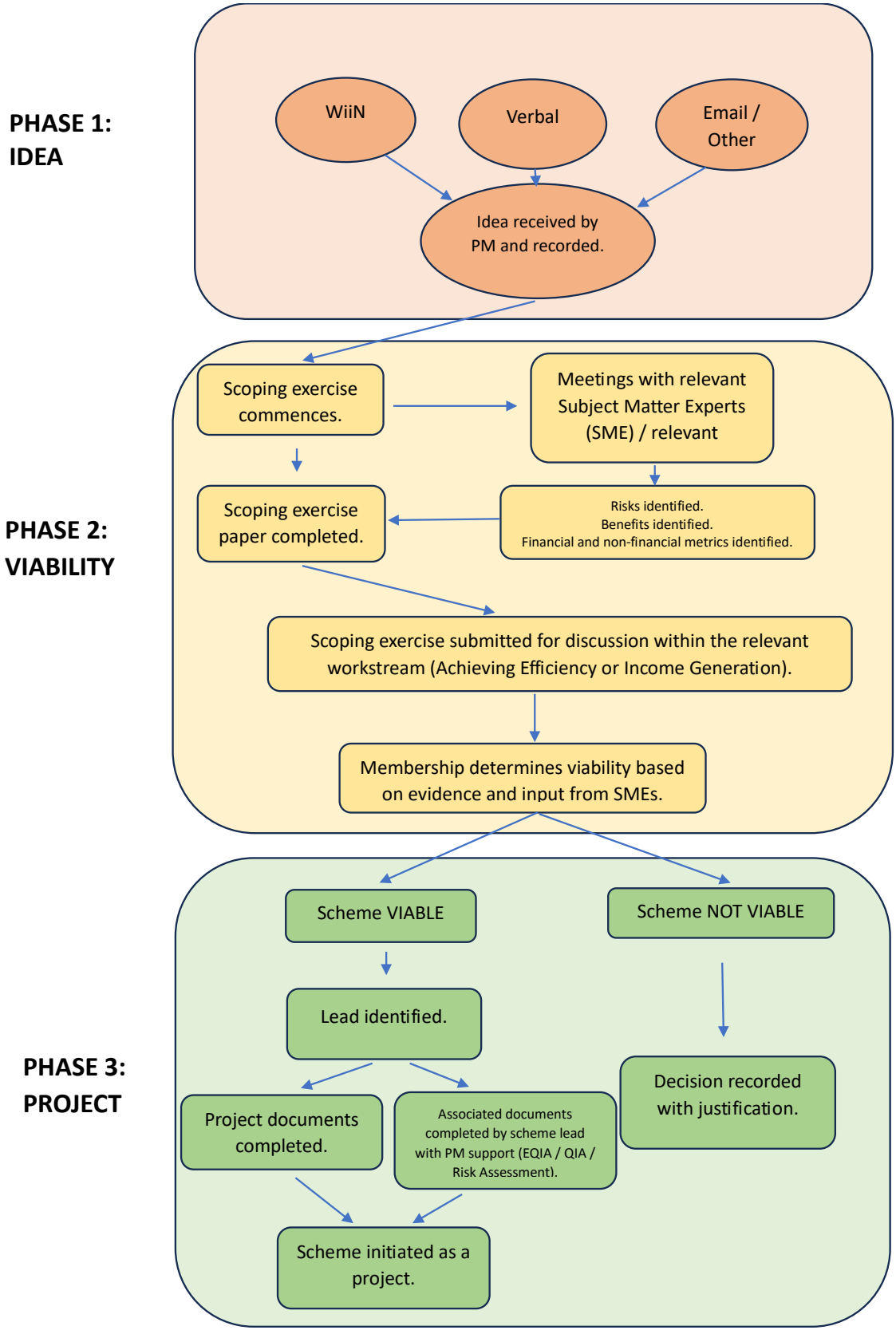
- The FSP Governance Group provides scrutiny prior to reporting into Strategic Transformation Board. The purpose of the Governance Group is to provide executive oversight and discuss threats, risks, and opportunities that may impact the long-term viability of the Financial Sustainability Programme.

- The FSP Project Manager is responsible for reporting progress upwards to the Strategic Transformation Board, via the FSP Governance Group, against the designated Quarter Milestones. **Appendix B** is an example progress report (in line with agreed template) that was submitted to Strategic Transformation Board in August 2023.

- The FSP Project Manager also provides update reports that feed into the Finance and Performance Committee, Executive Leadership Team, Assistant Director Leadership Team, and (when requested) the Academic Partnership Committee.

Recommendation: In order to provide an additional layer of scrutiny and assurance, it is recommended that a progress update be provided to Finance and Performance Committee on a quarterly basis.

Appendix A – Scheme Process Map



Appendix C: FSP Governance Group Membership

Angela Lewis – Director of People and Culture (SRO)
Chris Turley – Executive Director of Finance and Corporate Resources
Navin Kalia – Deputy Director of Finance and Corporate Resources
Liz Rogers – Deputy Director of People and Culture
Gareth Taylor – FSP Project Manager
Sarah Davies – People and Culture Directorate Business Manager

Welsh Ambulance Services NHS Trust

FSP Written Update

STB 14th August 2023

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

FSP Written Update
Version 1.0
Released: 04/08/2023

by Gareth Taylor
Gareth.taylor3@wales.nhs.uk

Content

1. FSP Highlight Report
Costs Update

2. Income Generation
Highlights, ongoing work, and next steps

3. Achieving Efficiency
Highlights, ongoing work, and next steps

4. Risks and Issues

5. Priorities for Next Reporting Period

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

STB Update

Month	Previous RAG	Current RAG	FY23/24 Target	STB Action Required	SRO:	Angela Lewis (TBC Formally)
Aug-23	-			Note the risks regarding long-term viability and strategy of the FSP, and around risk appetite.	Chair(s):	Navin Kalia, Liz Rogers
					Project Manager:	Gareth Taylor

Description	Status	Current Position	Forward View
Income Generation To explore opportunities for income generation across WAST		1. Four workstreams being pursued with identifiable income of approximately £1.1m that are likely to be delivered in FY23/24. These include expenditure reviews, sale of clinical equipment (£225,000), interest receivable (£500,000), and VAT rebates 2. Income from External call handling minimal, but being monitored and recorded. 3. Schemes currently being scoped include the sale of estate surplus to requirements 4. Schemes scoped and deemed not viable recently include leasing WAST estate to Ionity, Event Medical Cover, and Ambulance Advertising. 5. Commercial Directorate/ Resource Paper to be re-written following updates, and commercial training to be explored. 6. There are two schemes currently being actively scoped, which includes NEPTS contracts over the border, and marketing our Quality Exemplar. Subject to comment from Ops SLT. To be discussed at STB 18th September 7. Balanced financial plan presented following submission of Operation Financial Savings Group schemes. Financial Leads working with Heads of Service to ensure delivery of targeted savings, however subject to volatility and subsequent impact on other parts of the service. (e.g. overtime)	1. Additional income generation schemes currently being explored / scoped over the next on over the next reporting period will include scoping the sale of potential estate deemed surplus to requirements, the 108 EMS Service (India). 2. Schemes that have undergone scoping in the last reporting period and continue to be explored (NEPTS Tenders) will continue to follow the relevant approval route, to collate feedback ahead of STB 18th September 3. Alignment of FSW with ongoing programmes of work continues, with Fleet representation providing updates on the Merthyr Workshop Programme, and NEPTS Providers work; Digital feeding into the Achieving Efficiency Group on Robotics, and data from Ops around the Intelligent Routing Platform being fed into the Income Generation meetings on a regular basis. 4. Continue approximate estimates for unidentified income generation schemes where viable.
Achieving Efficiency To explore and pursue opportunities for cost avoidance, or efficiency savings across WAST		1. Balanced financial plan presented following submission of Operation Financial Savings Group schemes. Financial Leads working with Heads of Service to ensure delivery of targeted savings, however subject to volatility and subsequent impact on other parts of the service. (e.g. overtime). 2. NEPTS Plurality savings integrated into BAU 3. Fleet warranty scheme integrated into BAU from 2026/27. 4. Fleet Efficiencies paper to be redrafted 5. Support Service Review completed in July. Draft provided to SRO, and to be presented to EMT in August. Recommendations refer to continued emphasis on automation, and administrative streamlining. 6. Continued scoping around proposed ideas / schemes that come via WiiN or other avenues.	1. Alignment with the Operational Savings Group critical to delivery of balanced financial plan for 23/24. 2. Robotics lead identified, and proposal on next steps to be completed following presentation of Administrative Review to EMT. 3. The FSP is aware of the ongoing work to identify further savings following the Welsh Government's request, and will work to align and support.

Risks and Issues

Title	Description	Mitigation / Actions
QIA Management of Clinical Risk	Current short-form QIAs limit assessment of overall clinical/patient impact of financial sustainability	Advice sought from JTR / CM. Overall FSP QIA being drafted
Commercial Attitudes	Developing commercial mindsets critical to success, as outlined in IMTP	Commercial Training / Commercial Directorate
Long-term goal of FSP	Transformative Savings required	STB Workshop 18th September
Resource	Programme investment / administrative shortages	STB Workshop 18th September

Financial Sustainability Programme

Report Month:	Current RAG	Previous RAG	STB Action Required		
Aug-23	Exceeding Financial Forecast	New FY23/24 Reporting Cycle	FSP Workshop to be held at STB 18th September.	SRO:	Angela Lewis
				Project Manager:	Gareth Taylor

Workstream	Q1 Key Milestones		RAG	Narrative
Income Generation	Commercial and Efficiency Mindsets - Scope potential structure for delivery and oversight of commercial opportunities on behalf of WAST.	1) Develop SBAR outlining the options, risk, and benefits associated with a dedicated commercial opportunities oversight structure 2) Take SBAR through ADLT and STB for comment and approval	R	SBAR requires further updating due to time delay. Work to be expanded to tie in with IMTP priority around embedding commercial mindsights and improved financial management and understanding.
	NEPTS Tenders	1) Complete scoping and benchmarking of available tenders 2) Undertake initial market research on providers, delivery models, and cost analysis 3) Draft baseline service delivery bid and attach costings 4) Determine financial viability of scheme based on data	A	1) Complete 2) Incomplete – collaboration with 365 on market research following feedback via appropriate governance routes. 3) Complete 4) Incomplete – further data required, which will be added following initial feedback.
	NEPTS Quality Exemplar	1) Undertake Market Research including copyright opportunities/requirements 2) Assess viability and produce viability plan	A	1) Complete 2) Incomplete - change in Ambulance Care structure, uncertainty over lead potential moving forward
Achieving Efficiency	Support Services Review (Administrative Review)	1) Establish project team and approve review Terms of Reference 2) Commence directorate meetings to confirm and review structures (c. 6-weeks) 3) Develop recommendation report; commence Q1, due by August 1st	G	Complete – Project Lead submitted Report. Awaiting final comments from Executive Director of Finance and Corporate Resource prior to submission to EMT.
	Services Review	1) Develop and approve Terms of Reference, and identify project lead * Likely to commence in July following completion of the Support Services Review	G	Complete – Lead identified, and project plan currently being developed.
	Robotics	1) Confirm consultancy allocation – RPA development capacity for FY23/24 2) Confirm internal project lead 3) Develop plan to identify RPA opportunities aligned with the Support Service review	G/A	1) Incomplete - ongoing. Assistant DoD compiling business case and proposal to follow recommendations from Support Service Review. 2) Complete 3) Complete as per 1)
	Terms and Conditions Alignments	1) Collate current spend data 2) Generate spend SBAR in conjunction with RTC and RTI / Staff welfare data 3) Scope investment opportunities for greater data collection 4) Submit SBAR for approval through Fleet Managers Meeting 5) Submit SBAR for approval and feedback to Fleet SOP	G	1) Complete 2) Complete (although request to be split out) 3) Incomplete 4) Complete - approved 5) Complete - rejected by Operations. Further amendments to made to the paper in Q2.

Costs Update – Month 3*

*Month 4 currently being finalised

Savings Tracker – Month 3

RED – Below forecast target and off-track

Amber – Below or meeting forecast target but on-track

Green – Exceeding forecast target

Grey – not yet commenced

	Annual	In Month			Cumulative			Forecast			RAG
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	
Accident Repair	20	0	0	0	0	0	0	20	20	0	
Acting Up Allowances	11	0	0	0	0	0	0	11	11	0	
Apprentice Income	350	29	4	-25	89	26	-63	350	287	-63	
Asset Disposal (Defib)	225	0	0	0	0	0	0	225	225	0	
Balance Sheet support	200	20	20	0	20	20	0	200	200	0	
CSD - ECNS Non Pay	20	2	0	-2	4	0	-4	20	0	-20	
Decarb	2	0	0	0	0	0	0	2	2	0	
End of Shift Overrun	30	3	23	21	5	37	32	30	61	32	
Fuel (forecourt price saving against	306	30	69	39	116	167	51	306	357	51	
Fuel (swip, chip & pin and reduction	33	0	0	0	0	0	0	33	33	0	
FYE of 22/23 VERS	66	2	2	0	2	2	0	66	66	0	
Intelligence Routine Platform	100	0	0	0	0	5	5	100	100	0	
Interest Receivable	500	75	90	15	225	271	46	500	894	394	
MS Office VAT Rebate	250	0	0	0	0	0	0	250	250	0	
Net - Vacancy Management (111 EA	27	13	13	0	27	27	0	27	27	0	
Net - Vacancy Management (CSD an	120	40	40	0	80	78	-2	120	118	-2	
Non Pay Local Schemes	530	51	38	-13	166	197	31	530	462	-68	
Other local schemes - Non Pay (Trav	26	2	0	-2	5	0	-5	26	21	-5	
Overtime	254	0	0	0	0	0	0	254	254	0	
Private Providers	250	21	21	0	63	63	0	250	250	0	
Reduction in variable pay	38	3	3	0	7	7	0	38	38	0	
Stock Control (MSE etc)	50	3	3	0	3	3	0	50	50	0	
Taxi Review	50	4	4	0	7	7	0	50	50	0	
Vacancy Management	2,275	225	210	-15	834	834	0	2,275	1,953	-322	
Vacancy Management (non frontlin	51	26	29	4	51	55	4	51	55	4	
Vacancy Management (non frontlin	151	5	5	0	14	14	0	151	151	0	
Volunteer Car Drivers	66	5	5	0	7	7	0	66	66	0	
Totals	**6,000**	**558**	**578**	**20**	**1,725**	**1,819**	**95**	**6,000**	**6,000**	**0**	

Highlights – Income Generation

- Recent Income Generation schemes scoped include IONITY Charging Units. Scoping paper completed and returned to Jason Killens 27th June, and decision followed not to pursue. Potential opportunity to allow staff use of charging units, however complications remain around on-site regulations. To be scoped further.

- Further schemes currently proposed and yet to be scoped or are undergoing scoping include
  - The potential sale of estate surplus to requirement (conversations with NWSSP ongoing around legal complexities, and meeting required with Ops around potential uses)
  - 108 EMS Service. A contracted opportunity with the Government of India in partnership with SCAS and LAS. Details continue to emerge. Scheme in very early stage.

- Paper drafted on progress of NEPTS Tender Bids as of 23/06/2023, and feedback received. Meeting 7th August to discuss feedback pathway, and paper due to be added to Ambulance Care Business Meeting 23rd August ahead of STB 18th September. Appropriate governance route currently being identified.

- Decision on Commercial Directorate / Subsidiary yet to be made due to amendments to paper required. Paper to be presented at STB FSP Workshop on the 18th September.

- Income Generation Update paper requested by Academic Partnership Committee. Submitted Friday 4th.

Highlights – Achieving Efficiency

- Operational Financial Savings Group have earmarked £2m which will close the unidentified savings gap within the 23/24 Financial Plan, however yet to be delivered. Based largely on Overtime which is subject to significant volatility.

- Robotics Lead identified (Jon Whitehead), however concerns around requirement of Business Case to request further resource funding following Achieving Efficiency 24th July. Leanne currently drafting Business Case, as well as proposal to coincide with recommendations from the Support Service Review. Meeting with Jon and Leanne to confirm details to be arranged imminently.

- Fleet Efficiencies Paper presented at Fleet SOT 26th June following Fleet Management 21st May. Further feedback received, and amendments to be made ahead of submission to Fleet SOT.

- Fuel Savings T&F Group yet to commence due to A/L

- Administrative Review completed and presented to SRO by JW. Due to be presented to EMT in August 2023.

- Service Review to commence imminently, led by James Haley. Meeting 8th August to begin draft project plan.

Risks & Issues

Risks and Issues		
Title	Description	Mitigation / Actions
QIA Management of Clinical Risk	Current short-form QIAs limit assessment of overall clinical/patient impact of financial sustainability	Full QIA currently being completed
Commercial Attitudes	Developing commercial mindsets critical to success, as outlined in IMTP	Commercial Training approaches and reinforcing the need for commercial resource
Long-term goal of FSP	Transformative Savings required	STB Workshop 18th September
Resource	Programme investment / administrative shortages	STB Workshop 18th September
Time	Long-term programmes such as the commercial directorate, will not be established within the current financial year	
Volatility	The income generated by VAT and Interest schemes are entirely dependent on market volatility.	Continuous monitoring and reporting.
WG Funding	Some asset sales are dependent on additional funding from Welsh Government to replace current equipment.	Target lowered pending confirmation of funding

Next Steps

Priorities

- Develop an agenda for the FSP Workshop at STB 18th September
- Complete the FSP QIA and submit to CQGG
- Complete an FSP Guidance Document, Delivery Framework, and associated principles
- Initiate Fuel Savings Task Group
- Support Project Lead in the development of the Service Review project plan
- Complete scoping work around potential sale of WAST site and feed back to Jason Killens.
- Gather more information regarding 108 EMS service and begin scoping exercise.
- Complete appropriate EQIAs

AGENDA ITEM No	**8**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Finance & Performance Committee
DATE	18th September 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 8 risks that are relevant to Committee's remit for oversight and additionally the Trust's 2 highest scoring risks which are assigned to the Quality, Safety & Patient Experience Committee (QuEST) for oversight.

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

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

4. The principal risks were presented to the Trust Board on 27th July 2023 and are updated as at 1st September 2023. Each principal risk has been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3. Focus has been given to the risk ratings and the mitigating actions identified and taken to ensure risks achieve their target score. This is in addition to the review of controls, assurances, and any gaps.

5. Specific updates made in respect of actions, controls and assurances are highlighted in blue on the BAF.

RECOMMENDATION:

6. **Members are asked to consider the contents of the report.**

KEY ISSUES/IMPLICATIONS
7. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
8. The BAF was considered by: • ADLT (14 August 2023) • EMT (30 August 2023)

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

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

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** →
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	Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage		
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	**16 (4x4)** →
458 FPC	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	**IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis **THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed	Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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 **RESULTING IN** a partial or total interruption in WAST's effective ability to deliver essential services	Director of Digital Services	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004	Director of Operations	**15 (3x5)** →
100 FPC	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	**IF** WAST fails to persuade EASC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered	Director of Strategy Planning & Performance	**12 (3x4)** →
283 FPC	Failure to implement the EMS Operational Transformation Programme	**IF** there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme **THEN** there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters	Director of Strategy Planning & Performance	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		RESULTING IN potential patient harm, deterioration in staff wellbeing and reputational damage		

Annex 2 - Risk Scoring Matrix

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

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

Annex 3 - Frequency of Risk Review

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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/08/2023	TREND	25 (5x5)
		Date of Next Review:	08/09/2023	➡	

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

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

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

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

Risk Commentary Q2 2023/24

The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death as a result of the Trust not being able to reach patients in the community.

There were over 28,000 hours lost outside EDs in March 2023, a comparable figure to the pre Christmas delays. Whilst there has been improvement in some Health Board areas (Cardiff and Vale where there has been a corresponding improvement in red performance), other Health Board continue to experience protracted delays. The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes and extended recovery times. Delays across the system continue to be the main focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. **Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.**

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

a) Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E)
b) Consideration of additional WAST schemes to support risk mitigation through winter (I)
c) NHS Wales 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)

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Regional Escalation Protocol	1. Daily conference calls to agree RE levels in conjunction with Health Boards
2. Immediate release protocol	2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)
3. Resource Escalation Action Plan (REAP)	3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure.
4. 24/7 Operational Delivery Unit (ODU)	4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
5. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans	5. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
6. Limited Alternative Care Pathways in place	6. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
7. Consult and Close (previously Hear and Treat)	7. 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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/08/2023	TREND	25 (5x5)
		Date of Next Review:	08/09/2023		

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

	performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information Management Internal Audit report February 2022 (External Assurance). Consult and Close rate has increased from 12% to circa 15% March 2023.
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	8. 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. APP Navigation – Test of Change Framework (Swansea Bay & Hywel Dda). Review of despatch criteria for APPs. EMT have agreed to offer contracts to the 22 APPs who are about to complete their Masters programme. This will take our APP headcount to 88.7FTE. An investment proposal has been submitted to Welsh Government AHP in primary and community care pot. I think that there is low expectation that the bid will be successful. We are currently workforce planning to increase our APP headcount by 40 per year.
9. Clinical Safety Plan	9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group
10. Recruitment and deployment of CFRs	10. Volunteers are another resource for response, Volunteer
11. ETA scripting	11. 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
12. Clinical Contact Centre (CCC) emergency rule	12. CCC Emergency Rule is policy that has been signed off by Execs.
13. National Risk Huddle	13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
14.	14.
15. Summer/Winter initiatives	15. Monitoring through SLT and STB
16. CHARU implementation	16. Monitored via the EMS project Board
17. National Transfer & Discharge Model	17.
18. Conveyance Reduction	18. This is part of the weekly performance review and aligned to Care Closer to Home Programme
19. Access to Same Day Emergency Care (SDEC) for paramedic referrals	19. This forms part of the handover improvement plans in place with Health Boards, however assurance is limited given that the acceptance of paramedic referrals is low (less than 1%) and inconsistent.
20. Mental Health Practitioners in cars	20.
21. Roll out of ECNS	21. Reported through QuEST
22. Clinical Model and clinical review of code sets	22. Reported through QuEST
23. Remote Clinical Support Strategy	23. Strategic Transformation Board – IMTP deliverable
24. 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)	24. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)
25. Information sharing	25. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
26. Completed EMS Roster Review	26. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner
27. Work underway to reduce the number of multiple attendances dispatched to red calls	27. This will increase vehicle availability generally across the Trust

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/08/2023	TREND	25 (5x5)
		Date of Next Review:	08/09/2023	➡	

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

28. Transfer of Care	28. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief
29. New 2023 EMS Demand and Capacity (roster) review	29. **To commence in order to ensure we continue to match capacity and demand to our best ability**
30. Connected Support Cymru – an innovative approach to supporting patients to remain at home with clinically appropriate support mechanisms, thus avoiding admission to hospital where appropriate.	30. **Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform and a Community Welfare Responder model to enhance community resilience.**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards
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.	
8. During industrial action days, Health Boards demonstrated compliance with reducing handover delays in order to maximise WAST resources. Despite a reduced volume of conveyance as a result of the industrial action, there is however a demonstration that reduced handover delays are achievable, and this therefore warrants a triangulation of data.	
9. 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.	
10. 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	
11.	
12. Handover Improvement Plans agreed between WAST and Health Boards	12. Handover Improvement Plans have been replaced by Integrated Commissioning Action Plans (ICAPS) and are subject to review with EASC; However, it is noted that previous plans did not demonstrate sufficient improvement in reducing handover delays
18. National Transfer & Discharge Model	18. National Transfer & Discharge model is yet to be determined. A task and finish has been established to progress this piece of work
21. Mental Health Practitioners	21. Mental Health Practitioners – not yet implemented but part of the Care Closer to Home workstream
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	08/08/2023	TREND	25 (5x5)
		Date of Next Review:	08/09/2023	➡	

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters	Assistant Director of Operations EMS	Complete	Majority of EMS rosters complete and implemented
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]	Director of Paramedicine / Director of People & Culture	**30.07.23 Checkpoint**	Offers to 22 in July 2023. 13.33 FTE uplift. Continue to seek opportunities for funding APPs to improve service delivery.
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	31.03.23 Complete	Work undertaken to map influences and progress towards each. Current % of Consult and Close increased from 12% to 15% at March 2023.
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	Complete 21.03.23	Additional CFR Trainers and Operations Assistants appointed to support recruitment and training of new CFRs. Volunteer Management Team, supported by the Volunteer Steering Group, now embarking on volunteer recruitment programme and increasing public engagement to raise awareness about volunteering opportunities available within WAST. Volunteer team has recruited and trained 173 additional volunteers between November and March 2023.
10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]		Superseded	
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	Ended March 2023	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT.

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:	03/08/2023	TREND	25 (5x5)
		Date of Next Review:	11/09/2023	➡	

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

Risk Commentary Q1 2023/24

The risk score remains constant at 25 for quarter 1 2023/24 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. There were over **1,440** +4 hour patient handover delays in **June 2023**; the target being 0 from September 2022 has now moved to the end of 2023/24. **In June 2023, over 18,000 hours were lost to hospital handover, equivalent to 21% of the Trust's conveying capacity.** The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes and extended recovery times. Delays across the system continue to be the main focus of patient safety incidents, complaints, coronial enquires and redress / claims. **The Trust received two Prevention of Future Death Reports (Regulation 28) from HM Coroner in North Wales in June 2023, both citing concerns regarding system delays and one case related specifically to the patient being significantly delayed outside of the hospital on arrival.**

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

Improvement actions led by Welsh Government and system partners include:

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

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

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:	03/08/2023	TREND	25 (5x5)
		Date of Next Review:	11/09/2023		

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

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

5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership. WAST membership at system workshops supported by Commissioners looking at handover of care delays which includes the implementation of the Fit2Sit programme and handover of care checklist pan NHS Wales. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours.	5. Monthly Integrated Quality and Performance Report
6. Hospital Ambulance Liaison Officer (HALO) (Some Health Boards).	6.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP). Proactive and forward-looking weekly review of predicted capacity and forecast demand. Deployment of predetermined actions dependant on assessed level of pressure. Consideration of any bespoke response/actions plans in the light of what is expected in the coming week. WAST has updated the REAP in advance of winter, including revised triggers (higher) for handover lost hours.	7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation is via the Strategic Command structure.
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process **and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST**
9. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays.	9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.	10. Shift reports from ODU & ODU Dashboard received by EMT, SOT and On-Call Team at start/end.
11. Escalation forums to discuss reducing and mitigating system pressures.	11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.	12. Monthly Integrated Quality and Performance Report (**June 2023 overall 77%** - Safeguarding and dementia over 90%.
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time 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 including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board July 2023 and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

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:	03/08/2023	TREND	25 (5x5)
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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

16. Implementation of Duty of Quality, Duty of Candour and new Quality Standards requirements in April 2023.	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of July 2023 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candour Implementation Group and is actively engaged in developing resources.
	External Sources of Assurance Management (1st Line of Assurance)
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures.	1.
2.	2. Implementation of the revised Joint Investigation process remains in pilot stage with good engagement seen by system partners. A number of overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has **25** overdue nationally reportable incident investigations. **Shared system learning from the Joint Investigation Framework is currently limited.**
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales*.	3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. In **June 2023**, **18,000** hours were lost with **1,440 +4 hour** delayed patient handovers.
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*.	4. Strengthening of patient safety reports and audit processes as e PCR system embeds.
5.	5.
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. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.
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

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:	03/08/2023	TREND	25 (5x5)
		Date of Next Review:	11/09/2023	➡	

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• TBC - Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	• Q4 2023/24	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available. Work on-going with Health Informatics regarding patient safety and health board dashboards.
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Q4 2023/24	• Bid not successful. However, Trust decision to proceed with 18 MSC places. • **RAG status reframed around the new timelines /programme.** • **22 trainee APPs expected to complete training in Jun-23.** • **EMT has agreed to offer places to these 22 trainee APPs funded from a reduction in technician posts 1/2s i.e. internal movement.** • **The Trust submitted a national bid to support APP expansion as part of the £5million additional Welsh Government funding for AHP expansion in Primary & Community Care.** • **In June-23 the Trust were informed that the bid was not successful. The funding had been allocated to health boards based on the initial funding allocation specified by Welsh Government. WAST is involved with two health board bids in BCU and C&V which require the Trust to support for delivery.**
5. Overnight falls service extension	Executive Director of Quality & Nursing	• **June 2023**	• Night Car Scheme extension agreed to 31 March **2024** (2 regional resources) • **Nighttime falls assistance 64% Utilisation (Apr 2023 -Jun 2023)** • **Day resources progress continuing toward 60% utilisation target. April – June responded to 1,845 incidents an 18% increase on same period 2022.** • **Falls level 1 and 2 impact evaluation report completed - and presented to Clinical Quality Governance Group (CQGG) Jan 2023.** • **Optima modelling underway to examine optimal resourcing level. The has been delayed due to prioritisation of Executive requests.**
6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded.	Executive Director of Quality & Nursing	• Q3 2023/24	• Monthly updates to progress against actions following the baseline assessment and readiness returns. • **RL Datix Dashboards and KPIs under development nationally.** • Key policies updated and approved. • **National Policy on Patient Safety Incident Reporting & Management adopted in June 2023.** • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly. • Quality Management System workshop to be held 12 June 2023.
7. Virtual Ward now Connected Support Cymru	Executive Director of Quality & Nursing	• Q**3** 2023/24	• **Service live.** • **Currently identifying a 48% EA avoidance rate.** • **Staff absence and roster gaps in SJA (provider) an issue currently.** • **Funding also obtained to support the capacity to recruit volunteers (600 in total).**
8. Organisational change process of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	• Q**3** 2023/24	• Informal consultation phase commenced May 2023.

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:	03/08/2023	TREND	25 (5x5)
		Date of Next Review:	11/09/2023		

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

9. Connect with All Wales Tissue Viability Network to explore strengthening the current investigations into harm from pressure damage across the whole patient pathway.	Assistant Director Quality & Nursing	• Q2 2023/24	• Meeting planned August 2023 with the Chair of the TVN Network.
10. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	CEO	• Q4 2023/24	• Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital; access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Expected outcomes in 2023/24.
11. Internal Audit to undertake a review of Serious Adverse Incidents & Joint Investigation Framework	**Executive Director of Quality & Nursing**	• **Q3 2023/24**	• **Terms of reference drafted.**
Completed Actions	**Action Owner**	**When /Milestone**	**Progress Notes:**
1. 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	Completed	
2. Representation at the Right care, right place, first time Six Goals for Urgent and Emergency Care Delivery Boards and Clinical Advisory Board.	Chief Executive Officer	Completed	• 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 • WAST will be represented on the Clinical Reference Group by Andy Swinburn with first meeting now held. • The Trust recently reported to EASC that is has further updated how it maps into six goals programmes. The programme structure nationally is being embedded and the Trust now has presence on goals 2, 5 & 6 at delivery board level and on the clinical advisory board.
3. Participation in the CASC led workshop to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019.	Executive Director of Quality & Nursing	Completed	• Revised joint investigation approach agreed and now formalised.
4. Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation	Director of People & Culture	Completed	• Strong focus from Executives with detailed updates to EMT every two weeks. • Year-end position is +85 FTEs, with a vacancy factor of just 1%, rather than the often used 5%, which would produce a figure of -88 FTEs rather than the estimated - 15 FTEs. • Further non recurrent funding has been secured for 2023/24
5. Transition Plan	Chief Executive Officer	Completed	• Action complete, but the Trust will continue to undertake strategic and technical workforce planning in support of the Trust's ambition e.g. inverting the triangle etc.
6. Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	Completed	• Winter ended. Focus now on forecasting and modelling for the summer, but Trust not aiming to produce specific Summer Plan (the Trust did during the pandemic linked to travel restrictions). • The Trust needs to determine whether there is value in producing a specific winter plan, particularly, within the context of the financial constraints NHS Wales is not operating in.
7. National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	Completed	• The national awareness campaign was undertaken as planned and ended in March 2023. An evaluation will be provided to the 111 Board.

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	31/07/2023	TREND	16 (4x4)
		Date of Next Review:	31/08/2023		

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

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

EXECUTIVE OWNER	Executive 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.
	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.

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	31/07/2023	TREND	16 (4x4)
		Date of Next Review:	31/08/2023		

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/24 – Checkpoint Date	22/23 Finances have been agreed as part of year end agreement of balances. Issue currently around the 100 WTE £6m funding and negotiations continue.
2. Embed a transformative savings plan and ensure organisational buy in	ADLT and Savings subgroup	31/03/24 – Checkpoint Date	The Financial Sustainability workstreams that were launched in May 2023 have now been rebranded as the Financial Sustainability Program (FSP) and the work of the program underpins the need of the organisation to deliver transformative savings via the Achieving Efficiencies and Income Generation subgroups.
3. Embed value-based healthcare working through the organisation	Executive Management Team and Value Based Healthcare Group	31/03/24 – Checkpoint Date	Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.
4. WIIN support for procurement, savings and efficiencies	WAST Improvement and Innovation Network group	31/03/24 – Checkpoint Date	WIIN ideas are regularly communicated across to the Achieving Efficiencies subgroup of the FSP.
5. Foundational economy, Decommissioning and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/24 – Checkpoint Date	The organisation utilises the NWSSP Shared Services Procurement framework to ensure contracts tendered provide best vfm while ensuring criteria within the tender docs ask bidders to highlight their ability to serve the aims of FE, Decommissioning, Decarbonisation and social as well as the economic wellbeing of Wales.

Risk ID 424	Resource availability (capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	11/08/2023	TREND	16 (4x4)
		Date of Next Review:	11/09/2023	➡	

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

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

IMTP Deliverable Numbers: 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
8. Financial Sustainability Programme – savings and income work streams	8. FSP programme highlight reports
	Independent Assurance (3rd Line of Assurance) 2. Subject to Internal Audit

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Project and programme management (PPM) framework to be reviewed	1. PPM needs to be reviewed and approved through STB
~~2.~~	2. Benefits have not been fully linked to benefits realisation
3. Lack of a commercial contractual relationship with Commissioners (link to risk 458)	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Recruit a Head of Transformation	Assistant Director of Planning	30.09.22 complete	Recruited 02.08.22 in post on 01.11.22
2. Review the PPM	Head of Transformation	Extended from 31.03.23 – To 31.06.23 and then to 30.09.23 in line with milestone for delivery	Currently (January 2023) working through delivery structures for 2023-26 which will inform the PPM review – changed checkpoint date to 31.06.23. Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3. **Planning Framework approved by STB on 04.07.2023 which sets out the Project Path framework at a high level.**
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. Further extend to 31.06.23 and then to 30.09.23 in line with milestone for delivery	Reviewed action and extended checkpoint date further as approach being developed for next iteration of IMTP. Work ongoing. Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3 as part of Project Path Framework.
4. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)	Director of Finance	31.12.22 – checkpoint date 31.06.23 and then to 30.09.23	Extend checkpoint date to 31.03.2023 on basis of new financial allocations for 2023 to be worked through with Commissioner

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:	08/08/2023	TREND	16 (4x4)
		Date of Next Review:	08/09/2023	➡	

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

	Likelihood	Consequence	Score
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 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.	Executive Management Team	31.12.23	Update: 22/23 Recurrent & non-recurrent Finances have been agreed as part of year end agreement of balances. Issue currently around the 100 WTE £6m funding and negotiations continue. **Recent letter from Commissioners indicates funding will be forthcoming however with conditions.**
5. 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	31.12.23	Update: Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Date of Review:	04/08/2023	TREND	15 (3x5)
		Date of Next Review:	08/09/2023		

IF	THEN	RESULTING IN
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

	Likelihood	Consequence	Score
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. **04/08/23 – Exploring procurement of additional penetration tests with the aim of annual testing of all critical systems.**
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
	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
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. **04/08/23 – Monthly KPI reports now being generated routinely and fed into the Digital Leadership Group. Needs to transfer to assurance – no longer gap?**
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. **04/08/23 – Latest campaign commenced 01/08/23 to raise staff awareness. Needs to transfer to assurance – no longer gap?**
3. No organisational information security management system in place	

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:	04/08/2023	TREND	15 (3x5)
		Date of Next Review:	08/09/2023	➡	

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

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

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	31.03.23 complete	KPI format agreed and will be produced from Q1 2023-24 with a retrospective annual report produced for 2022-23.
2. Discuss how cyber risk is reviewed and frequency of review	Director of Digital Services	28.10.22 Close – now Business as Usual	a. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources. b. The corporate cyber risk assessment will be reviewed monthly at the Digital Leadership Group informed by the threat and intelligence monitoring and national strategic trends.
3. Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	28.10.22 Complete	The Trust has run two exercise Joshua & Joshua 2 to test departments readiness
4. Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 - Ongoing	Exercise reports being drafted.
5. Formalise Cyber Incident Response Plan	Head of ICT	30.06.23 – complete Checkpoint Date 31.12.2023	Cyber Incident Response Plan adopted, and CRU Assessment conducted during May 2023 with report expected by end June 2023. Review of CRU Cyber assessment and development of action plan in response to any recommendations.
6. Implement Meta Compliance Policy Solution	Senior ICT Security Specialist	**30.06.23 – Checkpoint Date**	Additional learning modules purchased, and both will be rolled out from Q1 2023-24. **04/08/23 – Latest campaign commenced 01/08/23 to raise staff awareness.**

Risk ID 543	Major disruptive incident resulting in a loss of critical IT systems	Date of Review:	08/08/2023	TREND	15 (3x5)
		Date of Next Review:	08/09/2023		

IF there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems	THEN there is a risk of a loss of critical IT systems	RESULTING IN a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

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

IMTP Deliverable Numbers: TBC

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

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	31.12.22 extend to 30.06.23 now complete	Suite of exercise available via BC teams channel.
2. Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 extend to 30.06.23 now complete	Joshua and Joshua 2 reports produced and circulated.
3. Cyber Essentials assessment to be completed	Head of ICT	30.06.23 **Extend to 31.12.23**	Evidence submitted to assessor – further works required to meet requirement. Review of CRU Cyber assessment and development of action plan in response to any recommendations

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	11/07/2023	TREND	15 (3x5)
		Date of Next Review:	11/08/2023	NEW	

IF a major incident or mass casualty incident is declared	THEN there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	RESULTING IN catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004

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

IMTP Deliverable Numbers: TBC

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Immediate release protocol	1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report provided weekly to the DG for Health & Social Services.
2. Resource Escalation Action Plan (REAP)	2. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure.
3. Regional Escalation Protocol	3. Daily conference calls to agree RES levels in conjunction with Health Boards
4. Incident Response Plan	4. The Incident Response Plan has been ratified via EMT
5. Mutual Aid arrangement with NARU	5. AACE National Policy on mutual aid in place
6. Clinical Safety Plan	6. CSP adopted by EMT and operational; reviewed annually by SLT
7. Operational Delivery Unit 24/7 cover	7. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end of shift
8. In hours and Out of hours command cover	8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan
9. Notification and Escalation Procedure	9. Published procedure in operation, reviewed 3 yearly by SLT
10. Continued escalation of risk to partners and stakeholders	10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasises at the face to face COO Peer Group meeting on 14 April 2023.
	External Independent Assurance N/A

GAPS IN CONTROLS	GAPS IN ASSURANCE
Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.	The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.
	Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. CEO letter to Health Boards dated 3 Jan 2023, and DOO letter to Chief Operating Officers dated 30 March 2023 to seek assurance on plans	CEO/DOO	3 Jan 2023 Complete	Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&VHB and ABUHB. This has been sustained form some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in ABUHB commencing at 4 hour tolerance with a plan to reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs.
2. Multi Agency Exercise to be arranged	4 x LRF	Dec 2023	
3. Review of Manchester Arena Inquiry	EPRR Team	Dec 2023	
4. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration	DOO	Feb 2023 Complete	All Health Boards responded with assurance of plans except BCU and HDUHB.

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:	04/08/2023	TREND	12 (3x4)
		Date of Next Review:	03/11/2023		

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

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

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

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

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. NEPTS is covered in the WAST Provider Report to EASC.**
2. Governance coordination between NCCU and WAST to be improved.	2. Identified need for a governance meeting between NCCU and WAST to manage the overall commissioner/provider interface. Actioned but has lapsed due to capacity and resourcing in NCCU team. HB to reboot.
3. WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	**3. Ministerial direction on handover reduction**
4. Funding does not flow in a manner to balance demand with capacity (outside of WAST's control)	**4. Strategic demand and capacity review being undertaken with output due to be reported to EASC in Jan-24.**

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

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	03/08/2023	TREND	12 (3x4)
		Date of Next Review:	03/11/2023		

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

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

IMTP Deliverable Numbers: 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
	External Management (1st Line of Assurance)
	a. Deputy Ambulance Services Commissioner sits on the Implementation Programme Board
	b. Emergency Ambulance Service Committee Management Group receives a highlight report every two months
	c. EASC receives an update every 2 months on the programme as part of the WAST Provider Report

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Increase in engagement on the specifics of change through facilitation mechanisms	Assistant Director – Commissioning & Performance	**02.08.23 Checkpoint Date**	30.09.22 Significant engagement through roster review project. 12/01/23 Largely complete. 02.05.23 There remains some minor engagement as the project concludes.
2. More capacity requested (transition plan)	Assistant Director of Planning & Transformation	**02.08.23 – Checkpoint Date**	30.09.22 Transition plan not funded, but +100 FTE agreed. 12/01/23 Recurrent funding not secure. 02.05.23 this has not been **forthcoming,** and handover lost hours are offsetting all of the gains that the Trust has made. **03.08.23 More capacity unlikely within current** financial pressures, but Trust has recently started the next iteration of the strategic EMS Demand & Capacity Review.

Risk ID 283	Failure to implement the EMS Operational Transformation Programme			Date of Review:	03/08/2023	TREND	12 (3x4)
				Date of Next Review:	03/11/2023		

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

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

3. Engage with key stakeholders to reduce handover delays	CASC	**02.08.23 – Checkpoint Date**	30.09.22 Reduction commitments agreed, but trend is still upwards. 12/01/23 Extreme and upward trend. 02.05.23 handover hours remain extreme. **28.07.23 Increasing focus through ICAP meetings, with C&V showing notable progress and early signs of progress in some other health boards.**
4. Reduce abstractions in particular sickness absence	Deputy Director of Workforce & OD	**02.08.23 Checkpoint Date**	30.09.22 Sickness absence reducing, but abstractions high linked to sickness, but also training abstraction linked to the +100. 12/01/23 Abstractions have reduced, but still very high. Sickness is reducing and on trend to achieving the 10% Mar-23 target. High abstractions linked to internal movements caused by internal recruitment. 02.05.23 the Trust achieved 7.99% in Feb-23 but levels are higher in Operations. Continued focus into 2023/24 to reach 6% by 31/03/23. **28.07.23 Abstractions, which includes sickness now less than 35% with benchmark to 30%**
5. Engage with Assistant Director of Planning and Transformation on process for PID updates	Assistant Director – Commissioning & Performance	**02.08.23 Checkpoint Date**	30.09.22 HoT recruited and now started. Initial contact made with HoT. PID is up to date. 12/01/23 PID has been further updated but requires sign off by the SRO and STB. 02.05.23 PID has been updated but nees to be signed off by Executive Sponsors. **28.07.23 PID updated and programme aligned to new arrangements required by HoT.**

AGENDA ITEM No	**9**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

Integrated Medium-Term Plan (IMTP) 2023 – 2026
Q1/Q2 Delivery & Assurance

MEETING	Finance & Performance Committee
DATE	18th September 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 provide Finance & Performance Committee with the progress and delivery of actions in the IMTP 2023/26. A full delivery and assurance report is included as an appendix to this paper, alongside a detailed assurance report in relation to the Inverting the Triangle Programme.

RECOMMENDED: That the Finance & Performance Committee notes the overall delivery of the IMTP detailed in this paper.

KEY ISSUES/IMPLICATIONS

Following Trust Board approval on 30 March 2023, the WAST IMTP for 2023-26 was submitted to Welsh Government on 31 March 2023. We are currently awaiting formal feedback and approval, including any accountability conditions. However, the financial planning within NHS Wales has shifted and WAST has undertaken some choices to propose further savings opportunities alongside our IMTP committed savings plan.

Appendix 1 is a full delivery and assurance report which includes a written update from each of the IMTP Delivery Programmes:

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

These programmes will provide a written assurance report quarterly to STB, including progress against agreed milestones. Appendix 2 provides a further update on the discrete work being undertaken to Invert the Triangle.

Appendix 1 also includes updates by exception on the IMTP Enabling Programmes:

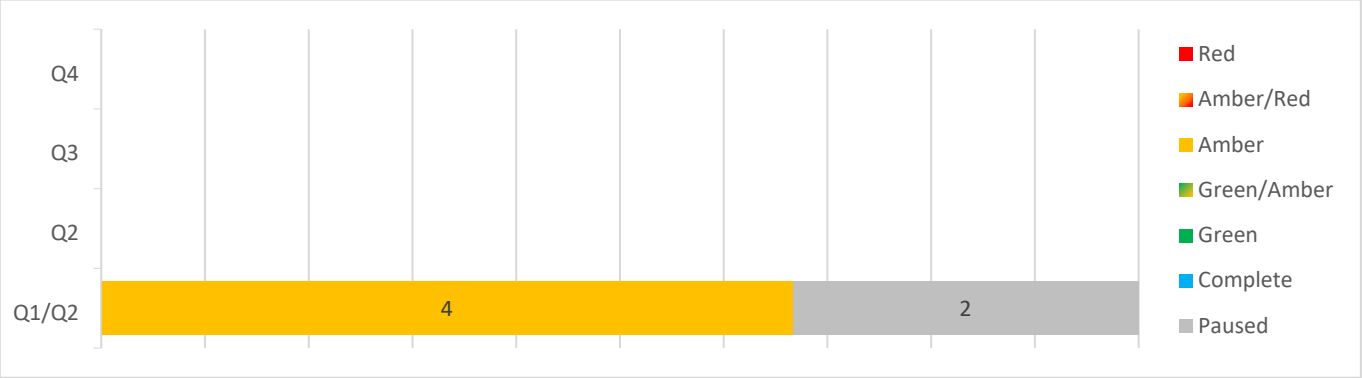
- People and Culture
- Digital
- Infrastructure
- Fundamentals (including Quality Safety & Patient Experience, and Corporate Governance)

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

IMTP Delivery Programmes

EMS Operations Programme

Overall RAG Status: AMBER

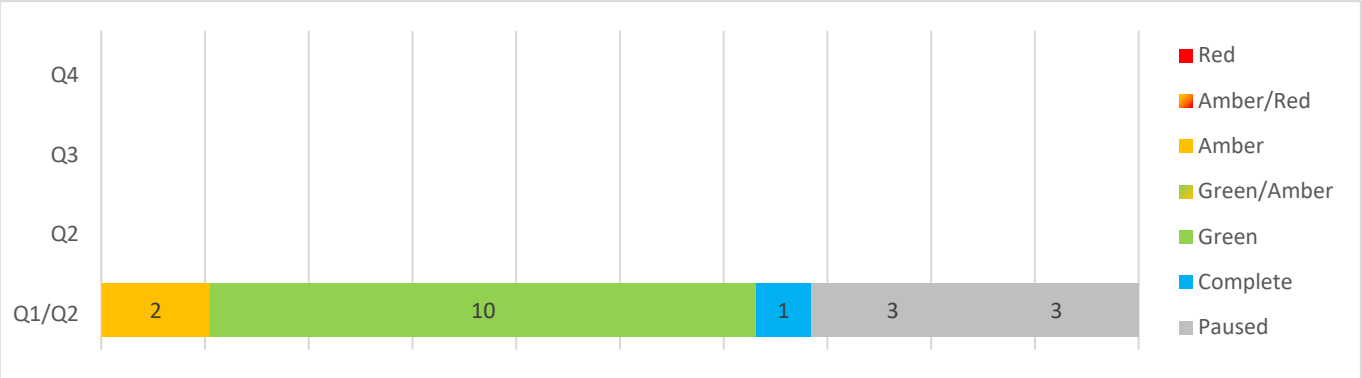


4 Amber, 2 Paused:

- The EMS Response Roster Review completed implementation last year, but the project evaluation remains outstanding due to limited planning team capacity and has therefore been identified as Amber.
- Work is ongoing in terms of how we amend rosters in the light of decisions on resource prioritisation, for example, as a result of decisions to offer APPs who have finished their training a permanent APP role. This is complex work that is ongoing and is taking slightly longer than originally planned.
- The EMS Control Reconfiguration Project has experienced slippage across all three workstreams, with both Boundary Changes and the CCC Roster Review paused for a variety of reasons.
- CHARU work is also rated Amber as there continues to be a gap of 44 against the original target of 153 WTE in post. Discussions are ongoing in relation to how this gap is filled, in the light of the national position on finances.

