Bundle Finance and Performance OPEN 17 July 2023

Agenda attachments

ITEM 0 Open F and P Agenda - 17 July 2023 (2)

0 OPENING ITEMS

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

2 Declarations of Interest
*Declarations of Interest
*
*
*

3 Minutes of last meeting

ITEM 3 OPEN F and P Minutes - 15 May 2023

4 Action log and matters arising

ITEM 4 Full F and P Action and Decisions Log

ITEM 4.1 ePCR update to SIREN F&P action

5 Operations Quarterly Report

ITEM 5 Operations Quarterly Report for Committees 23-24 Q1 FINAL

5.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

6 Financial Position for Month 3 - PRESENTATION

7 Risk Management and Board Assurance Framework

ITEM 7 Executive Summary Risk Management Report FPC 170723

8 Integrated Medium Term Plan (IMTP) Delivery and Assurance Arrangements for 2023/24. (Post Implementation Review Process)

ITEM 8 Executive Summary - FY2324 IMTP Delivery & Assurance Arrangements

ITEM 8.1 2305 - IMTP Assurance Report_v1.0

ITEM 8.2 230704 - ITT and Strategy Dev Assurance Report

9 Monthly Integrated Quality Performance Report

ITEM 9 MIQPR SBAR FPC May 2023

ITEM 9.1 Annex 1 MIQPR FPC May 2023 (Revised version)

ITEM 9.2 Appendix 2 Metrics Review FPC July 2023

9.1 COMFORT BREAK - 10 MINUTES

10 Annual Emergency Preparedness, Resilience, and Response Reporting:
10.1 Manchester Arena Inquiry Volume 2
10.2 Review of Civil Contingencies in Wales (Sent separately to Members by e mail
10.3 End of Year summary
10.4 WG Annual Emergency Planning report
10.5 UK Resilience Framework

ITEM 10 EPRR Annual report to FP Committee June 23 V3 FINAL

ITEM 10.1 MAI-Volume-2-Part-ii

ITEM 10.3 End of Year summary 22.23

ITEM 10.4 Annual EP Report 2023 WAST Final

ITEM 10.5 UKG_Resilience_Framework_FINAL_v2

11 Internal Audit Tracker Report and IA Reports:
11.1 Savings and Efficiency
11.2 Information Management &Technology (IM&T) Infrastructure
NB: Audit Tracker to be e mailed separately

ITEM 11 Executive Summary FPC Audit Tracker 170723

ITEM 11.1 WAST_2223-4_Savings and Efficiencies_Final Internal Audit Report_for issue

12 Policy report

ITEM 12 Executive Summary Policy Report FPC 170723

ITEM 12.1 Tab 1 Policy Tracker 200623

12.1 CONSENT ITEMS

13 May Committee AAA Report

ITEM 13 Finance and Performance Committee Highlight Report May 2023

14 Cycle of business monitoring report and review of Committee priorities

ITEM 14 F&P Committee Priorities and Cycle Monitoring Report

ITEM 14.1 Annex 1 - Finance and Performance Committee Cycle of Business 2023-24 - Monitoring Report

14.1 CLOSING ITEMS

15 Reflection & Summary of Decisions and Actions

16 Any Other Business

17 Date and Time of Next Meeting; 18 September 2023 09:30

MEETING OF THE OPEN FINANCE AND PERFORMANCE COMMITTEE
Held on 17 July 2023 from 09:30 to 12:35
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	Kevin Davies	Verbal	5 Mins
2.	Declarations of Interest	Information	Kevin Davies	Verbal	
3.	Minutes of last meeting – 15 May 2023	Approval	Kevin Davies	Paper	
4.	Action Log and Matters Arising	Review	Kevin Davies	Paper	
5.	Operations Quarterly Report	Information	Judith Bryce	Paper	10 Mins
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
6.	Financial Position for Month 3	Assurance	Chris Turley	Presentation	20 Mins
7.	Risk Management and Board Assurance Framework	Assurance	Julie Boalch	Paper	10 Mins
8.	Integrated Medium Term Plan (IMTP) Delivery and Assurance Arrangements for 2023/24. (Includes Post Implementation Review Process)	Assurance	Rachel Marsh	Paper	30 Mins
9.	MIQPR 9.1. Top Indicator dashboard 9.2. Review of Metrics	Endorsement Assurance Assurance	Rachel Marsh	Paper	30 Mins
COMFORT BREAK – 10 MINUTES					
10.	Emergency Preparedness, Resilience and Response (EPRR) Annual Report: 10.1. Manchester Arena Inquiry Volume 2 **10.2. Review of Civil Contingencies in Wales**	Assurance	Judith Bryce	Paper	30 Mins

No.	Agenda Item	Purpose	Lead	Format	Time
	(Sent separately to Members by e mail) 10.3. End of Year summary 10.4. WG Annual Emergency Planning report 10.5. UK Resilience Framework				
11.	Internal Audit Tracker Report and IA Reports: 11.1 Savings and Efficiency 11.2 Information Management &Technology (IM&T) Infrastructure	Assurance	Julie Boalch Chris Turley Leanne Smith	Paper	15 Mins
12.	Policy Report	Assurance	Julie Boalch	Paper	10 Mins
CONSENT ITEMS **The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.**					
13.	May Committee AAA Report	Information	Trish Mills	Paper	5 Mins
14.	Cycle of Business Monitoring Report and Review of Committee Priorities –	Information	Trish Mills	Paper	
CLOSING ITEMS					
15.	Reflection & Summary of Decisions and Actions	Discussion	Kevin Davies	Verbal	10 Mins
16.	Any Other Business	Discussion	Kevin Davies	Verbal	
17.	Date and Time of Next Meeting; 18 September 2023 09:30	Information	Kevin Davies	Verbal	

Lead Presenters

Name	Position
Julie Boalch	Head of Risk/Deputy Board Secretary
Judith Bryce	Assistant Director of Operations
Kevin Davies	Non-Executive Director (Chaired meeting)

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

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 15 MAY 2023 VIA TEAMS

Meeting started at 09:30

PRESENT:

Joga Singh	Non-Executive Director and Chair of Committee
Bethan Evans	Non-Executive Director
Kevin Davies	Non-Executive Director (left after item 32/23)
Ceri Jackson	Non-Executive Director

IN ATTENDANCE:

Wendy Herbert	Deputy Director of Quality and Nursing
Fflur Jones	Audit Wales
Navin Kalia	Deputy Director of Finance and Corporate Resources
Osian Lloyd	Head of Internal Audit
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Duncan Robertson	Assistant Director of Clinical Development
Liz Rogers	Deputy Director of People and Culture
Leanne Smith	Interim Director of Digital Services
Sonia Thompson	Assistant Director of Operations
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Representative

APOLOGIES:

Lee Brooks	Executive Director of Operations
Angie Lewis	Director of People and Culture
Liam Williams	Executive Director of Quality and Nursing

27/23 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. Apologies were received from Lee Brooks, Angie Lewis and Liam Williams.

Minutes

The minutes of the open session held on 21 March 2023 were considered by the Committee and confirmed as a correct record.

Action Log

The Action log was considered and the following was recorded:

Action 17/23 – Committee to receive an update on risk 139 (Failure to Deliver our Statutory Financial Duties in accordance with legislation) – This was on the agenda under the finance update. Action closed.

Action 18/23 – IMTP updates to include specific narrative on the Red actions within the IMTP – This was on the agenda under IMTP update. Action closed.

Action 20/23 – Update on Staff and mandatory training to be included in future MIQPR reports. Rachel Marsh explained that the MIQPR contained details on this in the MIQPR. Action closed.

Action 20/23a – Deep dive on clinical call back times to be included in MIQPR. Agreed to defer to 17 July 2023 meeting. Action to remain open.

Action 21/23 – Cyber/Digital updates to be added to Committee cycle of business. Action Completed and closed.

RESOLVED: The minutes of the meeting held on 21 March 2023 were confirmed as a correct record and the action log was considered.

28/23 OPERATIONS QUARTERLY REPORT

Sonia Thompson presented the update and drew the Committee's attention to the following areas:

1. The Covid Mobile Testing Unit (CMTU) has now been closed since the end of March 2023 when the contracts came to a natural close. It was noted that the CMTU had carried out over 75k tests across Wales.

2. Analgesia issued to volunteers – Approval has now been given for analgesia to be issued to Community First Responders (CFR) for them to administer to patients when appropriate; this includes the use of Penthrox. WAST is the first UK ambulance service to issue Penthrox to CFRs.

3. A new Integrated Communication Control System (ICCS) has been fully implemented in collaboration with the Ambulance Radio Programme. Feed back to date has been very positive.

4. The Committee were reminded on the impact of Industrial Action (IA) across the Emergency Medical Services (EMS), and noted that the RCN will take IA on 6 and 7 June 2023.

Comments:

Members were keen to understand what the expected trajectory was in terms of Immediate Release Directives (IRD) going forward. Sonia Thompson advised the Committee of the concerns with IRD, noting that Cardiff and Vale University Health Board were leading in reducing their tolerance for handover of patients. There were measures in place for hospitals to set a four hour backstop; and it was hoped that there would be improvements going forward. Rachel Marsh added that by the end of quarter two, it was anticipated that pan-Wales, the target was 15k lost hours, improving to 12k lost hours by quarter three. This was the trajectory expected by the Minister of Health and Social Services.

Members noted there continued to be increasing system pressures and acknowledged the challenges associated with IA and asked to be kept updated on the situation going forward.

Following a query in terms an update on actions following the Manchester Arena Inquiry, the Committee asked for future updates to include the recruitment of additional posts to be included in next Operations update.

The Committee discussed overall recruitment and how and when the Trust planned any recruitment drives to fill any gaps as they appeared.

RESOLVED: That the Committee noted the report.

29/23 FINANCIAL POSITION MONTH 12 2022/23 AND MONTH ONE 2023/24

The Committee received an update from Chris Turley on the financial position for Month 12, 2022/23. Key highlights from the report included:

1. The Trust was reporting a small revenue surplus (£62k) for the 2022/23 financial year (subject to audit).

2. Capital expenditure was fully spent in line with updated plans.

3. In line with the financial plans that support the IMTP, gross savings of £4.392m have been achieved against a target of £4.300m.

4. Public Sector Payment Policy was on track with performance, against a target of 95%, of 97.4% for the number, and 97.8% of the value of non NHS invoices paid within 30 days.

Comments:

The Committee congratulated the finance team in achieving a small surplus and also all Directorates in achieving the gross savings target.

Month One

In terms of the financial position as at Month one the Committee were given a presentation by Chris Turley who drew their attention to the following areas:

1. The cumulative year to date (M1) revenue financial position reported was a small overspend against budget of £0.008m.

2. The forecast for 2023/24 was one of breakeven.

3. The capital plan was being worked through and expenditure was forecast to be fully spent.

4. In line with the financial plans that supported the IMTP, gross savings of £0.552m has been achieved against a year-to-date target of £0.573m.

5. Public Sector Payment Policy was on track with performance, against a target of 95%, of 97.8% for the number, and 99.7% of the value of non-NHS invoices paid within 30 days.

6. There were several key assumptions which Members should be aware of in particular; agreement of funding for the 100 front line Whole Time Equivalent (WTE) and delivery of the £6m in savings. It was noted that the current gap in savings had been reduced with further areas of savings identified.

7. In terms of financial performance by directorate, it was acknowledged that most directorates were broadly in line with the budget plan for Month one. It was noted that savings were underachieved by £21k thus far.

8. In respect of the Financial Savings Programme (FSP), the Committee were updated on progress to date which included updates on recruitment and identification of further savings could be achieved in other areas across the Trust, specifically, the Operations Directorate has tasked itself to identify £2m worth of savings.

9. The Committee were briefed on the overall financial risks which included the challenging savings targets for 23/24 financial year and the impact of any future Industrial Action. Members were also updated on the actions being taken to mitigate risk 139 (Failure to deliver our Statutory Financial Duties in accordance with legislation). Chris Turley added that the Board would continue to receive regular updates through the finance report.

10. Members were informed that the draft accounts for 2022/23 had been submitted to Welsh Government and Audit Wales on 5 May 2023; Audit Wales have confirmed the audit certification deadline of 31 July 2023.

Comments:

1. Given the level of demand and service pressures, the Committee queried the confidence levels in terms of achieving the efficiencies which need to be seen. Chris Turley commented that it would be a challenge, however it was early in the year. .

2. Acknowledging there were financial pressures across the whole NHS, the Committee were keen to understand whether Directors of Finance (DoF) of other Health Boards understood the impact on WAST, whilst appreciating their own challenges. Chris Turley suggested that the DoF's were cognisant of WAST's challenges; however, in terms of their priorities, this was not a top one. He added that the key themes from DoF meetings have focussed on the financial deficits and how, across the whole system, this can be managed.

RESOLVED: The Committee:

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

(2) Noted the delivery of the 2023/24 savings plan as at Month 1, and the context of this within the overall financial position of the Trust;

(3) Noted the Audit Wales extended audit certification deadline to 31 July 2023 for 2022/23 accounts;

(4) Noted a detailed paper on the financial position will be presented to the Board at the 25th May meeting.

30/23 RISK MANAGEMENT AND CORPORATE RISK REGISTER

Trish Mills presented the report which contained details of the nine risks relevant to the Committee's remit, and additionally the Trust's two highest scoring risks which were assigned to the Quality, Safety and Patient Experience (QuEST) Committee.

The report included a new risk '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' with a score of 15 which was still in development.

Comments:

The Committee held a discussion in which they considered where risks were monitored and reviewed on a regular basis.

Trish Mills commented that at each Committee agenda setting meeting, details of the highest rated risks were now included on the agenda as a reminder.

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.

31/23 INTEGRATED MEDIUM TERM PLAN (IMTP) 2022-2025 AND END OF YEAR POSITION 2022/23

Rachel Marsh presented the report as read and noted that the Trust continued to progress on the conditions as set out in the Welsh Government accountability letter dated 22 July 2022.

In terms of the Financial year 2022/23 an IMTP delivery tracker had been put in place to map all the priorities and actions; details of those actions and their status were illustrated within the update report.

Comments:

The Committee acknowledged that some of the actions had not been achieved, however despite the ongoing challenges, a significant number had been completed.

In terms of the compassionate training for staff, the Committee noted this had been paused due to Industrial Action, and queried if there were any updates on recommencing the training. Liz Rogers advised the Committee that three sessions had been rescheduled in the next few months. Following these sessions, it was estimated that 150 staff will have been trained face to face in the compassionate practices element. There were virtual sessions planned later in the year and depending on attendance could boost those numbers up to 250.

RESOLVED: The Committee noted the update against WAST's IMTP accountability conditions and the overall delivery of the IMTP.

32/23 ANNUAL REVIEW OF KEY PERFORMANCE INDICATORS

Rachel Marsh gave a presentation which gave details on how the Trust measured its performance through the use of key metrics underpinned by the Quality and Performance Management Framework.

The Monthly Integrated Quality Performance Report (MIQPR) provided a narrative on the metrics at Board level in which there were 37 headline metrics agreed at Board. The narrative sets out analysis of the data and the actions taken to continue to provide a good level of performance or how to improve that level.

Each metric was assigned to one or more of the committees and they then have primary and regular oversight of that quality or performance area.

The MIQPR also includes additional data on patient safety indicators and this sets out a series of more detailed measures on quality.

The Committee were then presented with slides which provided in more detail the dashboard metrics which had been agreed by Board; these metrics were contained under the headings of; Our patients, Our people, Value and Partnerships and system contribution. There were several metrics which were yet to be completed and processes were in place to report on these in the near future. Rachel Marsh outlined each one of these in more detail.

In terms of the metrics listed under the four headings, the Committee were shown slides which set out the current and proposed new metrics to be added, replaced or removed.

The Committee was asked to consider whether there was the right balance, appropriateness and allocation of metrics and to note that the Executive Management Team (EMT) will review in early June. A further review will be undertaken virtually by the People and Culture Committee and QuEST Committee with a final review by this Committee on 17 July in readiness for approval at Board on 27 July 2023.

Comments:

In terms of the process involved the Committee felt it would be useful for EMT to review the effects of the Duty of Quality and the Duty of Candour and how that could be measured. There were several other metrics which the Committee asked for to be reviewed at EMT and these included; Respect and resolution cases and Immediate Release Directives. The Committee were apprehensive that consideration was being given for the IRD metric to be removed.

If possible, the Committee felt it would be beneficial to have a broader conversation on metrics at a future Board Development Day. In the meantime it was agreed that Members would provide direct feedback on the presentation to Rachel Marsh.

Wendy Herbert added that the national quality and safety advisory forum met on a quarterly basis and looked at standard metrics from a patient outcome and quality

measures perspective; which will include the Duty of Candour. This information would be captured in the MIQPR.

A discussion ensued in which Members considered, and on the whole were very supportive of the new metrics as illustrated in the presentation. They also were of the opinion that it was important to have metrics which measured the impact of the Duty of Candour and the Duty of Quality. Other topics discussed included the requirement to have sufficient resource for example, to capture and respond to calls in welsh.

It was agreed that the presentation would be circulated to Members and any comments to be sent to Rachel Marsh in advance of the next meeting.

RESOLVED: The Committee reviewed the metrics and it was agreed Members would provide feedback on the presentation prior to the next meeting.

33/23 MONTHLY INTEGRATED QUALITY AND PERFORMANCE DASHBOARD

The Monthly Integrated Quality and Performance Report (MIQPR) was received.

Rachel Marsh advised the Committee on the following areas for noting:

1. It was noted that the call answering times for the 111 service during April had improved slightly from previous months. Further work was still required to reduce capacity lost through sickness absence, and aligning capacity with demand and improving the efficient use of resource. A priority now was to re-roster the 111 service, which will involve a further consideration of the required number of staff to meet demand.

2. In terms of the ambulance response times, the Red 8 minute response for April was 53% and whilst an improvement when compared to March was still below the target of 65%. The Trust continued to deploy several actions to improve Red performance and this included the roll out of Cymru High Activity Response Units (CHARU).

3. One of the key factors in relation to response times was the capacity lost to handover outside Emergency Departments. 23,082 hours were lost in April 2023, a decrease compared to the 28,620 hours lost in March 2023. The levels remain so extreme that all the actions within the Trust's control cannot mitigate and offset this level of loss.

4. Hours Produced: The emergency ambulance unit hours production (UHP) was 98% in April and was above the target of 95%.

5. Personal Appraisal Development Review (PADR) rates had fallen slightly in March to 72.1%, still below the 85% target. Compliance for Statutory and Mandatory training had also fallen below the target and for March was 73.69%; the reason for this decline was under review.

Comments:

The Committee, whilst acknowledging there were some positive trends in the report, expressed their concern with the staggeringly high number of hours lost due to hospital handover delays; and as a consequence avoidable harm to patients was occurring.t was similarly acknowledged that although Immediate Release Directives had improved for Red, there had been 72% declined for Amber one.

A Member raised a concern that the Trust was still not achieving the target for 111 call answering times; accepting the challenges and demands on the service. Rachel Marsh outlined the efficiency measures the Trust had in place to improve these times which included reducing staff sickness and re-rostering with the aim being to re-align capacity at busier times.

RESOLVED: Noting the comments above, the report was considered and provided sufficient assurance of progress against the 26 key performance indicators detailed, which demonstrate how the Trust was performing against the following areas of focus: - Our Patients (Quality, Safety and Patient Experience); Our People; Finance and Value; and Partnerships and System Contribution.

34/23 DEMAND AND CAPACITY PLANS

At a previous meeting, Rachel Marsh advised that the Committee requested a report which detailed matters relating to demand and capacity.

Whilst the focus of the report was on forecasting and modelling, the Trust has also made significant progress in the workforce planning, recruitment & training and rostering.

It was noted that the Trust had undertaken strategic demand and capacity reviews for each of its three main patient pathways: Emergency Medical Services (EMS), Non-Emergency Patient Transfer Service (NEPTS) and the 111 service.

The responsibility for forecasting and modelling in the Trust was discharged through the Forecasting & Modelling Group. The Group involved colleagues from across the Trust, but also the NHS Executive (Delivery Unit). The Forecasting & Modelling Group was currently modelling the following areas; EMS strategic demand and capacity, unscheduled care service, proposed national discharge and transfer service, end of shift modelling and seasonal modelling.

Going forward the Trust would ideally like to record data in a formal forecasting and modelling framework which would provide the Committee with formal assurance of this business critical process; however, at this time, the Trust does not have the sufficient resource capacity to implement it.

Comments:

In terms of the forecasting and modelling framework, the Committee asked if it would be possible to re-align resources to develop the framework. Rachel Marsh commented that at this stage it was not realistic due to the paucity of current resource available within the team and the competing range of priorities. She added that consideration would be given as to whether the framework could be aligned to the Quality Performance Management Framework.

The Committee recognised that the 111 Demand & Capacity Review had a less successful outcome and queried whether the Trust had lost the opportunity to apply any lessons learned. Rachel Marsh explained that the review had highlighted areas where the Trust can work differently and improve on.

RESOLVED: The Committee noted the work being undertaken in relation to forecasting and modelling.

35/23 QUALITY AND PERFORMANCE MANAGEMENT FRAMEWORK (QPMF) UPDATE

A verbal briefing was provided by Trish Mills who advised that the QPMF would, as it was a framework for assurance it was suggested that it would be more appropriate for it to be reviewed and endorsed by the Audit Committee. The Finance and Performance Committee would continue to monitor performance, however the Audit Committee will oversee the implementation of the Framework

Comments:

The Committee discussed the suggestion in more detail and it was agreed that Trish Mills would converse with the Chair of Audit Committee and speak with Committee Members offline prior to any formal decision being made. In the meantime should there be any other comments it was requested they be circulated to Trish Mills.

RESOLVED: The Committee noted the update.

36/23 VALUE BASED HEALTHCARE (VBH) UPDATE

Chris Turley gave a verbal update in which it was noted a VBH workshop had been scheduled at which Non-Executive and Executive Directors will focus their attention on ideas for VBH. The workshop will also look at the wider engagement and education across WAST and to build a framework which outlines how to achieve VBH.

RESOLVED: The update was noted.

37/23 DECARBONISATION UPDATE

Chris Turley presented the report as read and drew the Committee's attention to the following areas:

1. As part of the capital structure a Decarbonisation Programme Board has been established with one of its main tasks to review risks.

2. Going forward the Committee noted there would be more updates on waste management.

3. Members were advised that funding from the Welsh Government Estates Funding Advisory Board had been confirmed for 2023/24 and 2024/24; with a range of schemes receiving support.

Comments:

It was queried how staff were being informed of any updates. Chris Turley advised that the Decarbonisation Programme Board will see this as one of their priorities going forward.

RESOLVED: The Committee:

(1) Noted this update, specifically in relation to the Decarbonisation Action Plan reporting and establishment of programme management arrangements;

(2) Noted annual waste reporting requirements, changes to waste policy & upcoming changes to waste legislation.

38/23 ELECTRONIC PATIENT CARE RECORD (ePCR) BENEFITS REALISATION

The report was presented by Duncan Robertson who drew the Committee's attention to the following key points:

1. The aim of the benefits realisation process was to ensure that the ePCR system delivered and would continue to deliver tangible improvements in service efficiency, patient care, and operational cost savings. The process also provided a framework for learning and continuous improvement, informing future technology investments by WAST.

2. Following a review of the original benefits, 31, a change in the approach was undertaken to test each benefit and that resulted in reducing the number to 12.

3. The revised set of benefits were successfully mapped to the investment objectives and a final report was received in April 2022.

Comments:

With regards to benefit number one, 'Improved Quality of Clinical Informatics', the Committee noted that as the target had been missed queried the scope and timing into investigation. Duncan Robertson explained that the investigation had already commenced which was looking into the auto-closure aspect of ePCR which may have led to the initial issue.

Members queried why benefit number four 'Improved Patient Experience' had been postponed. Duncan Robertson explained that as part of the ePCR closure this would be addressed through liaison with the Patient Experience and Community Involvement team.

RESOLVED: The report was noted.

39/23 DIGIPEN CLOSURE REPORT

Duncan Robertson reminded the Committee that the Digital Pen was the means of collating the WAST PCRs from 2015 until the deployment of ePCR. An initial contract extension had been agreed in March 2021 via a Chair's Action to enable the system to be used until such time as ePCR was ready for operational use.

The ePCR was deployed into operational practice in December 2021, and phased into each Health Board area, with the final Health Board becoming operational on 30 March 2022; work had commenced in summer 2021 to plan the decommissioning of the Digital Pens as part of the overall ePCR Programme.

Digital Pen docking systems were deactivated on 4 April 2022 with the exception of the Clinical Intelligence Team who required to retrieve Patient Clinical Records from returned Digital Pens.

A lessons learned exercise was held with members of the Clinical, Digital and Strategy & Planning Directorates where several key lessons were learned; these included the need to have improved reporting mechanisms between the Trust and the supplier and the late adoption of the ePCR by Health Boards as part of their Emergency Department handover processes.

RESOLVED: The Committee noted the report.

40/23 INTERNAL AUDIT TRACKER REPORT

The report was presented by Trish Mills who informed the Committee there were 23 internal recommendations assigned to the Committee for oversight which were overdue. It was noted there were no external audit reports that were overdue.

Members noted that the Audit Tracker would undergo a revision in the next few months with a recommendation to the Audit Committee to approve a revised process and format.

Comments:

It was asked when there would be an update on the digital strategy. Leanne Smith explained that the timelines were currently being worked through.

RESOLVED: The update was noted.

41/23 COMMITTEE CYCLE OF BUSINESS

Trish Mills presented the updated cycle of business as the final step in the 2023/24 effectiveness review process.

The Committee noted that the cycle of business was a maturing document and would inevitably change throughout the year.

RESOLVED: The Committee:

(1) Reviewed and approved the 2023-24 cycle of business; and

(2) Noted the cycle of business monitoring document.

42/23 MARCH COMMITTEE AAA REPORT

The report was presented for information.

43/23 REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

The Committee acknowledged it was starting to see those areas reflected in the Committee terms of reference being presented, for example the demand and capacity review and the benefits realisation.

Members welcomed a varied agenda which gave a fuller picture of the overall situation.

Should there be a lengthy report on the agenda more time should be allocated to that particular item.

Meeting concluded at 12:45

Date of Next Meeting: 17 July 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	17 July 2023	Update for 17 July 2023 On Agenda under Item 9	Complete
28/33	15 May 2023	Operations Update	Update on actions following the Manchester Arena Inquiry. To be included in next Operations update	Sonia Thompson	17 July 2023	Update for 17 July 2023 Details included in Operations update on Agenda Item 5	Complete
33/23	15 May 2023	Annual Review of Key Metrics	Circulate to Committee seeking comments in readiness for next meeting	Rachel Marsh	17 July 2023	Update for 17 July 2023 On Agenda under Item 9	Complete
38/23	15 May 2023	ePCR	Provide Comms Team with information on ePCR for circulation to staff	Duncan Robertson	17 July 2023	Update for 17 July 2023 Details sent to Comms Team, see attached Item 4.1	Complete

DECISION LOG
FINANCE AND PERFORMANCE

Minute Ref	Date	Agenda Item	Decision/Approval

Instructions for Action Log:

An action is marked as 'Complete' when the Committee Governance Officer is assured that the

To save agenda time and be clear for the Board/Committee, all actions must have a position st
statement, leave the item 'Open' and add the words 'verbal update at [insert] meeting'.

Where it has been done, the action is marked as 'Complete' for the meeting at which it is due.
Committee PA is to put a narrative in the progress/comment column to allow for an audit trail.
at [date] meeting due to [add in here the action which completed the matter]'. The status is th

For each new meeting, the Committee PA will filter out the 'Closed' items, rather than 'hide' line

Each meeting will show actions 'Open', 'Complete' and 'Not due'.

Minutes narrative to indicate that the Committee reviewed the action log and the position state
Action xx/xx - [state the type of action]: [state the verbal or position statement provided] and tl

Decision log on second tab enables us to keep a simple list of approvals in particular, making i
added to the meeting pack.

e action has been done. If in doubt, leave the item 'Open'.

tatement when presented at the meeting. Where it has not be possible to obtain a position

Where the Board/Committee is satisfied that it has been completed and can be closed, the
That narrative should commence with something along the lines of 'Action agreed to be closed
ıen changed to 'Closed'.

es.

ment updates for open items, noting the following items were closed:
hat 'The item was closed'. This will allow us to maintain an audit trail in the minutes.

it simpler to keep track of these rather than going through minutes. This would not need to be

No:	DATE RAISED	MINUTE REFERENCE	**ACTION**
51	10-Jan-19	15 QLIK SENSE	**Benefits Realisation update report**
52	16-Sep-19	15/19 Financial Performance	**Formal update report on ESMCP delay**
53	16-Sep-19	15/19 Financial Performance	**A further update report on the ongoing NEPTS financial position and outlook**
53	16-Sep-19	24/19 NEPTS, third party solution	**Living Wage - Clarity whether providers were paying this to staff**
54	21-May-20	18/20 - Financial Performance	**Job vacancies - Savings process. Update at next meeting**
52	16-Sep-19	15/19 Financial Performance	**Formal update report on ESMCP delay**
53	16-Sep-19	15/19 Financial Performance	**A further update report on the ongoing NEPTS financial position and outlook**
56	16-Jul-20	31/20	**To receive an update on the Committee Assurance Framework report and rsiks relevant to the Committee**
57	16-Jul-20	32/20	**To receive a report on IA actions from the Tracker**
58	16-Jul-20	Closed Session 37/20	**To receive an analysis report on Estates tenders case study**
59	16-Jul-20	Closed Session 38/20	**To receive the ePCR FBC**
60	37/20	15-Sep-20	**IMTP**
62	39/20	15 September 2020 and 19 November 2020 and 14 January 2021	**Operational Delivery Unity**
63	01-Apr-21	14-Jan-21	**IMTP**
64	May-21	14-Jan-21	**Operational Update**

65	01-May-21	14-Jan-21	**Operations Update**
61	38/20	15 September 2020 and 14 January 2021 and 13-May-21	**MIPR**
62	27/21	13-May-21	**MIPR**
63	27/21	13-May-21	**MIPR**
64	31/21	13-May-21	**Committee Assurance report**
65	33/21	13-May-21	**Sustainability and Decarbonisation**

61	35/21	22-Jul-21	**MIPR - Refined report with more key metrics.**
66	37/21	22-Jul-21	**111 call abandonment rates**
67	39/21	22-Jul-21	**IMTP**
68	39/21	22-Jul-21	**IMTP**

DATE DUE	ASSIGNED TO
23/01/2020	Interim Director of Finance and ICT
24/10/2019	Assistant Director of Operations
24-Oct-19	Interim Deputy Director NEPTS
24/10/2019	Interim Director of Finance
16/07/2020	Chris Turley
24/10/2019	Assistant Director of Operations
24-Oct-19	Interim Deputy Director NEPTS
15-Sep-20	Chris Turley
15-Sep-20	Chris Turley
15-Sep-20	Chris Turley
15-Sep-20	Brendan Lloyd
A further update on final outcome of the prioritisation with progress against the priorities will be brought to the next Finance and Performance Committee meeting in November 2020.	Rachel Marsh
ODU, Details of Governance Procedure to be reported at next meeting. Agreed that Jonathan Sweet would review in detail	Lee Brooks
Details on progress being made on deliverables in the amber category to be included in next report	Rachel Marsh
To provide and update on the Red Cross evaluation.	Lee Brooks

Update on NEPTS experience survey	Lee Brooks
Report to be more refined with a deep dive on a subject to be decided offline with Rachel Marsh and the NED's and also to consider Key metrics from other Committees	Rachel Marsh
Rachel Marsh agreed to provide the Committee with the Gant chart detailing the recruitment timeline as shown at the programme Board	Rachel Marsh
A report highlighting the actions being taken to mitigate the deteriorating red performance be presented at the next meeting	Lee Brooks and Rachel Marsh
Risk ID 109, resource availability. In terms of the recruitment to 111 and the additional frontline staff it would be useful to understand further details and confirm whether it was purely financial or was it a resource issue	Julie Boalch
Action plan to be presented at the next meeting	Chris Turley

Following an update by the Chair and Rachel Marsh, the Committee noted that the current metrics would be finalised by the next meeting and continue until 31 March 2022 when a review would take place to consider effectiveness and any potential changes.	R Marsh
Deep dive in to reasons for high abandonment rates	R Marsh
Development of other measures around quality and patient safety outcomes in terms of patient experience. Update to be provided at next meeting following liaison with Claire Roche	R Marsh
Deep Dive on any foreseeable risks to the delivery of the IMTP	R Marsh

UPDATE
Update provided by Chris Turley on 16 July , full report to be provided at 24 October meeting. Note: Update report deferred to 23 January 2020 meeting
On Agenda

On Agenda

On Agenda COMPLETED

On Agenda COMPLETED

On Agenda

On Agenda

On Agenda

On Agenda
On Agenda

Update report due 11 March 2021

See attached Item 1.4a
Due 11 March 2021

Ops are establishing monitoring to cover what is set out below. This will accompany some form of staff feedback. Hopefully from this, assurance can be taken that there will be an evaluation for us to assess the merits.

No. of WAST crews supported per day per hospital being covered
The type of support provided to WAST crews i.e. practical support for things like refreshments, emotional support, liaising between crews and ED staff
No. of ambulance patients supported (on ambulances or indoors but those who are still under ambulance crew responsibility)

Type of support provided to patients still under WAST care (refreshments, liaison with families or nursing staff, emotional support, etc.)

No. of patients still under WAST care signposted/referred to other services by BRC
No. of My Winter Plans completed for patients still under WAST care

No. of safeguarding referrals made for patients still under WAST care

We will also provide case studies to bring the support provided a bit more to life.
The outputs will go to QUEST. Ops team is to meet with the PECI team the week after next to work through how we pull our survey & their survey together and the up and outwards reporting methods in more detail.

Report due 22 July 2021

By 22 July 2021

Report due 22 July 2021

This risk has been split into two separate risks, one for resource and one for capital. The capital risk is currently being assessed for inclusion on the Risk Register.

Report due 22 July 2021

On Agenda

Ongoing

On Agenda

Open
Complete
Closed
Not Due

ePCR Update

Scale

We have been live with the ePCR system across the whole of WAST since the end of March 2022. In that time, we have set up 3,248 application users as well as 3,169 web based portal users. We have, to-date, created 424,843 individual ePCR records since the launch.

We have worked closely with 15 Emergency Department sites in Wales and 8 English Emergency Department sites, as well as our supplier Terrafix, Digital Health and Care Wales, GPC Wales and Corpuls to get to the point where we have an integrated system. However, there is still more to do!

We are getting very positive feedback from clinicians across NHS Wales who are able to access the ePCR through the Welsh Clinical Portal. What we record at scene has an impact on decisions further into the care pathway and provides data that influences treatment and discharge. This is only possible once the patient has been matched to their record on the ePCR.

Scope

We continue to work to upgrade the application based on user feedback and have a number of planned upgrades coming later this year. These will include the linkage to the Corpuls defibrillators and the referral pathway for falls (which will remove the need to make a phone-call to refer an older adult who has fallen).

New pages have been designed specifically for the Advanced Paramedic Practitioners, who have had early access to the Welsh GP record (as have the Senior Paramedics). We are meeting with GPC Wales in July (2023), to provide them with an update and we are planning on then being able to release aspects of the GP record to all EMS users.

Ambition

We now have a huge amount of clinical data derived from the ePCR. Our five Clinical Indicators (which are publicly reported) are now re-established with ePCR data, which allows for monthly reports to be generated. You can access the results via the intranet here

We are working with DHCW to enable sharing of the clinical data set. This will enable our data to be linked and help us to explore patient pathways. With this intelligence, we can look to design better pathways and improve outcomes.

We are feeding ePCR data into work examining our response to particular MPDS codes and with this data we can really start to understand our patient population, how we respond to their needs and contribute to the transformation of services.

In the future, we are looking at using data to understand where we may need to improve care. This is particularly so for under-represented communities. ePCR data will allow us to look at how we provide care for example, through the lens of intersectionality as well as understanding the care we provide to black, Asian and minority ethnic communities, all of which are aimed at exploring how we can improve.

Thank you!

We are grateful for our team of early adopters and ePCR champions and to everyone who has submitted an idea to improve the system or who has spotted a problem that needed fixing. We are still getting to grips with what ePCR can do for us and for that, we need good data, so please continue to input into every field and complete the demographic matching.

ePCR Support Forms are available here

Submit your ideas for improvement via the WIIN portal here

Thank you to all EMS users of ePCR, your support and willingness to adopt a new way of working is greatly appreciated. This has been a significant change in practice to move a clinical record from Digital pen and paper to a fully digitised system and that is just the beginning.

OPERATIONS DIRECTORATE
QUARTERLY REPORT FOR COMMITTEES
2023-24 Q1 (Apr – Jun 2023)

National Operations & Support

Challenges

EPRR Manchester Arena Inquiry Report (MAI)

The EPRR team has now recruited into the Operations Support Manager (MAI) role. Since this member of staff has been in post the 149 recommendations within Volume 2 of the report have been reviewed. WAST is currently progressing 71 of the recommendations, as these recommendations have been assessed as being relevant to the Trust. WAST is working closely with a number of groups to ensure the recommendations are implemented within the Trust; this includes UK health subgroups who report into Department of Health and Social Care, subgroup of the UK National Director of Operations Group (NDOG), subgroup of the Joint Emergency Services Group (JESG) within Wales, all four Local Resilience Forums (LRFs) within Wales and the UK Heads of EPRR group.

IMTP

EPRR

A programme of work is in place across EPRR to quantify and improve our culture, and make our work environment the best it can possibly be; to date, this has included allyship training, drop in EDI sessions and manager training. In order to raise awareness of the functionality of HART and promote opportunities, two open days for HART have taken place in June, including a women's open day.

General Update

EPRR

Exercise Dollhouse. Exercise Dollhouse is a Tier One national Counter Terrorism exercise that is being undertaken in July. This exercise will allow the Trust to test and exercise our multiagency response to a Manchester Arena style incident. We will have members of staff from our frontline and from our specialist assets taking part in the exercise. The exercise is affording the Trust an opportunity to test the new patient triage system, which is a direct outcome from the Manchester Arena Inquiry recommendations.

Annual Report. The EPRR annual report is being submitted to the Finance and Performance Committee in July. This report provides Committee with a strategic update on the main areas of work that the Trust's EPRR team are undertaking. Content includes 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 and the Welsh Government Annual Emergency Planning Report that have been submitted to Welsh Government and give assurance on the Trust's preparedness for and ability to respond to incidents. The report describes the updates that have been made to the Trust Incident Response Plan and the areas that will be updated within the plan. Lastly the report introduces the intension to review the Trust's business continuity structures with the aim to strengthen business continuity within the organisation.

Volunteering

A grant of £315,000 across two years has been secured from NHS Charities Together. This funding will be used to develop a Community Welfare Responder role within phase one of the Connected Support Cymru project. An adaptation form will be submitted to NHSCT with slight amendments to proposed spends.

Roll-out of analgesia (paracetamol and Penthrox) to CFR volunteers is on track. All volunteer training has now been completed and volunteers are able to go live within their respective locality.

Community First Responder numbers are currently around 600 volunteers. The number of active CFRs is currently circa 450. The newly appointed Support Officer (Compliance) is working with colleagues to ensure swift re-activation. However, Volunteer Car Service recruitment has remained flat during 2023. The current recruitment for the Operations Manager (VCS) post will develop this service and grow VCS volunteers by 25% across Q2-4.

Resourcing & EMS Coordination

Challenges

EMSC

Recruitment and Retention within EMS Coordination remains a concern with the attrition rate for the rolling 12-month period (July 22 to June 23) at 17.54% peaking at 24.16% in September 22 and remaining above 22% until May 23. This attrition figure only relates to external attrition and does not account for internal moves to other departments, which account for a further 31 staff moves during the same period. Significant recruitment initiatives have been implemented since September 2022 with 100 staff being recruited in the last 12 months (29% of the total workforce 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 1 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.

Concerns

The workload for the Operations Quality Concerns Team remains high at 257 outstanding tasks. This is however a reduction from 283 at end of Q4. The Operations Quality Team continues to work closely with the Putting Things Right (PTR) Team to prioritise work to meet deadlines and requests. There continues to be sustained improvement in the status of outstanding concerns investigations, with 68% of concerns within the agreed timeframe to return to PTR. The outstanding coroner statements remain high at 29, however, 7 of these have been delegated to wider Ops to complete and 17 remain unallocated. It is anticipated that more outstanding statements will be delegated outside of Operations Quality and EMS Coordination in Q2.

Resourcing

The workload for the Resourcing function remains high, although abstraction trajectory (sickness) is reducing across ADO portfolios. Abstractions overall remain above funded relief capacity. Operations establishment (vacancies) and skill mix also a contributing factor to production. This in turn reduces capacity within the resource function to develop and improve aligned with IMTP ambitions.

Resource team are pivotal in the trust financial savings plan for pay and workload for the team is envisaged to increase further whilst overseeing the overtime considerations process aligned to the financial savings plan, with the introduction of daily overtime time considerations meetings.

IMTP

EMSC

On 25th April 2023 WAST implemented a new national Control Room Solution for Integrated Communications Control Systems (ICCS). The Control Room Solution (CRS) project is a UK wide programme, overseen by the UK Ambulance Radio Programme (ARP) which started in 2018 to replace the current DS2000 ICCS with a new solution developed by software designer Frequenits and known as LifeX. The Emergency Services Network (ESN) will replace the current Airwave network and once fully built all Emergency Services in the UK will transition onto ESN. LifeX is compatible with both the current Airwave network and ESN. Transition to the LifeX system now is a step towards full ESN transition.

The new Life X system is now in operation across all EMS Coordination Centres (ECCs), NEPTS Journey Coordination Centres (JCC) as well as Emergency Medical Retrieval and Transfer Service (EMRTS) Critical Care Hub (ECCH). Following extensive development, testing and training collaboratively across multiple directorates and organisations WAST was the first large scale Ambulance Service to implement the new LifeX solution sharing knowledge and strategic approaches with other UK ambulance services to support future transitions successfully.

Resourcing

Resourcing continues to support discussions and data requests in support of "inverting the triangle", EMT3 expansion, CHARU expansion, APP expansion and subsequent skill mix and rightsizing requirements aligned to funding.

Engagement with trade union partners on 6-week relief planning continues with an options appraisal shared with partners and regular meetings taking place to work through a mutually agreeable way forward.

General Update

MPDS Audits

WAST is required to reaccredit with the International Academy of Emergency Dispatch (IAED) every 3 years, and this is due in September 2023. To do this, the Trust must follow the reaccreditation process set out by the IAED. Work is ongoing to meet deadlines and the required standards to reaccredit as a recognised centre of excellence.

Emergency Medical Service

Challenges

Industrial Action and WAST Non-Pay Annex

Three of our four unions have voted to accept the revised pay offer from Welsh Government in response to the dispute over pay and conditions which has led to the industrial action which started last year. The RCN has rejected the offer, and two industrial action days took place on 6th and 7th June. The industrial action planning team reconvened and planned sufficient mitigation across the Trust. Consequently, there were no adverse impacts on patient safety across these two days. The further two days of industrial action at the time of preparing this report are expected not to take place as discussions continue.

Relevant unions have also accepted the terms of the WAST specific non pay annex as part of the pay dispute and specific action relating to EMS: -

- **Start and End of Shift arrangements to reduce overruns** – this amendment to the Standard Operating Procedure sets out that relieving off going crews is to be a high priority. EMS and UCS crews in the last hour of their shift that are not already deployed to an incident will begin to return to base as a matter of course. The nature of calls they can be despatched to in this last hour is also set out, thus reducing the likelihood of an overrun occurring. Two pilot schemes for handover crews at Morriston Hospital and Ysbyty Glan Clwyd will also commence. We have agreed this position for so long as more than 9,000 hours a month are lost to extended handover delays as these delays inhibit our people from ending work on time.

WAST Facilitation of Extended Transfer of Care

As reported at the WAST Trust Board in March, the Executive Director of Operations raised concerns focussed on two risks being exacerbated by a worsening position on the time taken for transfer of care at emergency departments with Chief Operating Officers. At the face-to-face COO Peer Group meeting in April, the Executive Director of Operations spoke about several issues emanating because of extended transfer of care times (including WAST staff exposure to diesel fumes) and informed COO colleagues that local management teams would be mobilised to discuss with local emergency department teams. Local WAST management teams were mobilised on the issues of ED Swaps (the practice of one patient taken into the ED provided one patient is taken out and returned home – discharge transport), the use of WAST equipment inside the ED and the use of WAST staff for the purpose of portering. The purpose being to achieve an improved transfer of care time so that emergency crews can respond to undifferentiated patients at greatest clinical risk in the community. Following local engagement, the Executive Director of Operations wrote again to health board colleagues in June to share the dates of the cessation of these issues. The response across the system has been mixed. There has been no response from some health boards, where others have lodged reports with external partners without engaging with the author of correspondence.

WAST has never supported its staff being used for portering and neither have health boards engaged WAST on pre-hospital clinicians undertaking extended duties following arrival at the emergency department. WAST has facilitated some patients requiring diagnostics by allowing the pre-hospital ambulance paramedic/EMT to provide clinical escort to a diagnostic test with a hospital porter, particularly where the diagnostic is time critical to the patient outcome. With regret, this position has been taken advantage of, and it appears that the pathway has systematised use of WAST staff not only to provide clinical escort for a broader range of diagnostic tests, but also to fulfil the portering role. It is of concern that transfer of care improvements at some hospital sites appear to depend on this being done by WAST, without engaging us first or fully assessing the broader consequences. This is said in the context of feedback that WAST not undertaking these in-hospital tasks will extend the transfer of care time.

In coming to this position, the following points have also been considered:

- WAST is not licensed for systematic care delivery inside the hospital and while the Welsh Risk Pool would likely support WAST where there was an exceptional clinical requirement for us to act, the current situation is not exceptional any longer.
- We must also be cognisant of the recent challenging period of industrial action. The use of WAST staff in a way for which they are not trained or commissioned specifically creates bad will and this has come through from our people during picket line visits by members of the WAST Executive. The WAST staff experience has been negatively impacted due to hospital handover delays including prolonged exposure to vehicle diesel fumes outside the emergency department (for which health boards have been asked to consider the health and safety implications and mitigations that can be put in place), late shift finishes, delayed access to periods of rest, and skill degradation as patient contact reduces for which there is additional clinical risk.
- From a safeguarding perspective there are two considerations; first for the patient waiting outside the emergency department and secondly, for the patient seeking WAST care but to whom we are unable to respond. As already stated, the latter patient is at highest risk as no healthcare is being made available to them and so action that promotes an earlier transfer of care for patients from an ambulance would improve the quality, safety, and safeguarding risks for all patients within our care, or to whom we have a duty of care. It is important to note that an inhibited emergency ambulance response to patients with acute medical conditions has led to self-conveyance and patients dying en-route, in hospital car parks, or waiting for ambulance attendance. Not to mention the unknown consequences for patients we do not attend either due to the Clinical Safety Plan or those who cancel the ambulance in favour of making their own arrangements.
- The ratio of two WAST pre-hospital clinicians to one patient demonstrates poor value for money. In staff cost alone, in December 2022 and March 2023, more than £4.5m of staff cost was lost to extended transfer of care times.

IMTP

EMT2/EMT 3

There are currently 55 WTE staff (64 people) who are Band 5 out of a current total EMT funded establishment of around 660 WTEs. At present, the EMT3 role is a closed role which means that as these staff leave their position, they are not replaced on a like for like basis. We have previously given a commitment to change this as part of the agreement on the UCA role (later known as ACA2). We have been in discussion with lead Trade Union Partner reps over the last few months to discuss how this could be taken forward, and a proposal has been shaped through these positive and progressive collective discussions.

In broad terms, the proposal we have been working closely with our Trade Union partners is:

- EMT3s will continue to be recognised as a valued and important part of the workforce
- The EMT3 role will be part of a broader career offer and opportunity for staff, continuing to strengthen and grow the career structure we offer for our people beyond other roles we have added in the last couple of years such as Senior Paramedics
- We will initially grow the number of EMT3s from the current number to a total of around 255 WTEs. This will mean that around 35% (a little more than 1 in 3) of the technician workforce will then be an EMT3 at band 5.

A Task and Finish Group has been established to take forward this piece of work which has focused on developing: -

- Scope of Practice for the EMT3 role
- Recruitment and selection process
- Frequently Asked Questions

The position currently is that Trade Union Partners have declared that they intend to consult with their members on the package and have offered to advise Management on the associated timelines. Unfortunately, that does push back the selection process with the first cohort scheduled to enter training in October 23.

General Update

Mobile Data Vehicle Solution

Emergency Services Mobile Communication Programme (ESMCP) is a Home Office led cross-government programme delivering a new critical communication system for Great Britain's emergency responders; the Emergency Services Network (ESN).

ESN will transmit fast, safe and secure voice, video and data across the 4G network and give first responders immediate access to life-saving data, images and information in live situations and emergencies. It will provide total end to end critical communication system for UK Ambulance Services; the Ambulance Radio Programme (ARP) are working with Trusts to deliver the total solution.

A project Board has been established since February 2022 will oversee the delivery of the Mobile Data Vehicle Solution (MDVS) project in accordance with the agreed project documentation and plans.

On the 29th July 2023 the Project Board sanctioned the commencement the MDVS Pilot is due to begin w/c 3rd July 2023 using 3 EMS vehicles in North Wales.

Ambulance Care

Challenges

Performance Standards Refresh

The service has implemented a refreshed set of performance standards from April 23. These were agreed in conjunction with the commissioner and all Health Boards. The new standards reflect our funded capacity much more accurately, in particular on oncology transport where ORH, in the NEPTS demand and Capacity review, identified a funding gap equivalent to 148 WTE .

To support the roll out of the new standards, an implementation plan has been developed focusing on improving process, data, reporting, performance management and most importantly the culture of the service.

IMTP

NEPTS Eligibility

A review of how the service applies national eligibility criteria has begun and a proposal has been developed for an improved process, which should improve patient experience and reduce late notice cancellations of transport. These improvements will be supported by a review of alternative options available to patients across Wales.

Quality Assurance

The service continues to drive through the quality assurance agenda as per the IMTP. A revised patient survey is now live with QR codes to link to it being rolled out across the NEPTS fleet and hospital based estate. The results of the survey support the service's move to a balanced scorecard of reporting on service delivery. They also inform the NEPTS QA dashboard, elements of which are reported onward to trust committees.

CAD Upgrade

Following the upgrade of the NEPTS CAD in Quarter 4 22/23, work has begun on implementing the additional functionality that the new hosted platform allows. The first step on this journey will be the launch of a 'Patient Zone' which will allow patients to initially check and cancel journeys as well as see online where their transport is. The next phase of

this rollout will be online booking functionality. It is anticipated that the patient zone will be active in late 2023.

General Update

Urgent Care Service Strategic Review

The service has been conducting a review of the Urgent Care Service, focusing on identifying the current case mix for the service and developing options for a tighter case mix in the future.

The review has been supported by modelling from ORH and the final meeting of the steering group is planned for July 2023. The outcomes of the review, once agreed, will then be discussed with colleagues within their team prior to being presented for formal approval.

Integrated Care

Challenges

111 SALUS Operations Implementation

The teams have started to prepare to implement SALUS into the 111 operation. Following product specification testing scheduled in July we can begin to train trainers and later staff. There are several groups within WAST and with the 111 Programme team to understand more about the new bespoke system and to prepare for its implementation in November.

IMTP

CSD Community Welfare Responder / Connected Support Cymru

The CSD Operations and Clinical team have been busy working on supporting the pilot scheme for the Community Welfare Responder and have created new processes and working practices to enable the efficient use of the available St John CWR crews. Positive results have been returned where the crews have been able to be on scene and take observations for the CSD Clinicians, enabling consult and close, protection of vulnerable callers, welfare checks and calling on failed contacts. The pilot continues for several more weeks and more positive results are expected.

Red Review in CSD

The existing process of remotely reviewing calls continues and the SOP has been updated to refresh and make the process more robust. This will also include tracking to identify where the red call has been reviewed but was not able to be downgraded allowing for improved reporting.

General Update

Industrial Activity in 111 and CSD

The Royal College of Nursing staged two days of action in June. Collaborative discussions took place with the RCN industrial action management team on derogations and cover for the two days which allowed for measured action in WAST with little or no impact on service delivery across the two days. Both days were managed within the Integrated Care leadership team without need for wider operational structures.

AGENDA ITEM No	**7**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**5**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Finance & Performance Committee
DATE	17th July 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 9 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 25th May 2023 and are updated as at 6th July 2023. The high rated risks have 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. Specifically, The Trust's highest rated Risks 223 and ID 224, scoring 25, remain unchanged despite a series of mitigating actions being in place. These risks continue to be closely monitored by management, Board Committees, and the Trust Board.

6. All current mitigating actions within WAST's control have been completed or superseded in relation to Risk 223. The Trust will continue to challenge itself that all possible mitigations are in place or planned, this includes considering a potential breakdown of risk score by Health Board.

7. A deep dive in relation to Risk 224 was undertaken by the Quality & Nursing Directorate and it was agreed that the score should remain at 25 (5x5) given recent cases of patients deteriorating outside of Emergency Departments.

8. Risks 139 and 458 remain at a score of 16 4x4) given the current financial climate. Monthly detailed finance reports will continue to provide key information to Committee as to the level of risk the organisation is experiencing including elements of non-recurrent as opposed to recurrent funding and how this is being managed financially and operationally.

9. The risk score has increased on Risk 424 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.

10. Risk 245 was approved by the EMT for closure from the Corporate Risk Register as this has achieved the target score of 8 (2x4) having reduced from 16 (4x4). The Control Room Solution implementation is complete across all 3 Emergency Medical Services Clinical Contact Centres which has increased dispatch capability in all areas and the risk has reduced from 16 (4x4) and reached the target score of 8 (2x4). The remaining risk in relation to the ability to accommodate call handling functionality will be managed at a directorate level and reviewed when the telephony capacity in the new Vantage Point House resilient suite is identified. The risk of not being able to meet civil contingencies has now significantly reduced.

11. All original actions are now complete in relation to Risk 260; however, a review of the recent CRU assessment is to be undertaken to identify any further actions. On this basis the score remains the same given continued activity by cyber actors due to wider world events. There is a general heightened alert for government and public sector bodies although no specific threat has been identified against NHS bodies.

12. The majority of mitigating actions complete on Risk 543 and so the score remains unchanged as further reviews of the CE assessor and CRU reports are required to identify any further actions that need to be undertaken.

13. Risk 594 – The risk score remains at 15 following review. While the Health Boards have responded to the original letter sent from the Chief Executive highlighting this risk the responses have provided limited assurance. To this end the Trust is working with the Welsh Government NHS Executive to provide further assurances that the response from Health Boards is sufficient to reduce this risk. A Mass

Casualty Exercise is being arranged for October 2023 to test the response and this will provide a further opportunity to review this risk and score at that time.

14. Risks 100 and 283 are not due for review until August 2023.

15. Updates made in respect of actions, controls and assurances are highlighted in blue on the BAF.

RECOMMENDATION:

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

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

REPORT APPROVAL ROUTE
18. The BAF was considered by: • EMT – 5th July 2023 • ADLT – 26th June 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 • Appendix 1 - Guidance on Interpreting the 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 Standing Financial Instructions (SFIs)	Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage		
245 FPC **CLOSED**	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	**IF** CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident **THEN** there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities **RESULTING IN** potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)	Director of Operations	**8 (2x4)** ↓ **16 (4x4)**
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)** ↑ **12 (3x4)**

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
458 FPC	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	**IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis **THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients. **RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage	Director of Finance & Corporate Resources	**16 (4x4)** →
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **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)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
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)** →
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)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
283 FPC	Failure to implement the EMS Operational Transformation Programme	**IF** there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme **THEN** there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters **RESULTING IN** potential patient harm, deterioration in staff wellbeing and reputational damage	Director of Strategy Planning & Performance	**12 (3x4)** 

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:**	**26/06/2023**	**TREND**	**25 (5x5)**
		Date of Next Review:	**25/07/2023**	➡	

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**

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 Q4 2022/23

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.

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 performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	26/06/2023	TREND	25 (5x5)
		Date of Next Review:	25/07/2023		

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

	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**
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**

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	26/06/2023	TREND	25 (5x5)
		Date of Next Review:	25/07/2023		

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

	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**
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	

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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	26/06/2023	TREND	25 (5x5)
		Date of Next Review:	25/07/2023		

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

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 Workforce & OD	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:	27/06/2023	TREND	25 (5x5)
		Date of Next Review:	27/07/2023	→	

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

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

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 (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 **2,000** +4 hour patient handovers in **April 2023**; the target being 0 from September 2022 **has now moved to the end of 2023/24.** Currently < 0.0**14**% of the Trust's demand is going into Same Day Emergency Care currently is <0.025% (modelling 4%). 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. **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).**

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) ***by*** *revised to March 2023/24.*
c) Alternative capacity equivalent to 1,000 beds project (LHB CEOs)
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 is currently in pilot phase and an evaluation is to be undertaken in quarter 1 2023/24 by EASC. 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 monitors, reports on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place 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:	27/06/2023	TREND	25 (5x5)
		Date of Next Review:	27/07/2023	➡	

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.
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 (**April 2023 overall 75%** - **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 May 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:	27/06/2023	TREND	25 (5x5)
		Date of Next Review:	27/07/2023	→	

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

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 February 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) and Joint Executive Team (JET) meeting Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and 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 30 (as of 07.03.2023) overdue nationally reportable incident investigations.
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. **23,082** hours were lost in **April 2023 with 2021 +4 hour patient handovers in April 2023.**
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:	27/06/2023	TREND	25 (5x5)
		Date of Next Review:	27/07/2023	➡	

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

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

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 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. 10 started in September (North) with the balance (eight) on target for March 2023 start. • 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 has recently submitted a bid to increase AHPs in Primary and Community Care (WG fund) for more APPs.
5. Overnight falls service extension	Executive Director of Quality & Nursing	• June 2023	• Night Car Scheme extension agreed to 31 March 2023 (2 regional resources) • Aim to achieve 60% utilisation of Falls Assistant resources, by December 2022 and achieve consistent utilisation of 60% + through Jan-Mar 2023. Good progress has been made on this. • Falls level 1 and 2 impact evaluation report completed - presenting to Clinical Quality Governance Group (CQGG) 18 Jan-2023.
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. • Key policies updated and approved. • 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	• Q2 2023/24	• **Commencing Test of Change deployments with SJAC – two vehicles at present have been utilised, 2 to follow.** • **Arrangements – CSD selecting cases for SJAC to respond and take patient observation. To date, the small number of cases have negated any EA attendance to the scene.** • **Funding – CASC have awarded SJAC a direct commission for circa 20 weeks provision.** • **Small Business Research Initiative – has 'kicked off' phase one, with a virtual warding technology platform in development for the pre-hospital/community used (within WAST).**
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	• Q2 2023/24	• Informal consultation phase **commenced** May 2023.
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**	
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)**

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:	27/06/2023	TREND	25 (5x5)
		Date of Next Review:	27/07/2023		

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

			• **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.**
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 Workforce & Organisational Development	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:	20/06/2023	TREND	16 (4x4)
		Date of Next Review:	20/07/2023	➡	

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:	20/06/2023	TREND	16 (4x4)
		Date of Next Review:	20/07/2023		

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:	23/06/2023	TREND	16 (4x)
		Date of Next Review:	23/09/2023	⬆	

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. Head of Transformation vacancy~~	2. Benefits have not been fully linked to benefits realisation
3. Lack of a commercial contractual relationship with Commissioners (link to risk 458)	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Recruit a Head of Transformation	Assistant Director of Planning	30.09.22 complete	Recruited 02.08.22 in post on 01.11.22
2. Review the PPM	Head of Transformation	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.**
1. 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.**
2. 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:	20/06/2023	TREND	16 (4x4)
		Date of Next Review:	20/07/2023		

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 e.g. November 2021 3 and 8 EASC management meetings. Monthly meetings with EASC and DAG meetings for NEPTS. Meetings are diarised. 9. Monthly monitoring returns
9. Welsh Government reporting on a monthly basis	**Independent Assurance (3rd Line of Assurance)** 2. Internal Audit reviews of financial policies & procedures as part of their audit plan
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Lack of clarity regarding EASC/Welsh Government commitments with respect to recurrent funding	1. Dialogue with EASC and DAG does not always result in recurrent arrangements (outside of WAST control)

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. A formal approach to service change to be developed providing secure recurrent funding with commissioners.	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.
3. 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:	25/06/2023	TREND	15 (3x5)
		Date of Next Review:	25/07/2023		

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

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

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Appropriate policy and procedures in place for Information/Cyber Security	1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
2. Trust Business Continuity Procedure and Incident Response Plan	2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
3. IT Disaster Recovery Plan	3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
4. Relevant expertise in Trust with respect to information security	4. Staff undertake relevant training courses e.g. CISSP to increase knowledge and expertise
5. Data Protection Officer in post	5. In job description of Head of ICT
6. Cyber and information security training and awareness	6. Training statistics are available on ESR and from Phish threat module
7. Mandatory Information Governance training which includes GDPR	7. Training statistics reported on by Information Governance department
8. ICT tests and monitoring on networks & servers	8. Any issues would be identified and flagged and actioned
9. Information Governance framework	9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
10. Internal and NHS Wales governance reporting structures in place	10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.
11. Checks undertaken on inactive user accounts	11. Software in place to run check on inactive accounts as and when
12. Business Continuity exercises	12. Annual schedule of testing
13. Operational ICT controls e.g. penetration testing, firewalls, patching	13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when.
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
	External **Independent Assurance** NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Not all information security procedures are documented	1. No regular Cyber/Info Security KPIs are reported to senior management committees
2. Lack of understanding and compliance with policy and procedures by all staff members	2. Cyber awareness campaigns could be undertaken more regularly e.g. bi-monthly
3. No organisational information security management system in place	

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:	25/06/2023	TREND	15 (3x5)
		Date of Next Review:	25/07/2023		

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 – Checkpoint Date	**Cyber Incident Response Plan adopted, and CRU Assessment conducted during May 2023 with report expected by end June 2023.**
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.

Risk ID 543	Major disruptive incident resulting in a loss of critical IT systems	Date of Review:	25/06/2023	TREND	15 (3x5)
		Date of Next Review:	25/07/2023		

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.
8. Robust security architecture and protocols	8.
9. Diverse IT network (both data and voice) delivery at key operational sites	9.
10. Regular routine maintenance and patching	10.
11. Environmental controls	11.
12. Intelligence gathered from suppliers with respect to future tool sets and enhancements	12. Via email and webinars
	External **Independent Assurance** • 2021_16 Internal Audit review of IM&T Control Assessment – baseline exercise • 2021_19 Internal Audit review of ICT Disaster Recovery – Limited Assurance • NIS Directive internal audit report 2022 – Reasonable Assurance (covering controls 1-12)
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Non identified	Undertaking Cyber Essentials assessment

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	31.12.22 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 30.12.23**	Evidence submitted to assessor – awaiting feedback. CRU Assessment **conducted during** May 2023 **with report expected by end June 2023.**

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	➡	

				Likelihood	Consequence	Score
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	**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:	05/05/2023	TREND	12 (3x4)
		Date of Next Review:	03/08/2023	➡	

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
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	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.
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.	7. This is a new structure that has been established and is yet to be embedded and tested for assurance
Xx WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	
Xx Funding does not flow in a manner to balance demand with capacity (this is outside of WAST's control)	

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.
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.
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.

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:	05/05/2023	TREND	12 (3x4)
		Date of Next Review:	03/08/2023	➡	

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

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 ofNCCU to undertake.
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.

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	02/05/2023	TREND	12 (3x4)
		Date of Next Review:	03/08/2023	→	

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.
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.

Risk ID 283	Failure to implement the EMS Operational Transformation Programme			Date of Review:	02/05/2023	TREND	12 (3x4)
				Date of Next Review:	03/08/2023		

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

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. 02.025.23 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.
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.