Ambulance Care Programme

Overall RAG Status: GREEN

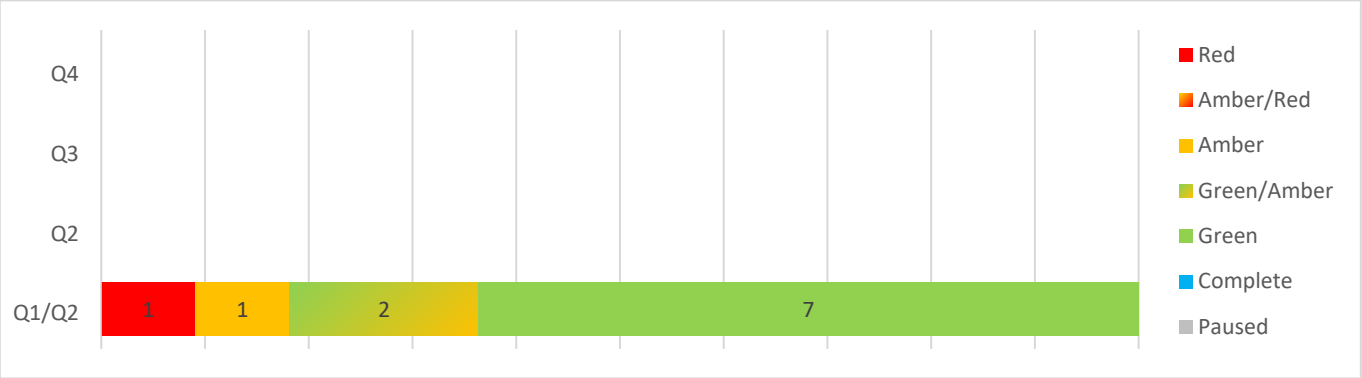


2 Amber, 10 Green, 1 Complete, 3 Paused, 3 Not Started:

- Implementation of the new NEPTS roster pan-Wales is paused as discussions continue with TU colleagues and the additional 12FTE Planning and Day Control have been paused due to lack of funding.
- The Urgent Care Service (UCS) Demand and Capacity review is now complete and was presented to the UCS Steering Group. Next steps for the UCS review will now be considered alongside the EMS Demand and Capacity review refresh and the ongoing work to develop a transfer and discharge model for Wales.
- The development of a CAD Business Case is Amber due to the need for greater cross-organisational coordination. NEPTS continue to work with Cleric to improve the CAD, however NEPTS and EMS CAD system contracts come to an end at the same time, and procurement of a single CAD should be considered by the organisation.

Gateway to Care Programme

Overall RAG Status: GREEN/AMBER



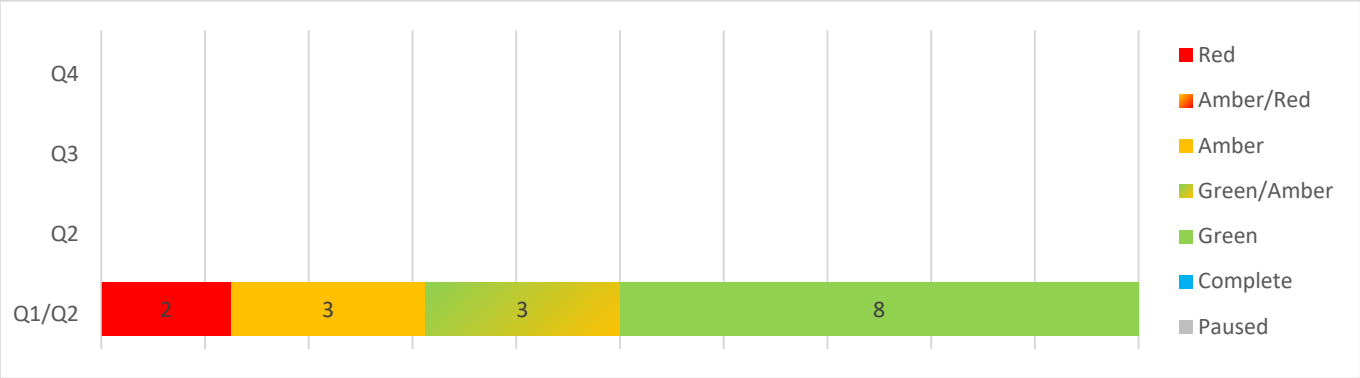
1 Red, 1 Amber, 2 Green/Amber, 7 Green:

- **Delivery risk around SALUS remains Red;** User Acceptance Testing (UAT) was due to conclude on w/e 07/08, however, due to the missed delivery of CMM Prescribing module into the UAT environment in Jul-23, there is a risk to the delivery of the full solution in November. Train the trainer was due to commence on 31/07 but has been paused whilst the issues around CMM are resolved.

- Improvements to the 111.Wales website are Amber as work depends on funding availability and discussions with the 111-commissioning team continue.
- Implementation of text and email functionality in ECNS continues to be pursued with the Supplier (Green/Amber). A range of options have been presented and testing will now be arranged.
- The 111 re-roster is Green/Amber as the establishment of the project group has been delayed due to procurement framework discussions, however this continues to progress. Of note, this deliverable is being led by the commissioner, with WAST heavily engaged.

Clinical Transformation Programme

Overall RAG Status: AMBER

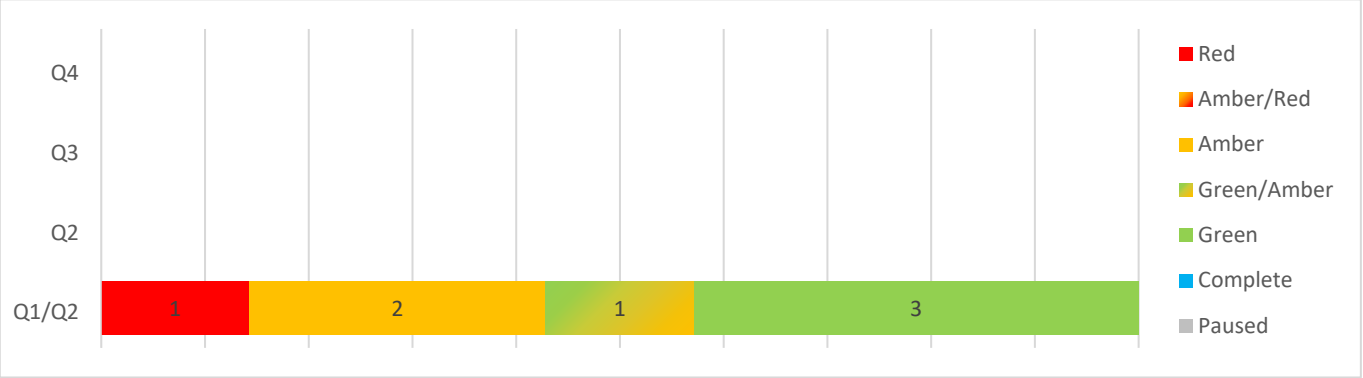


2 Red, 3 Amber, 3 Green/Amber, 8 Green:

- **Development of the WAST Principles of Advanced Practice and the Independent Prescribing Programme remain Red** and are anticipated to remain so until the lack of Trainee Advanced Paramedic Practitioner (TAPP) and APP supervisory support is resolved, linked to available funding.
- The BCU breathing and chest pain pathway pilot is currently Amber as BCU are considering PTAS/SICAT provision given the challenging financial context.
- Expansion of L1 Falls and Frailty commissioning arrangements are being explored to address gaps in dedicated provision in Anglesey and Gwyneth and regional night-time provision.
- The SBRI 10-week feasibility is now complete. Phase 2 evaluations were received from both LUSCII (wearable technology) and Fujifilm (mobile x-ray) and the status was Amber at the time of reporting. However, scoring and evaluations are now complete with a recommendation through EMT to progress to Phase 2 with the Luscii solution, but to suspend collaboration with Fujifilm due to requirement for Health Board leadership.

Financial Sustainability Programme

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



1 Red, 2 Amber, 1 Green/Amber, 3 Green:

- The Income Generation workstream continues to explore how the organisation could develop a **Commercial and Efficiency Mindset by scoping the potential for a dedicated structure for oversight and delivery of commercial opportunities.This work is currently Red**, and flagged as at risk due to proposal viability. Commercial training to be explored and a STB workshop is planned for 18/09.
- NEPTS Tender and Quality Examplar initiatives are Amber as changes in the Ambulance Care structure have led to uncertainty over ownership to take this work forwards.
- An internal project lead has been identified to take forward Robotic Process Automation opportunities, however this is currently flagged as Green/Amber as consultation allocation to deliver the plan is still to be confirmed.
- Having completed the Administrative Review, a proposal on next steps and recommendations will be prepared and presented to ADLT and EMT for consideration. A Services Review is now in its planning phase to be rolled out during quarter 3 which will take an in-depth view of all WAST service lines (corporate and operational) to identify further opportunities for greater efficiency.

IMTP Enabling Programmes (by exception only)

People & Culture

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

CULTURE

Develop and articulate our target culture: GREEN/AMBER

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

Refresh TU partnership working arrangements: GREEN/AMBER

On track overall, and ACAS action plan has now been developed and agreed in partnership with TUPs. Implementation of the plan is underway, but timelines have been updated in the context of IA with work due to commence in Sep-23. Flagged to STB that ongoing challenges with relationships may interrupt or stall progress.

CAPACITY

Develop our employee offer: GREEN/AMBER
Delivery against our commitment to address the 3 biggest issues facing staff (flexible working, shift overruns, and digital experience) continue to progress.

1. **Shift Overruns** – Pilot for shift overruns undertaken in Swansea Bay and an SBAR was presented to Operations Senior Leadership Team (Ops SLT) (21/08) highlighting the positive impact on staff wellbeing but flagging that the costs to deliver this at scale could be prohibitive. Viability and alternative methods to address handover delays will now be considered and progressed by Ops SLT.

2. **Flexible Working Policy** – Flexible working policy being reviewed with additional activity around agile working, 4-day week pilot group, self-rostering/improved rosters (in 111). All Wales review of flexible working in progress, with a timeline to complete this FY. Internal review underway and first draft of project plan almost complete.

3. **Digital Experience** – ESR exception form pilot completed and rolled out on 01/07/23. This will be continuously monitored via auditing with a formal evaluation at the end of the financial year. Further planned work including single sign-on have not yet started but progress will be monitored by STB going forwards.

CAPABILITY
Promote personal responsibility: GREEN/AMBER
On track overall, however there is a **Red status against increasing Apprenticeship provision**, due to inability to draw down previously secured funding (income), the financial implications of which have been highlighted.

Digital

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

National Data Resource Programme Support: GREEN/AMBER
All planned activities are complete, however longer-term funding has not been agreed.

Upgrade 999 Telephony Platform: AMBER
Further supplier side UAT slippage has caused testing delays. Now due to commence at the end of Q2 Sep, with testing into Q3 early October.

Fundamentals

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

Welsh Language Policy: GREEN/AMBER
Policy is in draft and on track for approval in 2024, however the policy continues to require regular revisions to incorporate new Welsh Government elements.

Quality Management System Implementation: AMBER

Progress impacted by capacity; however, Senior Quality Governance Lead (SQGL) has now been appointed (commencing Sep-23). SQGL will lead the new Quality Management Group that will be instrumental in driving forward the QMS agenda.

IMTP Project Delivery

The development of the Project Path Framework and associated templates continues, however vacancies within the Transformation Support Office (TSO) have created capacity challenges across the team, delaying completion and socialisation of a first draft of the framework. The aim was to present to Integrated Strategic Planning Group (ISPG) for approval in September, however this is likely to be deferred until October/November.

In addition to the development of the Project Path Framework, the TSO are in the process of building and testing the Verto 365 project management platform. This platform will standardise the way that projects are delivered and controlled, by replacing local project control tools held in various formats including MS Excel, and MS PowerPoint.

A comprehensive organogram of all projects and workstreams reporting into STB via the IMTP Programme Boards and Transformation Steering & Assurance Group has been produced and is currently being reviewed by the team with support from Corporate Governance. An options appraisal will now be undertaken with subsequent recommendations to refresh the IMTP portfolio structures.

REPORT APPENDICES

Appendix 1 – 2308 – IMTP Delivery Assurance Report
Appendix 2 – 230815 – STB Assurance Report - StratDev

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

Welsh Ambulance Services NHS Trust

IMTP Delivery – Q1/Q2 Assurance and Highlight Report

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

IMTP Delivery – Q1/Q2 Assurance & Highlight Report
Version 1.0
Released: 10th August 2023

by Transformation Support Office
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IMTP Delivery Programmes

- EMS Operations
- Ambulance Care
- Gateway to Care
- Clinical Transformation
- Financial Sustainability
- IMTP Enablers & Fundamentals

Use hyperlinked section headers to navigate to each section

Use the arrows to progress through the report

EMS Operations Programme

Hugh Bennett

EMS Operations Programme

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Hugh Bennett
Aug-23	Amber	New FY23/24 Reporting Cycle	To note the slippage across EMS Reconfiguration Project workstreams due to competing operational pressures.	Business Partner:	-
				Project Manager:	Richard Baxter

Objectives	Upcoming Key Milestones	RAG	Current Position
EMS Response Roster Review	**Complete part 1 evaluation:** 1. Collate and review survey feedback 2. Complete formal evaluation 3. Complete project closure report	A	Currently out to survey for feedback, focus groups to take place. Planning team capacity presents a barrier to completion of evaluation and project closure activities.
	Rightsizing following roster changes	A	Report went to Ops SLT on 08/08 and EMT on 09/08 recommending 3.5 EA reductions.
EMS Reconfiguration Project	**CCC Roster Review Workstream:** 1. Complete Phase 1 lessons learnt report 2. Agree a revised set of Core Principles 3. Update and approve the PID via the Project Board 4. Develop a detailed project plan for delivery of Phase 2 following project recommencing	P	**SLIPPAGE:** Project was paused towards the end of Jun-23 due to talks / withdrawal of Trade Union's engagement. Anticipated that work will recommence towards late-Aug-23/early-Sep-23.
	Broader Ways of Working Workstream: 1. Develop the workstream terms of reference / Project Specification Document 2. Develop the detailed project plan	A	**SLIPPAGE:** Due to operational and service delivery pressures milestones due in Q1 have moved across to Q2.
	Boundary Changes Workstream: 1. Review ORH Data 2. Update Project Plan 3. Recommence project working group meetings	P	**SLIPPAGE:** Additional ORH data remains outstanding. Data was due in May-23 but was delayed due to competing requests and capacity. Data now due by the end of Aug-23.
Cymru High Acuity Response Unit (CHARU) Workstream	1. Review target position in the context of organisation-wide financial savings	A	Target of 153 – including 11.5 SP contribution. 97 currently with a gap of 44. Plan had been to go out externally but due to the current financial issues this has been paused.

Next Slide

Ambulance Care Programme

Mark Harris

Ambulance Care Programme Summary

Objectives	Milestone Status				Current Position
	Q1	Q2	Q3	Q4	
Implement the new roster pan Wales (NEPTS)	G	P			No funding identified to progress
NET Centre Project					
Seek funding for 12FTE planning and day control	A	P			No funding identified to progress
Re-roster NET Centre	G	A			Unable to progress further if pause on roster review remains
Urgent Care Transformation					
Complete the UCS demand and capacity review	G	C			
Review the recommendations from the D&C review	NS	G			
Develop a transformation plan for UCS	NS	NS			
Transfer & Discharge					
Understand commissioning appetite for the All-Wales T&D model	G	G			
Review modelling and scope Business Case	A	G			
Collaborative Business Case development with NCCU	NS	G			
Develop a plan for implementation	NS	NS			
Develop interim plans to support system/strategic service changes	NS	G			
Transport Solutions					
Implement refreshed performance parameters	G	G			
Revise and implementing the new eligibility criteria	G	G			
NEPTS Plurality Model					
Continue to drive forward the Quality Assurance agenda	G	G			
Scope opportunities for expansion of ambulance car service	G	P			No opportunities identified /supported; not progressing at present.
CAD Business Case					
Establish cross-organisational group	A	A			Escalation of issue around CAD Business Case development and the need for a cross-organisational approach.
CAD Business Justification Case development	NS	NS			
NEPTS Operational Improvement					
Discharge Lounge trial	G	G			
Continue to roll out the refresh of the ambulance care fleet mix	G	G			

Ambulance Care Programme

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Mark Harris
Aug-23	Green	New FY23/24 Reporting Cycle	To note the issue/risk around NEPTS and NET Centre re-roster projects.	Business Partner:	Deborah Kingsbury
				Project Manager:	Richard Baxter

Objectives	Upcoming Key Milestones	RAG	Current Position
NEPTS Roster Project	**Implement new NEPTS roster pan-Wales**	P	**ISSUE:** Lack of funding to support implementation. Paper to SLT outlining additional funding requirement; decision made by SLT to pause until funding available to support.
NET Centre Project	**Funding for Planning and Day Control (12FTE):** 1. Formal position from Commissioner re: funding	P	**ISSUE:** Commissioners indicated no funding available for 12 additional FTE.
	Re-roster NET Centre: 1. Relief capacity establishment to be completed by end of Q2	A	Continued work with resource to align resource and shift patterns for relief lines. **AT RISK:** Unable to progress if pause on roster review remains.
Urgent Care Transformation	**UCS Demand & Capacity Review:** 1. Final version of report to be completed. 2. UCS Steering Group to consider the final report	C	Review complete and presented to UCS Steering Group. Senior TU reps have been engaged on the proposal and further staff comms and engagement will be undertaken.
	Demand & Capacity Review recommendations: 1. Establish governance route for formal decision on future UCS model	G	SBAR to SLT on 08/08 with onward submission to EMT/STB. Proposal that ITPG will oversee delivery of the recommendations.
	UCS Transformation Plan development	NS	Due to commence Q3
Transfer & Discharge	**Commissioning appetite for all-Wales model**	G	Continued liaison with Commissioners to emerging options
	Business Case scoping: 1. Finalise the ORH modelling 2. Focus on/ Deep dive sessions to consider outcomes of the modelling and potential to develop a business case	G	Further scenario modelling completed by ORH and focus on/deep dive sessions facilitated with STB (04/07) and EMT (26/07). Exec and commissioner responses will now be considered and discussions with risk pool regarding funding.
	Collaborative Business Case development with NCCU: 1. Develop Comms & Engagement Plan 2. Finalise options to inform business case	G	Initial discussions regarding Comms Plan to engage EASC Management & NEPTS DAG.
	Develop Implementation Plan	NS	Some preparatory work is planned including finalisation of MTPS rollout and the submission of a GUH single system paper to Ops SLT (Aug-23).
	Develop interim plans to support strategic service changes: 1. Develop implementation plan for MTPS roll out 2. Engage in HB transport groups	G	A Process Mapping session was convened on 17/07 to review protocols to enable tailoring to requirements local system requirements. Engagement with HBs will continue to determine scope and requirements.

Ambulance Care Programme

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Mark Harris
Aug-23	Green	New FY23/24 Reporting Cycle	Escalation of issue around CAD Business Case development and the need for a cross-organisational approach.	Business Partner:	Deborah Kingsbury
				Project Manager:	Richard Baxter

Objectives	Upcoming Key Milestones	RAG	Current Position
Transport Solutions	**Refresh Performance Parameters:** 1. Develop implementation plan against themes identified	G	Implementation plan developed and actions are in progress.
	New Eligibility Criteria Implementation: 1. Engage with Llais 2. Complete impact assessment 3. Formal agreement from EMT to progress 4. Active by end of Q2	G	Impact assessment completed. Formal engagement with patient reps to commence.
NEPTS Plurality Model	**Quality Assurance Agenda:** 1. Finalise and approve the 3rd Q Dashboard 2. Hold 3rd Q engagement sessions with providers * 3 quality domains (3Q's). Dashboard development is complete for the 1st and 2nd Q's.	G	Finalising work and accuracy checks with Health Informatics on refining data within Qlik reporting. Working with 365 for automation re: info to complete dashboard. New performance parameters will then be implemented aligned to WAST standards.
	Scope Opportunities for Expansion of Ambulance Car Service 1. Present to Ops SLT	P	No opportunities identified /supported; not progressing at present.
CAD Business Case	**Establish Cross-Organisational Group:** 1. Formalise the scope of the BJC 2. Establish a formal workstream and governance	A	Internal workshop held to create a prioritised list of additional functionality required from the cleric CAD. Met with Cleric to review deliverability and plans to move forward. **ISSUE:** NEPTS and EMS CAD system contracts come to an end at the same time, and procurement of a single CAD should be considered by the organisation. Organisational alignment and ownership requires consideration before further progressing to a Business Case.
	CAD Business Justification Case Development	NS	Due to commence Q3 subject to outcome of escalation.
NEPTS Operational Improvement	**Discharge Lounge Trial:** 1. Complete and review trial	G	Review complete. Paper being prepared to close at next Programme Board.
	Ambulance Care Fleet Mix Refresh: 1. Embed B-class vehicles into operations and commence reviews 2. Review Customs feedback survey and feed into replacement schedule, vehicle amendments.	G	B-class vehicles delivered; awaiting communications equipment fitting prior to commencing rollout. Ford Custom roll out was evaluated during early months with positive feedback from staff and patients.

Gateway to Care Programme

Rachel Marsh

Gateway to Care Programme

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Rachel Marsh
Aug-23	Green/Amber	New FY23/24 Reporting Cycle	For noting.	Business Partner:	Kelsey Rees-Dykes
				Project Manager:	Lydia Hutton

Objectives	Upcoming Key Milestones	RAG	Current Position
Deliver a safe and high quality service, providing an excellent patient experience	**Re-roster for 111:** 1. Update procurement framework	G/A	Establishment of the project group is behind schedule due to procurement framework issues.
	Clinically confident and competent workforce: 1. Redesign of the call review audit tool trial to be completed (Aug-23) 2. Clinical Supervision for staff policy to be signed off 3. Discussions to take place with CAPITA on SALUS quality dashboard for managing call quality indicators 4. 6-monthly shift model to commence (Sep-23)	G	Conduct multidisciplinary team (MDT) styled tabletop exercise has been paused due to SALUS. 6 monthly shift model for clinicians observing clinical areas outside of their own speciality to start in Sept once SBAR and recommendations signed off.
Access to high quality remote clinical assessment	**Increase consult & close rates from the 9's:** 1. Explore more patient pathways to increase opportunities for patient flow following CSD telephone triage 2. Review success rate of 999 call types (MPDS codes) and propose codes for most successful conversion 3. Improve effectiveness of triages carried out in CSD through practice education support and learning	G	A 30-action draft plan is in development to support the 17% target.
	Develop a clinical specialty educational and career framework for Remote Clinical Decision-making (RCDM) 1. Collate survey results (Sep-23) 2. Circulate survey results for discussion and feedback (Sep-23)	G	Met with HEIW project manager to map out milestones for the project and agree timelines. Survey to be distributed and run for 4-6 weeks (Aug-23).
	Develop with commissioners a remote clinical support strategy 1. Strategy document and Closure report to be approved	G	Strategy document and Closure report have been tabled for discussion at the next G2C Board in Sep-23.

Gateway to Care Programme Summary

Objectives	Milestone Status				Current Position
	Q1	Q2	Q3	Q4	
Deliver a safe and high quality service, providing an excellent patient experience					
Re-roster call handlers and clinicians	G	G/A			Project group establishment is behind schedule due to procurement framework issues.
Develop clinically confident and competent workforce	G	G			
Access to high quality remote clinical assessment					
Identify opportunities to increase consult & close rates from the 999's	G	G			
Develop a clinical specialty educational and career framework for Remote Clinical Decision-making (RCDM)	G	G			
Develop with commissioners a remote clinical support strategy	G	G			
Seamless transfer of callers to further specialists or face to face assessment					
Implement 999 Triage system Emergency Communication Nurse System (ECNS)	A	A			Text and email functionality outstanding; meeting w/c 03/07 to scope options for email functionality and share API with Supplier. Awaiting quote for configuration.
Implement the new 111 system; SALUS	A	A/R			Missed delivery of CMM Prescribing module into the UAT environment in July presents risk to the delivery of full solution in Nov-23.
Develop and expand direct booking and pathway opportunities within CSD and 111	G	G			
Increasing numbers using digital frontend to meet patient's routine and urgent care needs / More people accessing 111 as their preferred port of call to meet their healthcare needs					
Deliver an improved Directory of Services	A	G			
Improve 111.Wales website, and enable better digital self-service	A	A			Ongoing resource envelope discussions with 111 commissioners.
Standardise information architecture and common approach to data and analytics					
Develop a data dashboard for G2C/Power Bi reporting to drive decision making through data and analytics	A	A			Digital team working through backlog of dashboard requests so an interim solution may be required using reports available through the MIQPR which is currently being developed.

Gateway to Care Programme

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Rachel Marsh
Aug-23	Green/Amber	New FY23/24 Reporting Cycle	Note the risk around SALUS delivery; delays in completion of UAT presents further barriers to WAST training in preparation for go-live.	Business Partner:	Kelsey Rees-Dykes
				Project Manager:	Lydia Hutton

Objectives	Upcoming Key Milestones	RAG	Current Position
Seamless transfer of callers to further specialists or face to face assessment	**Implement 999 Triage system Emergency Communication Nurse System (ECNS):** 1. Quote from Supplier for text and email integration 2. Plan and timescales for implementation	G/A	Project team continue to work with the Supplier to meet the standard DCB0129. Planning meeting w/c 03/07 to discuss the technical elements of implementation with the supplier. API shared with Supplier (text), and 3 configuration options for email have been presented to the Supplier for feasibility and costings. Awaiting Supplier response (chased 08/08).
	Implement the new 111 system; SALUS 1. Continued development of the core operating solution along with delivery of supporting Programme Workstreams	R	UAT was due to conclude on w/e 07/08, however, due to the missed delivery of CMM Prescribing module into the UAT environment in Jul-23, there is a risk to the delivery of the full solution in November. Train the trainer was due to commence on 31/07 but has been paused whilst the issues around CMM are resolved.
	Develop and expand direct booking and pathway opportunities within CSD and 111 1. SDEC PID to be finalised 2. Dental PID to be signed off 3. Palliative care evaluation to be finalised	G	SDEC to be potential offer in ICAPs; PID is currently in development. Pan-Wales urgent Dental review PID in development. Palliative Care patient trial of silent press 0 option implemented and evaluation underway.
Increasing numbers using digital frontend to meet patient's routine and urgent care needs & More people accessing 111 as their preferred port of call to meet their healthcare needs	**Deliver an improved Directory of Services:** 1. Funding options to be explored for National DOS	G	Potential for funding through the Further Faster Programme. WAST & DHCW are engaging with 6 Goals team.
	Improve 111.Wales website, and enable better digital self-service: 1. Funding to be secured for updating legacy content management system	A	Ongoing resource envelope discussions with 111 commissioners
Standardise information architecture and common approach to data and analytics	**Develop a data dashboard for G2C/Power Bi reporting which drives decision making through data and analytics** 1. Explore potential for G2C data dashboard	G	Digital team is currently working through backlog of dashboard requests so an interim solution may be required using reports available through the MIQPR which is currently being developed.

Clinical Transformation Programme

Brendan Lloyd

Clinical Transformation Programme Summary

Objectives	Milestone Status				Current Position
	Q1	Q2	Q3	Q4	
Optimising Care Group – Advanced Clinical Practice					
Evaluate APP Navigator and explore spread and scale	A	G			
Review the APP dispatch criteria (Perfect Day PDSAs)	G	G			
Develop WAST Principles of Advanced Practice	G	R			No APP Clinical Supervision infrastructure
Evaluate Independent Prescribing Programme	R	R			Lack of supervisory support for TAPPs and APPs
Optimising Care Group – Optimising Conveyance					
Deliver WAST clinical elements of 6 Goals	G	A			BCU proposed revisions to the operational scope could render the model inviable for WAST
Digitalisation of pathways and referrals	R	G			
Develop Pre-Dispatch Outcome Risk Stratification Tools	R	G			
Clinical Intelligence Assurance Group					
Data and Analytics development	A	G			
Older Persons & Falls					
Evaluate Powys Care Home PDSA and explore spread and scale	A	G			
Expand Falls and Frailty response across Wales	R	A			Optima modelling delayed; chasing with Supplier
Mental Health & Dementia					
Pilot Mental Health Response Vehicles	G	G/A			Funding to be agreed by HB Execs
Evaluate impact of Mental Health Practitioners in CSD	G	G			
Explore Dementia friendly ambulance environments	G	G			
Connecting Support Cymru					
CSC Project scoping and development	N/A	G/A			Feasibility progressing; SJAC availability is inconsistent
CSC volunteer scoping and development	N/A	G/A			Capacity and procurement challenges
Deliver testing phase of SBRI (Health Tech) initiative	N/A	A			Challenging timescales to evaluate applications

Clinical Transformation Programme

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Brendan Lloyd
Aug-23	Amber	New FY23/24 Reporting Cycle	For noting.	Business Partner:	Deborah Kingsbury
				Project Manager:	Under Recruitment

Objectives	Upcoming Key Milestones	RAG	Current Position
Older Persons & Falls	**Evaluate Powys Care Home PDSA and explore spread and scale:** 1. Complete Powys PDSA evaluation and present to OCG 2. Undertake Swansea Bay iStumble pilot and complete evaluation	G	Powys PDSA evaluation due to be presented to OCG on 01/09. iStumble pilot went live on 17/07 and evaluation on track to complete by the end of Q2.
	Expand Falls and Frailty response across Wales: 1. Undertake forecast modelling for system-wide response 2. Engage with BCU re: L1 and L2 commissioned service 3. Complete Community Falls Pathway Referral Rate Audit	A	BCU engagement continues with agreement to extend L2 falls vehicle pilot by 2-months and continuation of second L2 via RiFuntil 2027. L1 commissioning arrangements are being explored to address gaps in dedicated provision in Anglesey and Gwyneth and regional night-time provision. Optima are now progressing the modelling; however, slippage is possible due to WAST competing data priorities.
Mental Health & Dementia	**Pilot Mental Health Response Vehicles:** 1. Develop protocol for MHRV pilot 2. Gain HB commitment to deliver collaborative pilot(s)	G/A	T&F group to be established to develop MHRV protocol. Positive early initial meetings with BCUHB; funding needs to be agreed at Exec level to proceed. Ongoing discussions with ABUHB, and SBUHB to be arranged.
	Evaluate impact of Mental Health Practitioners in CSD: 1. Build Mental Health dashboard with HI 2. Build and implement ECNS Mental Health assessment algorithm	G	Phase 2 dashboard parameters agreed and in development. The MH algorithm for ECNS was due to be approved by CPAS.
	Explore Dementia friendly ambulance environnements: 1. Complete Phase 1 Pilot: Reminiscence/Rehabilitation & Interactive Therapy Activities (RITA) and evaluate 2. Commence Phase 2: Ambulance Environment	G	RITA pilot is progressing well, with early positive outcomes. Full evaluation to be completed in Q3. Phase 2 pilot has commenced in Ceredigion using local imagery on windows, reminiscence booklets and music therapy for 2 NEPTS vehicles.
Connecting Support Cymru	**CSC Project scoping and development:** 1. Undertake a twenty-week feasibility project 2. Finalise PID 3. Business Case development and EMT approval	G/A	Workforce planning challenges due to gaps in SJAC rota. SJAC attempting to fill gaps in the volunteer structure with paid staff, and rota positions are now being shared daily. Early PID being revised to include expanded scope of CSC (SBRI and volunteer workstreams). WAST Revenue Business Case process to be followed and progressing.
	CSC volunteer scoping and development: 1. Readiness for Phase 1 of the Volunteer pilot 2. Develop and procure volunteer kit bags 3. Recruit to B4 training positions	G/A	Potential CFR teams for the pilot have been identified; role profile drafted and awaiting approval. Development of kit bags is underway, but procurement will be needed before further on-boarding (rate limiting). JD for the B4 training position is complete and is being reviewed by job evaluation.
	Deliver testing phase of SBRI (Health Tech) initiative: 1. Deliver 'testing' phase of the Small Business Research Initiative	A	10-week feasibility complete. Phase 2 evaluations received from both LUSCII and Fujifilm; evaluation and scoring underway.

Clinical Transformation Programme

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Brendan Lloyd
Aug-23	Amber	New FY23/24 Reporting Cycle	To note the risk around Clinical Supervision capacity. Multifaceted barrier to upscaling of APP workforce and extension of APP scope of practice.	Business Partner:	Deborah Kingsbury
				Project Manager:	Under Recruitment

Objectives	Upcoming Key Milestones	RAG	Current Position
Optimising Care Group – Advanced Clinical Practice	**Evaluate APP Navigator:** 1. Evaluate Phase 1 App Navigator pilot 2. Undertake Phase 2	G	Lessons learnt from SBUHB pilot considered and used to inform APP Navigator pilot.
	Review the APP dispatch criteria (APP Perfect Day PDSAs): 1. Complete PDSA1 Evaluation Report 2. Undertake PDSA2 and evaluate 3. Commence planning for PDSA3	G	PDSA1 evaluation complete and findings presented to EMT. PDSA2 planned for 22/08; findings to be presented at STB 'Focus On' session (18/09)
	Develop WAST Principles of Advanced Practice: 1. Approval for the Clinical Supervision Policy 2. Commence writing the Principles of Advanced Practice document	R	Clinical Supervision Policy is out for consultation with Policy Group, however the APP Clinical Supervision implementation proposal was rejected by SOT due to lack of leadership capacity. **AT RISK:** No implementation plan for Clinical Supervision Policy and lack of APP Clinical Supervision infrastructure
	Evaluate Independent Prescribing Programme: 1. OCG will identify a solution to Independent Prescribing training challenges	R	**ISSUE:** Lack of supervisory support for TAPPs and APPs to be able to operationalise and lack of Primary Care rotational training opportunities.
Optimising Care Group – Optimising Conveyance	**Deliver WAST clinical elements of 6 Goals:** 1. Engage with BCU on PTAS/SICAT	A	PID developed for BCU pathway pilot providing an ED alternative for Code 6 (Breathing) and Code 10 (Chest Pain). BCU proposed revisions to the operational scope are being considered but could present a barrier to the pilot.
	Digitalisation of current and future pathways and referrals: 1. Deliver automated non-injured falls pathway in ePCR 2. Work with primary care to implement resolved epilepsy and hypoglycemia pathways	G	Implementation plan for non injury falls was submitted to ePCR Group. WAST Exec MD has gained agreement for resolved hypoglycaemia and recovered epileptic seizure pathways and GPC Wales consultation has been completed.
	Develop Pre-Dispatch Outcome Risk Stratification Tools: 1. Set clinical criteria for Code 6 (Breathing), Code 10 (Chest Pain), and Code 28 (Stroke)	G	Criteria agreed in principle for Code 6 and Code 10; to be approved by CPAS. Face, Arms, Speech, Time (FAST) test data required to inform Code 28 is not currently captured in AMPDS.
CIAG	**Data & Analytics development:** 1. Appoint Principal Clinical Information Officer 2. Develop criteria for 3 clinical indicator deep dives	G	Principal Clinical Information Officer appointed and in post. 3 clinical indicators have been identified and are progressing. Older Fallers – Commenced. Paediatric Trauma/Pain Management – Scoping. APP Practice (Condition Specific) – Scoping.

Financial Sustainability Programme

Angie Lewis

Financial Sustainability Programme

Report Month:	Current RAG	Previous RAG	FY23/24 Target	STB Action Required	SRO:	Angie Lewis
Aug-23	Green/ Amber	New FY23/24 Reporting Cycle	Green Exceeding Financial Forecast	To note the risk around commercial mindsets and the long-term viability and strategy of the FSP. STB workshop planned for 18/09 in place of standard STB agenda.	Business Partner:	-
					Project Manager:	Gareth Taylor

Objectives	Upcoming Key Milestones	RAG	Current Position
Income Generation	**Commercial and Efficiency Mindsets –** *Scope potential dedicated structure for delivery and oversight of commercial opportunities* 1. Develop SBAR outlining the options, risk, and benefits 2. Take SBAR through ADLT and STB for comment and approval 3. Explore commercial training opportunities	R	SBAR requires further updating due to time delay. Work to be expanded to tie in with IMTP priority around embedding commercial mindsights and improved financial management and understanding. **AT RISK:** Developing commercial mindsets critical to success, as outlined in IMTP; commercial training to be explored and STB workshop planned for 18/09.
	NEPTS Tenders 1. Complete scoping and benchmarking of available tenders 2. Undertake initial market research 3. Draft baseline service delivery bid and attach costings 4. Determine financial viability of scheme based on data	A	Benchmarking is complete and a baseline service delivery bid has been drafted, however further data is required and will need to be incorporated. Market research continues in collaboration with 365 following stakeholder feedback.
	NEPTS Quality Exemplar: 1. Undertake Market Research including copyright opportunities/requirements 2. Assess viability and produce viability plan	A	Market research and requirements gathering is complete however changes in the Ambulance Care structure have led to uncertainty over ownership to take this forward.

Additional Progress

- Four workstreams being pursued with identifiable income of approximately £1.1m that are likely to be delivered in FY23/24. These include expenditure reviews, sale of clinical equipment (£225,000), interest receivable (£500,000), and VAT rebates
- Income from external call handling minimal, but being monitored and recorded.
- Schemes currently being scoped includes the sale of estate surplus to requirements
- Schemes scoped and deemed not viable recently include leasing WAST estate to Ionity, Event Medical Cover, and Ambulance Advertising.
- There are two schemes currently being actively scoped, which includes NEPTS contracts over the border, and marketing our Quality Exemplar. Subject to comment from Ops SLT. To be discussed at STB workshop (18/09).
- Balanced financial plan presented following submission of Operation Financial Savings Group schemes. Financial Leads working with Heads of Service to ensure delivery of targeted savings, however subject to volatility and subsequent impact on other parts of the service. (e.g. overtime).

Forward View

- Additional income generation schemes currently being explored / scoped include sale of potential estate deemed surplus to requirements, the 108 EMS Service (India).
- Schemes that have undergone scoping in the last reporting period and continue to be explored (NEPTS Tenders) will continue to follow the relevant approval route, to collate feedback ahead of STB workshop (18/09).
- Alignment of FSW with ongoing programmes of work continues, with Fleet representation providing updates on the Merthyr Workshop Programme, and NEPTS Providers work; Digital feeding into the Achieving Efficiency Group on Robotics, and data from Ops around the Intelligent Routing Platform being fed into the Income Generation meetings on a regular basis.
- Continue approximate estimates for unidentified income generation schemes where viable.

Financial Sustainability Programme

Report Month:	Current RAG	Previous RAG	FY23/24 Target	STB Action Required	SRO:	Angie Lewis
Aug-23	Green/ Amber	New FY23/24 Reporting Cycle	Green Exceeding Financial Forecast	For noting.	Business Partner:	-
					Project Manager:	Gareth Taylor

Objectives	Upcoming Key Milestones	RAG	Current Position
Achieving Efficiencies	**Support Services Review (Administrative Review):** 1. Develop recommendation report; due by 01/08	G	Support Service Review completed in July. Draft provided to SRO, and to be presented to EMT in August. Recommendations refer to continued emphasis on automation, and administrative streamlining.
	Services Review: 1. Approve Terms of Reference and identify project lead	G	Lead identified, and project plan currently being developed.
	Robotic Process Automation: 1. Confirm consultancy allocation – RPA development capacity for FY23/24 2. Confirm internal project lead 3. Develop plan to identify RPA opportunities aligned with the Support Service review	G/A	An internal project lead has been identified, however consultation allocation to deliver the plan is still to be confirmed. Proposal on next steps to be completed following presentation of Administrative Review to EMT.
	Fleet Efficiencies: 1. Collate current spend data 2. Generate spend SBAR in conjunction with RTC and RTI / Staff welfare data and submit to Fleet Managers meeting 3. Scope investment opportunities for greater data collection	G	Spend data was collated and the SBAR produced and submitted for approval. The SBAR was approved at Fleet Managers meeting but was rejected by Operations with some amendment requests to the paper including disaggregation of spend data.

Additional Progress	Forward View
• Balanced financial plan presented following submission of Operation Financial Savings Group schemes. Financial Leads working with Heads of Service to ensure delivery of targeted savings, however subject to volatility and subsequent impact on other parts of the service. (e.g. overtime). • NEPTS Plurality savings integrated into BAU. • Fleet warranty scheme integrated into BAU from 2026/27. • Fleet Efficiencies paper to be redrafted. • Continued scoping around proposed ideas / schemes that come via WiiN or other avenues.	• Alignment with the Operational Savings Group critical to delivery of balanced financial plan for 23/24. • The FSP is aware of the ongoing work to identify further savings following the Welsh Government's request, and will work to align and support.

Costs Update – Month 3*

*Month 4 currently being finalised

Below forecast target and off-track
Below or meeting forecast target but on-track
Exceeding forecast target
Not yet commenced

	Annual	In Month			Cumulative			Forecast			RAG
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	
Accident Repair	20	0	0	0	0	0	0	20	20	0	
Acting Up Allowances	11	0	0	0	0	0	0	11	11	0	
Apprentice Income	350	29	4	-25	89	26	-63	350	287	-63	
Asset Disposal (Defib)	225	0	0	0	0	0	0	225	225	0	
Balance Sheet support	200	20	20	0	20	20	0	200	200	0	
CSD - ECNS Non Pay	20	2	0	-2	4	0	-4	20	0	-20	
Decarb	2	0	0	0	0	0	0	2	2	0	
End of Shift Overrun	30	3	23	21	5	37	32	30	61	32	
Fuel (forecourt price saving against	306	30	69	39	116	167	51	306	357	51	
Fuel (swip, chip & pin and reduction	33	0	0	0	0	0	0	33	33	0	
FYE of 22/23 VERS	66	2	2	0	2	2	0	66	66	0	
Intelligence Routine Platform	100	0	0	0	0	5	5	100	100	0	
Interest Receivable	500	75	90	15	225	271	46	500	894	394	
MS Office VAT Rebate	250	0	0	0	0	0	0	250	250	0	
Net - Vacancy Management (111 EA	27	13	13	0	27	27	0	27	27	0	
Net - Vacancy Management (CSD an	120	40	40	0	80	78	-2	120	118	-2	
Non Pay Local Schemes	530	51	38	-13	166	197	31	530	462	-68	
Other local schemes - Non Pay (Trav	26	2	0	-2	5	0	-5	26	21	-5	
Overtime	254	0	0	0	0	0	0	254	254	0	
Private Providers	250	21	21	0	63	63	0	250	250	0	
Reduction in variable pay	38	3	3	0	7	7	0	38	38	0	
Stock Control (MSE etc)	50	3	3	0	3	3	0	50	50	0	
Taxi Review	50	4	4	0	7	7	0	50	50	0	
Vacancy Management	2,275	225	210	-15	834	834	0	2,275	1,953	-322	
Vacancy Management (non frontlin	51	26	29	4	51	55	4	51	55	4	
Vacancy Management (non frontlin	151	5	5	0	14	14	0	151	151	0	
Volunteer Car Drivers	66	5	5	0	7	7	0	66	66	0	
Totals	**6,000**	**558**	**578**	**20**	**1,725**	**1,819**	**95**	**6,000**	**6,000**	**0**	

Slide 3 of 3 – Next Slide

IMTP Enablers & Fundamentals

- People & Culture – Angie Lewis
- Digital – Leanne Smith
- Fundamentals – Trish Mills and Liam Williams

N.B. *Infrastructure is not included within this report as IMTP delivery is managed through the Capital Management Board. Verbal updates to be provided to STB by exception only. Capital Management Board papers will be routinely added to STB meeting folders for information.*

Use hyperlinked section headers to navigate to each section

Use the arrows to return to the Navigation Page

People & Culture

Report Month:	STB Action Required	Executive Lead:	Angie Lewis
Aug-23	N.B. The People & Culture portfolio is monitored through a local Directorate Plan, with actions aligned to IMTP Objectives. The Directorate Plan has been reviewed and updates provided by exception.	Business Partner:	Sarah Davies

Objectives	Q1	Q2	Q3	Q4	Current Position
Culture – *Create an environment where colleagues have autonomy in their work, feel a sense of belonging, and are confident to make decisions, put forward ideas and raise concerns*					
Develop and articulate our target culture	G	G/A			On track overall, however there is an Amber status against rollout of EQIA training due to limited training capacity; online video tutorials and Share Point information created as interim solution.
Sustain our focus on improving wellbeing	G	G			
Increase levels of psychological safety	G	G			
Improve disciplinary and resolution processes	G	G			
Refresh TU partnership working arrangements	A	A			See below:
On track overall, and ACAS action plan has now been developed and agreed in partnership with TUPs. Implementation of the plan is underway, but timelines have been updated in the context of IA with work due to commence in Sep-23. Plan shared with TU lead for feedback and will be shared at WASPT (Aug-23). Activity includes development of relationships through joint sessions with managers and TU reps to promote a mutual understanding of each other's challenges balancing TU duties against operational delivery. Actions i dentified in the TU audit will progress at pace from Sep-23. **AT RISK:** STB are asked to note the ongoing challenges with relationships which may interrupt or stall progress.					
Amplify employee voices	G	G			
Capacity – *Ensure we have the right people in the right roles, at the right time, with the right skills, to enable WAST to realise its ambitious service redesign plans*					
Develop our employee offer	G	G			
Improve organisational onboarding processes	NS	NS			
Improve people related policies and processes	G	G			
Develop Strategic Workforce Plan	G	G			
Deliver Managing Attendance Programme	G	G			
Capability – *Ensure our people are suitably skilled and qualified, can work at the highest level of their scope of practise and are comfortable to make decisions within their control.*					
Build on our learning and development offer	G	G			
Promote personal responsibility	G	G/A			On track overall, however there is a **Red** status against increasing Apprenticeship provision, due to inability to draw down previously secured funding (income), the financial implications of which have been highlighted.
Improve talent management approach	NS	NS			
Enhance change capacity and expertise	G	G			
Respond to legislative changes	G	G			

Digital

Report Month:	STB Action Required		
Aug-23	N.B. Digital (including HI) is a critical enabler for many FY23/24 IMTP actions and is reported through relevant programme boards. An update has been provided against the digitally-led IMTP objectives.	**Executive Lead:**	Leanne Smith
		Business Partner:	Rhonwen Jones

Objectives	Upcoming Key Milestones	RAG	Current Position
National Data Resource Programme	**National Data Resource (NDR) Programme Support:** 1. Confirm FY23/24 funding to progress longer-term NDR activities	G/A	**AT RISK:** All planned activities are complete, however longer-term funding has not been agreed
Operations Communications Programme	**Mobile Data Vehicle Solution (MDVS):** 1. Integration CRS/MDVS 2. Testing due to complete/pending outcome. 3. Finalise application testing and pilot for NEPTS fleet 4. Commence Mass Deployment	G	Placement of Mobile Data Terminals (MDTs) and the application (NMA) design specification was finalised for NEPTS fleet. MDVS is in live pilot (hardware / software installation). There was a successful demo of the NEPTS application on 26/07 and testing is due to complete.
999 Platform Upgrade	**Upgrade 999 Telephony Platform:** 1. Supplier readiness (level of confidence) to test 999 platform solution during Q2 2. Q2 - testing Jul/Aug 999 platform solution	A	**SLIPPAGE:** Further supplier side UAT slippage has caused testing delays. Now due to commence at the end of Q2 Sep, with testing into Q3 early October.