IMTP Deliverable Key

No.	IMTP Deliverable
1	We will recover our systems of working and implement new ways of working developed during the pandemic as we learn to live with COVID-19
2	We will engage with a range of stakeholders, developing genuine Pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum
3	We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles)
4	We will work with partners to promote and expand use of 111 across Wales
5	We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team
6	We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations
7	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
8	We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice
9	We will increase and balance response capacity and capability across urban and rural area of Wales
10	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients
11	We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover
12	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
13	We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand
14	We will develop and implement with partners an-All Wales transfer and discharge service
15	We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery
16	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
17	We will improve resource availability, tackling absence and recruitment challenges to deliver improved performance
18	We will effectively manage risk, governance and compliance to promote and protect colleague and patient safety, and ensure a safe, productive and fair work environment
19	We will purposefully shape our future People and Culture Strategy to equip our people to thrive in a changing environment
20	We will foster a culture of belonging and wellbeing where our people can engage, feel supported and represented
21	We will improve access to, and availability of services via the 111 Wales website and other digital channels (NHS Wales app)
22	Improved signposting to the most appropriate service
23	Improved digital tools and services to empower our teams to do their best
24	We will use modern technology to reduce repeat tasks and improve processes
25	Standardised information architecture and common approach to data and analytics across the organisation
26	We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation
27	Improved resilience, flexibility and interoperability for the 999-call platform
28	We will provide an improved financial plan to support our ambitions
29	Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation
30	We will deliver the Estates Strategic Outline Plan
31	We will implement the Environmental and Sustainability Strategy
32	Deliver the Fleet SOP
33	We will secure and implement Quality Management and control systems
No.	**IMTP Deliverable**
34	We will transform the way we work and engage with people
35	We will revisit and implement the Public Health Plan
36	We will implement the Clinical Strategy to support developments across our service ambitions
37	We will deliver a values-based approach
38	We will deliver strong risk management processes and embed a Trust-wide risk culture that embeds the principles of good governance

AGENDA ITEM No	**8**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

Integrated Medium Term Plan (IMTP) 2023 – 2026
FY23/24 Delivery & Assurance Arrangements (incorporating Post Implementation Review)

MEETING	Finance & Performance Committee
DATE	17th July 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
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EXECUTIVE SUMMARY

1. The purpose of this paper is to provide Finance & Performance Committee with an overview of the agreed structure and governance/reporting arrangements for Strategic Transformation Board (STB) and the programmes it will oversee in its dual role:

2. Delivery of the Trust's IMTP to realise its strategic ambitions, with an oversight of the benefits of delivery.

3. Continually reviewing the strategic viability of the Trust's IMTP and driving forward the development of the Trust's strategic ambition.

4. The paper also sets out the development of an Evaluation Framework within a new Project Path Framework which will be the assurance mechanism for the Committee in ensuring project Post Implementation Reviews are being undertaken in a consistent and effective manner.

5. An assurance report reflecting on delivery during FY22/23 and confirming the forward view for FY23/24 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:

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

(2) Notes the approach to project delivery and Post Implementation Review set out in this paper;

(3) Advises on any further assurance required for the Board.

KEY ISSUES/IMPLICATIONS

6. 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.

7. During FY22/23 Q4 it was agreed that it was timely to review the governance arrangements for STB and the IMTP delivery programmes to identify opportunities to strengthen and improve their functioning. The Transformation Support Office (TSO) is also undertaking a review of the delivery and post implementation assurance mechanisms and has been developing a new Project Path Framework which incorporates the recommended approach to benefits realisation and post implementation evaluation.

8. A SWOT analysis (strengths, weaknesses, opportunities, threats) exercise was completed by all STB members in February-23 and the feedback used to develop a revised approach for FY23/24. The revised approach seeks to strengthen those elements of the programme and governance structures that are working well, and to resolve the issues identified in practice and through stakeholder engagement.

Assurance Principles

9. When revising the approach, the following principles were developed by STB members and have been applied in establishing the governance arrangements for FY23/24:

a) **Future Focused** – we will maintain a focus on our strategic ambitions.
b) **Quality & Value Driven** – we will focus on the quality of information and data, and value and benefits realisation when seeking assurance.
c) **Purposeful and Efficient** – we will always avoid duplication, scope creep, and complexity and will maintain a focus on driving delivery.
d) **Value our People** – we will value people's time and will encourage ownership, empowering at the lowest possible level.
e) **Interactive** – our programme boards will engage innovatively and will promote discussion.

IMTP Assurance Arrangements

10. All FY22/23 IMTP actions (c.150) have been reviewed and a single reporting line has been defined for actions continuing into FY23/24.

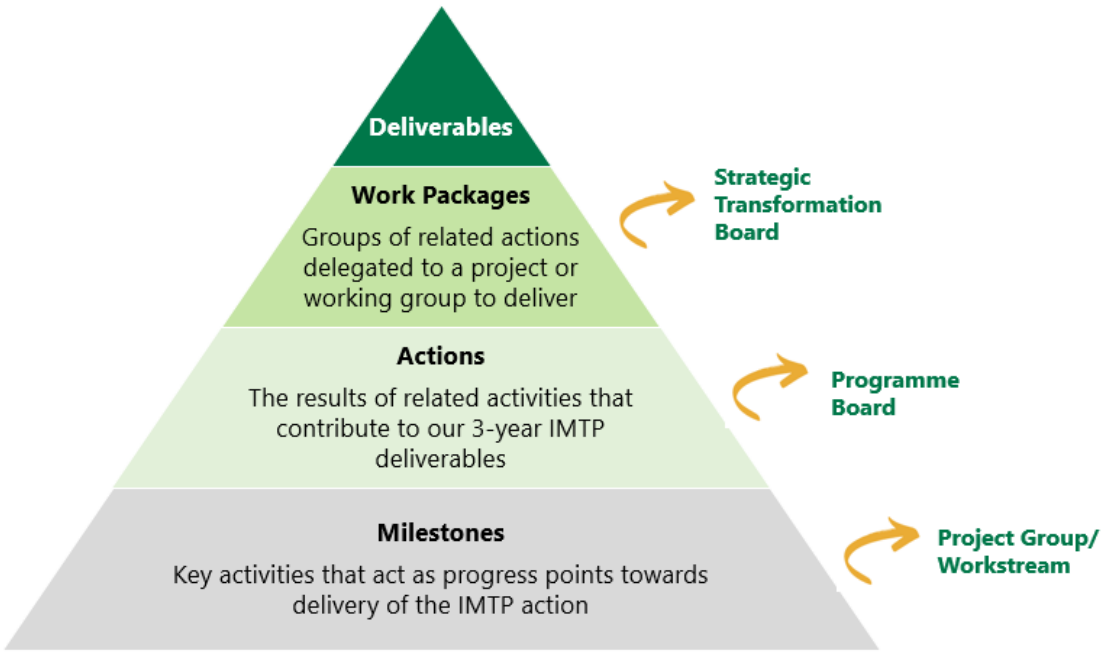
11. All actions for delivery in FY23/24 have been grouped into work packages. These work packages have been aligned to projects or workstreams. Many of these work packages will be managed through the main service focussed IMTP Delivery Programmes and will report directly to the relevant programme board, and to STB.

12. Others will be delivered locally within directorates and may report into alternative boards e.g. Capital Management Board or be tracked discretely through Directorate Plans and directorate Senior Leadership Team.

13. This 'sifting process' has been completed by the Head of Transformation in consultation with relevant leads, resulting in a single, clearly defined line of delegation for each action within the IMTP that has been documented and approved by STB on 22nd March (see attached Assurance Report for full details).

14. For IMTP projects and workstreams (work packages), a series of quarterly milestones have been agreed, and will be reviewed and updated at the end/start of each quarter. STB level reporting will provide a high-level progress update against each project and workstream, whereas actions will be tracked by the relevant Programme Board. This will form the basis of exception reporting to STB.

15. Q1 milestones have been agreed across all programmes (see attached IMTP Assurance Report). Updates are currently being collated and will be presented to STB on 15th August. STB meeting dates have been revised to bring these back in line with the start and mid-points of each quarter, to ensure that the presentation of end of quarter positions is timelier from Q2 onwards.



16. Whilst the Q1 IMTP Assurance Report is due to be presented at the next STB, it should be noted that the **delivery risk around SALUS remains Red and was raised for escalation** by the Programme SRO. SALUS presents several unique and high-risk challenges to the organisation:

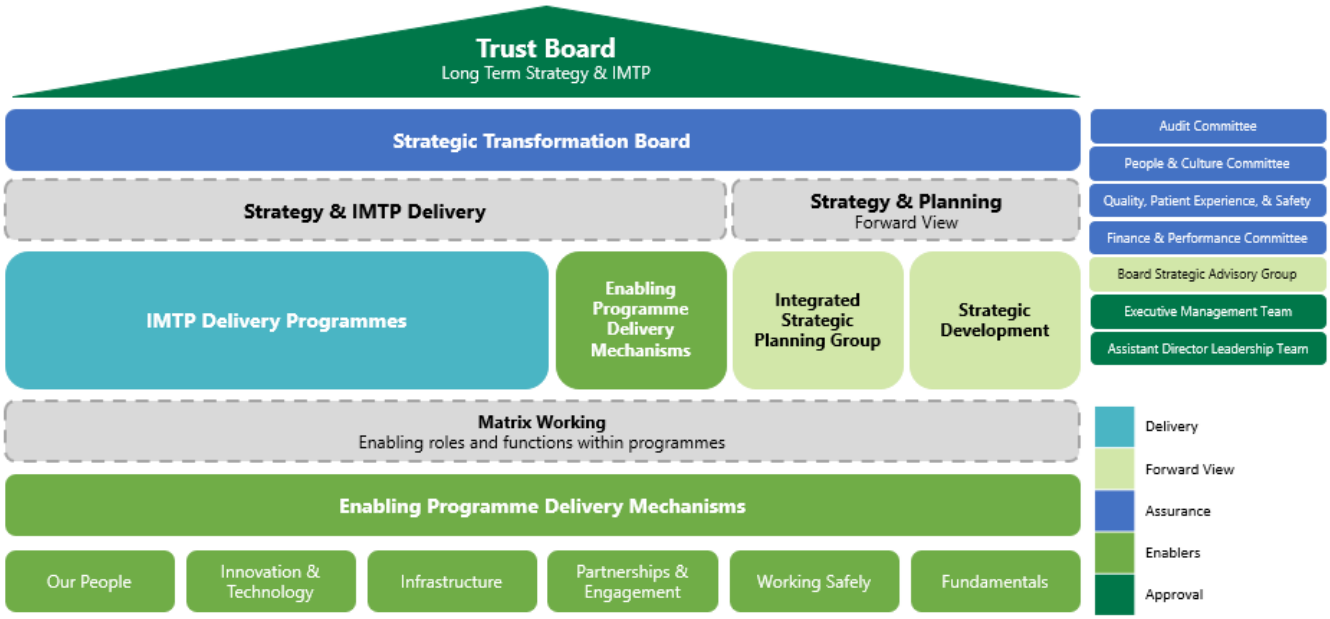
- User Acceptance Testing (UAT) is incomplete
- WAST 111 colleagues have had little meaningful sight of the product
- Consequently, development of Standard Operating Procedures (SOPs) is impeded
- Prevents user training from being meaningfully planned

- System has been developed against a product specification agreed in 2017
- WAST 111 have not had an opportunity to assess whether the product is operationally fit-for-purpose;
- No incremental go-live provision; the expectation is for WAST and all Health Boards to go-live on the same day
- Responsibility for co-ordination of the pan-Wales roll-out is unclear
- Any go-live delay would increase the risk due to winter pressures

17. Whilst many individuals across the organisation are engaged in SALUS readiness and are making significant progress despite the above constraints, it was noted that there is a lack of overall project coordination internally and that dedicated project management capacity would help to reduce some of the risks associated with implementation. The TSO is currently recruiting due to 60% planned vacancies within the next 2-6 weeks and subsequently alternative project management provision will need to be considered by Ops SLT with support from the Assistant Director of Commissioning and Performance and the Head of Transformation. An urgent meeting has been arranged for w/c 10/07 to consider options and next steps.

IMTP Delivery Structure

18. Most FY23/24 IMTP deliverables will be delivered and managed through our main service focused programmes; our IMTP Delivery Programmes. IMTP enabling deliverables will be managed through Directorate Plans and both monitored through Strategic Transformation Board (STB).



The defined IMTP Delivery Programmes for FY23/24 are:

- EMS Operations Programme
- Inverting the Triangle Programme (EMS Transformation Programme)
- Ambulance Care Programme
- Gateway to Care Programme
- Clinical Transformation Programme

- Financial Sustainability Workstreams

19. These programmes will provide a written assurance report quarterly to STB, including progress against agreed milestones. A summary of the alignment between key IMTP work packages for FY23/24 and the IMTP Delivery Programme Boards is presented in Table 1.

The defined IMTP Enabling Programmes for FY23/24 are:

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

20. 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.

21. It should be noted that the Inverting the Triangle (ITT) Programme is not included within the summary of IMTP Delivery Programme work packages. This is an evolving portfolio of work that brings together many workstreams, projects and tests of change being progressed through other IMTP portfolios including Clinical Transformation. This portfolio is currently being reviewed by the Strategy, Planning, and Performance team to consider the scope of the Inverting the Triangle Programme and potential revisions to current reporting lines to avoid duplication. Included as an appendix is a detailed assurance report in relation to the ITT Programme.

Table 1 – IMTP Delivery Programme Work Packages

IMTP Delivery Work Package	Delivery Mechanism	Programme Level Oversight
EMS Response Roster Review Project	Project	EMS Operations Programme Board
EMS Reconfiguration Project	Project	EMS Operations Programme Board
CHARU Workstream	Workstream	EMS Operations Programme Board
NEPTS Transport Re-Roster Project	Project	Ambulance Care Programme Board
NET Centre Re-Roster Project	Project	Ambulance Care Programme Board
Transfer & Discharge Project	Project	Ambulance Care Programme Board
Urgent Care Service Development Workstream	Workstream	Ambulance Care Programme Board
NEPTS Operational Improvement Workstream	Workstream	Ambulance Care Programme Board
Transport Solutions Workstream	Workstream	Ambulance Care Programme Board
CAD Business Justification Case Workstream	Workstream	Ambulance Care Programme Board
Optimising Care Workstream	Workstream	Clinical Transformation Programme Board
Mental Health Workstream	Workstream	Clinical Transformation Programme Board
Older Persons Workstream	Workstream	Clinical Transformation Programme Board
Clinical Intelligence Workstream	Workstream	Clinical Transformation Programme Board
Community Welfare Response Project	Project	Clinical Transformation Programme Board
CCC Clinical Review and ECNS Projects	Project	Gateway to Care Programme Board
111 Commissioning Framework Workstream	Workstream	Gateway to Care Programme Board
Remote Clinical Assessment Workstream	Workstream	Gateway to Care Programme Board
CSD Consult & Close Project	Project	Gateway to Care Programme Board
CSD Clinical Workforce Development Project	Project	Gateway to Care Programme Board
111 Confident & Clinically Competent Workforce Programme	Programme	Gateway to Care Programme Board
111 Re-Roster Project	Project	Gateway to Care Programme Board

111 SALUS Implementation Project	Project	Gateway to Care Programme Board
Pathway Development Programme	Programme	Gateway to Care Programme Board
Digital Patient Workstream	Workstream	Gateway to Care Programme Board
Financial Sustainability Workstreams*	Programme	Assistant Director Leadership Team (ADLT)
** Achieving Efficiencies, Income Generation, and Value Based Healthcare each have Project Board meetings and ad hoc, informal Executive steering and oversight meetings.*		

IMTP Project Delivery

In addition to reviewing the IMTP assurance arrangements, the Transformation Support Office have been developing project management guidance for all Trust staff.

A previous WAST Project Management Framework based on PRINCE2 methodology, was developed, and approved and approved for rollout, however this unfortunately failed to embed and is not widely adopted across the organisation.

22. This was partly due to the timing of its publication as this aligned with organisational reprioritisation in response to COVID-19. However, the complexity and administrative burden of the framework also made it impractical to adopt organisation-wide, particularly when so many of our projects and change initiatives are managed by operational and corporate colleagues, alongside business as usual. Within WAST we have limited project management capacity and subsequently need to be smart in our approach to project management.

23. The Project Path Framework aims to provide a simple and practical 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.

24. 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.

25. Once approved, we will begin to socialise the Project Path Framework across the organisation and will start to review our current project portfolios to identify any areas that could be strengthened or streamlined.

Post Implementation Review

26. Recent audits of the ePCR Project and the IMTP Delivery Programme delivery and assurance mechanisms highlighted a number of themes for development including the need to **increase focus on benefits realisation, lessons learnt, and quality management**. The Finance and Performance Committee Terms of Reference then also require that assurance is provided around project delivery through post implementation review

27. These recommendations are fully accepted and the TSO have developed an **Evaluation process** alongside the Project Path:

28. A key component of the Project Path Framework is the need to scope, define, and deliver projects based on outcomes and benefits (**benefits-led approach**), and not on outputs (output-led approach). This requires a clear and consistent approach to defining the project benefits at the very start of the lifecycle, evaluating these throughout delivery, transitioning the new capabilitties into business and usual, and then continuting to review benefits post implementation. Additionally, we need to consider **quality management** and whether outputs are fit-for-purpose. A project may deliver an output to time and cost, however if the product does not meet critical quality standards like usability, safety, or regulatory standards, then the product is not fit-for-purpose and cannot successfully transition to business as usual.

29. For medium to large projects, a **benefits realisation plan** should be developed during the project definition stage and a new template has been developed that includes guidance on benefits realisation and evaluation prinicples. Guidance has also been develeoped around

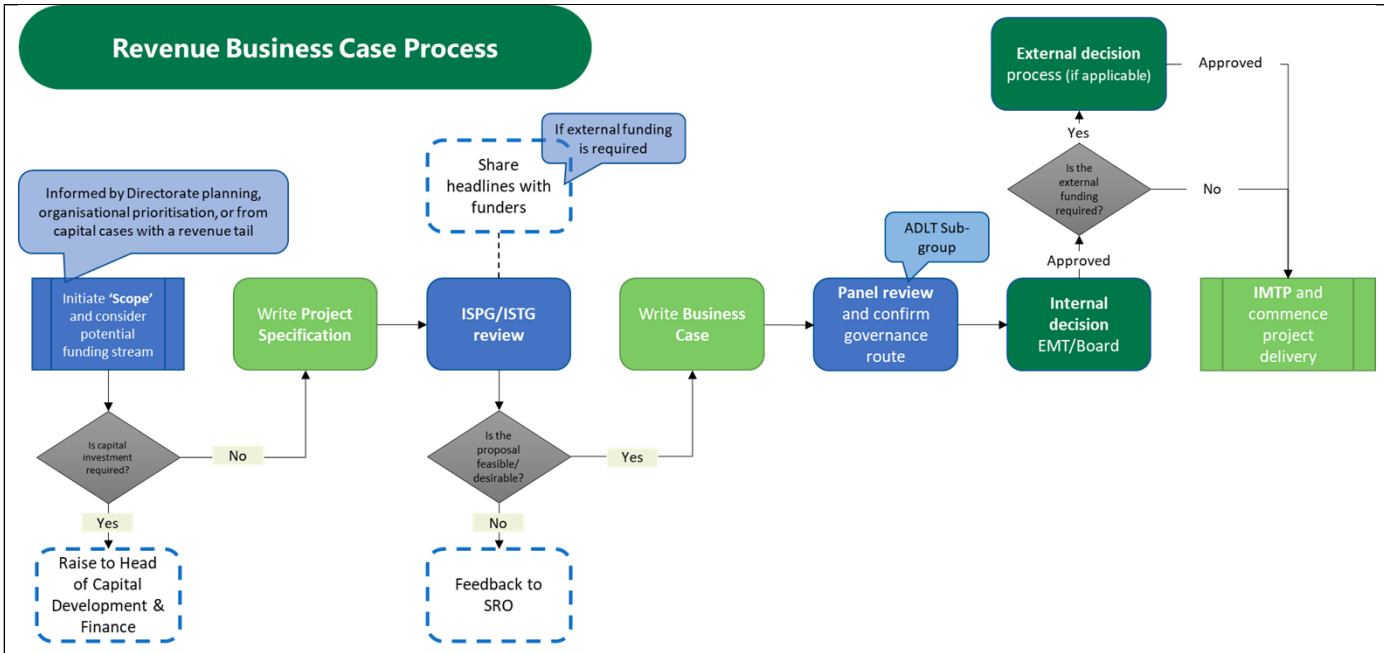
quality management and the need to define requirements clearly, and then to evaluate against these throughout delivery and post implementation.

30. In addition to an enhanced focus on benefits realisation, the need to evaluate **lessons learnt** from previous projects, and to proactively capture new lessons throughout the project lifecyle, has ben embedded within the framework. The ePCR lessons learnt workshop in October 2022 was a good example of how an immediate post implementation review can inform further improvement of a product or service post transition to business as usual as well as informing other projects and programmes, to improve project and programme delivery going forward. The Transformation Support Office keeps a central repository of lessons learnt.

31. The Grange University Hospital Transfer Service was also a good example of lessons learnt but also was the subject of an independent evaluation by the National Collaborative Commissioning Unit in summer 2021 (around 7months following the implementation of the new service). This measured the service against a set of project deliverables, key performance indicators and service specification requirements. This was reported to the Committee in September 2021 – Bundle Finance and Performance OPEN 23 September 2021 (nhs.wales).

32. Once the Project Path Framework has been fully developed and approved, we will prioritise the development of benefits realisation plans across our IMTP Delivery Programmes.

33. In determining the justification and/or funding for projects and programmes, the Planning Team has also developed a **revenue business case process** which has incorporated into the Trust's Planning Framework for 2023-24 planning cycle. This sets out the requirement to scope projects and in some cases develop full business cases. The role of the panel review is to ensure that business cases set out the required components of a case before being put forward for decision to EMT or the Board. This is where there will be scutiny of whether benefits, evaluation criteria and methodology have been clearly set out. The same panel can be used to review post project implementation and evaluation of projects both immediately following implementation but also on a rolling basis as a matter of 'good housekeeping'.



34. Once projects and programmes have transitioned to business as usual it is essential going forward that a routine schedule of evaluation takes place. Currently the Financial Sustainability programme has identified a number of investments over recent years to determine where we need to evaluate against the original benefits set out through the investment case. However, it is good practice to develop a schedule of routine evaluations of any new service (revenue) or capital investment going forward. This practice has also been embedded within the draft Project Path Framework as part of the transition stage, emphasising the need to handover management of the project and benefits to business as usual.

35. The plan for establishing the post implementation review as routine business is to bring the Project Path Framework through STB for governance and sign off, then deliver some education and awareness sessions and a project delivery network to support staff for whom project management is not a core component of their role. Through this we aim to develop a more consistent approach to project scoping, definition, delivery and evaluation.

REPORT APPROVAL ROUTE
Finance and Performance Committee – 17 July 2023

REPORT APPENDICES
Annex 1 IMTP Assurance report **Annex 2 ITT and Strategy Development Assurance 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	YES
Environmental/Sustainability	YES	Legal Implications	N/A
Estate	YES	Patient Safety/Safeguarding	N/A
Ethical Matters	N/A	Risks (Inc. Reputational)	YES
Health Improvement	YES	Socio Economic Duty	N/A
Health and Safety	YES	TU Partner Consultation	YES

Welsh Ambulance Services NHS Trust

Assurance Report

IMTP Delivery

Strategic Transformation Board (STB)
22nd May 2023

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

Assurance Report – IMTP Delivery
Version 1.0
Released: May 2023

by Transformation Support Office
Heather.holden@wales.nhs.uk

Process

FY22/23 Housekeeping

All FY22/23 IMTP actions (c.150) have been reviewed and a single reporting line has been defined for actions continuing into FY23/24.

In some cases, this means that actions will be monitored outside STB and has been clearly documented to record delegation.

FY23/24 Refresh

All actions for delivery in FY23/24 have been grouped into work packages. These work packages have been aligned to projects or workstreams.

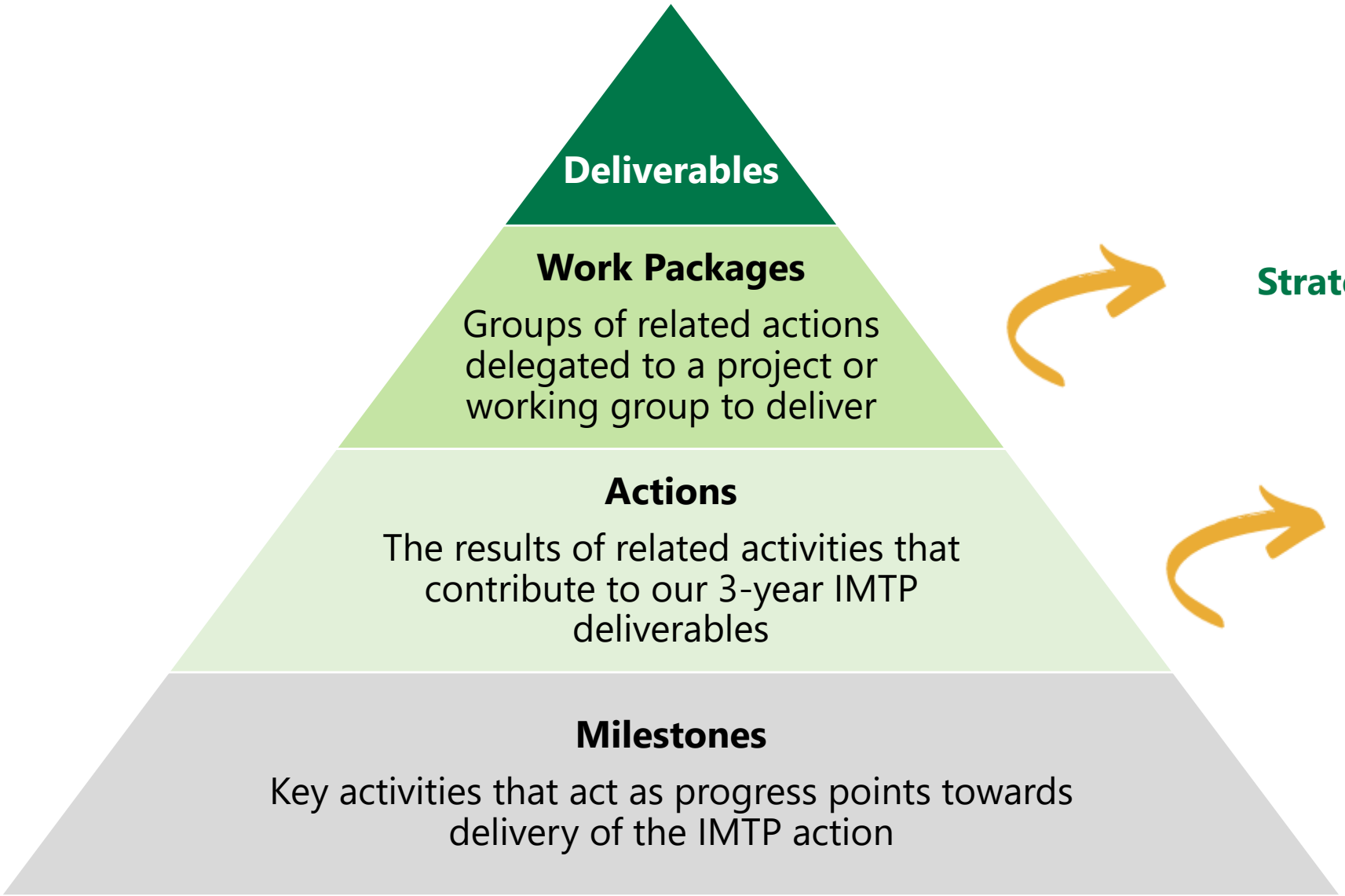
Meetings have been convened with project and workstream leads to agree a small number of milestones that will evidence progress against the actions defined in each work package.

FY23/24 Assurance

Quarterly meetings will be continue to review progress against the agreed milestones, with escalation to STB by exception only.

STB level reporting will provide a high-level progress update against each project and workstream.

Oversight & Assurance by Exception



Strategic Transformation Board

Programme Board

Project Group/ Workstream

Oversight & Assurance by Exception

Deliverable	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess, treat and then stream patients to the services that best meet their needs		
Work Package	*Groups of related actions delegated to a project or working group to deliver*	**Strategic Transformation Board**	**Advanced Practice Development Workstream**
Actions	*The results of related activities that contribute to our 3-year IMTP deliverables*	**Clinical Transformation Programme Board**	- Evaluate the APP Navigator and if appropriate look to expand via a spread and scale approach with HB colleagues - Develop WAST Principles of Advanced Practice document - Contribute to transformational "case for change" to secure funding to recruit APPs - Evaluate the impact of the Independent Prescribing programme to secure funding to increase capabilities - Explore the opportunities for developing the Independent Prescribing programme remotely.
Milestones	*Key activities that act as progress points towards delivery of the IMTP action*	**Optimising Care Group**	1. APP Perfect Day planning workshop (18/05) to develop PDSA Cycle 1 (aim to go-live w/c 19/06) 2. Set clinical criteria for Code 6 (breathing), Code 10 (chest pain), and Code 18 (stroke) 3. Audit team development of red flag system to identify patients requiring EA response

IMTP Delivery Programmes

- EMS Programme
- Ambulance Care Programme
- Gateway to Care Programme*
- Clinical Transformation Programme
- Financial Sustainability Workstreams
- Governance Arrangements Summary

* FY23/24 Q1 Milestones are in development for G2C programme; a workstream restructure was presented to G2C programme board (12/05) and is being reviewed and finalised following the output of a follow-up Integrated Care workshop (17/05)

Each programme section includes:

- **FY22/23 End of Year Status**
- **FY22/23 to FY23/24 Transition**
- **FY23/24 Q1 Milestone Summary**

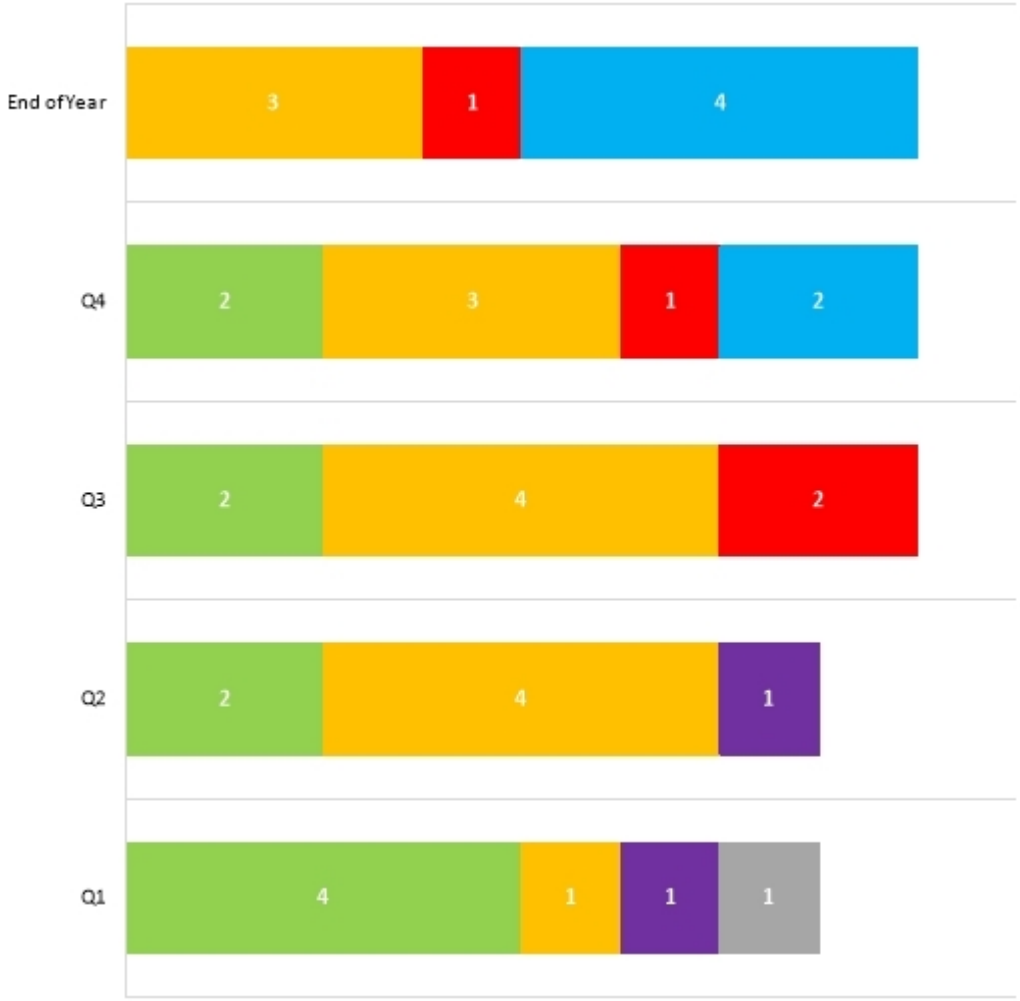
EMS Programme – **FY22/23 End of Year Status**

Navigation Panel

Workstream and IMTP Action		RAG	Latest Update	Assurance Route
Recruitment & Training Workstream	Maintain closure of relief gap and implement transition plan, increasing by up to 294FTE subject to funding		Complete: Target establishment was 1,761FTE for FY22/23 and was delivered with a minimal shortfall of <10FTE = 0.5% vacancy level	No Further Action: Complete
Rural Model Workstream	Continue to work with rural areas to improve red response times		Gaps in rural establishment remain; options to close the gap are being considered by EMT.	**Integrated Technical Planning Group** Reporting route to STB will be via ITPG -> ISPG -> STB
EMS Response Roster Review Project	Implement roster changes		Roster changes have been fully implemented, however formal project evaluation and closure is outstanding. This has been delayed as Project Management was withdrawn following roster implementation.	**EMS Programme Board** Complete formal evaluation and project closure
CHARU Workstream	Implement a CHARU model to improve clinical outcomes, ROSC rates and response times		Currently at 83FTE (exceeded original target). Target of 153FTW. Estimated shortfall of c.40 due to rural recruitment challenges. Options paper to Ops SLT.	**EMS Programme Board** Complete full rollout by mid-May
EMS Operations*	Take forward year 2 actions of our volunteering strategy	*	Revised target of +80FTE by year-end. +54FTW CFR in place, and +26FTE in training	Operations SLT/Quarterly Assurance Meetings
	Consider appropriate and achievable reductions in PPLHs	*	Established reporting route is via Managing Attendance Programme direct to EMT	Executive Management Team
	Reduce roster abstractions due to sickness absence through implementation of robust action plan	*	7.99% - under 8% Y/E target Established reporting route is via Managing Attendance Programme direct to EMT	Executive Management Team
	Work with partners to significantly reduce handover delays	*	CVUHB has been recognised as a positive outlier compared to other HBs that are experiencing extreme and rising levels	Executive Management Team
	*All work will continue to progress but will not report to STB to avoid continued duplication			

EMS Programme – **FY22/23 to FY23/24 Transition**

Navigation Panel



The EMS programme was established to oversee the delivery of Demand & Capacity review recommendations. Most actions have now been delivered, with the aim to complete all residual actions from FY22/23 by the end of Q2 FY23/24, presenting the opportunity to close this legacy programme and to rescope as part of the Inverting the Triangle programme.

The residual workstreams and projects for STB oversight are:

- **Rural Model Workstream** (delivered through Integrated Technical Planning Group)
- **EMS Response Roster Review Project** (completion of FY22/23 activities only, aim to complete in Q1)
- **CHARU Workstream** (completion of FY22/23 activities only, aim to complete in Q1)
- **EMSC Reconfiguration Project*** (including Boundary Changes, Broader Ways of Working, and CCC Roster Review)

*Not captured in FY22/23 action tracker, but ongoing and in scope

EMS Programme – **FY23/24 Q1 Milestone Summary**

Navigation Panel

Period	RAG Status	Trend	Notes
FY23/24 Q1		↔	Below are the milestones agreed for delivery during Q1.

SRO:	Hugh Bennett
Business Partner:	Not Applicable
Programme Support:	Richard Baxter

Project/Workstream		Status	Q1 Milestones
EMS Response Roster Review Project		In Progress	1. Complete formal evaluation and project closure
EMS Reconfiguration Project	CCC Roster Review Workstream	In Progress	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 by the end of Q2
	Broader Ways of Working Workstream	In Progress	1. Develop the workstream terms of reference 2. Develop the detailed project plan
	Boundary Changes Workstream	On Hold	1. Paused, awaiting additional ORH data (due May-23)
Cymru High Acuity Response Unit (CHARU) Workstream		In Progress	1. Complete full rollout by mid-May; gap anticipated due to rural recruitment challenges

Risks and Issues

None for noting

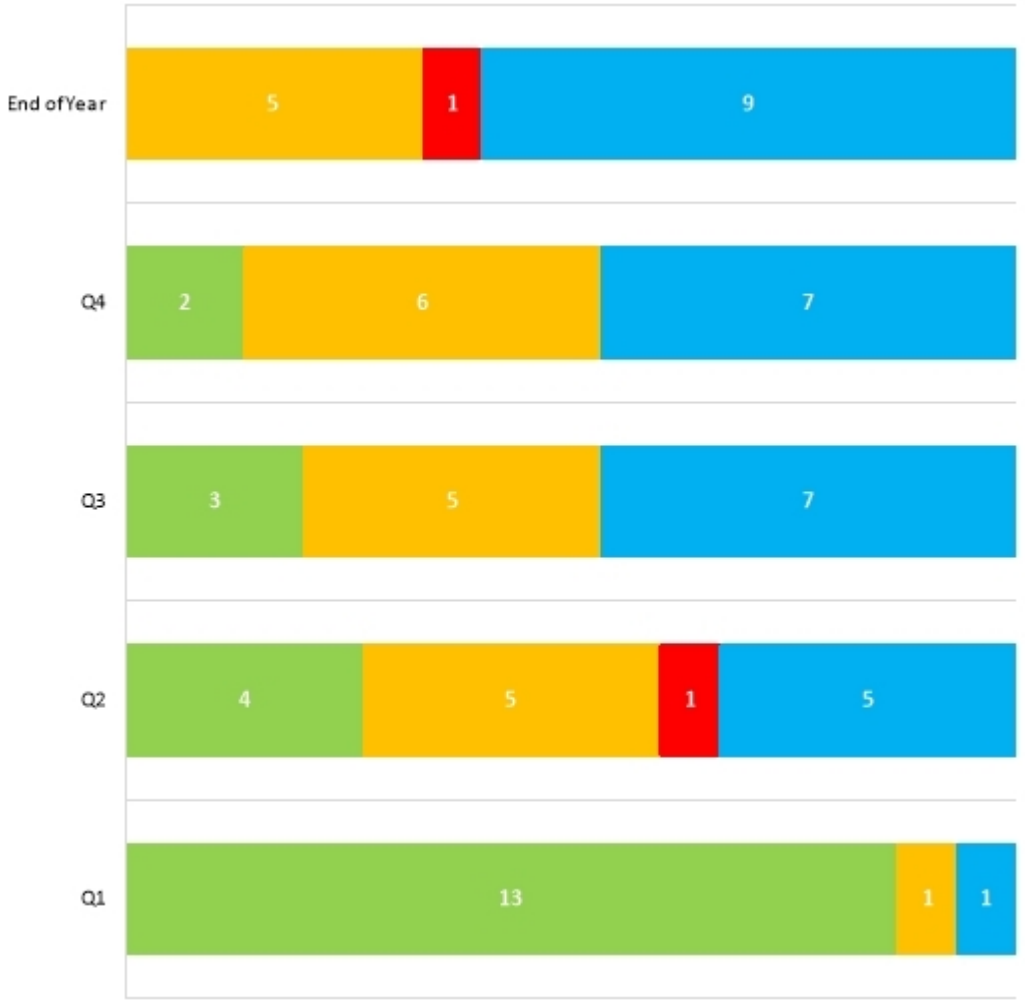
Ambulance Care Programme – **FY22/23 End of Year Status**

Navigation Panel

Workstream and IMTP Action		RAG	Latest Update	Assurance Route
Demand and Capacity Workstream	Roster review pan-Wales (NEPTS ambulance staff)		Agree Roster keys pan-Wales (NEPTS ambulance staff) - Revisit PID and seek agreement to proceed from SLT	**NEPTS Transport Re-Roster Project**
	Possible 12 FTEs for planning and day control (subject to funding)		Closed: Funding not agreed for 22/23	No Further Action: Closed
	Re-roster of NET centre staff		Roster keys agreed	**NET Centre Re-Roster Project**
	Reduction in T1 walkers demand – work with commissioners on eligibility criteria		Confirmation of position required from EASC & WG	**Transport Solutions Workstream**
NEPTS Operational Improvement Workstream	Review resource downtime (previously referred to as post-production lost hours		Complete	No Further Action: Complete
	Work with a local hospital to maximise the usage of the discharge lounge, to reduce cancellations		Discharge lounge trial halted due to BCU operational pressures; engagement recommenced	**NEPTS Operational Improvement Workstream** Aim to complete in Q1
	Finalise the National Standardised guidance and risk assessments		Reduced pace due to Q4 prioritisation	
Transfer & Discharge Project	Respond to Peer Review of the Major Trauma Network		Complete	No Further Action: Complete
	Work in partnership on Commissioning Framework / business case for Transfer and Discharge services (including mental health)		Reduced pace due to Q4 prioritisation; D&C analysis is progressing by ORH and is due for completion in Q1	**Transfer & Discharge Project**
	Implementation of the Vascular Network in SE Wales		Complete	No Further Action: Complete
Transport Solutions Workstream	Transfer of IMTP as 'business as usual' and benefits realisation of the use the PNA and signposting document.		Complete	No Further Action: Complete
	Work with Commissioners on agreement and implementation of eligibility criteria		Complete	No Further Action: Complete
	Agreed Standard Operating Practice document for bookings		Complete	No Further Action: Complete
NEPTS Plurality Model Workstream	Development of quality standards approach for external providers		Complete	No Further Action: Complete
	Review and consider use of ambulance car service		Complete	No Further Action: Complete
NEPTS CAD Worktsream	Upgrade of existing CAD		Complete	No Further Action: Complete

Ambulance Care Programme – **FY22/23 to FY23/24 Transition**

Navigation Panel



Most FY22/23 actions relating to the Demand & Capacity review are complete, presenting the opportunity to review the programme structure and workstreams. This review is in progress, with a proposal to Ambulance Care Programme Board.

The workstreams and projects for STB oversight are:

- **NEPTS Transport Re-Roster Project**
- **NET Centre Re-Roster Project**
- **Transfer & Discharge Project**
- **Urgent Care Service Development Workstream**
- **NEPTS Operational Improvement Workstream** (aim to complete and close in Q1)
- **NEPTS Plurality Model Workstream**
- **Transport Solutions Workstream**
- **CAD Business Justification Case Workstream**

Ambulance Care – **FY23/24 Q1 Milestone Summary**

Navigation Panel

Period	RAG Status	Trend	Notes
FY23/24 Q1		↔	Below are the milestones agreed for delivery during Q1.

SRO:	Mark Harris
Business Partner:	Deborah Kingsbury
Programme Support:	Richard Baxter

Project/Workstream	Status	Q1 Milestones
NEPTS Transport Re-Roster Project	In Progress	1. NEPTS Transport Re-Roster project team to be established
NET Centre Re-Roster Project	In Progress	1. NET Centre Roster Review project team to be established 2. Options paper to informal SLT
Transfer & Discharge Project	In Progress	1. Confirm parameters for modelling with commissioners 2. Finalise the ORH report, modelling resource against demand 3. Establish a Task & Finish group to design and implement new CAD protocols for transfers
Urgent Care Service Development	In Progress	1. UCS Demand & Capacity review will be complete 2. UCS development group to be established
NEPTS Operational Improvement Workstream	In Progress	1. Complete Health Board Discharge Lounge trial 2. Finalise the National standardised guidance and risk assessments
NEPTS Plurality Model	Under Review	1. Consider milestones for Quality Assurance agenda and Ambulance Car service opportunities
Transport Solutions Workstream	Under Review	1. Formal workstream definition, including key milestones for progressing eligibility criteria discussions
CAD Business Justification Case Workstream	Under Review	1. Formalise the scope of the BJC 2. Establish a formal workstream and governance

Risks and Issues

None for noting

Gateway to Care Programme – **FY22/23 End of Year Status**

Navigation Panel

Workstream and IMTP Action		RAG	Latest Update	Assurance Route
We will work with partners to promote and expand use of 111 across Wales	Evaluate core 111 service		Complete	No Further Action: Complete
	Roll out of 111 First across Wales (subject to further discussions)		Closed	No Further Action: Closed
	Work with Welsh Government to promote the use of 111		Complete: Campaigns delivered; evaluation to be received from PR agency for Goal 2 Board (scheduled for May 2023)	No Further Action: Complete
	Work with 111 Programme Team to support the development of a National Strategy for 111 including associated workforce strategy		Requirement to set out new milestones and workstreams that will support the delivery of this action in FY23/24	**111 Commissioning Framework Workstream**
	Support the roll out of a 111 Press 2 Mental Health Service through continued engagement with Health Boards		WAST have delivered all actions to enable progress. RAG status aligned to the 111 Programmes progress	**Clinical Transformation Programme Board** Mental Health Board
We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations	Identify pilot opportunities to test direct booking system for 111 patients to Health Board services		Closed: to be rescoped to include various actions around pathway development and referral opportunities	No Further Action: Closed
	Implement the new 111 system; SALUS		Delays through FY22/23 in Capita Delivery Plan approval. Formal delivery date now confirmed as 20/11/23; 111 go-live date to be confirmed. 111 programme team are seeking support from WAST to deliver in line with Nov go-live, however dedicated capacity is required.	**SALUS Implementation Project** 6 goals led programme
We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience	Continue to implement the 111 Stabilisation & Transformation Plan		Closed: to be rescoped to include various actions around workforce development & performance improvement	No Further Action: Closed
	Develop a strategic 111 workforce plan		Closed: superseded by 'Work with 111 Programme Team to support the development of a National Strategy for 111'	No Further Action: Superceded
We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team	Develop remote clinical support strategy		Closed: SBAR to be submitted to CPAS for review and consideration; continue to progress through CTPB	**Clinical Transformation Programme Board** Optimising Care Group
	Develop a case for change on the integration of clinical teams across 111 & 999		Closed: to be rescoped	No Further Action: Closed

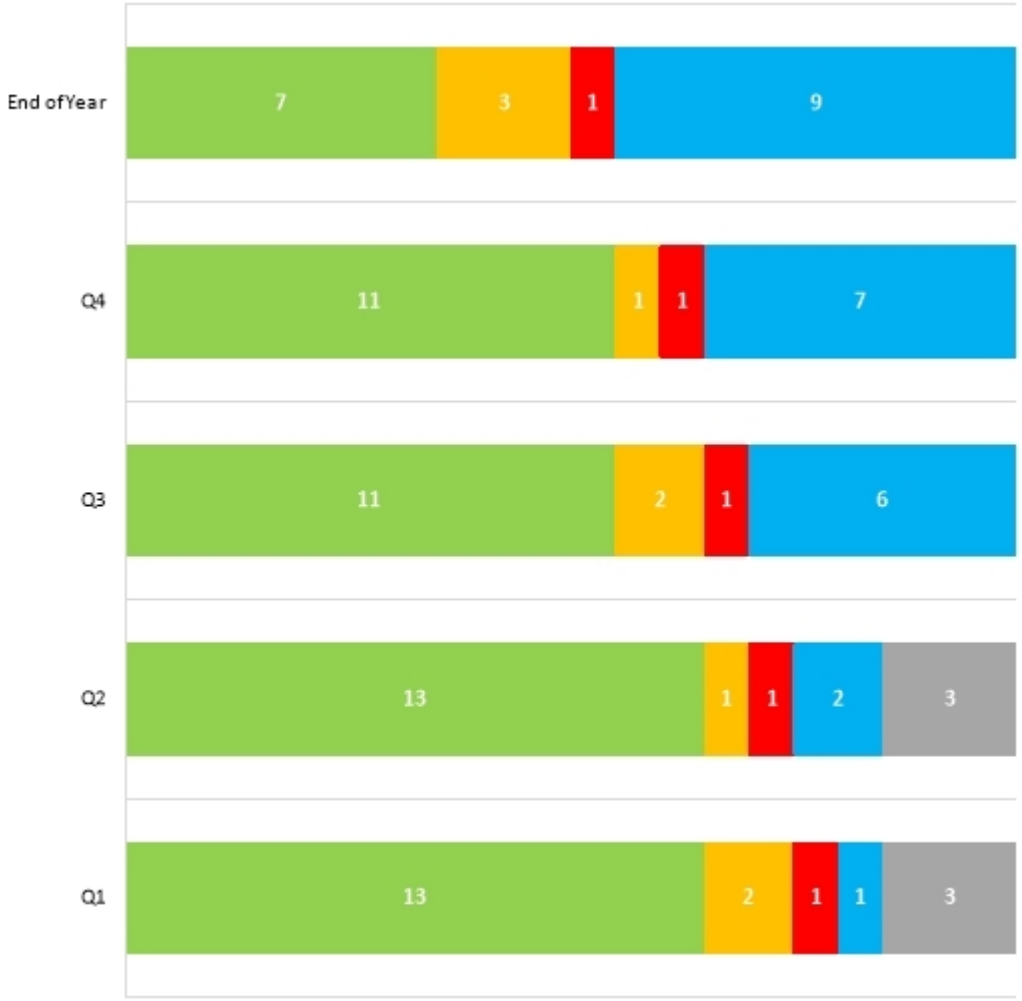
Gateway to Care Programme – **FY22/23 End of Year Status**

Navigation Panel

Workstream and IMTP Action		RAG	Latest Update	Assurance Route
We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team	Implementation of recommendations from CCC Clinical Review		Closure report to be brought back to G2C Board including evaluation	**CCC Clinical Review Project**
	Develop a clinical specialty educational and career framework for Remote Clinical Decision-making (RCDM)		Developed in collaboration with HEIW; recommendations from HEIW Strategic Review Project Board to be incorporated into plan	**Remote Clinical Assessment Workstream**
	Identify opportunities to increase 'consult and close' rates		Various actions associated with CSD performance improvement; recommendation to establish 'Consult & Close'/'Optimising Outcomes' project	**Consult & Close Workstream**
	Consider options for increasing proportion of 999 callers who have a clinical assessment		PTaS is now live in CTM. Discussions are underway with Powys however PTaS may not be appropriate for the Health Board and feasibility is being explored. The NCCU have confirmed that discussions with CVUHB should be paused due to competing organisational priorities.	
	Implement 999 Triage system (ECNS)		Aligned to CCC Clinical Review – closure report to be completed and SMS functionality to be implemented before handover to BAU	**ECNS Project**
We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice	Deliver an improved Directory of Services		Business proposal work for a single national DOS not yet started due to system pressures. This work will be led jointly by WAST and DHCW.	**Digital Patient Workstream**
	Improve 111.Wales website, and enable better digital self-service (subject to funding)		Review actions - for closure enhancements to areas - continual workstreams. Web team still in place in April - funding comes to an end at this time.	
	Develop a clearer vision with partners for a digital 111 offer in Wales, including case for longer term / recurrent investment		Investment case being drafted for a longer term/recurrent funding stream; links to above	
	Further enhance and develop WAST internal reporting functions for 111/111 First		Complete	No Further Action: Complete

Gateway to Care Programme – **FY22/23 to FY23/24 Transition**

Navigation Panel



The Gateway to Care Programme is expansive, incorporating 6 goals led projects, 111, and CSD stabilisation and transformation projects and workstreams, 111.Wales and digital front-end development, and Remote Clinical Strategy development.

An Integrated Care workshop was convened with 111 and CSD operational leads to fully define the work packages and projects aligned with the organisational priorities, and several significant projects and programmes were identified. These are currently being formally defined and will be presented at the next Gateway to Care Programme Board, including key milestones.

The likely workstreams and projects for STB oversight are:

- **CCC Clinical Review and ECNS Projects** – aim to close by Q2
- **111 Commissioning Framework Workstream**
- **Remote Clinical Assessment Workstream** – led by Mike Brady
- **CSD Consult & Close / Optimizing Outcomes Project**
- **CSD Clinical Workforce Development Project**
- **111 Confident & Clinically Competent Workforce Programme**
- **111 Re-Roster Project**
- **111 SALUS Implementation Project**
- **Pathway Development Programme** – including 111 Dental and Palliative Care projects
- **Digital Patient Workstream**

Clinical Transformation Programme – **FY22/23 End of Year Status**

Navigation Panel

	Workstream and IMTP Action	RAG	Latest Update	Assurance Route
Care Closer to Home Workstream*	Additional 50 APPs to commence training (subject to EMS Transition Plan Funding agreed)		Closed: EMS Transition Plan Funding was not agreed for FY22/23	No Further Action: Closed
	Existing APPs to commence Independent Prescribing training (subject to EMS Transition Plan Funding agreed)		Complete: Funding received by HEIW for 10FTEs; 5 commenced in Sep-22 and 5 commenced Mar-23	No Further Action: Complete
	Develop Optimising Conveyance Strategy		Closed: Decision made at Clinical Mapping Workshop (06/12/22) to close. This will be developed and aligned to "Inverting the Triangle" Programme evidence base	No Further Action: Closed
	Work with partners to develop ED avoidance Referral Pathway		BAU: Continue to work with Health Boards and progress agreed pathways via the Optimising Care Group	Optimising Care Group BAU: oversight and escalation to CTPB by exception only
	Embed preferred technical platform to access senior clinical support (subject to announcement from Welsh Government on provider 2021/22 Q4		Complete: Consultant Connect contract awarded	No Further Action: Complete
	Enhancing our provision of analgesia across our EMS and volunteers		Closed	No Further Action: Closed
	Agree case for longer term growth in APPs		SBAR to EMT outlining the number of APPs due out of placement over the next 3 years without funded positions; Workforce Planning have agreed the education commissioned funding for 2024/25	**Optimising Care Group**
	Explore use of technology to facilitate supported remote consultation via additional platform rather than solely face to face.		Ongoing discussions with Consultant Connect regarding Data Protection of Photos and Images. CC2HG approved Open Limb Fracture Pathway (Morriston); testing underway via the Trauma Desk	
	Scope opportunities for and benefits of eReferral mechanisms for frontline patient facing clinicians		Technical bridge testing to connect WAST iPads directly to referral services for non-injured falls, hypoglycaemia, and epilepsy is underway	
	Supporting the Urgent Primary Care and Same Day Emergency Care Centres		WAST have delivered all actions to enable progress. RAG status aligned to the programmes progress	**Optimising Care Group** 6 goals led programme
	*Care Closer to Home Group (CC2HG) has now transitioned into the Optimising Care Group (OCG)			

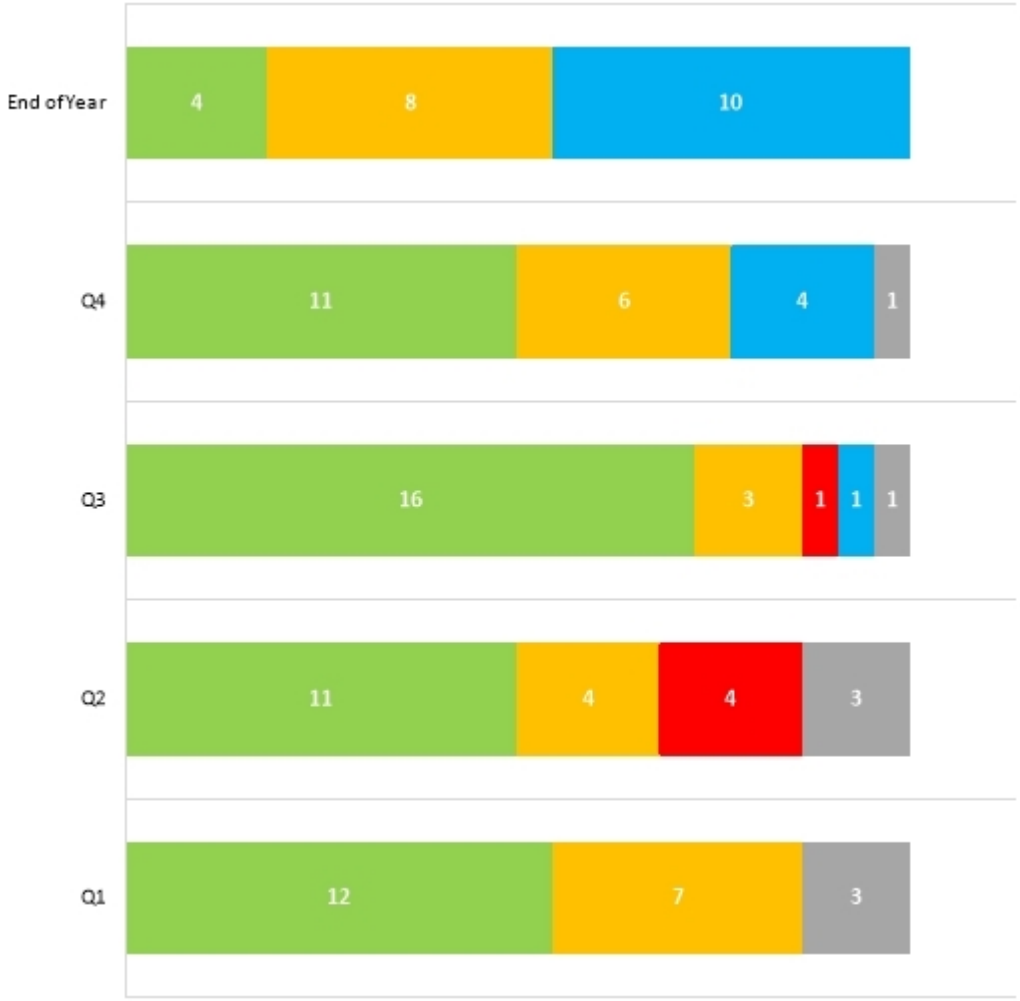
Clinical Transformation Programme – **FY22/23 End of Year Status**

Navigation Panel

	Workstream and IMTP Action	RAG	Latest Update	Assurance Route
Mental Health Workstream	Work in partnership with HEIW on developing a Faculty of Emergency Mental Health Practice		Closed: No further funding identified	No Further Action: Closed
	Pilot use of Mental Health Practitioners in Response Cars		Scoping paper completed and Exec agreement to proceed; potential opportunity to pilot this in BCUHB	**Mental Health Board**
	Undertake evaluation of Mental Health Practitioners in CSD		Ongoing conversation with Health Informatics to develop a dashboard to source the data for the evaluation	**Mental Health Board**
	Deliver the Mental Health and Dementia Plan		BAU: Continue to deliver the Mental Health & Dementia Plan	Mental Health Board BAU: oversight and escalation to CTPB by exception only
Falls & Frailty Workstream	Determine key improvements and opportunities for collaboration following the introduction of the Older Persons Framework		Powys Care Home PDSA of the iStumble tool is now complete and saw a 23% reduction in call outs for falls between Nov-22 (38%) and Feb-23 (15%); the PDSA is being fully evaluated to inform further spread and scale, subject to funding	**Older Persons Improvement Group** PDSA evaluation only; further spread and scale is subject to funding
	Deliver and implement the Clinician/Therapist Falls & Frailty Response across Wales, seeking collaborative programmes/services through partnerships and alliances with external stakeholders		Level 2 Falls Response Team available in ABUHB and 2 in BCUHB. Re-engagement and ongoing discussions with SBUHB, CTMUHB and CVUHB	**Older Persons Improvement Group**
	Assess and evaluate system wide improvements following the introduction of the Falls & Frailty Framework including the Falls & Frailty Response Model		Patient experience and outcome measures reported as part of the Level 2 Evaluation and Level 1 via St Johns, however further development is required via the Older Persons Improvement Group	
ePCR Project	Complete full TerraPACE Project (ePCR)		BAU: ePCR project is in closure stage and benefits realisation and lessons learnt is underway	ePCR Clinical Reference Group BAU: oversight and escalation to CTPB by exception only
	Deliver Year 2 Benefits of ePCR Full Business Case			
	De-commissioning of DigiPen		Complete: DigiPen decommissioning is now complete with 2,473 DigiPens returned and processed	No Further Action: Complete
Clinical Intelligence Assurance Group (CIAG)	Develop a clinical indicator plan		Continued development through FY23/24	**Clinical Intelligence Assurance Group**
Clinical Strategy	Review the strategy to incorporate activity related to "inverting the triangle" and Clinical Leadership and Continue the delivery of the Clinical Strategy through the Clinical Transformation Programme Board		Complete	No Further Action: Complete

Clinical Transformation Programme – **FY22/23 to FY23/24 Transition**

Navigation Panel



Various actions remain open to the programme, however the majority of these have been refreshed for FY23/24 and will be ongoing throughout the financial year. The ePCR project has been fully delivered and transitioned to BAU and will now be closed to the programme. The ePCR Clinical Reference Group has been permanently established to manage all ePCR related change requests.

The workstreams and projects for STB oversight are:

- **Optimising Care Workstream** – including Advanced Clinical Practice Delivery Group
- **Mental Health Workstream**
- **Older Persons Workstream**
- **Clinical Intelligence Workstream**
- **Community Welfare Response Project**

Clinical Transformation Programme – **FY23/24 Q1 Milestone Summary**

Navigation Panel

Period	RAG Status	Trend	Notes
FY23/24 Q1		↔	Below are the milestones agreed for delivery during Q1.

SRO:	Brendan Lloyd
Business Partner:	Deborah Kingsbury
Programme Support:	Sarah Parry

Project/Workstream		Status	Q1 Milestones
Optimising Care Group	Optimising Conveyance Workstream	In Progress	1. Review and approve the 'menu of pathway options' available to HBs 2. Deliver an automated non-injured falls pathway in ePCR 3. Work with primary care to agree approach to implementation of direct epilepsy and hypoglycaemia pathways
	Advanced Clinical Practice Delivery Group	In Progress	1. Consider the outcomes of the Phase 1 APP Navigator pilot, and develop an informed plan for Phase 2 2. Contribute to the Clinical Scope of Practice document 3. Identify a solution to Independent Prescribing training challenges 4. APP Perfect Day planning workshop (18/05) to develop PDSA Cycle 1 (aim to go-live w/c 19/06) 5. Set clinical criteria for Code 6 (breathing), Code 10 (chest pain), and Code 18 (stroke) 6. Audit team development of red flag system to identify patients requiring EA response
Mental Health Workstream *Mental Health Board*		In Progress	1. WAST Executive support to proceed with a Mental Health Practitioner in Response Vehicle (MHPRV) pilot 2. Formal Health Board (BCU) commitment to deliver a MHPRV pilot 3. Collaborate with HI to deliver an enhanced Mental Health dashboard, linking data across clinical systems Complete Phase 1 of the Dementia Friendly Ambulance pilot - Phase 1 - Reminiscence/Rehabilitation & Interactive Therapy Activities (RITA) Tablet
Falls & Frailty Workstream *Older Persons Improvement Group*		In Progress	1. Complete Powys PDSA evaluation report 2. Forecast modelling for system wide Falls & Frailty response
Clinical Intelligence Workstream *Clinical Intelligence Assurance Group (CIAG)*		In Progress	1. Complete FY22/23 audits (administration of TXA, use of documented diagnostic codes on ePCR, and safeguarding) 2. Identify three clincial indicators for data deep dive during FY23/24 3. Appoint a Principlal Clinical Information Officer to oversee delivery of the Clinical Audit plan 4. Release the Clinical Indicator Dashboard to internal Ops and HB, and regional clinical leads 5. Establish a data flow for Stroke and Stemi time based metrics
Community Welfare Response Project		In Progress	1. Gain WAST Executive support to proceed with the CWR feasibility project 2. Finalise the feasibility Project Initiation Document (PID) 3. Commence the feasibility project with SJAC through adoption of a PDSA approach

Risks and Issues

None for noting

Financial Sustainability Workstreams – **FY22/23 to FY23/24 Transition**

Navigation Panel

The Financial Sustainability workstreams (FSW) were established during FY22/23 and as such, did not have a defined set of IMTP actions.

FSW does not have an overarching Programme Board but is instead monitored through ADLT, with reporting into STB. This was agreed by FSW SROs to acknowledge the organisation wide impact of work being progressed through these workstreams e.g. the Support Service Review.

Financial Sustainability brings together 3 key workstreams:

- **Achieving Efficiency**
- **Income Generation**
- **Value Based Healthcare**

Financial Sustainability Workstreams – **FY23/24 Q1 Milestone Summary**

Navigation Panel

Period	RAG Status	Trend	Notes	SRO:	Angie Lewis
FY23/24 Q1		↔	Below are the milestones agreed for delivery during Q1.	Business Partner:	-
				Programme Support:	Gareth Taylor

Project/Workstream		Status	Q1 Milestones
Achieving Efficiences	Support Services Review	In Progress	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
	Service Review	Under Review	1. Develop and approve Terms of Reference ** Likely to commence in July following completion of the Support Services Review*
	Robotic Process Automation	In Progress	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
	Fleet Efficiences	In Progress	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
Income Generation	Commercial Efficiency	In Progress	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
	NEPTS Contract Tenders	In Progress	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
	NEPTS Quality Exemplar	In Progress	1. Undertake Market Research including copyright opportunities/requirements 2. Assess viability and produce viability plan
Value Based Healthcare		In Progress	1. Value in Health workshop 19/05 to discuss process for embedding VBHC principles into ongoing BAU work 2. Formal workstream definition, including key milestones for progressing PROMS and PREMS

Risks and Issues

None for noting

IMTP Delivery Programmes – **FY23/24 Governance Arrangements**

Navigation Panel

Project/Workstream	Delivery Mechanism	Programme Level Oversight	Executive Level Oversight
EMS Response Roster Review Project	Project	EMS Programme Board	Strategic Transformation Board
EMS Reconfiguration Project	Project	EMS Programme Board	Strategic Transformation Board
Cymru High Acuity Response Unit (CHARU) Workstream	Workstream	EMS Programme Board	Strategic Transformation Board
NEPTS Transport Re-Roster Project	Project	Ambulance Care Programme Board	Strategic Transformation Board
NET Centre Re-Roster Project	Project	Ambulance Care Programme Board	Strategic Transformation Board
Transfer & Discharge Project	Project	Ambulance Care Programme Board	Strategic Transformation Board
Urgent Care Service Development Workstream	Workstream	Ambulance Care Programme Board	Strategic Transformation Board
NEPTS Operational Improvement Workstream	Workstream	Ambulance Care Programme Board	Strategic Transformation Board
Transport Solutions Workstream	Workstream	Ambulance Care Programme Board	Strategic Transformation Board
CAD Business Justification Case Workstream	Workstream	Ambulance Care Programme Board	Strategic Transformation Board
Optimising Care Workstream	Workstream	Clinical Transformation Programme Board	Strategic Transformation Board
Mental Health Workstream	Workstream	Clinical Transformation Programme Board	Strategic Transformation Board
Older Persons Workstream	Workstream	Clinical Transformation Programme Board	Strategic Transformation Board
Clinical Intelligence Workstream	Workstream	Clinical Transformation Programme Board	Strategic Transformation Board
Community Welfare Response Project	Project	Clinical Transformation Programme Board	Strategic Transformation Board
CCC Clinical Review and ECNS Projects	Project	Gateway to Care Programme Board	Strategic Transformation Board
111 Commissioning Framework Workstream	Workstream	Gateway to Care Programme Board	Strategic Transformation Board
Remote Clinical Assessment Workstream	Workstream	Gateway to Care Programme Board	Strategic Transformation Board
CSD Consult & Close / Optimizing Outcomes Project	Project	Gateway to Care Programme Board	Strategic Transformation Board
CSD Clinical Workforce Development Project	Project	Gateway to Care Programme Board	Strategic Transformation Board
111 Confident & Clinically Competent Workforce Programme	Programme	Gateway to Care Programme Board	Strategic Transformation Board
111 Re-Roster Project	Project	Gateway to Care Programme Board	Strategic Transformation Board
111 SALUS Implementation Project	Project	Gateway to Care Programme Board	Strategic Transformation Board
Pathway Development Programme	Programme	Gateway to Care Programme Board	Strategic Transformation Board
Digital Patient Workstream	Workstream	Gateway to Care Programme Board	Strategic Transformation Board
Financial Sustainability Workstreams*	Programme	Assistant Director Leadership Team (ADLT)	Strategic Transformation Board

** Achieving Efficiencies, Income Generation, and Value Based Healthcare each have Project Board meetings and ad hoc, informal Executive steering and oversight meetings.*

Navigation Panel

IMTP Enablers & Fundamentals

- People & Culture
- Digital
- Infrastructure
- Fundamentals
- Governance Arrangements Summary

Each section includes:

- **FY22/23 End of Year Status**
- **FY22/23 to FY23/24 Transition**

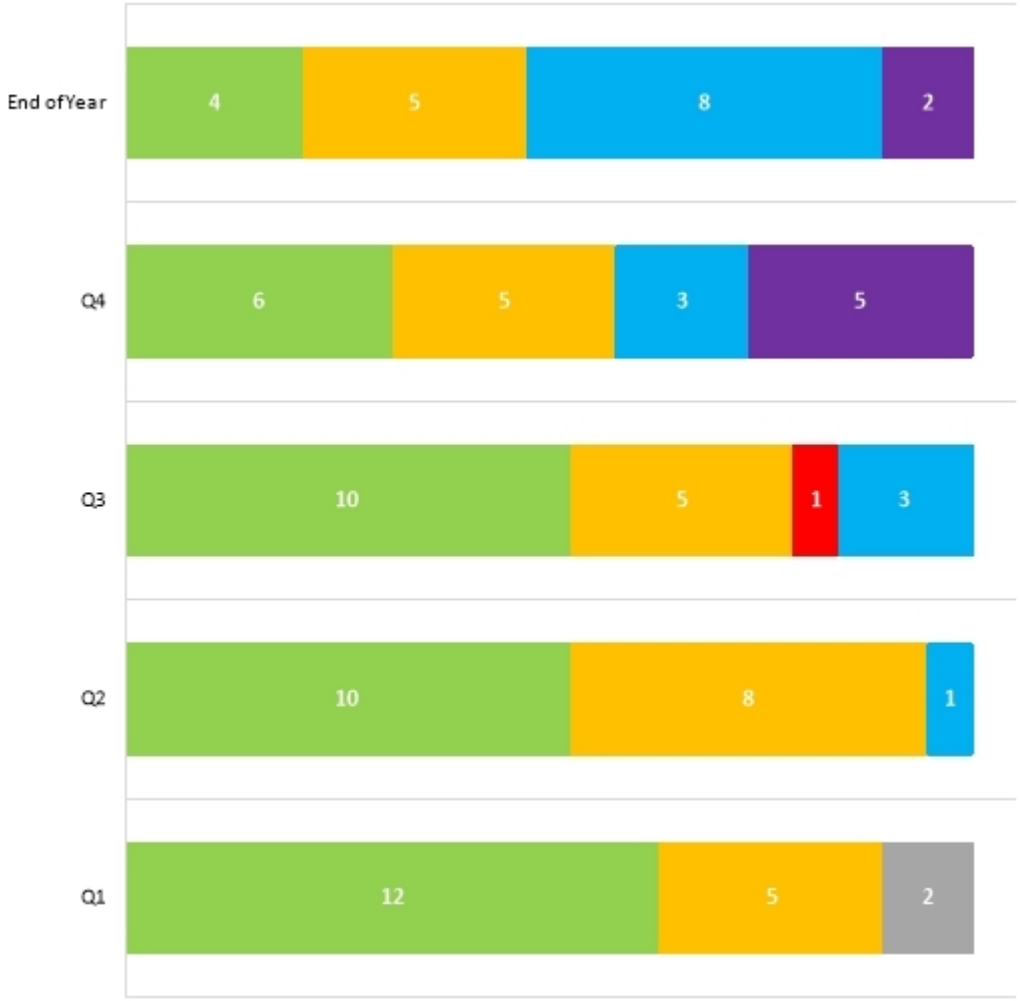
People & Culture – **FY22/23 End of Year Status**

Navigation Panel

IMTP Deliverable	IMTP Action	RAG	Latest Update	Assurance Route
We will take actions to increase the level of resources and support available to our people in relation to their well-being	Deliver the EMS Recruitment & Training plan		Complete: Target establishment was 1,761FTE for FY22/23 and was delivered with a minimal shortfall of <10FTE = 0.5% vacancy level	No Further Action: Complete
	Implement our absence management recovery plan		Complete: Work continues with monthly monitoring through BAU; 10-point plan developed to maintain current interventions and improvements	Directorate LDP/SLT -> STB (by exception)
	Find opportunities to create operational efficiencies		ACAS plan in place but on hold due to IA; to be reinstated	
	Develop our recruitment plans to enhance 'grow our own'		Paused to focus on Demand & Capacity and FY23/24 workforce planning	
	Develop our succession planning approach		Impacted by IA; to be carried over into FY23/24	
	Refine People and Culture Committee governance		Complete: Sub-group structure confirmed and established	No Further Action: Complete
	Create a shared vision for WAST as a learning organisation		Complete: Education and Training Enabling plan in place	No Further Action: Complete
	Develop change capacity and expertise		Complete: First course delivered Mar-23 with further courses planned	No Further Action: Complete
We will effectively manage risk, governance and compliance	Appropriately respond to the legislative changes associated with Section 19 of the Road Traffic Act		Centre is now validated to deliver the new FutureQuals course Legislation not yet implemented so this continues into FY23/24	Directorate LDP/SLT -> STB (by exception)
	Implement the All Wales Speaking Up Safely Guidance		National policy still in consultation	
	Improve the effectiveness and safety of our internal disciplinary, capability and resolution processes		Compassionate Practices training sessions restarting in May	
	Develop a strategic workforce plan		Training needs analysis to be conducted for managers across the Trust	
	Agile ways of working		Change management training progressing and Admin Review initiated	**Financial Sustainability** Superseded by Support Services Review
We will take actions to foster a culture of belonging and wellbeing where our people can engage, feel supported and represented	Continue to deliver the strategic equality objectives		Complete: Rhythm of training embed into the organisation	No Further Action: Complete
	Refreshed Leadership and Management Development Plan		Complete: Embedded into BAU	No Further Action: Complete
	Actively support Board and Board development activities		Complete: Board development sessions planned throughout next year	No Further Action: Complete
	Embed the refreshed partnership working arrangements and behaviours with TU partners and managers		Action plan written; pending resolution of strike action	Directorate LDP/SLT -> STB (by exception)
	Launch and embed our new behaviours		Plan developed to spotlight each of the behaviours on a 6 weekly basis	
	Develop opportunities to feedback by using a 'you said, we did' approach		Hive HR purchased; kick off meeting scheduled 17/05 to develop 6-8 week plan	

People & Culture – **FY22/23 to FY23/24 Transition**

Navigation Panel



Many actions associated with People & Culture are reviewed iteratively, refined, refreshed, and reissued e.g. workforce plans, training and education plans, absence management, and recruitment and retention plans.

The People & Culture Directorate has a comprehensive Local Delivery Plan (LDP) aligned to the IMTP that has been reviewed by the SPP. Some elements of this plan are reported direct to EMT due to the associated risks e.g. Managing Attendance Programme, and other elements that are critical enablers to our IMTP programmes e.g. demand & capacity, workforce modelling, recruitment, training and education, are reported through the relevant programme board.

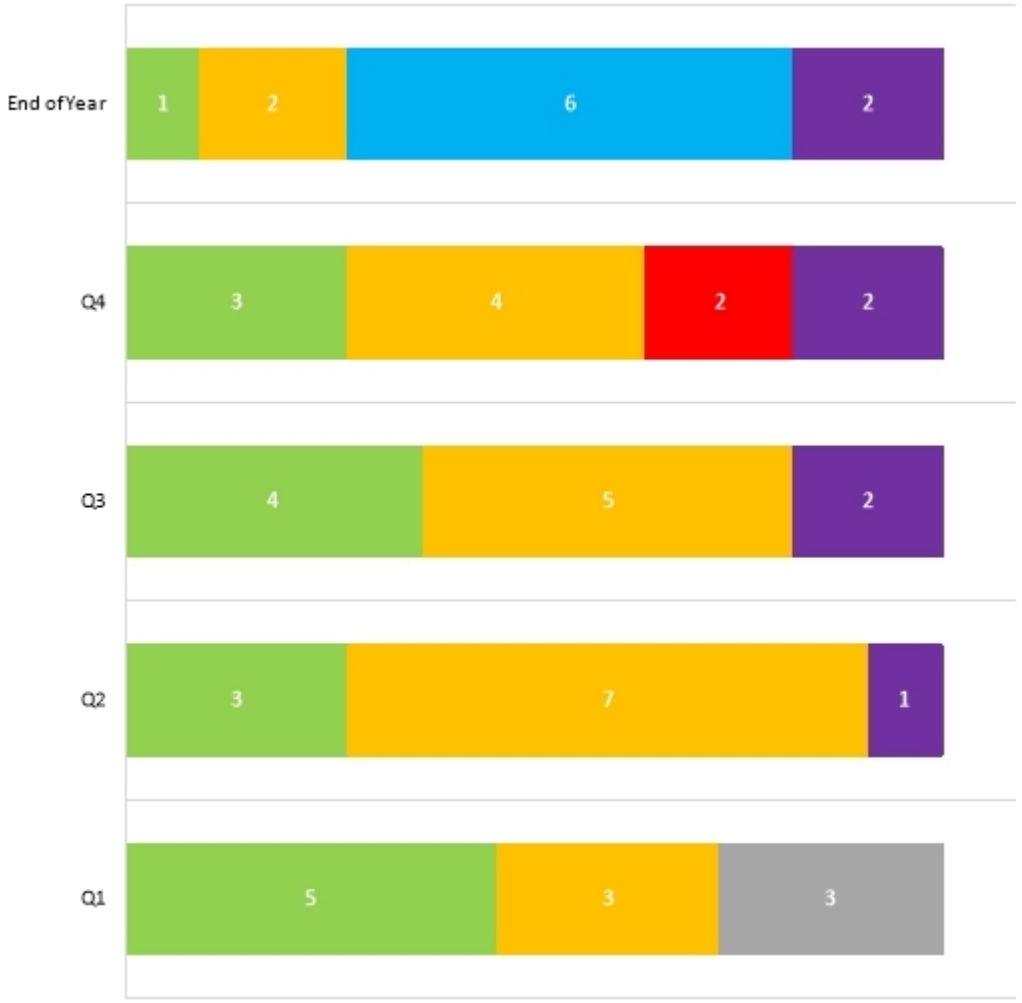
To avoid duplication, and in line with the People & Culture Committee Cycle of Business 2023/24, IMTP actions will be managed through the LDP and Directorate SLT, with **escalation by exception from the Director of People & Culture to STB**. Where actions/initiatives require escalation, these will be formally noted within the minutes of the meeting and noted within the Executive Summary to Finance & Performance Committee.

Digital – **FY22/23 End of Year Status**

Navigation Panel

IMTP Deliverable	IMTP Action	RAG	Latest Update	Assurance Route
We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation	Simplify the number of reporting tools and improve access and availability		A regular review cycle for all existing reports will be implemented	Directorate LDP/SLT Cross-organisational; HI dependencies reported through relevant Programme Board
	Deliver a modernised, more stable data warehouse		Complete: Data Warehouse Migration completed in April 2023, including review and consolidation of existing (ageing) servers to new server clusters	No Further Action: Complete
	Develop a forecasting and modelling framework		Closed: Closed as a digital deliverable. If development required this will be progressed through the ITPG	No Further Action: Closed
	Deliver our part of the National Data Resource Programme		Complete: All planned activities are complete. Awaiting confirmation of FY23/24 funding to progress longer-term NDR activities data linkage ambitions	No Further Action: Complete
Improved resilience, flexibility and interoperability for the 999 call platform	999 Platform upgrade		Supplier side delays have caused system delivery and testing to slip to Jul/Aug. Testing will commence in Q2 subject to supplier side progression).	Directorate LDP/SLT -> STB (by exception)
Improved digital tools and services to empower our teams to do their best	Deliver the new Control Room Solution as part of ESMCP		Migration commenced as planned and all 3 clinical contact centres went live successfully by 26/04 with positive feedback received to date.	No Further Action: Complete
	Mobile Data Vehicle Solution		Planning for live operational testing is underway and scheduled for w/c 15/05. Vehicle installation activities are planned to commence in Q2 FY23/24 and will take c.12 months to complete.	Operations Communication Programme Directorate LDP/SLT -> STB (by exception)
	Pilot Microsoft Viva as part of the national centre of excellence		Closed: Unable to progress due to operational pressures. Any reenergisation of work will be managed through Digital SLT	No Further Action: Closed
We will use modern technology to reduce repeat tasks and improve processes	Robotic Process Automation Pilot		Pilot complete, multiple automated processes live and will be maintained through. Funding identified for further consultancy in 23/24.	**Financial Sustainability** Further schemes to be managed through Achieving Efficiencies Workstream
We will provide an improved financial plan to support our ambitions	Digital Strategic Outline Case		Digital plans developed collaboratively with DHCW and presented to EMT.	No Further Action: Closed
We will improve access via the 111.wales website and other digital channels (NHS Wales App)	ePCR / WEDS Integration		Unable to progress in year due to National WEDs implementation delays, Any further development to be managed through G2C programme.	No Further Action: Closed

Digital – **FY22/23 to FY23/24 Transition**



Most FY22/23 actions have been completed or closed with no further identified actions.

Digital (including HI) is a critical enabler for many FY23/24 IMTP actions including SALUS implementation, 111.Wales, Robotic Process Automation, Community Welfare Response, SBRI etc. These actions are not digitally led and will subsequently report through the relevant programme boards to avoid duplication.

The digitally led initiatives – **999 Platform Upgrade, Operations Communications Programme, and National Data Resource (NDR) Programme** (subject to funding) will be managed through the Directorate SLT, with **escalation by exception from the Director of Digital to STB**. Where actions/initiatives require escalation, these will be formally noted within the minutes of the meeting and noted within the Executive Summary to Finance & Performance Committee.

Infrastructure – **FY22/23 End of Year Status**

Navigation Panel

IMTP Deliverable	IMTP Action	RAG	Latest Update	Assurance Route
Deliver the Fleet SOP	Deliver the vehicle replacement scheme as per the 2022/23 Business Justification Case		Vehicles identified under the 2021/22 Project are now complete Vehicles identified under the 2022/23 Project have been partially delivered, with some vehicles progressing in FY23/24 when as funding is released	Capital Management Board -> STB (by exception)
We will deliver the Estates Strategic Outline Plan	Develop OBC for Swansea MRD Replacement (AWC)		Land options in the area remain limited but NWSSP have commenced searches and are in discussion with land agents to identify new options	
	Develop long term solution for EMS CCC at Llangunnor (DC)		Discussions ongoing with Dyfed Powys Police regarding funding. To be set up as a formal project when resource becomes available within Capital Development Tea	
	Consider implications of NEPTS D&C Review		Complete	No Further Action: Complete
	Develop a permanent solution for Anglesey (Amlwch) (DC)		Complete: Lease was signed at Trust Board at the end of March-23	No Further Action: Complete
	Complete the redevelopment of VPH as an Operational Hub		Complete: All areas now occupied and operational	No Further Action: Complete
	Secure additional resources for further implementation of Transition Plan arrangements (if required)		Closed: No anticipated impact on capital programme; 100WTE to be accommodated within existing resources	No Further Action: Closed
	Implement an interim solution for NEPTS in Bridgend (DC)		Complete	No Further Action: Complete
	Implement a solution for NEPTS in Crosshands (DC)		Closed: Will be considered as part of the NEPTS D&C review and monitored through the Ambulance Care programme as required	No Further Action: Closed
	Development of business case for Llanelli solution (AWC)		PID, Terms of Reference, and site searches initiated	Capital Management Board -> STB (by exception)
	Development of business case for Newport solution (AWC)		PID, Terms of Reference, and site searches initiated	
	Full Business Case for the South East Fleet Workshop solution (AWC)		Aim for occupation and relocation of teams from Carephilly, Blackwood, and Blackweir by August/September 2023	
	Implement a permanent solution for Ruthin working with Fire and Rescue partners (DC)		Planning permission applied for and Project Board is being established	
	Implement a permanent solution for EMS/NEPTS in Dolgellau (DC)		Pre-planning application was submitted in Feb-23 with positive stakeholder feedback and an ecological survey is now being planned	
	Development of business case for Llandrindod Wells (AWC)		Not Started	
	Development of business case for Bangor Fleet Workshop (AWC)		Not Started	

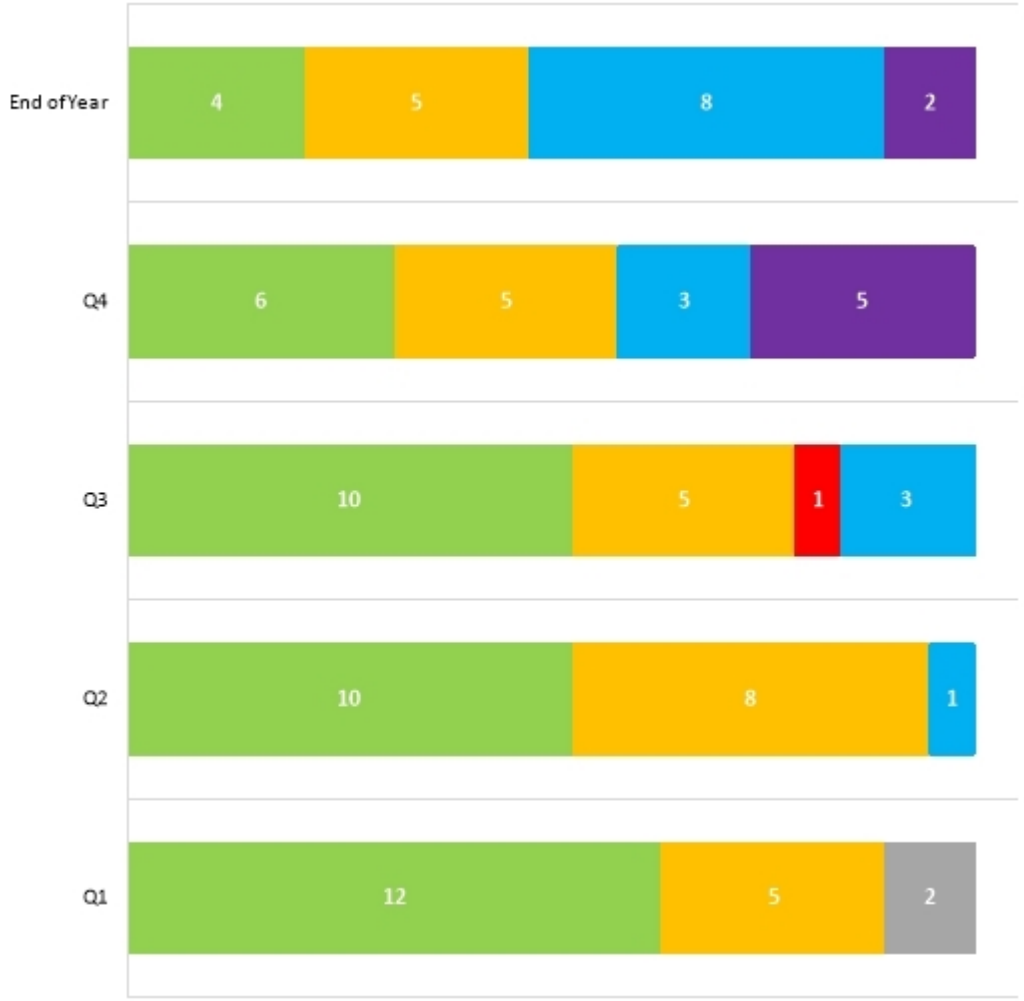
Infrastructure – **FY22/23 End of Year Status**

Navigation Panel

IMTP Deliverable	IMTP Action	RAG	Latest Update	Assurance Route
We will implement the Environmental and Sustainability Strategy	Implement our Carbon Reduction Plan looking forward to 2025-2030		Formal programme board established in Jan-23 to oversee the delivery of the Decarbonisation Action Plan. A Transport Group has also been established, chaired by the Head of Capital Development.	Capital Management Board -> STB (by exception)
	Further progression of the decarbonisation agenda			
	Develop an Electric Vehicle Strategy including a charging network		Significant progress made with the development of our EV charging network. Roll out of the 23 hybrid RRV has been successfully achieved and further work will continue to maximise coverage across the estate. There are now a total of 67 chargers over 54 sites.	
	Modernise our fleet including the increase in the number of Hybrid vehicles and roll out of vehicle solar panels.			
	Access further funding to support decarbonisation of the estate and our travel which will enable us to implement a Sustainable Travel Plan		WAST have secured funding from the WG Estates Funding Advisory Board for 2023/24 to further decarbonisation work. WAST were awarded a proportionally significant amount of the total funding available and have identified several schemes for progression.	
	Develop work packages arising from the condition surveys		All decarbonisation work, including development of work packages, is monitored by the Capital Management Board	
	Development of an Infrastructure and Sustainability Strategic Outline Process and recruitment to support this		ICMG Business Care prioritisation process embedded	

Infrastructure – **FY22/23 to FY23/24 Transition**

Navigation Panel



All actions associated with our Infrastructure, including estates, fleet, and decarbonisation plans, are managed through the Capital Management Board with comprehensive reporting against the Local Delivery Plan.

Activities that are critical enablers to our IMTP programme, and the infrastructure considerations in response to business change, are reported through the relevant programme board.

To avoid duplication, all Infrastructure actions will be managed through the Capital Management Board, with **escalation by exception from the Director of Finance to STB**. Where actions/initiatives require escalation, these will be formally noted within the minutes of the meeting and noted within the Executive Summary to Finance & Performance Committee.

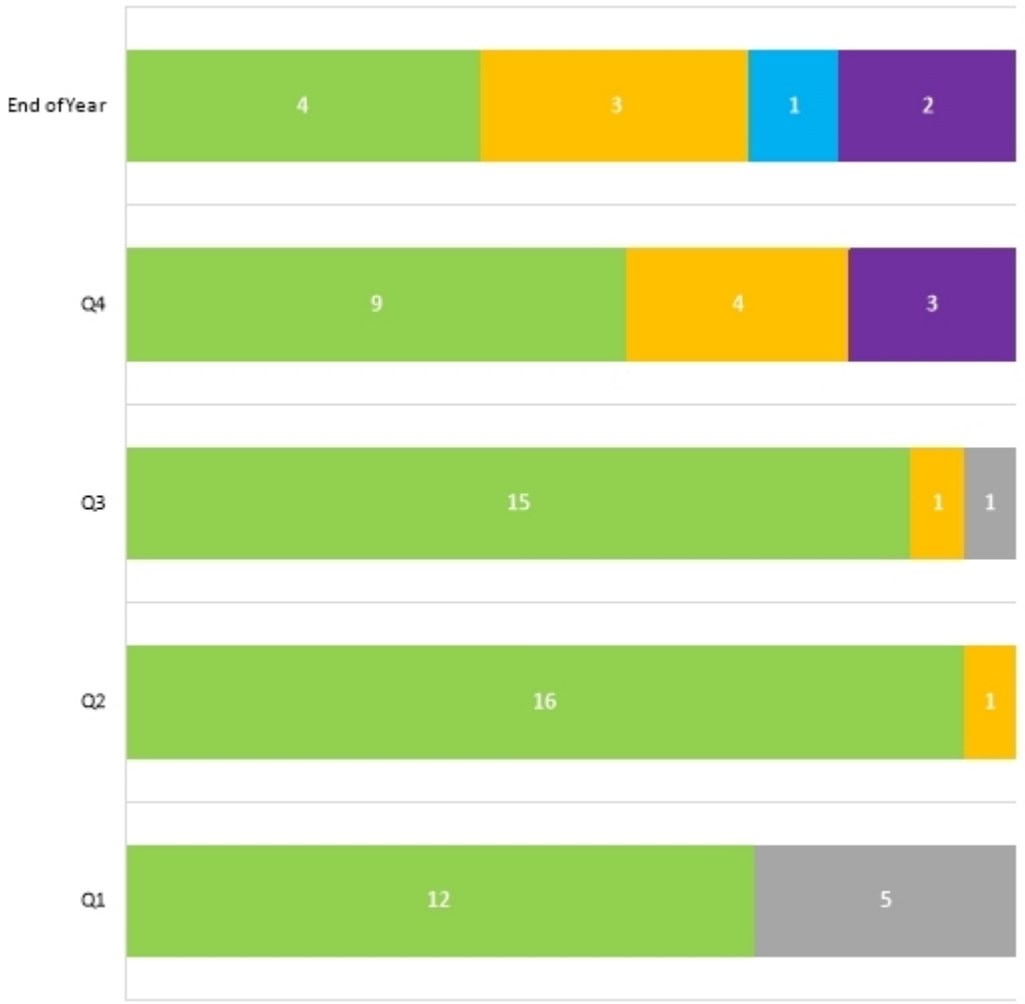
Fundamentals – **FY22/23 End of Year Status**

Navigation Panel

IMTP Deliverable	IMTP Action	RAG	Latest Update	Assurance Route
We will deliver strong risk management processes and embed an enterprise wide risk culture that underpins the principles of good governance	Development of a Risk Management Policy		Policy has been drafted and will be presented to Audit Committee in July	TBC
	Once for Wales Datix Risk Module Implementation		Progressing, but delayed by Provider; a road map is in development but no revised implementation date has been agreed	TBC
	Corporate Risk Review		Complete	No Further Action: Complete
	Refresh of the Risk Management Strategy and procedures		Closed: superseded by development of the Risk Framework including the policy, procedure/guidelines, training, education and platform.	No Further Action: Closed
	Board risk development		Closed: superseded and will be aligned to Director of SPP and Board development	No Further Action: Closed
	Develop a new Board Assurance Framework		Closed: This forms part of the IMTP 23-26	No Further Action: Closed
	Risk training and education		Closed: This forms part of the IMTP 23-26	No Further Action: Closed
We will secure and implement Quality Management and control systems	Implement the "Working Safely" Plan		PPP phase closure report submitted to STB in January 2023. IMTP Deliverable Action Plan developed focusing on four key workstreams. Annual Improvement Plan developed focusing on 6 key workstreams to further improve legislative compliance.	TBC
	Embed the Quality Management System (QMS)		Initial discussions to agree the Trust QMS model are in progress, utilising best practice guidance from Improvement Cymru and the NHS Wales Delivery Unit	TBC
	Evaluate the QuESt sub-structure		Complete: ToR approved by CQGG	No Further Action: Complete
We will transform the way we work and engage with people	Implementation of Once for Wales Service User Experience System		Complete: Implementation of the Once for Wales CIVICA system is now complete and all WAST experience surveys have been transferred to the new system. A	No Further Action: Complete
	Continued development of the People & Community Network		Complete: People & Community Network has officially launched and continues to register new volunteers	No Further Action: Complete
We will revisit and implement the Public Health Plan	Review and redraft the Public Health Plan (PHP) in light of COVID		Closed: No funding identified in FY22/23	No Further Action: Closed
	Work with PHW and Velindre to appointment a joint lead PHP lead		Closed: No funding identified in FY22/23	No Further Action: Closed
	Scope utilising the 111 website for public health messaging		Closed: Work on hold due to organisational priorities – further progress will be captured through G2C programme board	**Gateway to Care Programme**
We will deliver a value-based approach	Develop strategy and approach to Value-Based healthcare (VBHC)		Governance structure reviewed and exploring an Exec-led Steering Group. VBHC Workshop to be arranged for Summer 2023, with a planning workshop on 19/05.	**Financial Sustainability** Value-Based Healthcare
	Utilise PLICS to identify and address areas of unwarranted variation in service delivery		PLICS project has been delayed due to persistent data quality issues. The expected delivery date for Phase 1 has now been pushed back to Q3/Q4 23/24.	Capital Management Board

Fundamentals – **FY22/23 to FY23/24 Transition**

Navigation Panel



Last year, fundamentals included projects and workstreams across Quality, Safety & Patient Experience (QSPE), Corporate Governance, and Value Based Healthcare. This year, Value Based Healthcare will be delivered as a Financial Sustainability Workstream (FSW).

For QSPE and Corporate Governance, there are number of key priorities for FY23/24 including:

- **Once for Wales Datix Risk Module Implementation**
- **Risk Framework Development**
- **Welsh Language Plan**
- **Working Safely Plan**
- **Quality Management System (QMS) Implementation**

During Q1, a meeting will be arranged with leads from both directorates to consider the directorate-level governance and oversight and whether direct reporting to STB would be beneficial or should be by exception only.

Governance Arrangements – Enablers & Fundamentals

Navigation Panel

Directorate	Delivery Mechanism	Programme Level Oversight	Executive Level Oversight
People & Culture	Directorate-led	Local Delivery Plan (LDP) managed by Directorate Senior Leadership Team	Executive Director, with escalation to Executive Management Team and STB by exception
	Enabling	Relevant IMTP Programme Board	Strategic Transformation Board
Digital Including Health Informatics	Directorate-led	Local Delivery Plan (LDP) managed by Directorate Senior Leadership Team	Executive Director, with escalation to Executive Management Team and STB by exception
	Enabling	Relevant IMTP Programme Board	Strategic Transformation Board
Infrastructure Including Estates, Fleet, Decarbonisation, and PLICS	Directorate-led	Local Delivery Plan (LDP) managed by Directorate Senior Leadership Team	Capital Management Board
	Enabling	Relevant IMTP Programme Board	Strategic Transformation Board
Quality, Safety, and Patient Experience (QSPE) **Meeting required to consider the directorate-level governance and oversight and whether direct reporting to STB would be beneficial or should be by exception only*	Directorate-led	TBC	TBC
	Enabling	Relevant IMTP Programme Board	Strategic Transformation Board
Corporate Governance Including Welsh Language **Meeting required to consider the directorate-level governance and oversight and whether direct reporting to STB would be beneficial or should be by exception only*	Directorate-led	TBC	TBC
	Enabling	Relevant IMTP Programme Board	Strategic Transformation Board

Delivery Mechanism	Definition
Directorate-led	Discrete projects and work packages to be delivered by the directorate
Enabling	Work packages that are critical to delivering business change across our IMTP Programmes

Strategy Development – Progress & Planning Report

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Rachel Marsh
Jun-23			Note progress and updates reported.	Head of Strategy:	James Houston
				Project Manager:	Sarah Parry

Description	Status	Current Position	Forward View
Purpose Statement	**Delay**	• Purpose Statement endorsed at Board (Apr) • Video in development with communications team to formally launch Purpose Statement in Q2 (Aug)	• Video to be released in Q2 (Aug)
Strategic Review with Board Development	**On Track**	• Session held with Board Development to review Long Term Strategy and consider opportunities to refresh content	• Further consideration with EMT to discuss opportunities to refresh long term strategy and develop a more detailed strategic delivery plan (for internal consumption only)
NEPTs Strategy	**On Track**	• Paper submitted to EASC Management Board in June setting out aspirations to work with WAST to collaboratively develop a strategy for NEPTs	• Meeting arranged with Commissioning lead + WAST leads on 10th June to discuss expectations, approach and next steps
Strategy Development Siren Page	**Paused**	• Initial discussions held with the Communications Team to develop dedicated Strategy Development page on siren	• Work to design and develop the page will begin when the Engagement & Transformation Manager commences in post (Aug)

Inverting the Triangle – Progress & Planning Report

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Rachel Marsh
Jun-23			Note progress and updates reported. Note and discuss work streams reporting issues.	Head of Strategy:	James Houston
				Project Manager:	Sarah Parry

Workstream	Status	Current Position	Forward View
Setting Aim & Vision			
Case for Change	**Issues**	**Process** • Initial draft received April & detailed feedback provided end of April • Review meeting held with PWC (early May) & updated version received end of May • Number of cycles undertaken to provide feedback and make changes • Continued concerns regarding structure & flow, strength of economic appraisal & link to W/F plan • Further work being undertaken by PWC to address key issues raised including economic appraisal, alignment to w/f plan and structuring • Due to lack of access to an un-editable version, work being undertaken in a separate document, by WAST, to strengthen and develop key elements of the document **Risks / Issues** - Branding & document sharing issues resolved with legal team - Following protracted discussions with PWC legal team we are unable to receive an editable version (in draft or completed form)	**Next Steps** - WAST providing more detailed data for APP economic appraisal (5th July) - PWC to refresh economic appraisal section (12th July) - WAST to provide detailed feedback and summary slides (14th July) - PWC to update document and presentation slide deck (28th July)
Preparation for Change			
Establish Programme Team	**Complete**	• 5 out 5 posts filled • Engagement & Transformation Manager appointed 5th June	• Engagement & Transformation Manager anticipated start date 7th August.

Change Management Training	**On Track**	• Accredited Foundation Level Training
		  • Cohort 1 delivered at the end of March, with all trainees passing the exam
		  • Cohort 2 delivered mid-June
		  • Cohort 3 commencing early-July
		• Practitioner Level Training
		  • Scheduled for 18th & 19th July
			• Accredited Foundation Level Training: Cohort 3 to be delivered early July
			• Accredited Practitioner Level Training on 18th & 19th July

Inverting the Triangle – Progress & Planning Report

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Rachel Marsh
Jun-23			Note progress and updates reported. Note and discuss work streams reporting issues.	Head of Strategy:	James Houston
				Project Manager:	Sarah Parry

Workstream	Status	Current Position	Forward View
Enabling Change			
Advanced Practice Strategic WFP - AHP Funding Opportunity	**Issues**	• WAST Investment Bid submitted 12th May • Limited traction / engagement with Health Boards to submit joint bids • Oversight evaluation panel held in June • WAST APP bid not formally reviewed as part of submissions, noted by the panel. • WAST mentioned in 2 HB bids (C&V Frailty service & BCU 3 month extension of Falls pilot	• Engage with Health Boards to understand current WAST involvement with bids • Invitation to present at National Directors of Primary & Community Care Board (Aug or Sept) to explore opportunities further

Advanced Practice Strategic WFP	**On Track**	• Meeting held 21st June to discuss Advanced Practice strategic workforce plan with HEIW, Six Goals Leads and Commissioners
		• £220k education allocation for advanced practice for 2023/24, expected uplift due in 24/25.
		• Outcome of discussions included:
		  • Consensus that APP expansion is a key opportunity to support NHS Wales supply w/f constraints and future demand challenges
		  • Recognise need for longer-term funding commitment
		  • Impact of APP recruitment on EMT/Paramedic workforce
		  • Concerns around APP utilisation rates
			• Explore opportunities via strategic national forums to promote APP solution (increased engagement & promotion)
			• WAST to pick up actions through APP Test of Change to provide evidence base for utilisation levels and clinical outcome reporting

Engagement			
Bevan Conference	**On Track**	• WAST have been invited to provide a stand at the Bevan Commission Conference - The Tipping Point: Where next for health and care? • Opportunity for WAST, to use this platform to present the Trust's future ambition and plans for "Inverting the Triangle"	• Conference on 5th-6th July 2023 • Arrangements in place including an RRV & 2x large screens

Inverting the Triangle – Progress & Planning Report

Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Rachel Marsh
Jun-23			Note progress and updates reported.	Head of Strategy:	James Houston
				Project Manager:	Sarah Parry

Workstream	Status	Current Position	Forward View
Tests of Change			
APP "Perfect Day" Project – PDSA1	**On Track**	• Pilot complete on 19th June, with an additional 5 APPs from within the Clinical Directorate to "flood" the Cardiff & Vale area, operating from 09:30 – 17:30 • Initial key finding shared with TSAG (26th June) and STB (4th July)	• Finalise PDSA 1 Evaluation Report • Develop PDSA 1 presentation to inform the Health Minister • QIA and EQIA to be agreed at CQGG • Planning to commence for PDSA 2
Advanced Clinical Practice Improvement Plan	**On Track**	• Agreement at Optimising Care Group (9th May) to establish an Advanced Clinical Practice Delivery Group to develop, coordinate and deliver the Advanced Clinical Practice Improvement Plan • Workshop held 1st June to identify key workstreams and projects that sit within the Improvement Plan • Terms of Reference agreed by Optimising Care Group (6th June)	• First meeting to be scheduled beginning of July • Project Manager developing the overarching project plan.
Advanced Practice 111/CSD	**On Track**	• Circa £30k HEIW education funding ear marked for Advanced Practice education for Integrated Care • Proposal to G2C Programme Board (23-Jun) to consider proposal, 2 x places provisionally agreed for exploration pending further discussion with EMT.	• Expressions of interest to be offered to suitable staffing groups
SBRI Project - Lucsii	**On Track**	• Pre-workshop process mapping with Lucsii and WAST Clinical Leads completed • Process Mapping event held with wider stakeholders on 28th June • 'Drop in & play' showcase session undertaken on 30th June (South) • £70k funding agreed for Phase 2 to provide dedicated CSD leadership / clinical support	• 'Drop in & play' showcase session scheduled for 11th July (North) • Outputs from the process mapping event to be considered by WAST to support decision making for Phase 2
SBRI Project - Fujifilm	**On Track**	• Pre-workshop process mapping with Fujifilm and WAST Clinical Leads completed • 'Drop in & play' showcase session undertaken on 30th June (South)	• Process Mapping event to be held with wider stakeholders on 12th July • 'Drop in & play' showcase session scheduled for 11th July (North) • Outputs from the process mapping event to be considered by WAST to support decision making for Phase 2

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

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – May 2023

MEETING	Finance & Performance Committee
DATE	17th July 2023
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning & Performance Mark Thomas – Commissioning & Performance Manager
CONTACT	Hugh.bennett2@wales.nhs.uk Mark.Thomas12@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **May 2023.** The report puts forward a revised set of metrics for 2023/24 for agreement.

2. This report contains information on key indicators. The indicators used at this high-level show an easing of system pressure, in particular, handover lost hours and therefore improved quality and performance for the Emergency Medical Service (EMS), but the operating context remains very challenging. 111 performance is improving, 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. 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.

RECOMMENDATION

Finance and Performance Committee is asked to: -

- **Consider** the May 2023 Integrated Quality and Performance Report and actions being taken and determine whether:
  - a) The report provides sufficient assurance.
  - b) Whether further information, scrutiny or assurance is required, or
  - c) Further remedial actions are to be undertaken through Executives.

- **Agree** the new metrics for 2023/24 for onward approval at Trust Board.

SITUATION

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **May 2023.**

2. This report also sets out a revised set of metrics for 2023/24 further to discussion at the Finance and Performance Committee in May 2023 and a Board Development session in June 2023.

BACKGROUND

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

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

4. These four areas of focus broadly correlate with the Quadruple aims set out in '*A Healthier Wales*'.

5. As previously agreed, the metrics which form part of this committee/Board report will be updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (Integrated Medium-Term Plan - IMTP) and strategies. This report is based upon the annual review that was endorsed at the July 2022 Finance & Performance Committee.

ASSESSMENT

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

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

7. **999** answering times, having been challenging across winter, have now been on target for the last 5 months.

8. **111 call answering is improving,** with the call abandonment target of 5% almost achieved in May and 42% of calls answered within 60 seconds, although this remains substantially off target (95%). Negotiations with commissioners

have indicated that funding is available for 198 call handlers and recruitment has been underway to secure this number, but there remain a number of vacancies. The number of vacancies will increase as we move through the year with limited opportunity to recruit as a result of the SALUS implementation and urgent consideration is being given internally to how this risk can be mitigated. Further work is required to reduce capacity lost through sickness absence, aligning capacity with demand and improving the efficient use of resource. A priority is now re-rostering 111, which is dependent on commissioners initiating the procurement process.

9. **111 Clinical response:** whilst the Trust continues to see achievement of the clinical call back time target for the highest priority 111 calls (P1CT – 98.9%) the P2 and P3 call back times continue to remain slightly below the 90% performance target, with the respective figures for May being 83% and 83%. Numbers of clinicians are now broadly at agreed establishment levels (recently agreed as 100 WTE).

10. **Ambulance Response** (safety / patient experience): the Red 8-minute response performance for May 2023 was 54.4%, a further improvement when compared to April 2023, but still below the 65% target. The Amber 1 median was 55 minutes (ideal 18 minutes) and the Amber 1 95th percentile was just over 4 hours. Although both times show improvement, these long response times continue to have a direct impact on outcomes for many patients. Actions within the Trust's control include:

    Capacity:
    - Recruitment: Confirmation has been received of further non recurrent funding in 2023/24 to support the 100 WTE staff recruited in 2022/23. Work will continue through the year to ensure that establishment remains at commissioned levels.
    - Some additional funding has also been made available to pilot the new Connected Support Cymru service in partnership with St John Cymru.

    Efficiency (rosters, abstractions/sickness absence and post-production lost hours)
    - The Managing Attendance Programme continues, which includes seven work-streams. This has reduced overall sickness levels, with further work to reduce to 6% in 2023/24. There remain risks associated with delivery of this level of improvement.

    Demand Management
    - The increase in Clinical Support Desk capacity has meant that the Trust has been able to increase its consult and close rate, achieving 14.1% in May 2023, with a further target to achieve 17% in 2023/24.

    Red Improvement Actions

- The full roll out of the Cymru High Acuity Response Units (CHARUs). Recruitment and training is being undertaken at pace with the aim to fully populate the CHARU rosters keys (153 full time equivalents (FTE)). The Trust is commissioned for 52 FTEs currently, so the 89.5 FTEs is an internal movement between the emergency ambulance roster and the CHARU rosters, not additional resource.
- The clinical screening of Red calls. This is being undertaken within additional resource, when possible, but ideally clinical screening, as previously modelled, would require additional FTEs. A further request to model the balance between consult & close v clinical screening is currently being actioned.
- A more efficient response logic, which went live on 19 June 2023.

11. One of the key factors in relation to response times is the capacity lost to handover outside Emergency Departments. Over 20,000 hours were lost in May 2023, a decrease compared to the 23,000 hours lost in April 2023; however, the levels remain so extreme that all the actions within the Trust's control cannot mitigate and offset this level of loss. There has been a noticeable improvement in Cardiff & Vale's handover lost hours linked to an organisational focus, with other health boards reporting that they are seeking to learn lessons. Immediate Release figures for May 2023 were: Red 159 accepted and 10 declined; and Amber 1 100 accepted and 232 declined.

12. Modelling has indicated that red performance could improve by 7% to around 58% as a result of the CHARU implementation, red logic changes and a reduction to 15,000 lost hours. Further modelling is currently being undertaken to determine the further potential improvements in line with a reduction to 12,000 hours, an improvement to 6% sickness and the increase in consult and close rates.

13. **Ambulance Care (formally NEPTS) (Patient Experience)**: Oncology performance was on target (70%) in May. Discharge performance improved slightly to 83% (target 90%). Overall demand for the service continues to increase, although it has not yet recovered to pre-COVID-19 levels. The Trust has a comprehensive Ambulance Care Transformation Programme in place, which includes delivering a range of efficiencies and improvements, for example: improved procurement through the plurality model, aligning clinic patient ready times to ambulance availability, re-rostering (NET Centre and NEPTS transport) and addressing oncology performance.

14. **National Reportable Incidents (NRIs) / Concerns Response**: The Trust reported 8 NRIs to the NHS Executive in May 2023, the same as in April 2023; 25 serious patient safety incidents were referred to health boards under the Joint Investigation Framework, which has now been adopted NHS Wales wide. In May 2023 complaint response times decreased slightly to 32%, failing to meet the 75% target with cases remaining complex. Reviews of lower graded concerns are

being undertaken to ensure proportionate investigations are undertaken. The Trust has put more capacity into the Putting Things Right (PTR) team, which has had a positive impact for the Legal Team until periods of long-term sickness absence. The Concerns Administrators responding to patients and families continue to have lengthy and repeated calls due to protracted response times in the community, compounded by an inability to always respond in a timely manner to their concerns and questions. The Trust is concerned for the welfare of the team, given the nature and volume of the PTR work across all functions and a number of supportive actions are progressing/planned for both the corporate team and EMS Coordination & Resourcing.

15. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 74.5% in May 2023**,** below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system. The return to spontaneous circulation (ROSC) rate moved above 20% in May, the highest recorded by the Trust.

Our People (workforce resourcing, experience, and safety)

16. **Hours Produced**: The Trust produced 124,692 Ambulance Response ambulance unit hours in May 2023, its highest recorded level since the start of the clinical response model. Emergency ambulance unit hours production (UHP) was 97% in May 2023, thus achieving the 95% target. CHARU UHP also increased month on month to 121% in May (note this is of the commissioned level, not full roll out). Key to the number of hours produced are roster abstractions, which remain above benchmark, but are reducing i.e. improving.

17. **Response Abstractions:** abstraction levels increased to 34.27% in May 2023, remaining above the 30% benchmark. A deep dive is being organised on abstractions. EMS Response sickness abstractions stood at 9.44% in May 2023 (benchmark 5.99%).

18. **Trust sickness absence:** the Trust's overall sickness percentage was 8.33% in March 2023 and improved to 8.04% in April 2023. Actions within the IMTP concentrate on staff well-being with an aim to start to reduce this level.

19. **Staff training and PADRs:** PADR rates did not achieve the 85% target in May 2023 (72.04%), compliance for Statutory and Mandatory training increased slightly to 76.32%.

Finance and Value

20. **Financial Balance**: The reported outturn performance at Month 2 is a deficit of £22k, with a forecast to the yearend of breakeven.

Partnerships/ System Contribution

21. **Shift left:** much of Trust's work relates to working with health boards and other partners to provide the right care closer to home and reducing the number of patients who need to be conveyed to hospital. Good progress has been made through the year in increasing **consult and close** rates after 999 calls; and the Trust achieved 14.1% in May 2023, close to the Trust's 2022/23 IMTP ambition of 15%.

22. The Trust **conveyed** 40.3% of patients to emergency departments in May 2023. This figure needs to be treated with caution as analysis shows that conveyance rates are linked to pressures within the system and the application of the Clinical Safety Plan (CSP), which will trigger the Trust being unable to send ambulances to lower acuity calls, with many patients cancelling the ambulance due to the long response times. In May 2023, 8,044 patients cancelled their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 197 callers. A formal programme to take forward "inverting the triangle" has been established. The Trust has proceeded with growing the numbers of APPs in training. The current focus is on developing a "strategic case for change" and a stakeholder engagement process.

Summary

23. The indicators used at this high-level show an easing of system pressure, in particular, handover lost hours and therefore improved quality and performance for the Emergency Medical Service (EMS), but the operating context remains very challenging. 111 is improving, 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. 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.

Review of metrics

24. Each year a review of Board level metrics is undertaken. A presentation was provided to Finance and Performance Committee in May 2023 setting out some proposed changes. These were discussed further at EMT and at a Board development meeting in June 2023. As a result of these discussions a number of changes have been made and the final set of metrics is set out in Appendix 2 attached to this report. A total of 43 metrics are proposed, which is a slight increase in those which have been reported this year.

25. At the Board development session, there was a discussion about further iterations and considerations. In particular, it was felt that it would be helpful to be able to pull out and visualise those metrics which linked specifically to our long-term ambition and the inverting the triangle strategy and some initial ideas were presented which will be developed further. In addition, board members discussed the potential, over time, to develop a more tiered approach, with a

smaller set of metrics at Board and a more detailed set for each of the sub committees. It was noted that the one set enabled a reduction in workload and also ensured that each sub committee continued to review metrics in an integrated way. Further thinking will be undertaken through the year.

26. The proposed new set of metrics for this year will need to be approved at the Board meeting in July.

RECOMMENDATIONS

The Finance and Performance Committee is asked to: -

- **Consider** the May 2023 Integrated Quality and Performance Report and actions being taken and determine whether:

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

- Agree the new metrics for 2023/24 for onward approval at Trust Board.

REPORT APPROVAL ROUTE	
Date	**Meeting**
12 July-23	**Executive Management Team**
17 July-23	**Finance & Performance Committee**

REPORT APPENDICES
Appendix 1 – Top Indicator Dashboard **Appendix 2 – Review of Board level metrics**

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

Welsh Ambulance Services NHS Trust

Monthly Integrated Quality & Performance Report

May 2023

Annex 1 – Top Indicator Dashboard

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

Annex 1 – Top Indicator Dashboard
Version 1.0
Released: June 2023

by Commissioning & Performance Department

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2023/24	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	2 Year Trend	RAG
Our Patients - Quality, Safety and Patient Experience															
Timeliness Indicators															
NHS111 Call Handling Abandonment Rates	< 5%	15.0%	15.6%	13.3%	11.2%	14.8%	13.6%	49.5%	16.0%	14.9%	15.4%	11.8%	7.9%		R
111 Clinical Triage Call Back Time (P1)	90%	96.8%	96.9%	98.5%	97.9%	98.3%	97.2%	94.9%	99.0%	99.3%	98.5%	98.9%	98.9%		G
999 Call Answer Times 95th Percentile	95% in 00:00:06	00:50	00:57	00:36	00:52	01:03	01:11	01:34	00:03	00:03	00:06	00:03	00:03		G
NEPTS Call Answering	Improvement Trend	06:02	07:44	08:28	05:36	03:22	03:32	02:38	01:47	02:08	01:08	01:43	01:18		A
999 Red Response within 8 minutes	65%	50.8%	52.0%	50.7%	50.0%	48.0%	48.0%	39.5%	48.9%	50.9%	47.5%	53.0%	54.4%		R
999 Amber 1 Median	00:18	01:30	01:40	01:16	01:30	01:42	01:34	03:30	00:50	00:55	01:35	00:59	00:55		R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	71.9%	74.3%	73.1%	70.5%	71.3%	72.4%	71.7%	76.6%	75.5%	73.4%	76.5%	69.9%		A
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	87.1%	85.0%	86.0%	88.0%	85.0%	90.0%	90.0%	90.0%	78.5%	82.7%	82.2%	83.0%		A
Clinical Outcomes / Quality Indicators															
Return of Spontaneous Circulation (ROSC)	Improvement Trend	-	-	-	-	-	15.9%	14.2%	17.8%	15.9%	14.0%	16.0%	20.7%		A
Stroke Patients with Appropriate Care	95%	82.3%	82.5%	78.6%	79.1%	78.2%	80.2%	79.4%	76.2%	76.6%	72.2%	80.1%	74.5%		R
Acute Coronary Syndrome Patients with Appropriate Care	95%	44.3%	32.3%	43.9%	51.0%	44.0%	51.3%	37.9%	49.4%	42.1%	46.3%	38.3%	47.5%		R
National Reportable Incidents reports (NRI)	Reduction Trend	3	2	10	7	8	2	0	5	12	3	8	8		R
Can't Send & Cancelled by Patient Volumes	Reduction Trend	11,911	13,039	11,073	10,605	11,482	10,087	13,556	7,086	6,938	10,012	7,687	8,044		R
Concerns Response within 30 Days	75%	13%	22%	24%	28%	28%	24%	27.0%	21.0%	24.0%	20.0%	44.0%	32.0%		R
Our People															
Capacity															
Hours Produced for Emergency Ambulances	95-100%	94%	94%	95%	96%	90%	92%	91%	97%	95%	95%	98%	97%		G

Top Monthly Indicators	Target 2023/24	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	2 Year Trend	RAG
Health & Well-being															
Sickness Absence *(all staff)*	6.0%	9.19%	10.35%	8.72%	8.68%	9.48%	8.77%	10.65%	8.92%	8.06%	8.33%	8.04%	-		A
Mental Health Absence Rates	Reduction Trend	2.22%	2.36%	2.33%	2.30%	2.30%	2.44%	2.41%	2.36%	2.04%	2.12%	2.08%	-		A
Staff Turnover Rate	Reduction Trend	11.54%	11.64%	11.50%	11.35%	11.11%	10.70%	10.64%	10.69%	10.86%	10.38%	10.28%	9.89%		A
Statutory & Mandatory Training	>85%	85.13%	85.17%	85.44%	85.60%	85.58%	85.40%	84.63%	76.51%	60.10%	65.05%	75.55%	76.32%		R
PADR/Medical Appraisal	>85%	59.25%	64.66%	73.66%	78.75%	80.49%	80.75%	87.89%	79.12%	78.71%	72.10%	73.0%	72.0%		A
Number of Shift Overruns	Reduction Trend	3,843	3,960	3,785	3,786	3,901	3,758	3,799	3,720	3,431	4,064	3,839	4,087		R
Inclusion & Engagement / Culture															
NHS111 Welsh Call Volumes	TBD	28.0%	25.7%	29.5%	35.1%	28.8%	30.3%	15.8%	41.2%	31.7%	33.9%	36.6%	44.1%		TBD
NEPTS Welsh Call Volumes	TBD	0.8%	0.7%	0.6%	0.7%	1.2%	1.3%	0.8%	0.7%	0.9%	1.1%	1.4%	1.8%		TBD
Value															
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		G
EMS Utilisation Metric (All Vehicles)	Improvement Trend	61.0%	61.8%	61.6%	61.8%	62.6%	61.2%	64.6%	56.0%	56.6%	61.4%	58.8%	56.3%		A
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.50	2.51	2.46	2.43	2.46	2.48	2.38	2.23	2.32	2.28	2.39	2.45		A
NEPTS on the Day Cancellations	Reduction Trend	19.9%	19.3%	18.9%	19.9%	19.7%	18.3%	23.2%	19.4%	20.4%	21.6%	18.3%	17.8%		A
Partnerships / System Contribution															
Inverting the Traingle															
Successful Consult & Close Outcome	17.0%	11.9%	11.7%	11.7%	12.2%	12.8%	12.6%	14.6%	14.9%	14.2%	13.8%	14.7%	14.1%		R
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Improvement Trend	12.48%	11.95%	11.99%	11.14%	10.65%	11.04%	11.18%	10.72%	10.05%	11.1%	10.7%	11.8%		A
Number of Handover Lost Hours	15,000	23,380	24,021	24,295	25,174	28,038	25,020	32,098	23,525	19,110	28,620	23,082	20,397		R
NHS111															
NHS111 Dental Calls	-	5,927	5,892	6,038	5,913	6,051	5,829	4,657	6,063	5,746	6,668	6,723	6,723		TBD
Consult & Close Volumes by NHS111	Increasing Trend	1,091	1,323	1,283	1,180	1,287	1,196	1,338	811	949	973	996	996		A

In-Month RAG Indicates =

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

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

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

TBD: Status cannot be calculated (To Be Determined)

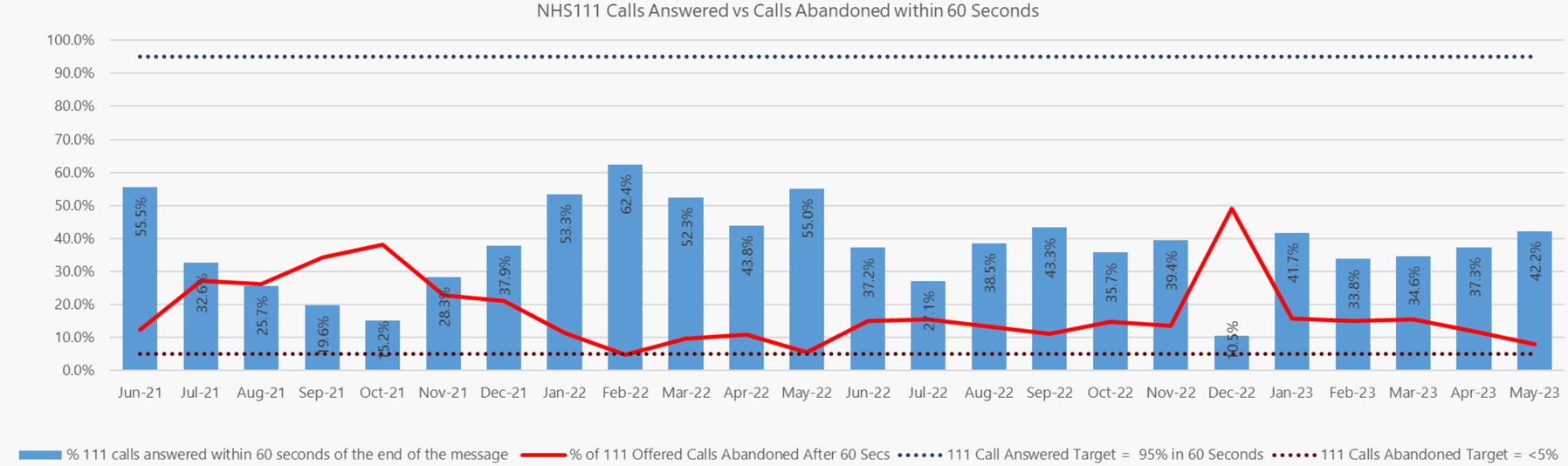
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators

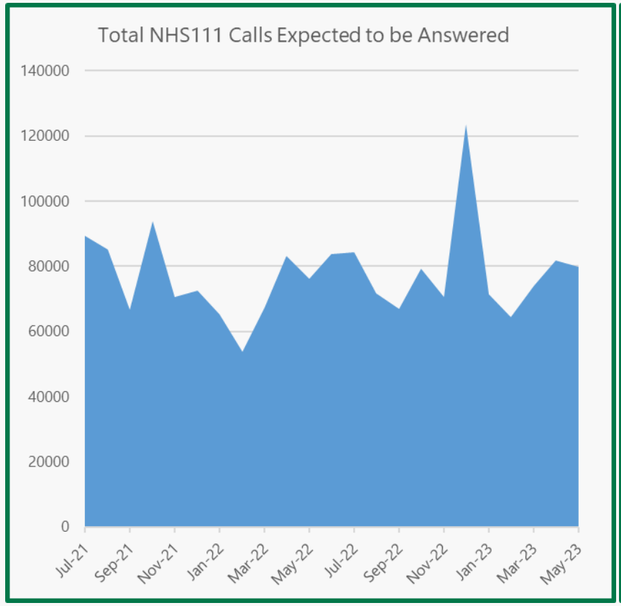
(Responsible Officer: Lee Brooks)

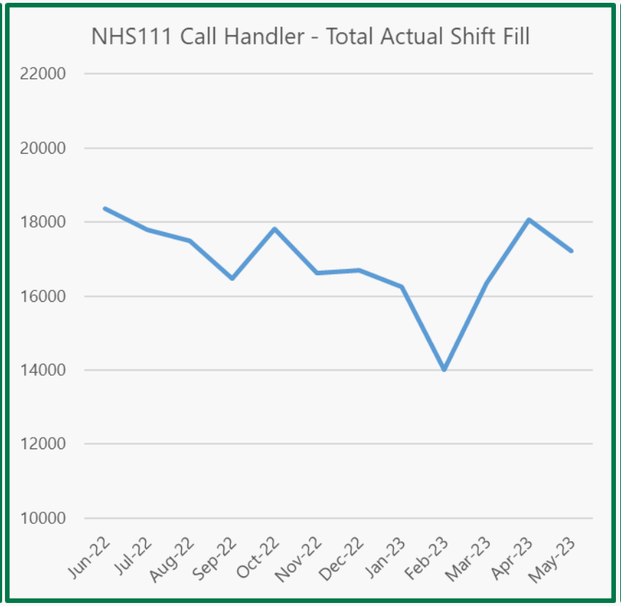
R

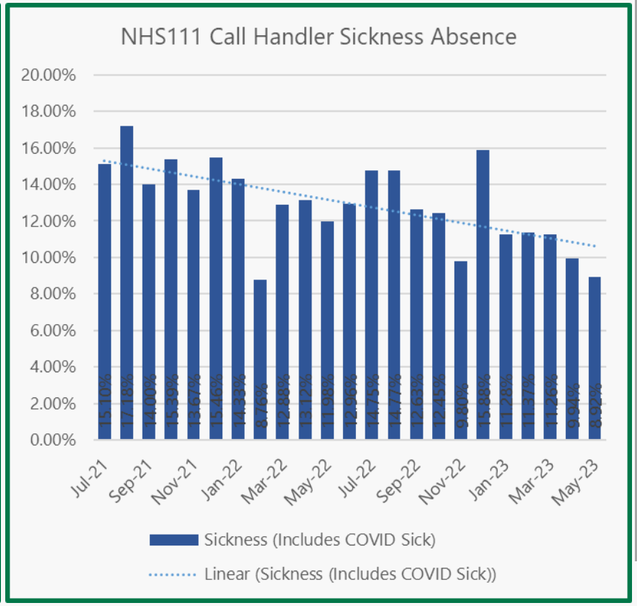
FPC

Influencing Factors – Demand and Call Handling Hours Produced









Analysis

111 call abandonment is a key patient safety indicator for the service. May 2023 saw an **abandonment rate of 7.9%,** an improvement when compared to the 11.8% figure seen in April 2023, and the 15.4% recorded for March 2023.