Fundamentals

Report Month:	STB Action Required		
Aug-23	N.B. These portfolios are monitored through local Directorate Plans, with actions aligned to IMTP Objectives. Directorate Plans have been reviewed and updates provided by exception	Executive Lead(s):	Trish Mills/Liam Williams
		Business Partner(s):	Deborah Kingsbury/Rhonwen Jones

Objectives	Milestone Status				Position
	Q1	Q2	Q3	Q4	
Risk Management					
Develop and deliver a risk management framework including policy and procedures	G	G			Policy in draft – approval due at Audit Committee March 2024
Transition to a strategic BAF reflecting strategic objectives and risks	NS	NS			Work due to commence Q3
Develop and deliver programme of training and education for the Trust	NS	NS			Work due to commence Q3/Q4
Deliver Board education on risk management	NS	NS			Work due to commence Q3/Q4
Welsh Language					
Centralised translation service	G	G			New Translator starting in post 23/08/23
More than just words 2022-27 action plan	G	G			More than just words year 1 report submitted to WG
Welsh Language Policy	A	A			Policy in draft – need to incorporate new WL elements – approval due 2024
Delivery of the Welsh Language Standards	G	G			Annual Report completed and due at Trust Board on 28/09/23 for approval
Quality, Safety, & Patient Experience					
Working Safely Plan	G	C	N/A	N/A	Working Safely Programme to be formally closed and transitioned to BAU; closed to STB pending receipt of closure report with local monitoring through Directorate Plan and Senior Quality Team. Programme closure report complete and to be circulated to STB members.
Quality Management System (QMS) Implementation	A	A			Progress impacted by capacity; however, Senior Quality Governance Lead (SQGL) has now been appointed (commencing Sep-23). SQGL will lead the new Quality Management Group that will be instrumental in driving forward the QMS agenda. A Quality Hub is in development to support the outputs of the QMS and ensure that robust evidence is available as part of annual reporting. Performance and Quality Management Steering Group TOR have been reviewed, with strategic oversight of the QMS as part of the Trust Quality and Performance Framework.

Welsh Ambulance Services NHS Trust

Strategy Highlight Report

Report period July 2023

(1) Organisational Strategy,
(2) NEPTS Strategy Development
(3) EMS Transformation ITT

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

Organisational Strategy Development

Report Month:	Current RAG	Previous RAG	STB Action Required		
Jul-23	AMBER	AMBER	Note and discuss work streams reporting (amber)	SRO:	Rachel Marsh
				Head of Strategy:	James Houston
				Project Manager:	Sarah Parry / Lauren Price

Description	Status	Current Position	Forward View
Review of WAST Organisational Strategy	**On Track**	• BDD discussion in July to review Long Term Strategy • Consensus the strategy is still fit for purpose • Opportunity to review and refresh elements • Requirement to develop an internal long term delivery plan (in addition to IMTP)	• Agreement to undertake a mid-point review of progress against strategy (Aug) • Further discussions planned for EMT session 30th / 31st Aug
Internal Audit – Strategy Development	**On Track**	• Internal Audit 'to review the arrangements in place to support the development of the Trust's strategic ambitions, processes for strategic decision making and communication'	• Fieldwork (Aug) • De-brief (Sept) • Audit Committee (Nov)
Purpose Statement	**Amber**	• Video in development with communications team to formally launch Purpose Statement in Q2 (Aug)	• Video to be released in Q2 (Aug)

NEPT Strategy Development – overview

Description	Status	Key Progress / Items for Highlighting	Forward View
NEPTS Strategy Development	**On Track**	▪ A paper outlining the requirement to develop a Long-Term Strategy for NEPTS was endorsed by NEPTS DAG, EASC Mgt Group & EASC Committee in June & July. ▪ WAST to work in collaboration with Commissioning leads to support the development of a long-term strategy for the service.	• More detailed discussion to take place in TSAG (16-Aug) • Proposal to establish internal working group to support this work. • Arrange internal workshop to consider future vision, opportunities and forward stakeholder engagement approach. • Meet with commissioning team to agree general approach / engagement.

Programme Progress (July)

ITT Programme – Progress Report (July)

Domain	Project / Workstream	RAG	
Setting Aim & Vision	**Case for Change (PWC)**	**R**	• Additional support provided to PWC to strengthen case for change and economic modelling
Preparation for Change	**Establish Programme Team**	**C**	• Strategy & Transformation Engagement Manager in post • Recruitment completed (5 out of 5 funded posts in place)
	Change Management Training	**G**	• 3 x cohorts (Foundation level) completed course • 1 x (Cohort Practitioner level) completed course
Engagement & Communication	**Communication Strategy**	**G**	• Internal Communication Notice in development, due for release end of August • Preparation underway to design month campaign
	Engagement Activities	**G**	• Ministerial Briefing submitted (Aug) • Bevan Commission Conference (5th / 6th Jul) & NASAT Meeting (28th Jul)
Enabling Change	**Advanced Clinical Practice Development**	**C**	• Advanced Clinical Practice Development Group established (first meeting scheduled 15th August) • PID and Improvement Plan developed reporting into OCG / CTPB
Setting Outcomes & Measures	**Evaluation Framework & Benefits**	**G**	• Work has commenced to develop a consistent evaluation framework
Tests of Change	**APP Perfect Day Project PDSA 1**	**G**	• PDSA1 Event complete. Initial evaluation data shared with OCG, SOT, TSAG, EMT (12th July) • Qualitative data being collated to append to final evaluation report by Sep-23
	APP Perfect Day Project PDSA 2	**G**	• PDSA 2 Event scheduled for 22nd August • Operational Event Plan approved by the Optimising Care Group and SOT sighted 15th August
	Connected Support Cymru	**A/G**	• CWR: Issues raised at PB regarding SJAC Rota • SBRI Phase 1 Evaluation completed • Business Case development commenced
	SBRI (Phase 1)	**A**	• Supported Stakeholder process mapping with suppliers undertaken • SBRI led evaluation process undertaken
Commissioning, Funding & Business Case		**NS**	• No active investment / business cases in development
Designing the Model		**NS**	• Detailed design of the model to formally commence following engagement process (focus on Tests of Change in advance of engagement activities)
Implementing the Model		**NS**	• Implementation not started (focus on Tests of Change in advance of engagement activities)
Evaluation & Benefits Realisation		**NS**	• Formal evaluation to commence following design and clinical model sign off

Programme Forward View

Domain	Project / Workstream	RAG	Next Steps	Aug	Sep	Oct
Setting Aim & Vision	**Strategic Case for Change (PWC)**	**R**	• Meeting scheduled 22nd Aug for final review. • Final version to be considered by EMT (Sep) • Discussion with Bevan Commission regarding opportunities to strengthen case (if required)			
	Vision Statement & Objectives	**G**	• Work to be undertaken to review programme objectives & vision statement			
Preparation for Change	**Change Management Training**	**G**	• Masterclass to be scheduled for Board • Potential opportunity for further foundation cohort • Change Community to be established			
	Programme Documentation	**G**	• Review PID / EQIA/ QIA • Review programme structures • Further work to update overarching programme plan with key leads			
Engagement & Communication	**Communication Strategy**	**G**	• Initial Communication Notice to be released in August • Undertake a focused month long communications campaign (Oct) • Develop and finalise detailed Communication Plan			
	Engagement Strategy	**A**	• Develop a re-profiled Engagement Delivery Plan • Re-engage with Consultation Institute to support Engagement Delivery Plan			
	Engagement Activities	**G**	• Schedule and undertake planned engagement activities for Phase 1 • EASC engagement (Sept) and opportunity to engage with Directors of Primary & Community Care (Sept)			
Enabling Change	**Strategic Workforce Planning (D&C Review 2023)**	**G**	• 2023 D&C Review to incorporate the ITT ambition • Steering Group established, first meeting scheduled in August			
Setting Outcomes & Measures	**Evaluation Framework & Benefits**	**G**	• Internal discussion and meeting with Swansea University to consider 'logic evaluation framework'			
Tests of Change	**APP Perfect Day Project PDSA 2**	**G**	• PDSA2 Event scheduled for 22nd August • Operational Event Plan approved by the Optimising Care Group and SOT sighted 15th August			
	APP Navigator HDUHB PDSA 2	**A**	• PDSA2 due to commence start of Q2 however, this has been delayed until 1st Oct, due to newly recruited APPs needing to complete ECNS and MPDS training in Sep			
	Connected Support Cymru	**A/G**	• CWR: Continue to develop the CFR Pilot • SBRI: Commence Phase 2 (pending outcome of evaluation of Phase 1)			
	SBRI (Phase 2)	**A**	• Subject to formal approval of P1, Phase 2 'Live testing' to commence with selected supplier(s)			
	Transformation Map	**G**	• Further mapping aligned to wider organisational work streams reported through ICAPs.			

Programme Forward View

Domain	Project / Workstream	RAG	Next Steps	Aug	Sep	Oct
Commissioning, Funding & Business Case		**NS**	• No active investment / business cases in development			
Designing the Model		**NS**	• Detailed design of the model to formally commence following engagement process (focus on Tests of Change in advance of engagement activities)			
Implementing the Model		**NS**	• Implementation not started (focus on Tests of Change in advance of engagement activities)			
Evaluation & Benefits Realisation		**NS**	• Formal evaluation to commence following design and clinical model sign off			

AGENDA ITEM No	**11**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

Digital Reporting 2023-24

MEETING	**Finance & Performance Committee**
DATE	**18th September 2023**
EXECUTIVE	**Interim Director of Digital Services**
AUTHORS	Digital Leadership Group + James Rowland (cyber)
CONTACT	Leanne.smith4@wales.nhs.uk

EXECUTIVE SUMMARY

This paper reminds of WAST's Digital Strategy, published in 2020, and brings forward a newly developed metrics report for oversight of the implementation of this strategy, as well as monitoring of digital systems status, service quality, and our cyber security and resilience position.

The Digital Report (Appendix 1) offers a snapshot of the current state of digital in WAST reflecting data from the period of 1st April to 31st July 2023; it intends to report to the Finance & Performance Committee on a bi-monthly basis from September 2023 onwards to build assurance.

The report is currently made up of the following sections:

1) Data & Analytics status
2) ICT Systems status
3) Service provision and quality
4) Summary of IMTP contributions
5) A 'spotlight' item (where the deep dive topic will change each month)
6) People (this page of the report is currently in development).

A report with metrics for the Cyber Security & Resilience position will be presented to the Closed meeting of this committee, also from September 2023 onwards.

The Committee are asked to **CONSIDER** the metrics report (Appendix 1 – Digital Reporting Sept-23), and **AGREE** if reporting in this form will meet the oversight & assurance requirements, with a frequency aligned to the Committee cycles.

KEY ISSUES/IMPLICATIONS
The people aspect is not yet considered by this report, but is a significant challenge for the Digital Directorate. Metrics around resource capacity and culture will be developed for the next publication of this report.

REPORT APPROVAL ROUTE
Digital Leadership Group – 23rd August 2023 (first review) + 5th September (final review of metrics report) EMT – 6th September 2023 (metrics report only) FPC – committee consideration 18th September 2023 (metrics report + SBAR)

REPORT APPENDICES
Metrics report: Digital Reporting September 2023 (reflects data from April-July 2023) **Cyber report:** Detail on the Cyber metrics are reported separately to FPC Closed, but are a continuation of this report and paper.

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

SITUATION

1. With the ambition of being a clinically-led, digitally-enabled, organisation, WAST has been prioritising technology and data in its strategic ambitions for several years. The Trust was one of the first NHS Wales organisations to fully enable home working with the rollout of O365 during the pandemic; over the past two years WAST successfully switched from paper-based care records to fully electronic versions; we delivered an award-winning implementation of a platform for the Clinical Support Desk service to enable remote (including video) triage of patients; and recently became the first major UK Ambulance Service to transfer to the new national Control Room Solution.

2. Progress against the direction laid out in the Digital Strategy can be seen through achievements of the previous, and commitments of the current, IMTP, and is predominantly monitored through the Strategic Transformation Board structures. However, as well as enabling the organisational strategy and other directorate plans, Digital has a number of areas that require development and innovation locally to help WAST continue moving forward and fully realise the vision of the Digital Strategy.

3. One of the priorities of the Finance & Performance Committee (FPC) in 2023-24 is oversight of the Digital strategy, with cycles of business stating:

> *3.26 Oversee, contribute to, and monitor the implementation of, the **Digital Strategy** with metrics for **digital systems infrastructure** being reported each meeting, and digital strategy updates reported periodically as required (following Strategic Transformation Board).*

4. Cyber Security and resilience also feature under the FPC Business Continuity heading, with cycles of business stating:

> *3.29 Oversight and scrutiny of **cyber resilience** including assurance on awareness and training of WAST staff and volunteers; maintenance of upgrades/ updates of systems, and replacement of legacy / high-risk systems*
>
> *3.30 Oversight and scrutiny of **cyber security** including assurance of regular monitoring of risks and threats, business continuity planning and engagement with nation cyber centres and stakeholders.*

5. Additional Digital objectives and elements feature in other forums, including: Audit Committee (which will monitor the Digital team contribution to the Q&PMF); QUEST (for Information Governance and Information Security); and ELT (with updates / escalations coming directly from the Digital Leadership Group – DLG, and the Information Governance Steering Group – IGSG).

6. This first overarching Digital progress paper to FPC intends to:

1) offer a reminder of the **digital strategy**;

2) provide an update on **progress** against this plan;

3) introduce a report of key digital system & service **metrics** to support monitoring and assurance by the committee.

BACKGROUND

Digital Strategy 2020

7. The Trust published the Digital Strategy in 2020 (link) at the height the Covid-19 pandemic, setting out the direction for our future. The Digital Strategy called out key **4 missions** (which are still relevant today):

8. Since the publication of the Digital Strategy, WAST has made great progress towards the goal, with a number of large **digital patient and digital workplace** transformation programmes completing in 2022-23 and others piloted and now progressing through 2023-24. These include:

- ePCR (full migration from paper to electronic patient care records)
- ECNS (implementation in CSD including functionality for video triage)
- Robotic Process Automation (supporting the Financial Sustainability Programme and People & Culture Plans)
- Migration to new Control Room Solution (as enabler of the broader Operational Communications Programme)
- 111 website user experience, integration & content enhancements

9. The **Digital Foundations mission** captures a number of the "back-end" technical projects which are vital for resilience and the success of other projects around the organisation. Recent achievements in this space have included:

- Enabling the re-purposing of *existing* estate for additional call taking capacity
- Provisioning of *new* estate with ICT infrastructure and equipment
- EMS CAD, telephony and network upgrades
- Enhancing security to meet the challenges of new and increasing cyber threats
- Upgrading and/or replacing legacy equipment and systems

10. In November 2022, a Digital Strategy update was presented at Strategic Transformation Board, specifically considering the direction of our Data & Analytics and the **Intelligence through Data mission**. Since then, the team has filled vacancies, introduced enhanced ways of working, strengthened internal relationships, and built new relationships with academia, resulting in progress under this mission such as:

    - Development of new Clinical Intelligence data layers and dashboards, supporting the migration of clinical indicators to the new ePCR minimum data set, along with development of a "Call to Door" metric
    - Introduction of ESR data into the WAST data warehouse for more flexible management and insight
    - Development of specialist dashboards for dementia and falls teams
    - Expert analytical support for the clinically-led 'Red Review'
    - Iterative approach to dashboard product development (e.g. CCC dashboard) and enhance provision of near real-time insight tools
    - Improved local data resource (and contribution to the national data resource programme led by DHCW)

11. Although the strategy is still aligned and relevant to the ambitions of the Trust, and gives a direction still suited to the wider NHS Wales landscape, there are some gaps in the depth of the plan:

    a. Cyber resilience and Information Security require specialist and dedicated focus, which is not drawn out in enough detail in the 2020 strategy.
    b. The changing landscape for data, data science and AI means governance and ethics in this area ought to draw on national guidance and be considered in the context of Data Protection, with clarity on ownership for technical governance within WAST.
    c. The Digital Foundations mission predominantly references major ICT systems, yet all areas of Digital have numerous workstreams under this heading, enabling local delivery plans around the Trust, which often do not feature in the IMTP, but require significant effort.
    d. The 2020 Digital strategy had an accompanying Target Operating Model (TOM) produced to support its delivery. This went some way to address the capacity issues and structure within such technical fields,

but progress towards this has been slow due to constraints on recurrent funding and challenge in recruitment.

Leadership

12. The Trust first created a Director of Digital Services post in 2019 to unify the functions of data & analytics and ICT, and saw the appointment of Andy Haywood. Since August 2022, an Interim Director has covered the portfolio, and a new substantive Director, Jonny Sammut, will enter post September 2023. The timeline of strategy implementation may be affected as a result; however, the current prioritised plans and projects will take WAST another leap forward to a modern, resilient, secure, and data-informed organisation.

13. The Director of Digital is supported by the Digital Leadership Group (DLG), made up of subject matter experts and leaders in ICT and Data & Analytics, and of the Operational Communications Programme (OCP). The group meets weekly, with Finance, People, and Planning & Performance business partner colleagues regularly supporting.

ASSESSMENT

Reporting

14. The accompanying Digital Report (Appendix 1) offers a snapshot of the current state of digital in WAST, and intends to report to FPC on a bi-monthly basis from September 2023 for oversight and to build assurance.

15. The report is currently made up of the following sections:
    7) Data & Analytics status
    8) ICT Systems status
    9) Service provision and quality
    10) Summary of IMTP contributions
    11) A 'spotlight' item (i.e. a deeper dive into a different area of digital or project each month)
    12) People (this page of the report is currently in development but intends to report on resource capacity, vacancies, sickness, professionalisation, and culture within the Directorate).

16. This month's report (September 2023) reflects highlights and monitoring for the period from 1st April up to 31st July 2023, unless otherwise stated. Points of note from the metrics report include:

17. **Data & Analytics:** Due to system pressure, there is extreme demand on the Putting Things Right team within WAST in relation to concerns and patient

safety. Investigations that arise from these concerns result in requests to various supporting teams, including Records Services in the Digital Directorate. Records Services provide personal information related to the incident, and have also seen an increase in volume of internal requests and from coroners. For a small team there is a risk of not being able to respond to request in a timely manner, impacting WASTs ability to be compliant.

18. **ICT Systems:** The metrics presented refer to availability of our critical systems with target rating defined according to UK industry standards. Where we are not meeting the target, this is often not within WAST control – where a supplier issue arose, the report does not yet differentiate between WAST mitigations reducing the user impact / unavailability, and supplier management. It shows impact to users, not successful resolution. We will look to develop these metrics further and separate this detail out in future.

19. **Service Provision:** This section represents the quality of the services provided by the Digital teams. It predominantly features volume and timeliness of response to requests, but also where we have added value for ourselves (e.g. use of automation to assist with more efficient responses to requests).
20. **Contributions:** The intention of this section is to allow at a glance a view of progress against the IMTP and digital missions. It is not at this stage scientific in its approach, and does not intend to duplicate the detailed, action-led, tracking through IMTP monitoring and Strategic Transformation Board. It is a high-level overview of the areas of involvement of our Digital people where it may not always be immediately obvious.

21. **Spotlight on Cyber:** The intel presented to FPC regarding Cyber reflects the elements of Cyber Resilience & Security that are managed by Digital – i.e. the technology and process elements of *People* > *Process* > *Technology*. A separate Information Governance & Information Security metrics report has been developed for QUEST, which features metrics related to the staff responsibilities of InfoSec & Cyber – i.e. the people elements of *People* > *Process* > *Technology* such as training compliance, understanding and individual breaches.

22. Note also that detailed reporting regarding **Cyber Resilience & Security** will regularly be found under the FPC Closed agenda from September 2023 onwards. This spotlight is a one-off offering of recent achievements.

Challenges

23. WAST Digital are not immune to the common challenges faced by public sector digital teams and champions. Capacity across the Digital Directorate often has a direct consequence on project/programme transformational change where

competing demands for key technical resource has a bearing on timelines. Recruitment and retention of technical experts and their specialist skills is difficult in what has become an increasingly challenged market since the pandemic.

24. Other challenges include: a decentralised approach to insights, analytics and modelling across WAST (where high demand for intel means the small central analytics team are often asked to share raw data, rather than produce insights, making verification and ensuring a single source of truth difficult); recent reductions in Welsh Government funding via the Digital Priorities Investment Fund (DPIF); appetite and curiosity from around the organisation for new technologies and innovations (such as Automation & AI) without correct investment around guidelines, frameworks and ethics; and gaps in support & funding for priorities (e.g. 111 ICT, analytics and web development).

RECOMMENDED: The Finance & Performance Committee are asked to CONSIDER the metrics report (Appendix 1 – Digital Reporting Sept-23), and AGREE if reporting in this form will meet the oversight & assurance requirements, with a frequency aligned to the Committee cycles (i.e. every 2 months).

Digital: Data & Analytics

Data Lifecycle

The 6 stages of the data and analytics lifecycle and related metrics.

Records Requests

Not including Police requests or ePCR processing

Data Warehouse completion (reduction of manual data sets e.g. for MIQPR)

tbc

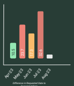
Metric in development

Warehouse availability

Metric in development

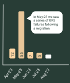
Information Requests Received vs Completed

Turnaround for non-trivial tasks (avg days)



Difference in Requested Date to Completed Date

Total Data Load Failures



Data Protection & Data Quality metrics found in Information Governance and Security Report

Digital: ICT Systems

System availability metrics

N.B. these are not reflective of SLAs, and do not yet differentiate supplier issues & resolutions

Definitions based on industry standards
<4.32 mins downtime >99.99%
>4.32 and <43.8 mins >99.9%
>43.8 mins downtime <99.9%

System	System Availability %	Note
EMSC CAD C3	A M J J A S O N D J F M	PSBA issues in April & June caused short network outages. Network outage following planned maintenance in July. Users experienced CAD impact.
999 EMS Telephony	A M J J A S O N D J F M	Shared issue as for CAD C3 in July.
NEPTS CAD Cleric	A M J J A S O N D J F M	
CSD ECNS Lowcode	A M J J A S O N D J F M	
ePCR Terrapace	A M J J A S O N D J F M	
111 CAS	A M J J A S O N D J F M	
111 Telephony	A M J J A S O N D J F M	

Digital: Service Provision

Quality, efficiency, and stakeholder feedback: JULY 23

ICT Service Desk

14 Service Desk hours saved in July through use of RPA

SLA* for new accounts (hours): **24**
*pre-RPA SLA = 6 days

Top 5 July Service Desk Requests
- RPA Service Requests 100
- Password Resets 53
- Hardware / Laptops 44
- Software issues 44
- Distribution Groups 34

1204 total requests

86% Incidents resolved within target
96% Requests resolved within target

Note: not all incidents or requests can be resolved by WAST

Records

RPA for PCR requests saved people hours in July 2023 **17**

Metrics in development
TBD - average number of breach days per breach

HI Help Desk

July Informatics Requests 89 total requests

Same day turnaround of 'quick' tasks **55%**

If non-quick tasks = 3 days on average to complete, then 89 requests = 2000 people hours, which would require >13 FTE analysts to complete each month.

111 Website

62% average engagement rate

Engagement = users with a session >10 seconds, a conversion event, or 2 or more page views.

Average engagement time via mobile and desktop **~1 MINUTE**

Digital Contribution 23/24

Digital Patient
- Digital Medicines
- 111 Website
- CSC Wearables

Digital Workplace
- MDVS Pilot
- MDVS Rollout
- 111 IIS
- Automation

Intelligence through Data
- Data Linkage
- Q&PMF reporting
- MSc Projects

Digital Foundations
- CRS
- 999 Upgrade
- ECNS Upgrade
- Estates / Fleet

Our People
- Dig Experience
- Dig Champions

See IMTP trackers (STB) for action & milestone based progress.

RAG and progress based on LDP tracker. Last updated 4th August 2023 by DLG

Digital: Spotlight

Cyber Security & Resilience

Exec Summary April-August 2023

Reporting
- Monthly **management report** developed for DLG from Apr-23
- **InfoSec metrics** developed and reported to DLG, IGSG and QUEST as part of IG KPI report from Aug-23
- **Resilience reporting** to flow through FPC from Sep-23

Awareness
- Roll-out of Trust supplementary cyber **awareness training** 'Metalearn': ~35% completion of each module
- Organisational **training compliance** for IG + InfoSec = 71% as of 31st July 2023 (threshold = 75%)
- Progress of **calendar campaign** inc. posters at sites + inclusion of recent EMT suggestions (e.g. content to be developed for Roadshows; screensaver / background)
- **Socialising impact** of attack on health & care (link)
- Plans for national cyber **career awareness** week (w/c 18th Oct) inc. Q&A, blogs, promotional items.

Incidents
- 1 **incident reported** to CRU under NIS regulations in June 2023 (BT outage affecting 999 telephony, met threshold for 'Significant' impact)

Assurance
- **Internal Audit** for cyber with 'reasonable' overall assurance level presented
- NIS regulation **assurance assessment** completed - recommendations are informing Improvement Plan
- Enforced **password reset** work underway (>1000 weak passwords identified across the Trust)
- **Improvement plan** progress:
- **Patching** progress (recommendation of audit and improvement plan)
- InfoSec **policy** out for consultation

The intel presented to FPC reflects the Digital-led elements of Cyber Security & Resilience only (e.g. Tech + Process). See Information Security & Governance KPI Report (as presented to QUEST first in Aug-23) for metrics related to staff responsibility of InfoSec (i.e. People elements).

See Cyber Management Report under Closed FPC agenda for supporting detail - this will be presented regularly to FPC from Sept-23.

Digital: People

Page in development

AGENDA ITEM No	12
OPEN or CLOSED	
No of ANNEXES ATTACHED	1

Mobile Data Vehicle Solution - Project Assurance Review

MEETING	Finance & Performance Committee
DATE	18th September 2023
EXECUTIVE	**Dr Leanne Smith, Director of Digital Services**
AUTHORS	Keith Williams
CONTACT	Keith.williams4@wales.nhs.uk

EXECUTIVE SUMMARY

The Mobile Data Vehicle Solution (MDVS) project seeks to replace the legacy Mobile Data Terminals (MDTs) which forms part of the WAST safety and critical communications infrastructure.

The project secured Welsh Government funding approval in June 2022 which triggered the formal commencement of the project.

The committee will recall a Project Assessment Review (Gate 3) conducted in January 2022, at the time of submission of the Full Business Case, awarded an "Amber" Delivery Confidence Assessment which was presented to Committee in May 2022.

Subsequently, as the project progressed to the "***readiness for service***" stage the Review Team were invited back to conduct a further gateway review. The review (appendix 1) awards an Amber/Green delivery confidence assessment, defined as "***successful delivery appears probable. However, constant attention will be needed to ensure risks do not materialise into major issues threatening delivery".***

The Review Team made 5 recommendations which have subsequently been actioned by the MDVS project, the status of which being: -

1. ***Project Documentation*** – should be updated to ensure consistency and accuracy.
   The MDVS Project implemented a review process governed by the Programme Management Office Manager to manage documentation in line with best practice.

2. ***Stakeholder Engagement*** – a round of stakeholder engagement / communications, aligned to the project plan should be conducted.

   The MDVS project has actively sought to engage with all key stakeholders, whilst utilising communications channels inclusive of MS Teams and Siren to ensure dissemination of project information.

3. ***Risk Register*** – the risk register should be updated to include mitigation.

   The Project Team have enhanced the risk management process, established bi-monthly reviews and transferred the risk register to the Trust Datix system with mitigation activities captured.

4. ***Monitoring of Key Risks*** – the SRO should ensure constant monitoring of key risks to ensure they don't escalate into delivery issues which present a cost / schedule overrun.

   The delivery risks, relating to Road Traffic Act, logistics and installation facilities and deployment of the Control Room Solution have now been resolved.

   Though new emerging risks relating to technical interfaces between new technologies (CRS to NMA) and delay in the development of the NEPTS specific application have delayed mass deployment. The Trust moved into Live Pilots (May 2023) and anticipates mass deployment beginning in October 2023.

5. ***Benefits Matrix*** – complete the benefits matrix and ensure that benefits outcomes and measurements are identified.

   A Benefits Management Plan has been ratified through project governance.

A third and final project assessment review will be planned for 12months post project completion.

Recommendation: The Committee are asked to note:

1. **The positive delivery confidence assessment (Amber/Green) and the actions taken in response to the recommendations made by the review team.**

KEY ISSUES/IMPLICATIONS
• No significant issues / implications identified.

REPORT APPROVAL ROUTE
Digital Leadership Group –

REPORT APPENDICES
Appendix 1 **Gateway review 4 Report attached.**

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

Llywodraeth Cymru
Welsh Government

OGC Gateway™ Review 4: Readiness for Service

Project Title:	**WAST Mobile Data Vehicle Solutions**
IAH ID number:	**AH/22/087**

Version number:	Draft 1.0 – 14th December 2022 Final 1.0 – 4th January 2023
Senior Responsible Owner (SRO):	Keith Williams
Date of issue to SRO:	Draft: 14th December 2022 Final: 4th January 2023
Department/Organisation of the Project	Welsh Ambulance Service Trust
Review dates:	12th to 14th December 2022
Review Team Leader:	Robin Davis
Review Team Members:	Beverley Jenkins Alison Tang
Previous Review:	PAR 25th to 27th January 2022 AMBER
Security Classification:	Official

This assurance review was arranged and managed by:

Welsh Government Integrated Assurance Hub (IAH)
Cathays Park 2
Cathays
Cardiff
CF10 3NQ
IAH helpdesk: Assurance@gov.wales

1.0 Delivery Confidence Assessment (DCA)

Delivery Confidence Assessment:	**Amber/Green**

The Review Team finds that successful delivery appears probable. However, constant attention will be needed to ensure risks do not materialise into major issues threatening delivery. The Review Team found that good progress has been made since the last Review was undertaken in January 2022.

The Review Team have seen a Project on a Page (POAP) document which indicates that the rollout of the MDVS will start in May 2023 and last 13 months. The proposed 'Go Live' date is known to the Project Team and Ambulance Radio programme (ARP) stakeholders with many who are confident that these timescales are achievable. The Review Team found that SAT testing is completed as a process, but there are some aspects which WAST wish to revisit given the delivery of further Road Traffic Act (RTA) functional software. As such they will revisit those elements of the testing when they have access to the upgraded software. The Control Room Solution (CRS) programme will go live in March 2023 although the Review Team believes this is not a show stopper should it be delayed.

Following the successful Service Acceptance Testing (SAT), a Live Operational Pilot has been scheduled to start in February 2023 for a 3-month period. The pilot will consist of 4 vehicles with the new Mobile Data Terminal (MDT) equipment installed.

The next phase starts in May 2023 and covers the actual rollout of MDVS across the entire WAST fleet. The Review Team found that the next phase has three main risks that need to resolved prior to the start of the deployment. These are currently not issues as the key stakeholders believe they will be resolved. The current key risks are:

1. MDVS Software updates due to changes in Road Traffic Act.
2. Vehicle Installation Locations.
3. Control Room Solution.

As the project moves into the next phase, so communications with the end users and key stakeholders will be crucial. It should be noted that some seem confused

around the dependency on Emergency Services Network (ESN) and do not know when delivery of the end solution will start.

As the deployment is completed so ongoing monitoring of benefits will become even more important.

The Review Team makes 5 recommendations for the Senior responsible Owner (SRO) to assist in ensuring a successful project outcome is achieved.

1.1 Delivery Confidence Assessment

The Delivery Confidence assessment RAG status should use the definitions below:

RAG	Criteria Description
Green	Successful delivery of the project to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery.
Amber/Green	Successful delivery appears probable. However, constant attention will be needed to ensure risks do not materialise into major issues threatening delivery.
Amber	Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and, if addressed promptly, should not present a cost/schedule overrun.

Amber/Red	Successful delivery of the project is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and establish whether resolution is feasible.
Red	Successful delivery of the project appears to be unachievable. There are major issues which, at this stage, do not appear to be manageable or resolvable. The project may need re-baselining and/or overall viability re-assessed.

2.0 Summary of Report Recommendations

The Review Team makes the following recommendations which are prioritised using the definitions below:

Ref. No.	Recommendation	Urgency (C/E/R)	Target date for completion	Classification (Please enter the categorisation number from the list provided here)
1.	The Project Team should update all Project Documentation to ensure that it is consistent and accurate.	E- Essential	End of March 2023	3.2
2.	The Project Team should undertake a round of stakeholder engagement / communications to ensure that everyone is aligned to the new project plan.	E- Essential	End of April 2023	2.2
3.	The Project Team is to update the Risk Register to include mitigating actions and all residual risks.	E- Essential	End of January 2023	9.2
4.	The SRO should ensure constant monitoring of the key risks is in place to ensure that these do not escalate into a delivery issue that will present a cost/schedule overrun.	C- Critical	Do Now	9.2
5.	The Project Team is to complete the Benefits Matrix and ensure that benefit outcomes and measurements are identified.	E- Essential	End of March 2023	6

Critical (Do Now) – To increase the likelihood of a successful outcome it is of the greatest importance that the programme should take action immediately

Essential (Do By) – To increase the likelihood of a successful outcome the programme/ project should take action in the near future.

Recommended – The programme should benefit from the uptake of this recommendation.

3.0 Comments from the SRO

WAST would like to extend its thanks to the Review Team for their dialogue and advice throughout the review period, as well as for their efficient production of such a comprehensive report. The last 12 months in particular have been some of the most challenging in the history of our organisation, with records broken for hours lost to handover delays with the demand on our service compounded by impending industrial action which prevented WAST Operations Stakeholders participating in the review. As such, the Operational Communications Programme (OCP) team continue to do an incredible job maintaining momentum in delivering this project. We welcome the findings of the Review Team and recognise the rationale for the Amber / Green rating. We also recognise and welcome the fact that all the recommendations within the report are within our gift to rectify swiftly.

However, we will always remain dependent on the overarching ESN and ARP Programmes for key support surrounding certain delivery aspects. A summary of how we anticipate addressing the recommendations made by the Review Team are highlighted below:

Recommendation 1 - The Project Team should update all Project Documentation to ensure that it is consistent and accurate.

Action 1 – The PMO will implement a process that governs the consistency and accuracy of project documentation. Due date 31.01.2023

Recommendation 2 - The Project Team should undertake a round of stakeholder engagement / communications to ensure that everyone is aligned to the new project plan.

Action 2 – The Project Team will schedule a round of engagement events for key stakeholders. Due date 31.03.2023

Recommendation 3 - The Project Team is to update the Risk Register to include mitigating actions and all residual risks.

Action 3 – The Project Team with the respective Project Boards will review the risk register ensuring residual risk and risk mitigation is adequately managed. Due date 31.01.2023

Recommendation 4 - The SRO should ensure constant monitoring of the key risks is in place to ensure that these do not escalate into a delivery issue that will present a cost/schedule overrun.

Action 4 – The SRO will pro-actively monitor the key risks ensuring these are mitigated prior to go-live, specifically: -

- MDVS Software updates due to changes in Road Traffic Act: - The Project Team will work with ARP and the operational leads in supporting the software development as mitigation to the RTA. All software upgrades will be deployed in advance of live pilots due Feb 2023.
- Vehicle Installation Locations: - The Project Team are currently reviewing the Telent vehicle installation proposal with a recommendation on the way forward planned to be presented to the Operational Communications Board on the 26th January 2023.
- Control Room Solution: The CRS and MDVS Project Team are closely linked in order that any changes to the CRS migration date can inform the MDVS deployment plan, with CRS Trust Milestone 6 (end to end testing) will provide a definitive understanding if there is a challenge to the migration plan. Due date 01.05.2023

Recommendation 5 - The Project Team is to complete the Benefits Matrix and ensure that benefit outcomes and measurements are identified.

Action 5 – The Project Team will schedule 3 benefits realisation workshops between January and March 2023 that will complete the individual benefit outcomes and measures templates. Due date 31.03.202.

Keith Williams, Head of Operational Communications Programme (MDVS- SRO)

4.0 Background

The aims of the project:

The Welsh Ambulance Service Trust (WAST) Mobile Data Vehicle Solution (MDVS) Project formed part of the overarching Emergency Services Mobile Communications Programme (ESMCP). The MDVS Project deals with the in-vehicle communication platform that will be used by Operational staff in the field. Due to serious delays in the delivery of ESMCP, the MDVS Project is now decoupled and can be delivered without any reliance on the successful delivery of ESN.

The WAST fleet of vehicles currently have Mobile Data Terminals (MDT) fitted that are at obsolescence. These are fitted across the fleet and include Emergency Ambulances (EA), Rapid Response Vehicles (RRV), Non-Emergency Patient Transport Service (NEPTS), Training vehicles and specialty vehicles such as the Hazardous Area Response Team (HART) vehicles.

The MDT screen allows the Coordination Centres (CC) to send data packages to the operational crews for them to read on the screen. The MDT also has satellite navigation functionality and can be used to send and receive two-way data messages to and from the CC. The original MDT screens within the WAST fleet are circa 20 years old and are now end of life. The software solution used currently is supplied by Terrafix. WAST are working with the Ambulance Radio Programme (ARP) to provide the end-to-end data solution for the WAST fleet. The proposal is to fit all vehicles with a replacement MDT which will host the Terrafix National Mobilisation Application (NMA), the interface between the operational users and the CC.

The ARP Full Business Case Phase 4 was approved by DHSC committee in July 2021.

WAST are working with their Full Business Case, dated 18th August 2021.

The driving force for the project:

The Scope of the Project is for the successful delivery of the Ambulance Radio Programme: Mobile Data Vehicle Solution (MDT) across the WAST fleet to provide critical data communication using new MDT screens, whilst replacing the obsolete technology. This covers:

- Procurement and installation of all necessary infrastructure.
- Testing of the MDT (NMA) system.
- Staff training.

The key objectives for the Project are:

- No effect on day-to-day operations - To ensure that the MDVS Project is delivered with minimal disruption to the day-to-day operations of WAST or to patient care.
- Improve current solution available to operational staff - To improve the technology currently available in the operational field with enhanced mapping, screen clarity and interaction opportunities with the MDT.

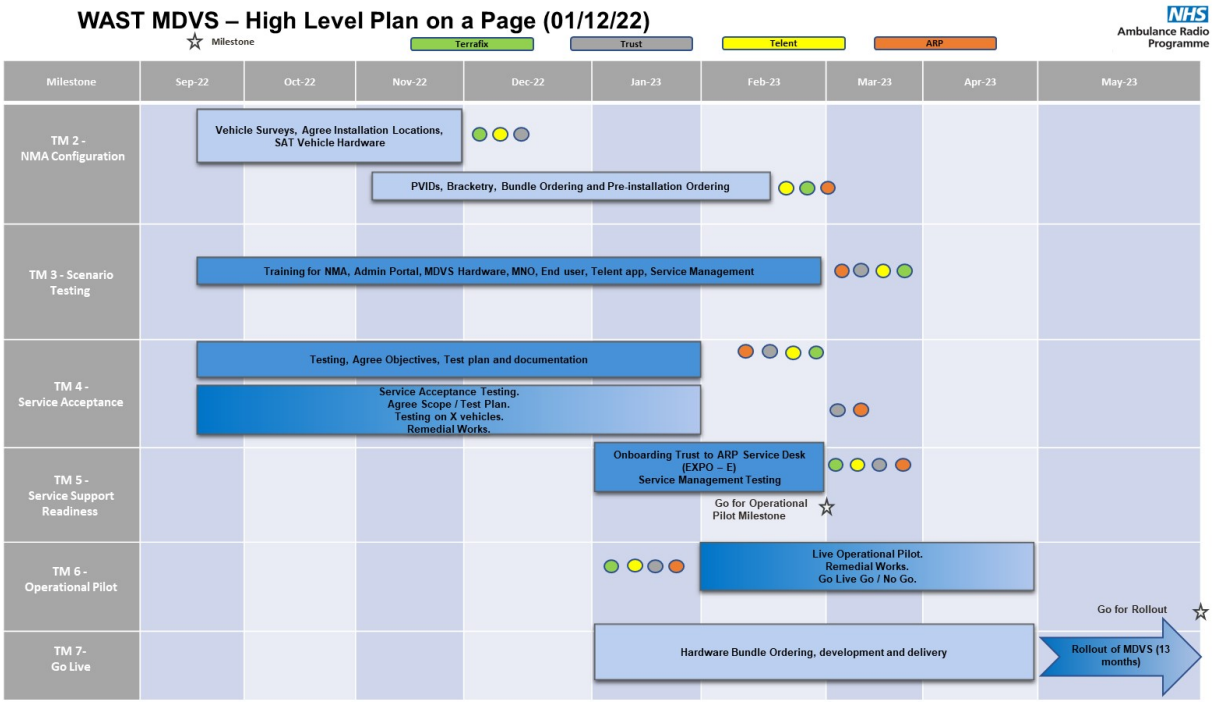
The Critical Success Factors for the Project are:

- Minimal disruption during the assimilation to the new MDT screen and NMA.
- Engaging with staff to ensure staff are trained in the use of the MDT and NMA ahead of the roll out in their area.

The delivery status:

The Testing matrix states that the current testing has passed 97% of the tests undertaken. Preparations to start a Live Operational Pilot in February 2023 are ongoing.

The Project timeline is shown below:



Current position regarding previous assurance reviews:

A PAR was undertaken in January 2022 with an Amber DCA. All Actions were accepted by the SRO and Project Team. A summary of recommendations, progress and status from the previous assurance review can be found in **Annex C.**

5.0 Purposes and conduct of the OGC Gateway Review

The primary purposes of an OGC Gateway Review 4: Readiness for service, is to confirm that contractual arrangements are up to date, that necessary testing has been done to the client's satisfaction and that the client is ready to approve implementation.

Annex A gives the full purposes statement for an OGC Gateway Review 4.

Annex B lists the people who were interviewed during the review.

6.0 Acknowledgement

The Review Team would like to thank WAST stakeholders for their support and openness, which contributed to the Review Team's understanding of the project and the outcome of this Review. Particular thanks go to Steve Lynch for his work in managing the logistics and preparing for the review.

The stakeholders interviewed are included in **Annex B**.

7.0 Scope of the Review

The scope of the Review follows the standard Gateway 4 review process with the Project Team asking the Review Team to assess the readiness for service relating to the project and its ability to deliver a safe and successful transition to ARP Mobile Data Vehicle Solution (MDVS). The Review should follow lines of enquiry relating to:

- Whether the solution is robust before implementation and meets the agreed policy and strategic need;
- How ready the organisation is to implement the business changes that occur before and after delivery;
- Confirming that the contract (MOU) management arrangements are in place or being arranged;
- Confirm contingency options for project delay, whilst covering the residual programme risks and mitigation plans; and
- Whether there is a basis for evaluating ongoing performance.

8.0 Review Team findings and recommendations

8.1: Business Case and stakeholders

Business Case

The Review Team received a copy of the WAST Mobile Data Vehicle Solutions Full Business Case, dated 18th August 2021. WAST are working to that Business Case, although it is worth noting that the timeline has been updated to the timeline as shown in Section 4 of this Report.

Funding is available and signed off on the 7th June 2022 by WG NHS Capital, Estates & Facilities. Progress is reported via the Capital Management report (PPR) that is sent to Welsh Government every 2 months. The finance section is completed by the WAST Finance Team before it is submitted so as to ensure WG understand rate of spend.

Stakeholders

The Review Team found that not all stakeholders understood that the MDVS Project had been decoupled from ESMCP and that some believed successful delivery was predicated on delivery of ESN – noting that this is now forecast for many years in the future. Secondly, some stakeholders seemed unaware of the dates the project are working with and when the actual solution would appear in Ambulances. Thirdly, Stakeholders seemed confused about the reliance on completion of the Control Room Solution (CRS) and if this was detrimental to successful delivery of the MDVS solution. It is worth noting that this feedback took the Review Team a long time to unpack and understand clearly, this was also not helped by inconsistencies in the project documentation received. In moving forward, it is important to ensure that all documentation is updated and accurate and that all stakeholders are aligned to the delivery plan through thorough and clear stakeholder engagement and good communications.

Recommendation 1: The Project Team should update all Project Documentation to ensure that it is consistent and accurate.

Recommendation 2: The Project Team should undertake a round of stakeholder engagement / communications to ensure that everyone is aligned to the new project plan – and that they understand when the solution will go into Live Service and what training will take place.

The Review Team found that the WAST project team continues to work well with the Department of Health Ambulance Radio Programme Team.

The projects leadership have a good understanding of operations and their colleagues requirements which helps with understanding the logistical impact and planning, although at present this thinking is not up to date in terms of documentation.

8.2: Risk management

The Review Team received a copy of the MDVS Risk Register dated, 1st December 2022. The Risk Register is updated monthly as part of formal governance. The Risk Register does not include any mitigating actions against identified Risks, and this would be useful so that stakeholders understand what needs to be done to resolve them. Also, this would hopefully avoid any stakeholder confusion with over emphasis and making problems larger than they actually are. Clarity is key to manging expectations. In addition, there are no residual risks listed at all and that these could evolve and create serious impact on the projects delivery so reporting them is good practise.

Recommendation 3: The Project Team is to update the Risk Register to include mitigating actions and all residual risks.

The Review Team found that the Project Team are currently dealing with three main risks:

1. MDVS Software updates due to changes in Road Traffic Act - This is being managed by ARP nationally and should be complete by time of rollout starting in May 2023.
2. Vehicle Installation Locations – there was an initial assumption that WAST would provide locations for installation of equipment into vehicles. Given the current operational demands this has been identified as now not possible. Meaning that WAST need to obtain additional sites for installation. Discussions with the ARP installer Telent are ongoing and again should be concluded by time of rollout starting in May 2023. This might present a cost overrun, it might not.
3. Control Room Solution – The Review Team received mixed messaging on the dependency of this and whether it was key to successful delivery or not. The Project Team seem to have a plan to mitigate this but it was not totally understood by all stakeholders.

In order to ensure that the current plan is not adversely affected the Project Team and the SRO will need to ensure constant attention is given to these three risks in order to ensure that they do not become issues that affect project delivery.

Recommendation 4: The SRO should ensure constant monitoring of the key risks is in place to ensure that these do not escalate into a delivery issue that will present a cost/schedule overrun.

8.3: Review of current phase

The current phase goes up to the Live Operational Pilot which ends in April 2023.