The percentage of 111 calls answered within 60 seconds of the end of the message increased again in May 2023 to 42.2%, the third consecutive month in which an improvement has been seen.

Total capacity measured through shift fill decreased in May but remains relatively high compared with the last six months.

Remedial Plans and Actions

The key to improving call answering times is having the right number of call handlers, rostered at the right time to meet demand, and to maximise efficiency.

- Agreement has been reached with commissioners that 198 WTE call handlers will be funded in 2023/24. The Trust is currently 21.25 FTE short of establishment. The Trust is aiming to address this in quarter four.
- Work continues on sickness absence in line with the Trust's managing absence work programme with an IMTP aim to get organisational sickness down to 6%
- A roster review in three parts is due to start, in collaboration with the 111 commissioners to review rosters and ensure that capacity is aligned to demand, and to try and even out performance through the week. This is not timetabled to be implemented before Christmas.
- Work also continues in reviewing the use of the Clinical Advice Line which is available to call handlers who want some clinical advice whilst on call with the patient. The call handler has to wait for a clinician to answer the call and therefore call times are related to clinician availability. In May, the % of calls passed to the CAL was 24%, a reduction from 34% in recent months.

Expected Performance Trajectory

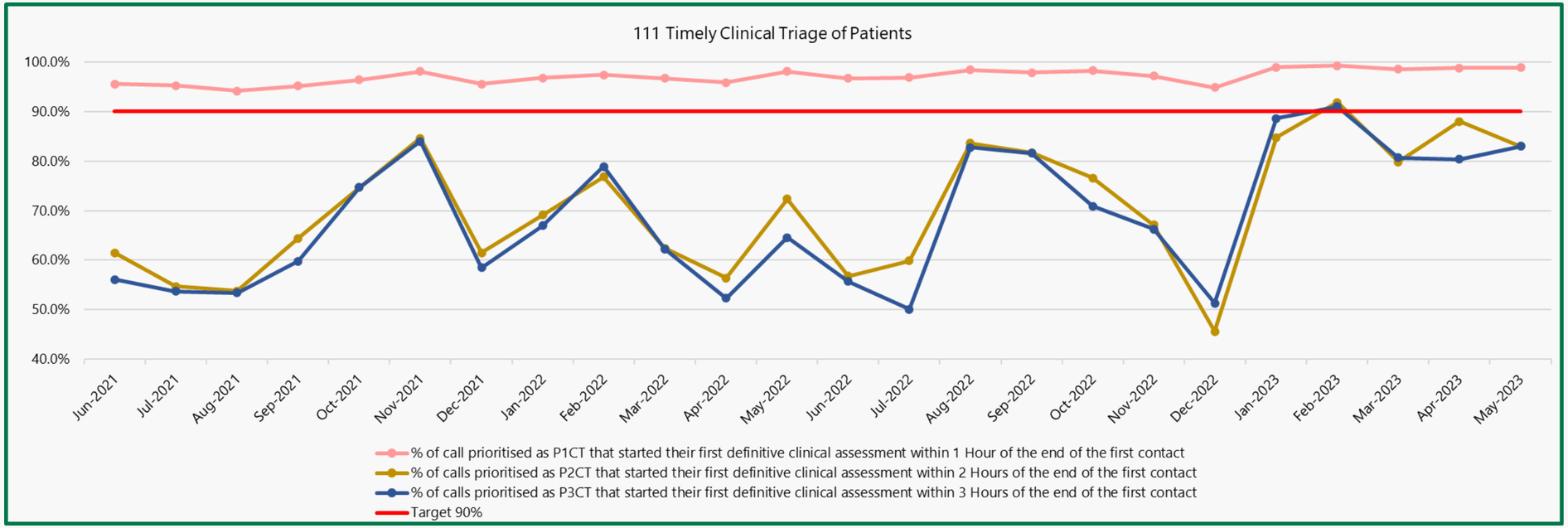
As call handler numbers reduce through the SALUS implementation phase and additional abstractions for SALUS training are accommodated performance is expected to deteriorate month on month until Q4. Agreed further action to address this.

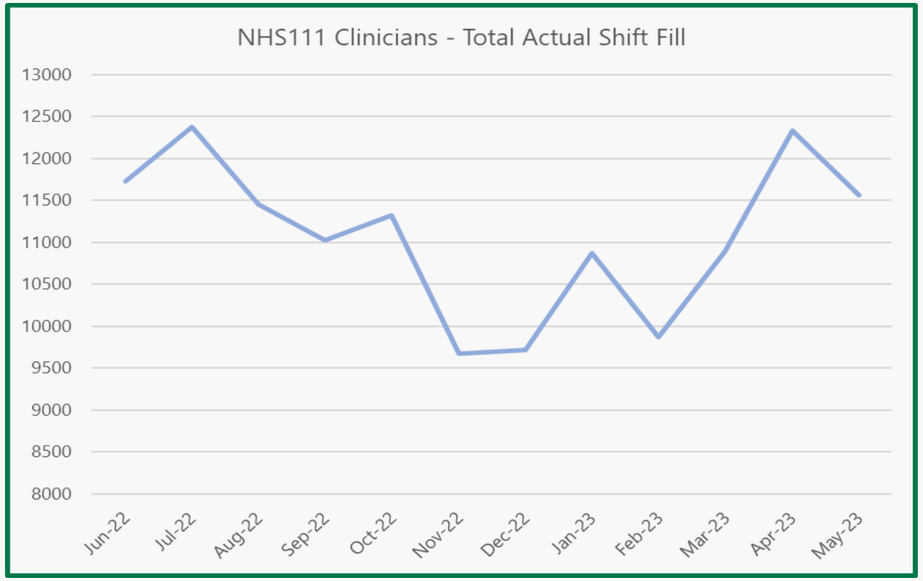
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators
Influencing Factors – Demand and Clinical Hours Produced

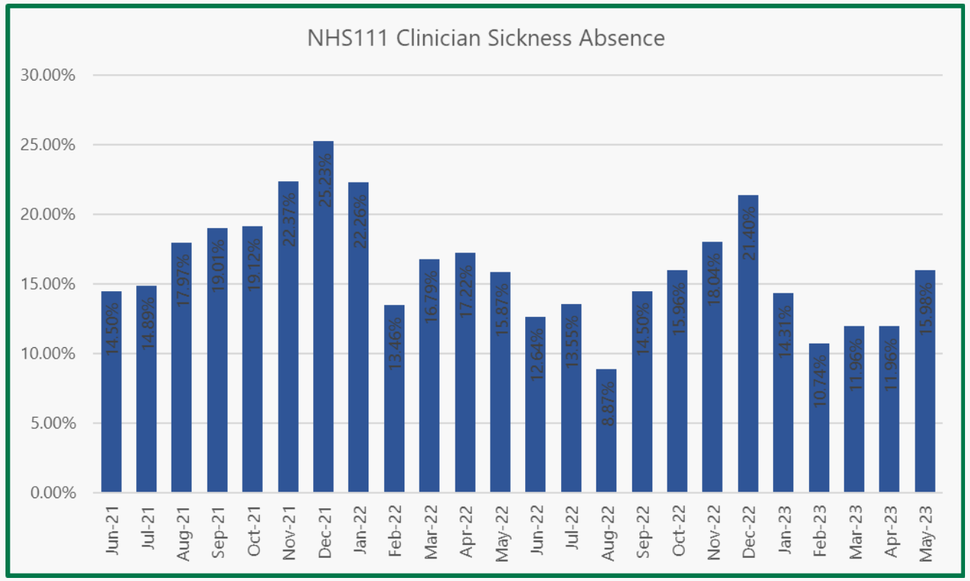
(Responsible Officer: Lee Brooks)

P1CT G

FPC







Analysis
The highest priority calls, P1CT, continues to achieve the 90% target (98.9%).

For lower category calls P2CT decreased in May 2023 when compared to April 2023, achieving 83% while P3CT rose slightly, also to 83%.

Clinical staff capacity is the key issue. 11,561 hours were filled by clinicians in May 2023, a decrease when compared to April 2023. Clinician sickness absence increased to 15.98% in May 2023, from the 11.96% seen during April 2023.

Remedial Plans and Actions
The main driver for improved performance will be the correct number of clinicians in post to manage current and expected demand. At present 103.71 FTE nurses and paramedics are in post, and commissioners have indicated that they have funding available for 100 WTE. Additional staff have been recruited recently which will help the service through the SALUS implementation, with numbers expected to fall to around the 87 WTE mark by the end of the year.

Expected Performance Trajectory
Clinical performance whilst much improved is expected to decline due to attrition and abstractions arising as a result of SALUS.

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

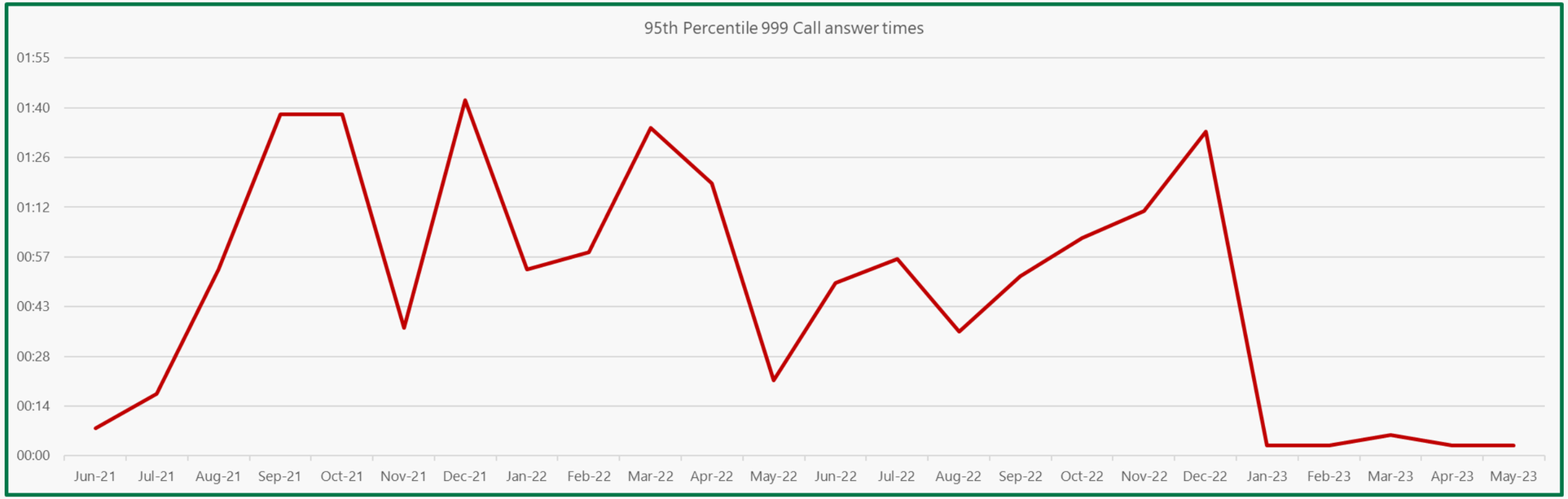
(Responsible Officer: Lee Brooks)

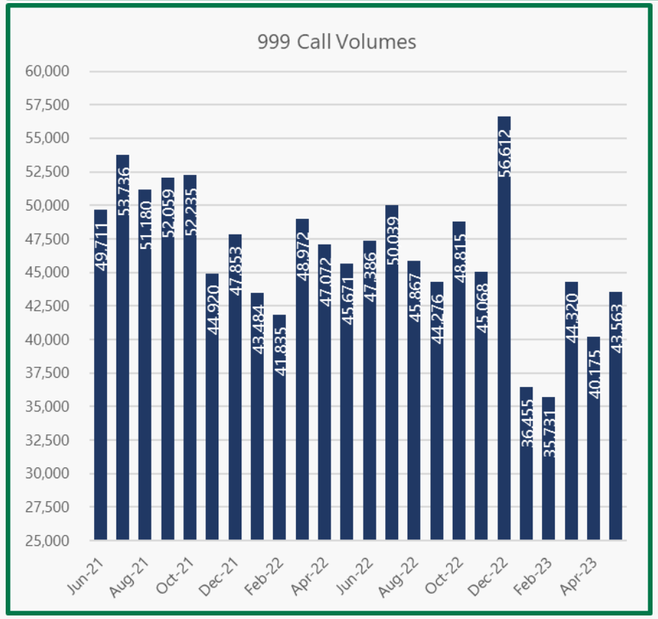
G

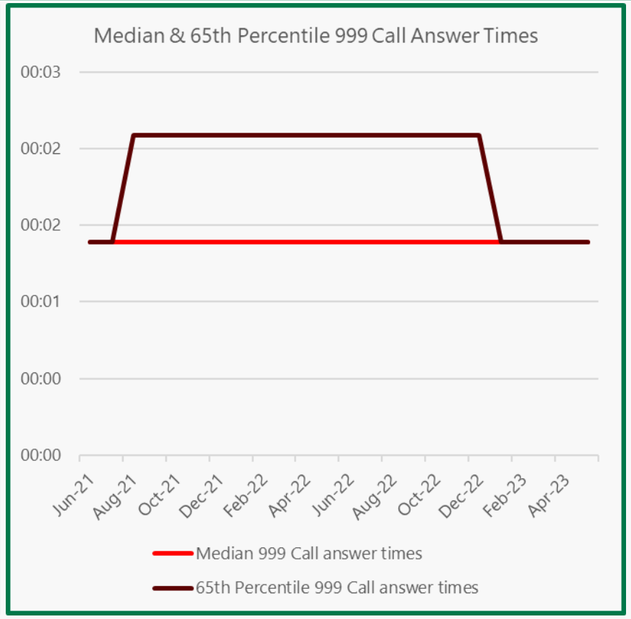
FPC

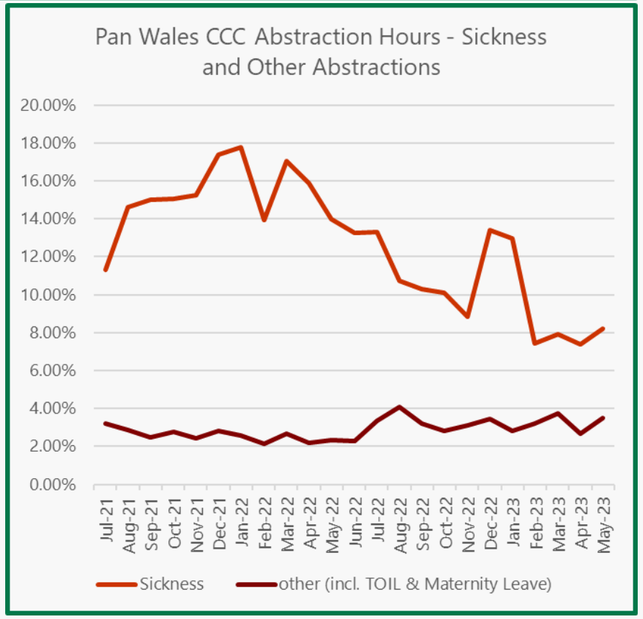
CI

Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance remained at 3 seconds in May 2023, above the 6 second target..

The median call answer time for the 999 service remains consistent at 2 seconds.

The Trust received 43,563 emergency 999 calls in May 2023, an increase from the 40,175 calls received in April 2023.

Overall sickness abstractions are on a downward trajectory, although they increased slightly in May 2023 to 8.22%, which is the first time they have risen above the 8% target since January 2023. Over the past few months lower demand and fewer sickness abstractions has resulted in a positive effect upon call answering times.

Remedial Plans and Actions

- EMS Coordination meet twice weekly to review demand profiles and design tactics for service delivery based on demand, staffing levels and business continuity plans.
- EMD FTE is currently 119.89 against a funded establishment of 111.76. However, this includes new starters still in the sign off period. Once qualified, experienced staff will be re-aligned to vacant dispatcher posts.
- Intelligent Routing Platform is now in operation following configuration changes.
- Five new EMD cohorts were trained during May and June across 3 EMS co-ordination centres. 19 new EMDs are already live call handling from these cohorts with another 11 currently training and due to go live in the next 2 weeks. A further cohort was agreed for North CCC, which will begin training in the next couple of weeks.
- Three workstreams are currently being progressed through the EMS Reconfiguration project (the complete reconfiguration has not commenced due to cost pressures required to fund the agreed model approved by EMT).
  Roster Review. Having successfully implemented an EMD roster review in February 23 the project has now progressed to commencing a dispatch Roster review for Allocators and Dispatchers however this is currently on pause while negotiations continue with TUP
  Boundary changes. In line with ORH recommendations in the Demand & Capacity Review of 2019 EMS Coordination intend to realign dispatch boundaries to balance workload and pressures for individual dispatch teams.
  Broader Ways of Working. This project is looking to create efficiency, effectiveness and improved productivity through a review of processes and procedures as well as providing consistency and lack of variation across centres.

Expected Performance Trajectory

Performance is expected to remain on track, subject to continued good work around capacity management.

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

(Responsible Officer: Lee Brooks)

65% R

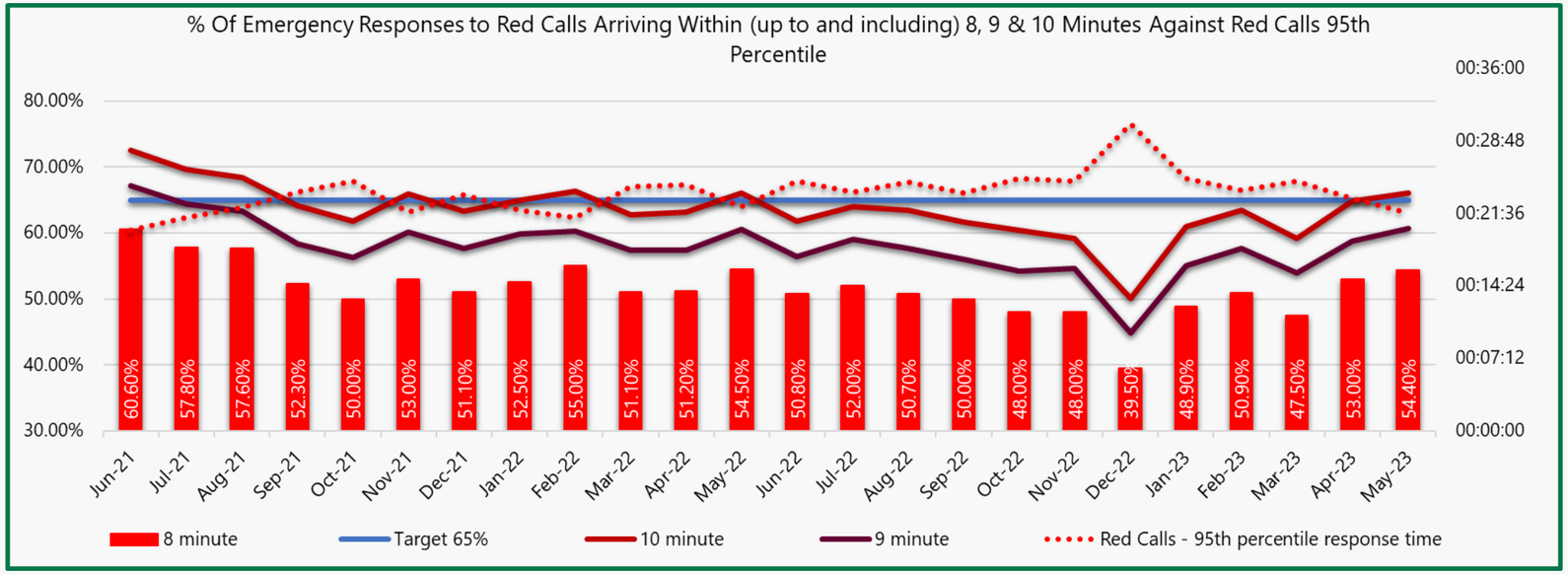
95% R

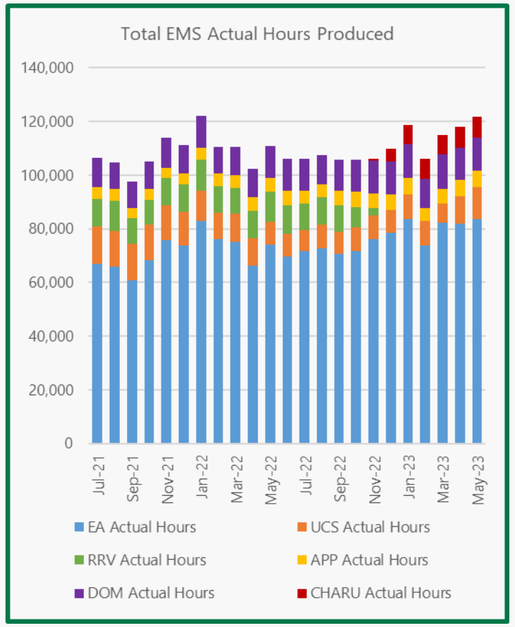
QUEST

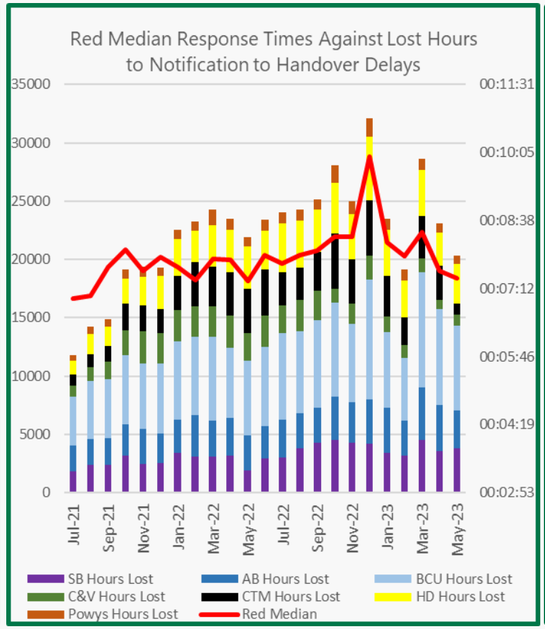
FPC

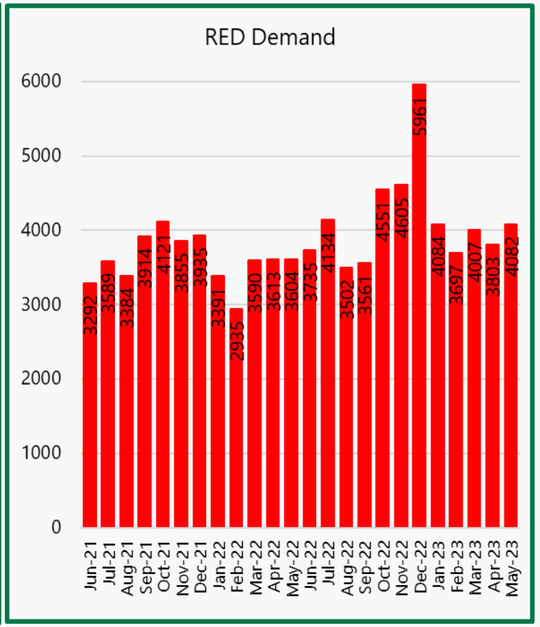
CI

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

Red performance improved again in May 2023, with Red 8-minute performance increasing to 54.4% although it continues to remain below the 65% target. Although there was variation, none of the seven health boards achieved this target. Red 10-minute performance was 66% for May 2023, improving from 64.8% in April 2023.

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

Red demand has generally been increasing over the past two years, reaching a peak in December 2022. Although demand has fallen since that peak, it remains higher than the same period last year.

Hours produced have increased at over 120,000 hours in May which will be contributing to improved performance. .

The lower centre graph demonstrates the correlation between overall Red performance and hospital handover lost hours. Lost hour are now lower than their peak in December, falling again in May 2023 to 20,397 hours lost compared to 23,082 in April 2023. However, these levels remain significantly above where they need to be.

Remedial Plans and Actions

The main improvement actions are:

- To maintain commissioned establishment levels overall. WG have confirmed funding for the additional 100 will remain in place for this financial year
- Full roll out of the Cymru High Acuity Response Unit (CHARU), now largely complete with the exception of some hard-to-reach areas. Further actions to address;
- Potential changes to the response logic and clinical screening of red calls, which are now live (19 June 2023);
- Reduce hours lost through sickness absence via managing attendance programme – trajectory for improvement in place as part of Integrated Medium-Term Plan (IMTP) (8% by Mar-23/6% Mar-24);
- Working closely with Health Boards to support reduction in lost hours and a reduction in conveyances to ED. This is undertaken within local Integrated Commissioning Action Plan meetings and will include work on improvements in referrals to Same Day Emergency Care Units (SDECs).

Expected Performance Trajectory

The Red modelling estimates a 7%-point improvement in Red 8-minute performance if CHARUs are fully rolled out, and associated Red improvement actions are delivered. Including a reduction in lost hours to 15,000.

*NB: Data correct at time of abstraction

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

(Responsible Officer: Lee Brooks)

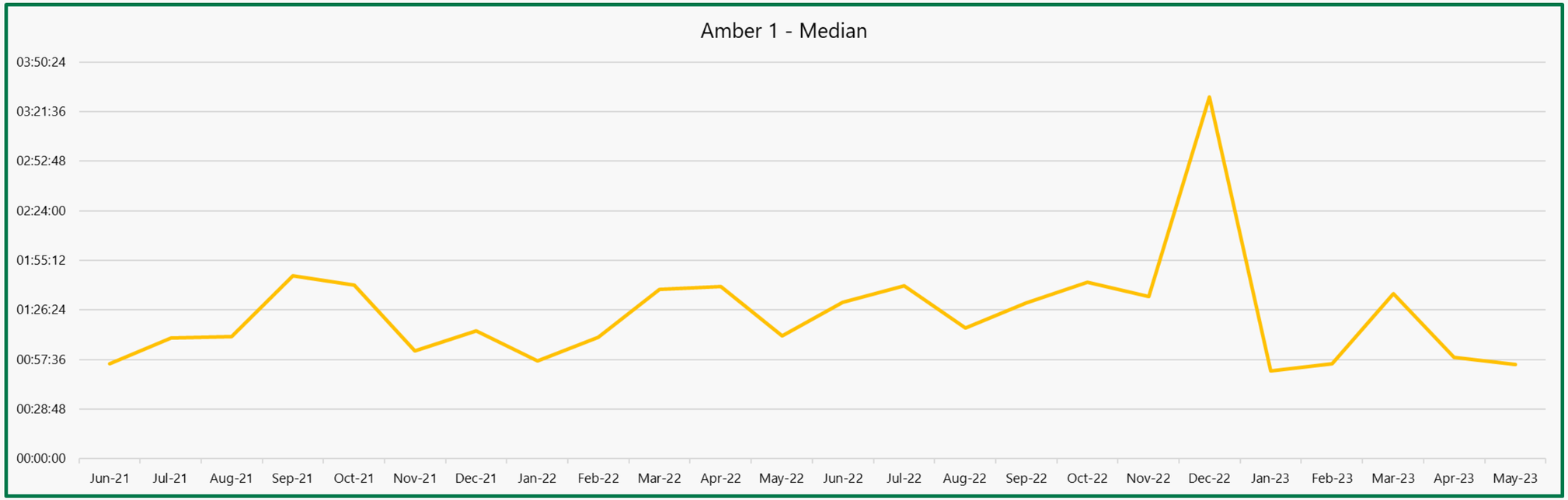
R

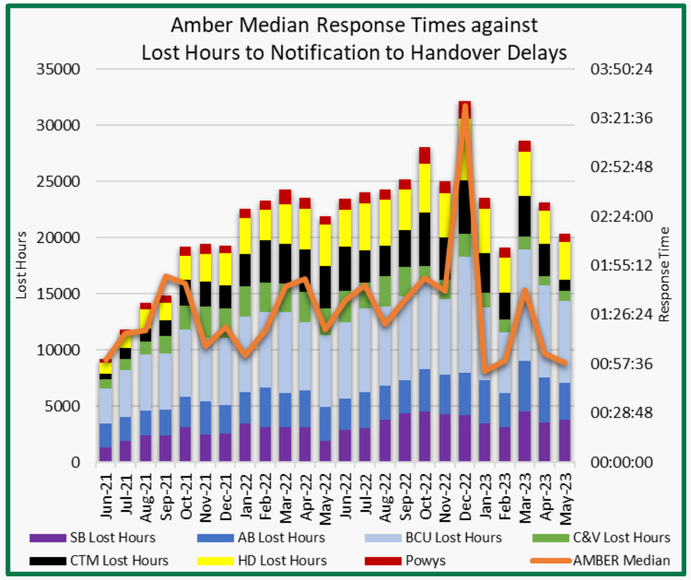
FPC

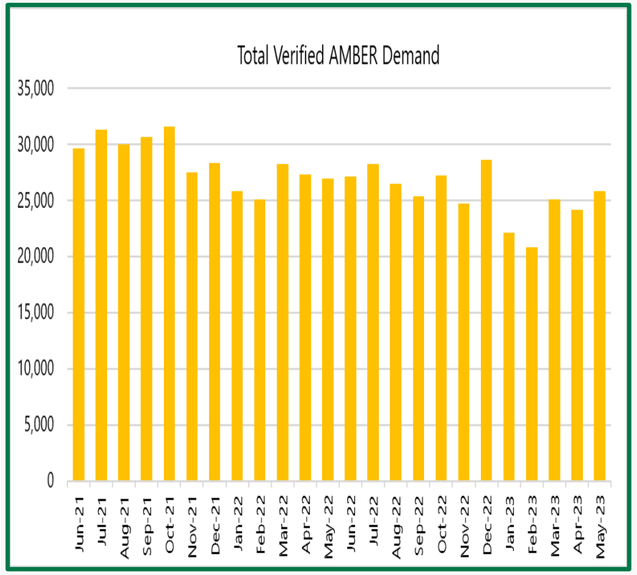
CI

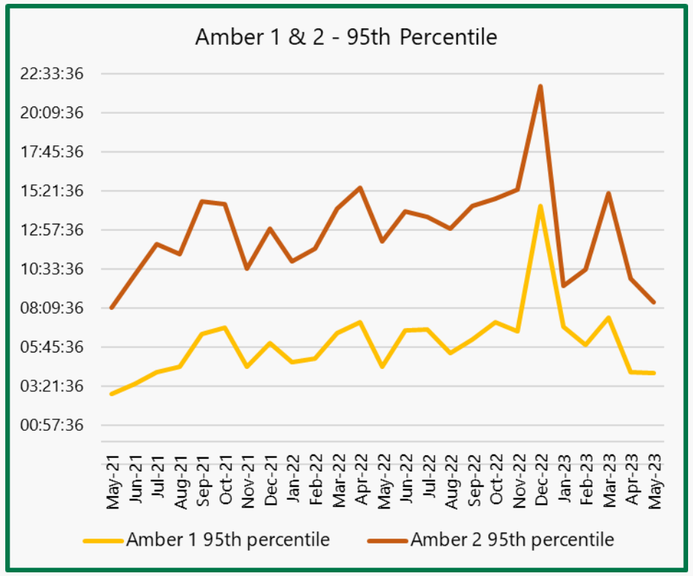
QUEST

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

Amber 1 median improved slightly in May 2023 to 55 minutes, from the 59 minutes recorded in April 2023. The ideal Amber 1 median response time is 18 minutes. The 95th percentile also reduced to 4 hours and 12 minutes.

There were still some long patient waits in May 2023, with 1,697 patients (all categories, not just Amber) waiting over 4 hours. This is however a decrease on the 2670 recorded for April 2023.

Amber demand increased in April 2023 to 25,811 verified incidents.

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

Remedial Plans and Actions

The actions being taken are largely the same as those related to Red performance on the previous slide.

Expected Performance Trajectory

The EMS Operational Transformation Programme is the Trust's key strategic response to Amber. As per the commentary on Red performance delivering these benchmarks is dependent on a range of investments and system efficiencies, not all of which are within the Trust's control.

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

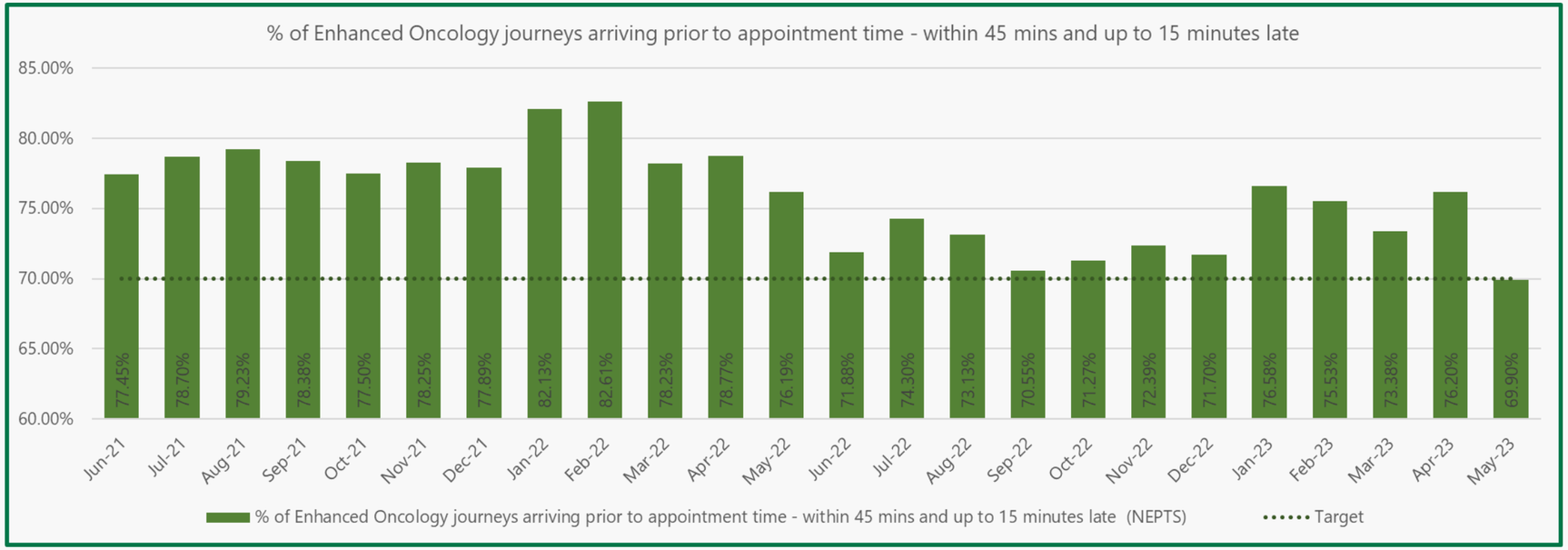
(Responsible Officer: Lee Brooks)

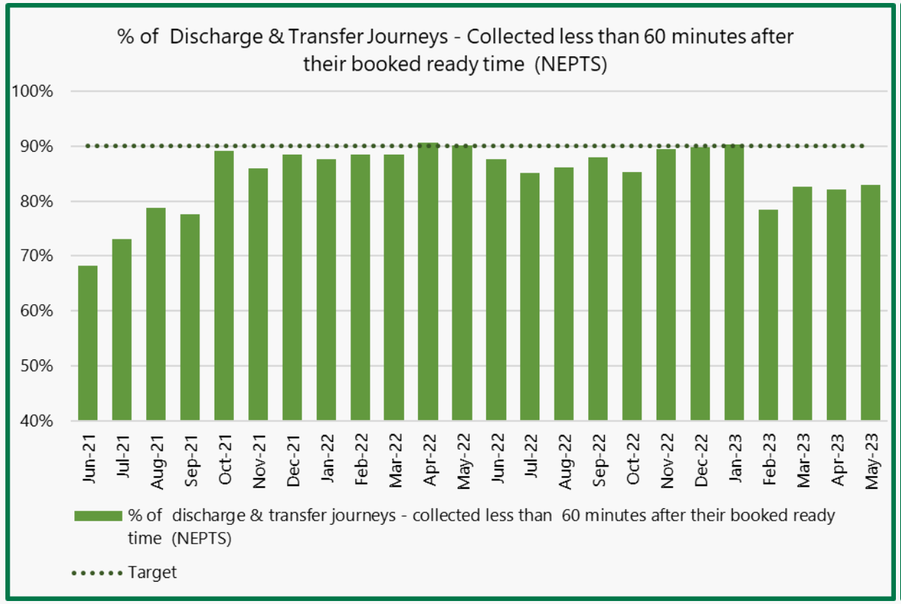
Renal	D&T
G	A

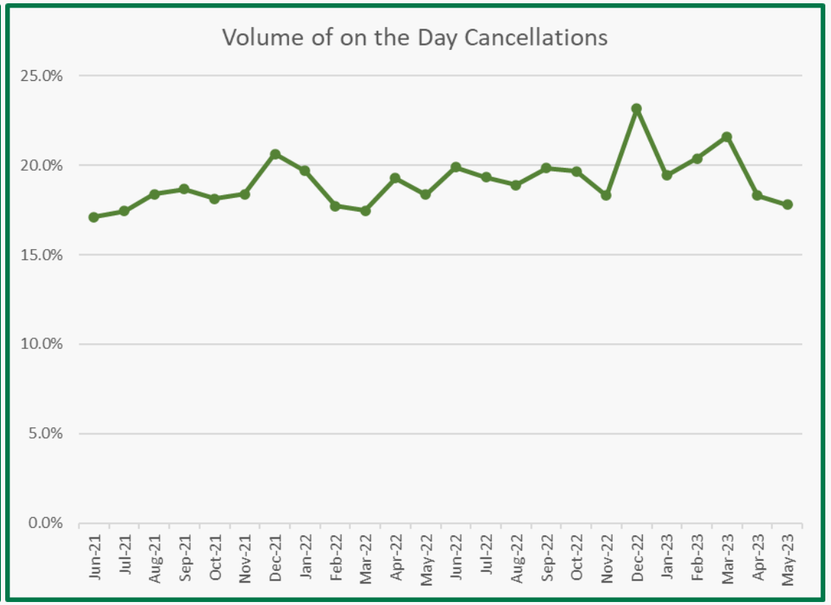
FPC

CI

Patient Experience







Analysis

Ambulance Care (NEPTS element) performance declined during May 2023. 69.9% of enhanced oncology journeys arrived within 45 minutes prior and up to 15 minutes late to their appointment time, down from 76.2% in April 2023, and the first time over the two-year time frame it has failed to achieve the 70% target.

83% of discharge & transfer journeys were collected within 60 minutes of their booked ready time, up slightly in April 2023 (82%), but the fourth consecutive month where the 90% target has not been achieved.

Key factors affecting these indicators are demand and capacity:

- Overall demand has been increasing since the initial reduction at the beginning of the pandemic, but generally it is still not quite at pre-pandemic levels.
- Increased pressure on the unscheduled care system has increased the volume and proportion of on the day, short notice bookings for discharge & transfers
- Days of continuing Industrial Action across the service have adversely affected the Trust's capacity during the past few months.

Remedial Plans and Actions

- D&C Project: roster review of NETPS transport paused as part of IMTP prioritisation exercise.
- Transfer and Discharge Service: work is in progress with regards to the modelling (initial results received, almost complete).
- Transport Solutions: Training of Health Boards for the online booking system was completed in December 2022, and going forward telephone bookings from HCP's will no longer be accepted.
- Updated NEPTS performance parameters went live in April 2023, these will separate out on the day and advance booked journeys. At present most bookings are made on the day, which makes it difficult to respond to within the times allowed. A focus on pre-planned discharge should support work being completed by working groups 5&6 of the 6 goals programme board.

Expected Performance Trajectory

Overall NEPTS performance is stable. At present, the uncertainty around demand as health boards move through system recovery following the pandemic, with the potential addition of austerity and a move to different performance parameters, means that it is difficult to forecast performance. WAST will continue to work with the HBs through the commissioning DAG (NCCU) to deliver the best performance possible for the patient.

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

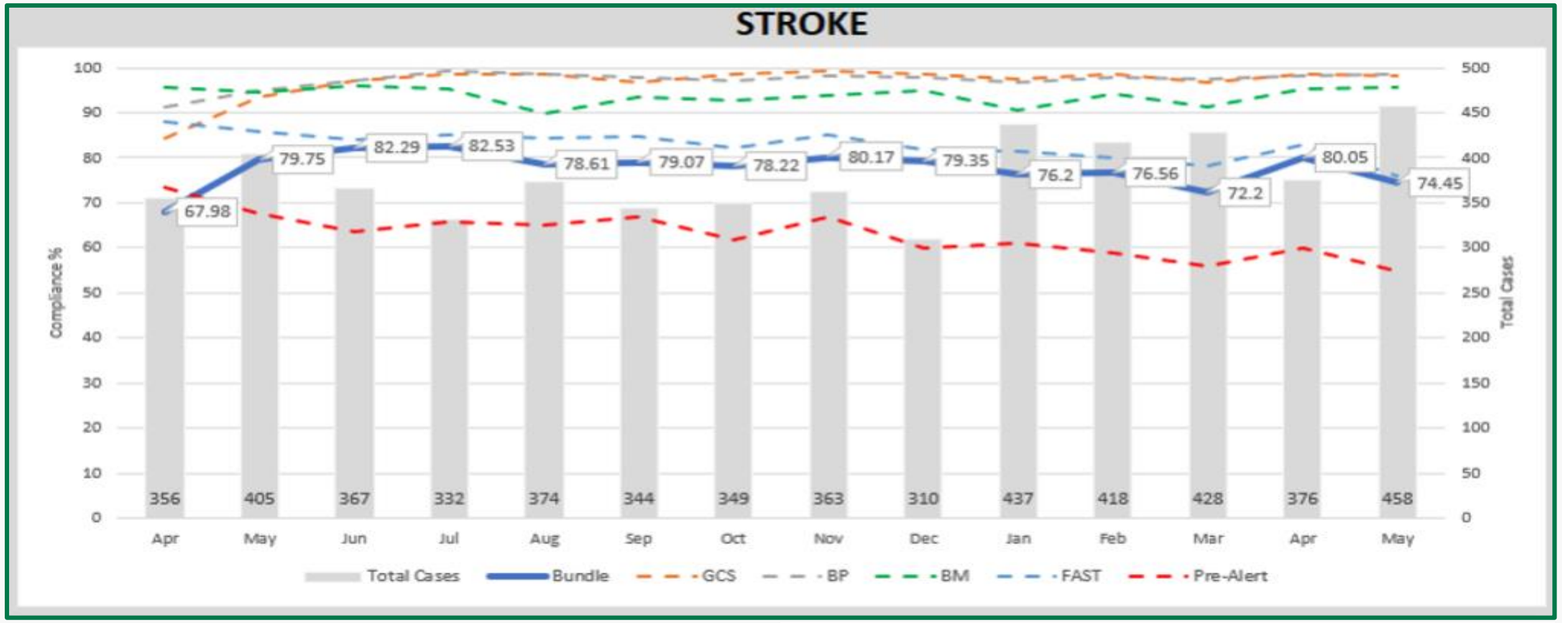
(Responsible Officer: Andy Swinburn)

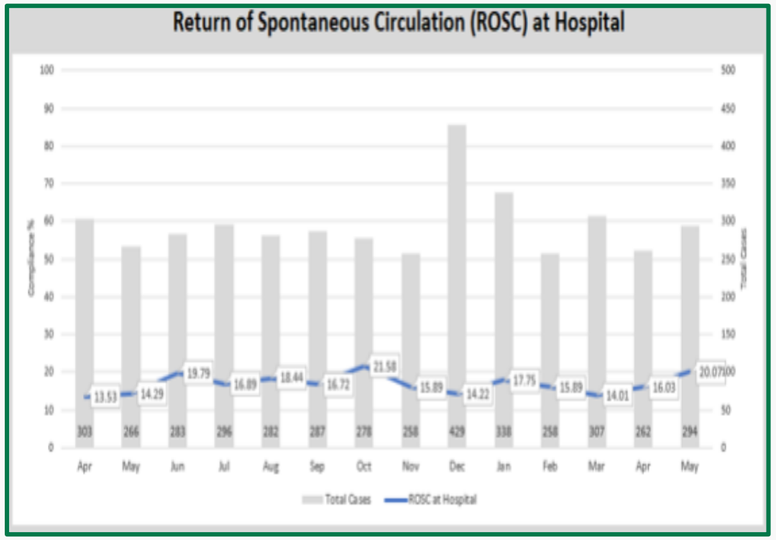
Stroke/Hip Fracture/Hypo glycaemic. R

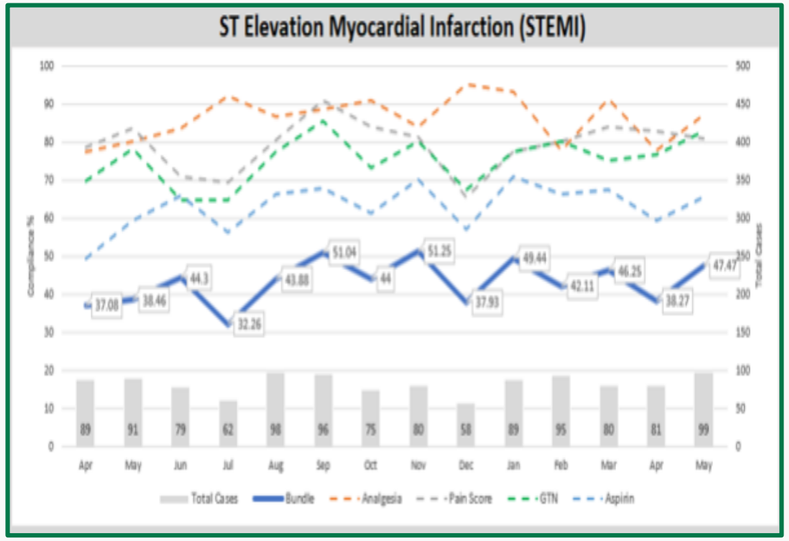
Self Assessment: Strength of Internal Control: Moderate

QUEST

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







Analysis

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

In relation to ROSC rates, these fluctuate from month to month and are impacted by many factors external to WAST.

Remedial Plans and Actions

The Trust's introduction of the Cymru High Acuity Response Unit (CHARU) model, based on improved clinical leadership and enhanced training, will further improve outcomes for patients and ROSC rates. This has been in place since October 2022 in some areas but is currently being extended and rolled out fully. ROSC rates moved up to 20%, their highest recorded

An improvement approach has been taken in relation to accurate reporting of clinical indicator compliance. A series of 'Top Tips' posters have been circulated and specifically shared with Senior Paramedics to support their conversations with WAST clinicians as part of the ride-out process. This is based on deep dive quality assurance audits conducted for each of the CIs and reported through the Clinical Intelligence Assurance Group prior to approving publishing CI data as Ambulance Service Indicators to EASC. In addition, the deep dive quality assurance audits are contributing to recommending improvements that can be made to the ePCR user interface to enable better data capture in future versions of the application, change requests have been submitted to Terrafix and are being processed.

Expected Performance Trajectory

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

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

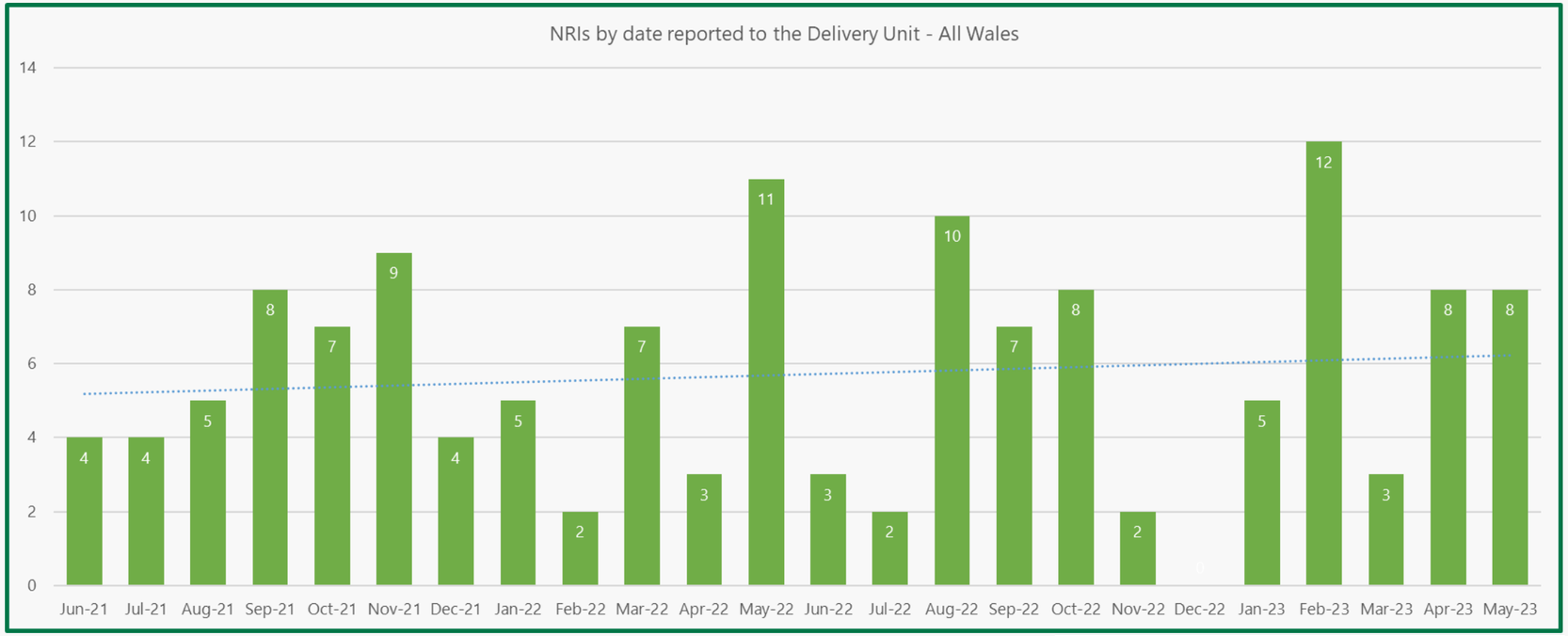
(Responsible Officer: Liam Williams)

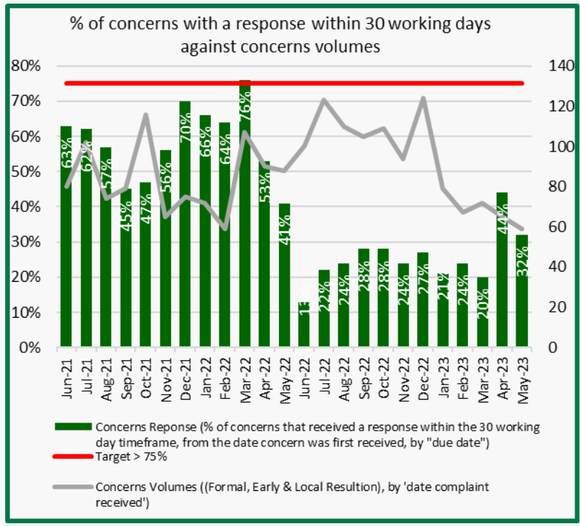
NRI. R

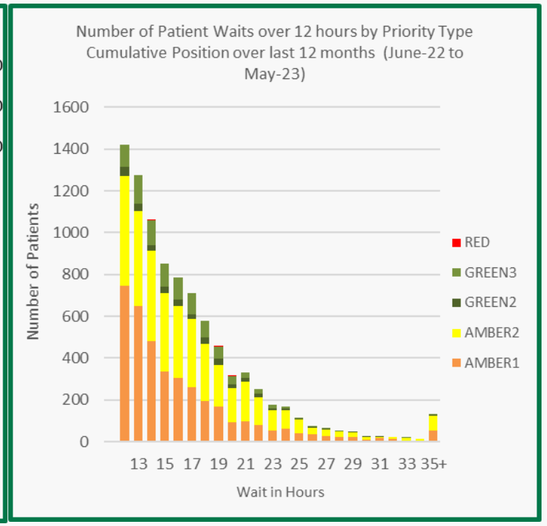
Self Assessment: Strength of Internal Control: Moderate

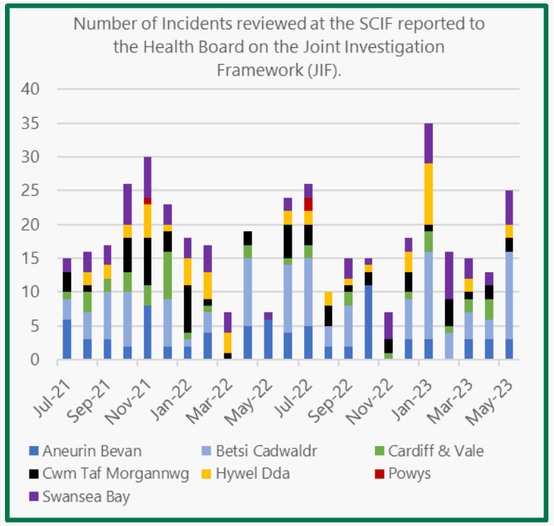
QUEST

Health & Care Standard
Health - Safe Care / Timely Care









Analysis

The percentage of responses to concerns in May 2023 is 32% against a 75% target (30-day response). Several factors continue to affect the Trust's ability to respond to concerns, including, overall increased demand, a rise in the number of inquests, continuing volumes of Nationally Reportable Incident's (NRIs) and timely response to requests for information from key parties. The number of total concerns continues to decrease with 59 complaints being received in May 2023, however these complaints are frequently complex with our concerns administrators frequently taking lengthy calls from distressed patients or family members. From April 2023 the 2-day acknowledgment measure for complaints has been revised to a 5-day acknowledgement measure (92% compliance May 2023). This is to bring the Putting Things Right Regulations in line with Duty of Candour. The 2-day measure will continue to be monitored internally due to the fragile position.

Eight Serious Case Incident Forums (SCIF) were held during the month and forty-two cases were discussed. Following discussion eight serious patient safety incidents were reported to the NHS Wales Executive (Delivery Unit) and twenty-five cases were referred to Health Boards for investigation under the Joint Investigation Framework. The Trust received no referrals from Health Boards under the Joint Investigation Framework during the period.

All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team, who will consider the requirement to enact the Duty of Candour and contact patients and families.

Themes relating to serious patient safety incidents reported to the NHS Wales Executive (Delivery Unit) as Nationally Reportable Incidents (NRIs) include delayed community response times and call categorisation.

In May, 264 patients waited over 12 hours for an ambulance response, a further significant decrease month on month.

107 Compliments were received from patients and/or their families in May 2023.

Remedial Plans and Actions

A range of actions are in place:-
Recruitment, redeployment and assessment of workload and where to best place resources continues corporately and within the EMS Coordination Team. An organisational change process is planned across the Putting Things Right functions in quarter two 2023/24. Additionally, we are working closely with the Trust's Wellbeing Team to understand what additional support can be provided to staff across the Putting Things Right functions.

Delayed community response (Risk 223) and handover of care delays at hospitals (Risk 224) are the two highest rated risks on the Trust's Corporate Risk Register (both rated 25) and include detailed mitigations, current actions and are considered at Board sub-committee level and at Trust Board.

The Joint Investigation Framework is now formally in place across NHS Wales and is referenced in the recently published NHS Wales National Policy on Patient Safety Incident Reporting & Management (May 2023) which will be considered in respect of the Trust's internal documents.
Immediate improvement actions following the Serious Case Incident Forum (SCIF) include education and training for individual staff, updates to operating procedures and circulation of bulletins to share learning and provide updates.

Expected Performance Trajectory

The Trust is expecting continuing challenges with performance especially as hospital delays remain a significant challenge impacting on the quality and safety of care to patients in the community and those delayed outside of hospitals awaiting transfer to definitive care which are detailed on the Corporate Risk Register.

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

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

***NB: 30 Day Compliance reported from Power BI and therefore data is not yet validated*

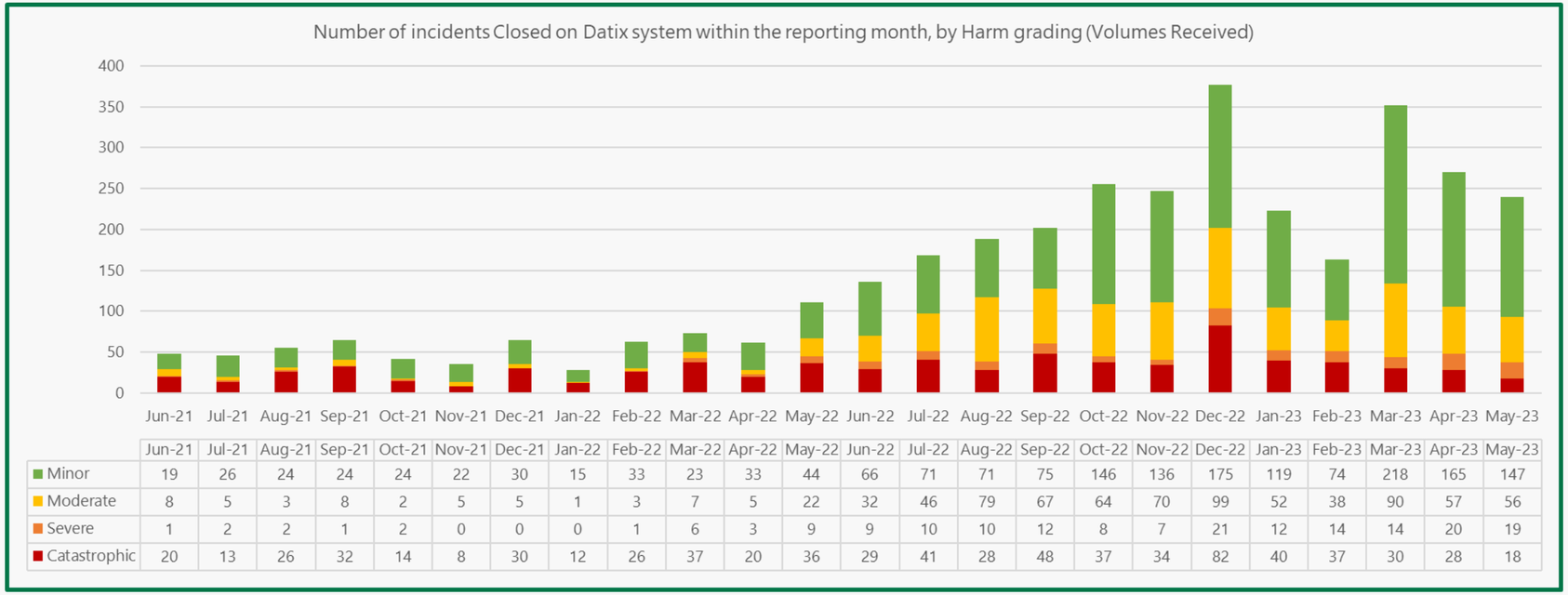
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

(Responsible Officer: Liam Williams)

Self Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care



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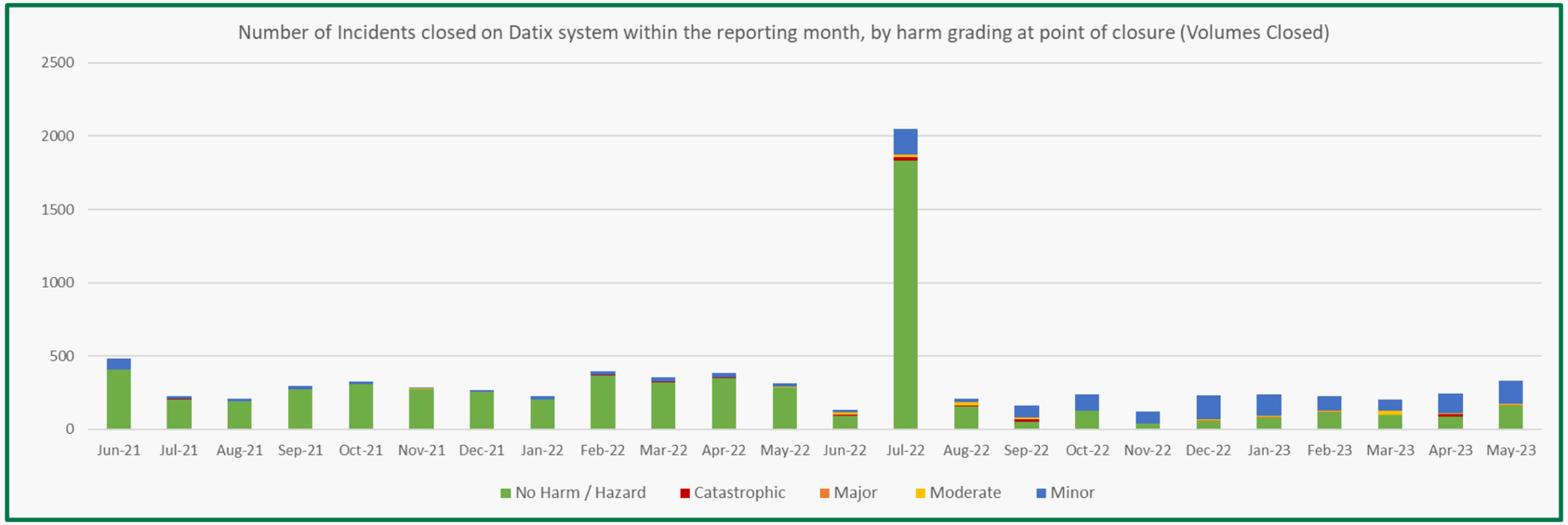
Minor	19	26	24	24	24	22	30	15	33	23	33	44	66	71	71	75	146	136	175	119	74	218	165	147
Moderate	8	5	3	8	2	5	5	1	3	7	5	22	32	46	79	67	64	70	99	52	38	90	57	56
Severe	1	2	2	1	2	0	0	0	1	6	3	9	9	10	10	12	8	7	21	12	14	14	20	19
Catastrophic	20	13	26	32	14	8	30	12	26	37	20	36	29	41	28	48	37	34	82	40	37	30	28	18



Analysis

Once cases are investigated and any improvement actions / learning is identified by the Patient Safety or Clinical Team, (or for instances where serious harm has occurred referred to the Serious Case Incident Forum (SCIF) for review) they are closed.

All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team, who will consider the requirement to enact the Duty of Candour and contact patients and families. The Datix Cymru System has recently been updated nationally to allow Duty of Candour to be captured and reported and further work to develop a dashboard is in progress. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

- No harm or hazard – 201
- Minor harm – 147
- Moderate harm - 56
- Severe Outcomes - 19
- Catastrophic - 18

(*NB: Volumes received).

The bottom graph highlights the 328 Incidents that were closed on the Datix system in May 2023. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

Remedial Plans and Actions

Workload for all members of the team continues to be high due to continued system pressures resulting in a backlog of Putting Things Right concerns which are frequently complex. It is expected that the combination of the implementation of the Duty of Candour, Duty of Quality and the Medical Examiner Service will involve additional activity for the Putting Things Right team.

Early informal engagement on the structure of the Putting Things Right team has begun ahead of the formal organisational change process planned for quarter 2 2023/24 which will consider our local and national priorities and resources to meet the needs of our patients and families.

The Trust is represented at national networks including Duty of Candour, Complaints, Mortality, Claims and Redress and Datix Cymru development groups as resources allow.