The Review Team have seen a Project on a Page (POAP) document which indicates that the rollout of the MDVS will start in May 2023 and last 13 months. The proposed 'Go Live' date is known to the Project Team and ARP stakeholders with many who are confident that these timescales are achievable.

The Review Team found that SAT testing is completed as a process, but there are some aspects which WAST wish to revisit given the delivery of further RTA functional software. As such they will revisit those elements of the testing when they have access to the upgraded software.

The Control Room Solution (CRS) programme will go live in March 2023 although the Review Team believes this is not a show stopper should it be delayed. The Review Team have heard the MDVS project is pretty much a standalone project and any delays or slippage to the CRS project would not impact the MDVS project as the kit being installed in the vehicles would be able to connect to the CRS whether this is the new or the existing solution. Development work to the existing CAD update may be delayed which could cause a slippage to the Live Operational Pilot.

The Review Team found that a campaign across the estate was undertaken to engage with the front-line colleagues to ensure they have early sight of changes and benefits of the new equipment that will be installed in the vehicles. This gave colleague opportunities to see a demonstration, examine/test the equipment and provide feedback.

A Training plan consisting of relevant videos available online and use of up to 3 hours of CPD time per person has been put in place. This was a lesson learnt from previous projects as a preferred tool to use for training without causing too much disruption and burden to the front-line colleagues.

Following the successful SAT, a Live Operational Pilot has been scheduled to start in February 2023 for a 3-month period which could be reduced should there be any slippage elsewhere. The pilot will consist of 4 vehicles with the new MDT equipment installed.

The Review Team had sight of the MoU which enables the WAST team to utilise the ARP contract. However, it was noted the MoU was dated 2018 and it was clearly defined as to what services was being purchased and if there was any leverage for WAST for any delays or suppliers not meeting their contractual obligations. Stakeholders intend to update this MOU as the project moves into Go-Live and on-going Service Delivery.

From January to April 2023, the Project will be purchasing the equipment for the rollout and there are no foreseen delivery issues as ARP have already pre-ordered equipment for Wales. This is a welcome improvement on the last Review where global supply issues were affecting the projects timelines.

8.4: Readiness for the next phase – Rollout of MDVS

The next phase starts in May 2023 and covers the actual rollout of MDVS across the entire WAST fleet.

The FBC (Phase 3) set out the case for ARP to proceed with an incremental delivery which includes the vehicle hardware to be implemented into ambulances.

The Review Team found that the next phase has three main risks that need to resolved prior to the start of the deployment. As stated above the risks are:

1. MDVS Software updates due to changes in Road Traffic Act.
2. Vehicle Installation Locations.
3. Control Room Solution.

The Review Team found that the project team are currently working on resolving the Vehicle Installation Locations challenge and have developed a number of options to resolve this. There was an initial assumption that WAST would provide locations for installation of equipment into vehicles. Given the current operational demand on WAST this has been identified as now not possible, meaning that WAST need to obtain additional sites/ people for installation purposes. Discussions with the ARP installer Telent are ongoing and again should be concluded by time of rollout starting in May 2023. This might present a cost overrun.

Service Support and service delivery is being considered prior to rollout and will be refined as deployment takes place in conjunction with ARP colleagues. It should be noted that elements of the ARP service desk are already in place and used on other projects.

As the deployment is completed so ongoing monitoring of benefits will become even more important. The Review noted that need for the Project Team to develop a benefits matrix during the last review. Whilst some work was done on this, this was not totally completed and will need to be completed and managed throughout the life cycle of the project. WG in particular are very keen to see ongoing routine reporting of benefits.

Recommendation 5: The Project Team is to complete the Benefits Matrix and ensure that benefit outcomes and measurements are identified.

9.0 Next Assurance Review

The next Assurance Review will be a Gateway Review 5: Operations review & benefits realisation. This Review should take place 12 months after the completion of MDVS deployment.

ANNEX A

Purposes of OGC Gateway™ Review 4: Readiness for service

- Check that the current phase of the contract is properly completed and documentation completed.
- Ensure that the contractual arrangements are up-to-date.
- Check that the Business Case is still valid and unaffected by internal and external events or changes.
- Check that the original projected business benefit is likely to be achieved.
- Ensure that there are processes and procedures to ensure long-term success of the project.
- Confirm that all necessary testing is done (e.g. commissioning of buildings, business integration and user acceptance testing) to the client's satisfaction and that the client is ready to approve implementation.
- Check that there are feasible and tested business contingency, continuity and/or reversion arrangements.
- Ensure that all ongoing risks and issues are being managed effectively and do not threaten implementation.
- Evaluate the risk of proceeding with the implementation where there are any unresolved issues.
- Confirm the business has the necessary resources and that it is ready to implement the services and the business change.
- Confirm that the client and supplier implementation plans are still achievable.
- Confirm that there are management and organisational controls to manage the project through implementation and operation.
- Confirm that contract management arrangements are in place to manage the operational phase of the contract.
- Confirm arrangements for handover of the project from the SRO to the operational business owner

- Confirm that all parties have agreed plans for training, communication, roll-out, production release and support as required.
- Confirm that all parties have agreed plans for managing risk.
- Confirm that there are client-side plans for managing the working relationship, with reporting arrangements at appropriate levels in the organisation, reciprocated on the supplier side.
- Confirm information assurance accreditation/certification.
- Confirm that defects or incomplete works are identified and recorded.
- Check that lessons for future projects are identified and recorded.

ANNEX B

List of Interviewees

The following stakeholders were interviewed during the review:

Name	Organisation and role
Leanne Smith	Interim Director of Digital Services
Tony Bracey	WG – Head of Programmes Community Safety Division
Ian Gunney	Deputy Director NHS Capital, Estates & Facilities
Craig Jones	WG – MDVS Business Case Co-Author
Michelle Williams	JESG - Programme Manager - All Wales Communications Projects
Kevin Alexander	ARP – Head of Contract Management
Matthew Cann	Programme Manager Emergency Medical Retrieval and Transfer Service
Keith Williams	Head of Operational Communications Programme
Debbie Richardson	MDVS Project Manager
Ian Hough	ARP Programme Director
Damon Turner	Trade Union Partner
Stuart Murphy	ARP – Senior Programme Manager - MDVS
Aled Williams	Head of ICT

ANNEX C

Progress against previous assurance review 25th to 27th January 2022 recommendations:

Taken from Mobile Data Vehicle Solution PAR Action Plan V1.1, 28th January 2022.

Recommendation	Progress/Status
The SRO should review project staffing to ensure that there is adequate resource to deliver the project as it enters into a critical phase of delivery.	Completed
The SRO should drive the completion of the scrutiny grid and engage with WG regarding approvals of the business case to ensure funding is available and can flow against a defined payment profile.	Completed
The Project Team should develop a more detailed plan for the project identifying key tasks, milestones and resources required.	Completed
The SRO should undertake a contingency planning session and build this into requisite plans.	Not Complete - Due to the nature of the project there is very little if any contingency approach. The ESMCP business case and independent assessment by the JESG in Wales have reviewed alternative approaches to ESMCP determining that there is no other than to ultimately move away from Airwave as a service. Though recognising that the programme is currently securing an extension to Airwave in order to mitigate current re-procurement activities. WAST will therefore continue to utilise Airwave services as a contingency to delays until a time when there is confidence in the Emergency Services Network.
The SRO should undertake a contingency planning session and build this into requisite plans.	Completed

The SRO should undertake a contingency planning session and build this into requisite plans.	Partially Completed – Benefits workshop reported as ongoing.

AGENDA ITEM No	**13**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**6**

Environment, Decarbonisation and Sustainability Update August 2023

MEETING	Finance & Performance Committee
DATE	18th September 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 Lucinda Wassall – Project Manager
CONTACT	Joanne.williams10@wales.nhs.uk

EXECUTIVE SUMMARY

To provide an update on:

- Decarbonisation Programme Board and other wider governance
- WAST Decarbonisation Action Plan update
- NWSSP Decarbonisation Co-ordination Reporting (DCR)
- Welsh Government reporting
- Surveying of WAST estate to support development of EV charging network
- Internal Audit – Decarbonisation
- Capital Investment – EFAB Funding
- Waste Management – internal audit, update report and legislation.
- Reinforced Autoclaved Aerated Concrete (RAAC)

RECOMMENDATIONS:

- **NOTE** this update, specifically in relation to the DAP reporting and establishment of programme management arrangements.
- **NOTE** the quantitative carbon report,
- **ENDORSE** the 2022-23 Sustainability Report, for subsequent approval by Trust Board.
- **NOTE** the DCR submission to NWSSP, approved for submission by the Executive Director of Finance & Corporate Resources.
- **NOTE** annual waste reporting requirements, changes to waste policy & upcoming changes to waste legislation.
- **NOTE** the outstanding internal audit recommendations and plans for their closure.

- **NOTE** the Utility, Water & Waste report.
- **NOTE** the update and assurances provided in relation to RAAC.

REPORT APPROVAL ROUTE
Capital Management Board – 8th September 2023 Executive Leadership Team – 13th September 2023 Finance and Performance Committee – 18th September 2023

REPORT APPENDICES
Appendix 1: Decarbonisation Programme Board Terms of Reference Appendix 2: Risk register Appendix 3: DCR Submission Report *Emailed separately.* Appendix 4: Quantitative report to Welsh Government *Emailed separately.* Appendix 5: Sustainability Report 2022-23 Appendix 6: Annual Utility, water and & waste report

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	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 & PERFORMANCE COMMITTEE

Environment, Decarbonisation & Sustainability Update

September 2023

SITUATION

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

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

BACKGROUND

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

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

ASSESSMENT

Decarbonisation Programme Board and other wider governance

5. As Committee members will recall, the Programme Board was established in January 2023 and has met regularly since on a quarterly basis, with the most recent meeting taking place on 21st August 2023. The Board is chaired by the Director of Partnerships and Engagement and is comprised of members from across the Trust. As the Programme Board is developing, it is maturing in its work programme and approach, and updates currently focus on overseeing the work of the Decarbonisation Action Plan, and bringing into one place the various reporting requirements, which are also set out later within this report.

6. The Terms of Reference and Project Initiation Document have been reviewed and agreed by Programme Board members. The terms of reference are

included, for information, at ***Appendix 1***. Work has commenced on the development of all project documentation including a detailed risk register and this is reviewed at each Programme Board meeting. This risk register development is also linked to work on the Corporate Risk Register; work has been ongoing to articulate the level of corporate risk for consideration at Board level. Given the complexity and range of risks within this work, it has now been agreed that a programme level risk management approach is the most appropriate, with specific high level/corporate impact risks escalated as necessary. Risk 542 is currently in development at a CRR level, but will need further consideration and may need to be separated into several risks rather than one composite risk.

7. The highest rated risks continue to be highlighted within this report. The list below details those risks with a score of 25:

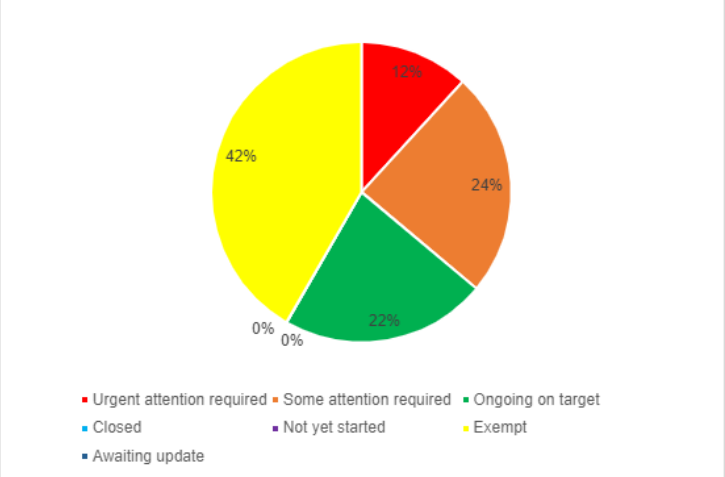
    a. If there is a failure to secure adequate funding then this would impact on improving the estate/fleet and reducing carbon emissions resulting in an inability to meet the targets set by WG
    b. If there is a failure to improve/upgrade leased buildings then this would prevent building being brought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

8. It should be noted that other risks are identified at a lower but still significant (15 – 20 score rated) level. The risk register will continue to be reviewed and mitigation action accelerated wherever possible. However, some of the mitigation is outside of WAST control, sitting with industry, partner organisations, Welsh Government or within funding constraints currently being experienced. The risk register is enclosed, again for information, at ***Appendix 2***.

WAST Decarbonisation Action Plan update.

9. Capital Management Board have received regular reporting on action plan progress since September 2022. The reporting follows the standard Strategic Transformation Board reporting, but given the breadth of actions within the report, a "Gateway Review" type scale has been deployed to indicate overall programme rating; it is noted that this continues to evolve and is somewhat subjective but helpful in identifying an overall value. From a starting point of Red/Amber, the assessment is now Amber and the progress against several of the actions has been recorded as outlined below.

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



Total actions on report	**144**
Urgent attention required	17
Some attention required	35
Ongoing on target	32
Closed	0
Not yet started	0
Exempt	60
Awaiting update	
OVERALL REPORT RATING	**AMBER**

11. This September 2023 report therefore differs from that set out in the previous update (May 2023), as the total number of actions has increased from 106 to 144. However, the number of exemptions have changed, in line with the new NWSSP DCR reporting and increased to 60. This means that WAST now has 84 actions for which it has to report. Of these, 17 are marked as red/urgent attention required and a 'deep dive' session was undertaken by the team on 4th September to consider those actions which can be accelerated. The DCR is included at ***Appendix 3***.

12. Given the ambitious timescales for the completion of the DCR report, it has not been possible to review each action individually, but this work will be completed over the coming weeks to provide a line of sight between the DAP and DCR report. However, it has been confirmed that no actions have been 'lost' in the translation between DAP and DCR reporting.

Welsh Government reporting (including reporting via NWSSP)

Qualitative and Quantitative reporting

13. Following the quantitative and qualitative reporting cycle in September 2022, a further qualitative report was requested in April, and this was reported to the Committee in the May 2023 update. The Trust has now been informed that qualitative reporting timeframe will move from bi-annually to annually to align with the IMTP. A date for this submission is not yet confirmed.

14. Public sector carbon reporting quantitative data for 2022-23 required a submission by 4th September 2023. This data set does not require approval by the Finance and Performance Committee. However, as this information feeds both carbon reporting and the associated carbon reduction performance narrative it is presented for noting. This is enclosed at ***Appendix 4***.

15. The annual Sustainability Report, which forms part of the Trust's Annual Report amalgamates both the qualitative and quantitative information and data sets and includes sustainability updates on environmental initiatives and the Trust's ISO14001 accreditation. This document (enclosed at ***Appendix 5***) however does require **endorsement** by the Finance and Performance Committee and subsequent submission to Trust Board for **approval**.

16. It should be noted that the Sustainability Report, on the face of it, presents a headline value of a significant increase in WAST's carbon emissions between 2021/22 and 2022/23 as outlined below. However, the reasons behind this are then also further explained below and links into that previously highlighted as one of the higher risks currently being described in paragraph 7 and the

ability to currently track movements in emissions of a consistent basis. It is also a challenge that will be similarly faced by all NHS Wales organisations.

WAST Emissions (*Units of tCO^2e*)	
2022-23	773,379
2021-22	32,342

17. This significant increase is predominantly due to a change in the data collection required by Welsh Government and the inclusion of aspects of emissions data which were previously not applicable. Changes to WG carbon calculation methodology since the strategic plan development, and current public sector carbon reporting has created an inability to compare current information with the 2018/19 baseline; this also includes a change in denominator from tonnes (CO^2e) to Kgs (CO^2e). Therefore, to enable WAST to have some understanding of its carbon footprint data during this time, the annual carbon emissions for years 2018/19 to 2020/21 have been re-calculated using the 2021/22 methodology.

18. It should be noted that data prior to 2021/22 excluded supply chain emissions data, as this is gathered by NWSSP as the procurement provider. However, this data (scope 3 emissions data) is now included in the reported figures therefore 2021/22 and 2022/23 data incorporates this. It is therefore not possible to directly compare the data for 2018/19, 2019/20 and 2020/21 to the past two year's worth of data as a whole. The Sustainability Report therefore separates this out within the document to demonstrate variation by category during this 5 year period.

19. The table below demonstrates the variations across key categories and it can be observed that the majority impact of the increased headline reported emissions has been generated by the inclusion of data for medical gases (739,904,200 Kg CO^2e in 2022/23) and FGas (Flurocarbonated gas used in AC systems) (971,686 Kg CO^2e in 2022/23). All other figures remain broadly comparable. It should be noted that there have been significant savings in gas/LPG use as we move to decarbonise the estate; however this does lead to a corresponding increase in electricity use (to a lesser extent as some of this is offset by renewable energy solutions such as PV panels).

Table 3: Trust emissions by category 2021-22 & 2022-23

Category	2022-23	2021-22	Difference +/-
	Kg CO^2e	Kg CO^2e	Kg CO^2e
Medical Gasses	739,904,200	n/a	n/a
FGas	971,686	n/a	n/a
Fleet Fuel	13,039,762	13,066,596	-26834
Electricity	855,981	951,327	-95346
Water	2,654	2,604	50
Gas/LPG	605,076	732,989	-127914
Business Miles	543,227	503,687	39540
Domestic Waste	39,767	48,751	-8984
Fleet Waste	781	639	142
Commuting & homeworking	283,737	275,193	8544
Land sequestration	-14,535	n/a	-14535
Supply Chain	17,146,514	16,759,929	386,585
Total	**773,378,849**	**32,341,716**	
Renewables	-27312	-4117	-23195

20. As noted in the context of financial sustainability and cost savings programmes, business mileage increased between 2021/22 and 2022/23 as the Trust emerged from the pandemic and returned to more frequent meeting in person and greater travel across the estate. This will need to be kept under review, as business mileage should be kept to a minimum to ensure that the Trust's carbon emissions are not negatively impacted.

21. Commuting and homeworking data is not robust at this point in time. The Trust, in line with all other NHS Wales organisations, does not have a methodology nor means of data capture for this data set. Welsh Government have outlined a methodology for calculating this value which is based on total staff numbers. Therefore, whilst this data is based on some significant assumptions, the suggested increase currently is due purely to the increased staffing WAST has seen over the past two years. It is acknowledged that a majority of staff increases are front line staff which would be exempt from the commuting and homeworking figures, but there is currently no way of distinguishing this within the data.

22. Lastly, the final line in the table demonstrates the return on investment through renewable energy, and it can be seen that there is a benefit to the Trust of c23,000 Kg CO^2e reduction in emissions through installation of this technology. It is anticipated that this figure will be even greater for 2023/24 reflecting on the investment in technology within all current capital investment estate projects.

NWSSP Decarbonisation Co-ordination Reporting (DCR)

23. NWSSP has received a significant investment to further increase its capability to oversee and monitor delivery of NHS organisations' DAPs and we anticipate a significant requirement for completion of information on a regular basis. This in turn places a significant pressure on the small WAST team and potentially distracts from the ability to focus on progressing actions, as required.

24. Via the WG led "Community of Experts" discussions and in line with feedback from other organisations, WAST continues to represent the view that any reporting should be directly into Welsh Government and should be proportionate and corporately approved by the Trust prior to submission. As the DCR Team matures its approach, there have been complex, varied and changing requests around information requirements by NWSSP. WAST expects further requirements and timescales to be confirmed by NWSSP in due course, but capacity to respond to these continued requests which often duplicate information being requested elsewhere, is limited. Whilst approval requirements are still emerging, and undoubtedly will now be out of alignment with pre-determined work programmes for various Trust internal reporting groups and the Finance and Performance Committee, it is acknowledged that reporting lines within the Trust including via this forum take supremacy and external reporting should align with Trust requirements.

25. The first (pilot) NWSSP DCR report was submitted in June 2023, this report covered only Transport and Procurement (TaP) initiatives progress for Q4 2023. The Trust has now received the updated reporting timeline, which is quarterly. All actions within the DAP will require an update each quarter. The first report required submission by 31st August 2023. The DCR report is attached to this report therefore for information, and the Committee is asked to retrospectively note its submission, which was approved by the Executive Director of Finance and Corporate Resources prior to submission. The risk register was also submitted, and this has been reviewed by the Decarbonisation Programme Board (also attached for information).

26. Within completion of the range of information required, and the associated adjustments to the DAP and other internal reporting mechanisms, it has been identified that there is both duplication, and a significant time commitment. In the current financial climate, the dedication of finite resource to the completion of documentation and reporting which duplicates existing information and process poses the Trust with a challenge. The Trust may want to consider the commitment required going forward, and the ability to manage continued requests for information from NWSSP. This risk has also been raised at the Decarbonisation Programme Board, and an action agreed to review this further.

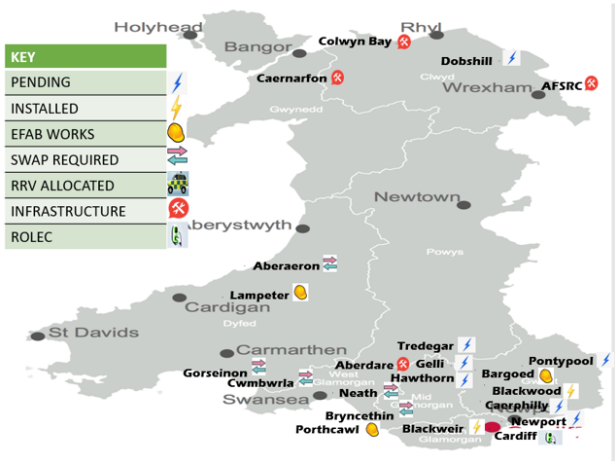
Surveying of WAST estate to support development of EV charging network

27. The end of the 2022/23 financial year saw a reflection on significant progress made with the development of our EV charging network. Generated by a need to establish a network to support the roll out of the 23 hybrid RRVs which was successfully achieved, further work then continued to maximise coverage across the estate.

28. The graphic below highlights the contrast between the coverage of EV charging as at June 2022 compared to March 2023, and a total of 67 chargers over 54 sites.

29. The Project team are working to develop an updated graphic through Power Bi. This will provide an opportunity to combine EV charging use with financial data in an automated dashboard, and will represent a significant shift forward in how we capture, monitor and report data on EV charger use.

EV Charging Capability in WAST



June 2022

March 2023

30. It should be noted that this has now addressed the areas where additional capacity could be added within the remit of WAST control. The remaining stations/areas now mostly comprise of non-WAST owned estate such as leasehold stations or where we retain space from partners e.g. Fire Services and Health Boards. In addition, there are electrical capacity limitations on other sites especially in parts of rural mid Wales and North West Wales where the regional infrastructure does not currently allow for installation of charging points.

31. Welsh Government provided a sum of £60k in 2022/23 which was used to survey the remaining WAST estate and provide an estimate of requirements to upgrade the infrastructure to provide for enhanced EV charging. The total cost of this work (excluding leased sites and shared sites) would be c£3m to upgrade the network capacity from the Distribution Network Operator (DNO). It should therefore be noted that any further expectations around additional charging capacity across the estate will need to be considered. Current limitations on Fleet BJC 2023/24 funding mean that currently further EVs are not due to be purchased in this financial year.

32. In accordance with the request of the Executive Management Team, the newly established Transport Group was tasked with considering how staff charging capacity could be provided across the Trust. The Trust has previously determined that the Pod Point chargers should be allocated for Trust vehicle use only. Whilst further information has been made available to indicate that the chargers could perform a dual function in use for both, the practical implications of this make such a dual use difficult to manage and this will need to be scoped in further detail. In the meantime, requested further actions regarding identifying opportunities to trickle charge via external sockets have identified few opportunities that would be considered safe or practical and again these would need to be managed on an operational and practical basis. This work has been on hold whilst the Head of Capital Development has been out of post, but will be reinstated for further consideration in due course.

Internal Audit – Decarbonisation

33. An Internal Audit (IA) took place during October 2022, as part of the 2022/23 agreed IA plan, and a significant amount of information (comprising c50 pieces of information) was provided to the Internal Audit Team. The output of the work was a generic all NHS Wales report and the resultant management response/action plan is being managed through the Decarbonisation Programme Board. At the August meeting, members noted that 6 actions remained ongoing within the context of the wider programme timescales, with one (engaging with HEIW regarding training opportunities) requiring attention and this will be progressed.

34. A second Internal Audit started on the 06/07/2023, this audit has a standard scope, set centrally and will again be undertaken pan NHS Wales. The project team have facilitated the provision of all required information and are awaiting an update on the outcome of the audit. This will be reported to Capital Management Board and ELT and Committee once known.

Capital Investment – EFAB Funding

35. Further WG Estates Funding Advisory Board (EFAB) funding for 2023/24 and 2024/25 has 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. The 30% contribution to be made by WAST has been identified within the Capital Expenditure Limit. Schemes range across decarbonisation and infrastructure and planning for the 2023/24 schemes will commence immediately to ensure the delivery of projects in year. As the first step in this work, a full scoping of the bids will be completed to ensure that the schemes provide value for money and return on investment opportunities. Currently the schemes identified are:
    a. Decarbonisation: AFSRC Wrexham, Blaenau Ffestiniog, Cardiff Ambulance Station, Glynneath
    b. Roofing projects: Glynneath and Bryncethin

36. The delivery of schemes under the EFAB funding scheme is project managed by the Capital Development and Estates Teams and overseen by the Decarbonisation Programme Board. In line with discussions at previous Capital Management Board meetings, project management and capital delivery resource have been identified to progress these schemes.

Waste Management

37. An audit of Trust waste management processes took place in April 2022. The audit found limited assurance of compliance to waste management requirements and compliance with Welsh Health Technical Memorandum (WHTM) 07-01 health care waste. Ten recommendations were made including identifying an executive director with responsibility for waste. A Management response detailed a series of actions to be taken forward and an action plan was produced and approved to support delivery of the action plan, a Waste Management Task and Finish Group was established comprising membership from across the Trust.

38. Four of the ten recommendations relating to the internal audit are yet to be fully completed. The latest status update against each of these is provided below:

1.	Writing of a Waste Management Policy	The recommendation is open until approval and publication of the draft policy. This is drafted however discussions regarding Director level responsibility for clinical waste are

		being held. The SOPs that form part of the master list of waste in the policy have been implemented however it is the overarching policy that brings them together with roles, responsibilities and governance structures that is out for consultation. Given the clinical waste ownership discussions, it is proposed that this action be moved to November 2023 for the policy to be presented back to the Policy Group to enable those discussions to be held. The policy will thereafter be approved by the Committee, now therefore scheduled for the January 2024 meeting.
2.	Waste management training	The recommendation was re-opened as there is currently no formal reporting route for waste management training compliance within the Trust for operational staff, with only compliance levels for Administrative and Clerical currently being undertaken. Discussions are ongoing on the development of a training needs analysis (TNA) as that was the action we agreed to. Any training packages will come from that TNA and are unlikely to be put in place now until after April 2024 as new legislation will be introduced then requiring a change in the training. IT issues raised in the audit arose because of the training on ESR was put together by BCUHB so everyone who did it were classed under ESR as a BCU member of staff and it proved impossible to segregate which staff member worked where. WAST has no control over this however the training packages that fall out of the TNA will be WAST training and WAST will be able to report on all levels of compliance. Propose closure once TNA is completed, by the end of December 2023.
3	Clinical waste transfer arrangements	Current clinical waste transfer arrangements form part of a service level agreement (SLA) with NWSSP. The current SLA does not specifically define clinical waste arrangements and is therefore deemed non-compliant. Until the Trust is able to demonstrate how the associated risk is

		being monitored and actively managed the recommendation will remain open. A hazardous waste transfer note was sent to HCS but they have not signed it, stating it was not required. Natural Resources Wales have also confirmed that we have an exemption for transferring clinical waste to HCS and that the only agreements that need to be in place are between HCS and Stericycle (which they are). The only body to whom WAST could have a contract that satisfied WHTM 07-01 is NWSSP (the authors of that WHTM) and they have declined to do so. It is proposed therefore that this item is closed when a paper is taken to a future meeting of the Finance and Performance Committee, setting out the ways in which the risk regarding the absence of a contract for clinical waste for WAST is mitigated. It is proposed that the timing for this is when the Waste Management Policy is taken to FPC (as above January 2024) so that director responsibilities for clinical risk are clear.
4	Clinical waste – hospital transfer sites.	Under WHTM 0701 an agreement to leave waste at hospital sites is required. Agreements have been written and agreed with five of the seven health boards. The recommendation was re-opened by internal audit noting that a paper to be prepared and shared at an appropriate forum detailing the current status and the proposals to manage the risk. As above, only two HBs have not returned the duty of care transfer. CVUHB are awaiting the appointment of their waste manager to sign the document. BCUHB did not sign it based on improvements being required on WAST segregation methods. WAST has held fortnightly meetings with local mangers in the HB region, as well as BCUHB management and conducted waste management audits in the area. WAST has identified issues and put in place mitigations and have written to BCUHB indicating as much and seeking their agreement to the duty of care

		transfer note. It is also therefore proposed that this action is closed when the above paper which encompasses the Waste Management Policy, etc are presented to the FPC in January 2024.

39. Upcoming changes to regulations and contracts for clinical waste could find the Trust open to fines for non-compliance. Historical, and unfortunately more recent clinical waste non-compliances have identified the need for more robust hazardous waste management, this is being addressed, including via a detailed presentation being widely provided to the organisation.

40. An additional internal audit recommendation, to include an annual waste report to this Committee has been included into an annual utility, water, and waste report. This report is included for noting by the Committee at ***Appendix 6***.

41. Confirmation has now been received that the new waste regulations (as a provision under the Environment (Wales) Act 2016) will come into force on 1st April 2024. A link to the written statement can be found here Written Statement:

    This regulation requires:

    - occupiers of non-domestic premises (including businesses, charities, and public sector bodies) to present specified recyclable materials for collection separately from each other and separate from residual waste.
    - Require those that collect the specified recyclable materials to collect them separately from other recyclable materials;
    - Require those separately collected recyclable materials to be kept separate and not mixed, and
    - Provide for civil sanctions to be available in relation to criminal offences associated with these requirements.

42. WAST had submitted representations asking for exemptions similar to those granted to acute hospitals, related to mixed municipal waste within ambulance vehicles, and the IPC concerns of manually emptying these bags and segregating the waste stored, however, no exception has been agreed. This is disappointing but not surprising. The consultation summery of responses shows the ambulance services objections. A written statement can be found here Consultation – summary of responses.

43. Due to the regulation changes WAST current waste management systems will have to be amended, and as such will include additional resource, both in working hours but also finance. The Trust will also be open to civil sanctions for non-compliance, this will be a concern at all sites but primarily those with lower-than-average recycling percentages, at some sites a recycling rate of less than 15% of total waste is not unusual.

    WAST will have to move from the two-bin approach we currently have to the following:

    - glass.
    - paper and card.
    - metal, plastic, and cartons and other fibre-plastic composite packaging of a similar composition.
    - food (produced by premises producing more than 5kg of food waste a week).
    - Other waste.

44. Additionally, further waste streams will be introduced after this initial change. These further changes are intended to minimise the risk of increasing waste crime and/or exports of low-quality textiles/ sWEEE, causing environmental problems elsewhere in the world.

    - unsold small waste electrical and electronic equipment (sWEEE);
    - unsold textiles – with the use of textile banks or recycling plants required.

45. A meeting has been arranged with our current waste disposal company to discuss the changes above and to ascertain the changes to collection costs. Further work is underway to quantify the numbers of new bins needed, in conjunction with sites who are already short of space both internally and externally.

46. These major changes may require the Trust to make difficult decisions, especially related to food waste – alongside the reduction of internal wastebin availability, moving from waste bins to waste stations. Discussions will be required with NWSSP procurement, and their intentions related to reducing waste packaging, alongside a discussion relating to old uniform. A schedule of works and resource requirements will be developed and considered by ELT in the next few weeks.

Reinforced Autoclaved Aerated Concrete (RAAC)

47. In line with other NHS Wales organisations, WAST has conducted a detailed independent inspection of all sites within scope, which details a nil return in relation to the presence of RAAC in all buildings up to 1990. In addition, further detail has been sought for buildings where WAST colleagues share estate with the Fire and Rescue Services. Both of these reports have been shared with NWSSP Shared Estates Services colleagues previously.

48. Further to this, and as a result of a subsequent request by NWSSP Shared Estates Services to increase the scope of the surveys for buildings built prior to 1995, this was further increased by the Estates team to include buildings built prior to 2000 (to seek to ensure any possible estate is now further reviewed). A desk top review of the remaining buildings built between 1990 and 2000 was undertaken and this identified a further seven buildings; each was reviewed to ascertain their construction. Two of the seven identified required a further independent survey to be conducted (by the same contractor to ensure continuity with surveys previously carried out). The result of this was a further nil return for the presence of RAAC within the seven buildings built up to 2000.

49. No further action is currently required across any of the WAST sites in relation to RAAC. A confirmation letter has been provided to the NHS Wales Chief Executive, to further support information already provided to NWSSP Shared Estates Services.

RECOMMENDATION

Finance & Performance Committee is asked to:

- **NOTE** this update, specifically in relation to the DAP reporting and establishment of programme management arrangements.
- **NOTE** the quantitative carbon report,
- **ENDORSE** the 2022-23 Sustainability Report, for subsequent approval by Trust Board.
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WELSH AMBULANCE SERVICES NHS TRUST

Welsh Ambulance Service
Decarbonisation Programme Board
Terms of Reference



Document Control

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Author: Lucinda Wassall, Project Manager

CHANGE RECORD

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23.01.2023	V5	Joanne Williams	Changes made
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DISTRIBUTION

Date	Version	Who	Role
07.09.2022	V1	Joanne Williams	Head of Capital Development
10.01.2023	V4	Joanne Williams	Head of Capital Development
23.01.2023	V5	Lucinda Wassall	Project Manager
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07.06.2023	V8	Joanne Williams	Head of Capital Development
15.08.2023	V9	Joanne Williams	Head of Capital Development
21.08.2023	V9	Programme Board	Programme Board

FORMAL APPROVAL TABLES

Date	Version	Who	Role

CONTENTS

1.0 INTRODUCTION

1.0 This document explains how the established Programme Board for the delivery of the Decarbonisation Strategic Plan will be managed and organised within the Welsh Ambulance Services NHS Trust.

2.0 PROGRAMME STRANDS

2.1 The key strands of the programme include:

- Staff Engagement
- Communications
- Workforce Organisational Change
- Procurement
- Construction/modification
- Facilities Management
- ICT Provision
- Site Operational Practices
- Commissioning
- Health and Safety
- Finance

3.0 CONSTITUTION

3.1 The Trust hereby resolves to establish a Management Group known as the Decarbonisation Programme Board. The Programme Board reports to the Capital Management Board with a dotted line into Strategic Transformational Board and ADLT (as per the ADLT terms of reference which indicate that it has a remit for this work) and has the powers specifically delegated in these Terms of Reference.

3.2 The Programme Board forms part of the Trust's overall governance framework which serves to ensure that the Programme Board gains the required assurances to be able to discharge its duties effectively and efficiently.

4.0 ORGANISATIONAL STRUCTURE

4.1 The Programme Board fits within a wider organisational structure.

4.2 The membership of the Programme Board and any associated Sub-Working Groups is to be agreed by the Programme Board.

4.3 Programme Assurance will be undertaken by the Programme Director and Programme Delivery.

5.0 PROGRAMME BOARD COMPOSITIONS AND QUORUM

5.1 The Programme Board will have the following members:

Name	Role of Programme Board	Title
Chris Turley	Senior Responsible Officer	Director of Finance
Estelle Hitchon	Chair of Programme Board	Director of Partnerships and Engagement
Benjamin Collins	Operational Lead	EMS Service Manager
Martyn Crimmins	Project Support	Senior Project Support Officer
Richard Davies	Project Director	Assistant Director of Capital and Estates
Sarah Davies	Workforce Lead	Workforce and OD Directorate Business Manager
Deborah Evans	Procurement Lead	Senior Procurement Business Manager
David Holmes	Fleet Lead	Fleet Manager
Lois Hough	Communications Lead	Head of Communication
Ian James	Trade Union Representative	Trade Union Representative
Sharon Jones	Project Support	Environmental and Sustainability Officer
Thomas Lewis	Programme Manager	Programme Manager
Trish Mills	Corporate/Risk Lead / Deputy Chair	Board Secretary
Edward Roberts	Finance Lead	Head of Financial Business Intelligence & Capital Planning
Nicci Stephens	Decarbonisation Lead	Environmental and Sustainability Manager
Jonathan Turnbull-Ross	QSPE Lead	Assistant Director of Quality Governance
Lucinda Wassall	Project Manager	Project Manager
Nicola White	Health and Safety Lead	Head of Health and Safety
Aled Williams	ICT Lead	Head of ICT
Joanne Williams	Project Director	Head of Capital Development
Keith Williams	Deputy ICT Lead	ESMCP Programme Manager
Jonathan Wilson	Clinical Lead	Head of Clinical Logistics
Susan Woodham	Estates Lead	Head of Estates and Facilities
TBC	Operations Integrated Care	
TBC	Operations Ambulance Care	
TBC	Operations Specialist Support	

5.2 In line with the outlined requirement within the Decarbonisation Action Plan that the Programme Board is chaired by a Director, the Chair is nominated to be the Director of Partnerships and Engagement. In the event of the Programme Board Chair being unavailable, the meeting will be rearranged, or the Deputy Chair Board Secretary will chair the meeting.

5.3 Additional members will be invited as and when required.

5.4 Informed deputies may attend in the absence of a member in exceptional circumstances; however, deputies must be fully briefed on the programme and must have the authority to make decisions on their member's behalf. Whether a colleague deputises must be agreed by the Chair prior to the meeting.

5.5 A quorum shall be the Chair or Deputy Chair, Programme Assurance and one Senior Users, one from Operations.

5.6 If any urgent fundamental decision are required to be made a meeting via Teams will be arranged in the first instance. Due to work pressures of the Programme Team if a meeting does not have a high attendance or is not quorate, the Project Manager will send out an e-mail clearly stating its urgency and that a reply is required by return of e-mail.

5.7 Before each meeting, an agenda will be produced by the Project Manager and approved by the Programme Director specifying the business proposed to be transacted and this shall be sent by email a minimum of five working days prior to the meeting.

5.8 The Programme Board will meet quarterly. However, the Programme Director and Project Manager may call a meeting at any time, providing as much notice as possible.

5.9 The minutes of the meeting along with an action sheet shall be formally recorded and verified by the Programme Director and distributed to the Programme Board within a week of the meeting. The minutes will then be submitted for approval to the following Programme Board.

5.10 Meeting dates will be arranged at the beginning of the programme and circulated to ensure maximum attendance. Dates and times of the meetings shall only change in extenuating circumstances.

5.11 Due to the nature, scale, and type of programme within the Programme Boards remit, it is important to have Senior Managers on the Programme Board.

5.12 This responsibility is in addition to their normal workload and, therefore, it is essential that they are allowed to manage by exception; keeping them regularly informed, but only asking them to meet for joint decision making at key points in the programme.

6.0 INFORMATION GOVERNANCE AND COMMUNICATIONS

6.1 Programme Board members are reminded of the staff impact of this programme and their need to sensitivity manage information, comments, and documents about the developments so as not to prejudice internal or external negotiations or release formal information in advance of planned communication exercises. The Programme Board will be updated on all communications in advance of release, please also refer to the Communications Plan.

7.0 PROGRAMME BOARD KEY ROLES

The key roles of the Programme Board include:

7.1 SENIOR RESPONSIBLE OWNER

The Senior Responsible Owner will be kept fully up to date on the progress made on a regular basis via highlight reports being presented to the Capital Management Board and Finance and Performance Committee and via e-mail communication from the Programme Director and Project Manager.

7.2 PROGRAMME DIRECTOR

The Programme Director is the single focal point responsible for the management of the Programme. As such he/she facilitates all communication, changes in scope of work and manages all issues relevant to the scheme. In essence, the Programme Director leads the whole process from the outset of the scheme. They will be responsible for:-

- Development and continuation of the Programme Business Cases.
- Programme organisational structure
- Programme plans (scanning / approval)
- Monitoring progress
- Problem referral and resolution
- Formal closure of the Programme; and
- Post Programme review.

7.3 PROJECT MANAGER

The Project Manager reports to the Programme Director and manages the scheme within the business case parameters of time, quality, and cost. The Project Manager takes over the delivery function from the Programme Director. The Project Manager is a named individual and assumes a number of defined duties and acts as a single point of contact.

7.4 SENIOR USER

The Senior User is responsible for the following:-

- Providing user resources for the Programme.
- Ensuring that the programme produces products that meet user requirements that are fit for purpose and meet the specifications provided or required by the users; and
- Ensuring that the products provide the expected user benefits
- Ensuring that action plans and work programmes agreed at Programme Board are supported for delivery

8.0 PROGRAMME BOARD REMIT AND FUNCTION

8.1 The Programme Board will be responsible for recommending and monitoring the developments and delivery of the DAP. The Board represents at managerial level the business user and supplier interests of the programme and are the decision makers responsible for the commitment of resources (staff, money, equipment etc) to the programme.

8.2 The Programme Board approves all major Programme plans, authorises any major deviation from plans and signs stages off when they have been completed.

8.3 Oversee, contribute to, and monitor the implementation of the Environmental Strategy

8.4 Ensure compliance with environmental regulations and national targets.

8.5 The Programme Board is a key decision-making body with responsibility for directing the Programme within its remit by:

- Approving key decisions in the procurement process e.g. appointment of advisors, short listing suppliers, selection of suppliers and any major changes to the scope of the programme;
- Identifying resources;
- Resolving issues referred from the Project Manager;
- Monitoring overall progress against plans and expenditure within its remit; and
- Ensuring timely commissioning of new services and facilities.

9.0 PROGRAMME BOARD AUTHORITY

9.1 The Programme Board recommends all major plans and any major deviation from agreed stage plans to the Finance and Performance Committee with a dotted line report into the Strategic Transformational Board. It has the authority to sign off the completion of each stage as well as authorising the start of the next stage. It ensures that the required resources are committed and arbitrates on any conflicts within the programme or negotiates a solution to any problems between any parties beyond the scope of the programme.

Tolerances - the two standard elements to tolerance are time and cost.

- **Time** - The timescales for the programme will be defined in the Programme Plans. Any slippage in timescales on critical path activities will need to be reported to the Programme Board.

- **Cost** - The Programme must fall within the budget allocation agreed as part of its procurement. However, the Programme Board will be informed if the costs of the Programme are projected to exceed the budget in the opinion of the Programme Accountant.

10.0 PROGRAMME TEAM

10.1 A Programme Team will be set up to manage the delivery of the programme strands, comprising of the following:

NAME	ROLE ON PROGRAMME BOARD	TITLE
Richard Davies	Programme Director	Assistant Director of Capital and Estates
Joanne Williams	Programme Director	Head of Capital Development
Lucinda Wassall	Project Manager	Project Manager
Nicci Stephens	Decarbonisation Lead	Environmental and Sustainability Manager
Susan Woodham	Estates Lead	Head of Estates and Facilities
Martyn Crimmins	Project Support	Project Support Officer
Sharon Jones	Project Support	Environment and Sustainability Officer

11.0 REPORTING

11.1 Highlight Reports will be prepared by the Project Manger and submitted to the Programme Board to inform of the progress made internally as deemed required. These will include information on:

- Progress made against plans
- Issues to be escalated
- Identification of risks
- Provide early warning of any other changes
- Next stages

Decarbonisation Programme Board

Project Open Risks

No.	Risk and Background	Date Raised
	Format: If…. Then... Resulting in ….	
1	It there is a failure to secure adequate capital funding then this would impact on improving the estate/fleet and reducing carbon emissions resulting in an inability to meet the targets set by WG	03/23/23
2	If there is a failure to improve/upgrade leased buildings then this would prevent building being brought up to modern standards. This would result in WAST missing DAP targets and the opportunity to lower emissions from a significant part of the estate	03/23/23
3	If the Trust does not have the correct resource/skill sets assigned to Decarbonisation projects then they will not deliver the solutions required, resulting in the need to spend additional funding to source these externally and greater overall project costs.	03/23/23
4	If the Trust is unable to influence NWSSP procurement decarbonisation work, then the Trust will not have control of carbon emissions which come from supply chain. This would result in WAST not reaching identified targets	03/23/23
5	If technology is unavailable to change fleet to full electric, then the Trust will be unable to procure ULEVs resulting in targets being unachievable	03/23/23

6	If the Trust is unable to deliver all of the actions in the DAP then the emissions will not be reduced resulting in not achieving the Decarbonisations emission targets by 2025 and 2030	03/23/23
7	If there is a lack of enough electrical infrastructure or means to upgrade the electrical supply, then the Trust will be unable to install further EV charging capacity resulting in the inability to further progress the charging network and deliver on a full EV fleet	03/23/23
8	If there is a failure to identify what investment needs are then WAST could potentially miss deadlines for funding applications. This would result in missed opportunities to invest in decarbonisation improvements and an inability to make the changes needed.	03/23/23
9	If there is insufficient directorate buy-in to the programme then the actions in the DAP cannot be progressed with specialist knowledge of how departments work, resulting in the recommendations and actions not being achievable or practical	03/23/23
10	If the Trust is unsighted on any additional decarbonisation/sustainability reporting requirements linked to the Wellbeing and Future Generations Act (as WAST will be a named Trust), then the ability to respond to this may be impacted and the Trust will fail to comply in its duties under the Act	03/23/23

11	If there is insufficient clarity on the governance structure for the project then this could lead to delays in decision making and projects being out of scope which will result in focus on the wrong things or not delivering on key actions within the DAP	03/23/23
12	If the Trust cannot install EV chargers at shared sites then this could stop the development of an EV infrastructure across WAST, resulting in WAST fleet not being able to change to hybrid/full electric vehicles in some areas.	03/23/23
13	If additional growth to the workforce is not managed appropriately then this could impact on the Trust carbon emissions through increased fleet and estate requirements resulting in the Trust not achieving DAP actions and meeting WG targets	03/23/23
14	If WAST does not have contractual and procurement frameworks available which specialise in environmental, sustainability and decarbonisation issues then WAST would be limited to the frameworks accessible for specific project's resulting in the purchased product being ineffective, unfit for purpose, time consuming to deliver and/or poor value for public money	03/23/23
15	If project costs are not accurately identified at the outset in line with robust specifications then there is a risk of budget overspend which may delay the project being successful and result in a failure of the project	03/23/23
16	If project risks are not accurately identified then this could lead to unforeseen circumstances which delay the projects being successful and result in project failure.	03/23/23

17	If there is a lack of good communication coverage and staff engagement then this could potentially impact staff awareness and directorates following incorrect procedures resulting in increased carbon emissions, incorrect disposal procedures or a failure to comply with environmental legislation	03/23/23
18	If there is poor or limited communications between departments within WAST then there is a risk of not having the knowledge of workstreams/projects being undertaken which results in an inability to reflect WAST successes and impacts on reducing carbon emissions with the DAP reporting	03/23/23
20	If there are too many demands on the team for information and/or reporting then there is a risk of duplication, contradiction or omission resulting in inconsistent reporting and possible reputational damage	03/23/23
21	If there is an inability for WAST to control all DAP actions then there will be an inability to provide information as required to parties such as audit resulting in limited assurances around the Trust's ability to deliver on its targets	03/23/23
22	If clarification on reporting schedules/templates from Welsh Government is not provided then delays could be seen due to limited resource to action which would result in deadlines not being met and increased scrutiny/reputational damage	03/23/23
23	If there is insufficient information within Procurement processes and documentation in relation to project carbon and disposal procedures, then this could result in more carbon being produced from projects completed which will mean the Trust is unable to comply with targets	03/23/23
24	If there is a governmental or wider political change then there is a risk that the focus of work will change resulting in wasted investment and an inability to complete projects which have been set in progress. This will result in WAST being unable to play its part in reducing carbon emissions and responding to the Climate Emergency	03/23/23
25	If the current NHS Wales financial challenge continues there will be reduced revenue and Capital funding to support decarbonisation initiatives. This will result in inability to follow through on commitment needs e.g., REGO energy, EV, vehicle replacement, infrastructure upgrade	14/08/2023

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NHS Trust

Date 23/03/2023

Owner	Risk Score			Notes and background (if required)
	Likelihood	Impact		
Decarbonisation Programme Board	5	5	25	
Decarbonisation Programme Board	5	5	25	A significant proportion of WAST estate is leased. We are unable to make significant changes, especially to existing infrastructure, without landlord consent. There are also accounting issues to factor in, given that we would be investing in a non-Trust asset.
Decarbonisation Programme Board	5	5	25	The consideration of options for retrofitting the estate, and design of new schemes is a specialist skill. This is an emerging area of expertise especially given speed of technology developments.
Decarbonisation Programme Board	5	5	25	All of WAST procurement is managed centrally. The Trust is yet to see any strategy which outlines how NWSSP will reduce supply chain carbon emissions through its processes. Procurement processes weighted in favour of cost often exclude higher quality, more environmentally focussed contractors, and their submissions.
Decarbonisation Programme Board	5	5	25	

Decarbonisation Programme Board	5	5	25	
Decarbonisation Programme Board	5	5	25	The Trust has now installed EV chargers everywhere there is electrical capacity and/or infrastructure available. Any further installations will be dependent on the electrical supply to buildings being increased. In some cases, this can be done by applying to the Distribution Network Operator (DNO) to increase capacity to site. However, in some parts of rural Wales, far more significant intervention will be required to boost electrical supply to whole villages/areas.
Decarbonisation Programme Board	4	4	16	
Decarbonisation Programme Board	4	4	16	
Decarbonisation Programme Board	5	3	15	Trust is due to be a named organisation under the WBFGA. Reporting arrangements and statutory obligations are yet to be determined.