Work is progressing in respect of the development of dashboards to inform reporting and oversight internally with Health Informatics and through the national Once for Wales team (Datix Cymru).

Expected Performance Trajectory

The Trust will continue to identify quality and safety improvements through the PTR processes.

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

Data source: Datix

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

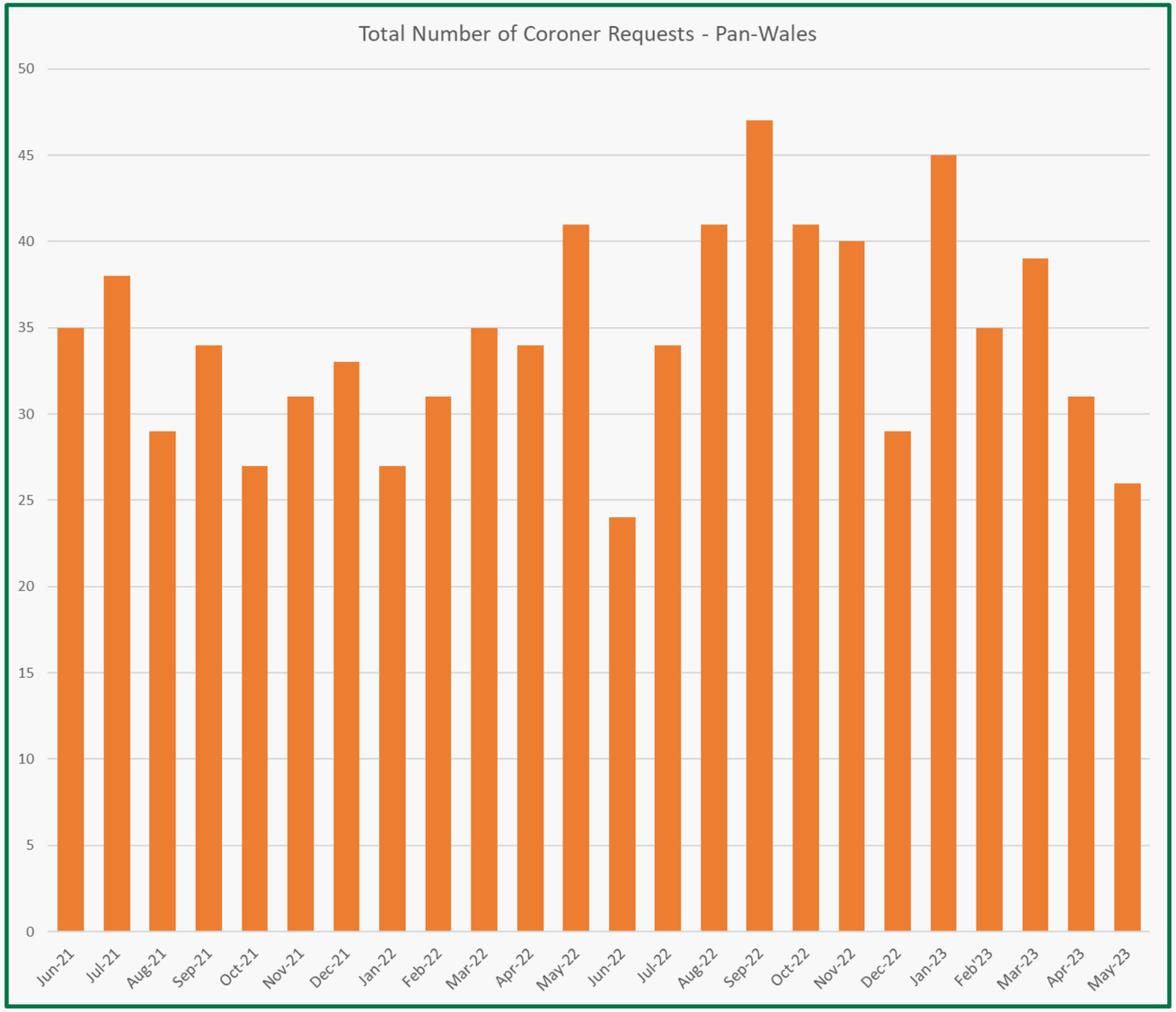
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



*NB: Temporary graph at All-Wales level: The Trust is currently unable to report Coroner requests at Health Board level due to the implementation of the new Datix system

Analysis

Coroners: The number of in month request continues to be higher than pre pandemic. Pre pandemic a financial year saw 244 cases in 2019/2020. Last financial year saw 450 requests being received. This increased number of approaches is now the norm, rather than the exception. The complexity remains high, with multiple statements per approach. The Trust is moving the cases from the Datix web system (legacy) to the new Datix Cymru system. This will affect how we record our data and what we will be able to report on, as we come in line with an all-Wales format. Additionally, 50% of the staff managing coroner and Road Traffic accident cases have not been in work this financial year.

At the end of May 2023 there were 492 claims open; these relate to Personal Injury (76 Claims); Personal Injury - Road Traffic Accidents (60 Claims), Clinical negligence (129 claims); Road Traffic Accident (210 claims) and Damage to Property (17 claims).

Ombudsman: There are currently 7 open Ombudsman cases in May 2023. At present cases are not being investigated, which supports the Trust's actions. Intermediate actions are being agreed to close without full investigations by the Ombudsman.

Mortality Review: The Trust continues to participate in Health Board led mortality reviews as appropriate, with attendance from the patient safety team and clinical colleagues. Data and information is also provided by the Trust as required to the Medical Examiner Service to inform their reviews of deaths in acute care. To date the Trust have received over 500 requests for information from the Medical Examiner Service.

To date the Trust has not received any requests to undertake a Level 2 mortality review of patients in our care under the new processes in place across NHS Wales. Currently the focus of the Medical Examiner Service is undertaking mortality reviews in the acute care setting and the plan is for all non-coronial deaths, including community deaths to be reviewed by the Medical Examiner Service from September 2023 when an increase in activity for requests / reviews for the Trust is expected..

The NHS Wales Executive (Delivery Unit) is leading a thematic review of 'do not attempt cardiopulmonary resuscitation' (DNACPR) processes across Wales with an initial workshop held on 23 May 2023 with WAST representation. The outcomes and learning from the day are being collated to inform next steps.

Remedial Plans and Actions

Coroners: Cases continue to be registered and distributed, however due to staff illness within the Team there are some delays currently being experienced. If there is likely to be a delay in responding the Trust ensures that the coroner is kept informed of the expected date of response. Inquests are now being arranged into 2024. All cases being monitored where we may be an interested party will now be closed.

Ombudsmen: The Trust is in the process of transferring all Ombudsmen cases from the Old Datix system to the new system

Mortality Review: The Trust is in the process of developing the internal mechanisms in order to facilitate mortality reviews under the new approach and our internal framework has been approved at the Clinical Quality Governance Group and an internal mortality group (learning from deaths) is being established, closely aligning to the Serious Case Incident Forum.
Representation and contribution by the Trust at the All-Wales Mortality Working Group will continue and a task and finish group has been established to review the process for contacting families following their meetings with the medical examiners. Additionally, the Trust are engaged in the meetings lead by the Once for Wales Datix Cymru team who are developing the Datix Cymru Mortality Module currently.

Expected Performance Trajectory

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

Ombudsmen: Whilst the multiple benefits of the ME process are recognised there will undoubtedly be significant resource implications for the Trust, particularly as the process expands to every non-coronial death in NHS Wales and the Health Boards (who are at different levels of maturity regarding mortality reviews) start to develop and embed their processes. It is recognised that some cases will have already been reviewed via PTR processes internally.

Data source: Datix

Mortality Reviews Data source: Internal Web Application

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

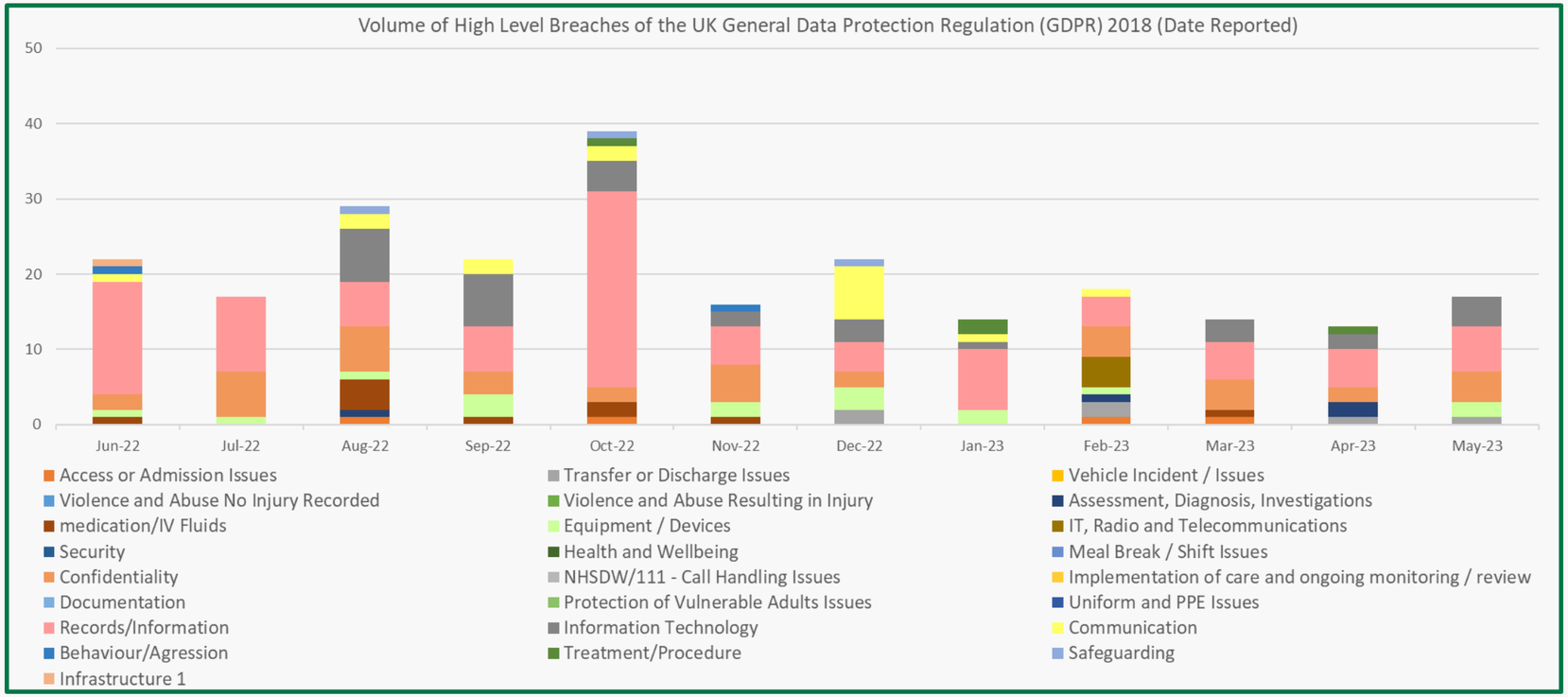
(Responsible Officer: Liam Williams)

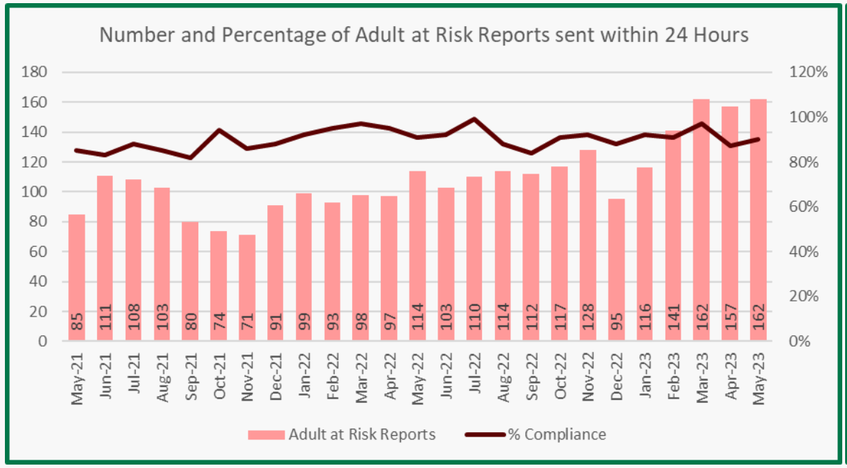
Self Assessment: Strength of Internal Control: Strong

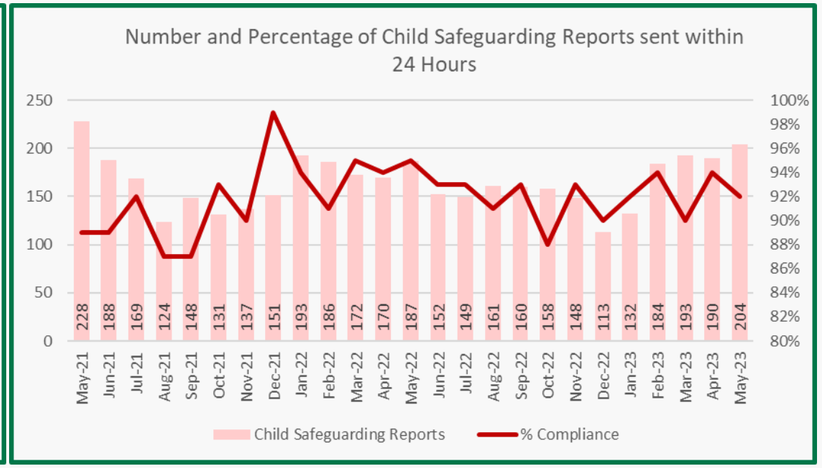
QUEST

Safeguarding Data source: Doc Works

Health & Care Standard
Health – Safe Care







Analysis

Safeguarding: In May 2023 staff completed a total of 162 Adult at Risk Reports, 90% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 508 referrals were received and processed to the local authority during this reporting period.

There have been 204 Child Safeguarding Reports in May 2023, 92% of these were processed within 24 hours.

Data Governance: In May 2023 there were 18 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 18 breaches, 4 related to Information technology, 6 records/information, 1 infrastructure, 4 confidentiality, 1 Transfer and Discharge, and 2 equipment and devices.

Public Engagement: During May, the Patient Experience and Community Involvement Team attended 8 community engagement opportunities, engaging with 150 people. At engagement events throughout the month, we continued to use these engagement opportunities to listen to people's experiences of using our services and to recruit people to join our People & Community Network. During May we also continued to make a series of Patient Reported Experience Surveys (PREMS) available, asking people to provide feedback about their interactions with our services. Outcomes of our engagement results collected from surveys remain consistent and tell us that people continue to be concerned that help will not be available when they need it and that people have experienced delays after calling 999. 111 callers have told us that they experienced long waits for their calls to be answered and reported long waits for call backs. NEPTS users told us that overall, they continue to be happy with the transport they receive but experience long delays when making their initial telephone booking.

Remedial Plans and Actions

Safeguarding: The Trust primarily manages all safeguarding reports digitally via Docworks and regular monitoring of the system by the Safeguarding Team provides a means to identify any problems with delayed reports with appropriate action taken to support staff with the use of the Docworks Scribe App and liaise with local authorities when or where required. Numbers of paper safeguarding reports have significantly reduced with the embedding of Docworks; however, they are used as a back-up and are sent directly to the Safeguarding Team for further action. Continued monitoring supports practice in this area which is seeing a steady improvement.

Data Governance: During the reporting period, of the 18-information governance related incidents reported on Datix, 0 incidents were deemed to meet the risk threshold for reporting to the Information Commissioner's Office (ICO). The IG team has provided advice and determined remedial actions for relevant incidents where appropriate.

Public Engagement: Community involvement and engagement with patients/public will form an integral part of the Trust's ambition to 'invert the triangle' and deliver value-based healthcare evaluated against service users' experiences and health outcomes. The work delivered by the PECI Team is supporting the Trust's principles of providing the highest quality of care and service user experience as a driver for change and delivering services which meet the differing needs of communities we serve without prejudice or discrimination. The PECI Team will continue to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve services they receive. In April we began to roll out the new 'Once for Wales' Patient Experience Recording solution Civica. Civica will enable us to improve our patient experience reporting but will rely on us increasing the amount of PREMS data we capture. We are working with colleagues across the Trust to identify suitable processes to ensure our patients and service users are offered opportunities to share their feedback with us.

Expected Performance Trajectory

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

Data Governance: The submission for the FY22-23 IG Toolkit opened in February 2023 and is due to close on 30th June 2023. Work continues on collating the evidence required for the submission.

Public Engagement: All feedback received has been shared with relevant Teams and Managers and continues to be used to influence ongoing service improvement.

**NB: Data Governance Incidents are based on 'Date Reported' rather than 'Incident Date' as the process is currently manual until a dashboard is implemented and is therefore subject to change*

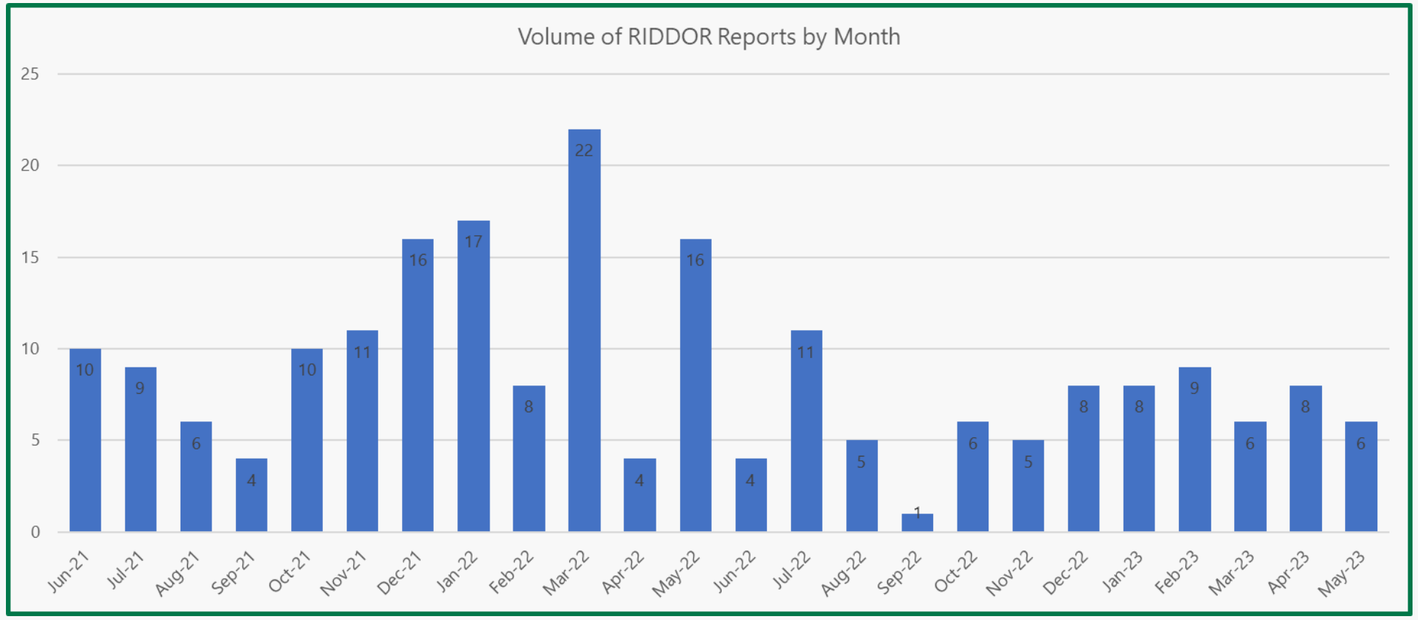
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

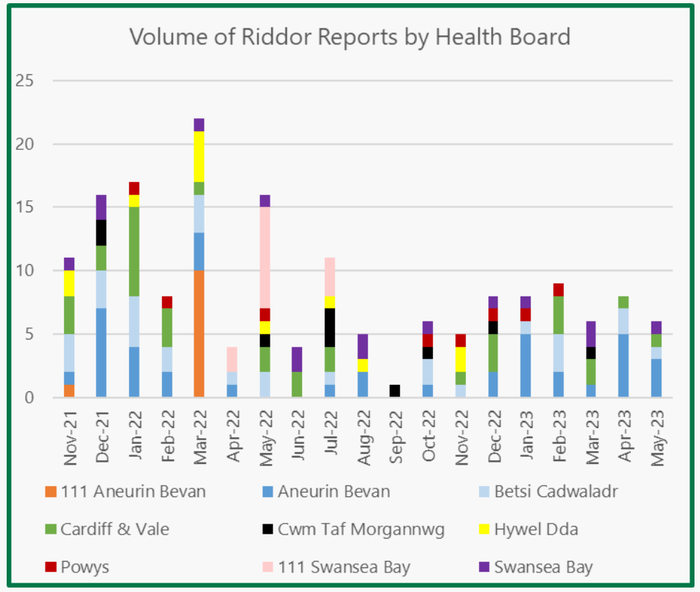
(Responsible Officer: Liam Williams)

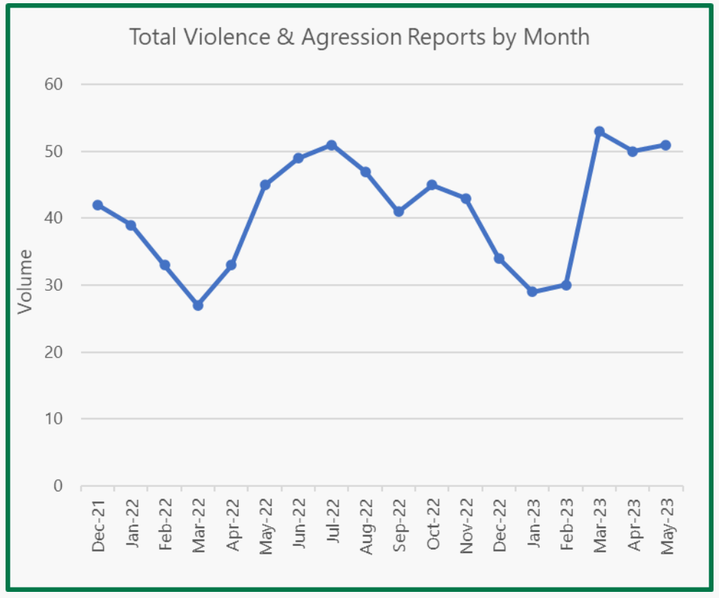
Self Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care







Analysis

RIDDOR: There were 7 incidents requiring reporting und RIDDOR during May. 6 were due to staff being absent from work for over 7 days as a result of their injury and 1 reported as a Specified Injury following a diagnosis of a broken writs. All RIDDOR reportable incidents were as a result of manual handling activities, 6 were whilst moving patients and 1 whilst moving equipment.

4 of the incidents occurred at the patient's property where we have little control over the environment, 2 were whilst handling stretchers where greater control of the manual handling method used may have prevented the incident.

83% of the reports were completed within the reporting required timeframes the reduction in reporting on time percentage was due in part to late diagnosis of a broken wrist. Communication between the Health and Safety Team and the incident investigators continues to provide high levels or reporting performance.

Risk 199 remains rated 15. The revised Health and Safety Policy and Safety Annual Improvement Plan has articulated actions required to implement the controls identified in the risk that will beneficially impact the risk rating during this financial year.

Violence and Aggression: The number of V&A incidents reported in May continues to remains high at 51 for the month. Physical Assaults on staff have reduced to 3 in this reporting period with incidents of verbal abuse increasing on this period.

Remedial Plans and Actions

RIDDOR: The importance of good manual handling techniques in the prevention of muscular skeletal injuries is of vital importance a deep dive of manual handling incidents is ongoing to identify common causation and propose a suitable action plan.

An investigation carried out into the specified injury reported in May for the broken wrist sustained by a member of staff is underway to identify suitable controls to prevent a reoccurrence.

RIDDOR performance continues to be presented in monthly reports and service units business meetings.

Violence and Aggression: Collaborative working with AACE regarding V&A training is continuing with the aim of improving the current training to better support staff. Particularly around clinical restrictive physical intervention.

Reestablishment of the Strategic Anti-Violence Collaborative will commence next month continuing to improve working relationships with all four Welsh police forces and Crown Prosecution service and the Trust

Toolbox talks , raising awareness of case management support are taking place across the Region by the Case Manager & V&A Manager to support staff and raise awareness, it is planned to establish regular interaction with staff directly affected by incidents of V&A.

Expected Performance Trajectory

RIDDOR: The reporting of Trust-wide incident statistics has seen an increase in reporting in a number of areas. This is to be encouraged as it provides valuable data that can be trended to identify immediate and underlying causes that can be address by the Health and Safety Team.

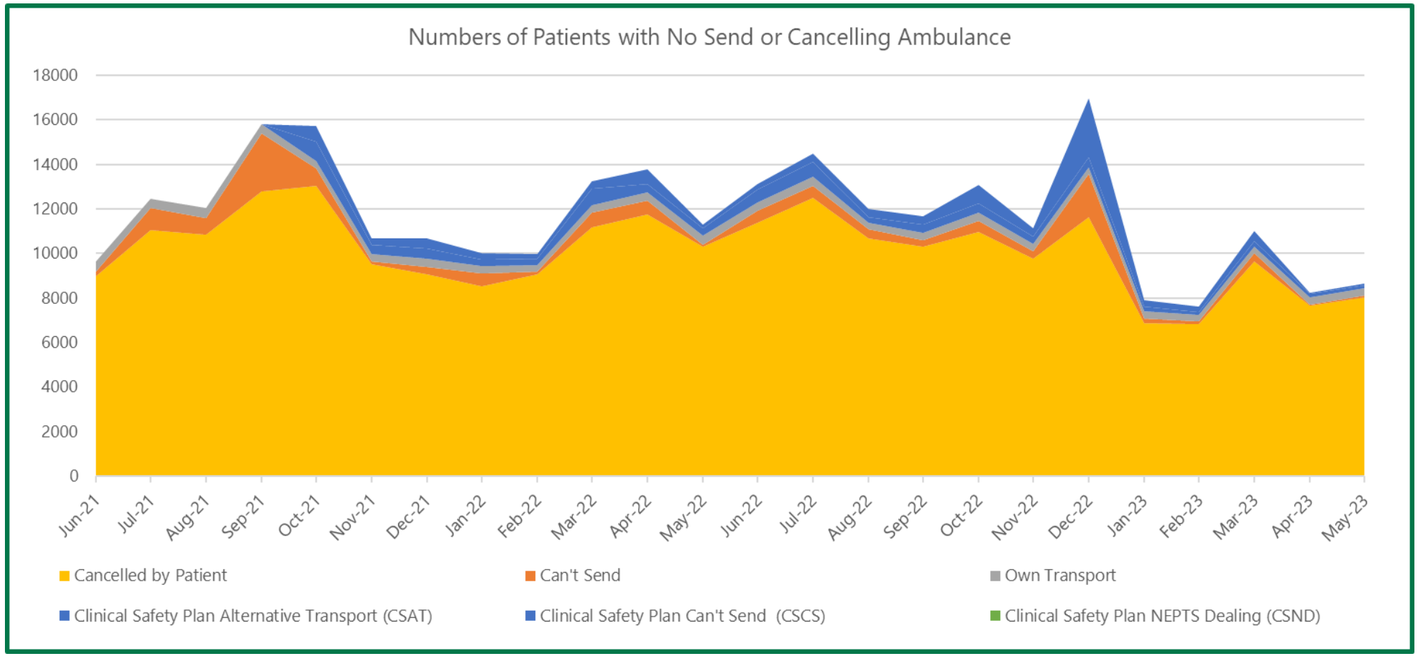
Violence and Aggression: Work is continuing in the development of further DATIX dashboards to allow for further scrutiny into V&A incidents by both operational area and Health Board Area with the aim of influencing local interventions where required.

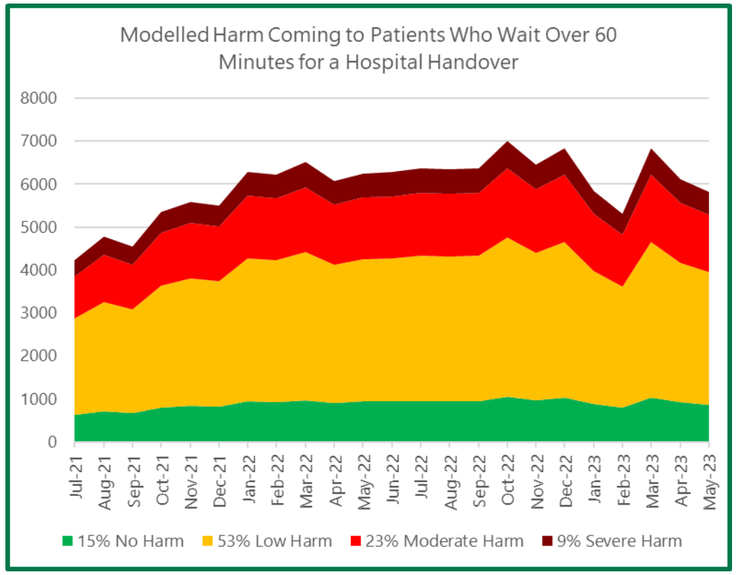
**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

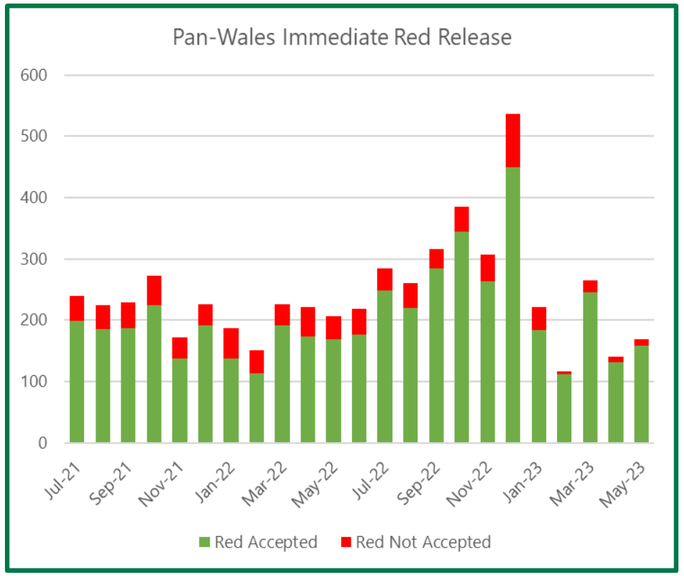
Data source: Datix

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

(Responsible Officer: Andy Swinburn) TBD FPC







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

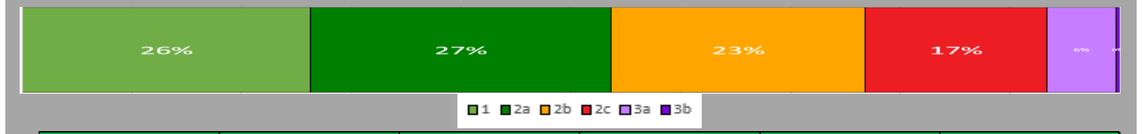
Analysis

In May 2023, 136 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 61 were stopped as a result of CSP 'Can't Send' options. In addition, 8,044 ambulances were cancelled by patients (including patients refusing treatment at scene) and 354 patients made their way to hospital using their own transport.

There were 501 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in April 2023. Of these 159 were accepted and released in the Red category, with 10 not being accepted. Further to this, 100 ambulances were released to respond to Amber 1 calls, but 232 were not.

The graph in the bottom left shows that in May 2023 of the 5,810 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, the Trust could assume that 15% (872 patients) would experience no harm, 53% (3,079 patients) would experience low harm, 23% (1,336 patients) would experience moderate harm and 9% (523 patients) would experience severe harm.

In May 2023 CSP levels for the Trust were:



CSP Level	RED	AMBER 1	AMBER 2	GREEN	HCP
0	Business As Usual				
1	Respond	Respond	ETA - ALT Transport		
			Respond to Exceptions		
2a	Respond	Respond	ETA - ALT Transport		
			Respond to Exceptions		
2b	Respond	65th ETA Script			
		ALT Transport			
		Respond to Exceptions			
2c	Respond	65th ETA Script			Can't Send
		ALT Transport		Can't Send	Pass to ROU or EMG
		Respond to Exceptions			
3a	Respond	90th ETA Script	Clinical Screening	Can't Send	
		ALT Transport			
		Respond to Exceptions			
3b	Respond	Clinical Screening	Can't Send		
4a	Clinical Screening		Can't Send		
4b	Clinical Screening	Can't Send			

Remedial Plans and Actions

Red immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Red Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings have commenced with Health Boards, the Commissioner and the Trust and performance is reviewed monthly with questions posed to Health Boards regarding immediate release and handover reduction plans and actions.

Expected Performance Trajectory

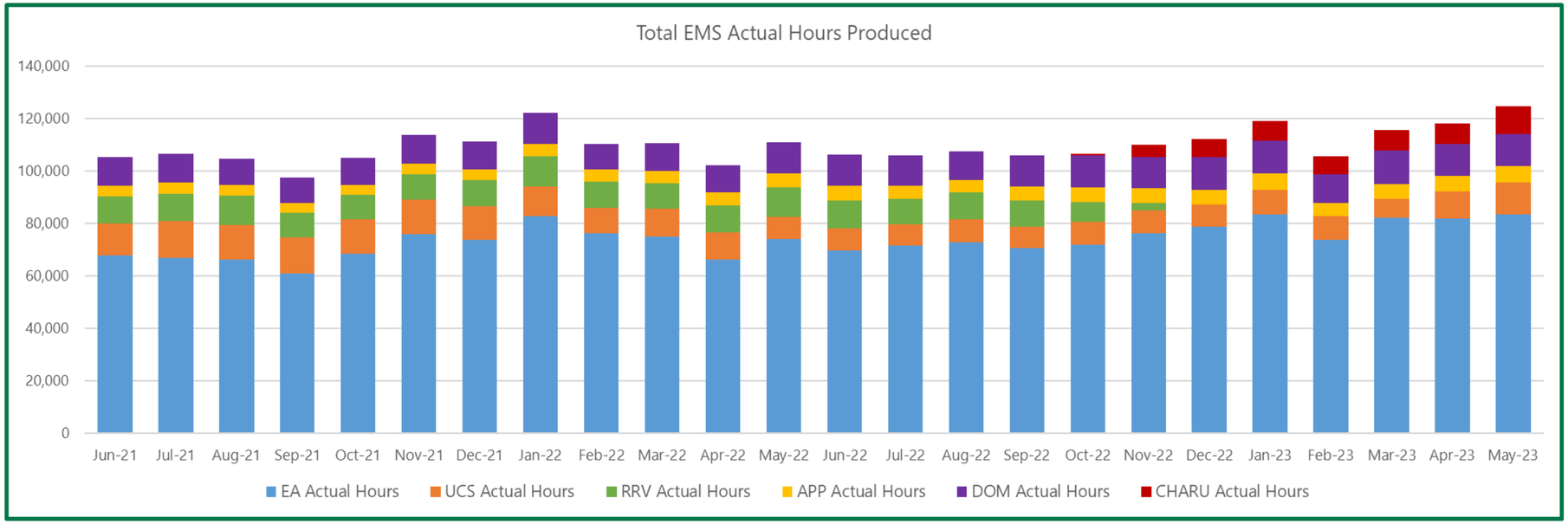
The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trusts ability to respond to demand. Seasonal pressures impact the Trust and planning is being used to prepare for this through a range of measures including the use of forecasting and modelling.

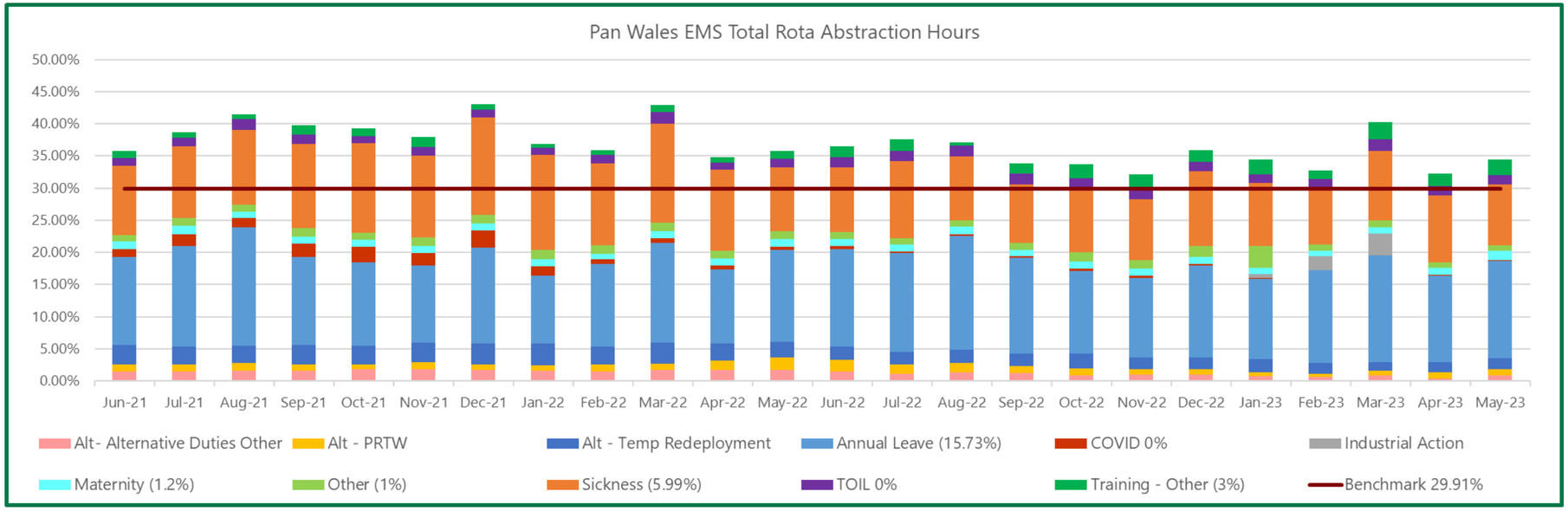
Our People
Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions
G	R

CI PCC FPC





Analysis

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced. In May 2023, total EMS abstractions (excluding Induction Training) stood at 34.27%. This was an increase from the 32.26% recorded in April 2023. However, this percentage remains above the 30% benchmark figure set in the Demand & Capacity Review. The highest proportion of abstractions was due to annual leave at 15.12% followed by sickness at 9.44%. This figure for sickness abstractions for May 2023 was lower when compared to the same month last year (9.90%). COVID-19 (non-sickness) related abstractions remains low at just 0.13%.

Emergency Ambulance Unit Hours Production (UHP) was 97% in May 2023 (83,485 Actual Hours), CHARU UHP achieved 121% (10,775 Actual Hours) compared to 92% in April 2023 (this is the commissioned level not the modelled level. The total hours produced is a key metric for patient safety. The Trust produced 124,692 hours in May 2023, which is higher than the figure produced in April 2023 (118,141).

Remedial Plans and Actions

The EMS Demand & Capacity Review benchmark for GRS sickness absence abstractions is 5.99%. A formal programme of work has commenced to review and take action to reduce sickness absence / alternative duties, which is reported into EMT every two weeks.

The Trust has a budgeted establishment of 1,761 FTEs for 2022-23. This is changing due to internal movements e.g., new APPs, EMT3s, maximising the inflow of NQPs. The vacancy factor has been very low with a prediction to widen to 5% by August, which will be reviewed.

The Trust is currently widening out its focus on sickness absence to look at all abstractions recognising that abstractions are already regularly reviewed in Operations performance meetings.

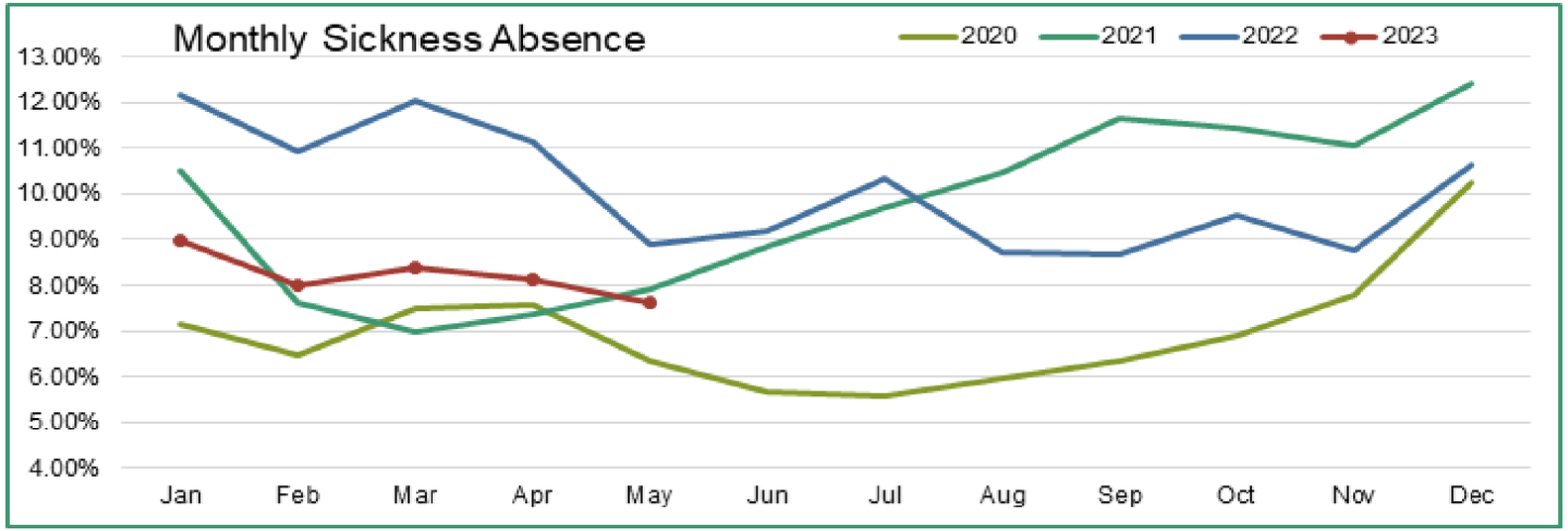
Expected Performance Trajectory

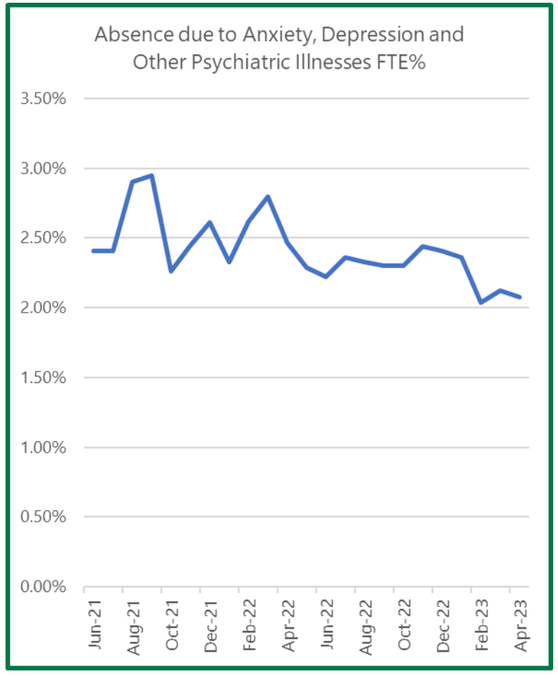
UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to EMT. A further meeting to deep dive and finalise the Trust's position for 2023/24 was arranged for 17 May 2023.

Our People
Capacity - Sickness Absence Indicators

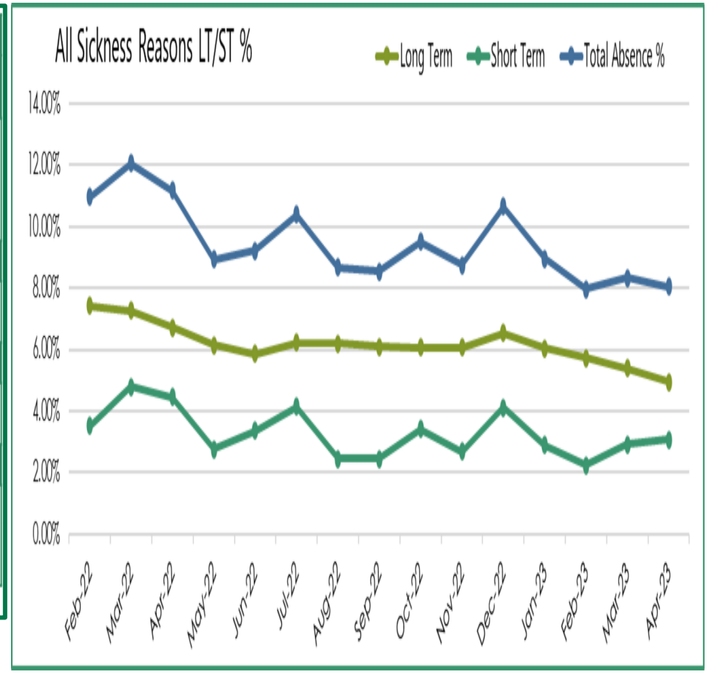
(Responsible Officer: Angela Lewis) G CI

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





Average working days lost per FTE (Annual)	
20.50 days	
Single month Absence %	
8.04%	
Long Term	**Short Term**
4.95%	3.09%
Mental Health	**Other MSK**
(S10 Stress/Anxiety) 2.08%	(excluding Back) 1.09%



Analysis

There was a decrease in sickness absence in April, decreasing from 8.33% in March 2023 to 8.04% in April 2023. Short term absence increased from 2.93% in March to 3.09% in April, but long-term absence decreased from 5.40% in March to 4.95% in April.

Indicative figures (as of 25.05.2023) show a further decrease in sickness absence in May 2023 to 7.69%, with long term absence showing a decrease to 4.69% and a small decrease in short term absence to 3.00%.

The number of long COVID cases continues to decline with 2 colleagues absent (as of 23.05.2023) with long COVID compared to 15 in July 2022.

Remedial Plans and Actions

- Targeted support continues to be directed to current 'hotspot' areas with ongoing reviews in two HB areas. Senior Manager review meetings to track sickness and provide support are undertaken each month.
- MAAW training and bitesize training sessions have taken place in April, with further sessions scheduled for May, June & July 2023.
- Promotion of the Body Hotel (included within the MAAW training) which offers a programme of free employee wellbeing workshops across the health and social care sector in Wales. The programme provides a wide variety of options to employees to engage with their own self care, prevent burnout and support challenging work transitions.
- Long term sickness case management continues and indicative figures for May 2023 show a decrease to 4.69% from 4.95% in April.
- Indicative figures for short term absence in May 2023 shows a decrease to 3.00% from 3.09% in April. The highest reason for short term absence in March, April & May 2023 was COVID related. Short term absences for Cough/ Cold/ Flu, Headache/ Migraine and Gastrointestinal have also increased.
- There is currently 1 Long COVID case as of 25.05.2023 (compared to 15 in July 2022) with a comprehensive plan developed.
- A revised Improving Attendance Action Plan has been developed and will replace the action plan for 2022/23.

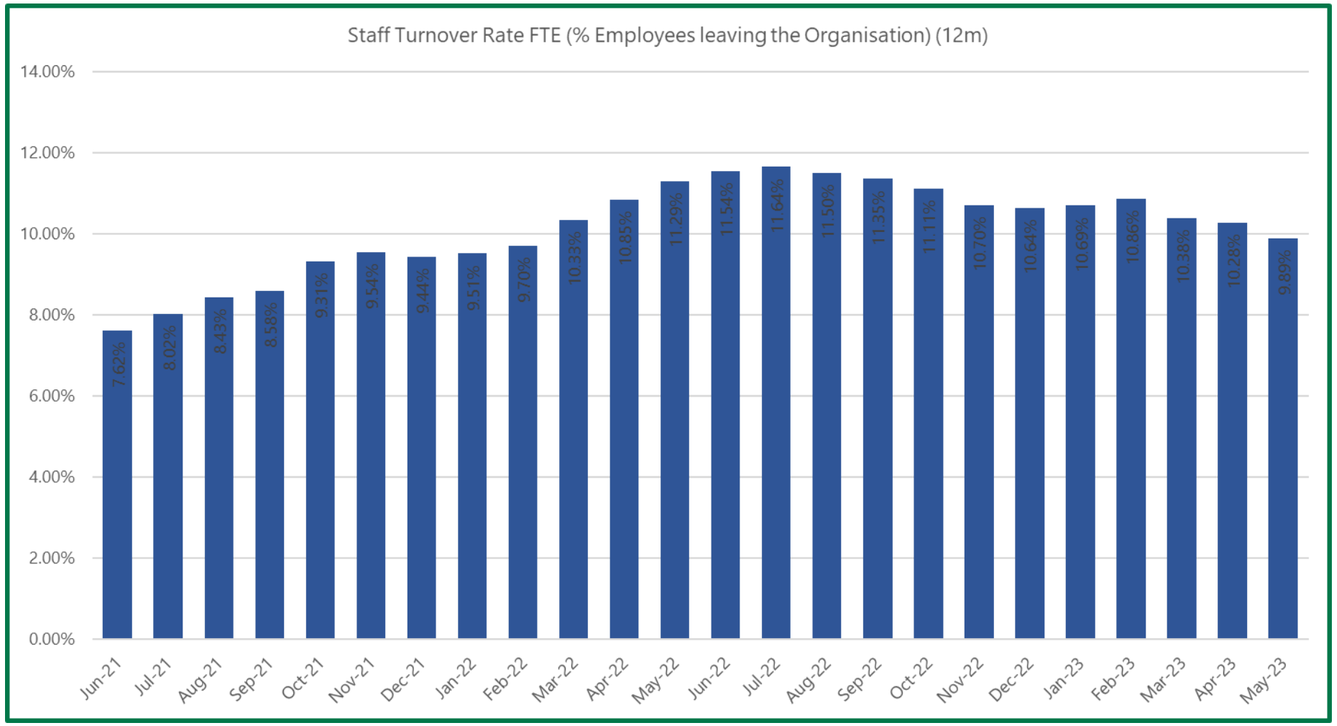
Expected Performance Trajectory

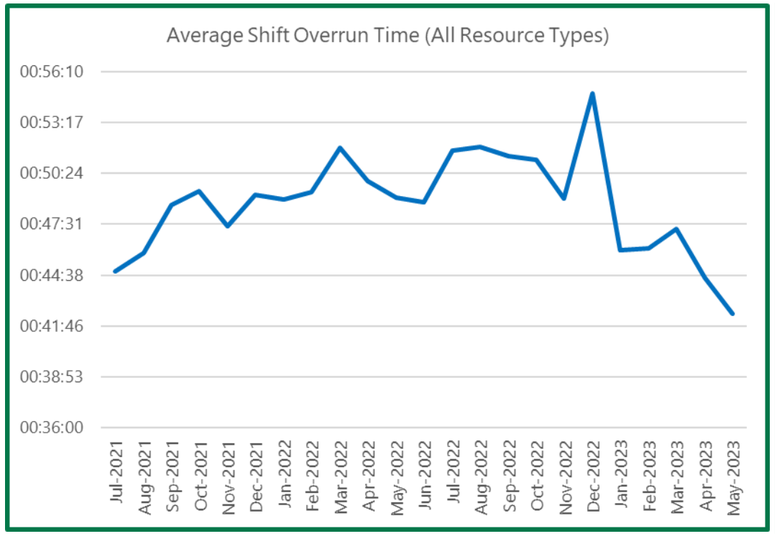
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but that there remain risks to delivery.

Our People
Capacity - Turnover

(Responsible Officer: Angela Lewis)

A





May-23 Org L4	FTE by Post
020 Ambulance Care L4 (NX10)	908.09
020 Emergency Medical Services L4 (DX04)	1,785.90
020 Integrated Care L4 (DX03)	435.19
020 National Operations & Support L4 (DX02)	134.57
020 Resourcing & EMS Coordination L4 (DX05)	347.03
Grand Total	**3,610.78**
Ambulance Response	**1536.81**
020 Ambulance Care L4 (NX10) ACA2/Team Leaders	**281.2**

Analysis

Staff turnover rates in May 2023 were 9.89%. However, rates have gradually been declining since they peaked in July 2022, with the current monthly rate being the lowest reported since February 2022. Staff leave the Trust for a variety of reasons including promotions, relocations, culture and due to the pressures of NHS working.

WAST remains committed to colleague wellbeing, and ensuring appropriate provisions are in place to support colleagues. We have an EAP which enables our people to access support 24/7, with access to counselling. We continue to deliver workshops for colleagues on stress, and wellbeing and resilience to support them in their roles. We have had guest speakers join our Circle of Support and Women's Health Group this month, delivering talks on cold water swimming and how to deal with chronic pain. We continue to run health promotion, having focused on mental health awareness week and men's health more recently.

Remedial Plans and Actions

Accessible financial wellbeing support is available to colleagues through a dedicated page on Siren. The page links to a short video presentation outlining available support, ideas shared through the digital suggestion box which remains open to all colleagues (including our volunteers) and broader employee benefits information. A podcast has been recorded with the Money & Pensions Service and will be shared through communications platforms in April 2023.

The WAST Voices Network held its first Advocate meeting in March 2023 and activity continues relating to themes of misogyny and sexual safety within the organisation. Reverse mentoring relationships have been established and the impact of these will be measured after 2 sessions of Senior Leaders hearing from lived experience of these issues. The network have a collaborative event with North-West Ambulance Services taking place in April.

Work around improving the preparedness of new colleagues has begun and we now facilitate group discussions around anti racism and sexual safety at all welcome sessions. We are also capturing organisational culture experiences through the 3 months check in carried out with all new colleagues. The allyship programme continues to be rolled out for current colleagues and where required, team interventions taking place.

A volunteer wellbeing package has been put together and the OD Team are running monthly evening Warm WAST Welcome sessions for new volunteers.

WAST Outdoors initiatives being trialled.

Expected Performance Trajectory

The situation regarding wellbeing of staff remains challenging, many of the difficulties and frustrations are difficult to influence and change. Management development will continue with a focus on people skills and support with robust wellbeing offers so colleagues know where to get support. The People and Culture Plan will continue to highlight that employee experience and culture contribute to overall wellbeing.

The wellbeing offer is regularly reviewed and fully described on SharePoint.

Our People
Culture - Staff Vaccination Indicators

(Responsible Officer: Angela Lewis)

Self Assessment: Strength of Internal Control: Moderate

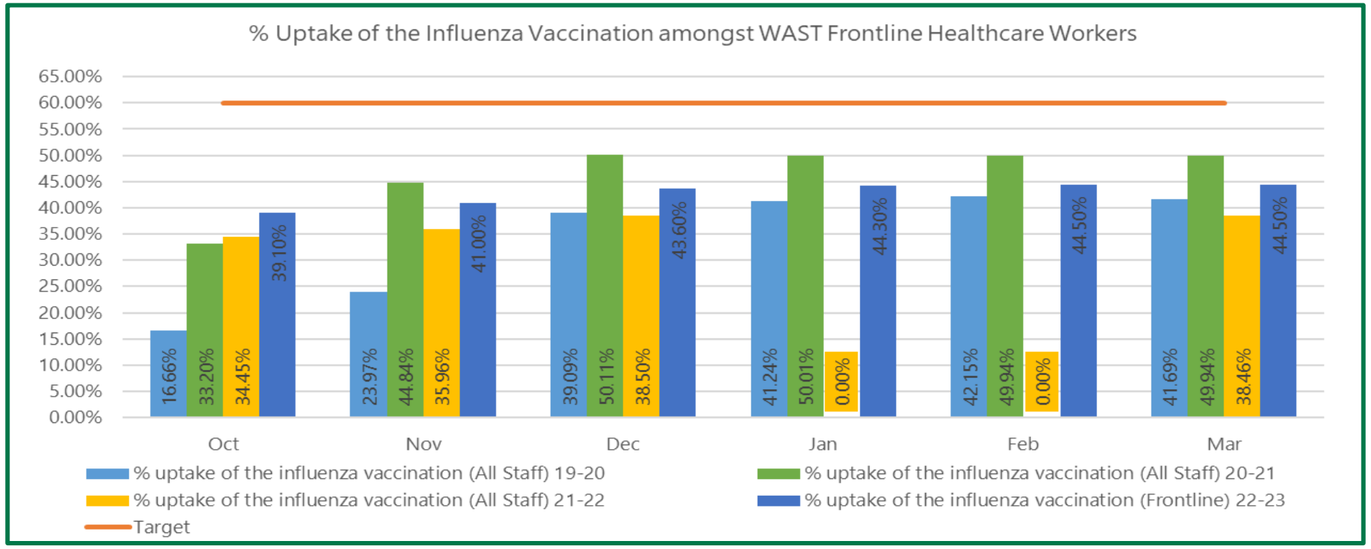
Flu R

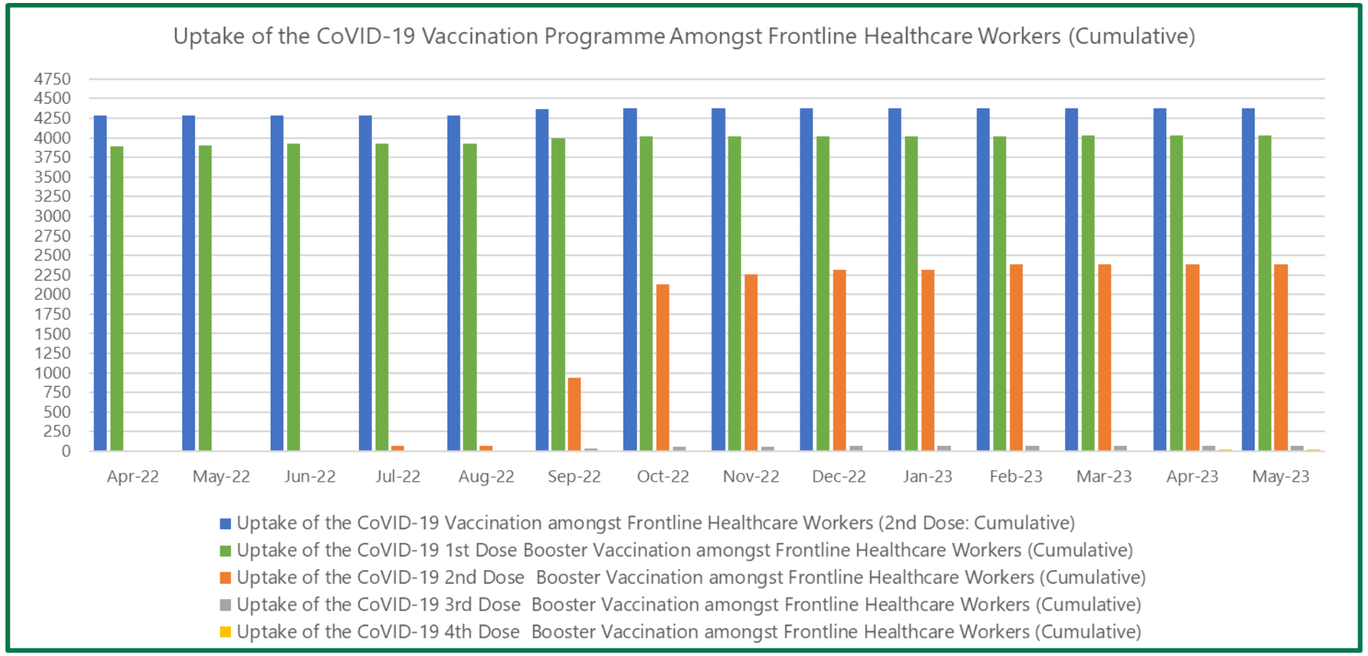
PCC

CI

Health & Care Standard - Health (PPI)

NB: Flu – Next reporting schedule is October 2023





Analysis

Flu: The 2022-23 Flu Campaign has officially come to an end, concluding data collection as of 28th February 2023. During the campaign 1,813 flu vaccines administered by Occupational Health Vaccinators and Peer Vaccinators (including flu vaccines administered to PHW staff / Students / HCS staff etc.) Of these vaccines administered within the Trust, 1,601 were received by WAST staff. There was a further 289 given to staff elsewhere (i.e., GP surgery, COVID Booster setting) therefore a total of 1,890 WAST staff received the vaccination against flu, equating to 44.5% of the overall workforce. Additional engagement was received from 247 WAST staff completing the Microsoft Form indicating that they have chosen to opt-out of having the flu vaccine, concluding the campaign with 50.3% engagement rate.

Both the vaccine uptake and Microsoft Form engagement surpassed that experienced in the previous campaign last year, 2021-22. There was a 6% increase on vaccinations and a 9.6% increase in engagement. Patient facing staff specifically saw a 46.3% uptake of the vaccine this year (a 5.2% increase from last year).

COVID-19: As of end of May 2023, front line (Patient Facing and Non-Patient Facing staff), 94% (4,404) of staff have received a first dose COVID-19 vaccination, 94% (4,377) have received a second dose, 86% (4,026 Staff) have received the Booster 1 vaccination and 51.2% (2,389) have received the Booster 2 vaccination.

Remedial Plans and Actions

Flu: Following a full review of this year's campaign, recommendations have been devised based on some of the key areas of learning and development. The aim is to streamline current processes, remove duplication of effort and improve engagement with the workforce. It is evident that positive steps have been made, and a number of the lessons learnt from the previous campaign have been implemented. However, there is a range of areas that require continued development for future campaigns. Planning for the next Flu Campaign is expected to start shortly, earlier than ever before.

COVID-19: Welsh Government have been involved in discussions between the four UK Chief Medical Officers (CMOs) regarding the UK Covid-19 alert level. This alert level system has been in operation since May 2020. Its function is to clearly communicate, to the public and across governments, the current level of direct Covid-19 risk. Since September 2022, we have been at level 2. The four UK CMOs have agreed it is appropriate to pause the alert level system. It was suspended on 30 March.

Routine testing will be paused for all symptomatic health and social care workers, care home residents, prisoners and staff and residents in special schools over the (2023) spring and summer.

Expected Performance Trajectory

The 2022-23 Flu campaign has now concluded. The Trust will continue to monitor influenza and COVID-19 through intelligence gathered by the Forecasting & Modelling Group on a weekly basis. Any learning from southern hemisphere countries will be shared and used for modelling purposes for the 2023-24 winter flu season.