Decarbonisation Programme Board	3	4	12	
Decarbonisation Programme Board	3	4	12	It cannot be assumed that WAST will be able to install chargers at shared sites. Health Board and other partners will also have a need for vehicle charging in time, and therefore the Trust will need to share resources, or make arrangements for dedicated chargers which do not adversely impact on available site capacity. This may include paying for additional capacity at non-Trust-owned sites.
Decarbonisation Programme Board	4	3	12	
Decarbonisation Programme Board	3	3	9	WAST is reliant on a network of external contractors. Currently, suppliers are on a framework which limits the specialist expertise which is accessible. Further work is required to ensure that appropriate frameworks exist for accessing both advice/expertise and appropriate equipment.
Decarbonisation Programme Board	3	3	9	
Decarbonisation Programme Board	3	3	9	

Decarbonisation Programme Board	3	3	9	Without knowledge of the Trust's commitment to decarbonisation, directorates/teams could take actions which increase our emissions or fail to comply with assurances/statutory obligations.
Decarbonisation Programme Board	3	3	9	Some teams may be undertaking actions which are beneficial to the Trust. Examples may be found in the Digital work or virtual/remote triage of patients. It will be necessary to be kept informed of this work so that the wider decarbonisation benefits can be demonstrated.
Decarbonisation Programme Board	5	3	15	There are currently many demands on the team for information sharing. Most recently Audit Wales, Internal Audit, Welsh Government (and various associated Programme/Project Boards and Task and Finish Groups) and NWSSP have all made requests to
Decarbonisation Programme Board	4	2	8	Some actions are owned/part owned by others e.g., procurement reporting or achievement of uniform disposal
Decarbonisation Programme Board	3	2	6	The Trust is waiting for clarification on the role and requirements of the newly established NWSSP team which will oversee reporting on behalf of WG. It is understood this is an additional requirement to the statutory reporting.
Decarbonisation Programme Board	3	2	6	
Decarbonisation Programme Board	3	2	6	
Decarbonisation Programme Board	5	4	20	This was added because of the recent changes to the procurement of REGO energy - starting to see tangible impacts in relation to financial pressures.

Risk Levels	
High	Significant Action needed
Medium	Some actions required
Low	All practical measures

Current or proposed mitigation	Revised anticipated risk score after mitigation	
	Likelihood	Impact
Identification of requirements and opportunities so that bids/business cases can be developed prospectively. This will enable WAST to respond quickly to any funding bid processes and also to bid for internal funding for schemes should circumstances arise.	4	5
Early engagement with landlords/building owners to establish opportunities for improved estate condition, including work by landlord. Scope out opportunities and cost of schemes which will assist in establishing feasibility/VFM of schemes	4	5
Projects to be scoped and resourced appropriately. Specialist skills and experienced identified from existing team to be used, as well as identification of any gaps/development requirements. Use of specialist external consultancy services where needed but ensuring lessons are learned for future projects so that external support is minimised in future.	3	5
Continue to engage with NWSSP and convey core messages to both NWSSP and WG. NWSSP Procurement representative invited to WAST Decarbonisation Programme Board. Work with NWSSP colleagues to support development of supply chain decarbonisation.	4	5
Continue to engage in wider UK ambulance trust work on ULEV trials e.g., YAS and LAS. Engage with suppliers to scope requirements and opportunities. Continue to engage with WG regarding financial impacts of exploring emerging technology and ability to respond quickly if opportunity arises.	5	5

Decarbonisation Programme Board to oversee delivery of DAP. Actions to be categorised by workstreams and overseen by nominated leads. Regular reports and escalation to oversee delivery. Early warning if work is off track.	2	5
£60k of WG investment has allowed for the survey of the WAST estate (not sites shared with other partners) and identification of supply upgrade requirements. Each supply upgrade will come with a cost (an average £51,177.39) and this will need to be included within investment bids. Further work will be required with partners to explore opportunities on shared sites. The Trust has 117 sites. to upgrade infrastructure on 60 sites there would be a cost of £3,070,643.56. Discussions ongoing with WG and WGES to influence feedback to DNOs at national level	5	5
Estate retrofitting guide being developed. This will need to be considered, and specifications for requirements developed. Identification of requirements and opportunities so that bids/business cases can be developed prospectively. This will enable WAST to respond quickly to any funding bid processes and also to bid for internal funding for schemes should circumstances arise.	3	4
Decarbonisation Programme Board established with representation from across the Trust. Operational representation on specific schemes e.g., Transport Group and waste management streams project will be crucial to ensure key messages are conveyed and feedback is received directly from those the changes will impact most on	2	4
Early confirmation of impacts for WAST will be required so that these can be considered by the team, and any future requirements factored into BAU. Programme Board Chair and SRO to continue to represent decarbonisation interests at EMT to ensure join up of discussions as/when more information is known	3	3

Programme Board will oversee the entirety of the DAP delivery and the governance arrangements will be set out in a PID and Terms of Reference. Workstreams will take responsibility for specific actions and report in to the Programme Board. Each workstream will report on a regular basis and escalate progress. Whilst overall Programme Board reporting sits with Capital Management Board and F&P Committee, there is a further need for clarity on the role of other groups such as EMT and STB.	2	4
Early discussions with partner organisations. Information sharing. Consideration of whether Trust chargers could be accessible to other organisations to allow reciprocal arrangements. Clear information about what is required at each site.	3	4
Significant limitations on what the Programme Board can influence given Ministerial/CASC priorities, but it will be possible to share information about energy consumption of WAST sites and fleet and impacts of growth through data. Wider actions to decarbonise the estate and fleet will support in the long term but in the short to medium term growth is more than offsetting any gains in terms of reduction in emissions.	4	3
Work with NWSSP regarding an increased and more diverse range of frameworks which can be accessed by NHS organisations to allow appropriate, timely and value for money support which enables the Trust to implement effective and efficient solutions.	4	3
Specialist expertise (both internal and external) to be deployed in scoping out requirements on a project level with detailed specifications produced which can be assessed by a Cost Advisor, and accurate estimates provided. Ability to access high quality and value for money contractors to undertake the work (via available Frameworks or wider tender arrangements) in partnership with NWSSP	2	3
Project level risk registers to be developed alongside Programme Board risk register. PRINCE2 Project Management of schemes.	1	3

Regular communication from Programme Board via the governance routes. Development of a Communications Strategy which may include regular newsletters, team briefings, bulletins on specific issues.	2	3
Regular communication from Programme Board via the governance routes. Development of a Communications Strategy which may include all of the above, as well as mechanisms to communicate with the team such as a generic mailbox, engagement at team meetings, opportunities for feedback on the work of teams/IMTP delivery.	2	3
Retain a log of information requests and information provided so that this can be re-provided if appropriate. Challenge ad-hoc requests to ensure they are genuinely needed and that the output from the work will benefit the Trust. Prioritise statutory and mandatory reporting requirements and signpost others to the information wherever possible. The ability to refuse	3	2
All actions to report through Programme Board. Where there are dependencies on other requests should be made for updates and Programme Board will still need to oversee delivery	3	2
Continued engagement with WG and ensuring that the team remains sighted on all communications. Development of a generic mailbox where information can be shared, and provision of this email address to WG, NWSSP and other partners so that the team can monitor returns.	1	2
Further work with NWSSP Procurement colleagues on the quality criteria for scoring tenders. Exploration of changing the format so that these questions do not detract from an already limit scope to score quality (40% quality/60% cost). Continued dialogue with contractors and suppliers during project delivery. Checklists of information/compliance as part of the project management and delivery processes. Needs to be applied across the Trust not just to C&E and Fleet processes.	2	2
Maintain overview of wider political context. Acknowledgement that WAST's ability to mitigate this risk is limited.	3	2
Options are limited, we will continue to make the case for investment and working differently.	5	4

Revised risk rating	Last update - Detail and Date	Date Closed / next update due
20	14/08/2023	
20	14/08/2023	
15	14/08/2023 - Risk score/ mitigation hasn't changed, reflected on improving Project Management approach.	
20	14/08/2023 - This risk needs escalation. Likelihood increase due to continuing lack of engagement with NWSSP.	
25	14/08/2023	

Likelihood of Occurence
1 Rare

10	14/08/2023 - We continue to monitor the delivery of the DAP actions, there is further work to complete to quantify how these actions translate into carbon. Every Health Board is facing challenges in confirming a methodology to do this. There is also a lack of technology which is required to meet a number of actions.		**2 Unlikely**
25	14/08/2023 - reviewed Infrastructure reports and cost added.		**3 Possible**
12	14/08/2023		**4 Likely**
8	14/08/2023 -		**5 Almost Certain**
9	14/08/2023		

8	14/08/2023 - reviewed, no further information shared at this point.	
12	14/08/2023	
12	14/08/2023	
12	14/08/2023	
6	14/08/2023	
3	14/08/2023	

Risk Rating

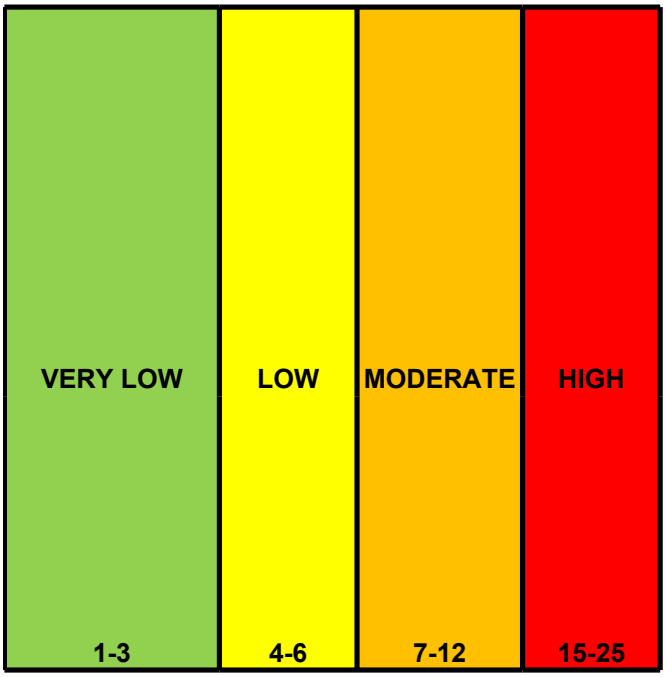
Likelihood

6	14/08/2023	
6	14/08/2023	
6	14/08/2023 Likelihood and impact score revised due to growing demand in information requests.	
6	14/08/2023	
2	14/08/2023	
4	14/08/2023	
6	14/08/2023	
20	14/08/2023	

1 Rare
2 Unlikely
3 Possible
4 Likely
5 Almost Certain

Severity of Consequence						
1	2	3	4	5		INSIGNIFICANT
Insignificant	Minor	Moderate	Major	Catastrophic	Finance	Insignificant cost increase (<0.5%)
					Service Delivery	Insignificant schedule slippage, no impact on delivery
1	2	3	4	5	Finance	Insignificant budget slippage, no impact on finances

2	4	6	8	10	Quality	Peripheral element of service suboptimal
3	6	9	12	15	Public Safety	Potential for public concern
4	8	12	16	20	Service Delivery	Loss or interruption of service for up to 8 hours
5	10	15	20	25	Compliance	Minimal breech of guidance or statutory duty
					Service Delivery	Incident whichdoes not impact patients



Description

Will probably never happen again - a one-off
Do not expect it to happen again, but it is possible
Might happen again from time to time
Will happen again, but is not a persistent issue
Will undoubtedly happen again, possibly frequently

MINOR	MODERATE	MAJOR	CATASTROPHIC
Minor cost increase (<5% of project budget)	Moderate cost increase (5-10% of project budget)	Major cost increase (10-25% of project budget)	Incident leading to cost increase >25% of project budget
Minor schedule slippage, will be recovered with no ultimate impact on delivery	Moderate schedule slippage, will not be recovered and will have some impact on delivery	Major schedule slippage, will impact delivery of project objectives	Incident causing failure to deliver project objectives
Minor budget slippage (0.1-0.5% of project budget)	Moderate budget slippage (0.5%-1% of project budget)	Major budget slippage (1%-2.5% of project budget)	Incident causing budget slippage of over 2.5%

Overall service suboptimal	Service has reduced effectiveness and has caused a complaint	Service significantly reduced, multiple complaints	Failure to provide service
Minor implications for patient safety if unresolved	Moderate implications for patient safety if unresolved	Major risk to patients, non-compliance with national standards	Gross failure to ensure patient safety
Loss or interruption of service for 8hrs to 1 day	Loss or interruption of service for 1 - 7 days	Loss or interruption of service of between a week and a month	Permanent loss of service or interruption of > 1month
Breech of statutory duty/legislation	Multiple breeches of statutory duty/legislation	Breeches of different statutory duties/legislations	Complete system change required
Incident which impacts a small number of patients	Incident which impacts a small number of patients	Incident which impacts a large number of patients	Incident which impacts a large number of patients

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NHS Trust

Welsh Ambulance Services NHS Trust

Sustainability Report

2022-23

Version 3.0 21.08.2023

PREFACE

This report provides a detailed and comprehensive breakdown of Welsh Ambulance Services NHS Trust (WAST) carbon emissions arising in 2022-23 from across WAST's operations and estate. WAST has used Welsh Government (WG) carbon calculation methodology, as instructed via the Public Sector Net Zero Reporting Guide

This report also provides a comparative analysis of performance in relation to the previous years' data and to the updated baseline year of 2018. It has been prepared following a review of internal and external documentation, interrogation of source data and data collection systems.

WG Sustainability Report writing guidance as detailed in the NHS Wales 2022-2023 Manual for accounts, chapter 3, has been followed with consideration given to HM Treasury reporting guidance.

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1.0 EXECUTIVE SUMMARY

The Welsh Ambulance Service (WAST) is aware of its obligation to reduce its effect on the environment, and as such shares a common ambition with Welsh Government (WG) to be a key player in meeting the public sector net zero carbon status by 2030.

To support this journey, WG published the NHS Wales Decarbonisation Strategic Delivery Plan (NHSW-DSDP) in 2020. This plan sets out goals and milestones for NHS bodies in order to deliver a carbon reduction target of 34%, of the combined 2018-19 annual baseline of 1,001,378 tCO_2e by 2030. In order to understand the effectiveness of the plan both qualitative and quantitative reporting is produced and reported to WG, identifying both positive and negative outcomes. A decarbonisation action plan (DAP) has been published by WAST, to identify actions and action owners to meet the required outcomes.

WAST Emissions (*Units of tCO^2e*)	
2022-23	773,379
2021-22	32,342

WAST's calculated carbon (equivalent) emissions for 2022-23 are over 773,000 tCO_2e, a substantial increase on 2021-22 reported emissions, and those calculated to develop the NHS accumulative 2018-19 baseline. However, it should be noted that changes to WG carbon calculation methodology for quantitative reporting, between strategic plan conception and current public sector carbon reporting, has brought about challenges, not least being the inability to advise on carbon reduction/ increase in comparison to baseline. This has further been affected by additional reported emission areas being included within reported data, from both baseline and the previously reported emissions. Therefore, for WAST to have some understanding of its carbon footprint, data from 2018-19 until 2020-21 has been converted into carbon emissions, using 2021-22 carbon reporting methodology. Presenting an effective comparison carbon emissions journey. This report provides a comprehensive explanation of report factors and reported guideline differences, including the change to reporting emissions in Kg's rather than tonnes, plus additional comparison data, allowing the reader to further understand the Trust's carbon reduction journey. This however does not include supply chain emission.

Work is ongoing to mitigate the trusts carbon emissions within the existing Estate by installing Solar Panels and Battery Storage with the addition of low carbon heating

systems such as Air Source Heat Pumps where appropriate, a move away from high emitting fossil fuel heating. New additions to the Trust's Estate have been designed to maximise operational carbon emissions, including renewable technology as standard. To support the capital development team a sustainable retrofit guide, specific to WAST estate has been written, with NWSSP framework guidance on new builds and major refurbishment due imminently. Waste use requires attention, with the use of this finite resource showing little change since baseline. Design changes to the Trust fleet and transition to low emission vehicles, supported by a new electric vehicle charging network across the trust has seen a positive effect on fleet emissions, assisted by active travel response by the Trusts CRU Team. Business travel remains low compared to baseline figures, however a published Green Travel Plan for all trust activities is a required action under the DAP, therefore a travel hierarchy must be established within the next 2 years to reduce these emissions further. Waste emissions, both domestic and clinical remains comparatively low, however recycling targets set by WG are not being met at the majority of sites, which will be further impacted by new legislation set to come into force in April 2024. A focused waste reduction plan is to be developed to support change to new legal compliance. Additional reporting avenues within scope 3 emissions include commuting and homeworking which, at this time, cannot be successfully quantified. Additional workstreams will have to be resourced and agreed. Supply chain emissions have been calculated by NWSSP Procurement. Challenges to procurement streams related to both environmental and financial impacts are imperative. Product lifecycle assessments should be prioritised to ensure a true cost is identified. New emissions reported for 2022-23 include medical gasses and fluorinated gases. Limited emission factor options for Entonox has in all probability increased emissions by more than required, however as both types of gas have high emission factors the Trusts emissions would have increased on last year's figures significantly.

In addition to these decarbonisation aspects the Trust has retained its ISO14001 accreditation, the only ambulance service in the UK to hold this environmental accreditation standard.

2.0 INTRODUCTION

The Welsh Government (WG) have committed to reducing national carbon emissions, with the ambition to meet a net zero target by 2050. The Welsh public sector have been identified as releasing 1% of the national calculated carbon emissions. WG have enshrined in law the need for the public sector, as a collective to be carbon neutral by 2030. To support this aim, the WG have instructed all public bodies to reduce their carbon emission, with varying percentages of reduction per service, dependent on their current impact. Carbon sequestration offsetting will be included in the public service reduction target.

2.1 NHS WALES DECARBONISATION STRATEGIC DELIVERY PLAN

In 2021, WG, aided by the Carbon Trust, published the NHS Wales Decarbonisation Strategic Delivery Plan (NHSW-DSDP). This plan sets out goals and milestones for the Welsh NHS to achieve by 2030. The strategy is structured into six activity streams.

- *Carbon management*
- *Buildings*
- *Transport*
- *Procurement*
- *Estate Planning & Land Use*
- *Approach to Healthcare*

These streams include 46 ambitious initiatives and over 130 actions with various dates of implementation and completion. WAST has been instructed within the strategy to meet initiatives and actions beyond those asked of other health boards and Trusts. WAST are the only NHS Wales organisation specifically named, apart from NHS Wales Shared Services Partnership.

The NHS in Wales, including WAST, have been set the target of reducing its combined annual carbon emissions of 1,001,378 tCO_2e by 34% by 2030, on 2018-19 baseline figures, with an incremental date of 2025, where a reduction of 16% is required. (Carbon Trust , 2021). Emissions have been attributed to the three scopes as defined by the Green House Gas Protocol (GHGP). *Figure 1*.

In 2018-19 WAST contribution using 2018-19 calculation methodology was 12,254 tCO2e (excluding supply chain scope 3 emissions).

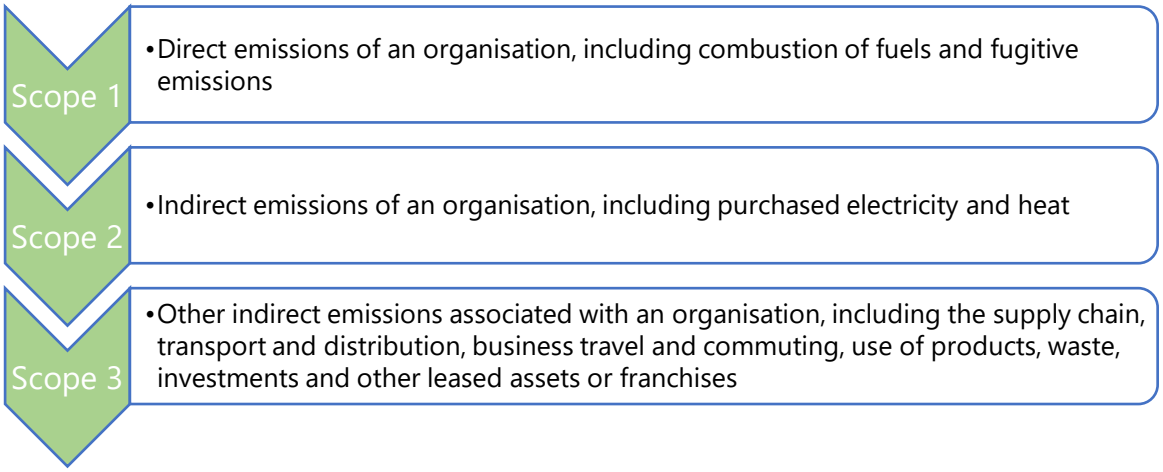


Figure 1: Emission scopes as defined by the Green House Gas Protocol (GHGP).

The following charts detail the emissions attributed to each scope & carbon footprint category.

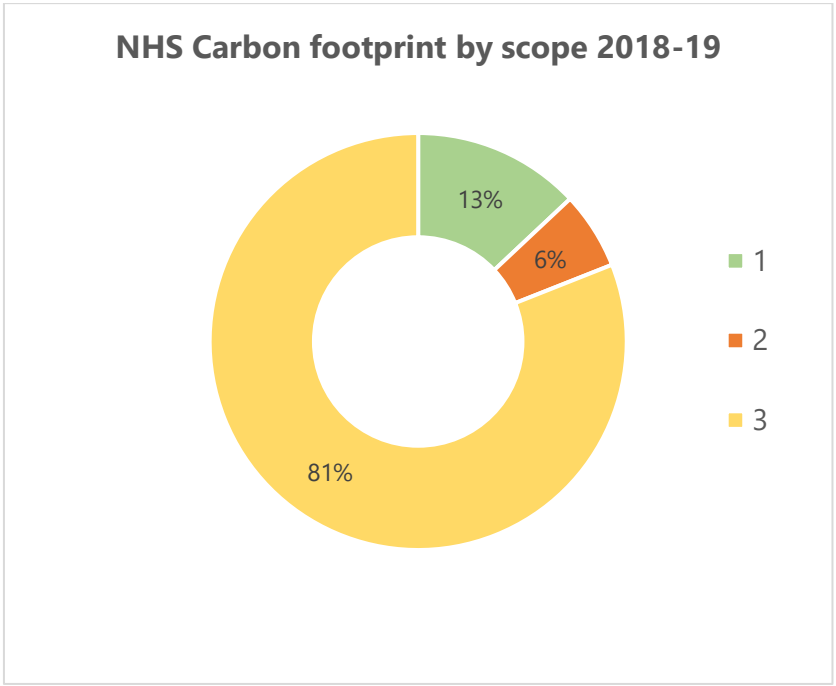


Figure 2: NHS carbon footprint by scope 2018-19 (Carbon Trust , 2021)

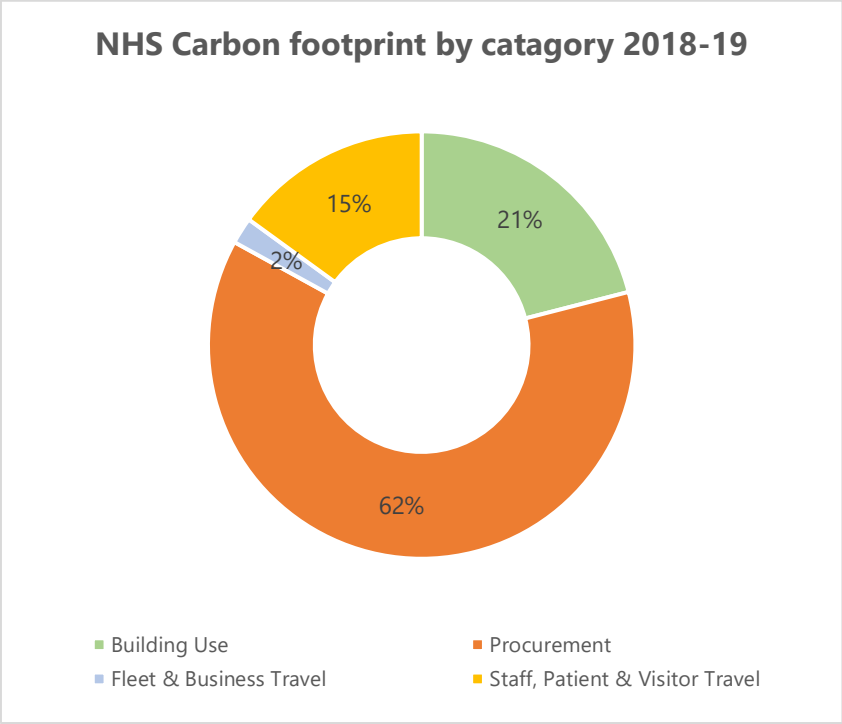


Figure 3: NHS Carbon footprint by category, 2018-19 (Carbon Trust , 2021)

To deliver the requirements of this strategy, a Decarbonisation Project Board and supplemental project teams have been assembled, alongside a Decarbonisation Action Plan (DAP), detailing specific actions and action owners.

2.2 PUBLIC SECTOR NET ZERO CARBON REPORTING.

Following the publication of the NHSW-DSDP changes to benchmarking, reporting and response were directed. In previous years NHS bodies reported carbon emissions following HM Treasury guidance, however, due to the collective nature of a net zero public sector ambition, in 2021 WG, supported by Aether, a climate change specialist consultancy, produced an annual carbon reporting data set for all public bodies to complete and report. Changes to reporting guidance and previous benchmarking data calculation methodology has been challenging, this includes excluding previously agreed carbon emissions benefits, such as Renewable Energy guarantees of Origin (REGO) certificate purchased energy, which previously was reported as renewable energy, now cannot. In 2022-23 this data set was expanded to include medical gasses and F-gas (a/c systems), this addition has significantly increased reporting emissions. To this end it has been noted by WG that the initial NHS 2018 baseline of 1,001,378 tCO_2e is insufficient, and therefore requires revisiting. Calculation factors are published annually by DEFRA for the previous

financial year, factors do not stay stagnant, they increase/decrease dependent on new research and guidance.

The reported data for each carbon element is categorised in scope, but also quality. A tier system was included to quantify the data value, plus its ease of collation, tier 1 has the lowest form of accuracy, tier 2 an intermediate choice where some data is available and tier 3 for accurate quantifiable data.

Table 1: Carbon reporting, category, and tier.

Category	Tier	Metric	Data used
Electricity	3	kWh	Direct and indirect billing using smart meter reads & 3rd party invoicing. Some minor estimates are also included. Previous years usage taken from Sustainability Report and EFPMS report 2018-19 to present
Natural Gas /LPG	3	kWh/Litre	Direct and indirect billing using smart meter reads & 3rd party invoicing. Some minor estimates are also included Previous years usage taken from Sustainability Report and EFPMS report 2018-19 to present
Fleet Fuel – Diesel, Petrol & EV	3	Litre	Direct billing. Previous years usage taken from Sustainability Report and EFPMS report 2018-19 to present
Water	3	M^3	Direct billing- water meters. Some minor estimates are also included Previous years usage taken from Sustainability Report and EFPMS report 2018-19 to present
Medical Gas	3	Kg	Direct billing.
Fgas	3	Kg	Unit volume taken from F-Gas register for the Trust. Estates Shared Drive.
Business Travel	2	£/miles & km	Some mileage is reported for car use, public transport totals calculated using public transport benchmarking methodology via reporting guidance. Previous years usage taken from Sustainability Report and EFPMS report 2018-19 to present
Commuting	1/2	Number of employees	Calculated using commute methodology via reporting guidance.
Homeworking	1/2	Number of employees	Calculated using homeworking methodology via reporting guidance

Waste	3	Tonne/Kg	Direct billing – national tender includes instruction to weigh waste at collection. Previous years usage taken from Sustainability Report and EFPMS report 2018-19 to present
Land Use	3	Hectares	Land volume information already available – reported data is Flintshire AAC /Dobshill
Supply Chain	1	£	Supplied by NWSSP procurement and reported by SIC code.
Renewables	3	kWh	Generation information via solar edge portal and PV meter reads.

3.0 CARBON REPORTING DATA

2022-23 carbon reporting calculations have seen a significant increase on 2021-22 figures. *Table 2*. This increase is due to changes on reporting metrics and the inclusion of medical gasses and estate F-gas emissions to total emission values. 2022-23 calculations have included carbon sequestration from Trust land, mainly AAC Flintshire (Dobshill), meaning a carbon offset of -14535KgCO^{2}e has been subtracted from the overall emissions total. *Table 3*.

Table 2: WAST total carbon emissions by scope - 2021-22 & 2022-23: Public Sector Carbon Reporting

Units of $kgCO_2e$				
	Direct	**Indirect**	**Indirect**	**Total**
	Scope 1	**Scope 2**	**Scope 3**	
2022-23	**751,882,544**	**640,622**	**20,855,684**	**773,378,850**
2021-22	11,127,456	693,427	20,520,833	32,341,716

In order to understand if WAST has improved on its 2018-19 benchmarking position, 2021-22 carbon reporting metrics have been used to calculate the 2018-19, 2019-20 and 2020-21 emissions, using the Aether amended calculation methodology, utilising the annual EFPMS returns. This information and method of benchmarking will provide an efficient system of emission comparison. Reported categories have been segregated to show individual category reported data, plus additional benchmark categories, bespoke to WAST.

To conform with the WG requirement for sustainability reporting the following mandatory tables have been included within the report:

- Greenhouse Gas Emissions
- Waste

- Use of Resources

Table 3: Trust emissions by category 2021-22 & 2022-23

Category	2022-23	2021-22	Difference +/-
	Kg CO^2e	Kg CO^2e	Kg CO^2e
Medical Gasses	739,904,200	n/a	n/a
FGas	971,686	n/a	n/a
Fleet Fuel	13,039,762	13,066,596	-26834
Electricity	855,981	951,327	-95346
Water	2,654	2,604	50
Gas/LPG	605,076	732,989	-127914
Business Miles	543,227	503,687	39540
Domestic Waste	39,767	48,751	-8984
Fleet Waste	781	639	142
Commuting & homeworking	283,737	275,193	8544
Land sequestration	-14,535	n/a	-14535
Supply Chain	17,146,514	16,759,929	386,585
Total	**773,378,849**	**32,341,716**	
Renewables	-27312	-4117	-23195

Additional narrative will be included in connection to performance and targets, with any issues relating to data availability already noted within Table 1. HM Treasury guidance on sustainability reporting has been reviewed for consideration of incorporation, some aspects of which have been included. This report will be made available on the WAST website, under publications via the following link. https://ambulance.nhs.wales/about-us/publications/

Table 4: Greenhouse gas emissions table: WG: Sustainability Report Guidance

Greenhouse Gas Emissions		2021-22	2022-23
Non-Financial Indicators (Kg CO^2e)	**Total Gross Emissions**	**32,341,716**	**773,378,849**
	Gross Emissions - Fleet Fuel	13,066,596	13,039,762
	Gross Emissions - Natural Gas & LPG	732,989	605,076
	Gross Emissions - Electric	951,327	855,981
	Gross Emissions - Business Travel	503,687	543,227
	Gross Emissions- Clinical & domestic Waste	48,751	38,561
	Gross Emissions – Medical Gas	n/a	739,904,200
	Gross Emissions- FGas	n/a	971,686
	Gross Emissions- Water	2,604	2,654
	Gross Emissions- Fleet Waste	639	781
	Gross Emissions - Commuting & homeworking	275,193	283,737
	Gross Emissions- Supply Chain	16,759,929	17,146,514
	Gross Emissions- Land sequestration.	n/a	-14535
Related Energy Consumption (KwH)	Electricity - Non-renewable	3,265,800	3,272,725
	Electricity- Renewable	14,132	104,425
	Gas	3,417,040	3,083,010
Energy consumption in litres*/kWh**	Fleet Fuel- Diesel*	4,010,878	3,963,344
	Fleet Fuel – Petrol*	193,653.00	8,911.13
	Fleet Fuel- Electricity**	0	40,037
Financial Indicators (£) ***	Expenditure on Energy	£1,156,991	£1,543,566
	Expenditure on Official Business travel	£538,089	£697,353

*** Taken from EFPMS report 2021-22 & 2022-23

3.1 ELECTRICITY

With the exception of 2020-21, electricity has achieved a gentle reduction in use. Considering however the increase estate portfolio, increased numbers of building-based roles and associated electronic equipment required, plus a significant increase in workforce on 2018-19 figures, this reduction shows movement in the right direction.

Disposal of ineffective estate and inclusion of newer more efficient buildings has supported this downward trend, alongside increased energy efficiency of electronic

hardware. With the financial support of the WG, via the Estates Funding Advisory Board (EFAB), installation of direct renewable energy systems at 12 sites across Wales was achieved. This has shown a positive effect on external power requirements, generating 104,425 kWh of renewable power during 2022-23, a saving of over 27,000 Kg CO^2e and £43k on average gross cost rates.

Figure 4: PV installations Lampeter Ambulance Station, Bennett Street and Beacon House 2022-23.

Electric vehicle charging point (EV) related electricity usage, is reported outside of this category. Increased costs due to energy uncertainty globally has seen an overall energy cost increase per kWh on previous years values.

Calculated baseline comparison shows:

18% reduction of electricity use since 2018-19. *(Figure 5)*

22% reduction of electricity per m^2 since 2018-19. *(Figure 6)*

18% reduction of electricity per employee (WTE) since 2018-19. *(Figure 7)*

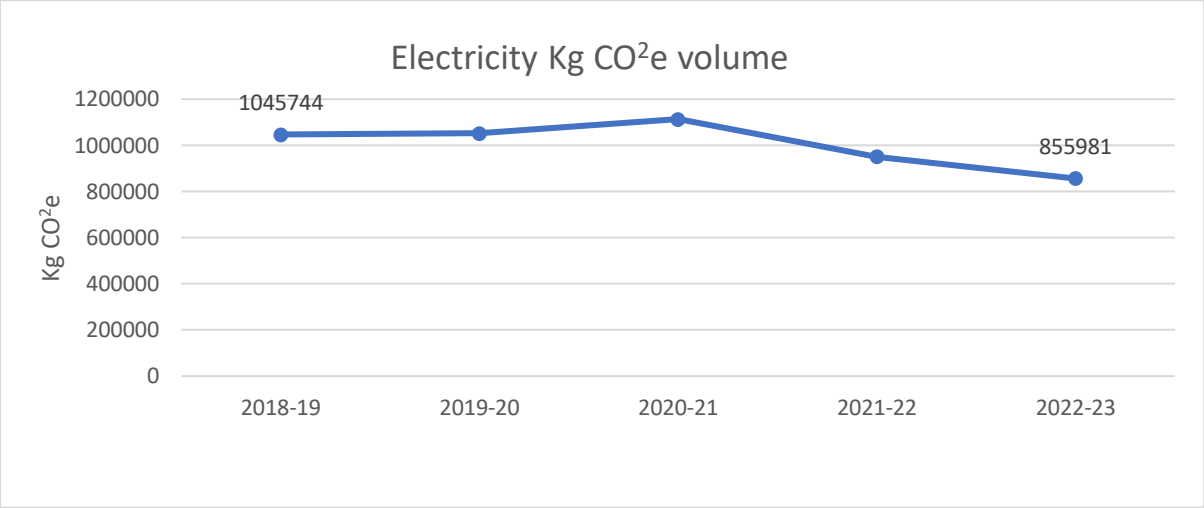


Figure 5; Electricity use in volume (per Kg CO^2e) 2018-19 to 2022-23

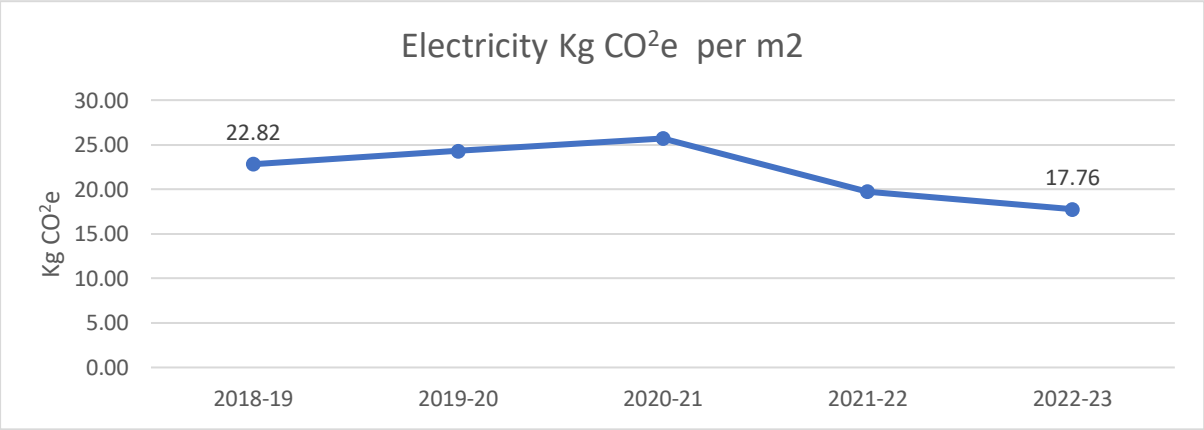


Figure 6: Electricity per m^2 of WAST estate (Kg CO2e) 2018-19 to 2022-23

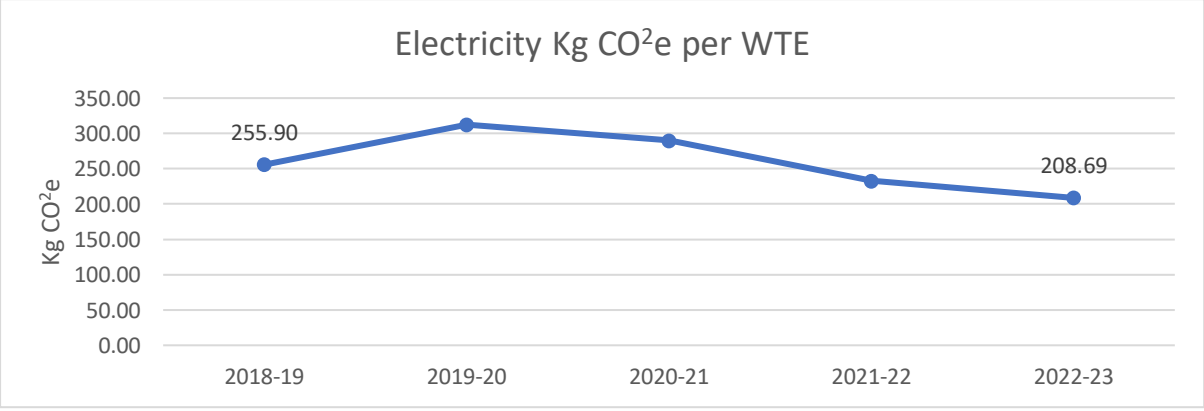


Figure 7 , Electricity use per employee, whole time equivalent (WTE) (Kg CO2e) 2018-19 to 2022-23

3.2 HEATING – NATURAL GAS/ LPG

Similar to electricity, heating fuel has achieved a gentle reduction in use across the Trust, again considering the increase estate portfolio, plus a 27% increase in workforce on 2018-19 figures, this reduction shows movement in the right direction.

Disposal of ineffective estate and inclusion of newer more efficient buildings has supported this downward trend, alongside the installation of air source heat pumps (ASHP) as an alternative to natural gas or LPG boilers (*Fig 8*). Plus, replacement glazing, from single to double glazed units at Port Talbot and Crickhowell Stations, help to support a secure building envelope requiring less heating.

Figure 8: Air Source Heat Pump: AAC Flintshire Dobshill

Increased costs due to energy uncertainty globally has seen an overall energy cost increase per kWh on previous years values.

Calculated baseline comparison shows:

24% reduction of heating fuel use since 2018-19. *(Figure 9)*

28% reduction of heating fuel per m^2 since 2018-19. *(Figure 10)*

23% reduction of heating fuel per employee (WTE) since 2018-19. *(Figure 11)*

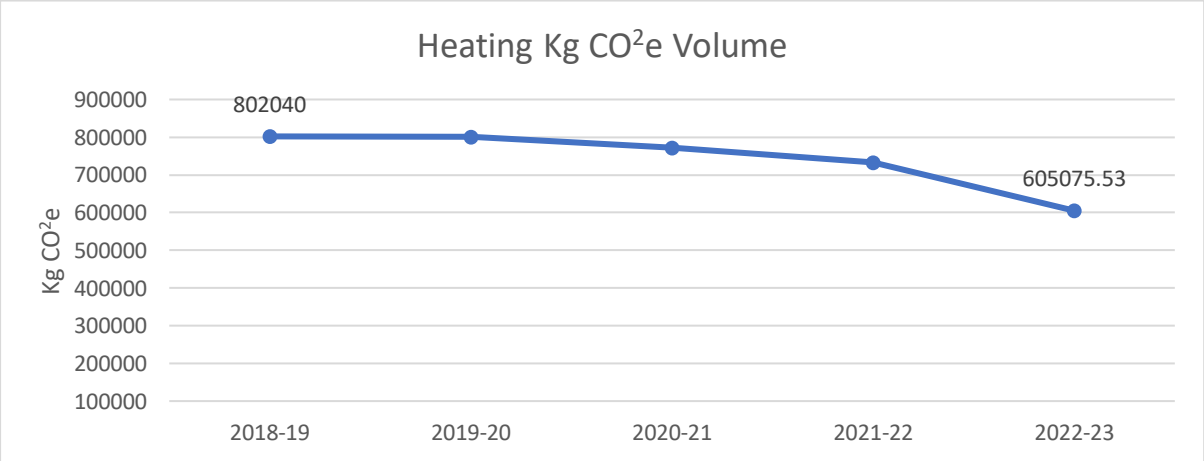


Figure 9: Heating Fuel use in volume (per Kg CO2e) 2018-19 to 2022-23

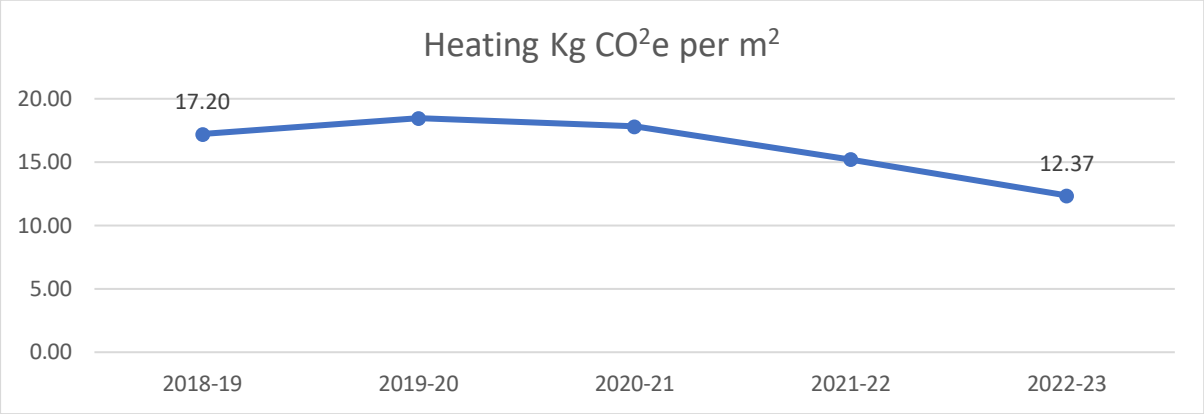


Figure 10: Heating fuel per m² of WAST estate (Kg CO2e) 2018-19 to 2022-23

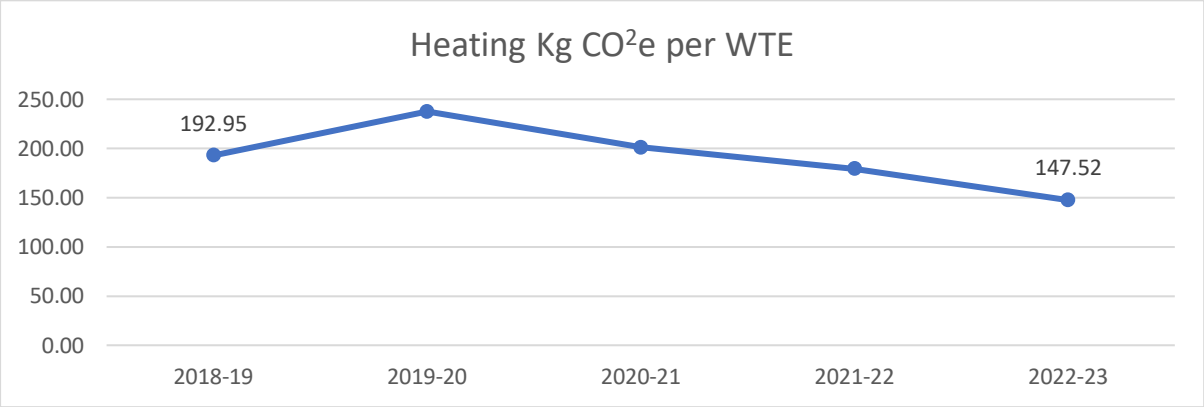


Figure 11; Heating fuel use per employee, whole time equivalent (WTE) (Kg CO2e) 2018-19 to 2022-23

3.3 WATER USE

Table 5: Finite resource data - 2021-2023: Utility invoices, various suppliers.