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

***NB: COVID Vaccinations are reported using the WAST definition of Frontline Patient Facing employees and therefore includes those employed within Clinical Contact Centres.*

****NB: Flu data accurate at time of publication and subject to change / Spikevax vaccination data correct at time of publication and subject to change.*

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

Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

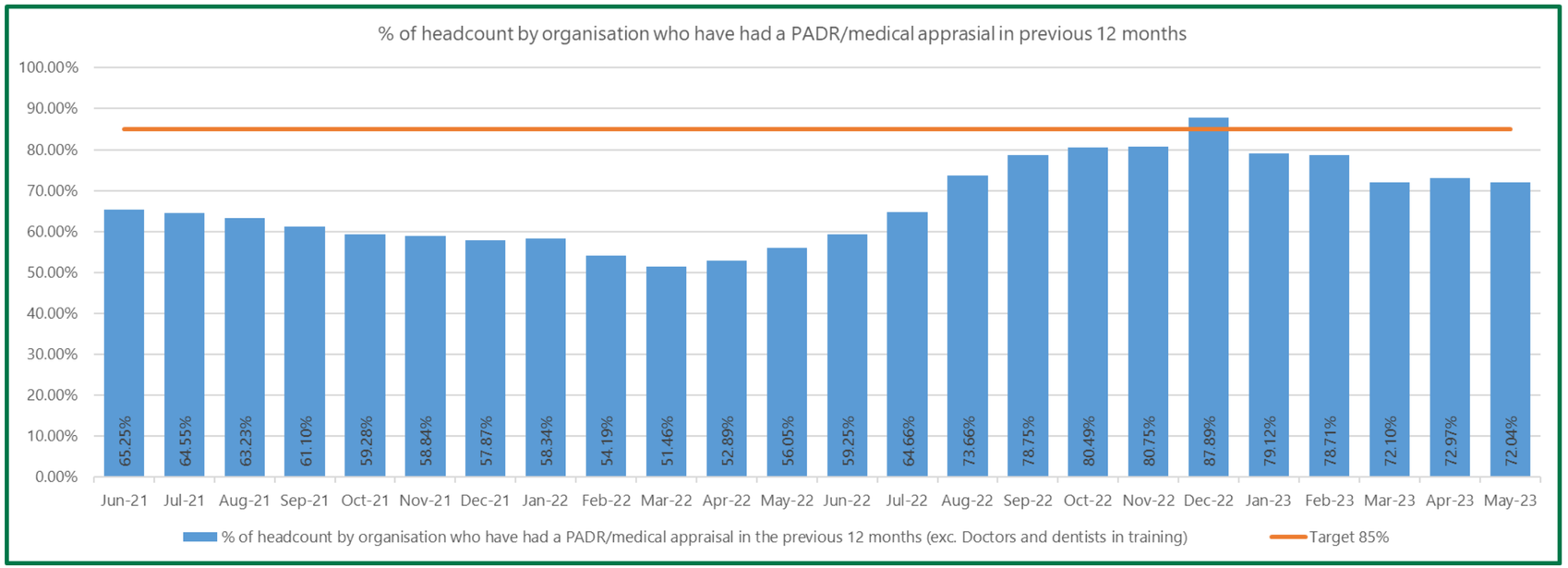
A

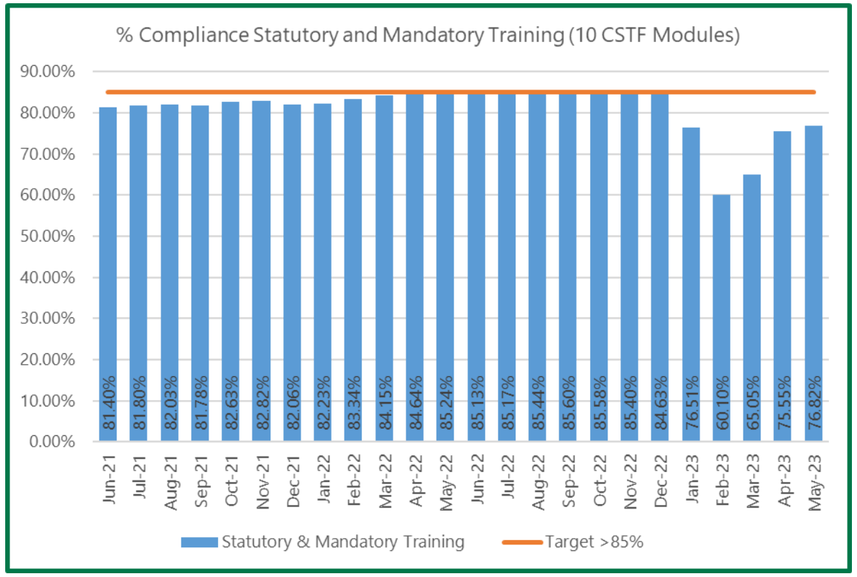
Self-Assessment: Strength of Internal Control: Strong

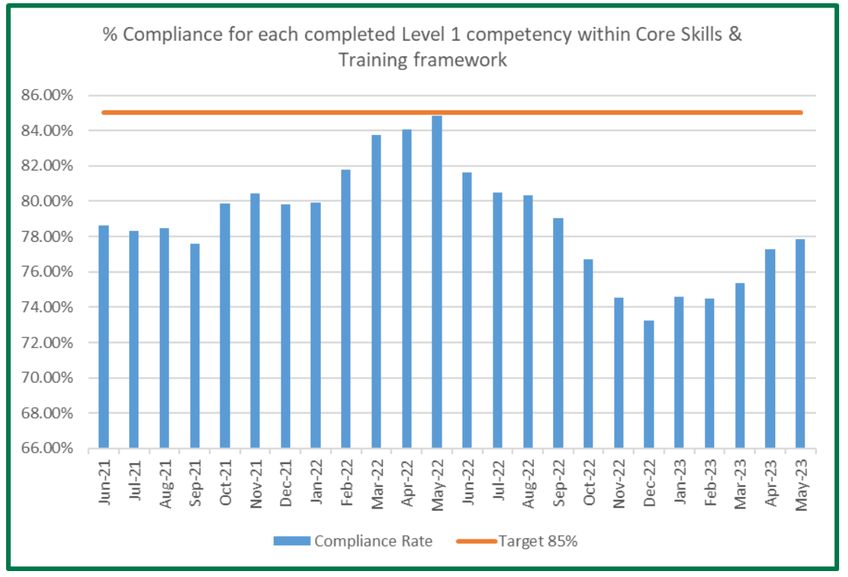
CI

PCC

Health & Care Standard
Health – Staff & Resources







Analysis

PADR rates for May 2023 declined slightly when compared to the previous month to 72.04% and remains below the 85% target. Over the reporting period this target was only been achieved once, in December 2022, although current rates are significantly higher than during the same period last year.

In May 2023 Statutory & Mandatory Training rates reported a combined compliance of 76.32%; with Safeguarding Adults (92%), Dementia Awareness (91.9%) and Violence Against Women all achieving the 85% target. Domestic Abuse & Sexual Violence (84.4%), Moving & Handling (77.6%), Fire Safety (74.9%), Equality & Diversity (74.6%), Information Governance (68.3%), and Paul Ridd (42.9%) all remain below this target. The Paul Ridd course is new and is the reason for a reduction in overall compliance.

There are currently 15 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table below:

Remedial Plans and Actions

At the time of reporting, 1200 of 1,836 EMS colleagues (65.3%), 94 of 284 ACA2 (33%) and 240 of 540 ACA1 colleagues (44.8%) have completed MIST Training days. Sessions continue to be facilitated Pan-Wales through the Education and Training Team, who Continue to manage and monitor these via the online booking system accordingly. Sessions have now completed for the training year 2022/2023, although we may have a small number of colleagues who complete it as a part of their return to work if they have been absent from patient facing duties for more than 6 months.

From the 01st April 2023 e-learning mandated by Welsh Government in relation to Welsh Language will be added to all colleagues' compulsory competencies via ESR. Communication to ensure colleagues are prepared and aware of this continues to be circulated via Siren and Yammer.

Expected Performance Trajectory

Performance is improving as compliance Has risen in relation to Paul Ridd

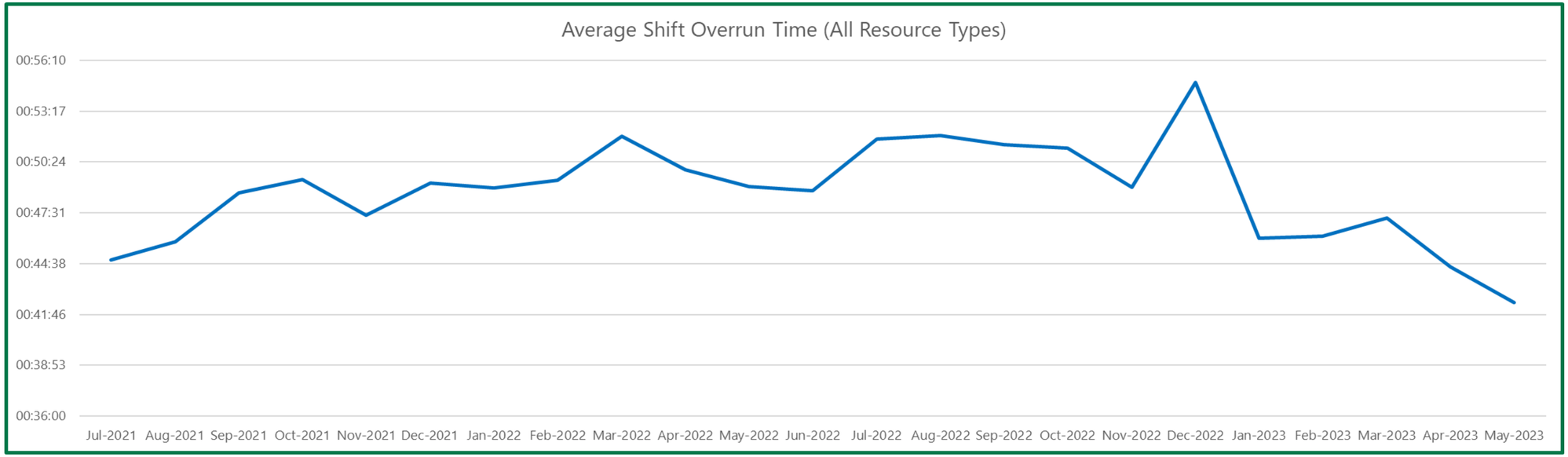
Skills and Training Framework	NHS Wales Minimum Renewal Standard
Equality, Diversity & Human Rights (Treat me Fairly)	3 years
Fire Safety	2 years
Health, Safety & Welfare	3 years
Infection Prevention & Control - Level 1	3 years
Information Governance (Wales)	2 years
Moving and Handling - Level 1	2 years
Resuscitation - Level 1	3 years
Safeguarding Adults - Level 1	3 years
Safeguarding Children - Level 1	3 years
Violence & Aggression (Wales) - Module A	No renewal
Mandatory Courses	
Violence Against Women, Domestic Abuse and Sexual Violence	3 years
Dementia Awareness	No renewal
Welsh Language Awareness	3 Years
Paul Ridd Learning Disability Awareness	No renewal
Environment, Waste and Energy **(Admin & Clerical staff Only)**	Yearly

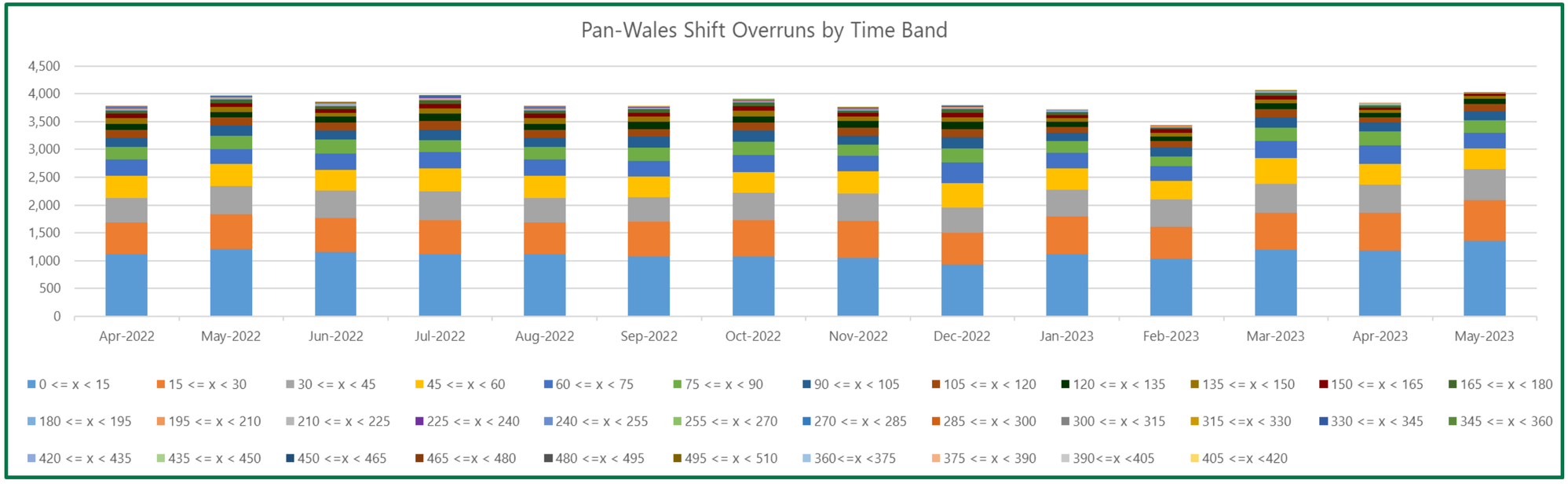
Data source: ESR

Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

CI





Analysis

The average shift overrun (for all resource types) in May 2023 was 42 minutes and 26 seconds, a decrease when compared to the previous month and when compared to 49 minutes in April 2022.

The highest volume of shift overruns occur in the 0 – 60-minute category, accounting for 78.8% of shift overruns, 20.6% of shift overruns fall in the 61–120-minute category, 6.6% in the 121 – 240 minutes category and 0.4% in the 241 minutes and over category.

Remedial Plans and Actions

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

Expected Performance Trajectory

A new People and Culture Plan is due to be launched in the coming months along with an accompanying enabling framework that covers People and Culture Directorate Plans that focus on our people.

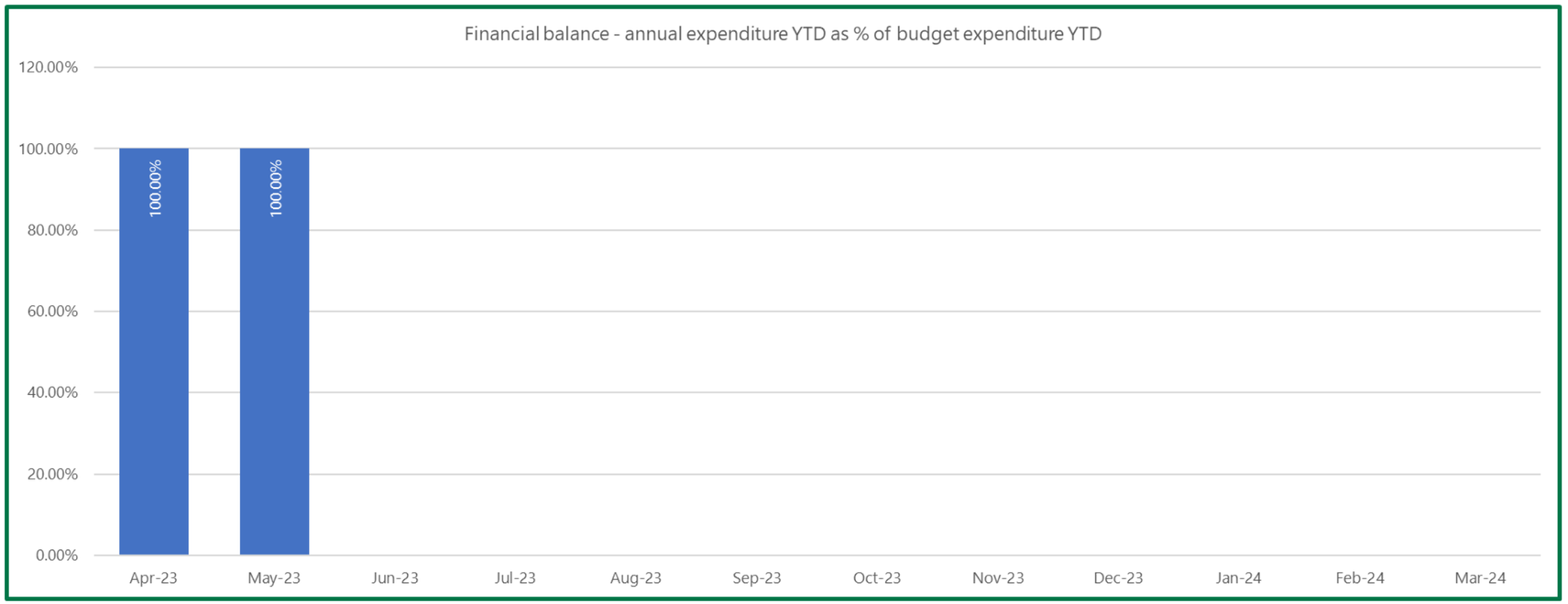
Slide Under Development

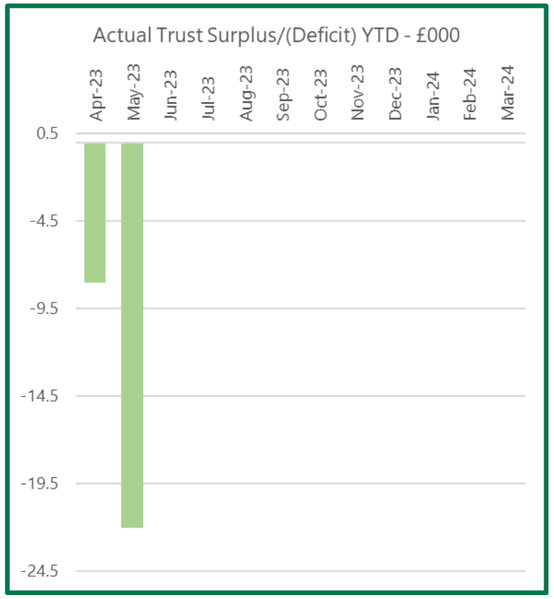
Finance, Resources and Value
Value - Finance Indicators

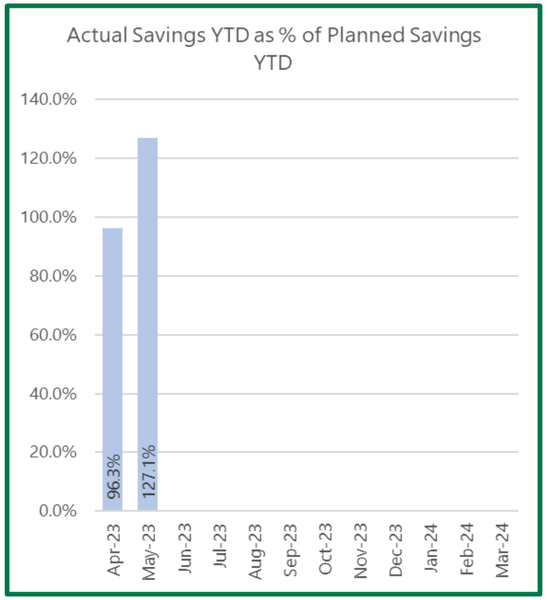
(Responsible Officer: Chris Turley)

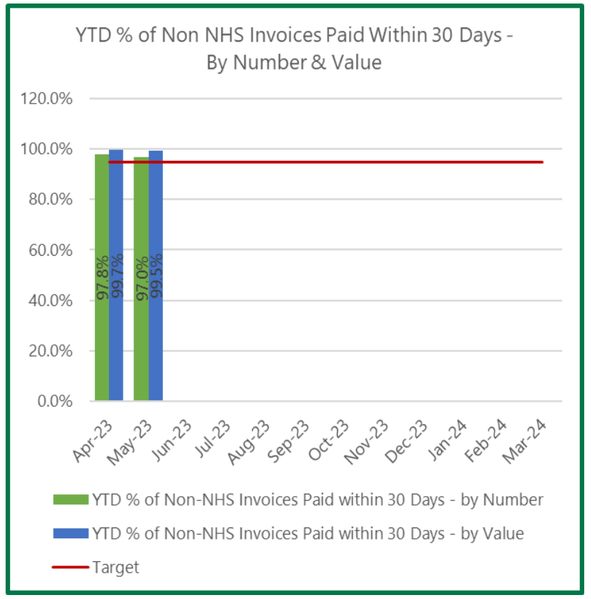
G

FPC









Analysis

The reported outturn performance at Month 2 is a deficit of £22k, with a forecast to the year end of breakeven.

For Month 2 the Trust is reporting planned savings of £0.977m and actual savings of £1.242m. The Trust's cumulative performance against PSPP as at Month 1 is 97.0% against a target of 95%.

At Month 2 the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit.

Remedial Plans and Actions

The Trust's financial plan for 2023-26 has been built on the plans and financial performance of the last few financial years, in which the Trust has, year on year, achieved financial balance; the 2023-26 financial plan was submitted to WG following Board sign off on 31st March 2023.

No financial plan is risk free. Financial risk management forms a key element of the project plans which underpin both the Trust's ambitions and savings targets. The Trust continues to seek to strengthen where it can its financial capacity and corporate focus on finance, and as an organisation have structures in place to drive through the delivery of our financial plan.

Key specific risks to the delivery of the 2022/23 financial plan and beyond include:

- Continuing financial support from Welsh Government in relation to Covid costs;
- Availability of capital funding to support the infrastructure investment required to implement service change, and the ability of the Trust to deliver the revenue consequences of capital schemes within stated resource envelope;
- Financial impact of EASC Commissioning Intentions, and confirmation of the EMS financial resource envelope as assumed within our financial plan;
- Ensuring additional avoidable costs that impact on the Trust as a result of service changes elsewhere in the NHS Wales system are fully recognised and funded;
- Ensuring any further developments are only implemented once additional funding to support these is confirmed;
- Delivery of cash releasing savings and efficiencies via the Financial Sustainability Program (FSP);

Expected Performance Trajectory

The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2023/24 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver further significant level of savings into the 2024/25 financial year.

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

(Responsible Officer: Lee Brooks)

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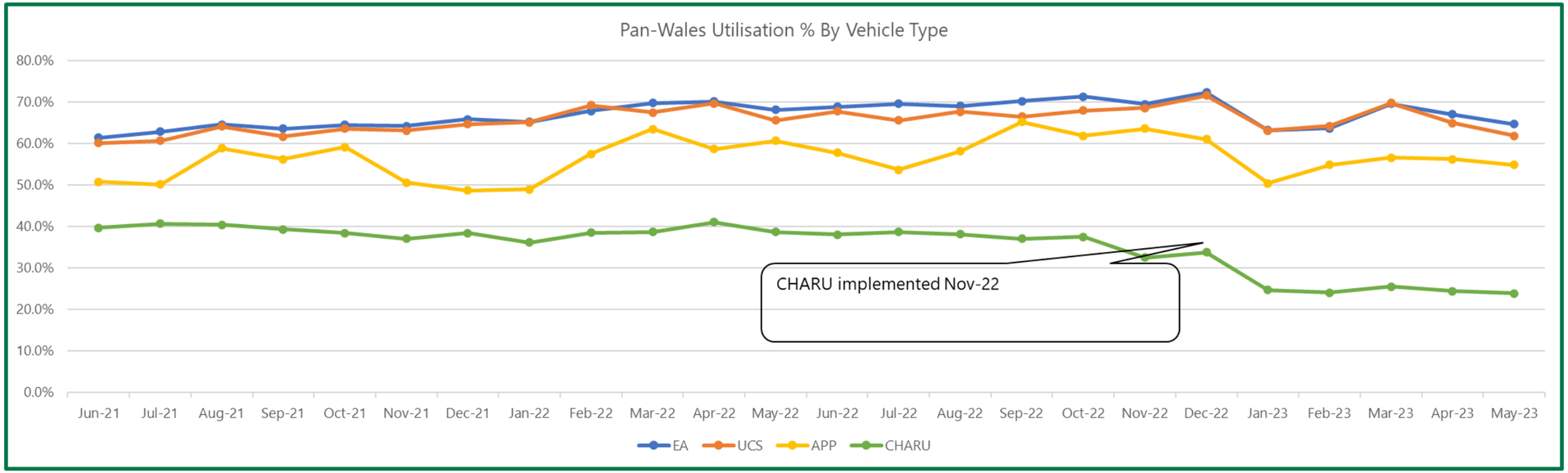

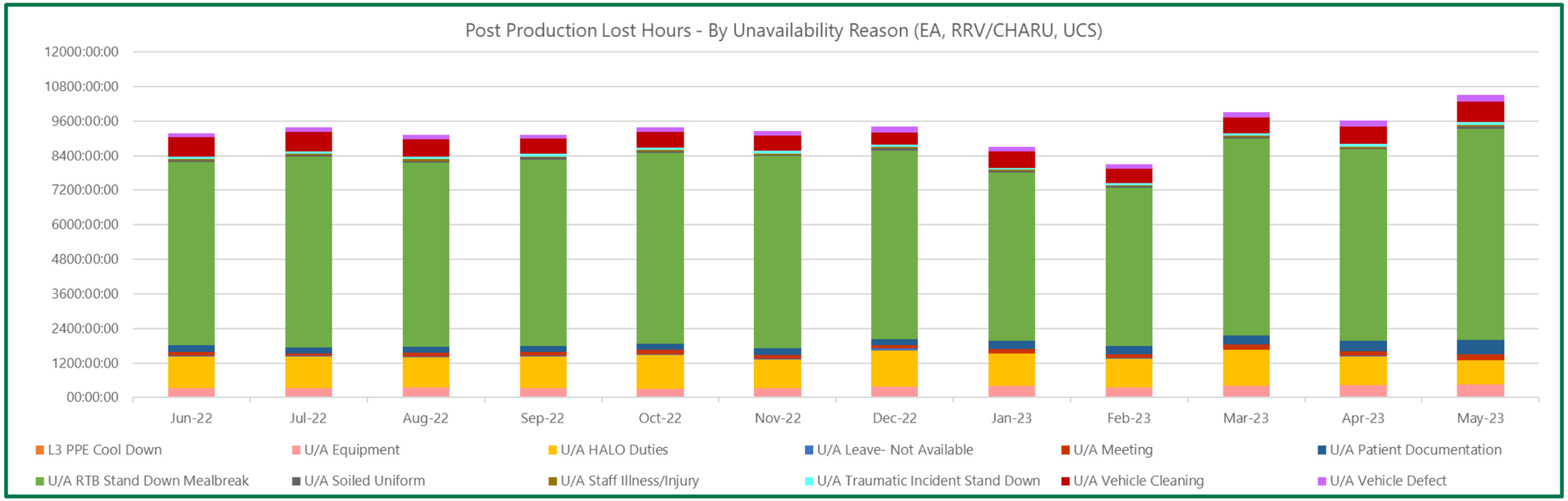

Analysis

Pan Wales Utilisation metrics in May 2023 was 56.3% for all vehicles types. EA achieved the highest rate during the month at 64.7% while UCS was at 61.9%. Both have seen a generally increasing trend over the past two years before dropping off slightly since February 2023. The optimal utilisation rate for EAs needs to lower so that they are free to respond to incoming calls.

There were 10,505 post-production lost hours (PPLH) across EA, RRV/CHARU, APP & UCS vehicles in May 2023; an increase when compared to April 2023 (9,631). PPLH are due to numerous factors, as outlined in the bar chart, which demonstrates they remained relatively consistent since May 2022 (the month a retrospective fix was undertaken for the under-reporting of U/A RTB Stand Down Meal-break code), albeit the last three months have seen the highest reported figures over the past year.

Remedial Plans and Actions

The Trust will not be able to eliminate PPLH, however, efficiency options continue to be worked through, and PPLH are monitored and scrutinised closely, forming part of the weekly performance meeting. In relation to the U/A RTB Stand Down Meal-break reason, the rest break automation initiative has been paused due to industrial relations. The Trust plans to revisit this once the industrial dispute with Welsh Government has concluded. Good progress has been made on other areas of PPLH.

Expected Performance Trajectory

The current data needs to be treated with a degree of caution. As stated above, the Trust will not be able to eliminate PPLH. Although delayed handover hours outside EDs have improved slightly from December 2022, the lost hours for March 2023 were extreme, meaning resources are returning to base for rest predominantly outside of the rest break window, resulting in an unavailable status being assigned.

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

Finance, Resources and Value
Resource and Value Indicators

(Responsible Officer: Chris Turley)

Decarbonisation: A

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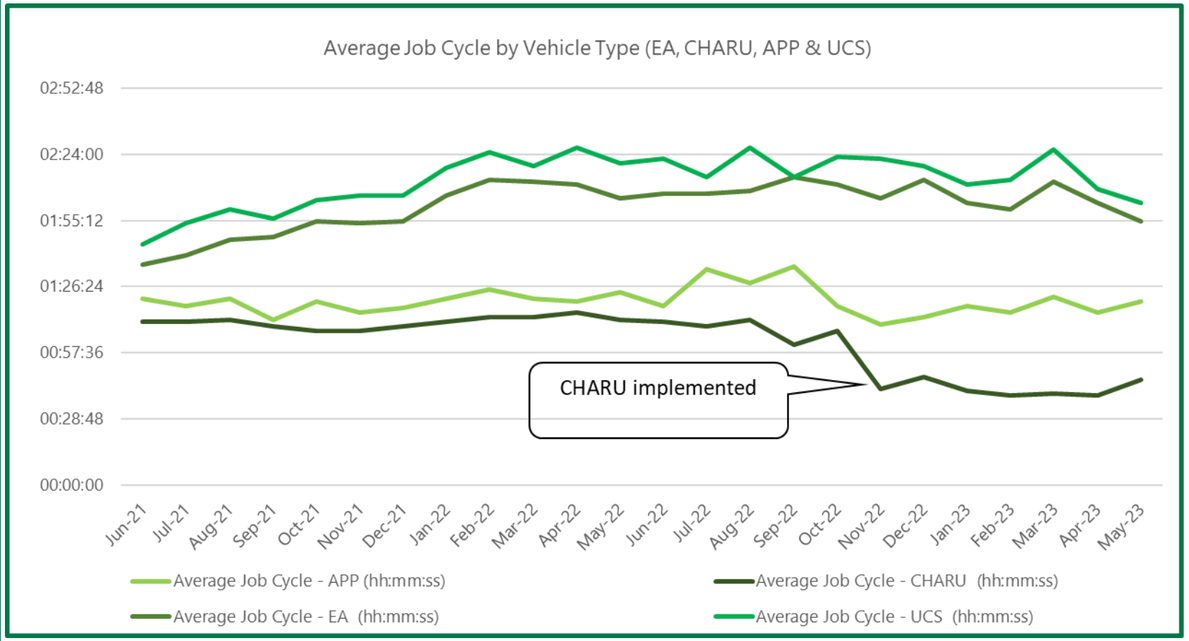

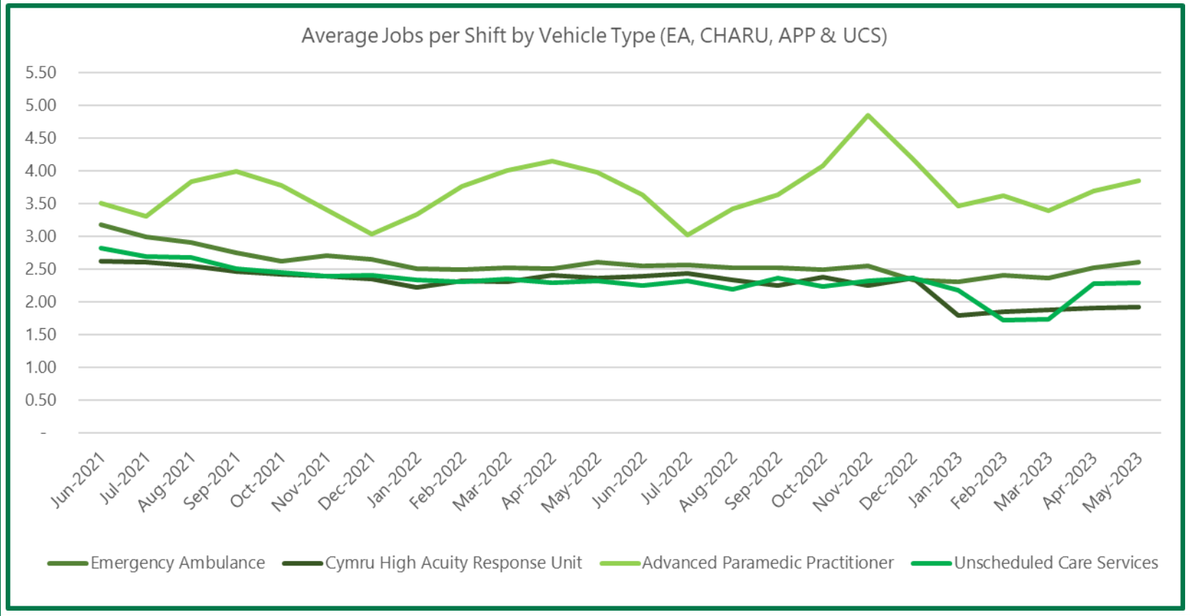

Value – Job Cycle and Volume

Analysis

As demonstrated in the top graph, the average job cycle in May 2023 decreased for both EA and UCS but increased slightly for both APP and CHARU. EA calls averaged 1 hours 55 minutes while UCS crews saw their average decrease to 2 hours 3 minutes.

APPs attended on average 3.86 jobs per shift, EAs 2.61 jobs per shift, UCS crews 2.29 jobs per shift and CHARU's 1.92 jobs per shift.

Overall average jobs per shift has remained relatively static for EA, CHARU and UCS throughout the past year, while in comparison average jobs per shift for APPs is on a fluctuating, but generally increasing, trajectory.

Remedial Plans and Actions

The increase in average job cycle time since 2021 can be attributed to numerous factors including the introduction of ePCR and increasing hospital delays (staff pre-empting and packaging patients in readiness for long waits and patients waiting longer for an ambulance response therefore requiring more treatment/assessment). These times are monitored at Weekly Performance Meeting and local work to establish appropriate efficiency initiatives is ongoing

Expected Performance Trajectory

The increase in job cycle time since 2021 is caused by numerous complex factors. As ePCR embeds, a decrease may be seen, but with the factors outside of WAST's control a reduction to pre pandemic levels may not been seen.

**NB: Average jobs per shift only includes data where the full shift worked is less than 20 hours.*
Total shift hours currently includes the meal break for the shift
Total shift hours also includes Postproduction Lost Hours

Resource - Decarbonisation

Analysis

Delivery of the capital programme in 2023/24 sought to maximise decarbonisation aspects associated with investment. Examples include PV panels and battery storage at Bridgend Ambulance Hub, PV panels, battery storage and installation of air source heat pump within the development of the SE Fleet Workshop, and other energy saving schemes such as LED lighting, glazing and building management systems where possible during the last quarter of 2023/24. The Trust's EV charging network (initially to support implementation of 23 PHEV car-based response vehicles) developed from minimal provision to 67 chargers over 54 sites.

Remedial Plans and Actions

WAST Decarbonisation Action Plan is currently reporting internally as Amber. Estates and Facilities Advisory Board funding in 2023/24 and 2-24/25 will allow for investment in further infrastructure and decarbonisation schemes across a range of sites. Plans for Building Management Systems, and a design guide for retrofit of estate continue to be developed. However, further funding will be required. The Trust has completed a scoping exercise for electrical capacity requirements across the WAST estate and work is ongoing with Welsh Government Energy Services on rapid EV charging. The first Programme Board meeting held on 30th January 2023 with Executive level chair. The Board will oversee the delivery of the DAP and all associated underpinning programme management elements such as workstreams, management of risks, identification of benefits and supporting ongoing programme lessons. The programme board then met again on 24th April 2023, and continues to develop its work programme and risk management approach with meetings every quarter.

The first meeting of the Transport Group took place on 29th March 2023 chaired by the Head of Capital Development. This group follows on from the small group (comprised of Fleet and Capital and Estates colleagues) which has overseen the EV charging network development in 2022/23 but looks to widen the scope of works to encompass all transport elements of the DAP including EV, other low emission vehicles, charging, staff EV charging, cycle and other transport initiatives and the grey fleet/staff vehicles aspects. The group will also be responsible for delivering associated policies and procedures underpinning the safe use of the network.

Expected Performance Trajectory

The Welsh Government targets of a net-zero position by 2030 pose real and complex challenges for WAST. In response to this, a key action over the next year will be to develop our Sustainability and Infrastructure Strategic Outline Programme, which will outline the financial and resource implications for the move to a carbon-neutral ambulance Trust. This will need significant input from our colleagues across the Trust and will require additional investment within the Finance and Corporate Resources

Directorate to manage this. The relevant business cases in support of Estates and Fleet developments will continue to reinforce the importance of this agenda, and to push us towards a position of carbon neutrality, maximising our use of new technology and responding in a flexible and agile way to the changing external environment. However, it should be noted that there continues to be global issues with motor vehicle supply chains which is hindering the progress of electric emergency ambulances, alongside limited funding.

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

(Responsible Officer: Lee Brooks)

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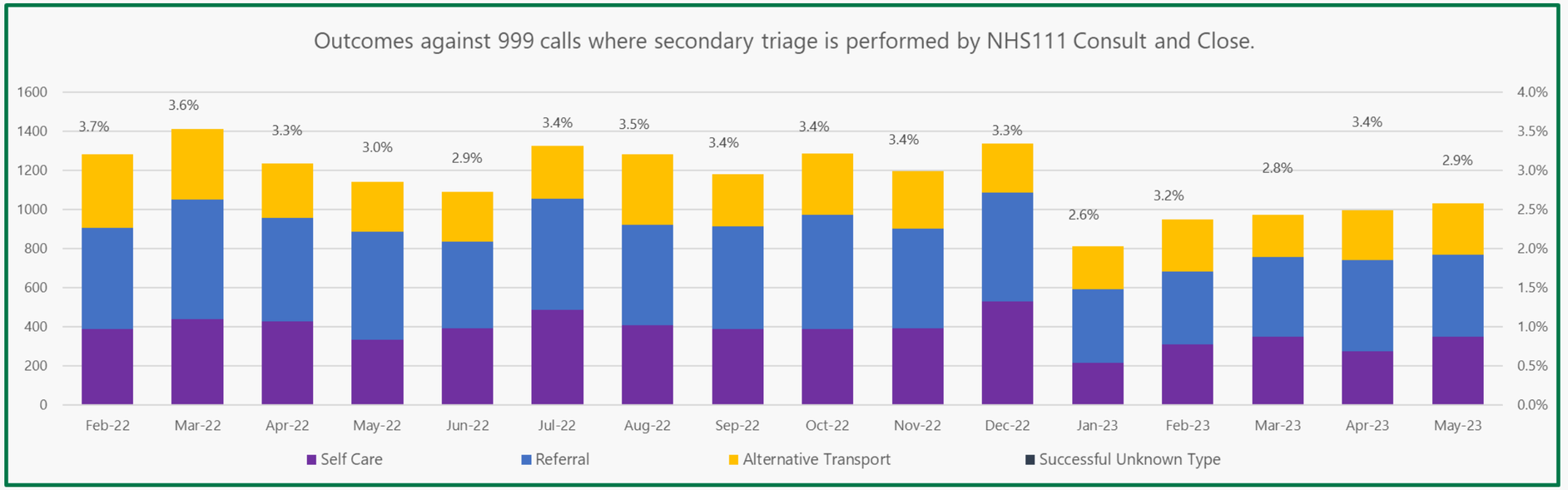
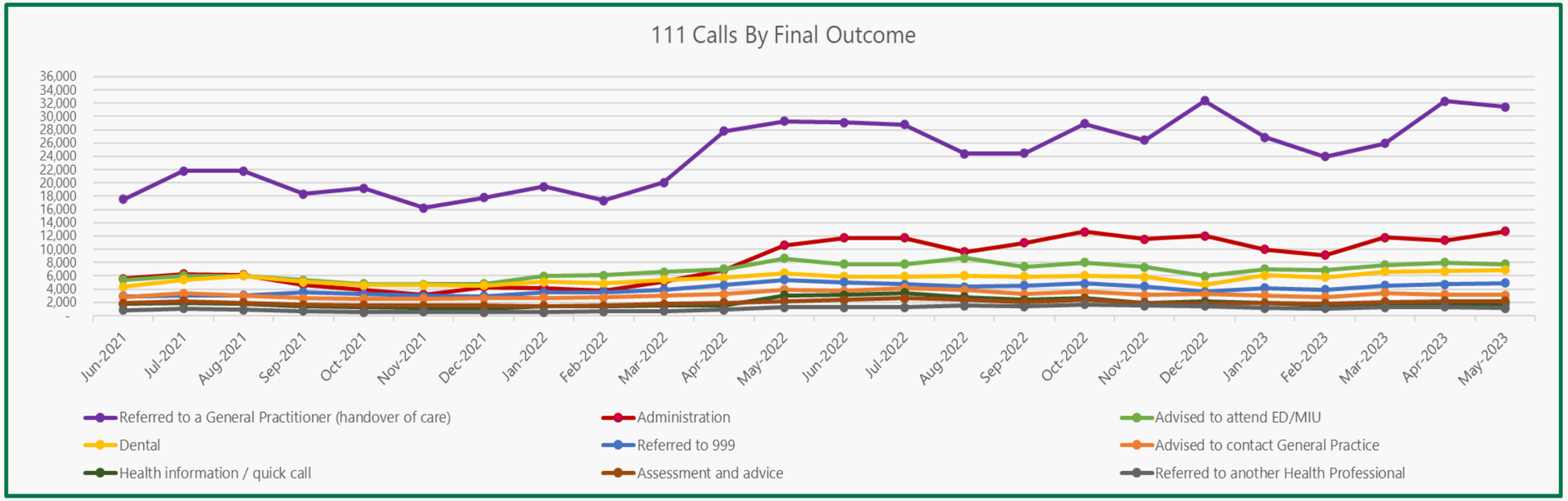
Influencing Factors – Demand and Clinical Hours Produced





Analysis

The top graph depicts the outcomes against 999 calls where secondary triage is performed by NHS111 Consult and Close. As demonstrated in the graph, in April 2023 referral was the top outcome for calls handled by NHS111 followed by self-care and alternative transport.

71,920 calls were received into the 9 categories displayed in the bottom graph during May 2023, a slight increase when compared to the 71,472 received during April 2023. This was also above the average volume of calls seen over the past 12 months (66,167).

In May 2023, calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 40% of all calls.

Remedial Plans and Actions

The new Consult and Close dashboard is now complete and live, enabling the Trust to report more meaningful and specific data in relation to calls ending in alternative transport, referral and self-care.

The use of video consultation has been implemented and is now live, early indications show this to be a useful tool.

Expected Performance Trajectory

The Trust currently have a target to consult and close 15% of calls and are ambitious in aims to increase the proportion of activity resolved at step 2 by increasing the current target to 17% by the end of Quarter 1 2023/24 through internal efficiencies. The IMTP aspiration is to advance this to 20% but will require further investment of FTEs in the Clinical Support Desk (CSD).

Partnerships / System Contribution
Consult & Close Indicators

(Responsible Officer: Lee Brooks)

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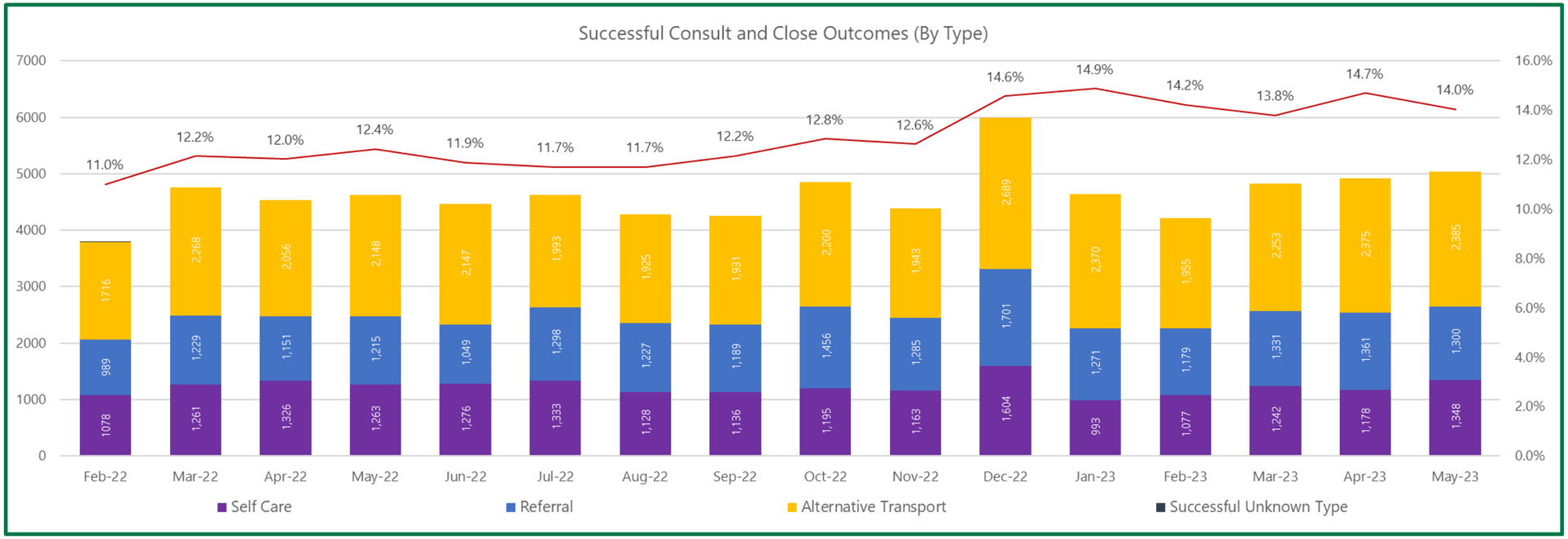

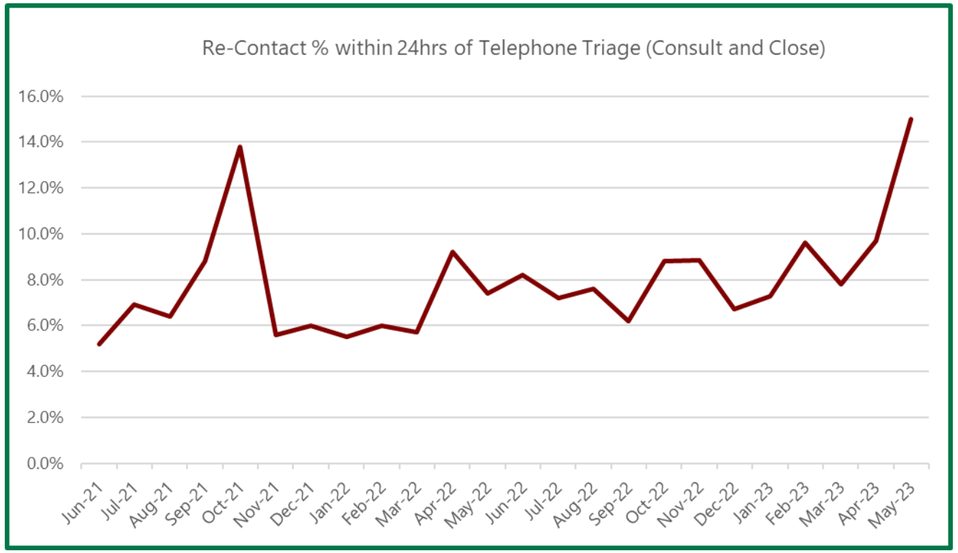

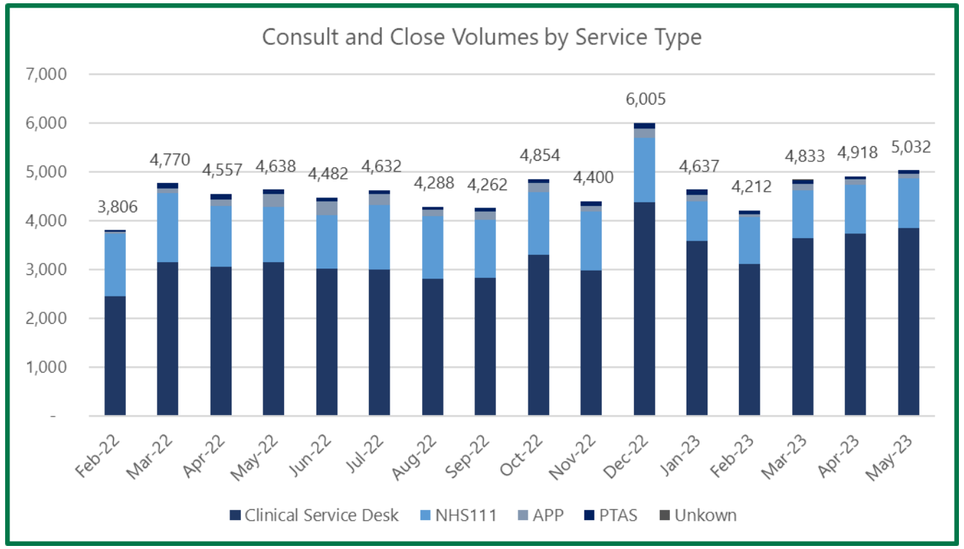

Analysis

Consult and Close with contributions from Clinical Support Desk (CSD) (10.7%), NHS111 (2.9%), as well as WAST APP (0.3%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.2%) achieved 14.1% in May 2023. This was a decrease on the 14.7% seen during April 2023 and remained short of the new 17% target figure. In May 2023, the number of 999 calls resulting in a Consult and Close outcome was 5,032, up from 4,918 in April.

Of the calls successfully closed in May 2023, 1,348 patients received an outcome of self-care; 1,300 patients were referred to other services (including to Minor Injury Units and SDEC) and 2,385 were advised to seek alternative transport services in order to acquire treatment.

Re-contact rates in May 2023 were 15%, a significant increase compared to 9.7% seen in April 2023, and the 7.4% in April 2022, although this rise can in part be attributed to one caller re-contacting the service on 74 occasions over the space of a few hours.

Remedial Plans and Actions

- The team are undertaking process maps of the work that they do in order to identify where improvements can be made.
- Red Review of 999 calls to confirm appropriate category selection continues to be a high priority for CSD in addition to Consult and Close activity.
- Discussions are ongoing to identify additional resources required on top of Consult & Close priorities.

Expected Performance Trajectory

The Trust currently have a target to consult and close 15% of calls and are ambitious in aims to increase the proportion of activity resolved at step 2 by increasing the current target to 17% by the end of Quarter 1 2023/24 through internal efficiencies. The IMTP aspiration is to advance this to 20% but will require further investment of FTEs in the Clinical Support Desk (CSD).

Partnerships / System Contribution
Conveyance to ED Indicators

(Responsible Officer: Andy Swinburn)

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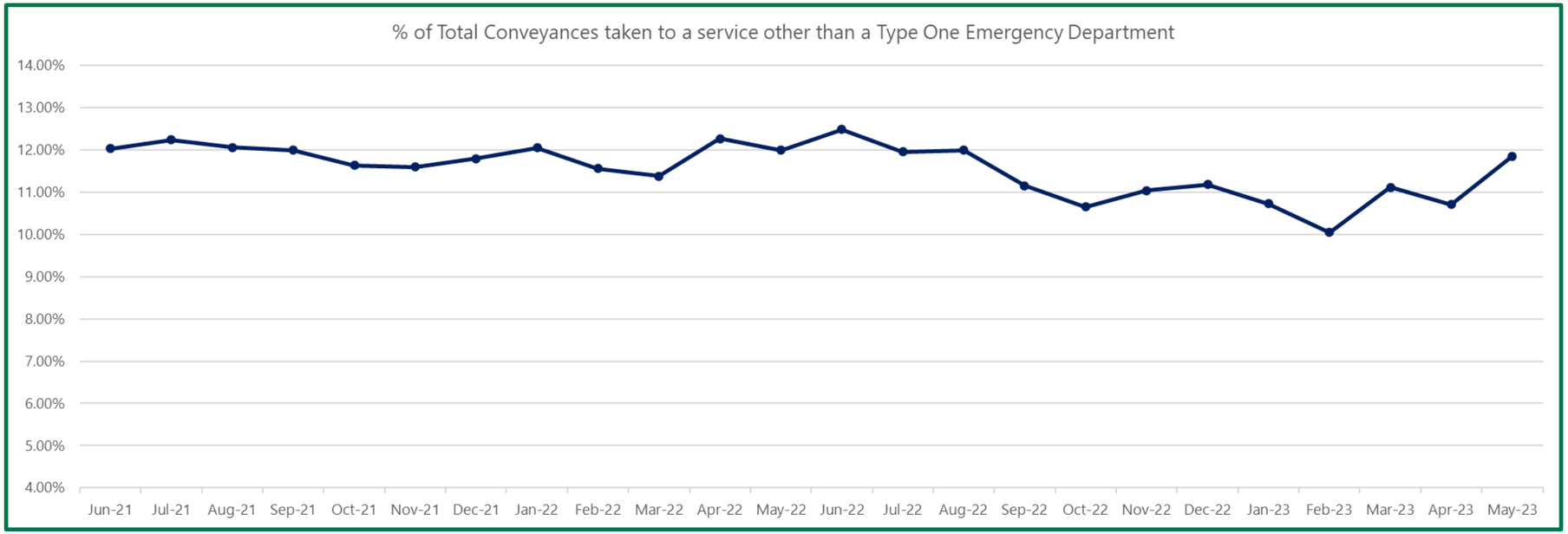
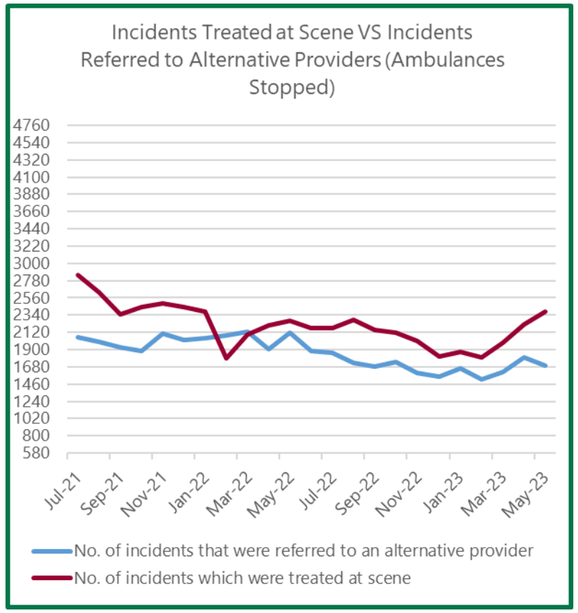
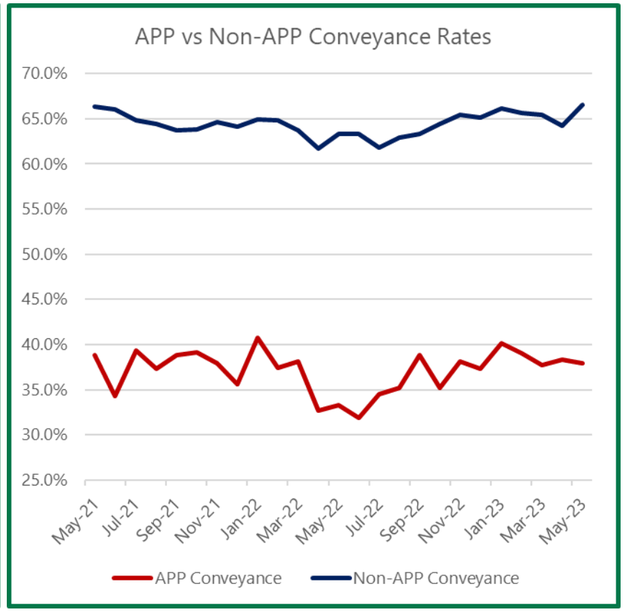
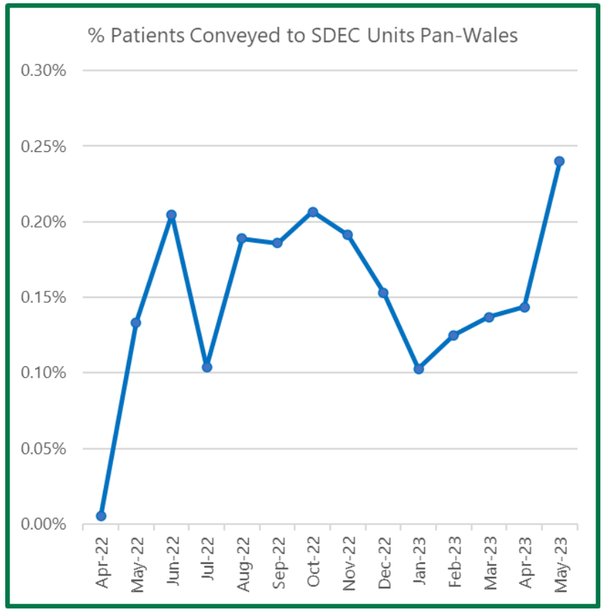
Ministerial Measure









Analysis

In May 2023 11.84% of patients (1,712) were conveyed to a service other than a Type One ED. Although not shown here, the percentage of patients conveyed to EDs increased compared to the same month last year by 1.2 percentage points. In May 2023 conveyance to EDs as a proportion of total verified incidents was 40.3% (compared to 39.1% in May 2022).

The combined number of incidents treated at scene or referred to alternate providers increased, from 4,027 in April 2023 to 4,080 in May 2023.

There has been a general increase in APP conveyance rates in recent months, due to several factors: -

- CSP means the right jobs are not always there for APPs to alter or influence the disposition.
- The tasking of APPs has changed, moving away from APPs reviewing the stack to mandatory code sets.
- There has been an increase in respiratory patients of all ages over the last quarter who have been poorly and required hospital admission.

The volume of patients conveyed to Same Day Emergency Care (SDEC) Units remains low, at 0.24% during May 2023.

Remedial Plans and Actions

The Trust has modelled the use of same day emergency care (SDEC) services and identified that they could take an estimated 4% of EMS demand; it is currently less than 0.5%. This modelling has been provided to both EASC and WG. The percentage increase in conveyance to services other than EDs is a Ministerial Priority. The Trust's ability to improve this figure is dependent on pathways that are open to the Trust, for example, SDECs.

Utilisation of APP resources will continue to be monitored as part of weekly performance reviews and evaluation of the appropriate APP code-set will be undertaken through the Clinical Prioritisation and Assessment Software (CPAS) group.

Expected Performance Trajectory

The Trust has completed modelling on a full strategic shift left, which identifies that the Trust could reduce handover levels by c.7,000 hours per month, with investment in APPs and the CSD; however, the modelling indicates that handover would still be at 10,000 hours per month. Health Board changes are required as well. This modelling indicates a reduction in patients conveyed of 1,165 per week but is predicated on large scale investment in APPs (470 v a starting position of 67).

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

Partnerships / System Contribution Handover Indicators

(Responsible Officer: Health Boards)

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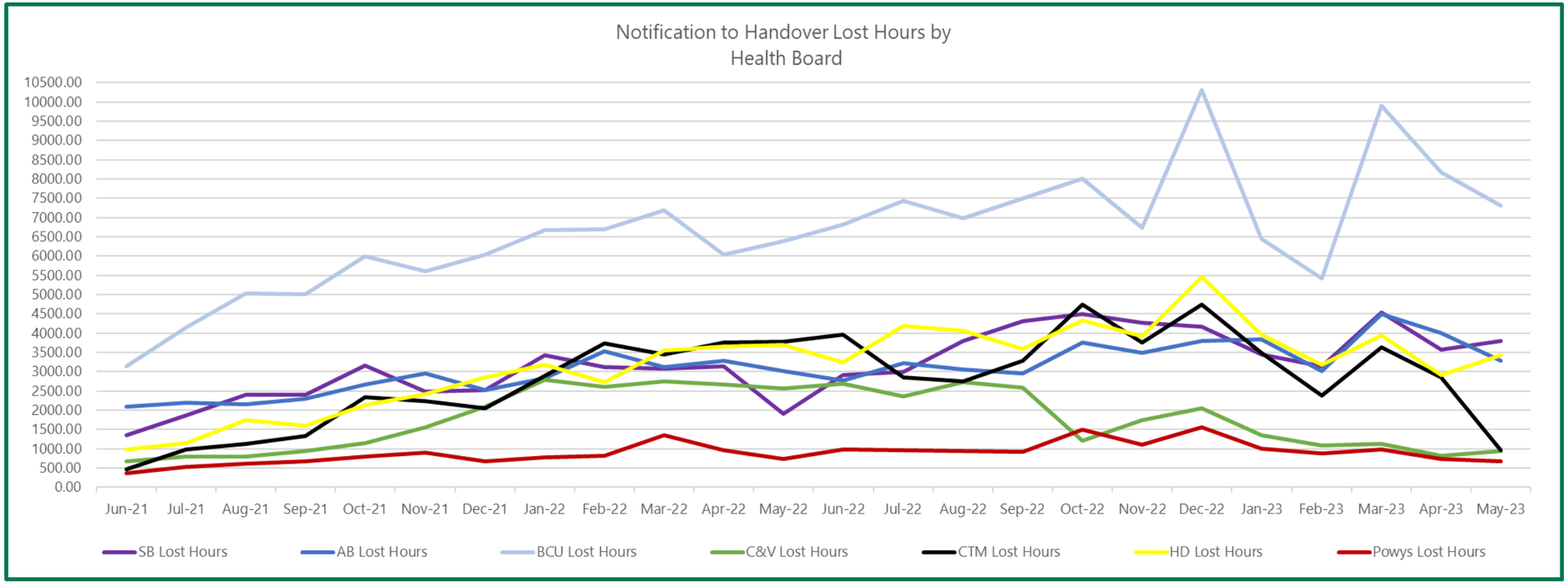
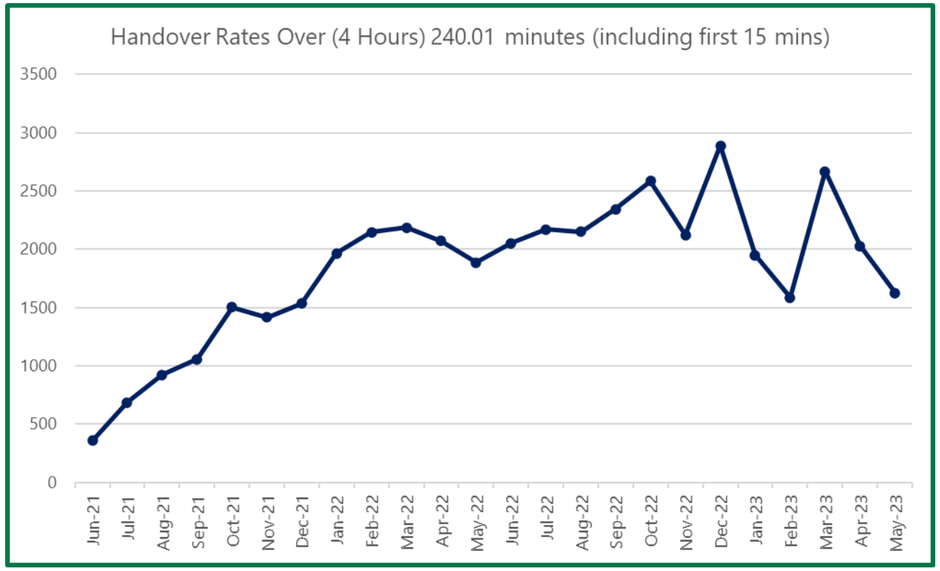
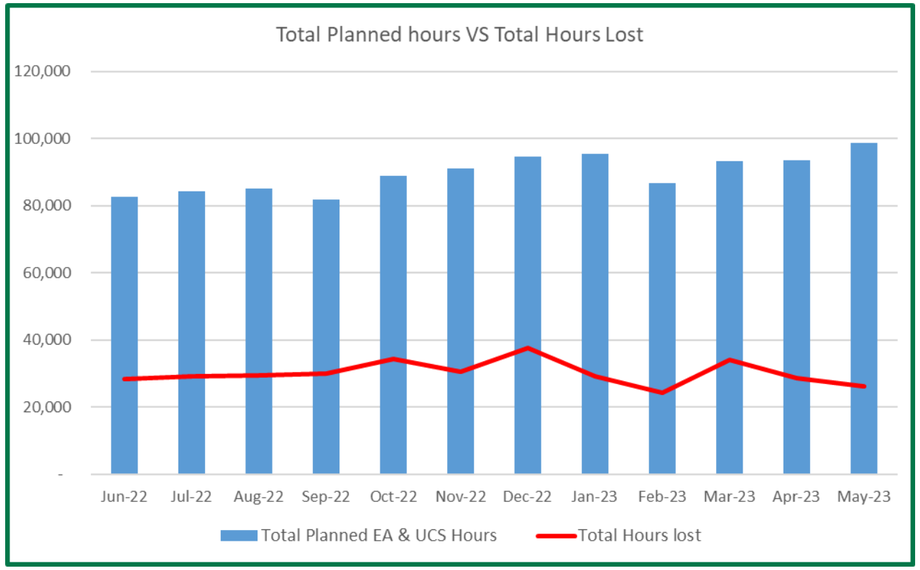






Analysis

297,653 hours were lost to Notification to Handover, i.e., hospital handover delays, over the last 12 months (Jun-22 to May-23), compared to 219,736 over the same timeframe the previous year. 20,397 hours were lost in May 2023, a decrease from the 23,082 lost in April 2023, and the second month in a row that the figure has come down.