Finite Resource Consumption			2021-22	2022-23
Non-Financial Indicators (m^3)	Water Consumption (All Estate)	Supplied	17479	17809
		Abstracted (Bore Hole)	0	0
		Sewerage	12385	13755
		Annual water consumption per FTE	4.28	4.34
Non-Financial Indicators (Kg CO^2e)	Water Consumption (All Estate)	Total emissions	2604	2654
		Annual water emissions per FTE	0.64	0.65
Financial Indicators (£million)	Water Consumption Costs (All Estate)	Water Supply Costs (All Estate)	£32,968	£35,407
		Sewerage Cost (All Estate)	£31,974	£34,772

With the exception of 2020-2021, water use emissions have remained constant since 2018-19. An increased focus on water saving should be seen as a priority for this finite resource. Changes to water saving devices, such as low flush toilets and push button taps, will support a reduction, however vehicle washing remains the significant focal point of usage. Ensuring effective equipment is used will support a downward usage trend, alongside practical controls of its use.

Calculated baseline comparison shows:

2% reduction of water use since 2018-19. *(Figure 12)*

7% reduction of water use per m^2 since 2018-19. *(Figure 13)*

1.5% reduction of water use per employee (WTE) since 2018-19. *(Figure 14)*

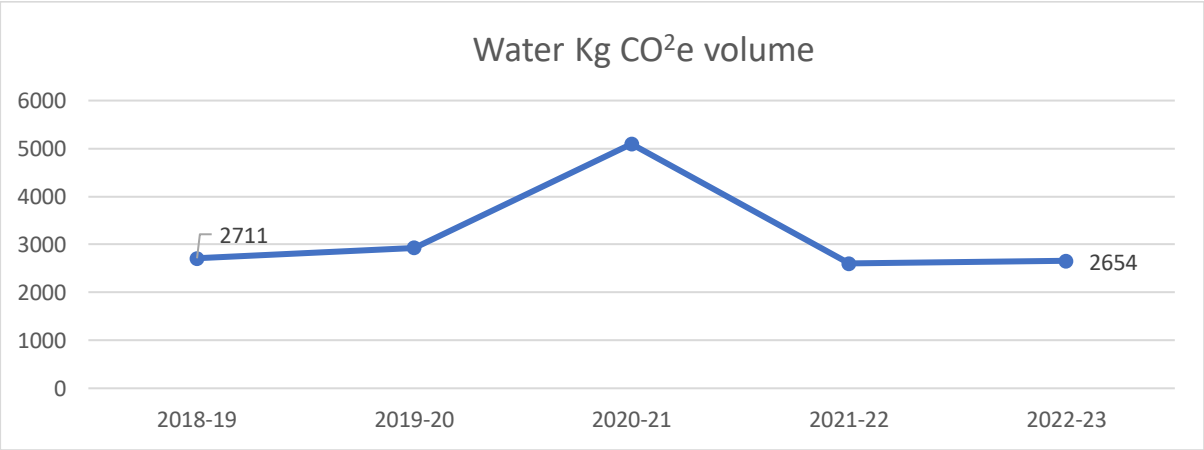


Figure 12 :Water use volume (Kg CO2e) 2018-19 to 2022-23

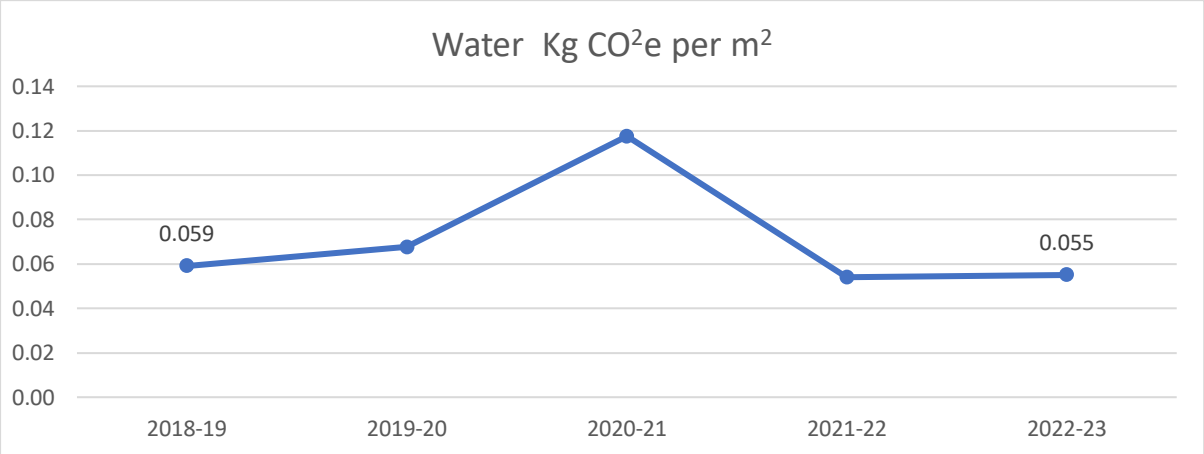


Figure 13 : Water use per m² (Kg CO2e) 2018-19 to 2022-23

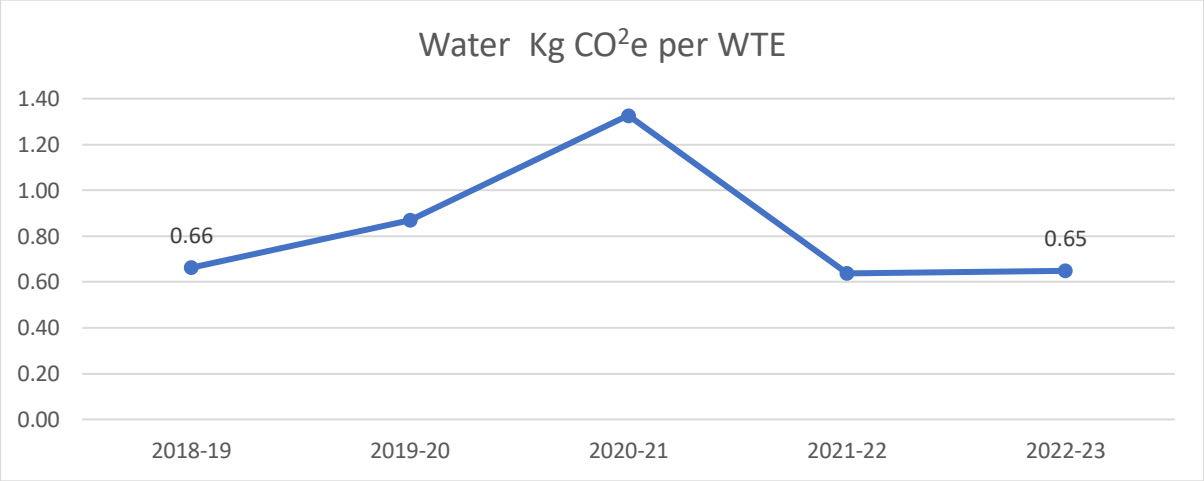


Figure 14: Water use per employee, whole time equivalent (WTE) in (Kg CO2e) 2018-19 to 2022-23

3.4 F-GAS (NEW FOR 2022-23)

The addition of reported Fluorinated gases (Fgas) emissions has significantly increased the Trust's reported carbon footprint by nearly 1 million Kg CO^2e. F-gasses are used in various industrial applications, within WAST this includes air conditioning and heating, ventilation, and cooling (HVAC). F-gasses are greenhouse gasses with high global warming potential (GWP). GWP was developed to allow comparisons of the global warming impacts of different gases, specifically it is a measure of how much energy the emissions of 1 tonne of a gas will absorb over a given period of time, relative to the emissions of 1 ton of carbon dioxide (CO_2) (Epa.gov, 2023).

Table 6: Global Warming Potential compassions of Fgas. .

F Gas	GWP
CO^2 comparison	1
R407C	1774
R401A	1182
HFC-32	677

Changes to retrofit of new and current estate will see a shift change, with the potential for passive ventilation use as an option, rather than initial move to mechanical ventilation. Therefore, removing potential increases in emissions alongside financial review costs for servicing and maintenance, required for currently used systems.

3.5 FLEET FUEL

In line with a fleet growing in numbers, and increased numbers of patient transfers, emissions from fleet fuel has grown significantly from 2018-19 baseline data. Apart from 2020-21, which is in all probability related to the COVID 19 pandemic. However, a promising downturn in emissions can been seen between 2021-22 and 2022-23. Efficient vehicles, increased servicing, and the introduction of hybrid vehicles have supported this downward trajectory. Unfortunately, due to funding constraints the replacement fleet programme will not see further electric vehicles purchased in the 2023-24 financial period, with the 2024-25 period unknown. The effect on emissions totals for WAST fleet will be monitored during the 2023-24 period.

During 2022-23, twenty-four electric plug in hybrid vehicles (PHEV) were purchased from Toyota, to replace older diesel rapid response vehicles. Changes to vehicle

commissioning has also seen a reduction in weight of the vehicles by nearly 100kg, with a redesign of the auxiliary electrical system requiring less charging connectivity. Solar panels have also been fitted to the vehicles to maximise on available renewable energy. The combined electrical charging and regenerative vehicle braking system delivers a 45-mile travel distance on electrical charge.

To support the new PHEV fleet, 66 electric vehicle (EV) charging points were installed across 52 sites, this will increase in 2023-24 with an additional 8 charging points being installed, includes 2 x 75kWh super chargers. The choice of Pod Point, as hardware provider for this service was determined in order to provide consistency with other NHS bodies.

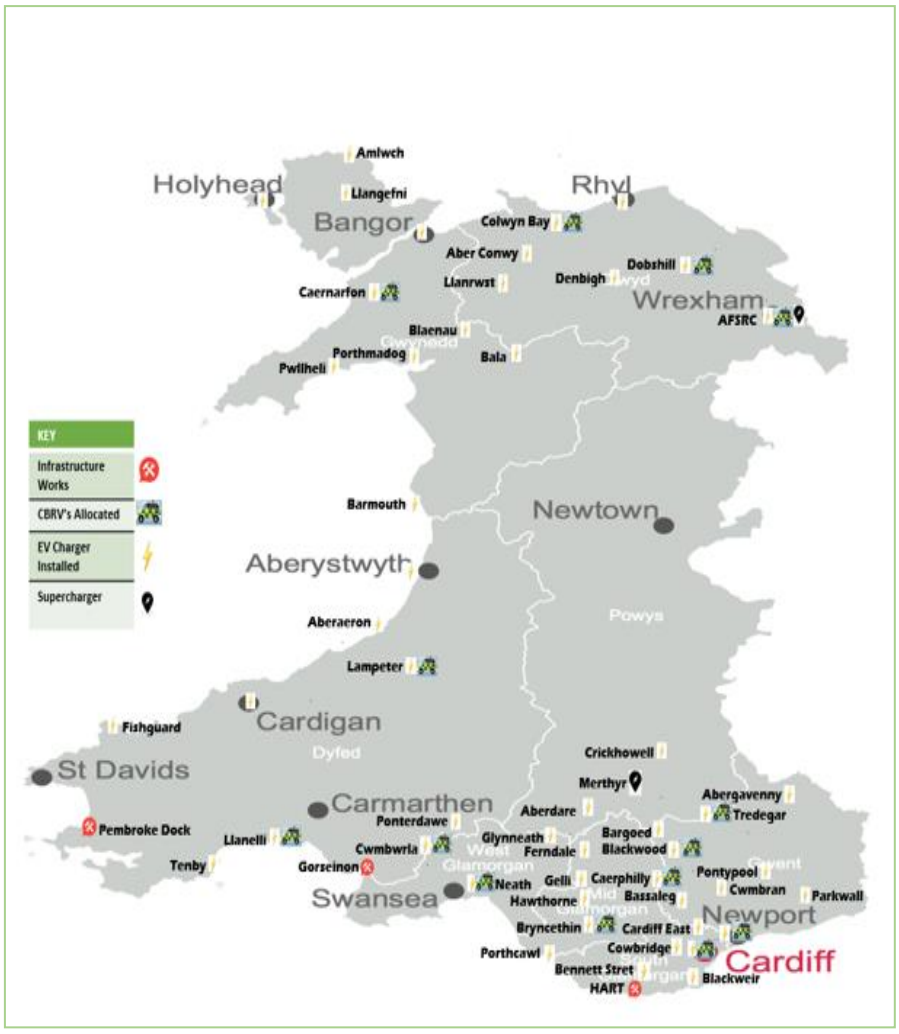


Figure 15: Electric Vehicle charging points within WAST estate 2022-23

Calculated baseline comparison shows:

6% increase of fuel emissions since 2018-19. *(Figure 16)*

5% reduction of fuel emissions per vehicle since 2018-19. *(Figure 17)*

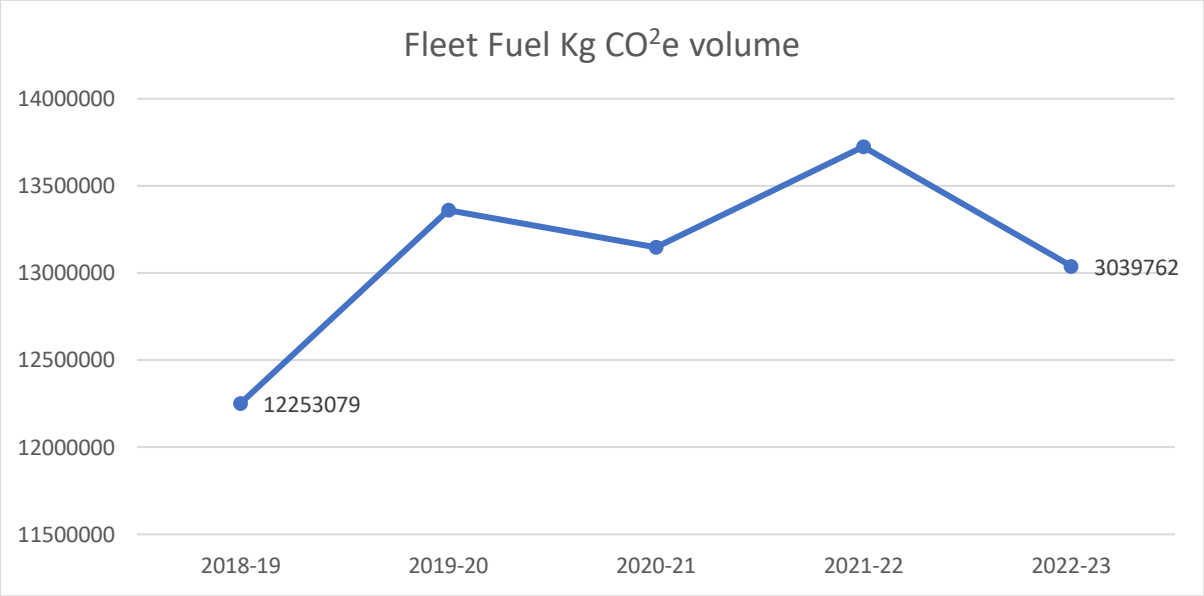


Figure 16 Fleet fuel volume of use in (Kg CO2e) 2018-19 to 2022-23

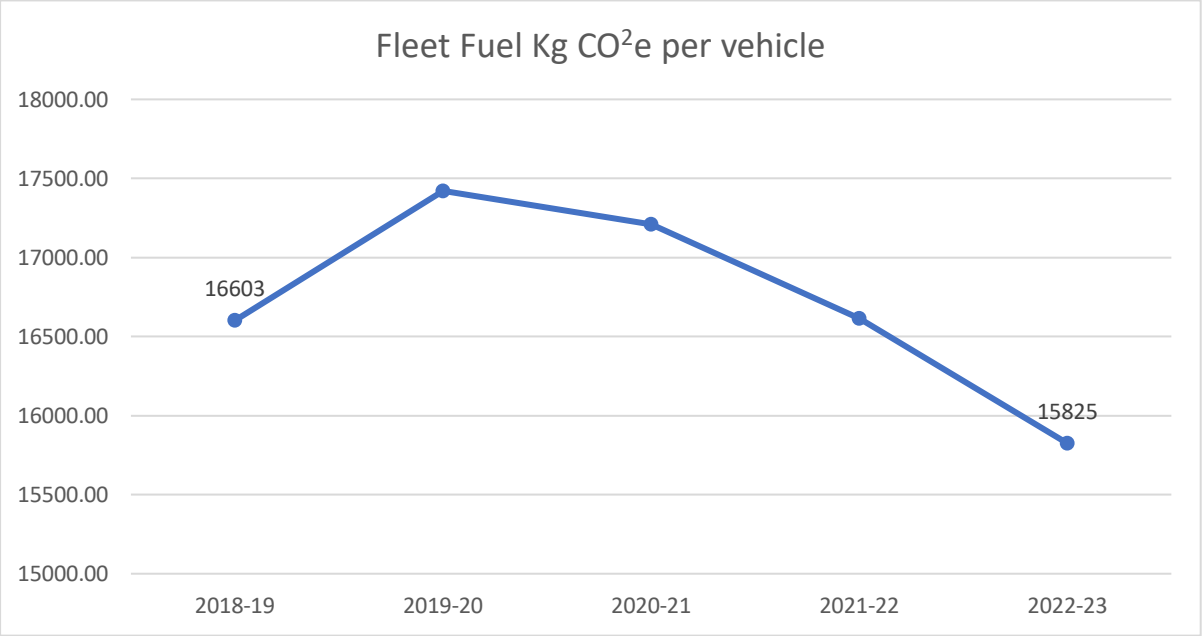


Figure 17 Fleet fuel emissions per vehicle in (Kg CO2e) 2018-19 to 2022-23

3.6 BUSINESS MILES

2020-21 saw business miles emission plumet during travel restrictions of the COVID 19 pandemic, however since this time business miles have increased significantly, although, not to benchmark levels. Progression of a Trust Sustainable Travel Plan has been slow due to lack of resource, be that as it may, agreement to prioritise active travel, public transport and low emissions pool car use using a travel hierarchy will support a business mile emissions reduction, alongside financial savings.

Calculated baseline comparison shows:

35% reduction of business mile emissions since 2018-19. *(Figure 18)*

49% reduction of business mile emissions per WTE since 2018-19. *(Figure 19)*

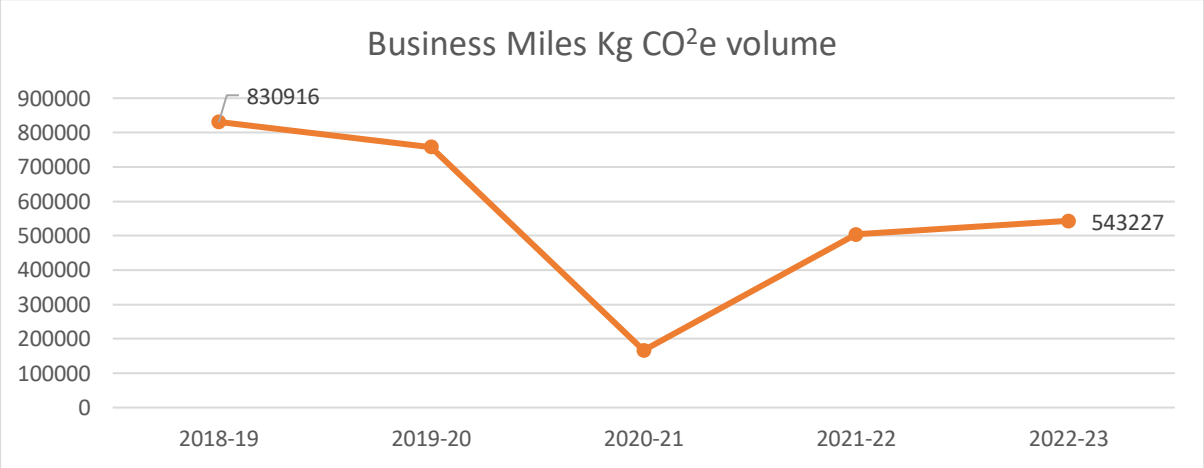


Figure 18 Business miles volume of use in (Kg CO^2e) 2018-19 to 2022-23

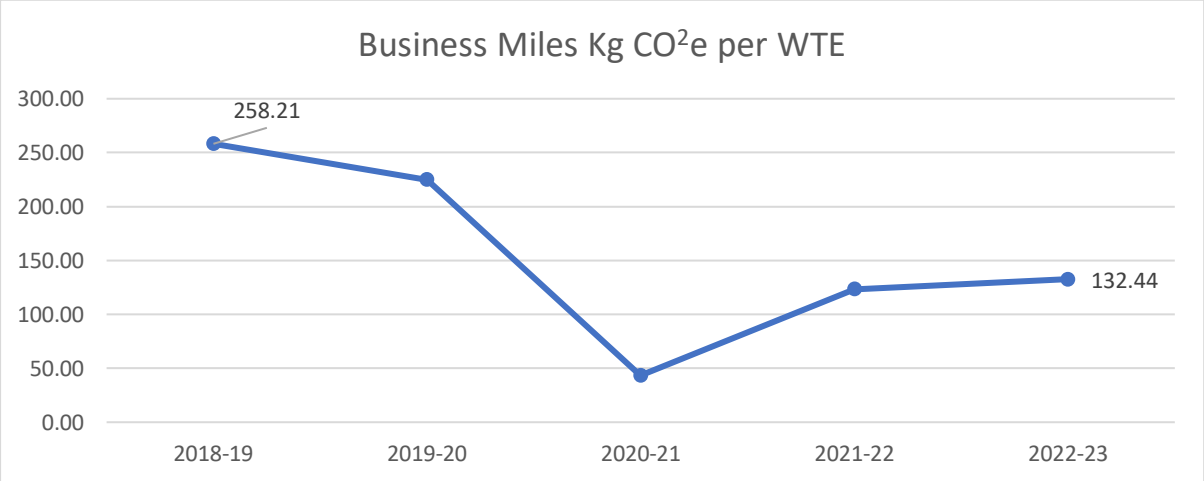


Figure 19 Business miles per WTE in (Kg CO^2e) 2018-19 to 2022-23

3.7 MEDICAL GASSES

The addition of reported medical gas emissions has significantly increased the Trust's reported carbon footprint by over 730 million Kg CO^2e. It should be noted however that this figure may not be completely correct. The carbon factor for Entonox has not been made available for reporting, therefore the carbon calculation for pure nitrous oxide has been used. A request has been made to amend the reporting factors for future years to ensure correct emission calculations are achieved. As with F-Gas nitrous oxide (NO^2) emissions are directly related to its GWP. Even though the individual GWP score is much lower than F-gas scores, the volume of Entonox used and released during bottle servicing, consequentially means the carbon footprint of the Trust has increased significantly. The introduction of Penthrox during 2023-24, will hopefully support a reduction in these specific emissions as Penthrox has a significantly lower GWP.

Table 7 Table 5: Global Warming Potential compassions of medical gasses

F Gas	GWP
CO^2 comparison	1
Nitrous oxide	298
Penthrox	4

3.8 DOMESTIC & CLINICAL WASTE

Table 8: Waste data - 2021-2023: various disposal contractors.

Waste		**2021-22**	**2022-23**
Non-Financial Indicators (tonnes)	Total Waste	321.64	252.73
	Landfill	1.19	1.93
	Composted	0	0
	Recycling	108.00	74.32
	Incinerated with energy recovery	212.45	176.48
	Incinerated without energy recovery	0	0
Non-Financial Indicators (Kg CO^2e)	Domestic Waste	5,251	4,577
	Clinical Waste	43,500	35,190
	Total Disposal Cost	£106,812	£99,121

Financial Indicators (£million)	Landfill	£323	£650
	Reused/Recycled	£25,382	£26,219
	Composted	0	0
	Incinerated with energy recovery	£81,107	£72,252
	Incinerated without energy recovery	0	0

With the exception of 2020-2021, domestic and clinical waste emissions has seen a progressive reduction in emissions. This is largely due to alternative treatments for the majority of waste, which in the past, was sent to landfill. Recycling waste sits at approximately 49% of the domestic waste produced within the Trust. This percentage must be increased to meet the targets set by WG for this strategy and other public body requirements. New waste legislation for Wales, due to be implemented by April 2023, will see the removal of current recycling processes of dry mixed recycling and cardboard, replaced with 6 different waste streams, segregating waste at source will be a challenge for some site, not just due to lack of space for additional bins both internally and externally, but also extremely small recycling percentages at some buildings, as low as 14%. This new legislation also provides for fines relating to non-compliance therefore building and locality managers will be advised monthly of their recycling rates, with support for those who's percentages fall short of expectations.

Calculated baseline comparison shows:

29% reduction of waste volume emissions since 2018-19. *(Figure 20)*

32% reduction of waste emissions per m^2 since 2018-19. *(Figure 21)*

44% reduction of waste emission per employee (WTE) since 2018-19. *(Figure 22)*

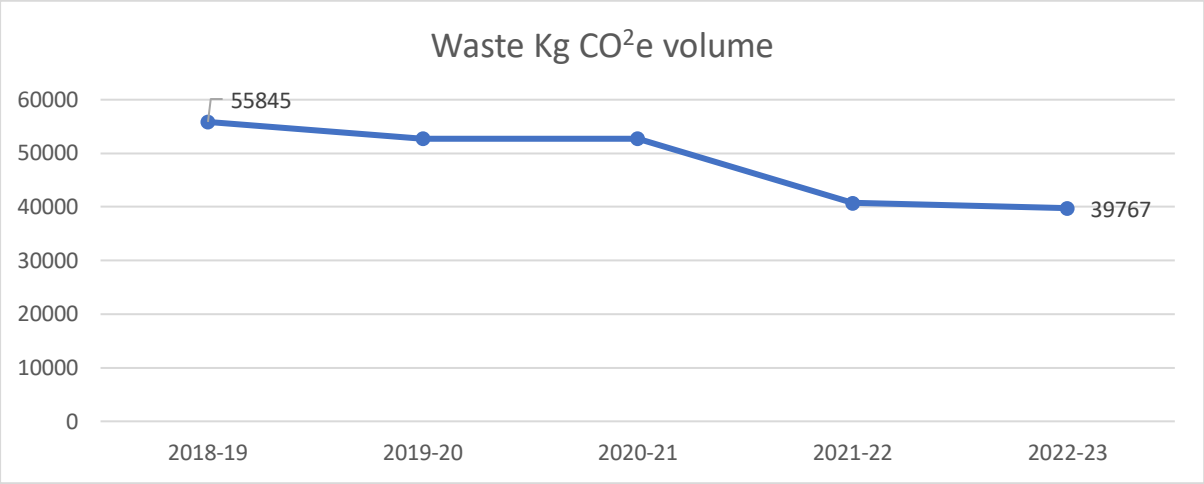


Figure 20: Waste emissions in volume. (Kg CO^2e.) 2018-19 to 2022-23

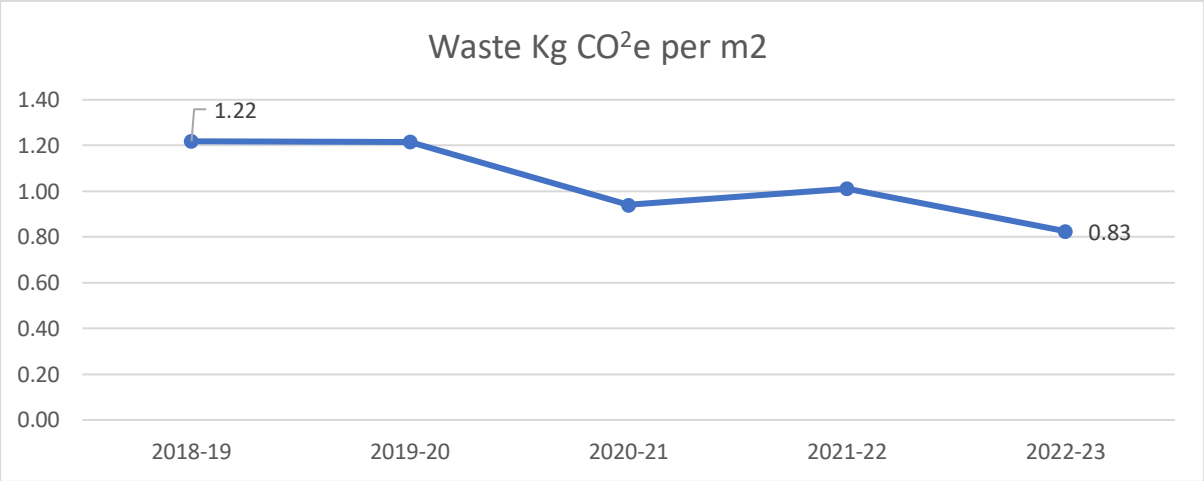


Figure 21 Waste emissions per m^2 in Kg CO^2e. 2018-19 to 2022-23

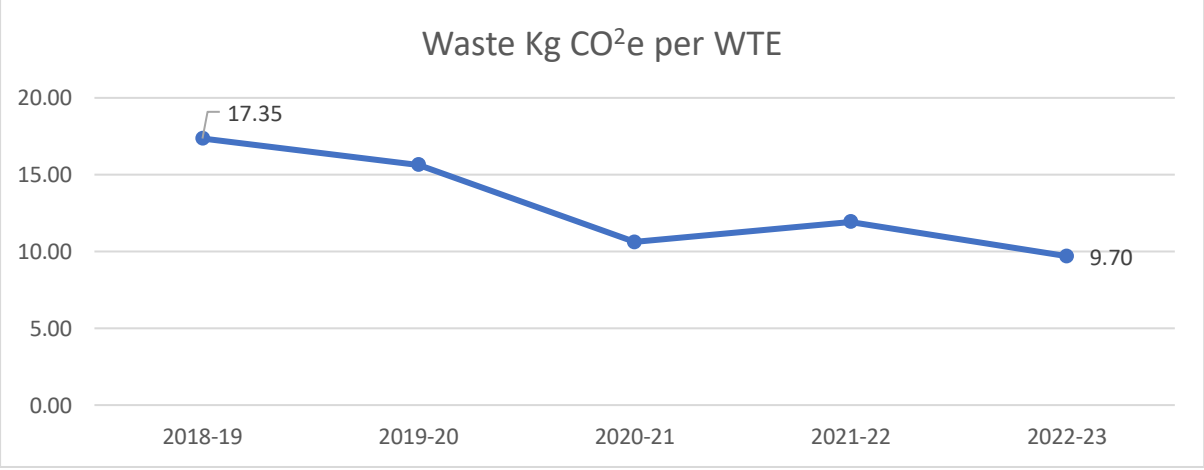


Figure 22 Waste emissions per WTE, in Kg CO^2e. 2018-19 to 2022-23

It should be noted that fleet waste is also reported as an emission. This waste has seen an increase in emissions on last years reported data by 142 Kg CO^2e, yet WAST fleet numbers for 2022-23 were down on 2021-22 figures. It should however be noted that WAST workshops maintain vehicles for HCS (NWSSP) who's numbers may have increased, plus better reporting structures within the Team has provided better understanding of waste than on the previous year.

3.9 MISCELLANEOUS REPORTED EMISSIONS

Various additional emissions are reported under scope 2 using calculation methodology as indicated via the reporting guidance document, this includes:

3.9.1 Commuting and Homeworking

Both commuting and homeworking are calculated using a tier 1 approach. Guidance has been provided for average percentage and calculation factors. Emissions have increased from 2021-22 figures due to an increase in workforce. To ensure correct reporting additional work will be required to understand number of hybrid working staff, plus their working patterns, and all employee commuting transport options.

3.9.2 Land Use

2022-23 reporting has included the carbon sequestration emission reduction for land use. The Trust has little unused land, however the additional of 2500 native trees to AAC Flintshire Dobshill has seen an offset subtracted from the Trusts emission total. 2023-24 will see potential biodiversity works at sites such as Ty Elwy and Blaenau Ffestiniog Station.


Figure 23: AAC Flintshire Dobshill- Gardd Gobaith. Images by author

3.9.3 Supply Chain

Due to the significant percentage of emissions related to procurement found during benchmarking calculations, supply chain emissions are reported as Scope 3. These emissions are calculated using standard industry classification codes (SIC) which relates to their waste stream, plus supply cost. This information is supplied by NWSSP procurement on an annual basis. Scrutiny of this data is challenging due to limited item description. Discussions are ongoing with NWSSP procurement relating to a streamlined process for data collection with more robust descriptions, allowing the Trust to investigate any changes that could be made to particular procurement streams.

4.0 SUSTAINABILITY UPDATES

4.1 ISO14001

The Welsh Ambulance Services NHS Trust (WAST) is the only ambulance service in the UK to have achieved ISO14001 accreditation for all of its activities. This accreditation has been held for 9 years.

The certification was originally awarded on the basis of the audit findings from sample sites in North Wales in August 2015, with the balance of the remaining qualifying sites to be visited by BSI in 2016 and 2017. This 3-year rolling programme has continued, with recertification completed in 2023 by BSI, with all previous non-conformances closed, and no new non-conformances raised.

An integral part of ISO14001 is the environmental management system, known as environmental governance system (EGS) within WAST. The EGS commits the Trust to reducing its impact on the environment by:

- Reducing risk of pollution to Air, Land and Water
- Upgrade utility monitoring and targeting all properties.
- Reduce carbon emissions and demands on natural resources by improving building thermal insulation.
- Reduce pollution potential in emergency situations.
- Reduce carbon footprint by closing buildings and relocating services.
- Increasing Recycling
- Reducing waste
- Improve staff awareness training.
- Disposal of poor estate
- Introducing renewable technology such as PV as well as energy storage where appropriate.

To support the EGS initiatives linked with the NHSDSDP, continue in the following areas.

- Thermally efficient new builds
- Retro-fitting energy efficient controls, plant, and equipment
- Improving the thermal performance of the fabric of existing buildings
- Retrofitting zero and low carbon technologies (includes on-site renewables)
- Partnership projects with other public bodies (Local Councils, Fire, Police etc.) in sharing buildings or facilities and rationalisation of their respective estates
- Improving drainage systems to facilitate vehicle washing.

4.2 CYCLE RESPONSE

Since conception the Cycle Response Unit (CRU) has grown significantly, both with the number of trained staff and the number of cycles used. The CRU now consists of 10 hybrid cycles, 4 specialised pitch and 6 genesis longitude, the latter being designed and built in Wales. With 24 trained staff of which include, Senior Paramedics, Advanced Paramedic Practitioners. Due to its success and associated expansion, the unit has now

moved to a purpose-built facility within the new ambulance complex in Pentwyn, Cardiff

The unit operates most Saturdays within Cardiff, covering between 10 to 20 miles a shift, within a 1.5 mile of the city centre.

The use of this active travel team not only means increased levels of response for patients, but also reducing the need for road-based response, reducing vehicle miles and corresponding fossil fuel emissions.

Figure 24: Cycle Response Unit (CRU) Pentwyn Cardiff

4.3 NEPTS PAPERLESS LIAISON BOOKING SYSTEM

The NEPTS liaison booking system completely transitioned during spring 2022, from paper via fax, to electronic booking. Paper and printing savings will be monitored over the next 12 months in order to quantify the volume of supplies saved, and their associated carbon emissions.

4.4 COMMUNITY SWAP SHOP

An internal WAST Community Swap Shop was introduced to support environmental goals and financial requirements of the Trust. Items that were no longer required, but are still serviceable such as:

- Furniture
- Consumables / Stationary
- Uniform
- Response Bags
- Clinical consumables/equipment.

WAST staff are able to view and add items on to the swap shop list, contacting the owner for collection. Supporting the waste hierarchy and saving supply chain costs.

Welsh Ambulance Services NHS Trust

Utility & Waste Update.

2022-23

Version 1.0 21.08.2023

CONTENTS

1.0 INTRODUCTION

This document will provide the reader with a brief overview of the WAST estate portfolios operational Carbon Footprint (OCF) for 2022-23, alongside the financial costs of supply. Included within these calculations will also be the usage, OCF and cost in relation to the building floor area (m^2). This information will hopefully provide a more robust data set.

Energy, water, and waste contributes to the Trust carbon footprint, alongside a significant financial spend. The calculation of individual sites OCF will identify those sites with not only the highest OCF, but also provides important information to the Estates and Facilities Team, in relation to unusual trends and anomalies requiring further investigation.

A full list of data can be found below.

2022-23 OCF.xlsx

1.1 OCF – WAST ESTATE PORTFOLIO

The largest OCF within the trust estate portfolio belongs to VPH, over double that of the 2nd largest emitter. This is primarily due to the significantly high electricity use at the site. *(Fig 1)*. However, using the floor area calculation, Central & West Control – Llangynnor has the highest emission value, more than double that of the 2nd highest emitter, Barry Make Ready. *(Fig 2)*.

It should be noted that VPH has significant finance requirements in relation to utilities and waste management, more than double that of the 2nd highest costing site. *(Fig 3)*. Notwithstanding, Monmouth Station (modular building), cost per m^2 represents an unusually high value. Both sites should be investigated to ensure environmental and financial aspects are being met. *(Fig 4)*.

Nº	PREMISES	Total CO_2^e
1	Vantage Point House	**246816**
2	Central & West Control - Llangynnor	**120119**
3	Ambulance and Fire Service Resource Centre - Wrexham	**113409**
4	Ty Elwy Administrative Building	**106350**
5	North Control Centre- Bryn Tirion	**93848**
6	Cardiff Area Ambulance Centre	**86412**
7	Blackweir Ambulance Station	**85132**
8	HART Emergency Response Centre	**63298**
9	Thanet House Control Centre - 111	**52320**
10	Beacon House	**37248**

Figure 1:WAST estates portfolio; Operational carbon footprint Top 10.

Nº	PREMISES	CO_2^e per m^2
1	Central & West Control - Llangynnor	251.29
2	Barry Make Ready	151.55
3	Newport Ambulance Station	94.81
4	North Control Centre- Bryn Tirion	87.54
5	Bronllys Ambulance Station	87.31
6	Monmouth Ambulance Station - Modular Building	86.35
7	Tredegar Ambulance Station	81.44
8	Blackweir Ambulance Station	73.39
9	Pwllheli Ambulance Station	71.60
10	Cowbridge Ambulance Station	70.75

Figure 2 :WAST estates portfolio; Operational carbon footprint per m^2: Top 10.

Nº	PREMISES	Total £
1	Vantage Point House	£409,531
2	Cardiff Area Ambulance Centre	£178,396
3	Ty Elwy Administrative Building	£141,776
4	Ambulance and Fire Service Resource Centre - Wrexham	£104,237
5	North Control Centre- Bryn Tirion	£71,916
6	HART Emergency Response Centre	£68,667
7	Blackweir Ambulance Station	£63,366
8	Central & West Control - Llangynnor	£61,710
9	Thanet House Control Centre 111	£57,714
10	Beacon House	£42,849

Figure 3 : WAST estates portfolio; overall cost: Top 10.

Nº	PREMISES	£ per m²
1	Monmouth Ambulance Station - Modular Building	£174.40
2	Central & West Control - Llangynnor	£129.10
3	Bronllys Ambulance Station	£123.52
4	Vantage Point House	£112.63
5	Newport Ambulance Station	£102.51
6	Holywell SDP	£99.72
7	Matrix House Workforce Education and Development Centre	£94.07
8	Barry Make Ready	£85.84
9	Aberaeron Ambulance Station	£80.24
10	Cardiff Area Ambulance Centre	£71.73

Figure 4 Figure 3: WAST estates portfolio; overall per m² cost: Top 10.

2.0 ELECTRICITY

As per previous years VPH is the largest electricity user within the estate portfolio, utilising approximately 22% of the trust's electricity use, at a cost of over £400k. *(Fig 5, 6,7)* However, it should be noted that VPH, alongside other sites (as indicated in blue) are single utility sites, where energy is used for building and water heating, alongside traditional electricity requirements. The building designation is also a key factor to a higher-than-average use, with significant numbers of staff using electrical technology on a 24/7 basis. This being said, the estates team are reviewing this usage for accuracy. Likewise, the estates 2nd, 3rd and 4th highest users of energy also have the same building designation.

During this period energy was identified a cost pressure due to ever increasing energy costs, related to inflation, market pressures and the Ukrainian war. UK Government support was made available to all UK households and businesses in the form of the Energy Bill Relief Scheme (EBRS). This scheme capped energy costs to £19.61 per megawatt hour (MWh) helping to reduce energy costs, but not reducing values to as seen in previous years. Energy costs per kilowatt hour (kWh) varied across the estate portfolio, dependent on direct or indirect billing. Direct NHS consortium billing averaged at 0.21p per kWh, whereas VPH, a leased building with landlord billed sub meter, averaged at 0.43p per kWh.

The top ten energy consumers, alongside emissions per floor area is concentrated at mostly buildings with a single energy supply. Monmouth modular building is a

significant user and emitter in relation to its size, with the highest cost for energy per m^2. (*Fig 8,9,10)*

Nº	PREMISES	kWh	%
1	Vantage Point House	942860	22
2	Central & West Control - Llangynnor	412766	10
3	Ty Elwy Administrative Building	369448	9
4	North Control Centre- Bryn Tirion.	256226	6
5	Ambulance and Fire Service Resource Centre - Wrexham	184302	4
6	Thanet House Control Centre- 111	139958	3
7	Beacon House	139842	3
8	HART Emergency Response Centre	127923	3
9	Barry Make Ready	121681	3
10	Cardiff Area Ambulance Centre	107063	2

Figure 5 : Electricity usage in kWh 2022-23 Top 10 users

Nº	PREMISES	$kgCO_2^e$
1	Vantage Point House	246605
2	Central & West Control - Llangynnor	107959
3	Ty Elwy Administrative Building	96629
4	North Control Centre- Bryn Tirion	67016
5	Ambulance and Fire Service Resource Centre - Wrexham	48204
6	Thanet House Control Centre-111	36606
7	Beacon House	36576
8	HART Emergency Response Centre	33458
9	Barry Make Ready	31826
10	Cardiff Area Ambulance Centre	28002

Figure 6 : Electricity emissions in kgCO2e 2022-23, Top 10

Nº	PREMISES	£
1	Vantage Point House	£403,950
2	Ty Elwy Administrative Building	£133,714
3	Cardiff Area Ambulance Centre	£99,521
4	Ambulance and Fire Service Resource Centre - Wrexham	£67,552
5	North Control Centre- Bryn Tirion	£60,572
6	HART Emergency Response Centre	£49,090
7	Thanet House Control Centre- 111	£45,842
8	Central & West Control - Llangynnor	£45,196
9	Beacon House	£41,442
10	Matrix One Administrative Building	£40,236

Figure 7: Electricity spend. 2022-23, Top 10

Nº	PREMISES	kWh per m²
1	Central & West Control - Llangynnor	863.53
2	Barry Make Ready	579.43
3	Bronllys Ambulance Station	333.85
4	Monmouth Ambulance Station - Modular Building	318.92
5	Vantage Point House	259.31
6	Matrix House Workforce Education and Development Centre	249.31
7	North Control Centre- Bryn Tirion	239.02
8	Holywell SDP	210.88
9	Aberaeron Ambulance Station	175.09
10	Hensol Ambulance Station	157.59

Figure 8: Electricity usage in kWh, per m² 2022-23, Top 10

Nº	PREMISES	$kgCO_2^e$ per m²
1	Central & West Control - Llangynnor	225.86
2	Barry Make Ready	151.55
3	Bronllys Ambulance Station	87.31
4	Monmouth Ambulance Station - Modular Building	83.42
5	Vantage Point House	67.82
6	Matrix House Workforce Education and Development Centre	65.21
7	North Control Centre- Bryn Tirion	62.51
8	Holywell SDP	55.15
9	Aberaeron Ambulance Station	45.79
10	Hensol Ambulance Station	41.22

Figure 9 :Electricity emissions in kgCO2e per m². 2022-23, Top 10

Nº	PREMISES	£ per m²
1	Monmouth Ambulance Station - Modular Building	£168
2	Bronllys Ambulance Station	£124
3	Vantage Point House	£111
4	Holywell SDP	£100
5	Central & West Control - Llangynnor	£95
6	Matrix House Workforce Education and Development Centre	£93
7	Barry Make Ready	£86
8	Aberaeron Ambulance Station	£80
9	Newport Ambulance Station	£64
10	Llandovery Ambulance Station	£62

Figure 10: Electricity spend in £ per m². 2022-23, Top 10

3.0 HEATING

As per previous years Blackweir is the largest natural gas user within the estate portfolio, utilising approximately 11% of the trust's electricity use, at a cost of over £76k. *(Fig 11,12,13)*. The building, a fleet workshop, is of poor condition, with little insulation and identified as an estates risk. During the latter end of 2023 the building will be closed and returned to the landlord – Cardiff Council. Fleet operations are being relocated to Merthyr Fleet Workshops, a new acquisition, fully refurbished, including on site renewable power generation. This percentage of use was closely followed by AFSRC Wrexham, a site housing another fleet workshop, plus make ready depot (MRD), The new Cardiff Ambulance Station also required a significant percentage of natural gas use. Both buildings are of a significant size, with multi-faceted usages. Following the Welsh Governments NHS Wales Decarbonisation Strategic Delivery Plan, no future building projects, both new builds and major refurbishments, cannot utilise a natural gas supply.

As with electricity natural gas was identified as a cost pressure, and was bolstered by the EBRS, however the cost impact was not to the same level as energy.

The top ten energy consumers, calculated via emissions per floor area, holds a more challenging explanation, with a mixture of both freehold and leasehold site, varying sizes, and designations. An exercise should be completed to identify heating use in relation to age of heating plant and building envelope condition to produce a schedule of future priority works. *(Fig 14,15,16)*.

Nº	PREMISES	kWh	%
1	Blackweir Ambulance Station	324068	11
2	Ambulance and Fire Service Resource Centre - Wrexham	293017	10
3	Cardiff Area Ambulance Centre	266287	9
4	HART Emergency Response Centre	131911	4
5	North Control Centre- Bryn Tirion	125596	4
6	Tredegar Ambulance Station	115183	4
7	Blackwood Ambulance Station & Fleet Workshop	81947	3
8	Carmarthen Ambulance Station & Carmarthen Regional Administration Centre	72146	2
9	Rhyl Ambulance Station	70,884	2
10	Thanet House Control Centre- 111	66978	2

Figure 11: Natural Gas / LPG usage in kWh 2022-23 Top 10 users

Nº	PREMISES	Kg CO_2^e
1	Blackweir Ambulance Station	69234
2	Ambulance and Fire Service Resource Centre - Wrexham	62600
3	Cardiff Area Ambulance Centre	56889
4	HART Emergency Response Centre	28182
5	North Control Centre- Bryn Tirion	26832
6	Tredegar Ambulance Station	24608
7	Blackwood Ambulance Station & Fleet Workshop	17507
8	Carmarthen Ambulance Station & Carmarthen Regional Administration Centre	15413
9	Rhyl Ambulance Station	15144
10	Thanet House Control Centre- 111	14309

Figure 12:: Natural Gas / LPG kg CO^2e 2022-23 Top 10 users.