The hospitals with the highest levels of handover delays during May 2023 were:

- Morriston Hospital (SBUHB) at 3,960 lost hours
- Glan Clwyd Hospital Bodelwyddan (BCUHB) at 2,947 lost hours
- The Grange University Hospital (ABUHB) at 3,146 lost hours
- Maelor General Hospital (BCUHB) at 2,733 lost hours

Notification to handover lost hours averaged 658 hours per day during May 2023 compared to 769 hours a day in April 2023. There were 1,697 handovers over 4 hours Pan-Wales in May 2023 a decrease compared to April 2023 (2,670).

In May 2023, the Trust could have responded to approximately 6,434 more patients if handovers were reduced, which highlights the impact the numbers are still having on service.

Remedial Plans and Actions

Significant time has been spent by all Executives and non-Executives highlighting this patient safety issue to EASC, Health Boards and to Welsh Government / Minister, and this will continue through the year as we seek to influence and put pressure on the system to improve. Healthcare Inspectorate Wales (HIW) has undertaken a local review of WAST to consider the impact of ambulance waits outside Emergency Departments, on patient dignity and overall experience during the COVID-19 pandemic.

The WIIN platform continues to focus on patient handover delays at hospital and Electronic Patient Care Record (ePCR).

Expected Performance Trajectory

The Commissioning intention for 2023/24 is that handover lost hours should reduce to 15,000 hours per month, the same seen levels seen in the winter of 2019/20, which were considered extremely high, 12,000 hours by the end of Quarter 2 and sustained and incremental improvement in quarters 3 and 4. The ambition that there should be no waits over 4 hours during 2023/24. Non-release for Immediate Release Requests should become a Never Event.

**NB: Data correct at time of abstraction.*

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

Definition of Indicators

Indicator	Definition	Indicator	Definition
111 Abandoned Calls	An offered call is one which has been through the Interactive Voice Response messages and has continued to speak to a Call Handler. There are several options for the caller to self serve from the options presented in the IVR and a proportion of callers choose these options. An example is to guide the caller to 119 if they wish to speak to someone about a Coronavirus test. Once the caller is placed in the queue for the Call Handler if they hang up they are counted as "abandoned" as we did not answer the call. The threshold starts at 60 seconds after being placed into the queue as this allows the callers to respond to the messages and options presented as it often takes a short while for the caller to react. Starting the count at 60 seconds provides a picture of abandonment where the caller has chosen not to wait, despite wanting to speak to a Call Handler	**Hours Produced for Emergency Ambulances**	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
111 Patients Called back within 1 hours (P1)	(Welsh Government performance target) which prescribes that 111 has up to 1 hour (longer for lower priory callers) for a 111 Clinician to call the patient to discuss their medical issue. These callers will already have been screened by Call Handlers and received an outcome which needs a conversation with a 111 Clinician. WAST operates a queue and call back method for all Clinical Calls.	**Sickness Absence (all staff)**	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
999 Call Answer Times 95th Percentile	Time taken (in Minutes) to answer 999 emergency calls by call handlers. A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 95th percentile is the value below which 95 percent of the observations may be found.	**Frontline COVID-19 Vaccination Rates**	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
999 Red Response within 8 Minutes	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	**Statutory and Mandatory Training**	Combined percentage of staff who are compliant with required statutory training undertaken by staff where a statutory body has dictated that an organisation must provide training based on legislation and mandatory training which relates to trade-specific training that the employer considers essential or compulsory for a specific job. (A detailed list of these can be found on slide 20).
Red 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Red (immediately life-threatening) calls (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	**PADR/Medical Appraisal**	Proportion of staff who have undertaken their annual Performance Appraisal & Development Review (PADR) or Medical Appraisal. This is a process of self-review supported by information gathered from an employees work to reflect on achievements and challenges and identify aspirations and learning needs. It is protected time once a year.
999 Amber 1 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Amber 1 calls (other life-threatening emergencies – including cardiac chest pains or stroke). (NB: The 95th percentile is the value below which 95 percent of the observations may be found.	**Ambulance Response FTEs in Post**	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Return of Spontaneous Circulation (ROSC)	Percentage of patients for whom Return Of Spontaneous Circulation occurs. This refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure.	**Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post**	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Stroke Patients with Appropriate Care	Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of caret hat have a greater effect on patient outcomes if done together in a time-limited way ,rather than separately).	**Financial Balance – Annual Expenditure YTD as % of budget Expenditure**	Annual expenditure (Year to Date) as a proportion of budget expenditure.
Acute Coronary Syndrome Patients with Appropriate Care	Proportion of STEMI patients who receive appropriate care. ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.	**Post Production Lost Hours**	Number of hours lost due to ambulance vehicles being unavailable due to a variety of reasons (A detailed list of these is show in the graph on slide 22).
Renal Journeys arriving within 30 minutes of their appointment (NEPTS)	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	**111 Consult and Close**	Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust's Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response.
Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	**999 / 111 Hear and Treat**	Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services.
National reportable Incidents (NRI)	Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare.	**% Incidents Conveyed to Major EDs**	Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents. (NB: An ED provides a wide range of acute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions, and which usually has an Accident and Emergency Department).
Concerns Response within 30 Days	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	**Number of Handover Lost hours**	Number of hours lost due to turnaround times at EDs taking more than 15 minutes. Transferring the care of a patient from an ambulance to an ED is expected to take no longer than 15 minutes, with a further 15 minutes for ambulance crews to make their vehicle ready for the next call.
EMS Abstraction Rate	The percentage of Emergency Medical Services (EMS) staff unavailable for rostered duties due to reasons, such as: annual leave, sickness, alternative duties, training, other and COVID-19.	**Immediate Release requests**	The number of requests submitted to Health Boards for the immediate release of vehicles at Emergency Departments to release them back into the community to respond to other urgent and life-threatening calls

Welsh Ambulance Services NHS Trust

Review of Board Level Metrics

June 2023

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

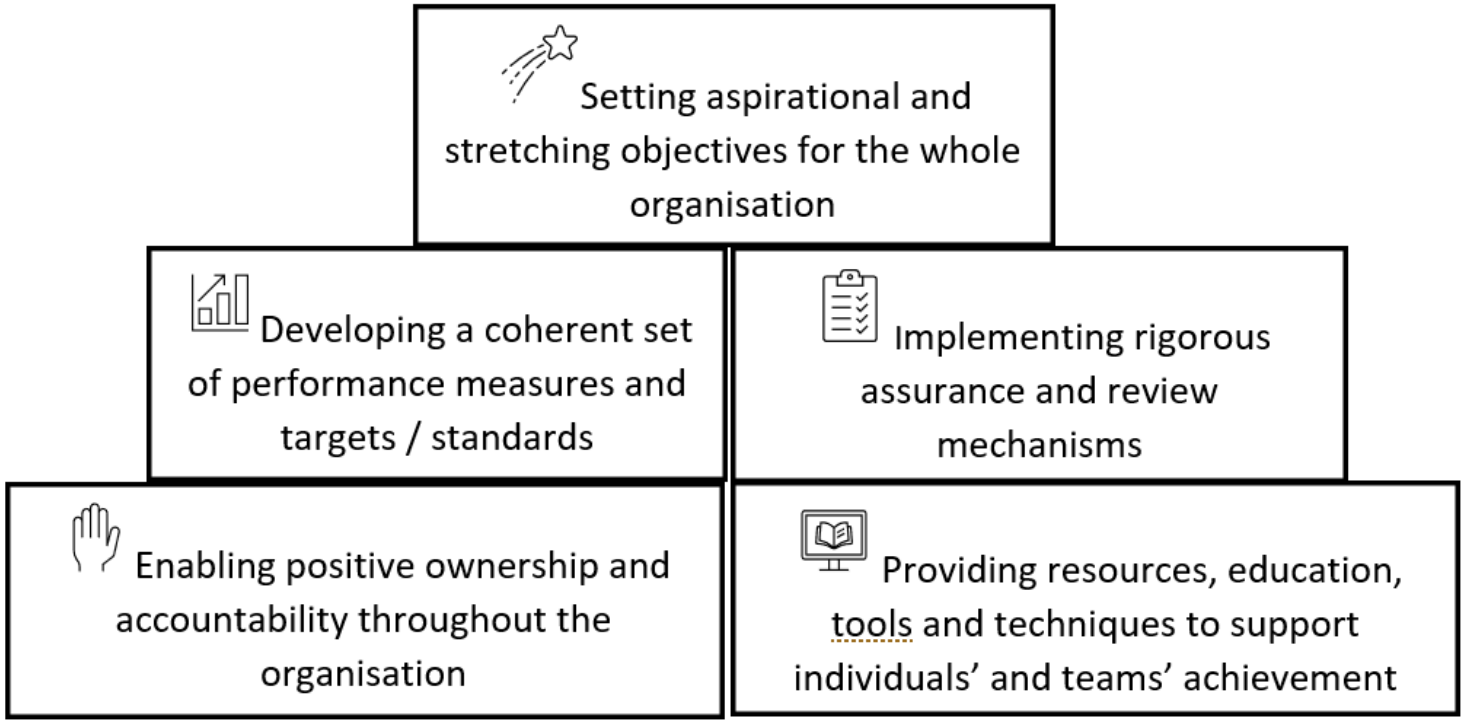
Review of Board Level Metrics
Version 2.0
Released: June 2023

by Commissioning & Performance Team

Recap on QPMF

Quality and Performance Management Framework

- The Framework sets out 5 organisational building blocks
- Enabler for improving **the quality of our services and achieving our ambitions**
- Measures are expected to be developed at **each level** of the organisation
- Measures will reflect the quality of services to patients, our people, value and system contribution.



MIQPR

- MIQPR provides a narrative on the metrics at Board level
- The headline metrics are grouped into 4 themes: Our Patients (Quality / Safety / Pt Experience); Our People; Value; and System Contribution.
- Board level metrics are chosen to reflect the smaller number of quality and performance indicators which
  - relate to key Welsh Government or commissioner priorities / targets;
  - would impact on reputation;
  - provide assurance on progress towards long term strategy.
- Each metric is assigned to one or more of the committees and they then have primary oversight of that quality or performance area
- The MIQPR also includes additional data on patient safety indicators to reduce duplication
- As part of the QPMF, a series of appropriate metrics and indicators needs to be agreed at every level of the organisation (sub committees / EMT / Directorate / team / individual)

2022/23 Dashboard Metrics agreed by Board

Our Patients	• 111 call handling abandonment rate • 111 Clinical triage ring back time • 999 call handling time 95th centile • Red 8 minute • Amber 1 median • ROSC rates • Stroke bundle compliance • ACS bundle compliance • NEPTS renal journey performance • NEPTS Discharge performance • Complaints response times • NRIs (WAST) • Immediate Release • Number of no sends / cancellations • PROMS / PREMS	**Our People**	**Capacity** • Total EMS Hours produced against commissioned levels. • Other hours produced against. commissioned levels for 111. **Health and Well-being** • Organisational sickness absence • Ops sickness absence. • Turnover rate. • Vaccination rates. • Statutory / Mand compliance. • PADR compliance. **Inclusion & Engagement and culture** • Age / gender profiles
Value	• Financial balance. • Utilisation metric EMS. • Post production lost hours EMS. • Numbers of jobs per shift / hour. • Emissions.	**Partnerships and System Contribution**	• Consult and close (111). • Consult and close rates (999). • See, treat and refer rate. • Percentage of total conveyances taken to a service other than a Type One ED. • Hospital handover lost hours. • Number of patients over 4 hours wait • Numbers of completed symptom checkers

Existing & Proposed Metrics 2023/24 – Our Patients

Proposed new	
Proposed remove	

Our Patients	**Timeliness** • 111 call handling abandonment rate. • 111 clinical triage call back time (P1). • 999 call handling time 95th centile. • Red 8 minute. • Amber 1 median • NEPTS renal journey performance. • NEPTS Oncology • NEPTS Discharge performance. **Clinical Outcomes / Quality** • ROSC rates. • Stroke bundle compliance. • Call to Door Times STEMI/Stroke. • ACS bundle compliance. • NRIs (WAST). • Immediate release. • Numbers of no send / patient cancellation (unmet care need). • PREMs/ PROMS • Complaints response times. • Metric on Duty of Candour	Oncology is a commissioning intention Only one on stroke This will replace the stroke bundle metric from Q2

Existing & Proposed Metrics 2023/24 – Our People

Proposed new
Proposed remove

Our People	**Capacity** • Total EMS Hours produced against commissioned levels. • Total 111 hours produced against commissioned levels **Health and Well-being** • Organisational sickness absence level. • Mental health absence • Ops sickness absence. • Turnover rate. • Vaccination rates. • Statutory / Mand compliance. • PADR compliance. • Number / length of shift overruns **Inclusion & Engagement and culture** • Number of applicants and shortlisted number from under-represented groups • Number of R and R and disciplinaries by theme • 111/NEPTS calls in Welsh	Allows us to measure one of key priorities in IMTP How do we consider psychological safety?

Existing & Proposed Metrics 2023/24 – Value

Proposed new
Proposed remove

5

Value	• Financial balance. • Utilisation metric EMS. • Post production lost hours EMS. • Numbers of jobs per shift / hour. • Emissions. • Value indicators for 111 / CSD (TBD) • NEPTS cancellations on arrival	No further specific action on this in 2023/24 Emissions – unable to report monthly

Existing & Proposed Metrics 2023/24 – Partnerships/ System Contribution

Proposed new
Proposed remove

Partnerships / System Contribution	**Inverting the Triangle** • Consult and close rates (999). • See, treat and refer rate. • Conveyances to a service other than a Type One Emergency Department. • Hospital handover lost hours. • Number of over 1 hour waits **111** • Number of dental calls • Consult and close (111). • Numbers of completed symptom checkers. **Other** • Metric on reputation • Transfer service – number completed within agreed time	• SDEC a specific focus here – include in more detail slide • This is a WG target • Linked to ambition to grow 111 as gateway to care • May only be appropriate annually • We want an increased focus on T&D

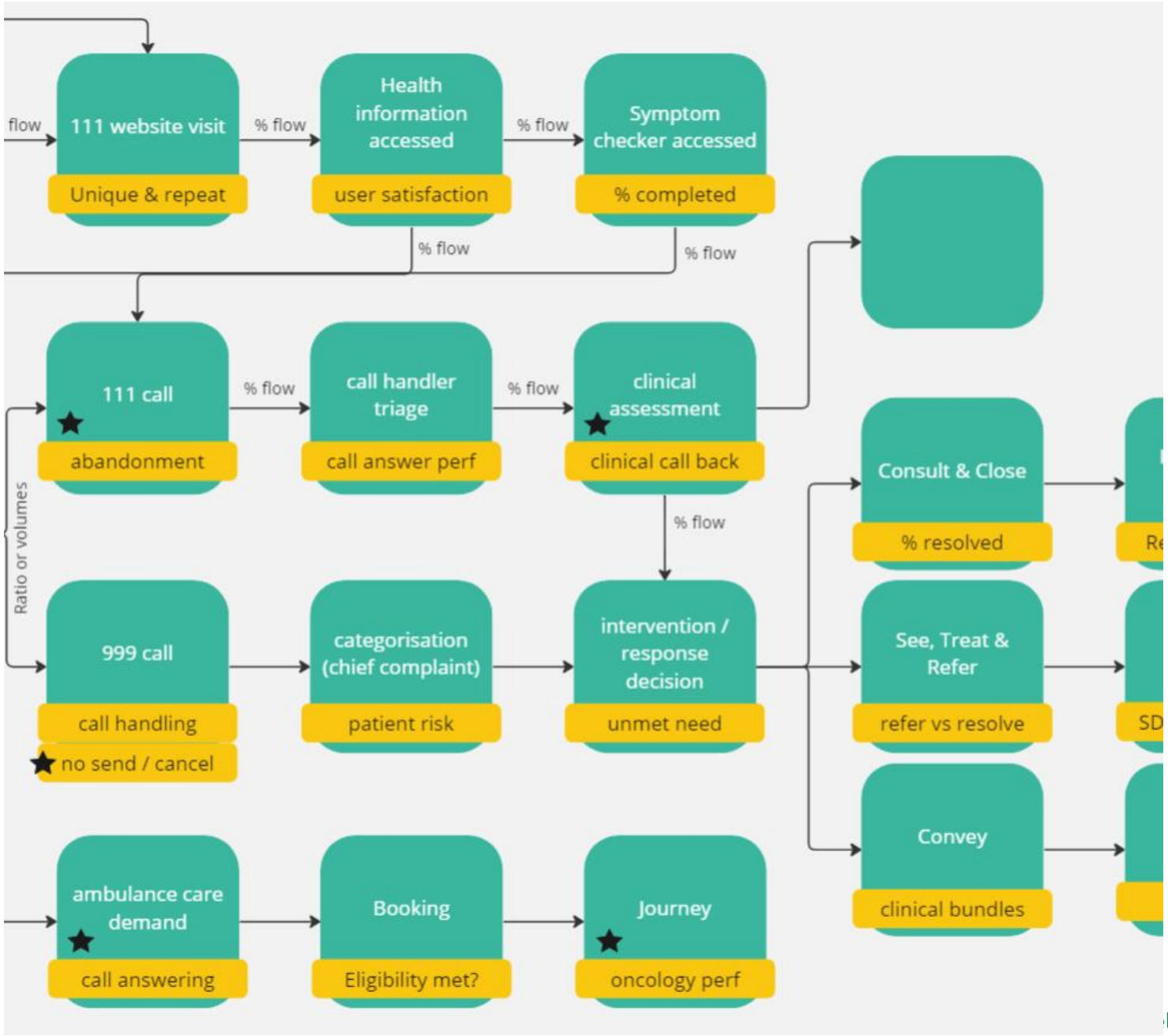
Next Steps

- Final review at F&P on 17th July
- Approval at Board on 27th July 2023
- Review of metrics at EMT / Directorate / team level to be completed within 23/24
- Further consideration to be given to development of a visualisation tool to pull out progress towards strategic ambitions specifically
- Over the course of 2023/24 further consideration will also be given to whether there are tiers of targets with a smaller number to come to Board and more detail at committee level.

Next Steps

- Consideration of total number of metrics at Board
- How do we move towards more outcome focused metrics
- How do we lift out those metrics that relate strongly to our long term ambition – perhaps visualising them more clearly?

Next Steps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Consult & Close
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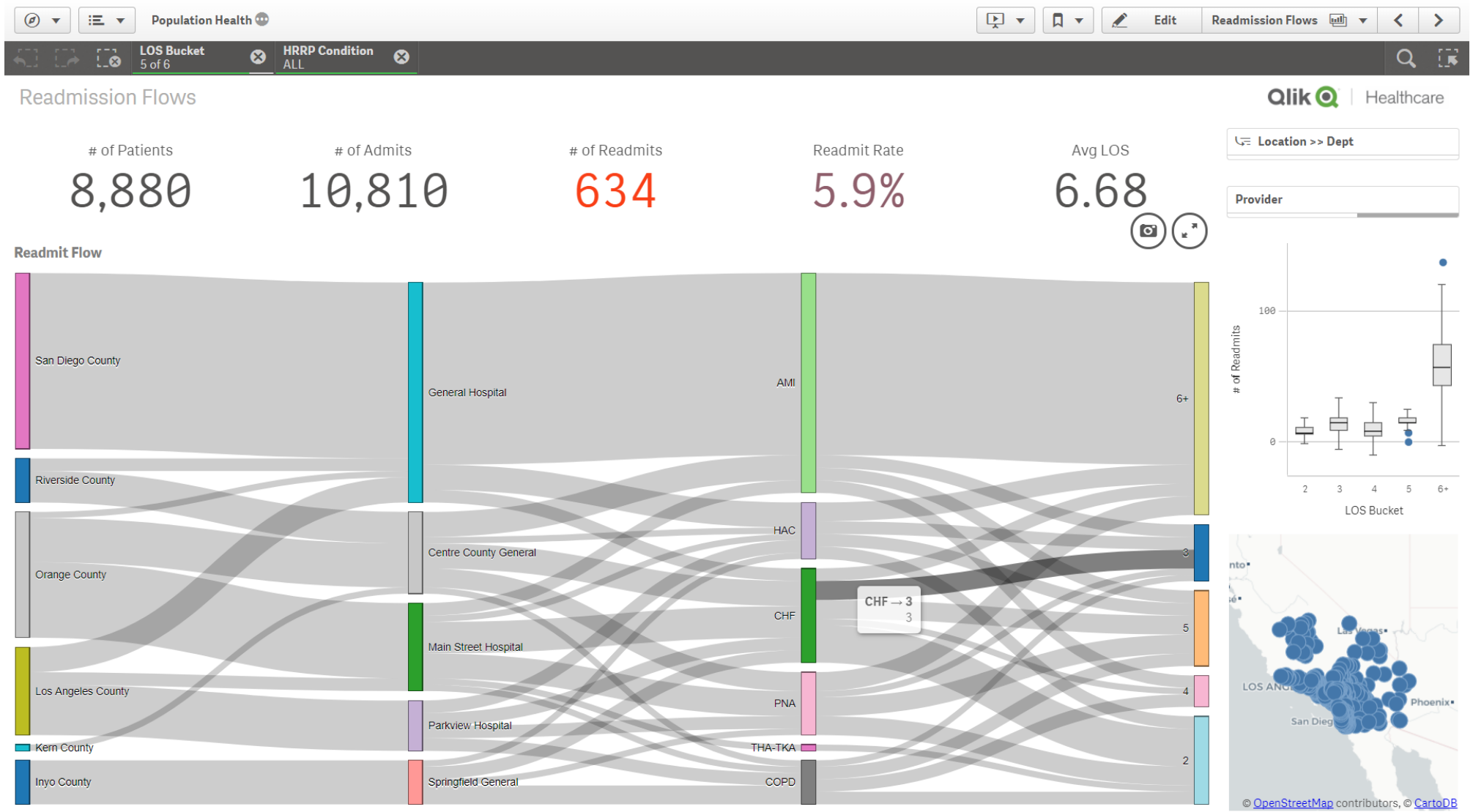
Next Steps


Population Health
Edit
Readmission Flows
LOS Bucket
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HRRP Condition
ALL
Readmission Flows
Qlik | Healthcare
# of Patients
8,880
# of Admits
10,810
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634
Readmit Rate
5.9%
Avg LOS
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Readmit Flow
San Diego County
Riverside County
Orange County
Los Angeles County
Kern County
Inyo County
General Hospital
Centre County General
Main Street Hospital
Parkview Hospital
Springfield General
AMI
HAC
CHF
PNA
THA-TKA
COPD
CHF → 3
3
6+
3
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4
2
# of Readmits
100
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3
4
5
6+
LOS Bucket
Las Vegas
Phoenix
San Diego
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AGENDA ITEM No	**10**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**4**

Emergency Preparedness, Resilience and Response (EPRR) Annual Report

MEETING	Finance and Performance Committee
DATE	17 July 2023
EXECUTIVE	Lee Brooks, Executive Director of Operations
AUTHOR	Clare Langshaw, Head of Service, EPRR & Specialist Operations Judith Bryce, Assistant Director of Operations
CONTACT	clare.langshaw@wales.nhs.uk

EXECUTIVE SUMMARY

This report is to provide Finance and Performance Committee with an annual assurance on key EPRR updates and activities. This SBAR highlights the key achievements and issues for committee.

KEY ISSUES/IMPLICATIONS

Contents to include updates on:

- Manchester Arena Inquiry report
- Review of Civil Contingencies in Wales report
- The UK Government Resilience Framework
- Annual HART/SORT Key Performance Indicator Report
- Welsh Government Annual Emergency Planning report
- Incident Response Plan
- Business Continuity Annual report

REPORT APPENDICES

Appendix 1 – Manchester Arena Inquiry Volume 2: Emergency Response
Appendix 2 – OFFICIAL SENSITIVE Review of Civil Contingencies in Wales **(NB, Circulated separately to Members)**
Appendix 3 – End of Year Summary 22/23
Appendix 4 – Health Emergency Planning Annual Report for 2022
Appendix 5 – UK Government Resilience 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)		Financial Implications	
Environmental/Sustainability		Legal Implications	
Estate		Patient Safety/Safeguarding	
Ethical Matters		Risks (Inc. Reputational)	
Health Improvement		Socio Economic Duty	
Health and Safety		TU Partner Consultation	

SITUATION

1.1 This report is to provide Finance and Performance Committee with an annual assurance on key EPRR updates and activities. This SBAR highlights the key achievements and issues for committee.

BACKGROUND

2.1 The last twelve months have heralded some key developments from an EPRR perspective with a number of national Welsh and UK developments, including the release of the Manchester Arena Inquiry (MAI) Report (volume 2), the release of the Review of Civil Contingencies in Wales Report and the release of the UK Government Resilience Framework.

2.2 Annual reports produced by the EPRR team to assure Welsh Government and the Trust on the Trust's preparedness to respond to an incident have been submitted, including the Annual Hazardous Area Response Team (HART) Key Performance Indicators (KPI) report, the Welsh Government annual Emergency Planning report and the Welsh Ambulance Services NHS Trust (WAST) Business Continuity Report.

ASSESSMENT

Manchester Arena Inquiry report

3.1 On 22nd May 2017, twenty-two innocent people were murdered in Manchester at the end of a music concert. In addition, hundreds were injured. Many suffered life-changing physical harm, many others psychological trauma. In March 2018, Lord Kerslake published a report following an initial review of the emergency response to the Manchester Arena bombing.

3.2 In June 2021 and November 2022, The Hon Sir John Saunders published reports from the Manchester Arena Public Inquiry. Three separate volumes have now been published.

3.3 Volume 2 deals with the emergency response to the attack and is most applicable to WAST. It examines the planning and preparation by the responders to an attack of the type which took place. It looks at what happened once the bomb had been detonated and how the response unfolded. It assesses the adequacy of the response. Volume 2 was published in November 2022.

3.4 Within the report there are:

- 149 recommendations
- 42 of these relate to ambulance services directly
- 21 of these relate to recommendations that require a multiagency response
- 8 relate to Local Resilience Fora (LRF) of which WAST is a member

3.5 A number of UK national EPRR groups have been set up to help ensure the recommendations are acted upon. The health aspects are being led by the UK Health Security Agency (UKHSA) and a number of sub-groups have been set up reporting to UKHSA and into the Home Office steering group, who are reporting to the inquiry on a UK-wide basis. WAST is represented on the UK groups and sits as part of the Joint Emergency Services Group (JESG) sub-group in Wales, working with blue-light partners on the multi-agency recommendations. The outcome of the JESG sub-group will feed into the Home Office steering group.

3.6 WAST has ring fenced funding for two dedicated posts (one manager and one support role) on a 12-month basis to specifically review the recommendations of the report and scope the implications and any necessary actions. The support post is currently in the recruitment stage. The manager appointed will represent WAST on specific groups both pan Wales and nationally and will generally be the WAST point of contact for MAI.

3.7 By way of progress to date:

- All recommendations have been assessed and Red Amber Green (RAG) rated
- A needs analysis is underway and high priority recommendations have been identified and will be reported on as a priority. Reporting and monitoring will be through the Operations Senior Leadership Team, and onto EMT and Committee.
- A large number of recommendations can be incorporated into the annual review of the Incident Response Plan later this year
- Work through the JESG MAI workstream is about to commence which will enable us to resolve some recommendations collaboratively with other blue light services across Wales

3.8 During June, correspondence was received from South Wales Local Resilience Forum seeking assurance from the Trust on a number of high priority recommendations from the Manchester Arena Inquiry report. An example being that

WAST hold a major incident plan which has been recently reviewed and updated, tested, exercised or successfully used in an operational scenario. WAST has provided a full response to the LRF, which the LRF have confirmed provides a high degree of assurance. This response has also been provided to the other three LRFs across Wales.

3.9 Please see Appendix 1 for more information on the recommendations.

Review of Civil Contingencies in Wales report

4.1 Central UK Government transferred powers to Welsh Government under Part One of the Civil Contingencies Act 2004 by way of a Transfer of Functions Order in 2018. This has subsequently enabled Welsh Government to provide a better-defined constitutional platform from which to develop preparedness, resilience, response and recovery across all agencies within Wales. Welsh Ministers are able to issue guidance in relation to the civil contingencies' duty, monitor compliance of the duties of devolved services, and to enforce duties under the Act.

4.2 A Welsh Government review of Civil Contingencies across Wales is currently underway; To inform the review, partnership engagement has taken place with a variety of stakeholders including WAST. This has been via the medium of interviews, workshops and discussion panels in which WAST has fully participated.

4.3 The findings of the review set out 15 recommendations, these recommendations relate to how Welsh Government and the LRFs will operate in the future. Welsh Governments' intention is to use the review findings to set out their Framework for a safer Wales, this is intended to be released in the autumn of 2023.

4.4 Only one of the recommendations is identified as critical:

"*A national assurance framework for Wales should be developed with monitoring to be managed by the Wales Resilience Board*".

WAST currently provides assurance to Health within Welsh Government on our preparedness under the Civil Contingency Act. However, other Category One responders, within Wales, do not currently have this requirement. Therefore, Welsh Government are seeking to put in place a National Assurance Framework that can be monitored and action taken against organisations who do not meet the required standards.

4.5 A multiagency working group is being established to review and plan the implementation of the recommendations, the WAST Head of Service, EPRR & Specialist Operations has been invited to join the Welsh Government Workshop to look at how this, and the other 14 recommendations

4.6 Please see Appendix 2 for the report. **(Circulated separately to Committee members due to sensitivity)**

The UK Government Resilience Framework

5.1 The UK Government Resilience Framework was released in December 2022 and sets out the UK Government's first articulation on how they will strengthen the systems and capabilities that support our collective resilience. The underlying basis of the report is that the UK government will be endeavouring to deliver a "whole of society" approach to preparing for incidents with a greater emphasis on preparation and prevention. The framework focuses on the UK's ability to anticipate, assess, prevent, mitigate, respond to, and recover from known, unknown, direct, indirect and emerging civil contingency risks.

5.2 Welsh Government have been reviewing the Resilience Framework and intend to use it as a basis, along with the Review Civil Contingency in Wales report to produce a Resilience Framework for Wales. This Framework will complement the UK Resilience Framework and detail Welsh Governments intentions across Resilience within Wales.

5.3 The framework introduces the new Resilience Directorate that has been established with the Cabinet Office as the new group that will drive the implementation of the measures set out by central government.

5.4 The framework sets out the six key themes that UK Government envisage as central to broadening and strengthening resilience systems: risk, responsibility and accountability, partnership, community, investment and skills.

5.5 There are a number of areas within the document that may impact on WAST; the UK Government is planning to strengthen standards for statutory responders to consider community resilience as an essential part of their work. Models for LRF funding will be reviewed to ensure they are adequate and appropriate for them to undertake their resilience work. Emphasis is also being placed on working with the private sector and the need for the private sector to be more cognisant of risks and more resilient to meet the new standards on resilience.

5.6 The measures set out with the framework relate to England, although the document is clear that all four nations are invested in the need to protect our communities from the impact of crises, and we can reasonably expect the Welsh Government to be including some of the same measures within their resilience review.

5.7 The Framework recognises the importance of EPRR within organisations and is supporting the introduction of a new Resilience Academy to ensure practitioners within EPRR have the capability and knowledge they need to undertake their role within EPRR.

5.8 The full framework document can be found in Appendix 5.

Annual Hazardous Area Response Team (HART)/ Specialist Operations Response Teams (SORT) Key Performance Indicator Report

6.1 Under the HART/SORT Service Level Agreement with Welsh Government, a report on the activities undertaken by WAST HART and SORT is submitted every quarter, and at the end of the financial year an annual report is submitted that provides an overview of the activities across the year.

6.2 Our Hazardous Area Response Team provide specialist capabilities within WAST in high risk and complex emergency situations. They are trained to work within inner cordons of major incidents, as well as skills such as working at height, in confined situations, in MTA (marauding terrorist attacks), security operations and water operations amongst others.

6.3 Our Specialist Operations Response Teams (SORT) are part of our existing clinical work force and have received additional training to support complex emergencies. These include responding to MTA incidents and incidents involving CBRNe (Chemical, Biological, Radiological and Nuclear) risks.

6.4 The 2022/23 annual report shows that we have maintained the correct number of operatives within the team and increased the number of female Operational Managers. It remains our ambition to increase this further and our female only sessions at our forthcoming HART open day on 30 June should encourage females into the team.

6.5 Whilst the overall number of HART deployments declined during the COVID-19 pandemic resulting in a lower overall decline on the number of HART deployments, the number of deployments have now returned to pre-pandemic levels.

6.6 In relation to SORT, the report highlights that the target of recruiting and training 50 personnel per region (150 pan Wales) is slightly below the target figure; This is as a result of high escalation earlier in the year, alongside the periods of industrial action when training has needed to be cancelled. Of particular impact is the number of SORT staff trained in Water rescue. However, training for SORT is now underway and being monitored by the Head of Service, EPRR & Specialist Operations. We intend to be back to target for the water training by November 2023.

6.7 The Epishuttle is a new capability for HART and SORT and was introduced during the pandemic as a means to transport high consequence infectious diseases (HCID) patients without the need for our staff to be in PPE. The Epishuttle is a single patient isolation and transport system designed to maintain public safety whilst allowing critical care and treatment to be performed on the contaminated patient inside the

Epishuttle. Welsh Government have requested that this capability remains within WAST beyond the pandemic and training is underway to ensure all SORT personnel are trained in Epishuttle operation. Welsh Government purchased two Epishuttles at the start of the Pandemic for WAST HART and SORT, in line with the English HART teams. Ongoing costs need to be included in the forthcoming 2023 review of the HART/SORT SLA with Welsh Government, as replacement parts are costly and are not currently included within the current SLA for HART and SORT.

6.8 A business case has been submitted to Welsh Government to fund the expansion of the SORT capability across Wales. This enhancement will bring Wales in line with other UK ambulance Trusts where the enhancement has already been funded. Should funding be confirmed through Welsh Government, the numbers of SORT operatives across Wales will be increased, along with the training and additional equipment to provide a greater capability to meet the presumed casualty numbers likely to be encountered in the event of a marauding terrorist attack (MTA) in the UK. Given that England has funded this capability, Wales will also have interoperability with other UK ambulance Trusts. This business case has recently been revised and resubmitted at the request of Welsh Government and dialogue is currently active.

6.9 Work has progressed in the development of a quality dashboard for HART. There is a requirement to provide a quantitative return to WG periodically as part of the service level requirements. However, a dashboard has been developed to provide a more balanced set of qualitative measures for HART which includes datix activity, TRiM referral volumes, health and safety issues, wellbeing referrals, controlled drugs issued, debriefs completed etc. This is reviewed and monitored through the Senior Operations Team and the Senior Leadership team.

6.10 During the 2022/23 audit plan, the Operations directorate commissioned two audits to assure on our organisational preparedness ahead of the publication of the Manchester Arena Inquiry report. One audit reviewed our HART team capabilities, and one reviewed our major incident preparedness. Both audits concluded a reasonable assurance rating and have been received through Audit Committee:

- Major Incident preparedness audit was completed in September 2022 with a reasonable assurance rating, with 5 recommendations only 1 of which was high priority
- HART capability audit was completed in November 2022 with a reasonable assurance rating, with 9 recommendations only 1 of which was high priority.

6.11 A key priority within the IMTP relates to organisational culture and ensuring that all of our work environments are an exceptional place to work, volunteer, develop and grow. This is important within a more “closed” culture such as HART where evidence tells us that behaviours can be different to those in a more mainstream or open culture. Work has commenced with the People Services team to explore this

further and ensure all of our team are supported, valued and able to bring their true selves to the workplace.

6.12 The annual HART/SORT key performance indicators report can be found in Appendix 3.

Welsh Government Annual Emergency Planning report

7.1 As assurance that WAST is meeting its obligations under the Civil Contingencies Act (CCA) 2004, Welsh Government requires WAST, along with all other health organisations across Wales, to report its compliance on an annual basis. This year's report was submitted in February 2023 and gave an overall assurance that WAST is compliant under the CCA.

7.2 The report covered a number of different areas related to the CCA; This includes:

- Assurance that we have emergency plans in place that allows us to respond to incidents of different types
- That our plans are reviewed and updated to reflect lessons identified internally and by external organisations
- Training and exercising assurance including details of the exercises that WAST has been involved in. We provided assurance that the Trust has undertaken weekly, monthly and six monthly communication tests, worked with partners on seven table top exercise and over 20 multiagency counter terrorism table top exercises over the previous year and participated in 12 multiagency live exercises over the previous three years. Using this data the Trust was able to assure Welsh Government that we have met the required standards.
- Assurance on command training delivered to our commanders and we were able to provide assurance in relation to the processes we have in place to train our commanders and have been able to provide refresher training at all levels of command.

7.3 The report asks organisations to self-identify any areas that could be improved on within the organisations emergency preparedness arrangements; Here we identified that we could undertake more stakeholder engagement with our emergency planning colleagues if the EPRR team was able to provide an EPRR Locality Manager to each LRF area. There is of course, cognisance of the Trust financial constraints and our statutory duty to balance our budget. This places pressure on the team to deliver its obligations under the CCA and impacts on the team's ability to fully engage with the LRFs across Wales.

7.4 We also highlighted that the Trust is aware of the Manchester Arena Inquiry recommendations and recognises that additional work will be required by the EPRR team to ensure the recommendations are implemented within the Trust.

7.5 The full Health Emergency Planning Annual Report is attached at Appendix 4.

Incident Response Plan

8.1 The WAST Incident Response Plan remains the overarching plan to determine the Trust's response to an incident. The plan has been updated in October 2022 to incorporate the following:

- Internal learning from incidents and exercises, specifically where it has been identified that more information was required on our mass casualty arrangements and critical and business continuity incidents.
- External learning from organisations such as Network Rail who have updated their own plans and to reflect updates from national guidance such as the Joint Operating Procedures for Marauding Terrorist Attacks and the updated Joint Emergency Services Principles.

8.2 The EPRR team recognises that the IRP will need further updates with the introduction of a new national triage system currently being rolled out, and the additional learning form the Manchester Arena Inquiry. The IRP is next due for annual review in October 2023 and will incorporate these amendments.

8.3 The IRP contains a matrix which predetermines the number of resources which should be deployed to an incident, dependent on the nature, severity and casualty numbers and the impact on the Trust. This is a standard practice within UK ambulance Trusts. However, the current levels of delays in handover of care at emergency department across Wales has caused sufficient concern in relation to the Trust's ability to comply with statutory responsibilities under the Civil Contingency Act and deploy adequate resources in line with the predetermined attendance matrix to a major or mass casualty incident. This has subsequently led to the raising of a corporate risk. Whilst some assurance has been provided by Health Board across Wales that in the event of an incident, resources would be released, in two recent incidents (albeit relatively small scale incidents) – the Pembrokeshire boat fire and the Swansea gas explosion, there was no significant release of vehicles from emergency departments. Dialogue with Welsh Government has been fruitful in eliciting support for further assurance such as action cards in emergency departments which will be tested at a forthcoming mass casualty exercise.

Business Continuity Annual report

9.1 This year's Business Continuity (BC) report is currently being compiled and will cover the areas that the BC groups within WAST have been engaged in.

9.2 Likely inclusions will be the BC plans that have been implemented through responses within the Trust, including the new ICT Disruption Plan that was used during the national cyber-attack on Advance (the provider of Adastra) and the plans

that have been developed in response to identified risks, such as the Power Outage Plan.

9.3 A likely recommendation will be to review and refresh the Business Continuity Steering Group structure, terms of reference, and governance processes to improve governance and assurance across the Trust.

RECOMMENDED:

It is recommended that the Committee **NOTE** the annual EPRR update.

manchester
arena
inquiry

Manchester Arena Inquiry
Volume 2: Emergency Response

Volume 2-II

Report of the Public Inquiry into the Attack on Manchester Arena on 22nd May 2017

Chairman: The Hon Sir John Saunders

November 2022

HC 757-II

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inquiry

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Volume 2: Emergency Response

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The twenty-two who died

Alison Howe

Angelika Klis Marcin Klis

Chloe Rutherford Liam Curry

Courtney Boyle

Eilidh MacLeod

Elaine McIver

Georgina Bethany Callander

Jane Tweddle

John Atkinson

Kelly Brewster

Lisa Lees

Martyn Hakan Hett

Megan Joanne Hurley

Michelle Kiss

Nell Jones

Olivia Paige Campbell-Hardy

Philip Tron

Saffie-Rose Roussos

Sorrell Leczkowski

Wendy Fawell

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Part 17
The explosion

THE CONTENT OF PART 17 IS PARTICULARLY DISTRESSING.
IT CONTAINS DETAIL IN RELATION TO THE EFFECT OF AN EXPLOSION AND THE IMPACT ON THOSE WHO SURVIVED

Introduction

17.1 The Improvised Explosive Device detonated by SA had a devastating effect. In Volume 3, I will describe its construction in greater detail. At this stage, it is sufficient to record that it comprised a high explosive element, triacetone triperoxide,[1] which was surrounded by a large number of small metal items. Those metal items comprised 29.26kg of metal nuts and 1.47kg of screws or cross dowels. It is estimated that there were approximately 3,000 such items in total.[2]

17.2 Those numbers give some idea of the terrible intent of SA and HA. They planned to cause as much harm to as many people as they could. In this Part, I deal with the effects of the explosion and the experience of some of the members of the public who were in the City Room and survived the Attack. This cannot be a complete summary of all of the effects of the Attack on each person who was in the City Room. It would be impossible to cover that in my Report. Rather, this Part sets out the accounts I heard from some of those most seriously affected by the events that night.

17.3 In Part 18, I will consider what happened to each of those who died following the detonation of the bomb. I will also consider whether any of those who were killed could have survived the Attack had the emergency response been different.

[1] 44/49/23-50/8
[2] 44/110/11-111/8

Effect of an explosion

17.4 I was assisted in understanding the effects of an explosion by a Blast Wave Panel of Experts, led by Professor Anthony Bull from the Centre for Blast Injury Studies.

17.5 When an explosion occurs, it causes a blast wave. A blast wave has two component parts. The first is the shock wave. This is a high-pressure wave of energy, which transmits through material. Behind the shock wave is the blast wind. This follows the shock wave and carries material with it. The material moved by the blast wind comprises 'primary fragments', which come from the device itself, and 'secondary fragments', which come from the environment.[3]

17.6 Blast injuries fall into five main categories.[4]

17.7 Primary blast injuries result from the contact of the shock wave with the body. The shock wave transmits through the structures of the body. Where there are spaces between those structures, it causes a tearing or separation. This is particularly significant where the two structures are of different densities, such as in a lung. The shock wave is capable of causing very serious injury.[5]

17.8 Secondary blast injuries are caused by objects moved by the blast wind. When they make contact with the body, they can disrupt the anatomy. Being struck by a fragment from a blast has been likened to being shot with a bullet. However, the fragment typically causes more devastation as the energy around the object does not travel in a straight line, rather it is tumbling. This means a small wound from a secondary blast injury can cause devastating internal injuries.[6]

17.9 Tertiary blast injuries are the damage caused when the body is thrown against an object or a large object strikes against the body. This commonly occurs when a person is pushed to the floor or against a wall by the force of the blast wind, causing crush injuries. The energy involved is often far higher than in a road traffic collision. This can result in very severe injury.[7]

17.10 Quaternary blast injuries are those not due to primary, secondary or tertiary blast injuries. Any part of the body can be affected. Often they are burn or inhalation injuries.[8]

17.11 Quinary blast injuries are caused by contaminants in the explosion, such as biological or radiological contaminants.[9]

[3] 150/10/3-18/23
[4] 150/21/18-20, INQ025364/9
[5] 150/21/15-24/8
[6] 150/25/15-27/11
[7] 150/29/11-30/18
[8] 150/31/1-5
[9] 150/31/6-15

17.12 The first four types of blast injury were caused to those present in the City Room by SA's detonation. Figure 41 provides a pictorial representation of the way in which blast injuries occur.

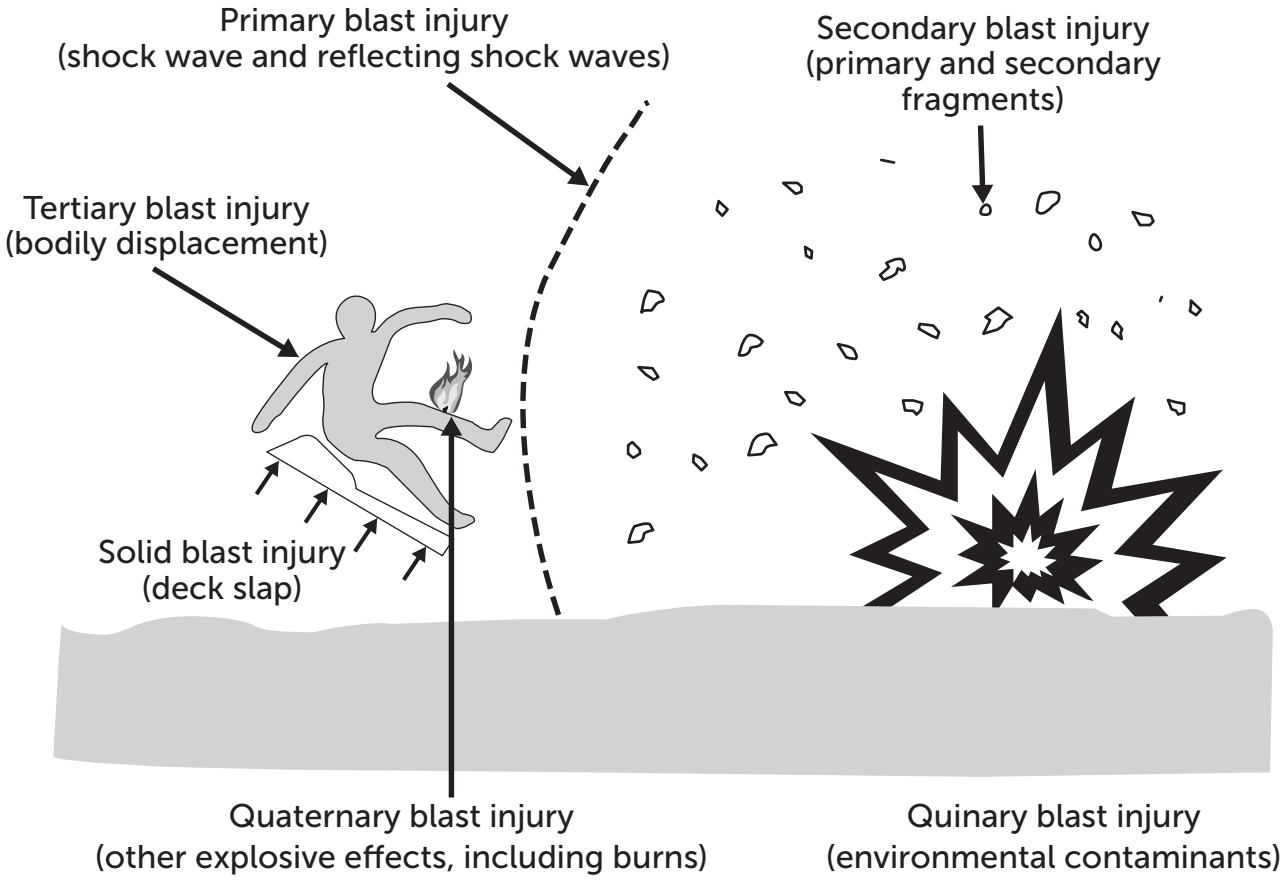

Figure 41: *Types of blast injury*[10]

[10] INQ025364/9

THE CONTENT OF THIS SECTION IS PARTICULARLY DISTRESSING. IT CONTAINS DETAIL IN RELATION TO THE EFFECT OF AN EXPLOSION AND THE IMPACT ON THOSE WHO SURVIVED

Those who survived

Introduction

17.13 In 2019, Greater Manchester Police (GMP) estimated that there were 940 victims of the Attack who survived. Of those 940 victims, 337 people were in the City Room at the time of the explosion and a further 92 people were in the immediate vicinity. Of the victims, 237 people were physically injured. A total of 111 people required hospitalisation. A total of 91 people were categorised as being seriously or very seriously injured.[11]

17.14 This section of the Report will describe the experience of some of those who were present in the City Room in the aftermath of the explosion and their recollection of the moment the bomb detonated. It will set out their views of the emergency response that followed, where it was effective and where it failed.

17.15 These accounts, which are harrowing, show the courage of the human spirit in adversity. For most, if not all, the Attack is something they will never forget. The physical and mental scars will always be there. The testimony each person gave to the Inquiry was moving and powerful. It forms an important part of the record of the events that night. I am very grateful to all those who provided evidence to the Inquiry and for the courage they showed in doing so.

17.16 In this section, I summarise and quote from the evidence given, largely without comment. This is to convey the experiences of each witness, through their words and their perspective. This section does not seek to review the experience of every person who was a victim of the Attack. Nor is it a record of the most seriously injured people. It provides the accounts of some of the members of the public in the City Room, many of whom were severely injured. Part 16 in Volume 2-I contained evidence from others in the City Room, viewed from the perspective of their contribution to the emergency response. Some of those I mentioned in Part 16 in Volume 2-I were also casualties themselves.

17.17 At the end of this section, I consider the experience of those who were present in the City Room and survived the explosion but whose loved ones died in the Attack.

17.18 Where appropriate, I have included references to occasions on which a survivor saw SA prior to the explosion.

[11] 138/58/4-59/15

Before the Attack

17.19 Many people described their excitement, and that of their children, at the thought of attending the Ariana Grande concert. For a large number, this was their first ever concert. For many, the ticket was a Christmas or birthday present, often purchased with a second ticket so that a friend could also attend.

17.20 In the moments immediately prior to the explosion, the atmosphere in the City Room was described as joyful. Josephine Howarth described a *"family atmosphere"*, with *"lots of parents and grandparents around waiting to pick up children"*. She said: *"Everybody seemed to be enjoying themselves."*[12]

17.21 Sarah Gullick described the atmosphere in the City Room as *"good natured"*. She recalled: *"You could hear the music playing and people were coming out of the arena excited with happy faces."*[13]

17.22 Janet Capper remembered standing in the City Room, looking back to the main doors to the Arena. She could still hear the music playing. The staff had opened the doors as there were people leaving. She said: *"I vividly recall seeing how happy all the children looked as they were leaving."*[14] David Robson recalled spotting his daughter and her friend. He started waving at them. He stated: *"I looked at them and they had spotted us and they were running towards us, excitedly."*[15]

17.23 What happened next is in stark contrast to those positive emotions. Witnesses heard a loud bang and saw a bright orange flash. Some were knocked to the ground. It was, many said, like nothing they had ever experienced before. Witnesses went on to describe a scene of chaos and devastation in the City Room in the immediate aftermath of the explosion.

After the Attack

Amelia Tomlinson and Lucy Jarvis

17.24 Amelia Tomlinson, known as Millie, went to watch the concert with her friend Lucy Jarvis.[16] They left just as the encore ended.[17] They walked across the City Room arm in arm.[18] Millie Tomlinson felt a rush of warm air. She said it was like when you jump in a pool and feel water in your ears.[19] Lucy Jarvis did not hear the explosion but recalled it being *"really hot"*.[20]

12 89/64/7-11
13 INQ006992/4
14 87/31/24-32/4
15 85/19/2-5
16 86/3/5-10
17 86/6/12-15
18 86/7/18-23
19 86/7/1-9
20 86/54/19-24

17.25 Millie Tomlinson and Lucy Jarvis were separated by the force of the blast.[21] They were able to get up and run back into the Arena bowl.[22] Lucy Jarvis fell over. She could not walk due to an ankle injury.[23] She was losing a lot of blood.[24] Millie Tomlinson tied her jacket around Lucy's leg to try to stop the bleeding.[25] Lucy Jarvis described having holes in her jeans from the shrapnel and an injury to her arm.[26]

17.26 Millie Tomlinson and Lucy Jarvis were helped out of the Arena bowl by SMG and Showsec staff.[27] Lucy Jarvis was evacuated first,[28] and recalled that she was taken to the Arena concourse, where two SMG staff cared for her and bandages were applied. After about 30 minutes, she was put on a stretcher.[29] The two SMG staff stayed with her, even though firearms officers told them to leave.[30] Lucy Jarvis was evacuated over the raised walkway and down in the lift.[31]

17.27 A Showsec first aider stayed with Millie Tomlinson while she waited for her family and then drove Millie Tomlinson and her family to Manchester Royal Infirmary.[32] She had injuries to her hand and foot.[33]

17.28 Lucy was assessed in the Casualty Clearing Station. Initially, she was triaged as 'orange' and wondered what that meant.[34] She had to wait on the station concourse floor for two hours. During that time she vomited. Her status became 'red' and she was taken to an ambulance immediately.[35] Lucy described her experience of waiting as *"quite stressful"* and *"scary"*.[36] People all around her were injured, but she did her best to remain calm.[37] Lucy Jarvis gave evidence to the Inquiry and set out the extent of her injuries.[38] She underwent a 14-hour operation and was in hospital for eight weeks.[39]

21 86/7/17-20
22 86/8/19-9/7
23 86/9/24-10/1, 86/55/25-56/2
24 86/10/23-11/2
25 86/11/23-12/2
26 86/61/2-5
27 86/59/11-62/10
28 86/12/13-14/2
29 86/61/22-24
30 86/63/7-17
31 86/64/5-9
32 86/13/7-17/13
33 86/13/15-22
34 86/64/21-65/2
35 86/65/3-11
36 86/66/2-7
37 86/64/17-67/10
38 86/67/11-68/9
39 86/70/6-14

Andrea Bradbury

17.29 Andrea Bradbury is a retired counter-terrorism police officer. She served for 30 years in the police and retired two months before the Attack.[40] She drove her 15-year-old daughter with her friend, and her friend's mother, Barbara Whittaker, to the concert.[41] Andrea Bradbury described her daughter, like so many of those who went, as an Ariana Grande *"addict"*, who loved watching her on television and wearing cat ears.[42] Andrea Bradbury texted her daughter throughout the concert. She said she had *"an absolute ball"*.[43]

17.30 At 21:52, Andrea Bradbury and Barbara Whittaker can be seen on CCTV on the raised walkway, walking towards the City Room.[44] They had arranged to meet their daughters on the McDonald's staircase after the concert.[45] At the time of the explosion, they were near to the merchandise stall, facing the doors to the Arena.[46] There was a massive blast from behind them. Andrea Bradbury described a *"big white flash"* and said it felt like her legs had been hit by a garden strimmer.[47]

17.31 Andrea Bradbury said, as a former counter-terrorism police officer, it was immediately obvious to her that it was a bomb explosion.[48] She did not think at any point that a firearm was involved, nor that it was an active shooter incident.[49] She was concerned about a secondary device and said to Barbara Whittaker that they needed to leave to get to a place of safety.[50] They were confident they had not seen the children come into the City Room before the explosion and crawled to the Arena bowl to find them.[51] In the period of time she was in the City Room, Andrea Bradbury did not see any members of the emergency services.[52]

17.32 It was loud inside the Arena, with tannoy messages and alarms.[53] They were able to speak to their children on the phone.[54] The children had left the Arena via Hunts Bank.[55] Andrea Bradbury said she went back through the City Room. She was only there a very short time. She saw three police officers run in but no wider emergency response at that stage.[56] Andrea Bradbury said she telephoned

40 89/86/24-87/12, 89/90/13-92/17
41 89/107/18-22
42 89/106/18-107/2
43 89/112/19-25
44 89/113/10-17
45 89/115/10-19
46 89/123/21-124/12
47 89/124/9-23
48 89/126/4-13
49 89/127/1-21
50 89/128/3-22
51 89/128/19-130/24
52 89/130/19-24
53 89/133/4-7
54 89/133/4-16
55 89/133/17-19
56 89/135/7-136/10

the on-call counter-terrorism officer in Lancashire to provide an account from the scene. She did this three times. She felt it was important for senior officers to know what had happened and that there had been a single explosion.[57]

17.33 Later that evening, once reunited with her daughter, Andrea Bradbury went to GMP Headquarters (GMP HQ). She went there to tell them what had happened.[58] She spoke to an officer at the security gatehouse and then a police officer who said she was *"Gold"*.[59] Assistant Chief Constable Deborah Ford, who was duty Strategic/Gold Commander for GMP on the night, said that this was not her.[60] Andrea Bradbury made concerted efforts, despite her own injuries, to give the police information about the Attack.

17.34 Andrea Bradbury required medical treatment and arrived at hospital at 00:48 on 23rd May 2017.[61] She has suffered permanent nerve damage to her legs.[62]

Darah Burke

17.35 Dr Darah Burke is a general practitioner.[63] He went to the concert with his wife, Ann, and their 10-year-old daughter.[64] They left the concert as Ariana Grande was singing the last song of her encore.[65] They made their way towards the railway station.[66]

17.36 Dr Burke described a sudden, very loud bang as the family made its way through the City Room. He was thrown forwards slightly.[67] His daughter was on the floor, screaming.[68] They were about halfway to the doorway leading out to the raised walkway.[69]

17.37 His daughter could not stand up. Dr Burke and his wife carried her out to the raised walkway.[70] Dr Burke and his wife were bleeding from their legs.[71] Dr Burke had shrapnel injuries to his right leg and left buttock. His wife had shrapnel injuries to her thigh and heel.[72] His daughter's right arm and leg were bleeding heavily, as was the right side of her head.[73] Dr Burke took off his shirt and tied a tourniquet around his daughter's arm and a coat around her leg.[74]

57 89/138/6-139/15
58 89/142/19-143/5
59 89/144/9-23
60 105/86/17-90/19
61 89/146/17-23
62 89/147/12-17
63 85/49/17-21
64 85/50/3-11, 85/52/13-14
65 85/52/9-15
66 85/53/2-11
67 85/55/13-16
68 85/56/1
69 85/56/8-17
70 85/57/16-58/6
71 85/58/9-10
72 85/60/16-21, 85/64/19-25
73 85/58/11-59/3
74 85/58/21-24

17.38 Dr Burke assessed that his daughter was not in immediate danger and went back into the City Room.[75] Due to his own injuries, he was not able to provide assistance, but described how he saw *"shadows and people were starting to stand and … provide assistance"*.[76] Dr Burke returned to the raised walkway where he ensured that an injured person was not in *"immediate danger"*.[77] He described how emergency responders arrived. He stated that as he and his family were *"relatively stable, not in immediate danger"*, he directed emergency responders onto the City Room.[78] He recalled police firearms officers pointing their guns at him and his family.[79]

17.39 He and his family were on the raised walkway for an hour.[80] At some point, they were given a trauma pack with bandages. They were small. There were no major trauma dressings.[81] A doctor in plain clothes re-dressed his daughter's wounds.[82] A police officer told them they needed to leave the area. The officer carried his daughter off the raised walkway in his arms.[83] No one triaged them when they were on the walkway or in the station.[84]

17.40 His daughter was carried to an area outside Chetham's School of Music. After about 15 or 20 minutes, they were triaged as a family as P3 casualties.[85] 'P3' refers to priority three casualties and means casualties whose treatment may be safely delayed for beyond four hours.[86] Dr Burke could not remember anyone giving his daughter a full medical examination.[87]

17.41 The family waited at Chetham's School of Music until about 02:00 on 23rd May 2017. By then, his daughter's situation had deteriorated. She was cold, shivering and light-headed. A decision was made to take her to hospital by ambulance.[88] She was reassessed as a P2 casualty.[89] 'P2' refers to priority two casualties and means casualties who require surgical or other interventions within 2–4 hours.

75 85/59/13-23
76 85/60/6-15
77 85/61/9-20
78 85/62/13-63/4
79 85/64/4-6
80 85/65/14-15
81 85/65/15-20
82 85/65/4-23
83 85/67/2-68/1
84 85/67/10-17, 85/69/10-15
85 85/70/3-16
86 INQ022339/5-7
87 85/70/17-22
88 85/75/10-77/15
89 85/78/9-13

17.42 Ann Burke accompanied her daughter in the ambulance.[90] Dr Burke went to a different hospital on a bus transporting casualties to hospital. Apart from Dr Burke, there were no medical practitioners on the bus.[91] He arrived at hospital at about 03:00.[92] His daughter arrived at hospital by ambulance at about 02:15.[93]

17.43 Dr Burke stated that the response from bystanders and first responders was *"rapid, highly professional"*.[94] He stated that there were, however, very few stretchers available and that the dressings in packs were inadequate.[95] He stated that they were reassessed frequently, it was slightly chaotic and they were asked the same questions. He stated that new dressings were removed unnecessarily[96] and not everyone seemed to be aware of the triage system.[97]

Janet Senior and Josephine Howarth

17.44 Janet Senior drove her sister, Josephine Howarth, and her two young nieces to the concert.[98] The girls were really excited.[99] Janet Senior and her sister arranged to meet the girls in the City Room after the concert.[100]

17.45 Janet Senior and Josephine Howarth returned to the City Room shortly before 22:00.[101] They initially sat on the JD Williams staircase and then moved to sit at the top of the McDonald's staircase. They can be seen on CCTV appearing from those steps and making their way across the City Room at 22:30.[102]

17.46 Janet Senior recalled a petrol-like smell and then the explosion happened.[103] She described it as a *"crack bang"* with a flash and that there was pink-coloured smoke.[104] Janet Senior felt a horrendous impact on her chest and neck. In common with others, she said it was similar to being underwater. She said: *"Everything seemed to move in slow motion for a few minutes."*[105] Shrapnel was *"buzzing around"*.[106]

90 INQ022339/5-7
91 85/78/20-23
92 85/79/21-80/2
93 85/80/11-14
94 85/81/1-6
95 85/81/14-82/5
96 85/82/12-83/6
97 85/82/14-83/23
98 89/2/1-11
99 89/6/12-19
100 89/8/25-9/16
101 89/14/5-9
102 89/14/12-16/24, 89/19/23-20/12
103 89/20/12-21/4
104 89/22/1-9
105 89/22/1-16
106 89/25/12-16

17.47 Josephine Howarth described seeing the merchandise stall turn *"to shreds"*. She knew instantly it was a bomb. She described rolling, orange flames. The explosion was *"very bright, very loud"*, and debris struck her.[107] Her leg was badly injured, and there was blood gushing from it.[108]

17.48 Janet Senior had the presence of mind to telephone 999. She told the operator that there had been an explosion, people had died and they needed help.[109] The connection was lost. Janet Senior later found a voicemail from the emergency services asking for her to call back. The voicemail was timed at 22:44.[110] At about this time, Janet Senior's nieces also left voicemails saying they were OK.