Nº	PREMISES	£
1	Cardiff Area Ambulance Centre	£76,084
2	Blackweir Ambulance Station	£37,307
3	Ambulance and Fire Service Resource Centre - Wrexham	£32,734
4	HART Emergency Response Centre	£16,993
5	Central & West Control - Llangynnor	£15,819
6	Tredegar Ambulance Station	£13,264
7	North Control Centre- Bryn Tirion	£11,344
8	Blackwood Ambulance Station & Fleet Workshop	£9,304
9	Rhyl Ambulance Station	£8,869
10	Carmarthen Ambulance Station & Carmarthen Regional Administration Centre	£8,666

Figure 13 :Natural Gas / LPG usage in £ 2022-23 Top 10 users

Nº	PREMISES	kWh per m^2
1	Blackweir Ambulance Station	279.37
2	Tredegar Ambulance Station	276.22
3	Cowbridge Ambulance Station	258.48
4	Newport Ambulance Station	245.57
5	Pwllheli Ambulance Station	244.74
6	Llandrindod Wells Ambulance Station	200.00
7	Welshpool Ambulance Station	175.54
8	Ambulance and Fire Service Resource Centre - Wrexham	172.67
9	Barmouth Ambulance Station	154.01
10	Bangor Ambulance Station	151.88

Figure 14: Natural Gas / LPG usage in kWh 2022-23 Top 10 users

Nº	PREMISES	Kg CO_2^e per m^2
1	Blackweir Ambulance Station	59.68
2	Tredegar Ambulance Station	59.01
3	Cowbridge Ambulance Station	55.22
4	Newport Ambulance Station	52.46
5	Pwllheli Ambulance Station	52.28
6	Llandrindod Wells Ambulance Station	42.73
7	Welshpool Ambulance Station	37.50
8	Ambulance and Fire Service Resource Centre - Wrexham	36.89
9	Barmouth Ambulance Station	32.90
10	Bangor Ambulance Station	32.45

Figure 15: Natural Gas / LPG usage in kWh per m² 2022-23 Top 10 users

Nº	PREMISES	£ per m^2
1	Central & West Control – Llangynnor	£33
2	Cowbridge Ambulance Station	£32
3	Blackweir Ambulance Station	£32
4	Tredegar Ambulance Station	£32
5	Cardiff Area Ambulance Centre	£31
6	Newport Ambulance Station	£30
7	Pwllheli Ambulance Station	£30
8	Llandrindod Wells Ambulance Station	£24
9	Llanfyllin Ambulance Station (LPG)	£23
10	Welshpool Ambulance Station	£21

Figure 16: Natural Gas / LPG usage in £ per m² 2022-23 Top 10 users

4.0 WATER

Water usage is one of three emission fields to have increased since 2021-22. During the first wave of the COVID pandemic 2020-21 the use of water increased significantly, for obvious reasons. 2021-22 saw a downturn of use, yet 2022-23 water use has increased. Following the Welsh Governments NHS Wales Decarbonisation Strategic Delivery Plan, the use of water requires efficient monitoring and a concerted effort to protect this finite resource. This, however, must not produce and infection control risk. The installation of washing machines at stations during the pandemic helped to support staff in reducing the need for unforms to be taken home for cleaning, however, most equipment installed were domestic type systems, not commercial, that will no doubt require replacement or removal in the near future.

The highest users of water within the portfolio are Newtown Ambulance Station and Ty Elwy St Asaph. Without explanation of this high value usage both sites should be

monitored and investigated for potential water leaks at both sites. The use at high footfall buildings such as VPH and Thanet House is understandable, alongside MRD's and larger ambulance stations. VPH has the highest financial cost, with unit costs defined by the site landlord. (*Fig 17,18,19).*

The top ten consumers, calculated via emissions per floor area, are primarily ambulance stations, with the assumption water is being used for vehicle washing. An exercise should be completed to identify vehicle washing equipment with reduced water requirements. Producing a whole of Wales specification. (*Fig 20,21,22).*

Nº	PREMISES	m^3	%
1	Newtown Ambulance Station	1462	15
2	Ty Elwy Administrative Building	1459	15
3	Vantage Point House	1006	11
4	Thanet House Control Centre- 111	924	10
5	Flintshire Make Ready Centre	905	10
6	Cardiff Area Ambulance Centre	805	9
7	HART Emergency Response Centre	793	9
8	Bryncethin Ambulance Station	715	8
9	Neath Ambulance Station	673	8
10	Rhyl Ambulance Station	652	7

Figure 17: Water usage in m^3 2022-23 Top 10 users

Nº	PREMISES	CO_2e
1	Newtown Ambulance Station	218
2	Ty Elwy Administrative Building	218
3	Vantage Point House	150
4	Thanet House Control Centre -111	138
5	Flintshire Make Ready Centre	135
6	Cardiff Area Ambulance Centre	120
7	HART Emergency Response Centre	118
8	Bryncethin Ambulance Station	107
9	Neath Ambulance Station	100
10	Rhyl Ambulance Station	97

Figure 18 : Water usage in $kgCO^2e$ 2022-23 Top 10 users

Nº	PREMISES	£
1	Vantage Point House	£4,631
2	Newtown Ambulance Station	£4,062
3	Ty Elwy Administrative Building	£2,143
4	Flintshire Make Ready Centre	£1,765
5	Cardiff Area Ambulance Centre	£1,466
6	Thanet House Control Centre - 111	£1,367
7	HART Emergency Response Centre	£1,177
8	Blackweir Ambulance Station	£1,098
9	Bryncethin Ambulance Station	£1,065
10	Hensol Ambulance Station	£994

Figure 19 Water costs in £ 2022-23 Top 10 users

Nº	PREMISES	m^3 per m^2
1	Newtown Ambulance Station	2.88
2	Hensol Ambulance Station	2.23
3	Newport Ambulance Station	1.94
4	Bryncethin Ambulance Station	1.30
5	Flintshire Make Ready Centre	1.27
6	Central & West Control Centre – Llangynnor	1.26
7	Bassaleg Ambulance Station	1.24
8	Tenby Ambulance Station	1.16
9	Neath Ambulance Station	1.10
10	Pembrokedock Ambulance Station	1.03

Figure 20: Water in m^3 per m^2 2022-23 Top 10 users

Nº	PREMISES	Kg CO_2^e per m^2
1	Newtown Ambulance Station	0.43
2	Hensol Ambulance Station	0.33
3	Newport Ambulance Station	0.29
4	Bryncethin Ambulance Station	0.19
5	Flintshire Make Ready Centre	0.19
6	Central & West Control Centre - Llangynnor	0.19
7	Bassaleg Ambulance Station	0.18
8	Tenby Ambulance Station	0.17
9	Neath Ambulance Station	0.16
10	Pembrokedock Ambulance Station	0.15

Figure 21: Water use in kg CO^2e per m^2. 2022-23 Top 10 users

Nº	PREMISES	£ per m²
1	Newtown Ambulance Station	£8.00
2	Hensol Ambulance Station	£4.44
3	Newport Ambulance Station	£3.01
4	Flintshire Make Ready Centre	£2.49
5	Bryncethin Ambulance Station	£1.94
6	Monmouth Ambulance Station - Modular Building	£1.92
7	Bassaleg Ambulance Station	£1.90
8	Tenby Ambulance Station	£1.78
9	Bala Ambulance Station	£1.78
10	Ferndale Ambulance Station	£1.57

Figure 22: Water usage in £ per m². 2022-23 Top 10 users

5.0 WASTE – (General & Recycling)

Waste management, related to municipal domestic waste, is managed by the Environment and Sustainability Manager supported by the incumbent contractor Biffa. Unlike utilities, higher weights within particular waste streams, such as mixed recycling, and primarily carboard/paper are a positive. However, the use of the waste hierarchy is key to reducing waste weights over all and meeting WG targets of zero waste to landfill by 2050. *(Fig 23)* Preventing the existence of waste should be a priority for the trust, alongside NWSSP procurement. Packaging waste presents a particular challenge, and is presumably the reason, alongside high foot fall, that the top 10 highest producers of waste are MRD, control rooms and larger locality offices/stations. *(Fig 24)*.

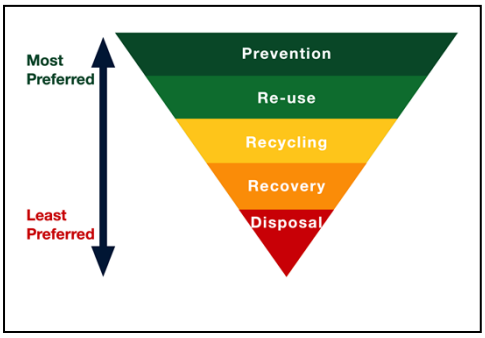


Figure 23: Waste Hierarchy

The calculation of carbon emissions for waste require different calculation factor dependent on the waste, and its means of disposal. Within the following tables emissions have been calculated for general waste collections presuming all of this waste goes to landfill, however there will be a percentage sent to energy recovery plants to generate electricity. The use of landfill waste in this manner is a step forward but does not negate the need for a more proactive approach to waste in general.

The top ten emission producers differ slightly to those sites with high volumes of waste. This is due to the volume of general waste collected in weight, and therefore producing higher emissions. Reducing general waste volumes and increasing recycling will reduce this figures. A recycling leaderboard has been produced and shared with service managers to show those sites with impressive levels of recycling, and those with concerning recycling averages. Newtown Ambulance Station leads the leaderboard by recycling over 70% of their waste, however Tenby Ambulance Station requires some more support to increase their 24% recycling figure. *(Table 1)*. The cost to response of general waste is also significantly more expensive than recycling waste. *(Fig 25&26)*.

Waste volumes, emissions, and costs per m^2 are interesting. The majority of sites on the top ten list are some of, if not the smallest buildings within the estate portfolio. The challenge would now be to understand how similar volumes of waste are being generated by smaller sites as larger ones. A full audit of the Trust estate will be undertaken 2023-24 detailing types of waste sent for disposal & lessons to be learned. *(Fig 27,28&29)*.

Nº	Premises	Tonne	%
1	Flintshire Make Ready Centre	6.15	13
2	Thanet House Control Centre- 111	5.28	11
3	Ambulance and Fire Service Resource Centre - Wrexham	5.23	11
4	Ty Elwy Administrative Building	5.13	10
5	HART Emergency Response Centre	5.10	10
6	Blackwood Ambulance Station & Fleet Workshop	4.71	10
7	Cardiff Area Ambulance Centre	4.59	9
8	Blackweir Ambulance Station	4.39	9
9	Bryncethin Ambulance Station	4.34	9
10	Swansea Ambulance Station	4.02	8

Figure 24 : Domestic waste per tonne 2022-23

Nº	PREMISES	Kg CO_2^e
1	Bryncethin Ambulance Station	1562.34
2	HART Emergency Response Centre	1540.23
3	Blackweir Ambulance Station	1477.79
4	Cardiff Area Ambulance Centre	1400.59
5	Flintshire Make Ready Centre	1349.04
6	Swansea Ambulance Station	1302.4
7	Ambulance and Fire Service Resource Centre - Wrexham	1269.21
8	Thanet House Control Centre-111	1267.18
9	Ty Elwy Administrative Building	1186.39
10	Blackwood Ambulance Station & Fleet Workshop	1166.9

Figure 25: Domestic waste per kg CO^2e produced 2022-23

Nº	PREMISES	£
1	NHS Direct Thanet House Control Centre	£2,815
2	Flintshire Make Ready Centre	£1,882
3	Blackwood Ambulance Station & Fleet Workshop	£1,882
4	Matrix One Administrative Building	£1,882
5	Ambulance and Fire Service Resource Centre - Wrexham	£1,645
6	Caernarfon Ambulance Station	£1,621
7	Bassaleg Ambulance Station	£1,548
8	Bryncethin Ambulance Station	£1,407
9	HART Emergency Response Centre	£1,407
10	Blackweir Ambulance Station	£1,407

Figure 26: Domestic waste cost in £. 2022-23

Nº	PREMISES	Tonne per m^2
1	Tywyn Ambulance Station	0.02
2	Bangor Ambulance Station	0.02
3	Newport Ambulance Station	0.02
4	Monmouth Ambulance Station - Modular Building	0.01
5	Amlwch Ambulance Station	0.01
6	Llandovery Ambulance Station	0.01
7	Pwllheli Ambulance Station	0.01
8	Hensol Ambulance Station	0.01
9	Flintshire Make Ready Centre	0.01
10	Bassaleg Ambulance Station	0.01

Figure 27: Domestic waste per tonne / m^2- 2022-23

Nº	PREMISES	Kg CO_2^e per m^2
1	Tywyn Ambulance Station	0.02
2	Bangor Ambulance Station	0.02
3	Newport Ambulance Station	0.02
4	Monmouth Ambulance Station - Modular Building	0.01
5	Amlwch Ambulance Station	0.01
6	Llandovery Ambulance Station	0.01
7	Pwllheli Ambulance Station	0.01
8	Hensol Ambulance Station	0.01
9	Flintshire Make Ready Centre	0.01
10	Bassaleg Ambulance Station	0.01

Figure 28: Domestic waste kg CO^2e per m^2 2022-23

Nº	PREMISES	£ per m^2
1	Tywyn Ambulance Station	£14.91
2	Bangor Ambulance Station	£7.11
3	Amlwch Ambulance Station	£5.97
4	Bassaleg Ambulance Station	£5.91
5	Llanrwst Ambulance Station	£5.85
6	Pwllheli Ambulance Station	£5.81
7	Newport Ambulance Station	£5.73
8	Llandudno Ambulance Station	£5.54
9	Blaenau Ffestiniog Ambulance Station	£5.44
10	Bala Ambulance Station	£5.09

Figure 29: Domestic waste £ per m2 2022-23

Table 1: Recycling leaderboard 2022-23

Site Name	Recycling	Site Name	Recycling
NEWTOWN AMBULANCE STATION	71%	LLANDUDNO AMBULANCE STATION	45%
PONTYPOOL AMBULANCE STATION	69%	PORTHMADOG AMBULANCE STATION	45%
BARMOUTH AMBULANCE STATION	65%	LLANDOVERY AMBULANCE STATION	44%
MATRIX ONE	63%	PEMBROKE DOCK AMBULANCE STATION	44%
HENSOL AMBULANCE STATION	61%	TUMBLE AMBULANCE STATION	44%
BEACON HOUSE	60%	BANGOR AMBULANCE STATION	41%
LLANGEFNI AMBULANCE STATION	59%	BARGOED AMBULANCE STATION	41%
FISHGUARD AMBULANCE STATION	57%	PORTARDAWE AMBULANCE STATION	40%
FLINTSHIRE MRD	56%	HAVERFORDWEST AMBULANCE STATION	39%
HOLYHEAD AMBULANCE STATION	56%	PARKWALL AMBULANCE STATION	39%
BLAENAU FFESTINIOG AMBULANCE S	53%	CWMBRAN AMBULANCE STATION	38%
BRECON AMBULANCE STATION	53%	ABERCONWY AMBULANCE STATION	37%
HAWTHORN AMBULANCE STATION	53%	HART FACILITY	37%
MONMOUTH AMBULANCE STATION	53%	CARDIGAN AMBULANCE STATION	36%
TRUST HEADQUARTERS	53%	MERTON HOUSE	36%
PWLLHELI AMBULANCE STATION	52%	PORT TALBOT AMBULANCE STATION	36%
RHYL AMBULANCE STATION	52%	ABERDARE AMBULANCE STATION	35%
BALA AMBULANCE STATION	51%	CARDIFF EAST AMBULANCE STATION	35%
DENBIGH AMBULANCE STATION	51%	GORSEINON AMBULANCE STATION	35%
THANET HOUSE	51%	LAMPETER AMBULANCE STATION	35%
AMBULANCE/FIRE SERV RES CENTRE	50%	TREDEGAR AMBULANCE STATION	35%
LLANELLI AMBULANCE STATION	50%	BANGOR FLEET WORKSHOP	34%
BLACKWOOD AMBULANCE STATION	49%	COWBRIDGE AMBULANCE STATION	34%
CEFN COED REGIONAL HQ	48%	GELLI AMBULANCE STATION	34%
LLANRWST AMBULANCE STATION	48%	MERTHYR AMBULANCE STATION	32%
NEWPORT AMBULANCE STATION	48%	NEATH AMBULANCE STATION	32%
TYWYN AMBULANCE STATION	48%	SWANSEA AMBULANCE STATION	32%
WELSHPOOL AMBULANCE STATION	48%	AMLWCH AMBULANCE STATION	31%
YSTRADGYNLAIS AMBULANCE STATIO	48%	PORTHCAWL AMBULANCE STATION	31%
BASSALEG AMBULANCE STATION	47%	BLACKWEIR AMBULANCE STATION	29%
CARMARTHEN AMBULANCE STATION	47%	LLANDEILO AMBULANCE STATION	28%
FERNDALE AMBULANCE STATION	47%	ABERYSTWYTH AMBULANCE STATION	27%
CAERNARFON AMBULANCE STATION	46%	AMMANFORD AMBULANCE STATION	26%
COLWYN BAY AMBULANCE STATION	46%	CRICKHOWELL AMBULANCE STATION	26%
CAERPHILLY AMBULANCE STATION	45%	ABERGAVENNY AMBULANCE STATION	25%
GLYNNEATH AMBULANCE STATION	45%	BRYNCETHIN AMBULANCE STATION	24%
		TENBY AMBULANCE STATION	23%

5.1 OCF – CHANGES TO WASTE LEGISLATION

Changes to waste regulations (as a provision under the Environment (Wales) Act 2016) will come into force on 1st April 2024.

This regulation requires:

- occupiers of non-domestic premises (including businesses, charities, and public sector bodies) to present specified recyclable materials for collection separately from each other and separate from residual waste.
- Require those that collect the specified recyclable materials to collect them separately from other recyclable materials; and
- Require those separately collected recyclable materials to be kept separate and not mixed.
- Provide for civil sanctions to be available in relation to criminal offences associated with these requirements.

Due to the regulation changes current waste management systems will have to be amended, with the Trust will also be open to civil sanctions for non-compliance. This will also require additional funding for initial infrastructure and additional waste collections.

The trust will have to move from the two-bin approach of dry mixed recycling and general waste to a five + bin approach:

- glass.
- Paper and Card
- metal, plastic, and cartons and other fibre-plastic composite packaging of a similar composition
- food (produced by premises producing more than 5kg of food waste a week)
- Other waste.

Additionally, further waste streams will be introduced after this initial change.

- unsold small waste electrical and electronic equipment (sWEEE).
- unsold textiles – with the use of textile banks or recycling plants required.

AGENDA ITEM No	**14**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

Manchester Arena Inquiry Recommendations - Progress Report

MEETING	Finance and Performance Committee
DATE	18/09/2023
EXECUTIVE	Lee Brooks, Executive Director of Operations
AUTHOR	Elliot Miller, Operations Support Officer- EPRR
CONTACT	Elliot.miller@wales.nhs.uk

EXECUTIVE SUMMARY

The Manchester Arena Inquiry: Volume 2 was released on the 22nd November 2022. 149 recommendations were made within the report and each emergency service across the UK is required to assess their own capabilities against these recommendations.

The attached paper was submitted to the Operations Senior Leadership Team (SLT) for approval on the 22 August 2023. The purpose of the paper being to provide an oversight of progress against the applicable recommendations and set out the governance route for the recommendations within the Trust.

71 actions have been assessed as being applicable to WAST and are described in full in Appendix 1.

Section 15 describes the recommendations that have been completed and formally signed off through the Operations Senior Leadership Team.

Appendix 2 describes the definitions of the RAG rating system.

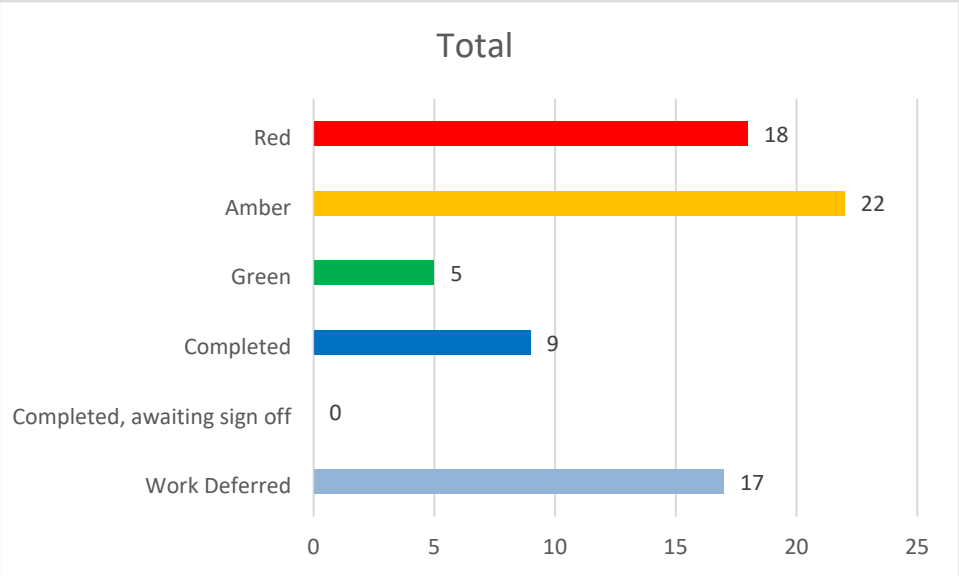
The paper was approved by SLT on the 22nd August 2023 and is now submitted to the Finance and Performance Committee for scrutiny and assurance.

KEY ISSUES/IMPLICATIONS

This paper describes the governance route for progress and formal closure of the MAI recommendations and sets out the review arrangements within the Operations Directorate and across the Trust.

An additional attachment has been included that expands upon Appendix 1 to include the current RAG rating for the benefit of clarity as requested by SLT. The cross-reference table includes details on the specific recommendation within the report, or a link to related evidence submitted to the Inquiry.

Progress against the recommendations has continued since this paper was originally approved by SLT on 22 August 2023, and the table below reflects the position in relation to the summary of recommendations at the start of September 2023.



Of note to Committee, following a recent workshop, 13 further recommendations are expected to be progressed through the annual update of the Incident Response Plan (IRP) which is scheduled for release in October 2023.

RECOMMENDATION:

It is recommended that Committee:

- **RECEIVE and DISCUSS the governance and assurance process, and progress on the completed recommendations related to the MAI recommendations, noting that the Operations Senior Leadership Team have approved the recommendations included in the paper.**

REPORT APPENDICES
Appendix 1 - MAI Recommendations **Appendix 2 - RAG Rating System** **Appendix 3 – Recommendations with RAG Rating**

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

SITUATION

1. The Manchester Arena Inquiry: Volume 2 was released on the 22nd November 2022. 149 recommendations were made within the report and each emergency service across the UK is required to assess their own capabilities against these recommendations. WAST have assessed seventy-one (71) as requiring review for the Trust.

2. This paper sets out the proposed governance route for the recommendations within the Trust.

BACKGROUND

3. A manager and a support officer have been appointed on a fixed term basis to review the implications of the MAI report, to provide a dedicated point of contact for the organisation, and to provide input to the various networks and groups UK wide which are focussed on the MAI recommendations.

4. All of the recommendations, within the report have been reviewed for relevance to WAST. 71 recommendations have been assessed as being relevant to WAST. These recommendations include those which are specific to ambulance only, multiagency recommendations and those applicable to Local Resilience Fora of which WAST is a member. There are also a small number of recommendations that apply directly to other emergency services but have a relevance to WAST, and these are included in Appendix A.

5. The 71 recommendations have been RAG rated in order of priority. The criterion for RAG is included in Appendix B.

6. Progress monitoring of this significant programme of work is in place across the operations directorate which includes:

   - Fortnightly meetings with the Head of Service and Service Manager, EPRR & Specialist Operations
   - Monthly meetings with the Assistant Director of Operations, National Operations & Support / Head of Service, EPRR & Specialist Operations
   - Bi-monthly meetings with the Executive Director of Operations / Assistant Director of Operations / Head of Service, EPRR & Specialist Operations.

7. Progress across all UK Ambulance Trusts is reported into a national group (MAROG - Manchester Arena Recommendations Operations Group). This is the MAI subgroup of the National Directors of Operations Group on which the Head of Service, EPRR & Specialist Operations sits as the WAST senior representative.

8. Within Wales, blue light partners are also coming together to review the MAI recommendations, some of which relate to a joint blue light response. The MAI subgroup of the Joint Emergency Services Group (JESG) is now set up and meets monthly. This group is looking to progress the multiagency recommendations across Wales and reports to the designated lead agency (South Wales Police) and subsequently into the Home Office on multiagency progress against the recommendations.

9. All information reported to the above groups is reviewed by the Head of Service and further verified by the Assistant Director of Operations if required.

10. As this programme of work progresses, the ambition is to ensure that all the 71 recommendations are completed to an appropriate standard and that the Trust is compliant with all of the relevant recommendations within the report.

11. Progress reports alongside any of the recommendations that are assessed within the programme of work to be completed, will be reported formally to the Operations Senior Leadership Team (SLT), setting out the appropriate progress, narrative and any rationale for completion. SLT will then consider the update and accept and approve any completed recommendations.

12. Formal papers to SLT will act as a governance route and will be subsequently reported onto to Executive Management Team (EMT) by way of the AAA reporting route.

13. Formal updates to Finance and Performance Committee will be made periodically.

ASSESSMENT

14. The recommendations are broken down as follows:

- Ambulance specific (n41)
- Related or Multi-agency (n30) **TOTAL n71**
- Not Assessed/Relevant (n78) **TOTAL n149**

Of the 71 recommendations, priority RAG has been assigned as follows:

Priority	Number of Recommendations	Status
Red	**18**	
Amber	**22**	
Green	**5**	
Deferred	**17**	**Other organisation dependency**
Complete	**9**	**For approval/closure**

15. The following recommendations have been assessed as completed:

Ref	Recommendation	Closure Rationale
14	North West Ambulance Service should review its Major Incident Response Plan to consider whether it should be updated to include a pre-determined attendance for Major Incidents.	WAST have a Pre-Determined Attendance (PDA) for 5 defined level of incidents (including Major Incidents) contained within its Incident Response Plan (IRP).
15	North West Ambulance Service should review its Major Incident Response Plan to consider whether, in order to speed up mobilisation, it should provide pre-determined attendances for the Hazardous Area Response Team, Ambulance Intervention Team and Special Operations Response Team crews for Major Incidents.	WAST IRP PDA includes auto-allocation of HART, Support units and Amber or Red alerts of SORT.
21	North West Ambulance Service should review its Major Incident Response Plan to make clear that the first resource on scene should assume the role of Operational Commander only once they have achieved situational awareness.	The action cards used by the trust are NARU issue and prompt the first resource on scene to obtain situational awareness and pass a METHANE message prior to appointing roles etc. This differs from the Inquiry slightly, but the outcome of the card aligns with the recommendation. As they are NARU action cards, these will be update in line with any changes in national guidance.
22	North West Ambulance Service should ensure that its commanders are adequately trained in the use of operational discretion.	Operational discretion is taught on both tactical and operational commanders' courses, as well as tools to assist commanders in making these decisions (e.g., ERICPD). This will also be enhanced further with the roll out of the new MTA JOPs.
73	The Home Office should consider the introduction of a national standard requiring a meeting of the Strategic Co-ordinating Group	The All-Wales Gold course indicates that a meeting of an SCG should occur within 1 hour (virtually) of an incident occurring. This is taught across all

	to take place no more than two hours after the declaration of a Major Incident where more than one emergency service is engaged in the response to that incident	Welsh emergency services and is compliant with this recommendation.
76	The Department of Health and Social Care, the NHS, the National Ambulance Resilience Unit, ambulance service trusts, Air Ambulances UK, Counter Terrorism Policing Headquarters and JESIP should consider whether air ambulances should be integrated into the emergency response to Major Incidents, including terrorist attacks, and, if so, how that is to be achieved	EMRTS and WAST are closely integrated and cover the same geographical area. EMRTS are included comprehensively in the PDA and have been embedded into the WAST control room which will improve integration during a response. EMRTS also form an integral part of the medical advisory capability at Major Incidents.
91R	The Home Office and College of Policing should ensure that any police officer whose position carries with it the expectation that they will assume a Tactical/Silver Commander role in the event of a spontaneous Major Incident (e.g. Night Silver in Greater Manchester Police) has undertaken an accredited course preparing them for that role.	This is a police specific action but has been covered by WAST for assurance. This relates to those undertaking Tactical command having undertaken accredited training. All Tactical commanders have undertaken at least the WAST foundation course (that has been accredited by NARU) as well as additional national courses and maintain a portfolio of CPD. There is not an expectation that an untrained individual would undertake this role, and we have additionally trained staff (e.g., EPRR team) that builds depth and resilience into our response.
121	The Department of Health and Social Care, the Faculty of Pre-Hospital Care, the College of Paramedics and the National Ambulance Resilience Unit should undertake a review into whether frontline ambulances should carry intramuscular tranexamic acid or TXA	In line with current PGDs, intramuscular TXA is available to WAST frontline clinicians, available on all emergency vehicles, and is well embedded as a practice.
122	The Department of Health and Social Care and the National Ambulance Resilience Unit should review whether stretchers should	We currently stock a variety of stretchers on the national capability vehicles that is over and above the stocklist for English trusts. These

	be carried on National Capability Mass Casualty Equipment Vehicles.	stretchers include 20 folding stretchers, 48 'Mega Mover' (carry sheet style) and 10 orthopaedic 'scoop' stretchers per vehicle.

16. **RECOMMENDATION:**

It is recommended that SLT:

a. **APPROVE** the governance and assurance process related to the MAI recommendations.
b. **APPROVE** the identified recommendations as complete.

Appendix 1

Ambulance Specific Recommendations (41)

Rec #	Recommendation	Agency
14*	**North West Ambulance Service should review its Major Incident Response Plan to consider whether it should be updated to include a pre-determined attendance for Major Incidents.**	**Ambulance**
15*	**North West Ambulance Service should review its Major Incident Response Plan to consider whether, in order to speed up mobilisation, it should provide pre-determined attendances for the Hazardous Area Response Team, Ambulance Intervention Team and Special Operations Response Team crews for Major Incidents.**	**Ambulance**
16*	**North West Ambulance Service should ensure that it has up-to-date site-specific plans for all large, complex or high-risk locations within its area**	**Ambulance**
17*	**North West Ambulance Service should ensure that all its site-specific plans are multi-agency and that all Category 1 responders operating in the areas it serves have contributed to them.**	**Ambulance**
18*	**North West Ambulance Service should ensure that it has a policy that sets out the circumstances in which an Operational Commander may be relieved and how that should occur and be communicated to the outgoing Operational Commander and beyond**	**Ambulance**

19*	**North West Ambulance Service should train its Operational Commanders on the appropriate practice for relieving another of command and being relieved of command.**	**Ambulance**
20*	**North West Ambulance Service should ensure that non-specialist ambulance personnel are involved in multi-agency exercising**	**Ambulance**
21*	**North West Ambulance Service should review its Major Incident Response Plan to make clear that the first resource on scene should assume the role of Operational Commander only once they have achieved situational awareness.**	**Ambulance**
22*	**North West Ambulance Service should ensure that its commanders are adequately trained in the use of operational discretion.**	**Ambulance**
23*	**North West Ambulance Service should review its policies for mobilising the Hazardous Area Response Team resource, to ensure that this team is available as soon as possible for an emergency where its specialist skills are required**	**Ambulance**
24*	**North West Ambulance Service should review how it rosters Tactical Advisors and National Interagency Liaison Officers so as to ensure that there is adequate geographical coverage enabling those on duty to arrive promptly at the scene of any Major Incident.**	**Ambulance**
25*	**North West Ambulance Service should review the number of Tactical Advisors and National Interagency Liaison Officers it has, and whether the number of such specialists, both generally and on call, should be increased.**	**Ambulance**
26*	**North West Ambulance Service should review its procedures with local NHS trusts to ensure that it has effective policies in place for quickly dispatching patients injured in a Major Incident to an appropriate hospital**	**Ambulance**
27*	**North West Ambulance Service should reflect on its approach to record-making during and immediately following a Major Incident, with a view to improving the current practice**	**Ambulance**
76	**The Department of Health and Social Care, the NHS, the National Ambulance Resilience Unit, ambulance service trusts, Air Ambulances UK, Counter Terrorism Policing Headquarters and JESIP should consider whether air ambulances should be integrated into the emergency**	**Air Amb**

	response to Major Incidents, including terrorist attacks, and, if so, how that is to be achieved	
77	**The Department of Health and Social Care, the NHS, the National Ambulance Resilience Unit, ambulance service trusts, Air Ambulances UK, Counter Terrorism Policing Headquarters and JESIP should consider what staff training and resources would be required to integrate air ambulance organisations into the emergency response to Major Incidents, including terrorist attacks.**	**Air Amb**
82	**The Department of Health and Social Care and the National Ambulance Resilience Unit should develop a system for ensuring that the duty command structure in each ambulance service has notice of any significant pre-planned event, such as a major concert or sports match, taking place within the ambulance service area**	**Ambulance**
105	**Ambulance service trusts should review their capacity to respond to a mass casualty incident. That should include an assessment of whether they have an adequate number of trained specialist personnel to respond effectively to a mass casualty incident.**	**Ambulance**
106	**Having carried out that review, the trusts should make recommendations to their NHS commissioners about the additional and/or different resources they require in order to ensure that they are able to respond effectively to a mass casualty incident in the numbers required.**	**Ambulance**
107	**The Department of Health and Social Care should give urgent and close consideration to any recommendations made by the trusts and the NHS commissioners**	**Ambulance**
108	**The Department of Health and Social Care and the National Ambulance Resilience Unit should develop procedures to ensure that, so far as possible, each ambulance service trust is able to deploy or call upon HART resources immediately in the event of a Major Incident. As part of that, the Department of Health and Social Care and the National Ambulance Resilience Unit should develop procedures to ensure that, so far as possible, each ambulance service trust can call upon cross-border support in respect of HART resources immediately in the event of a Major Incident. There may be some incidents that are so significant that an individual ambulance service will need to mobilise its**	**Ambulance**

	own HART resources and also draw upon cross-border support. Procedures need to accommodate this.	
109	**All ambulance service trusts should undertake training and exercising with neighbouring ambulance service trusts to ensure that cross-border support is efficient and effective**	**Ambulance**
110	**The Department of Health and Social Care and the National Ambulance Resilience Unit should ensure that all ambulance commanders receive regular Major Incident training. The training should include training on HART capabilities, on all the command roles and where they will be located, on how to gain situational awareness through the deployment of sector commanders and other roles, on the importance of getting ambulance personnel to casualties without delay and on the circumstances in which they may use operational discretion**	**Ambulance**
111	**The Department of Health and Social Care and the National Ambulance Resilience Unit should consider ensuring that there is further training of HART personnel so that at least one member on every HART deployment has the ability to deliver the most enhanced care interventions.**	**Ambulance**
112*	**The team led by Philip Cowburn has devised a tool that is designed to replace the existing systems of primary and secondary triage. It is known as the Major Incident Triage Tool. It already has the support of NHS England. The National Ambulance Resilience Unit and all ambulance services should consider introducing the Major Incident Triage Tool as a matter of urgency**	**Ambulance**
114*	**The Department of Health and Social Care and the National Ambulance Resilience Unit should consider whether the Advanced Medical Priority Dispatch System is fit for purpose and, if it is, whether it can be improved. Particular consideration should be given to how the system prioritises emergency calls**	**Ambulance**

115*	**The Department of Health and Social Care, the Faculty of Pre-Hospital Care, the College of Paramedics and the National Ambulance Resilience Unit should review the current model for evacuation to hospital operated in the UK by reference to the different approaches around the world in order to see whether triage at different times and in different places remains best practice, or whether there should be a greater emphasis on rapid evacuation to hospital.**	**Ambulance**
116*	**A significant issue in a mass casualty situation is that all of those paramedics who have arrived in ambulances may be required for the treatment of casualties, so that no paramedic is available to drive patients to hospital. The Department of Health and Social Care and the National Ambulance Resilience Unit should consider how to resolve that problem. Consideration should be given to the training of other emergency service personnel in driving ambulances.**	**Ambulance**
117*	**The Department of Health and Social Care and the National Ambulance Resilience Unit should consider whether the Basic Life Support and Advanced Life Support bags used by paramedics should contain SMART Triage Tags or an equivalent**	**Ambulance**
118*	**The Department of Health and Social Care and the Medicines and Healthcare products Regulatory Agency (MHRA) should consider urgently whether the regulatory regime should be altered to enable analgesia, such as fentanyl lozenges or sufentanil sublingual tablets, to be given by paramedics to injured persons.**	**Ambulance**
119*	**If the decision is that the regulatory regime should be altered in this way, the National Ambulance Resilience Unit should consider urgently whether the use of such analgesia should be rolled out to all Hazardous Area Response Team and other specialist operatives, as part of their basic equipment, and to paramedics more generally**	**Ambulance**
120*	**The Department of Health and Social Care, the Faculty of Pre-Hospital Care, the College of Paramedics and the National Ambulance Resilience Unit should consider whether all Hazardous Area Response Team operatives should be deployed with freeze-dried plasma and trained in its use**	**Ambulance**

121*	**The Department of Health and Social Care, the Faculty of Pre-Hospital Care, the College of Paramedics and the National Ambulance Resilience Unit should undertake a review into whether frontline ambulances should carry intramuscular tranexamic acid or TXA**	**Ambulance**
122*	**The Department of Health and Social Care and the National Ambulance Resilience Unit should review whether stretchers should be carried on National Capability Mass Casualty Equipment Vehicles.**	**Ambulance**
123*	**The Department of Health and Social Care, the Faculty of Pre-Hospital Care, the College of Paramedics and the National Ambulance Resilience Unit should consider issuing guidance on how to ensure that specialist paramedics take with them, into a warm zone, equipment that enables them to carry out bridging interventions**	**Ambulance**
124*	**All ambulance service trusts should consider appointing a person within their control rooms who, in the event of a Major Incident, has the sole role of gathering and collating all available information and intelligence, and sharing it internally and externally to the extent appropriate.**	**Ambulance**
125*	**The terms Casualty Collection Point and Casualty Clearing Station are capable of being confused, one for the other, particularly in circumstances of stress. That happened on the night of the Attack. The National Ambulance Resilience Unit should consider whether different and more distinct terms should be used for these two locations**	**Ambulance**
126	**The Department of Health and Social Care and the National Ambulance Resilience Unit should consider the scope of the role of an Ambulance Liaison Officer and issue guidance to ambulance services in that regard.**	**Ambulance**
127	**The Home Office and the Department of Health and Social Care should consider how the threshold for a requirement that an Ambulance Liaison Officer be present at an event is to be identified.**	**Ambulance**
128	**The Home Office, the Department of Health and Social Care and the National Ambulance Resilience Unit should consider how to ensure that the role of an Ambulance Liaison Officer is properly resourced and also whether venue operators should fund the presence of an Ambulance Liaison Officer where one is required**	**Ambulance**

129	**The Home Office should consider how the presence of an Ambulance Liaison Officer in appropriate circumstances may be made mandatory. This may need to be put on a statutory footing**	**Ambulance**

Multi-Agency/Shared Recommendations (30)

R relates to a recommendation not directed at the ambulance service but should still be addressed to ensure we as an organisation are not vulnerable to the same occurrence.

Rec #	Recommendation	Agency
1	**The Greater Manchester Resilience Forum should oversee, at least every six months, a regular tri-service review of the Major Incident plans used by Greater Manchester Police, Greater Manchester Fire and Rescue Service and North West Ambulance Service. The purpose of that review should be to ensure that there is a common understanding by each emergency service of the plans of the other emergency services. It should also ensure that the importance of joint working is embedded within each emergency service**	**LRF**
10*	**Greater Manchester Police's Major Incident Plan should be reviewed to ensure that it includes clear guidance on the capabilities of North West Ambulance Service, including its Hazardous Area Response Team, Ambulance Intervention Team and Special Operations Response Team, as well as on the importance of joint working**	**Police**

45	**The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit and JESIP should review and, as necessary, update the Joint Doctrine: The Interoperability Framework (the Joint Doctrine) and Responding to a Marauding Terrorist Firearms Attack and Terrorist Siege: Joint Operating Principles for the Emergency Services (the Joint Operating Principles). The following matters should be considered in that review: a. achieving a situation in which commanders understand that the critical decisions of the commander most directly concerned in the issue under consideration are followed, unless there is a good reason for not doing so; b. achieving a situation in which risk appetite is common across the three emergency services – this will require collaborative work; c. achieving a situation in which forward deployment of specialist resources is the presumption, to be displaced only in the presence of a properly evidenced basis for not deploying resources forward; and d. achieving a situation in which the possibility of a secondary device does not delay forward deployment of resources, unless there is a proper basis for believing that such a device exists**	**All**
46	**The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit, individual police services and JESIP should review what changes need to be made to the Major Incident plans and Counter Terrorism Policing Headquarters Operation Plato guidance in order to achieve the aims set out in R45.**	**All**
47	**The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit, individual police services and JESIP should develop a nationally agreed format for all plans, placing JESIP at their centre**	**All**
48	**The Home Office and the Department for Levelling Up, Housing and Communities should ensure that there exist robust national and local systems to identify and record the lessons learned from all multi-agency exercises and ensure that change is implemented as a result, where change is indicated**	**All**

49	**The Home Office and the Department for Levelling Up, Housing and Communities should ensure that there exist robust national and local systems and sufficient resources to make sure that the debrief process following multiagency exercises is effective to capture the lessons that need to be learned**	**All**
50	**The Home Office, Counter Terrorism Policing Headquarters, the College of Policing, the Fire Service College and the National Ambulance Resilience Unit should consider introducing the use of regular 'high-fidelity training' to give emergency responders better experience of the stress, pressure and pace of a no-notice attack.**	**All**
51	**The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit and all local resilience forums should take steps to ensure, whether through multi-agency training and exercising or otherwise, that the members of each emergency service are aware of the specialist capabilities of every other emergency service.**	**All**
52	**The Home Office, the National Ambulance Resilience Unit, the College of Policing and the Fire Service College should develop guidance as to where commanders should locate during a spontaneous Major Incident. Steps should be taken to ensure that a consistent approach is taken so that equivalent commanders locate in the same place. During the response to a terrorist attack, the need for commanders on scene who are not engaged in directing individual actions should be recognised and accommodated**	**All**
53	**The emergency services should prepare, train and exercise for how they will maintain effective radio communications between emergency responders on the ground, commanders and control rooms, during the response to a Major Incident.**	**All**
55	**The Home Office, the College of Policing, the Fire Service College and the National Ambulance Resilience Unit should consider together whether an app giving ready access to the contact details for all on-duty and on-call commanders is feasible and, if so, likely to be of benefit in the response to a Major Incident**	**All**

56R	**The College of Policing and Counter Terrorism Policing Headquarters should take steps to ensure that each police service establishes a hotline that enables those within the command structure of the three emergency services to make contact with the Force Duty Officer in the event of a declaration of Operation Plato**	**Police**
67	**The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit and JESIP should ensure that all emergency services use common terminology to describe the Operation Plato hot, warm and cold zones and all have a common understanding of those terms**	**All**
69	**The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit and JESIP should ensure that all emergency services use common terminology to describe the zoning of hazardous areas in non-Operation Plato Major Incident situations and that all services have a common understanding of those terms. The terms should be different from those used when Operation Plato is declared**	**All**
71	**The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College and the National Ambulance Resilience Unit should oversee the development and implementation of action cards for the police, fire and rescue service, and ambulance service for use in a Major Incident. This should include the following: a. ensuring that all control room staff and commanders are trained in the use of the action cards; b. ensuring that action cards act as a checklist, setting out the key functions of each command role, the role of control room staff and the need for joint working; c. ensuring that action cards are available immediately to commanders and control room staff during the course of the response to a Major Incident, whether in hard copy or electronically; d. ensuring that the use of action cards is tested regularly through exercising; and e. ensuring that the action cards within the control rooms include a prompt to the first commander on scene to co-locate with other emergency service commanders**	**All**

73	**The Home Office should consider the introduction of a national standard requiring a meeting of the Strategic Co-ordinating Group to take place no more than two hours after the declaration of a Major Incident where more than one emergency service is engaged in the response to that incident**	**All**
84	**The Home Office, the College of Policing, the National Ambulance Resilience Unit and the Fire Service College should ensure that all those who may be required to take up a command position in the event of a Major Incident are issued with a means to record what they say, hear and see unless there are good reasons why they should not be so equipped.**	**All**
85	**Consideration should also be given by those organisations to the provision of such equipment to key personnel within control rooms.**	**All**
86	**The Home Office, the College of Policing, the National Ambulance Resilience Unit and the Fire Service College should ensure that training is given to all who are issued with such equipment, on the circumstances in which it should be used and the importance of its use.**	**All**
87	**The Home Office, the College of Policing, the National Ambulance Resilience Unit and the Fire Service College should ensure that, in the course of exercises, such equipment is used by those who would use it in the circumstances of a real-life incident**	**All**
88	**The Home Office, the College of Policing, the National Ambulance Resilience Unit and the Fire Service College should take steps to ensure that all emergency services understand the importance of promptly obtaining comprehensive accounts from commanders as part of the debrief process following a Major Incident**	**All**
91R	**The Home Office and College of Policing should ensure that any police officer whose position carries with it the expectation that they will assume a Tactical/Silver Commander role in the event of a spontaneous Major Incident (e.g. Night Silver in Greater Manchester Police) has undertaken an accredited course preparing them for that role.**	**Police**

92R	**The College of Policing should consider whether the current process for maintaining and storing training records for all police officers can be improved. That should include assessing the following: a. the introduction of electronic training records in a standard form across all police services; b. the introduction of centrally held electronic training records for all police officers; and c. the introduction of a system whereby each police officer is required to view their record each year and identify any errors or omissions within it**	**Police**
99	**Each emergency service should ensure that it is represented at a senior level at every meeting of a local resilience forum**	**LRF**
113*	**The team led by Philip Cowburn has devised a tool that is designed for use by a wide range of emergency responders in a mass casualty situation. It is known as Ten Second Triage. The National Ambulance Resilience Unit, the College of Policing and the Fire Service College should consider as a matter of urgency whether all of their frontline staff should be trained in the use of Ten Second Triage.**	**All**
136*	**The Department of Health and Social Care should consider issuing guidance on the first aid equipment that event providers should have available on the relevant premises, as well as where that equipment should be stored to ensure that it is readily accessible when required and how often it should be checked to ensure that it is up to date and in good working order**	**Event med cover**
139*	**Guidance should be provided to event healthcare providers, to emergency service responders other than paramedics and to the public generally about the circumstances in which those who are believed to be dead should be covered. The guidance should make clear that this step should only be taken by a paramedic or other healthcare professional. The guidance should also make clear that paramedics at the scene of a mass casualty incident should inform others present that only healthcare professionals should cover those believed to be dead. The Department of Health and Social Care and the National Ambulance Resilience Unit should provide guidance addressing this important issue.**	**Event med cover**

148	**The Home Office, the Department of Health and Social Care, the Department for Transport and the Department for Levelling Up, Housing and Communities should conduct a review to ensure that stretchers that are appropriate in design and adequate in numbers are always available for use by the emergency services and in appropriate locations in the event of a mass casualty incident.**	**Gov**
149	**The Department of Health and Social Care should undertake a review, with input from other bodies as the Department considers appropriate, in order to identify the type of stretcher that is of the greatest utility in the event of a mass casualty incident. The product of that research should be rolled out to all of those with responsibility for the response to a mass casualty incident, including a terrorist attack, whether in the public or private sector.**	**Gov**

Other Recommendations that WAST are not reporting upon. (78)

Rec #	Recommendation	Agency
2*	**British Transport Police should ensure that all its Inspectors are trained to undertake the Bronze Commander role in the event of a Major Incident.**	**BTP**
3*	**British Transport Police should review its procedures to ensure the prompt appointment of a Bronze Commander during a Major Incident.**	**BTP**
4*	**British Transport Police should ensure that all its Sergeants are trained in what is required of a Bronze Commander in the event of a Major Incident. This will help to make sure that the first Sergeant on scene can undertake the initial steps in the emergency response, prior to the arrival of an Inspector.**	**BTP**
5*	**British Transport Police should work with the Home Office police services with which it shares policing responsibilities at or for a particular location: a. to agree which police service has primacy in the event of a Major Incident; b. to put in place appropriate plans to make clear the responsibilities of each police service in the event of a Major Incident; c. to conduct regular exercises, including joint exercises, to test those plans; and d. to ensure that all police officers and police staff are adequately trained in what will be required of them.**	**BTP**

6*	**The role of the Senior Duty Officer in a Major Incident should be clearly defined and explained in the British Transport Police Major Incident Manual. This role should have a corresponding action card.**	**BTP**
7*	**British Transport Police should reflect on its approach to record-making during and immediately following a Major Incident, with a view to improving the current practice.**	**BTP**
8*	**Greater Manchester Police should ensure that its role cards are always immediately accessible to the officers who are to perform those roles.**	**Police**
9*	**Greater Manchester Police's Major Incident Plan should be reviewed to ensure that it includes clear guidance on the capabilities of Greater Manchester Fire and Rescue Service, including its Specialist Response Team, as well as on the importance of joint working.**	**Police**
11*	**Greater Manchester Police should ensure that its plans for responding to a Major Incident, including a terrorist incident, are reviewed regularly by those with the appropriate skills and experience to make meaningful improvements to each plan. This must include a regular review of the Operation Plato plan, which must include obtaining the views of those with experience of firearms policing and of performing the role of Force Duty Office**	**Police**
12*	**Greater Manchester Police should review its Operation Plato plans to ensure that there is only a single plan to which all can work and that this plan gives clear and consistent guidance on how to respond to an Operation Plato incident.**	**Police**
13*	**Greater Manchester Police should reflect on its approach to record-making during and immediately following a Major Incident, with a view to improving the current practice.**	**Police**
28*	**North West Fire Control should take steps to ensure that it is involved in multi-agency exercises, particularly those that test mobilisation and the response to a Major Incident in line with the Joint Emergency Services Interoperability Principles (JESIP).**	**FRS Control**
29*	**North West Fire Control should ensure that it regularly tests how it operates, by ensuring that its staff participate in regular exercises and practical tests. These should include multi-agency exercises**	**FRS Control**

30*	**All North West Fire Control staff should be trained on the best practices for responding to a Major Incident, as identified through its participation in exercises. North West Fire Control should ensure that learning is kept under review**	**FRS Control**
31*	**North West Fire Control should review the way it captures and records key information on its incident logs in order to ensure that the information is stored in one place and is readily accessible at all times by those who need it**	**FRS Control**
32*	**Greater Manchester Fire and Rescue Service and North West Fire Control should conduct a joint review of the circumstances in which it is appropriate for Greater Manchester Fire and Rescue Service personnel to check the North West Fire Control incident log. Policies should be written by both organisations to reflect the outcome of this review. Training should be delivered to embed it into practice**	**FRS Control**
33*	**North West Fire Control should review its guidance and policies on how it receives and passes on information during a Major Incident. It is important that, for any update given, it is established when the last time the person receiving the update was provided with information, to ensure that they are completely up to date. See also R38.**	**FRS Control**
34*	**North West Fire Control should review how it allocates the best-trained and most suitable Control Room Operators to roles during a Major Incident. It should consider whether it is beneficial to allocate a Control Room Operator to monitor communications on a multi-agency control room talk group and another Control Room Operator as the specific point of contact for the fire and rescue service. Both roles could be supervised by a Team Leader**	**FRS Control**
35*	**North West Fire Control should reflect on its approach to record-making during and immediately following a Major Incident, with a view to improving the current practice**	**FRS Control**
36*	**Greater Manchester Fire and Rescue Service should ensure that its commanders are adequately trained in the use of operational discretion.**	**FRS**
37*	**Greater Manchester Fire and Rescue Service should review the policy by which the Incident Commander takes up the role, in light of the shortcomings I have identified in the policy in operation on 22nd May 2017**	**FRS**

38*	**Greater Manchester Fire and Rescue Service should review its guidance and policies on how it receives and passes on information during a Major Incident. It is important that, for any update given, it is established when the last time the person receiving the update was provided with information, to ensure that they are completely up to date. See also R33**	**FRS**
39*	**Greater Manchester Fire and Rescue Service should reflect on its approach to record-making during and immediately following a Major Incident, with a view to improving the current practice.**	**FRS**
40	**Counter Terrorism Policing Headquarters should review the procedures by which it is notified of a terrorist attack to ensure that all police services know that this is an early priority**	**CTP**
41*	**SMG should review its processes to ensure that it shares with Greater Manchester Police, Greater Manchester Fire and Rescue Service, British Transport Police and North West Ambulance Service its most current emergency response plans and policies for dealing with an incident at the Arena. It should apply this approach more generally to its operations.**	**Event owner**
42*	**SMG should ensure that the healthcare service provider at the Arena has a strong working relationship with North West Ambulance Service**	**Event owner**
43*	**SMG should ensure that the healthcare service provider at the Arena has adequate staffing and skill levels for every event at that location.**	**Event owner**
44*	**SMG should review its approach to the provision of healthcare service equipment at the Arena to ensure that adequate equipment is always available.**	**Event owner**
54	**All police services should ensure that they have made adequate provision for Airwave Tactical Advisors, in particular that an identified Airwave Tactical Advisor is either on duty or on call at all times**	**Police**
57	**The College of Policing, the Fire Service College and National Fire Chiefs Council should consider devising training packages for operators within control rooms, to enable them to give guidance on basic trauma care to 999 callers.**	**Control rooms**

58	**His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing and the Home Office should work together to put in place robust systems, policies and guidance to ensure that all police services have sufficient resources dedicated to the development of operational and contingency plans, particularly for responding to Major Incidents, including terrorist attacks.**	**Police**
59	**His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing and the Home Office should issue guidance for all police services on how often operational plans for responding to a Major Incident, including a terrorist incident, should be reviewed, how that review should be conducted, and what rank and experience the officers involved should have**	**Police**
60	**All police services should ensure that they have robust version control arrangements in place for all plans.**	**Police**
61	**The Inquiry heard evidence that the impact of public funding cuts fell disproportionately hard on metropolitan police services, such as Greater Manchester Police, compared with non-metropolitan services. In the event that public funding cuts are in the future considered necessary by the government, the Home Office should consider whether some funding arrangement for police services different from that applied in the post-2010 period is necessary**	**Police**
62*	**The Home Office, the College of Policing and Counter Terrorism Policing Headquarters should ensure that all police officers to be appointed to the role of Force Duty Officer or Force Incident Manager attend a comprehensive training course dedicated to Operation Plato before they take up their role. Such courses must ensure that those attending understand the exceptional demands that will be placed upon them in the event of an Operation Plato declaration. Any course should include training in the following: a. the need, following a declaration of Operation Plato, to carry out regular reviews of that declaration; b. the need to identify with clarity the Operation Plato zones at the scene or scenes covered by the declaration; c. the need to communicate those zones to all emergency services promptly; d. the need to keep zoning decisions under review; and e. the need to work jointly with emergency service partners in the response to an Operation Plato situation**	**Police**

63*	**Given the broad command responsibilities that the Force Duty Officer or Force Incident Manager will have in the early stages of the response to a Major Incident, the Home Office and the College of Policing should develop nationally accredited training to prepare those officers for that role**	**Police**
64*	**Counter Terrorism Policing Headquarters and the College of Policing should ensure that all firearms officers, including firearms commanders, receive adequate training in Operation Plato, including in what such a declaration means and the demands it will place upon them. This should include instruction in the importance of zoning, communicating zoning decisions to other emergency services and joint working with those other services in the course of the response to an Operation Plato situation**	**Police**
65*	**Counter Terrorism Policing Headquarters and the College of Policing should ensure that all unarmed frontline police officers receive training in what Operation Plato is and what will be expected of them following such a declaration. The training should include the importance of zoning, the identification of who can ordinarily work in different zones and the importance of joint working.**	**Police**
66*	**The College of Policing should issue guidance to all police services to ensure the following, in the event of a Major Incident: a. The Force Duty Officer is not expected to deal with media enquiries. b. The important task of ensuring that the media is kept informed is done in a way that does not interfere with the work of the police control room**	**Police**
68	**Those organisations should consider what changes need to be made to the Counter Terrorism Policing Headquarters Operation Plato guidance in order to achieve those aims**	**Police**
70	**Those organisations should consider what changes need to be made to Major Incident plans in order to achieve those aims.**	
72	**Counter Terrorism Policing Headquarters and the College of Policing should review the advantages and disadvantages of a combined Silver and Gold Control Room as opposed to separate rooms, and issue guidance for all police services on best practice**	**Police**

74	**Counter Terrorism Policing Headquarters should review the evidence heard during the Inquiry, including that heard in restricted sessions, to consider the advantages and disadvantages of embedding doctors with some police firearms teams, and how, if that is advantageous, it could be achieved.**	**Police**
75	**Counter Terrorism Policing Headquarters should review the experience of other jurisdictions that embed medics with police firearms officers, such as Recherche, Assistance, Intervention, Dissuasion (RAID) in France, to understand how their systems operate and whether they ought to be replicated in the UK or some further learning taken from them**	**Police**
78	**Counter Terrorism Policing Headquarters and the College of Policing should issue guidance on the circumstances in which a police officer or officers with responsibility for the tactical/silver command of the unarmed officers at the scene or scenes of a Major Incident should deploy to that scene or scenes.**	**Police**
79	**The College of Policing and His Majesty's Inspectorate of Constabulary and Fire and Rescue Services should ensure that each police service has in place a system that means appropriately qualified and experienced personnel are rostered 24 hours each day so that, in the event of a terrorist attack or any Major Incident, a prepared and effective command structure can be geared up swiftly**	**Police**
80*	**The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, Counter Terrorism Policing Headquarters and the College of Policing should take steps to ensure that all police services have in place effective systems for the prompt deployment of explosives detection dogs in circumstances in which such animals are needed**	**Police**
81	**The Home Office, the College of Policing and His Majesty's Inspectorate of Constabulary and Fire and Rescue Services should develop a system for ensuring that the duty command structure in each police service has notice of any significant pre-planned event, such as a major concert or sports match, taking place within the police service area.**	**Police**

83	**The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, and the Fire Service College should develop a system for ensuring that the duty command structure in each fire and rescue service has notice of any significant pre-planned event, such as a major concert or sports match, taking place within the fire and rescue service area**	**FRS**
89	**The College of Policing should assess whether delays in the provision of written accounts by some firearms officers involved in the response to the Attack were due to Post Incident Procedures. If so, those procedures should be reviewed.**	**Police**
90	**The Home Office, Counter Terrorism Policing Headquarters and the College of Policing should consider whether firearms officers should be equipped routinely with body-worn video cameras**	**Police**
93*	**The Home Office and College of Policing should ensure that all newly recruited and existing police officers and all frontline police staff, such as Police Community Support Officers, are trained in first responder interventions.**	**Police**
94*	**Each police service must ensure that adequate time is allocated to the training of all police officers and frontline police staff in first responder interventions.**	**Police**
95*	**The Home Office and the College of Policing should regularly assess and appraise the training on first responder interventions provided by each police service to ensure that it is of an appropriate quality and that adequate time is allocated to it**	**Police**
96*	**The College of Policing and Counter Terrorism Policing Headquarters should ensure that all firearms officers are trained to understand that, while their primary role in an Operation Plato situation is to neutralise any armed terrorist, their role also involves providing Care Under Fire.**	**Police**
97*	**The College of Policing and Counter Terrorism Policing Headquarters should review whether firearms officers should be deployed with analgesia and trained in its use, as part of providing Care Under Fire**	**Police**
98	**Local resilience forums have a vital role in the preparation for the response to any Major Incident. The Cabinet Office and the Home Office should consider implementing an independent inspection regime for local resilience forums**	**LRF**

100	**Local resilience forums should monitor attendance and participation at their meetings, and flag promptly any concerns about attendance by members to the leadership of the organisation concerned. The Home Office should ensure that this is being done by local resilience forums**	**LRF**
101	**The Home Office should consider empowering the leadership of local resilience forums to compel the attendance of a senior representative of its Category 1 and Category 2 responders at all local resilience forum meetings. Inspections by His Majesty's Inspectorate of Constabulary and Fire and Rescue Services should include an analysis of a service's engagement with its local resilience forum or forums. Consideration should be given to putting this on a statutory footing**	**LRF**
102	**The Home Office should consider how local resilience forums are to be funded consistently and sufficiently to enable them to do their important work**	**LRF**
103	**The Home Office should consider, together with local resilience forums, how they are to have sufficient staff and resources to enable them to function effectively**	**LRF**
104	**Local resilience forums should establish procedures to ensure that they oversee the process of identifying the lessons to be learned from major exercises, or serious incidents, in their areas, and that they are responsible for overseeing the debriefing of those events.**	**LRF**
130	**The National Fire Chiefs Council and the Fire Service College should establish a scheme for ensuring that all fire fighters are trained in first responder interventions.**	**FRS**
131	**All fire and rescue services should consider appointing a person within their control rooms who, in the event of a Major Incident, has the sole role of gathering and collating all available information and intelligence, and sharing it internally and externally to the extent appropriate.**	**FRS**
132*	**The Department of Health and Social Care should establish the standard for the level of healthcare services required at events. Consideration should be given to putting that standard on a statutory footing**	**Event med cover**
133*	**That standard needs to be regulated and enforced. The Care Quality Commission is the appropriate body to provide regulation and enforcement. The Department of Health and Social Care should give urgent consideration to making the necessary changes in the**	**Event med cover**

	law to enable the Care Quality Commission to become the regulator for this sector	
134*	**The Department of Health and Social Care together with the Care Quality Commission should consider what the consequences of breaching the appropriate standard should be. That should include consideration of whether the sanction should be criminal in nature.**	**Event med cover**
135*	**The Department of Health and Social Care and the Care Quality Commission should consider introducing guidelines to ensure that all event healthcare staff who work at events are trained in first responder interventions**	**Event med cover**
137*	**The Department for Levelling Up, Housing and Communities should review the guidance given to all licensing authorities on the decisions they make in relation to venues that hold events, and on what level of event healthcare services may be required at the events likely to be held at those venues. The guidance should indicate appropriate licence conditions to be used. The licensing authorities should then impose conditions accordingly or make those standards a requirement of meeting existing conditions**	**Event med cover**
138*	**The Home Office should consider whether the requirement for adequate healthcare provision at events is a topic that should also be addressed by the Protect Duty**	**Event med cover**
140	**The Security Industry Authority should take urgent steps to devise a training scheme in first responder interventions that educates all of those licensed by it, both existing licensees and new licence applicants. The Security Industry Authority may find it helpful to consult with the College of Policing in this, since it is apparent that the College of Policing has already undertaken a good deal of work in this regard.**	**Security Industry**
141	**The Security Industry Authority should take steps to encourage the security industry generally to ensure that even those members of staff who do not require a licence from the Security Industry Authority develop skills in basic trauma care.**	**Security Industry**

142	**As of September 2020, all primary and secondary school pupils were required to be taught health education, including first aid, as part of the National Curriculum. This involves children aged over 12 being taught CPR. This is necessary. The Department for Education should ensure that it continues**	**Public**
143	**The Department for Education should consider extending the National Curriculum to ensure that pupils, once of an appropriate age, receive education in all first responder interventions**	**Public**
144	**The Home Office should consider the introduction of a public education programme to educate the public in first responder interventions**	**Public**
145	**The Home Office should consider the introduction of a requirement into law, for example through regulations issued under the Health and Safety at Work etc. Act 1974, that employers train all employees, or certain categories of employees, in first responder interventions**	**Public**
146	**The Department of Health and Social Care should take steps to ensure that Public Access Trauma kits contain the equipment that is necessary to enable first responder interventions to be undertaken.**	**Gov**
147	**The Home Office and the Department of Health and Social Care should consider how to ensure Public Access Trauma kits are available in all locations where they are most likely to be needed.**	**Gov**

Appendix 2

The below table provides a guide for the different RAGs. The descriptors are not exhaustive but aim to provide an understanding of the rationale for the grading system.

RAG	Descriptor
RED	High level of urgency OR Work should have begun but delayed OR Work will require a high level of senior input/cross-department cooperation OR There is a significant gap in our ability to respond.
AMBER	Medium level of urgency OR Work has begun and is on track at an acceptable rate OR Work may be able to be resolved within one department quickly.
GREEN	Low level of urgency OR National project awaiting further guidance on topic OR Work is imminently about to complete without further EPRR/MAI Project input.
WORK DEFERRED	Work has been deferred whilst awaiting further national guidance. There may be a national working group on going to resolve a recommendation at a national level.
COMPLETED, AWAITING SIGN OFF	Work has been deemed completed by the team, and evidence for this completion has been provided. Awaiting approval from Senior Leadership Team.
WORK COMPLETED	Work has been completed and this recommendation has been closed.

Appendix 3

Manchester Arena Inquiry

Recommendations

High Level	Medium Level	Low Level
Completed	Work Deferred	Completed, Awaiting Sign Off

Updated 22.08.2023.

Recommendation 1 (R1)	Cross Ref	Agency	RAG Rating
The Greater Manchester Resilience Forum should oversee, at least every six months, a regular tri-service review of the Major Incident plans used by Greater Manchester Police, Greater Manchester Fire and Rescue Service and North West Ambulance Service. The purpose of that review should be to ensure that there is a common understanding by each emergency service of the plans of the other emergency services. It should also ensure that the importance of joint working is embedded within each emergency service.	12.4 to 12.81	Relates to LRF	
Recommendation 10 (R10)	Cross Ref	Agency	RAG Rating
Greater Manchester Police's Major Incident Plan should be reviewed to ensure that it includes clear guidance on the capabilities of North West Ambulance Service, including its Hazardous Area Response Team, Ambulance Intervention Team and Special Operations Response Team, as well as on the importance of joint working.	12.200 to 12.202	Relates to Police	
Recommendation 14 (R14)	Cross Ref	Agency	RAG Rating

North West Ambulance Service should review its Major Incident Response Plan to consider whether it should be updated to include a pre-determined attendance for Major Incidents.	12.448	Ambulance	
Recommendation 15 (R15)	Cross Ref	Agency	RAG Rating
North West Ambulance Service should review its Major Incident Response Plan to consider whether, in order to speed up mobilisation, it should provide pre-determined attendances for the Hazardous Area Response Team, Ambulance Intervention Team and Special Operations Response Team crews for Major Incidents.	12.449	Ambulance	
Recommendation 16 (R16)	Cross Ref	Agency	RAG Rating
North West Ambulance Service should ensure that it has up-to-date site-specific plans for all large, complex or high-risk locations within its area.	12.455 to 12.459	Ambulance	
Recommendation 17 (R17)	Cross Ref	Agency	RAG Rating
North West Ambulance Service should ensure that all its site-specific plans are multi-agency and that all Category 1 responders operating in the areas it serves have contributed to them.	12.455 to 12.459	Ambulance	
Recommendation 18 (R18)	Cross Ref	Agency	RAG Rating
North West Ambulance Service should ensure that it has a policy that sets out the circumstances in which an Operational Commander may be relieved and how that should occur and be communicated to the outgoing Operational Commander and beyond.	12.48	Ambulance	
Recommendation 19 (R19)	Cross Ref	Agency	RAG Rating
North West Ambulance Service should train its Operational Commanders on the appropriate practice for relieving another of command and being relieved of command.	12.5	Ambulance	

Recommendation 20 (R20)	Cross Ref	Agency	RAG Rating
North West Ambulance Service should ensure that non-specialist ambulance personnel are involved in multi-agency exercising.	12.5	Ambulance	
Recommendation 21 (R21)	Cross Ref	Agency	RAG Rating
North West Ambulance Service should review its Major Incident Response Plan to make clear that the first resource on scene should assume the role of Operational Commander only once they have achieved situational awareness.	14.121	Ambulance	
Recommendation 22 (R22)	Cross Ref	Agency	RAG Rating
North West Ambulance Service should ensure that its commanders are adequately trained in the use of operational discretion.	14.214	Ambulance	
Recommendation 23 (R23)	Cross Ref	Agency	RAG Rating
North West Ambulance Service should review its policies for mobilising the Hazardous Area Response Team resource, to ensure that this team is available as soon as possible for an emergency where its specialist skills are required.	14.25	Ambulance	
Recommendation 24 (R24)	Cross Ref	Agency	RAG Rating
North West Ambulance Service should review how it rosters Tactical Advisors and National Interagency Liaison Officers so as to ensure that there is adequate geographical coverage enabling those on duty to arrive promptly at the scene of any Major Incident.	14.542	Ambulance	
Recommendation 25 (R25)	Cross Ref	Agency	RAG Rating
North West Ambulance Service should review the number of Tactical Advisors and National Interagency Liaison Officers it has, and whether the number of such specialists, both generally and on call, should be increased.	14.574	Ambulance	

Recommendation 26 (R26)	Cross Ref	Agency	RAG Rating
North West Ambulance Service should review its procedures with local NHS trusts to ensure that it has effective policies in place for quickly dispatching patients injured in a Major Incident to an appropriate hospital.	12.370 to 12.373 14.503	Ambulance	
Recommendation 27 (R27)	Cross Ref	Agency	RAG Rating
North West Ambulance Service should reflect on its approach to record-making during and immediately following a Major Incident, with a view to improving the current practice.	19.13 to 19.42	Ambulance	
Recommendation 45 (R45)	Cross Ref	Agency	RAG Rating
The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit and JESIP should review and, as necessary, update the Joint Doctrine: The Interoperability Framework (the Joint Doctrine) and Responding to a Marauding Terrorist Firearms Attack and Terrorist Siege: Joint Operating Principles for the Emergency Services (the Joint Operating Principles). The following matters should be considered in that review: a. achieving a situation in which commanders understand that the critical decisions of the commander most directly concerned in the issue under consideration are followed, unless there is a good reason for not doing so; b. achieving a situation in which risk appetite is common across the three emergency services – this will require collaborative work; c. achieving a situation in which forward deployment of specialist resources is the presumption, to be displaced only in the presence of a properly evidenced basis for not deploying resources forward; and d.	20.40 to 20.45	Relates to All	

achieving a situation in which the possibility of a secondary device does not delay forward deployment of resources, unless there is a proper basis for believing that such a device exists.			
Recommendation 46 (R46)	Cross Ref	Agency	RAG Rating
The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit, individual police services and JESIP should review what changes need to be made to the Major Incident plans and Counter Terrorism Policing Headquarters Operation Plato guidance in order to achieve the aims set out in R45.	20.46	Relates to All	
Recommendation 47 (R47)	Cross Ref	Agency	RAG Rating
The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit, individual police services and JESIP should develop a nationally agreed format for all plans, placing JESIP at their centre.		Relates to All	
Recommendation 48 (R48)	Cross Ref	Agency	RAG Rating
The Home Office and the Department for Levelling Up, Housing and Communities should ensure that there exist robust national and local systems to identify and record the lessons learned from all multi-agency exercises and ensure that change is implemented as a result, where change is indicated.	12.758	Relates to All	
Recommendation 49 (R49)	Cross Ref	Agency	RAG Rating
The Home Office and the Department for Levelling Up, Housing and Communities should ensure that there exist robust national and local systems and sufficient resources to make sure that the debrief	12.749 to 12.758	Relates to All	

process following multiagency exercises is effective to capture the lessons that need to be learned.			
Recommendation 50 (R50)	Cross Ref	Agency	RAG Rating
The Home Office, Counter Terrorism Policing Headquarters, the College of Policing, the Fire Service College and the National Ambulance Resilience Unit should consider introducing the use of regular 'high-fidelity training' to give emergency responders better experience of the stress, pressure and pace of a no-notice attack.	20.49	Relates to All	
Recommendation 51 (R51)	Cross Ref	Agency	RAG Rating
The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit and all local resilience forums should take steps to ensure, whether through multi-agency training and exercising or otherwise, that the members of each emergency service are aware of the specialist capabilities of every other emergency service.	13.432	Relates to All	
Recommendation 52 (R52)	Cross Ref	Agency	RAG Rating
The Home Office, the National Ambulance Resilience Unit, the College of Policing and the Fire Service College should develop guidance as to where commanders should locate during a spontaneous Major Incident. Steps should be taken to ensure that a consistent approach is taken so that equivalent commanders locate in the same place. During the response to a terrorist attack, the need for commanders on scene who are not engaged in directing individual actions should be recognised and accommodated.	10.134 to 10.136 12.99 12.190 to 12.197 12.625 to 12.626 13.76 13.495 to 13.497 14.453 to 14.457	Relates to All	
Recommendation 53 (R53)	Cross Ref	Agency	RAG Rating

The emergency services should prepare, train and exercise for how they will maintain effective radio communications between emergency responders on the ground, commanders and control rooms, during the response to a Major Incident.	Parts 12 and 13	Relates to All	
Recommendation 55 (R55)	Cross Ref	Agency	RAG Rating
The Home Office, the College of Policing, the Fire Service College and the National Ambulance Resilience Unit should consider together whether an app giving ready access to the contact details for all on-duty and on-call commanders is feasible and, if so, likely to be of benefit in the response to a Major Incident.	13.133 to 13.134	Relates to All	
Recommendation 56 (R56)	Cross Ref	Agency	RAG Rating
The College of Policing and Counter Terrorism Policing Headquarters should take steps to ensure that each police service establishes a hotline that enables those within the command structure of the three emergency services to make contact with the Force Duty Officer in the event of a declaration of Operation Plato.	13.501	Relates to Police	
Recommendation 67 (R67)	Cross Ref	Agency	RAG Rating
The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit and JESIP should ensure that all emergency services use common terminology to describe the Operation Plato hot, warm and cold zones and all have a common understanding of those terms.	20.45	Relates to All	
Recommendation 69 (R69)	Cross Ref	Agency	RAG Rating
The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College, the National Ambulance Resilience Unit and JESIP	20.45	Relates to All	

should ensure that all emergency services use common terminology to describe the zoning of hazardous areas in non-Operation Plato Major Incident situations and that all services have a common understanding of those terms. The terms should be different from those used when Operation Plato is declared.			
Recommendation 71 (R71)	Cross Ref	Agency	RAG Rating
The Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services, the College of Policing, the Fire Service College and the National Ambulance Resilience Unit should oversee the development and implementation of action cards for the police, fire and rescue service, and ambulance service for use in a Major Incident. This should include the following: a. ensuring that all control room staff and commanders are trained in the use of the action cards; b. ensuring that action cards act as a checklist, setting out the key functions of each command role, the role of control room staff and the need for joint working; c. ensuring that action cards are available immediately to commanders and control room staff during the course of the response to a Major Incident, whether in hard copy or electronically; d. ensuring that the use of action cards is tested regularly through exercising; and e. ensuring that the action cards within the control rooms include a prompt to the first commander on scene to co-locate with other emergency service commanders.	12.165 to 12.166 13.253	Relates to All	
Recommendation 73 (R73)	Cross Ref	Agency	RAG Rating
The Home Office should consider the introduction of a national standard requiring a meeting of the Strategic Co-ordinating Group to take place no more than two hours after the declaration of a Major Incident where more than one		Relates to All	

emergency service is engaged in the response to that incident.			
Recommendation 76 (R76)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care, the NHS, the National Ambulance Resilience Unit, ambulance service trusts, Air Ambulances UK, Counter Terrorism Policing Headquarters and JESIP should consider whether air ambulances should be integrated into the emergency response to Major Incidents, including terrorist attacks, and, if so, how that is to be achieved.	20.85	Relates to Air Ambulance	
Recommendation 77 (R77)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care, the NHS, the National Ambulance Resilience Unit, ambulance service trusts, Air Ambulances UK, Counter Terrorism Policing Headquarters and JESIP should consider what staff training and resources would be required to integrate air ambulance organisations into the emergency response to Major Incidents, including terrorist attacks.	20.85	Relates to Air Ambulance	
Recommendation 82 (R82)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care and the National Ambulance Resilience Unit should develop a system for ensuring that the duty command structure in each ambulance service has notice of any significant pre-planned event, such as a major concert or sports match, taking place within the ambulance service area.	14.100	Ambulance	
Recommendation 84 (R84)	Cross Ref	Agency	RAG Rating
The Home Office, the College of Policing, the National Ambulance Resilience Unit and the Fire Service College should ensure that all those who may be required to take up a command position in the event of a Major Incident are issued with a means to record what they say, hear and see unless	19.22 to 19.29	Relates to All	

there are good reasons why they should not be so equipped.			
Recommendation 85 (R85)	Cross Ref	Agency	RAG Rating
Consideration should also be given by those organisations to the provision of such equipment to key personnel within control rooms.	19.22 to 19.29	All	
Recommendation 86 (R86)	Cross Ref	Agency	RAG Rating
The Home Office, the College of Policing, the National Ambulance Resilience Unit and the Fire Service College should ensure that training is given to all who are issued with such equipment, on the circumstances in which it should be used and the importance of its use.	19.22 to 19.29	Relates to All	
Recommendation 87 (R87)	Cross Ref	Agency	RAG Rating
The Home Office, the College of Policing, the National Ambulance Resilience Unit and the Fire Service College should ensure that, in the course of exercises, such equipment is used by those who would use it in the circumstances of a real-life incident.	19.22 to 19.29	Relates to All	
Recommendation 88 (R88)	Cross Ref	Agency	RAG Rating
The Home Office, the College of Policing, the National Ambulance Resilience Unit and the Fire Service College should take steps to ensure that all emergency services understand the importance of promptly obtaining comprehensive accounts from commanders as part of the debrief process following a Major Incident.	19.43 to 19.46	Relates to All	
Recommendation 91 (R91)	Cross Ref	Agency	RAG Rating
The Home Office and College of Policing should ensure that any police officer whose position carries with it the expectation that they will assume a Tactical/Silver Commander role in the event of a spontaneous Major Incident		Relates to Police	

(e.g. Night Silver in Greater Manchester Police) has undertaken an accredited course preparing them for that role.			
Recommendation 92 (R92)	Cross Ref	Agency	RAG Rating
The College of Policing should consider whether the current process for maintaining and storing training records for all police officers can be improved. That should include assessing the following: a. the introduction of electronic training records in a standard form across all police services; b. the introduction of centrally held electronic training records for all police officers; and c. the introduction of a system whereby each police officer is required to view their record each year and identify any errors or omissions within it.	13.488 to 13.490	Relates to Police	
Recommendation 99 (R99)	Cross Ref	Agency	RAG Rating
Each emergency service should ensure that it is represented at a senior level at every meeting of a local resilience forum.	12.21 12.44 to 12.61	Relates to LRF	
Recommendation 105 (R105)	Cross Ref	Agency	RAG Rating
Ambulance service trusts should review their capacity to respond to a mass casualty incident. That should include an assessment of whether they have an adequate number of trained specialist personnel to respond effectively to a mass casualty incident.	20.11 to 20.23	Ambulance	
Recommendation 106 (R106)	Cross Ref	Agency	RAG Rating
Having carried out that review, the trusts should make recommendations to their NHS commissioners about the additional and/or different resources they require in order to ensure that they are able to respond effectively to a mass casualty incident in the numbers required.	20.11 to 20.23	Ambulance	
Recommendation 107 (R107)	Cross Ref	Agency	RAG Rating

The Department of Health and Social Care should give urgent and close consideration to any recommendations made by the trusts and the NHS commissioners.	20.11 to 20.23	Ambulance	
Recommendation 108 (R108)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care and the National Ambulance Resilience Unit should develop procedures to ensure that, so far as possible, each ambulance service trust is able to deploy or call upon HART resources immediately in the event of a Major Incident. As part of that, the Department of Health and Social Care and the National Ambulance Resilience Unit should develop procedures to ensure that, so far as possible, each ambulance service trust can call upon cross-border support in respect of HART resources immediately in the event of a Major Incident. There may be some incidents that are so significant that an individual ambulance service will need to mobilise its own HART resources and also draw upon cross-border support. Procedures need to accommodate this.	20.24 to 20.25	Ambulance	
Recommendation 109 (R109)	Cross Ref	Agency	RAG Rating
All ambulance service trusts should undertake training and exercising with neighbouring ambulance service trusts to ensure that cross-border support is efficient and effective.		Ambulance	
Recommendation 110 (R110)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care and the National Ambulance Resilience Unit should ensure that all ambulance commanders receive regular Major Incident training. The training should include training on HART capabilities, on all the command roles and where they will be located, on how to gain situational awareness through the deployment of sector commanders and other roles, on	20.26 to 20.27 14.214	Ambulance	

the importance of getting ambulance personnel to casualties without delay and on the circumstances in which they may use operational discretion.			
Recommendation 111 (R111)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care and the National Ambulance Resilience Unit should consider ensuring that there is further training of HART personnel so that at least one member on every HART deployment has the ability to deliver the most enhanced care interventions.	20.86 to 20.87	Ambulance	
Recommendation 112 (R112)	Cross Ref	Agency	RAG Rating
The team led by Philip Cowburn has devised a tool that is designed to replace the existing systems of primary and secondary triage. It is known as the Major Incident Triage Tool. It already has the support of NHS England. The National Ambulance Resilience Unit and all ambulance services should consider introducing the Major Incident Triage Tool as a matter of urgency.	20.108	Ambulance	
Recommendation 113 (R113)	Cross Ref	Agency	RAG Rating
The team led by Philip Cowburn has devised a tool that is designed for use by a wide range of emergency responders in a mass casualty situation. It is known as Ten Second Triage. The National Ambulance Resilience Unit, the College of Policing and the Fire Service College should consider as a matter of urgency whether all of their frontline staff should be trained in the use of Ten Second Triage.	20.109 to 20.115	Relates to All	
Recommendation 114 (R114)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care and the National Ambulance Resilience Unit should consider whether the Advanced Medical Priority Dispatch System is fit for purpose and, if it is,	14.101 to 14.104	Ambulance	

whether it can be improved. Particular consideration should be given to how the system prioritises emergency calls.			
Recommendation 115 (R115)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care, the Faculty of Pre-Hospital Care, the College of Paramedics and the National Ambulance Resilience Unit should review the current model for evacuation to hospital operated in the UK by reference to the different approaches around the world in order to see whether triage at different times and in different places remains best practice, or whether there should be a greater emphasis on rapid evacuation to hospital.	20.88 to 20.96	Ambulance	
Recommendation 116 (R116)	Cross Ref	Agency	RAG Rating
A significant issue in a mass casualty situation is that all of those paramedics who have arrived in ambulances may be required for the treatment of casualties, so that no paramedic is available to drive patients to hospital. The Department of Health and Social Care and the National Ambulance Resilience Unit should consider how to resolve that problem. Consideration should be given to the training of other emergency service personnel in driving ambulances.	20.94 to 20.95	Ambulance	
Recommendation 117 (R117)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care and the National Ambulance Resilience Unit should consider whether the Basic Life Support and Advanced Life Support bags used by paramedics should contain SMART Triage Tags or an equivalent.	14.112	Ambulance	
Recommendation 118 (R118)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care and the Medicines and Healthcare products Regulatory Agency (MHRA)	20.118 to 20.128	Ambulance	

should consider urgently whether the regulatory regime should be altered to enable analgesia, such as fentanyl lozenges or sufentanil sublingual tablets, to be given by paramedics to injured persons.			
Recommendation 119 (R119)	Cross Ref	Agency	RAG Rating
If the decision is that the regulatory regime should be altered in this way, the National Ambulance Resilience Unit should consider urgently whether the use of such analgesia should be rolled out to all Hazardous Area Response Team and other specialist operatives, as part of their basic equipment, and to paramedics more generally.	20.118 to 20.128	Ambulance	
Recommendation 120 (R120)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care, the Faculty of Pre-Hospital Care, the College of Paramedics and the National Ambulance Resilience Unit should consider whether all Hazardous Area Response Team operatives should be deployed with freeze-dried plasma and trained in its use.	20.139 to 20.140	Ambulance	
Recommendation 121 (R121)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care, the Faculty of Pre-Hospital Care, the College of Paramedics and the National Ambulance Resilience Unit should undertake a review into whether frontline ambulances should carry intramuscular tranexamic acid or TXA.	20.141 to 20.143	Ambulance	
Recommendation 122 (R122)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care and the National Ambulance Resilience Unit should review whether stretchers should be carried on National Capability Mass Casualty Equipment Vehicles.	14.461	Ambulance	
Recommendation 123 (R123)	Cross Ref	Agency	RAG Rating

The Department of Health and Social Care, the Faculty of Pre-Hospital Care, the College of Paramedics and the National Ambulance Resilience Unit should consider issuing guidance on how to ensure that specialist paramedics take with them, into a warm zone, equipment that enables them to carry out bridging interventions.	20.218 to 20.219	Ambulance	
Recommendation 124 (R124)	Cross Ref	Agency	RAG Rating
All ambulance service trusts should consider appointing a person within their control rooms who, in the event of a Major Incident, has the sole role of gathering and collating all available information and intelligence, and sharing it internally and externally to the extent appropriate.		Ambulance	
Recommendation 125 (R125)	Cross Ref	Agency	RAG Rating
The terms Casualty Collection Point and Casualty Clearing Station are capable of being confused, one for the other, particularly in circumstances of stress. That happened on the night of the Attack. The National Ambulance Resilience Unit should consider whether different and more distinct terms should be used for these two locations.	14.230 14.335 to 14.349	Ambulance	
Recommendation 126 (R126)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care and the National Ambulance Resilience Unit should consider the scope of the role of an Ambulance Liaison Officer and issue guidance to ambulance services in that regard.	20.203 to 20.209	Ambulance	
Recommendation 127 (R127)	Cross Ref	Agency	RAG Rating
The Home Office and the Department of Health and Social Care should consider how the threshold for a requirement that an Ambulance Liaison Officer be present at an event is to be identified.	20.203 to 20.209	Ambulance	

Recommendation 128 (R128)	Cross Ref	Agency	RAG Rating
The Home Office, the Department of Health and Social Care and the National Ambulance Resilience Unit should consider how to ensure that the role of an Ambulance Liaison Officer is properly resourced and also whether venue operators should fund the presence of an Ambulance Liaison Officer where one is required.	20.203 to 20.209	Ambulance	
Recommendation 129 (R129)	Cross Ref	Agency	RAG Rating
The Home Office should consider how the presence of an Ambulance Liaison Officer in appropriate circumstances may be made mandatory. This may need to be put on a statutory footing.	20.203 to 20.209	Ambulance	
Recommendation 136 (R136)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care should consider issuing guidance on the first aid equipment that event providers should have available on the relevant premises, as well as where that equipment should be stored to ensure that it is readily accessible when required and how often it should be checked to ensure that it is up to date and in good working order.	16.63	Relates to Event Med Cover	
Recommendation 139 (R139)	Cross Ref	Agency	RAG Rating
Guidance should be provided to event healthcare providers, to emergency service responders other than paramedics and to the public generally about the circumstances in which those who are believed to be dead should be covered. The guidance should make clear that this step should only be taken by a paramedic or other healthcare professional. The guidance should also make clear that paramedics at the scene of a mass casualty incident should inform others present that only healthcare professionals should cover those believed to be dead.	14.187 to 14.188	Relates to Event Med Cover	

The Department of Health and Social Care and the National Ambulance Resilience Unit should provide guidance addressing this important issue.			
Recommendation 148 (R148)	Cross Ref	Agency	RAG Rating
The Home Office, the Department of Health and Social Care, the Department for Transport and the Department for Levelling Up, Housing and Communities should conduct a review to ensure that stretchers that are appropriate in design and adequate in numbers are always available for use by the emergency services and in appropriate locations in the event of a mass casualty incident.	20.220	Relates to Gov	
Recommendation 149 (R149)	Cross Ref	Agency	RAG Rating
The Department of Health and Social Care should undertake a review, with input from other bodies as the Department considers appropriate, in order to identify the type of stretcher that is of the greatest utility in the event of a mass casualty incident. The product of that research should be rolled out to all of those with responsibility for the response to a mass casualty incident, including a terrorist attack, whether in the public or private sector.	20.222	Relates to Gov	

AGENDA ITEM No	**15**
OPEN or CLOSED	**Open**
No of ANNEXES	**1**

Committee Priorities and Cycle Monitoring Report

MEETING	Finance and Performance Committee
DATE	18 September 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 2023/24 and progress against the agreed cycle of business for the Committee. There is nothing to escalate on the cycle of business progress.

2. Since the last Committee meeting it has been agreed that oversight of the implementation of the Quality and Performance Management Framework will move to the Audit Committee; a fuller update is provided herein.

RECOMMENDATION

3. The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Annex 1 – FPC Cycle of Business Monitoring Report

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

COMMITTEE PRIORITIES AND
CYCLE OF BUSINESS MONITORING FOR 2023/24

SITUATION

4. This report updates the Committee on progress against the priorities it set for 2023/24 and progress against the agreed cycles of business.

BACKGROUND

5. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2023 and will be tracked quarterly.

6. The Committee's cycle of business was approved by the Committee in May 2023. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

7. The monitoring report is at Annex 1. Items in green show they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports. The blue indicates that the item is either on the agenda as scheduled, or is an ad hoc item which was discussed in agenda setting.

ASSESSMENT

8. The Committee priorities, and progress against them is as follows:

Priority	Progress
Focused oversight on the implementation of the digital strategy	• The Digital Strategy Plan is scheduled for receipt by the Committee at its meeting on the 18 September 2023 by the Interim Director of Digital Services. • It is intended that this report will draw out the four sub-elements, consideration of digital systems infrastructure KPIs, and digital strategy elements of the IMTP.

	• The Committee will note that a new Digital Director will commence with the Trust shortly and the timeframe for this implementation may as a result be affected.
Focused oversight on the implementation of the Quality and Performance Management Framework (QPMF)	• Oversight of this has moved to the Audit Committee. The Committee's ToR require that it "*review the effectiveness of the Trust's Quality and Performance Management Framework and receive assurance on the value of outcomes produced by the framework*". • The Committee will remain responsible for reviewing of the effectiveness of the QPMF once the Framework has been implemented. The Committee Cycle of Business will be updated to reflect the change in oversight of implementation of the Framework to Audit Committee.

RECOMMENDATION

9. The Committee is asked to note the update.

PAPER	PRE-C'EE FORUM	FREQUENCY	MAY	JUL	SEP	NOV	JAN	MAR	LEAD	PURPOSE	COMMENTS
FINANCE AND PERFORMANCE COMMITTEE - CYCLE OF BUSINESS 2023/24											
See full cycle of business for reference to the duties in the terms of reference as they relate to Committee reports below											
MAIN ELEMENTS											
FINANCE											
Annual revenue budget	EMT	Annually							EDOF	Endorsement	
Annual capital budget	Capital M'ment Board	Annually							EDOF	Endorsement	Presented at May meeting (private session)
Financial report	EMT	Each meeting							EDOF	Assurance	
Business cases over £500K	TBC	As required							EDOF	Endorsement	No business cases for May, July, Sept meetings
IMTP financial plan	STB/EMT	Annually							EDOF	Endorsement	
Value Based Healthcare Report	TBC	Every other meeting							DOF	Assurance	Papers for May, November and March
Assurance paper on PIR process	TBC	One off and then cyclical							EDSPP	Assurance	PIR process in July IMTP paper
Post Implementation Reviews	TBC	As required							Relevant D	Assurance	No PIRs for May, July meetings [TBC re MDVS PAR]
Monitoring of key projects as requested from time to time	TBC	As required							Relevant D	Assurance	Salus monitoring in closed
PLANNING											
Refreshes of 2030 Delivering Excellence	EMT	Ad Hoc							EDSPP	Endorsement	No refreshes due
Service or Directorate Specific Plan New & Refreshes	EMT	Ad Hoc							EDSPP	Endorsement	No plans for revew May, July or Sept meetings
IMTP for following year	STB/EMT/Board	Annually							EDSPP	Endorsement	
Report on commissioning	TBC	TBC							EDSPP	Assurance	National Commissioning Review in September
Demand and capacity reviews	EMT	Ad Hoc							EDSPP	Endorsement	Paper in May meeting
PERFORMANCE											
Monthly Integrated Quality Performance report	EMT	Each meeting							EDSPP	Assurance	
MIQPR review of metrics	EMT/Board Committees	Annually							EDSPP	Endorsement	Delayed from May meeting to July
Annual HART KPI report	TBC	Annually							DO	Assurance	Reported in July meeting
IMTP progress updates	STB/EMT/Board	Each Meeting							EDSPP	Assurance	
QPMF update report	QPMF Steering Group	Bi-annually 22/23									This will be transferred to Audit Committee; remove temporarily until QPMF implemented.
ESTATES AND FLEET											
Estates and fleet strategy refreshes	TBC	Periodically as required							EDOF	Approval	No refreshes May, July, Sept meetings
Fleet replacement programme	Capital M'ment Board	Annual BJC see notes							EDOF	Approval/Endorsement	
Fire safety update	EMT	Periodically as required							EDOF	Assurance	No update May, July, Sept meetings
ENVIRONMENTAL AND SUSTAINABILITY											
Decarbonisation Update	Decarb Programme Board	Every other meeting									Reported in May and Sept meetings
Waste Management Update	Decarb Programme Board	Annually							EDOF	Assurance	
DIGITAL SYSTEMS AND STRATEGY											
Digital strategy	STB	Periodically as required							DD	Review and Endorse	No refreshes May, July, Sept meetings
Metrics for digital systems infrastructure	TBC	Each meeting							DD	Assurance	Reporting being developed - not yet reported
Review/Monitor of digital major projects	TBC	Ad Hoc							Relevant D	Assurance	Salus (closed); MDVS Sept meeting
BUSINESS CONTINUITY											
WG Annual Emergency Planning Report	EMT/Board	Annually							EDO	Assurance	Reported in July meeting
Incident Response Plan Report	EMT	Annually							EDO	Assurance	Due to report in November 2023
Business Continuity Annual Report	EMT	Annually							EDO	Assurance	Not reported in July. Date TBC
Cyber Resilience and Cyber Security Reporting	TBC	TBC							DD	Assurance	Reporting being developed
POLICIES AND RISK											
Report from policy group	Policy Grop	Annually							BS	Assurance	Policy Report presented July 2023 meeting
Policies for review and approval	Policy Grop	Ad Hoc							BS	Approval	No policies for review
Board Assurance Framework	Board	Each meeting							BS	Assurance	
Corporate Risk Register	Board	Each meeting							BS	Assurance	
Audit Recommendation Tracker	ADLT	Each meeting							BS	Assurance	
Audits within purview of Committee	Audit Committee	Ad Hoc							Relevant D	Assurance	
STANDARD ITEMS											
Quarterly operations update	TBC	Each meeting							EDQN	Information/Discussion	
GOVERNANCE											
Committee effectiveness review and annual report	Audit/Board	Annually							Board Sec	Approval	
Review of Terms of Reference	Audit/Board	Annually							Board Sec	Approval	
Committee cycle of business refresh	N/A	Annually							Board Sec	Approval	
Committee Cycle of Business review	Audit/Board	Each meeting							Board Sec	Approval	
Committee Review of Annual Priorities	None	Every other meeting							Chair	Review	
SUB-GROUPS											
Where applicable	N/A	Ad Hoc							N/A	N/A	No sub-groups established
PROMPTS											
External Reports	N/A	Ad Hoc							TBC	TBC	No external reports for review

EDOF - Exec Director of Finance and Corporate Resources
EDO - Exec Director of Operations
EDSPP - Exec Director of Strategy, Planning and Performance
DD - Digital Director

Cycled for each meeting
Ad hoc item - prompt for agenda setting
Presented as cycled/ad hoc item considered at agenda setting
Deferred