17.49 Janet Senior and Josephine Howarth were both seriously injured.[111] Josephine Howarth told her sister to use her handbag strap as a tourniquet.[112] They both had knowledge of first aid. Janet Senior had done a course as part of her role as a horse-riding coach. They had both been taught about tourniquets and how to use them to stem severe bleeding.[113]

17.50 The CCTV confirms that they were both evacuated from the City Room at 23:14.[114] Janet Senior arrived in the Casualty Clearing Station at 23:18.[115] She was placed in an ambulance at 00:42 and arrived at hospital an hour later at 01:40.[116] Josephine Howarth left the Casualty Clearing Station at 01:34. She was placed in an ambulance at 01:41 and arrived at hospital at 02:08.[117]

17.51 Janet Senior said that when she was in the City Room, she was praying for more people to come: *"time was clocking on"*, people were dying and the room was getting quieter.[118] She vividly recalled seeing a dog and hearing it panting. It was at that point she realised that a bomb had exploded and thought she and her sister were not going to make it home.[119] She said that help was very slow in coming. People were *"dotted about"*, but she did not think anyone was actually doing a lot.[120] Her experience of the Casualty Clearing Station was that it was *"organised chaos"*.[121] She felt that no one regularly checked on her, even though

107 89/67/20-68/17
108 89/68/18-24, 89/70/16-71/11
109 89/26/2-18
110 89/26/19-27/22
111 89/24/1-9, 89/70/16-71/11
112 89/29/13-30/8, 89/69/24-70/4
113 89/30/25-32/3, 89/71/16-72/4
114 89/24/10-20
115 89/24/19-20
116 89/44/23-45/8
117 89/74/5-14
118 89/33/3-9
119 89/32/17-34/19
120 89/38/7-18
121 89/41/1-8

she was a P2 casualty.[122] No one gave her pain relief.[123] When the ambulance drove her to hospital, it had to turn around because of road blocks.[124] The satnav did not work.[125]

17.52 Josephine Howarth said she slipped in and out of consciousness and only had short clips of memory.[126] She did recall seeing three people giving first aid in the City Room and thinking, *"[O]h my God, there's only three for all these people, where are the paramedics?"*[127] She also recalls being very cold, lying on a marble floor without any blankets.[128]

Martin Hibbert

17.53 Martin Hibbert went to the concert with his daughter, Eve. It was, he said, *"daddy and daughter time"*: a happy occasion.[129] The sun was shining. It was a beautiful day.[130] Martin Hibbert said that the concert was amazing. They were in a VIP box.[131]

17.54 On CCTV, they can be seen walking into the City Room, from the Arena bowl, at 22:30.[132] They were between five and six metres from SA.[133] Martin Hibbert said that he heard an *"almighty bang"*. There was a high-pitched, piercing sound.[134] Then it felt like a ten-tonne truck had hit him.[135] He immediately felt he could not breathe and noticed he was losing a lot of blood.[136]

17.55 At that point, he saw how seriously injured Eve was. It was *"like she had been shot through the head"*. She was bleeding and gasping for breath.[137] He had shielded Eve from much of the blast, but one bolt got through. Eve suffered a very significant brain injury.[138]

122 89/40/20-44/12
123 89/44/16-22
124 89/46/14-47/4
125 89/47/5-20
126 89/73/7-13
127 89/73/7-74/4
128 89/78/15-79/16
129 138/4/3-5
130 138/3/12-4/6
131 138/5/10-17
132 138/6/8-14
133 138/6/19-7/5
134 138/7/11-23
135 138/7/18-19
136 138/7/18-8/5
137 138/8/6-13
138 138/9/17-10/3

17.56 Martin Hibbert said he thought he was watching Eve die. He was not in pain. He did not panic. He had a job to do: make sure Eve survived.[139] He could feel his body shutting down, but fought to stay awake to ensure that Eve got out.[140] He kept asking: *"Where is everybody? Where are the paramedics?"* He got fed up of being told that they were on the way.[141] He said it seemed like forever.[142]

17.57 He saw Eve covered up twice with T-shirts and posters. People thought she had died.[143] Martin Hibbert said he could see she was gasping for breath. Her lips were quivering.[144] People thought her injury was non-survivable. They were going to cover her up and leave her. It was a *"big frustration"*, as he felt that if he had lost consciousness, Eve would have died.[145] He thought that unqualified people were being left to make a life or death choice.[146]

17.58 Martin Hibbert was taken out of the City Room at 23:21. Eve was taken out at 23:25.[147] They were both taken to the Casualty Clearing Station. Eve left by ambulance at 00:18.[148] He found it *"baffling"* that she was not put straight into an ambulance. In those circumstances, he thought it was a miracle that she was still alive. He said he had *"just no words for it"*.[149]

17.59 Martin Hibbert left for hospital at 00:24, 1 hour and 53 minutes after the detonation.[150] When he was placed in an ambulance, he was going to be taken to Wythenshawe Hospital. This was a 25- to 30-minute journey. The paramedic, however, went to Salford Royal Hospital, 10 minutes' away. Martin Hibbert said that decision was *"life saving"*.[151] A different paramedic might have made a different decision. That was another frustration for him.[152]

17.60 Martin Hibbert noted that the equipment that was available, such as plasters, scissors and bandages, was inadequate and that the responders didn't have *"the right equipment"*.[153] He has reflected on whether Eve's treatment would have been different with more strategic planning and marshalling of vehicles; whether it might have shortened the period to get to hospital.[154]

139 138/8/6-19
140 138/10/4-18
141 138/10/18-22
142 138/14/9-17
143 138/11/8-12/19
144 138/12/20-13/1
145 138/13/2-12
146 138/24/4-25/7
147 138/15/11-16/1
148 138/17/5-7
149 138/16/8-17/1
150 138/23/19-23
151 138/17/12-18/20
152 138/18/2-5
153 138/25/20-26/7
154 138/27/21-28/6

17.61 Martin Hibbert described the life-changing impact of his injuries. He suffered 22 shrapnel wounds, one to the centre of the back which severed his spinal cord. He has been left paralysed from the waist down.[155] Sometimes, he said, the post-traumatic stress disorder is a greater battle than the spinal injury.[156] He tries to motivate and inspire people. He does everything he had done before and more and is thankful to be alive.[157] Eve was in hospital for ten months. Initially, her family were told that Eve would probably remain in a vegetative state, but she can now eat, talk and walk unassisted. Martin Hibbert said she would *"inspire the world"*.[158]

Sarah Nellist

17.62 Sarah Nellist was in the City Room to collect her daughter and niece. She arrived at about 21:50 and waited by the box office, near to the exit doors from the Arena. This is where she was at the time of the explosion.[159] She described seeing SA a couple of minutes before the explosion. She thought he looked *"a bit odd"*.[160]

17.63 She saw the bomb detonate. It was, she said, like *"black powder paint"*.[161] There was a high-pitched noise. The heat was *"unbelievable"*.[162] The force of the blast knocked her over.[163] Sarah Nellist was able to get up.[164] She ran onto the Arena concourse and was then directed outside. She was able to find her daughter and niece, and they went to their car.[165] They did not see any paramedics but were assisted by members of the public.[166]

Suzanne Atkins

17.64 Suzanne Atkins took her daughter and her daughter's friend to the concert.[167] She described how the children were happy and excited as they went into the Arena.[168] They arranged to meet at the doors to the City Room after the concert.[169] Suzanne Atkins went back to the City Room with her mother at about 22:20 to collect the children.[170] At the time of the explosion, she was standing against railings by the merchandise stall.[171]

155 138/8/20-9/16
156 138/20/1-17
157 138/19/21-21/21
158 138/21/22-23/10
159 85/34/4-36/25
160 85/38/15-39/17
161 85/39/18-22
162 85/39/23-40/1
163 85/40/8-10
164 85/40/20-25
165 85/41/2-42/9
166 85/42/20-25
167 86/22/13-21
168 86/26/14-17
169 86/26/14-27/1
170 86/29/15-22
171 86/37/15-21

17.65 She described seeing SA walk across the City Room. He was about a metre in front of her. She said he was *"stooped and had a bit of a swagger about him"*.[172] He looked out of place in a crowd of young girls and families.[173] She said that SA looked like he was going somewhere, but from the direction he was going, he could not have been going anywhere.[174]

17.66 Suzanne Atkins described seeing an orange flash from the explosion. It felt like something had rolled into her that was burning her legs. The impact sent her backwards.[175] She found her mother on the floor and quickly took her out to the raised walkway.[176] Suzanne Atkins said she went onto autopilot. She went to find her daughter.[177] She recalled someone saying there had been another explosion.[178] She thought she had lost her daughter and needed to get into the Arena to find her.[179] She scoured the City Room.[180]

17.67 After some time, she was able to contact her daughter by mobile phone, but it kept cutting out.[181] She was trying to escort her mother away from the City Room and speak to her daughter.[182] It was a frightening situation. Suzanne Atkins explained: *"It felt like no one was coming ... and we had to deal with it ourselves."*[183] Suzanne Atkins saw a police officer, who told her to drive her mother to hospital. The police officer said people had been shot. Suzanne Atkins said to the officer that it was an explosion.[184]

17.68 Eventually, Suzanne Atkins was reunited with her daughter outside the station.[185]

Family of those who died

17.69 I heard oral evidence from a number of those bereaved by this atrocity who were at or near the City Room at 22:31. I am extremely grateful to them for the courage and dignity that they displayed when recounting their terrible experience of the Attack and its aftermath. What follows is a summary of that evidence.

172 86/34/10-25
173 86/35/7-25
174 86/36/1-11
175 86/37/14-38/2
176 86/38/13-39/2
177 86/38/24-39/15
178 86/39/20-40/4
179 86/41/5-17
180 86/42/12-19
181 86/43/9-14
182 86/44/6-12
183 86/43/22-44/5
184 86/45/23-47/11
185 86/47/15-48/2

Paul Price, partner of Elaine McIver

17.70 Paul Price and Elaine McIver were in the City Room to collect his daughter and her friend. As the concert ended, he recalled that a wave of people came out of the exit doors into the City Room. He was seriously injured by the explosion. He saw Elaine McIver lying about three or four metres away from him, but he could not reach her because of his own injuries. Paul Price was evacuated from the City Room at 23:18.[186]

Claire Booth, sister of Kelly Brewster

17.71 Claire Booth went to the concert with her daughter, Hollie, and her sister, Kelly.[187] Claire Booth said the drive to Manchester was a lovely one. Kelly and Kelly's partner Ian had just had an offer accepted on a house. Kelly and Kelly's partner Ian talked about all the plans for the move, the layout for a future nursery and a holiday they were planning to Disneyland.[188]

17.72 It was a good concert. They all enjoyed it. Claire Booth described *"loads of little girls just dancing"*.[189] They left their seats as the last song ended, walking in a line. Claire Booth was at the front, Hollie in the middle and Kelly at the back.[190] They went into the City Room and started to walk towards the Trinity Way link tunnel.[191]

17.73 As they passed the box office windows, there was a huge yellow flash. Claire Booth described it as like a *"blowtorch"*.[192] It was really loud and the hottest heat she had ever felt. The force of the blast pushed her into the box office wall.[193] Claire Booth described the room then going momentarily silent. It took a moment to focus, but then she was able to see shrapnel on the floor. At that point, she knew it was a bomb and could see some of its components.[194] She was worried about a second explosion or someone shooting them.[195]

17.74 Claire Booth described looking back to find Kelly and Hollie. Kelly was lying on her side. Hollie was leaning on her hands as if about to get up. Hollie called out.[196] Claire Booth explained how she picked Hollie up and started to run out of the City Room, towards the Fifty Pence staircase. She called for Kelly to follow them. Claire Booth only stopped when Hollie said she was bleeding. At that point, she realised that Kelly was not with them.[197]

186 156/46/7, 156/53/19-57/24, 156/50/16-17
187 138/63/13-17
188 138/65/2-66/5
189 138/70/6-12
190 138/71/11-72/1
191 138/72/6-73/1
192 138/73/14-74/5
193 138/73/19-74/8
194 138/74/9-75/12
195 138/75/18-76/1
196 138/76/3-25
197 138/76/3-77/16

17.75 Claire Booth described the scene as one of chaos and panic. People were screaming. Some were running and others were still on the floor. Hollie was very upset. Claire Booth was torn: she wanted to care for her daughter but also find her sister. She begged people to look after Hollie. People kept running past. No one helped. Claire Booth realised she was on her own. She ran back into the City Room and found Kelly was still lying on the floor where they had left her, as if she were asleep. She did not look injured. Claire Booth described kicking at her legs, shouting at her to get up. Kelly did not respond at all.[198]

17.76 Claire Booth went back to Hollie. She used her daughter's mobile phone and called Hollie's father, Dale, to tell him what had happened. He told her to go back and check on Kelly. Claire Booth went back and stood over her, screaming her name over and over. Dale said to check Kelly's pulse. It was only at this point, as she leaned over Kelly, that Claire Booth realised she was also injured. Hollie was screaming for her. Claire Booth described her sense of hopelessness. She said *"sorry"* to Kelly over and over and walked away.[199]

17.77 Some help started to arrive. Someone told her to elevate Hollie's legs. Claire Booth was by this time concerned about her own injuries. She did not know if she was dying. She asked a police officer if her throat had been cut. She was told that she had a facial injury. This made her calmer. She was then able to focus on getting help for her sister and Hollie. Claire Booth spoke to her own mother when her mother rang Hollie's mobile phone. Claire Booth told her mother that Kelly had died.[200]

17.78 Showsec staff tried to help. One person gave her a T-shirt to hold against Hollie's leg. When she pressed it down, another part of Hollie's jeans started to go a deeper red with more blood. She was given another T-shirt but noticed another hole. Hollie's legs were covered in holes. Claire Booth begged the Showsec staff not to let Hollie die.[201]

17.79 When asked about the emergency response, Claire Booth said: *"Every minute in the foyer felt like an hour."*[202] She told anyone who approached her to offer their help, to go to Kelly. She could see no one was staying to give first aid, and she could not understand why. Nobody came back to tell her anything. Eventually, an off-duty police officer did stay with Kelly. He moved her and checked her pulse.[203]

17.80 Hollie needed urgent attention. She had started to go quiet and close her eyes. She spoke very slowly and said she wanted to sleep. Claire Booth described calling out to Emergency Training UK staff.[204]

198 138/77/17-79/14
199 138/79/20-83/11
200 138/83/15-86/10
201 138/86/13-87/16
202 138/87/17-21
203 138/87/23-89/19
204 138/91/13-93/10

17.81 The room suddenly seemed full of police officers, all in different uniforms. At one point, she was told that Kelly had a faint pulse but did not hear anything further after this. Someone helped to cut Hollie's jeans, and it was clear her legs were very badly injured. Claire Booth said it felt like hours had gone by. She repeatedly asked where the ambulances were. She could hear sirens. She was told they were coming but then they would never arrive. At one point, firearms officers asked her to leave. She was asked to carry Hollie, which was impossible.[205]

17.82 Claire Booth described how it did not make any sense that ambulances were not arriving. Claire Booth said she was desperate. Police officers were helping to apply pressure to Hollie's legs. They found even more injuries at the top of her legs. She did not think Hollie was going to get out of the City Room alive. Dale telephoned and said he and Ian had arrived from Sheffield but could not get through the police cordon. He said he could see ambulances. Claire Booth said that she felt relieved because she hoped that Ian could stay with Kelly, so that Kelly would not be alone. Claire Booth said, at around this time, the atmosphere in the room started to change: things were happening. A paramedic saw them. It was very quick. Hollie was given a card with a number two on it. Claire Booth was given a number three.[206]

17.83 It became their turn to be taken out of the City Room to the Casualty Clearing Station. On the CCTV, this can be seen at 23:29. Hollie was put on a metal crowd barrier and Claire Booth in a wheelchair.[207] Hollie described the experience as *"very scary, incredibly painful"*.[208] She was not fastened to the barrier. She had to grip on. It felt like she would slide off. Claire Booth said it was a *"horrific way"* for anybody with injuries to be moved.[209]

17.84 Claire Booth and Hollie arrived in the Casualty Clearing Station at 23:31.[210] Claire Booth described how lost she felt there. It was cold and bright. They had no blankets, but someone gave them a curtain to wrap up in and keep warm.[211] There were lots of injured people. She described how it felt. It was chaotic. There was no plan. It seemed that no one knew who would be treated next. It felt like a long time before anyone checked Hollie. Hollie was reassessed as a priority, P1 patient, but it still took a long time for her to be taken to hospital.[212] They were taken to hospital at 01:59 on 23rd May 2017, 3 hours and 28 minutes after the explosion.[213] Both Claire Booth and Hollie received treatment for their

[205] 138/93/16-101/5
[206] 138/101/22-106/22
[207] 138/107/14-109/20
[208] 138/111/11-23
[209] 138/111/23-112/7
[210] 138/112/14-21
[211] 138/113/24-114/3, 138/123/18-124/8
[212] 138/113/1-122/5
[213] 138/121/20-122/5

injuries and were in-patients for weeks after the Attack. They underwent a number of operations. Hollie had lost so much blood that she needed a blood transfusion at hospital.[214]

17.85 Reflecting on what happened, Claire Booth said: *"I remember feeling like we had been abandoned ... I could hear the sirens so close by but help never came."*[215] She stressed the need to educate the public that in a situation such as this, medical help might not always come immediately. Claire Booth said if she had known that, she would not have sat and waited for help to arrive.[216]

Bradley Hurley, brother of Megan Hurley

17.86 Bradley Hurley attended the concert with his 15-year-old sister, Megan Hurley. His sister was a big Ariana Grande fan, and they were both excited to see the show.[217] Bradley Hurley described it as a *"really fun night"*.[218] They left as soon as the concert finished, and as they approached the doors to the City Room Megan Hurley said: *"What an experience that was."*[219]

17.87 Bradley Hurley said they were in the City Room for about five seconds before his vision went completely white. There was a high-pitched, piercing sound. It was like a mosquito. His whole body felt extremely hot. He thought he might have collapsed or had a heart attack.[220]

17.88 After the immediate shock, Bradley Hurley realised he was on the floor. He tried to get up but knew straightaway that his legs were broken. He lay on his back, propped up on his elbows. His legs were bent and his skin was burning all over. His vision was blurred and his hearing distorted, like being underwater.[221]

17.89 Bradley Hurley described looking at his sister. He knew straight away that she had died. She was not breathing. He tried, but couldn't find a pulse. Bradley Hurley said at that moment he felt strangely calm: he felt an acceptance about what had happened and that there was nothing he could do to change it.[222]

17.90 He knew it had been a terrorist attack: a bomb with shrapnel.[223] They were a few metres away from the seat of the explosion.[224]

17.91 Bradley Hurley found it difficult to put things in a precise order, but he described how the City Room quickly descended into chaos. There were screams of pain from every direction. The room was dimly lit and smoky, and he had never felt

214 138/126/13-129/11
215 138/129/15-22
216 138/136/23-138/10
217 138/146/22-147/1, 138/149/22-150/4
218 138/155/7-13
219 138/156/3-6
220 138/157/1-20
221 138/157/21-159/4
222 138/161/1-162/16
223 138/162/17-24
224 138/162/25-163/5

so alone or helpless. He could not move and was bleeding heavily. There were other people in a similar situation lying around, but he did not have the words to speak to them. He recalled it being *"the worst imaginable situation"*.[225]

17.92 Bradley Hurley remembered people coming over to him. One person wrapped their belt around his leg as a makeshift tourniquet. To him, it seemed like the right thing to do. Someone else later joined him and told him to take off the tourniquet. They said he could lose his leg. Bradley Hurley said he was *"conflicted"*, but the tourniquet was taken off.[226]

17.93 Someone was handing out Ariana Grande merchandise to cover those who had died. Someone covered his sister.[227]

17.94 More police arrived, and Bradley Hurley described trying to get their attention. He did not feel like anyone checked him properly. No one cut off his jeans to see how bad his injuries were.[228] He felt helpless, lying in pain on the floor, unable to move. The feeling of large police boots walking around close to his face was *"uncomfortable"* and *"scary"*.[229] From the CCTV, he later knew that North West Ambulance Service Advanced Paramedic Patrick Ennis assessed him at 23:06. This lasted ten seconds, but he had no memory of it.[230]

17.95 The police reassured him that the paramedics were on the way, but they also seemed to be frustrated and confused that the ambulance personnel were not in the room.[231] At some point, he was given a wristband with a number two on it.[232]

17.96 Bradley Hurley said that at some stage he was able to speak to his parents on Megan Hurley's mobile phone. He told his father that there had been a bomb and where he was in the City Room. He said that his sister was with him. Bradley Hurley's father told him that he was going to come to the Arena and to stay there. Bradley Hurley also described speaking to his mother. He told her that Megan Hurley had died. It was the worst thing he had ever had to do.[233]

17.97 Bradley Hurley's father can be seen on the CCTV in the City Room with Bradley Hurley and Megan Hurley at 22:56.[234] At that point, some men began to assess Megan Hurley. One of them thought she had a pulse. Bradley Hurley recalled that he suggested they get a defibrillator. He thought it was *"mad"* that he was the first person to suggest it.[235] The people using the defibrillator seemed to be in a state of shock and panic. His father was constantly asking for medical help.

225 138/163/6-166/5
226 138/166/6-168/21
227 138/168/22-169/14
228 138/169/15-170/9
229 138/171/12-23
230 138/170/20-25
231 138/172/10-25
232 138/173/1-7
233 138/174/21-177/15
234 138/178/2-9
235 138/178/20-179/9

Bradley Hurley said that the help they expected never came.[236] The defibrillator did not help Megan Hurley.[237] They were in a major city, and he could not fathom how few resources there seemed to be.[238]

17.98 Bradley Hurley's father left the City Room for a short time, but returned at 23:20 with his wife. Bradley Hurley described how hard it was seeing his parents confronted with what they saw. They were in shock. It was something he will never forget.[239] By this time, Bradley Hurley said, although his skin was still burning, he was getting very cold. His teeth were chattering. He was covered with a green plastic sheet. His parents were continually asking where the paramedics were.[240] There were police all around him. He was continually knocked, which was very painful. His mum asked for him to be given oxygen and pain relief.[241]

17.99 Bradley Hurley praised an officer, Police Constable (PC) Lauren Moore, who stayed with him. She reassured him and asked him about normal life. It meant a lot.[242]

17.100 Bradley Hurley's parents became frustrated with the speed of the evacuation. His father found a fence panel, but passed it on to another casualty who needed it. Bradley Hurley recalled the pain and discomfort of that person as they were put onto the makeshift stretcher. It made him scared.[243] His father found another barrier, and it was finally his turn to be moved. The pain from being moved onto the barrier was excruciating. He screamed and swore. The barrier was uncomfortable and unsteady. Every step would send a jolt of pain. He thought he would slide off.[244]

17.101 CCTV showed Bradley Hurley being taken out of the City Room at 23:39. He said he felt sick at leaving Megan.[245] Bradley Hurley explained how he struggles to understand why he was the last survivor taken out of the City Room, despite being assessed as a P2 patient.[246] He was on the floor of the City Room for one hour and eight minutes.[247]

17.102 Bradley Hurley arrived at the Casualty Clearing Station at 23:42.[248] He was placed on the floor. It was freezing cold. At some point, he was covered with a foil blanket. It felt like he was back to square one, waiting for treatment again.[249]

236 138/180/11-181/2
237 138/179/19-180/1
238 138/187/12-188/5
239 138/181/13-182/11
240 138/183/11-184/10
241 138/184/18-25, 138/188/6-22
242 138/185/5-186/17
243 138/189/18-190/16
244 138/191/2-192/169
245 138/192/20-193/7
246 138/173/7-174/20
247 138/174/11-17
248 138/193/25-194/3
249 138/194/4-195/20

An off-duty nurse, Bethany Crook, cut off his jeans up to his thighs and took off his shoes. It was the first time it felt that someone was taking charge. She assessed him properly.[250] He had 11 large holes in his leg and a large hole in his foot.[251] He was given pain relief and the anticoagulant tranexamic acid (TXA). He recalled that it did not seem to *"touch the sides"* and just made him sick.[252]

17.103 At 02:44 on 23rd May 2017, Bradley Hurley was taken from the Casualty Clearing Station to an ambulance. He arrived at hospital at 02:51, more than four hours after the detonation.[253] He was taken straight to theatre for an operation. His injuries were extensive, with shrapnel injuries to his legs, feet and jaw. His legs had external braces for six months. The impact on him, physically and mentally, has been significant. The loss of his sister affects his family every day.[254]

17.104 As someone who experienced it, Bradley Hurley did not believe that the emergency response to the Attack worked well. If his parents had not been there, he fears that his extraction would have taken even longer.[255]

Lisa Roussos, mother of Saffie-Rose Roussos

17.105 Lisa Roussos described how Saffie-Rose was a big fan of Ariana Grande and was so happy to be going to the concert.[256] Lisa Roussos accompanied her daughters, Saffie-Rose and Ashlee, to the concert and remembers how Saffie-Rose danced all night.[257]

17.106 As the concert came to an end, Lisa Roussos said she decided to stay for the encore. She had considered leaving to miss the crowds, but did not want to do that to Saffie-Rose. After the final song of the encore, they made their way out of the Arena bowl. Ashlee was in front. Saffie-Rose was pulling her mother's left hand, eager to see her father and brother. Lisa Roussos's last memory of Saffie-Rose before the explosion was of being pulled along by her, their arms outstretched.[258]

17.107 There was a big thud, and Lisa Roussos recalled lying on the floor. There was a muffled sound of white noise. She knew something serious had happened and that it was probably a bomb.[259] Lisa Roussos could remember trying to move her body, her arms and legs, but nothing would move. She forced herself to stay awake. She thought help would come soon, but it felt like hours before anyone

250 138/197/16-198/15
251 138/198/21-24, 138/173/21-24
252 138/198/21-200/1
253 138/205/7-18
254 138/209/1-213/11
255 138/213/17-214/2
256 174/143/5-10, 174/145/17-146/6
257 174/146/7-10, 174/148/9-149/3
258 174/149/14-150/12
259 174/150/16-25

approached her. When they did, she was really breathless and could only say *"Saffie"*.[260] Lisa Roussos said she wanted to keep her eyes open, to stay alive, so that she could make sure someone was taking care of Saffie-Rose.[261]

17.108 The next thing Lisa Roussos remembers was the feeling of being moved: her body being thrown from side to side, possibly from being taken out of the City Room on a stretcher. She tried to give someone her age, but because she was so breathless she gave the wrong age. Her breathing was very shallow and she could only take short breaths. She just wanted to close her eyes and give up.[262]

17.109 She could then recall being at hospital, her jeans being cut off and someone removing her jewellery. That was her last memory.[263] She was later told that while unconscious she had been assessed as having a very small chance of survival, and amputation had been discussed.[264]

17.110 Lisa Roussos was in a coma for about two-and-half weeks and underwent a number of operations as a result of the injuries she sustained.[265] When she woke up from the coma, her husband Andrew was holding her hand. He asked how she was feeling. He did not mention Saffie-Rose. Lisa Roussos said her last thought before she went into the coma was about Saffie-Rose, and she *"just knew"* when she woke up that Saffie-Rose had died. She wanted to go and be with Saffie-Rose to look after her.[266]

Andrew Roussos, father of Saffie-Rose Roussos

17.111 Andrew Roussos went with his son, Xander, to collect his wife, Lisa, daughter, Saffie-Rose, and step-daughter, Ashlee, from the concert. He spoke to Lisa at 22:29 to check where he should wait. As Ariana Grande was about to do an encore, he decided to find a parking space. Andrew Roussos was not present in the City Room at the time of the explosion but he was in the vicinity. His evidence relates to the adequacy of the emergency response and I have therefore included a summary of his evidence in this section.[267]

17.112 A few minutes later, after he parked in Cathedral Gardens, Andrew Roussos described hearing screams and seeing hysterical children running away. He tried to stop people to find out what had happened. Three women told him that either a bomb had exploded or a balloon had popped causing everyone to panic.[268]

260 174/151/5-15
261 174/151/22-25
262 174/152/1-153/5
263 174/153/6-12
264 174/158/3-7
265 174/155/11-158/19
266 174/154/13-25
267 174/115/19-116/22
268 174/117/1-119/4

17.113 Andrew Roussos decided he needed to find his family. Together with Xander and the family dog, they walked towards the Arena. As they turned onto Hunts Bank, the first person he saw was his step-daughter, Ashlee, on the floor near to Chetham's School of Music. She was stable, but injured and confused. He knew then that this was serious and feared that Lisa and Saffie-Rose would also be injured.[269]

17.114 There were two trainee doctors with Ashlee, who confirmed that a bomb had gone off. This was about 22:50. A police officer advised Andrew Roussos that everyone was out of the Arena and that he should go from person to person to see if he could find Saffie-Rose and his wife, Lisa. He could see hundreds of people now. Many were injured on the floor. The majority were children. He was frightened but trying to keep calm and not panic, for Xander's sake. It took about 30 or 40 minutes for Andrew Roussos to get to the bottom end of Hunts Bank.[270]

17.115 Andrew Roussos continued to search around the perimeter of the Victoria Exchange Complex for Saffie-Rose and Lisa. Unable to find them, at around 23:45 he went back to check on Ashlee. The trainee doctors agreed to stay with her, and he contacted her boyfriend who was also travelling to Manchester. They agreed to meet at Manchester Royal Infirmary to see how Ashlee's boyfriend could help with finding Lisa and Saffie-Rose before he continued on to be with Ashlee.[271]

17.116 Andrew Roussos waited at the hospital for hours. He gave the staff the details for Saffie-Rose and Lisa and felt a growing sense of *"panic"*.[272] Andrew Roussos said he called the helpline many times, but they were not able to give him any information. One hospital did not appear to know what was happening at another. They told him they would call back, but never did.[273]

17.117 At about 04:00, a friend found out that Lisa was at Salford Royal Hospital. Andrew Roussos arrived there after 04:30. He was taken into a private room and told of the extent of his wife's injuries. Lisa had been airlifted to Wythenshawe Hospital, which was better placed to treat her, but her chances of survival were small. Salford Royal Hospital had no news about Saffie-Rose. Andrew Roussos said that knowing that Ashlee was injured, then hearing of the serious injuries suffered by his wife, but still not knowing where Saffie-Rose was, was *"indescribable"*.[274]

17.118 Andrew Roussos drove to Wythenshawe Hospital to see Lisa. It was about a 40-minute drive. Lisa was so badly injured that she was put into an induced coma. Andrew Roussos said he broke down when he saw her. At 08:00, he

269 174/119/5-120/14
270 174/120/17-122/25
271 174/123/1-127/22
272 174/129/17-18
273 174/127/25-131/16, 174/137/11-14
274 174/130/12-16, 174/131/21-134/6

spoke to a police officer at the hospital and asked for help to find Saffie-Rose. He gave the police officer a photo. At about 12:30 on 23rd May 2017, the officer returned and told him that Saffie-Rose had been killed in the explosion.[275]

17.119 As a father, he wished he could have protected Saffie-Rose more. Andrew Roussos described the emergency response to the Attack as *"shameful"* and *"inadequate"*.[276]

[275] 174/138/1-140/24

[276] 174/113/23, 174/114/12-15

Part 18
Fatal consequences of the explosion

THE CONTENT OF PART 18 IS PARTICULARLY DISTRESSING. IT CONTAINS DETAIL ABOUT THE NATURE OF THE INJURIES SUSTAINED BY THOSE WHO DIED AND THEIR CAUSE OF DEATH

Introduction

18.1 My investigation into the Attack began as twenty-two inquests. As I set out in my Preface to Volume 1, it became necessary to continue that investigation as a statutory public inquiry. This Part has been drafted with the duties of a Coroner in mind.

18.2 The purpose of this Part is to provide a summary of the evidence about what happened to each of those who died. For each individual, I heard detailed evidence about the circumstances of their death during a period of the Inquiry's oral evidence hearings concerned exclusively with each of those who died.

18.3 The summary of that evidence within this Part is intentionally short. Its focus is on the most relevant information about the circumstances in which they were killed. It is not necessary, and would be distressing, to repeat every aspect of the evidence heard. The transcripts of the evidence, which provide far greater detail, are available on the Inquiry's website.[1] I have noted in this Part where some of the evidence has not been published on the Inquiry's website due to its graphic and distressing nature. This includes post-mortem reports.

18.4 I have summarised the position in relation to each person who died separately. I made exceptions for this in the case of two couples. For each of those who died, I set out where that person was in the period immediately after detonation, what care they received, when they were confirmed as dead and their cause of death. I confirm in the case of every person who died that they were unlawfully killed.

18.5 This is the information that, as a Coroner, I would have included in the record of inquest for each person.

18.6 The evidence set out in this Part is distressing. It sets out the tragic circumstances in which each person died. It is important to remember, as the Inquiry heard during the commemorative pen portrait evidence, that

[1] Transcripts by hearing date, Manchester Arena Inquiry website

each of those who died is *"not a number, each of them is not just one of the 22 who died: each was an individual, each was unique, each loss of life is a separate tragedy"*.[2]

Investigation

18.7 All of those who died were the subject of a post-mortem examination. These examinations were carried out by a team of forensic pathologists, led by Dr Philip Lumb.[3] The post-mortem examinations were assisted by a radiology team led by Colonel Dr Iain Gibb, who was supported by Lieutenant Colonel Dr Mark Ballard and Commander Dr David Gay.[4]

18.8 Extensive work was undertaken by Operation Manteline, the Greater Manchester Police (GMP) team who assisted my investigation. This included many hundreds of hours spent analysing the footage from 90 CCTV cameras, from 52 body-worn video cameras and from mobile phones. From that work, timelines were produced to show, as far as possible, what happened to each person who died and the individuals who interacted with them.

18.9 An important part of my investigation has been whether a different or better emergency response may have led to the survival of any of those who died. I have been assisted in this part of my investigation by experts. These experts and their qualifications are set out in Appendix 12. Such has been the complexity of some of the issues that have arisen that it has been necessary to call upon more than one expert in certain disciplines.

18.10 First, I instructed the Blast Wave Panel of Experts to consider the relevant evidence. The Panel are a multi-disciplinary team based at Imperial College London and the Defence Science and Technology Laboratory. The Panel have considerable expertise in blast injury. The Panel comprised Professor Anthony Bull, Colonel Professor Peter Mahoney, Colonel Professor Jonathan Clasper, Lieutenant Colonel Ballard and Alan Hepper. The purpose of their review was to consider whether any of those who died may have been able to survive their injuries with different or better care.

18.11 Second, in relation to two of those who died, the complexity of the evidence surrounding their deaths led me to instruct further experts. In the case of John Atkinson, I instructed cardiology expert Surgeon Commander Dr Paul Rees. In the case of Saffie-Rose Roussos, I instructed consultants in pre-hospital care and emergency medicine, Lieutenant Colonel Dr Claire Park, Dr Gareth Davies and Mr Aswinkumar Vasireddy, and consultant radiologist Dr Richard Wellings.

[2] 10/25/15-22

[3] 176/109/19-112/8

[4] 177/163/3-9

18.12 Third, I instructed forensic pathologists Professor Jack Crane and Dr Lumb to review the post-mortem evidence in the light of all the medical and scientific evidence. That included a review of relevant video footage. In relation to John Atkinson's post-mortem, Dr Naomi Carter, who carried it out, was invited to review her findings following receipt of Surgeon Commander Rees's report.

Survivability

18.13 The Blast Wave Panel of Experts were instructed to assess the available evidence and provide their conclusions on whether each of those who died may have survived, if they had received different medical care. The Panel defined the term *"unsurvivable"* as *"injuries so severe that even if the most comprehensive and advanced medical treatment [available in 2017] was initiated immediately after injury, survival was still deemed impossible"*.[5] I shall adopt this definition.

18.14 In the case of twenty of the twenty-two people who died, the Panel concluded that all of the evidence supports the conclusion that their injuries were unsurvivable. I accept this evidence. I record this fact in relation to each of those to whom it applies when I address the circumstances of their death.

18.15 The evidence was less conclusive in the cases of John Atkinson and Saffie-Rose Roussos. For this reason, it required more detailed analysis, which I will provide at paragraphs 18.154 to 18.234.

[5] 161/3/6-4/23

Alison Howe

18.16 Alison Howe was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.17 When the bomb detonated, Alison Howe was standing near to the Arena exit doors. She was approximately three metres from the seat of the explosion.[6]

18.18 Following the detonation, CCTV shows that Alison Howe was lying on her back on the floor of the City Room. After a short period, she was approached by a member of the public, who placed her in the recovery position.[7]

18.19 At 22:55, a Showsec staff member and a British Transport Police (BTP) officer gave Alison Howe chest compressions.[8]

18.20 A short time later, a paramedic assessed that Alison Howe's injuries were incompatible with life. CPR was stopped and Alison Howe was covered at 22:58.[9]

18.21 A tag was placed on Alison Howe at 23:34 to confirm that she was dead.[10]

18.22 As a result of the explosion, Alison Howe suffered multiple injuries. A post-mortem examination confirmed that Alison Howe's death was caused by a significant head injury. Her injuries were unsurvivable.[11]

6 152/11/19-20
7 152/11/21-12/2
8 152/12/14-20
9 152/13/2-3
10 152/13/11-13
11 152/13/20-25

Angelika and Marcin Klis

18.23 Angelika and Marcin Klis were unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.24 When the bomb detonated, Angelika and Marcin Klis were standing near to the Arena exit doors. Marcin Klis was approximately five metres from the seat of the explosion.[12] Angelika Klis was approximately four metres from the seat of the explosion.[13]

18.25 Following the detonation, Angelika and Marcin Klis were found lying on the floor of the City Room. They were together. Members of the public, Emergency Training UK (ETUK) first aiders and police officers checked on them. Both remained motionless.[14]

18.26 By no later than 22:50, Angelika Klis was covered.[15] Marcin Klis was covered by no later than 22:59.[16]

18.27 A tag was placed on Angelika Klis at 23:39 to confirm that she was dead. A tag was placed on Marcin Klis at 23:40 to confirm that he was dead.[17]

18.28 A post-mortem examination confirmed that Marcin Klis's death was caused by chest injuries. A post-mortem examination confirmed that Angelika Klis's death was caused by multiple injuries. These injuries were sustained as a result of the explosion. Their injuries were unsurvivable.[18]

12 150/105/20-21
13 150/105/21-22
14 150/105/24-107/17
15 150/108/12-13
16 150/108/22-24
17 150/109/24-110/4
18 150/110/17-112/18

Chloe Rutherford and Liam Curry

18.29 Chloe Rutherford and Liam Curry were unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.30 Following the detonation, Chloe Rutherford and Liam Curry were lying side by side. Neither showed signs of life.[19]

18.31 They were both covered shortly after 22:42.[20]

18.32 A tag was placed on Chloe Rutherford at 23:40 to confirm that she was dead.[21] A tag was placed on Liam Curry at 23:44 to confirm that he was dead.[22]

18.33 Post-mortem examinations for Chloe Rutherford and Liam Curry confirmed that their deaths were caused by multiple injuries. These injuries were sustained as a result of the explosion. Their injuries were unsurvivable.[23]

[19] 154/99/11-20
[20] 154/99/18-24
[21] 154/100/8-9
[22] 154/100/13-15
[23] 154/100/19-101/17

Courtney Boyle

18.34 Courtney Boyle was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.35 When the bomb detonated, Courtney Boyle was approximately four metres from the seat of the explosion.[24]

18.36 Following the detonation, Courtney Boyle was lying on the floor of the City Room on her right side. She was not moving.[25]

18.37 A member of the public checked on Courtney Boyle. She did not move or show any signs of life.[26]

18.38 By 22:51, Courtney Boyle was covered.[27]

18.39 A tag was placed on Courtney Boyle at 23:38 to confirm that she was dead.[28]

18.40 A post-mortem examination confirmed that Courtney Boyle's death was caused by multiple injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.[29]

[24] 150/118/10-11
[25] 150/118/12-13
[26] 150/118/18-25
[27] 150/119/1-2
[28] 150/119/8-11
[29] 150/119/14-23

Eilidh MacLeod

18.41 Eilidh MacLeod was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.42 When the bomb detonated, Eilidh MacLeod was approximately four metres from the seat of the explosion.[30]

18.43 Following the detonation, Eilidh MacLeod was lying on her right side on the floor of the City Room. She was motionless.[31]

18.44 By 22:51, 20 minutes after the explosion, Eilidh MacLeod was covered with clothing.[32] A police officer who saw Eilidh MacLeod believed she had died.[33]

18.45 A tag was placed on Eilidh MacLeod at 23:45 to confirm that she was dead.[34]

18.46 A post-mortem examination confirmed that Eilidh MacLeod's death was caused by multiple injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.[35]

30 153/65/18-19
31 153/65/20-23
32 153/65/24
33 153/66/11-15
34 153/66/19-21
35 153/67/2-23

Elaine McIver

18.47 Elaine McIver was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.48 When the bomb detonated, Elaine McIver was approximately four metres from the seat of the explosion.[36]

18.49 Following the detonation, Elaine McIver was seen lying face down. She was not moving. A few minutes later, Elaine McIver was lying on her back.[37]

18.50 An emergency responder checked on Elaine McIver about six minutes after the explosion. There was a small, sharp movement of her head but she otherwise did not respond.[38]

18.51 At 22:50, police officers attempted CPR. One of the officers noticed some movement to her mouth. Elaine McIver did not respond to CPR.[39] By 22:55, she was covered.[40]

18.52 A tag was placed on Elaine McIver at 23:45 to confirm that she was dead.[41]

18.53 As a result of the explosion, Elaine McIver suffered multiple injuries. A post-mortem examination confirmed that her death was caused by chest injuries. Her injuries were unsurvivable.[42]

[36] 156/46/2-3
[37] 156/46/4-8, 156/46/14-19
[38] 156/46/20-47/1
[39] 156/48/2-7, 156/49/3-50/6
[40] 156/48/16-18
[41] 156/50/22-25
[42] 156/51/11-53/5

Georgina Bethany Callander

18.54 Georgina Callander was unlawfully killed as a result of the Attack.

18.55 When the bomb detonated, Georgina Callander was approximately four metres from the seat of the explosion.[43]

18.56 Georgina Callander suffered a very serious head injury in the explosion. She remained in the City Room until 23:26 when she was evacuated to the Casualty Clearing Station.[44]

18.57 In the City Room, Georgina Callander was triaged as a P1 casualty, which meant that she was classified as priority one, among the most seriously injured, requiring immediate medical care.[45] She was breathing but she did not communicate with anyone who tried to help her.

18.58 Georgina Callander was carried into the Casualty Clearing Station at 23:28.[46] By this time, she was in cardiac arrest.[47] She was given CPR and a cardiac output was restored.[48]

18.59 An ambulance took Georgina Callander to Manchester Royal Infirmary at 23:40.[49] On the journey to hospital, initially she had a pulse but was assessed as having a very low score on the Glasgow Coma Scale.[50] This indicated deep unconsciousness.

18.60 Georgina Callander's condition deteriorated further in the ambulance. She went into cardiac arrest shortly before the ambulance arrived at Manchester Royal Infirmary at 23:48.[51]

18.61 At the hospital, Advanced Life Support was given to Georgina Callander for 30 minutes.[52] Georgina Callander remained in cardiac arrest. Her death was confirmed at 00:05 on 23rd May 2017.[53]

18.62 A post-mortem examination confirmed that Georgina Callander suffered multiple injuries as a result of the explosion. Her death was caused by a head injury and her injuries were unsurvivable.[54]

[43] 155/6/20-21
[44] 155/28/16-18
[45] 155/12/10-23, 155/45/20-48/4, 155/70/11-71/18
[46] 155/22/7-29/11
[47] 155/29/10-32/18
[48] 155/32/19-33/15, 155/134/15-21
[49] 155/35/21-25
[50] 155/37/4-5
[51] 155/36/17-38/21, 155/142/25-145/8
[52] 155/39/23-40/7, 155/154/20-155/25
[53] 155/40/8-23, 155/155/1-11
[54] 155/41/13-42/19

Jane Tweddle

18.63 Jane Tweddle was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.64 When the bomb detonated, Jane Tweddle was standing near to the box office. She was approximately 14 metres from the seat of the explosion.[55]

18.65 Following the detonation, a friend helped Jane Tweddle across the City Room, but she collapsed on the ground near to the staircase leading towards Trinity Way.[56]

18.66 A member of the public placed Jane Tweddle in the recovery position. An ETUK first aider and police officers gave CPR to Jane Tweddle for approximately 11 minutes. A defibrillator was used but could not detect any cardiac output.[57]

18.67 CPR was stopped at 22:59.[58] Jane was covered with clothing at 22:59.[59]

18.68 A tag was placed on Jane Tweddle at 23:47 to confirm that she was dead.[60]

18.69 A post-mortem examination confirmed that Jane Tweddle's death was caused by neck injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.[61]

[55] 151/29/7-9
[56] 151/29/10-14
[57] 151/31/14-33/23
[58] 151/33/24-25
[59] 151/33/24-34/4
[60] 151/34/10-12
[61] 151/34/23-35/6

John Atkinson

18.70 John Atkinson was unlawfully killed as a result of the Attack.

18.71 When the bomb was detonated, John Atkinson was approximately six metres from the seat of the explosion.[62] He suffered serious injuries, principally to his legs.

18.72 Following the detonation, John Atkinson attempted to drag himself across the floor of the City Room. He left an obvious trail of blood behind him.[63]

18.73 A member of the public assisted John Atkinson very shortly after the blast. The member of the public made the first 999 call to report the Attack.[64] He was advised to apply a tourniquet to John Atkinson's right leg, which he did during the call using his wife's belt.[65] In order to help stem blood loss, police issue *"leg restraints"* were also applied around the top of both of John Atkinson's legs approximately 43 minutes after the explosion.[66]

18.74 John Atkinson was in the City Room for 47 minutes after the explosion. He was conscious during that time and spoke to those helping him. Members of the public, Showsec employees, ETUK first aiders and police officers assisted John Atkinson. He was not triaged or treated by North West Ambulance Service (NWAS) paramedics while he was in the City Room.

18.75 It took eight minutes to move John Atkinson from the City Room to the Casualty Clearing Station. At 23:16, he was placed onto an advertising hoarding and was dragged from the City Room.[67] Between 23:19 and 23:20, attempts were made to manoeuvre John Atkinson on the advertising hoarding into the lift that joined the raised walkway to the station concourse. It was realised that the hoarding would not fit. At 23:21, after the advertising hoarding had given way, John Atkinson was lifted onto a metal barrier.[68] He was carried towards the Casualty Clearing Station at 23:22.[69] This was 52 minutes after the detonation.

18.76 John Atkinson remained in the Casualty Clearing Station for 24 minutes. At 23:47, while still waiting in the Casualty Clearing Station, he went into cardiac arrest.[70] NWAS paramedics and a doctor gave CPR.[71] At 23:50, John Atkinson was placed into an NWAS ambulance. In the ambulance, the doctor performed a chest decompression upon John Atkinson. This did not change John Atkinson's

[62] 158/7/12-13
[63] 158/7/18-20
[64] 158/8/25-9/19
[65] 158/11/17-14/10
[66] 158/33/8-34/7
[67] 158/36/15-39/22
[68] 158/50/8-51/8
[69] 158/54/9-11
[70] 159/16/24-17/3
[71] 159/17/4-23/6, 160/58/25-59/17

cardiac output.[72] The ambulance left Station Approach for Manchester Royal Infirmary at 00:00 on 23rd May 2017.[73] At approximately the same time, some degree of heart activity was detected,[74] but it is likely that this was merely intermittent activity and was in no sense a return to normal. On the contrary, circulation was continuing to reduce.[75] The cardiac arrest at 23:47 was, on the expert evidence to which I shall turn in paragraphs 18.165 to 18.173, the point beyond which John Atkinson was incapable of survival.

18.77 John Atkinson arrived at Manchester Royal Infirmary at 00:06.[76] By this time, he was again in cardiac arrest. He was taken to the resuscitation room and given Advanced Life Support.[77] This was unsuccessful. John Atkinson was declared dead by the treating clinicians at 00:24 on 23rd May 2017.[78]

18.78 The view of Professor Crane and Dr Lumb, which I accept, was that John Atkinson's death was caused by the leg injuries he sustained in the explosion.[79] I also accept the opinion of the Blast Wave Panel of Experts, which was that those were injuries from which he would have survived if given prompt and expert medical treatment.[80] As I shall explain when dealing with survivability in paragraphs 18.174 to 18.190, such treatment should have been provided.

[72] 159/23/7-19, 159/25/22-28/5
[73] 159/29/11
[74] 159/29/18-30/4
[75] 161/56/4-58/3
[76] 159/30/7-12
[77] 159/30/20-34/11, 160/201/15-206/24
[78] 159/34/12-15, 160/206/25-207/6
[79] 159/41/17-43/7
[80] 159/38/18-41/16

Kelly Brewster

18.79 Kelly Brewster was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.80 When the bomb detonated, Kelly Brewster was approximately nine metres from the seat of the explosion.[81]

18.81 Following the detonation, Kelly Brewster was lying on the floor of the City Room.[82] She was breathing erratically and was unconscious.[83] Kelly Brewster's sister, a member of the public, a TravelSafe officer, ETUK first aiders and police officers all sought to help her.[84]

18.82 Kelly Brewster stopped breathing shortly after 23:00. She was given CPR but this was not successful. Following an assessment by a paramedic, CPR was stopped at 23:11.[85] She was covered by 23:12.[86]

18.83 A tag was placed on Kelly Brewster at 23:45 to confirm that she was dead.[87]

18.84 A post-mortem examination confirmed that Kelly Brewster's death was caused by head and abdominal injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.[88]

[81] 154/40/1-2
[82] 154/5/24-6/6
[83] 154/26/21-27/7, 154/42/6-10
[84] 154/6/7-10/24
[85] 154/10/25-13/18, 154/14/3-18
[86] 154/14/22-15/8
[87] 154/22/1-4
[88] 154/22/14-24/4

Lisa Lees

18.85 Lisa Lees was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.86 When the bomb detonated, Lisa Lees was standing near to the Arena exit doors. She was approximately four metres from the seat of the explosion.[89]

18.87 Following the detonation, Lisa Lees was lying on her back on the floor of the City Room.[90] Members of the public present in the City Room went to assist Lisa. The extent of her injuries meant that she could not be helped. At 22:43, about 12 minutes after the explosion, she was covered.[91]

18.88 A tag was placed on Lisa Lees at 23:39 to confirm that she was dead.[92]

18.89 A post-mortem examination confirmed that Lisa Lees' death was caused by multiple injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.[93]

89 152/4/18-19
90 152/4/20-21
91 152/6/7-9
92 152/6/22-24
93 152/7/10-24

Martyn Hakan Hett

18.90 Martyn Hett was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.91 When the bomb detonated, Martyn Hett was approximately four metres from the seat of the explosion.[94]

18.92 Following the detonation, Martyn Hett was lying on his front on the floor of the City Room. He was motionless. A TravelSafe officer checked on him but Martyn Hett did not respond.[95]

18.93 Martyn Hett was seen on video footage subsequently, lying in the same position. He had not moved. By 22:53, Martyn Hett was covered.[96]

18.94 A tag was placed on Martyn Hett at 23:44 to confirm that he was dead.[97]

18.95 A post-mortem examination confirmed that Martyn Hett's death was caused by multiple injuries. These injuries were sustained as a result of the explosion. His injuries were unsurvivable.[98]

94 156/9/17-18
95 156/9/22-24
96 156/10/6-7
97 156/12/8-11
98 156/12/14-13/9

Megan Joanne Hurley

18.96 Megan Hurley was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.97 When the bomb detonated, Megan Hurley was approximately three metres from the seat of the explosion.[99]

18.98 Following the detonation, Megan Hurley was lying on her front on the floor of the City Room. She was not moving.[100] Efforts were made to help Megan Hurley by her family, an ETUK first aider and police officers.[101]

18.99 By 22:53, she was covered.[102] The covering was removed a few minutes later and, at approximately 23:00, Megan Hurley was given CPR. A defibrillator was used to check her cardiac output.[103]

18.100 Following a discussion with an NWAS paramedic, CPR was stopped at about 23:06.[104] Megan Hurley was covered again shortly afterwards.[105]

18.101 Megan Hurley's father remained with her in the City Room until 01:02 on 23rd May 2017.[106] No tag was put onto Megan Hurley to record her time of death.

18.102 A post-mortem examination confirmed that Megan Hurley's death was caused by multiple injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.[107]

99 153/5/8-9
100 153/5/18-6/1
101 153/8/1-16/22
102 153/6/19-21
103 153/8/14-17/12
104 153/17/12-24
105 153/17/23-18/1
106 153/24/2-3
107 153/24/17-25/11

Michelle Kiss

18.103 Michelle Kiss was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.104 When the bomb detonated, Michelle Kiss was standing at the top of the steps leading to JD Williams. She was approximately 20 metres from the seat of the explosion.[108]

18.105 Following the detonation, Michelle Kiss immediately fell to the floor. She was given assistance by those present in the City Room and emergency responders. Michelle Kiss did not respond and showed no signs of life.[109]

18.106 By 22:48, Michelle Kiss was covered.[110]

18.107 A tag was placed on Michelle Kiss at 00:32 on 23rd May 2017 to confirm that she was dead.[111]

18.108 A post-mortem examination confirmed that Michelle Kiss's death was caused by a head injury. This injury was sustained as a result of the explosion and was unsurvivable.[112]

108 151/23/5-6
109 151/23/14-24/12
110 151/24/13-25
111 151/24/13-25
112 151/25/10-22

Nell Jones

18.109 Nell Jones was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.110 When the bomb detonated, Nell Jones was approximately two metres from the seat of the explosion.[113]

18.111 Following the detonation, Nell Jones was lying on her front on the floor of the City Room. She was motionless.[114]

18.112 She made no response when a TravelSafe officer checked her two times. She was unresponsive when a police officer checked on her a short time after that.[115]

18.113 By 22:56, Nell Jones was covered with clothing.[116]

18.114 A tag was placed on Nell Jones at 23:41 to confirm that she was dead.[117]

18.115 A post-mortem examination confirmed that Nell Jones' death was caused by multiple injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.[118]

[113] 152/26/10-11
[114] 152/26/12-16
[115] 152/26/17-27/3
[116] 152/27/4-10
[117] 152/27/20-22
[118] 152/27/25-28/20

Olivia Paige Campbell-Hardy

18.116 Olivia Campbell-Hardy was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.117 When the bomb was detonated, Olivia Campbell-Hardy was approximately five metres from the seat of the explosion.[119]

18.118 Following the detonation, Olivia Campbell-Hardy was lying on her left side on the floor of the City Room. She appeared to be unconscious and was not moving.[120]

18.119 By 22:53, Olivia Campbell-Hardy remained in the same position but was covered.[121] She could later be seen in the same position, still covered, on the body-worn video footage of police officers.[122]

18.120 A tag was placed on Olivia Campbell-Hardy at 23:45 to confirm that she was dead.[123]

18.121 A post-mortem examination confirmed that Olivia Campbell-Hardy's death was caused by head and neck injuries. These injuries were sustained as a result of the explosion. Her injuries were unsurvivable.[124]

[119] 151/17/2-3
[120] 151/17/4-11
[121] 151/17/12-13
[122] 151/17/14-17
[123] 151/17/22-24
[124] 151/18/2-15

Philip Tron

18.122 Philip Tron was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.123 When the bomb was detonated, Philip Tron was approximately four metres from the seat of the explosion.[125]

18.124 Following the detonation, Philip Tron was lying on his front on the floor of the City Room. He appeared to be unconscious.[126]

18.125 An ETUK first aider and a police officer checked on Philip Tron but he was unresponsive. By 22:51, Philip Tron was covered with clothing.[127]

18.126 A tag was placed on Philip Tron at 23:28 to confirm that he was dead.[128]

18.127 A post-mortem examination confirmed that Philip Tron's death was caused by multiple injuries. These injuries were sustained as a result of the explosion. His injuries were unsurvivable.[129]

125 151/8/19-21
126 151/8/22-9/2
127 151/9/5-13
128 151/9/25-10/10
129 151/10/13-22

Saffie-Rose Roussos

18.128 Saffie-Rose Roussos was unlawfully killed as a result of the Attack.

18.129 When the bomb was detonated, Saffie-Rose Roussos was approximately five metres from the seat of the explosion.[130]

18.130 Following the detonation, Saffie-Rose Roussos was lying on the floor of the City Room. She was close to her mother. Saffie-Rose Roussos briefly pushed herself up off the floor with her arms. She also raised her left arm.[131]

18.131 Saffie-Rose Roussos remained in the City Room for a period of 26 minutes.[132] During that time, she drifted in and out of consciousness.[133] To the first member of the public who helped her, Saffie-Rose Roussos was able to give her name.[134] Members of the public, ETUK first aiders, Showsec staff and police officers helped her.[135] No tourniquets or leg splints were applied to her injuries.[136]

18.132 At 22:56, police officers and two members of the public placed Saffie-Rose Roussos onto an advertising hoarding.[137] It was clear that she was conscious as this was done. A minute later, she was carried out of the City Room, down the stairs and through the Trinity Way link tunnel.[138]

18.133 Saffie-Rose Roussos was carried onto Trinity Way at 22:58.[139] An NWAS ambulance arrived on Trinity Way at 23:01.[140] Five minutes later, Saffie-Rose Roussos was placed into the ambulance.[141] Her level of consciousness fluctuated.[142] For the next 11 minutes, Saffie-Rose Roussos was given emergency care in the back of the ambulance.[143] At one stage, she briefly spoke.[144]

18.134 At 23:17, 46 minutes after the detonation, the ambulance left Trinity Way for the Royal Manchester Children's Hospital.[145] The journey took six minutes.[146] From approximately 23:26, Saffie-Rose Roussos was treated by a trauma team in the

130 174/12/14-15
131 174/13/2-11
132 174/34/13-16
133 174/15/12-13
134 174/13/23-24
135 174/13/23-26/3
136 174/168/14-22, 174/234/10-18
137 174/30/10-19
138 174/30/20-38/14
139 174/39/2-8
140 174/50/7-10
141 174/65/6-16
142 174/82/24-83/17
143 174/67/13-71/4
144 174/87/18-88/1
145 174/89-1-4
146 174/92/6-9

hospital's resuscitation room.[147] She went into cardiac arrest at about 23:26. Four cycles of CPR were completed but her heart was asystolic. This meant that there was no electrical activity.[148]

18.135 Saffie-Rose Roussos was declared dead by the treating clinicians at 23:40 on 22nd May 2017.[149]

18.136 The view of Dr Lumb and Professor Crane, which I accept, was that the death of Saffie-Rose Roussos was caused by the multiple injuries[150] that she sustained in the explosion. Whether those injuries made her death inevitable is a complex issue, to which I will turn in paragraphs 18.191 to 18.234.

147 174/96/2-7

148 174/96/8-111/18, 175/199/8-216/21

149 174/111/19-22

150 176/45/22-46/5

Sorrell Leczkowski

18.137 Sorrell Leczkowski was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.138 When the bomb was detonated, Sorrell Leczkowski was approximately six metres from the seat of the explosion.[151]

18.139 Following the detonation, Sorrell Leczkowski was lying on her right side on the floor of the City Room. She was not moving.[152]

18.140 In the period that followed, efforts were made to help Sorrell Leczkowski by her mother, Showsec staff, ETUK first aiders and police officers.[153]

18.141 Sorrell Leczkowski was given CPR for more than half an hour. CPR was stopped at 23:08 and Sorrell Leczkowski was covered with clothing a couple of minutes later.[154]

18.142 A tag was placed on Sorrell Leczkowski at 23:46 to confirm that she was dead.[155]

18.143 A post-mortem examination confirmed that Sorrell Leczkowski's death was caused by a neck injury. Her injuries were sustained as a result of the explosion. Her injuries were unsurvivable.[156]

151 153/71/23-24
152 153/72/6-12
153 153/72/13-77/19
154 153/72/13-77/19
155 153/77/25-78/5
156 153/78/8-18

Wendy Fawell

18.144 Wendy Fawell was unlawfully killed on 22nd May 2017 in the City Room of the Manchester Arena in the Victoria Exchange Complex.

18.145 When the bomb was detonated, Wendy Fawell was approximately five metres from the seat of the explosion.[157]

18.146 Following the detonation, Wendy Fawell was lying on her left side on the floor of the City Room. She was not moving.[158]

18.147 A number of emergency responders checked on Wendy Fawell, but she was unresponsive. By 22:54, she was covered with clothing.[159]

18.148 A tag was placed on Wendy Fawell at 23:44 to confirm that she was dead.[160]

18.149 A post-mortem examination confirmed that Wendy Fawell's death was caused by a head injury. Her injuries were sustained as a result of the explosion. Her injuries were unsurvivable.[161]

157 152/18/3-4
158 152/18/5-7
159 152/20/4-5
160 152/20/19-25
161 152/21/3-19

Survivability

Key findings

- In the case of twenty of the twenty-two who died, I am sure that their injuries were unsurvivable. I am sure that inadequacies in the response did not fail to prevent their deaths.
- In the case of John Atkinson, his injuries were survivable. Had he received the treatment and care he should have, it is likely that he would have survived. It is likely that inadequacies in the emergency response prevented his survival.
- In the case of Saffie-Rose Roussos, it is highly unlikely that she could have survived her injuries. There was only a remote possibility that she could have survived with different treatment and care.

Introduction

18.150 I find the following people sustained unsurvivable injuries:

Alison Howe	Kelly Brewster
Angelika Klis	Lisa Lees
Marcin Klis	Martyn Hakan Hett
Chloe Rutherford	Megan Joanne Hurley
Liam Curry	Michelle Kiss
Courtney Boyle	Nell Jones
Eilidh MacLeod	Olivia Paige Campbell-Hardy
Elaine McIver	Philip Tron
Georgina Bethany Callander	Sorrell Leczkowski
Jane Tweddle	Wendy Fawell

18.151 Once the explosion had occurred, it was inevitable that each would die. I have set out in Parts 13 to 16 in Volume 2-I details in relation to the treatment and evacuation of some of these individuals on the night of the Attack. Any inadequacies in the emergency response, as set out in Parts 10 to 16 in Volume 2-I, did not contribute to their deaths.

18.152 For John Atkinson and Saffie-Rose Roussos, there was evidence about the possibility of their survival had the response been different. Due to its complexity, this requires a detailed analysis of the evidence.

18.153 Readers may find what follows particularly distressing.

THE CONTENT OF WHAT FOLLOWS IS PARTICULARLY DISTRESSING. IT CONTAINS DETAIL ABOUT THE NATURE OF THE INJURIES SUSTAINED BY JOHN ATKINSON AND HIS CAUSE OF DEATH

John Atkinson

Post-mortem examination

18.154 Dr Carter is a consultant forensic pathologist on the Home Office register. She was one of the team that carried out the post-mortem examinations of the twenty-two who died in the Attack.

18.155 Dr Carter performed the post-mortem examination of John Atkinson on 28th May 2017.[162] In her written report of that examination, Dr Carter listed 47 external injuries. Of those, 16 were to the right leg and foot and 14 to the left leg.[163]

18.156 Dr Carter concluded that John Atkinson had sustained very severe leg injuries as the result of penetration by multiple metal objects. These had shredded the musculature, damaged deep leg blood vessels and severely fractured the bones of the leg, particularly on the right side. While John Atkinson had suffered injuries to other parts of his body from penetrating objects, those injuries had not contributed to his death. Dr Carter's conclusion was that John Atkinson *"died principally of the effects of blood loss from his leg wounds"*.[164]

18.157 Surgeon Commander Rees, an expert in cardiology,[165] explained this in further detail during the oral evidence hearings. When a person suffers unchecked blood loss, their body will ultimately go into a state known as 'hypovolaemic shock'. This involves the body's circulation shutting down. Organs then fail, including the heart. In simple terms, blood loss causes hypovolaemic shock which causes cardiac arrest.[166] The view of Dr Carter was that this was the mechanism of John Atkinson's death.[167] The other experts agreed.[168]

18.158 There was, however, a complicating factor identified by Dr Carter on her post-mortem examination. On her internal examination, she noted that John Atkinson had pre-existing heart disease. One of his coronary arteries contained a blockage and there was also scarring to his heart that had been present for months or years. In medical terms, John Atkinson had a condition known as 'ischaemic heart disease'. Dr Carter considered that this disease might have been a contributory factor in John Atkinson's death, either by making his

162 161/21/13-16
163 INQ015996/6-13 [not published]
164 INQ015996/17-18 [not published]
165 161/19/16-21/9
166 161/26/8-27/17
167 INQ015996/18 [not published]
168 161/92/7-10

heart more likely to fail in the context of the blood loss from his leg injuries and/or by reducing the chances of successful resuscitation.[169] Dr Carter was right to identify this as a potential issue.

Reports of the Blast Wave Panel of Experts in John Atkinson's case

18.159 The Blast Wave Panel of Experts carried out an assessment of survivability in the case of each of the twenty-two killed, including John Atkinson.

18.160 In their first report dated 27th September 2019, the Panel expressed the view that John Atkinson had *"potentially survivable"* injuries.[170] The Panel used that term to describe injuries which *"could prove fatal"*, but which they were aware of individuals surviving.[171] Their assessment assumed that the right people with the right skills and right equipment would be available immediately after the injury had been sustained.[172]

18.161 It follows that, in their first report, the Panel considered that John Atkinson might have survived with prompt and effective treatment. However, the Panel did raise a proviso, namely the potential impact on survivability of John Atkinson's pre-existing heart disease, as commented upon by Dr Carter.[173]

18.162 After preparing their first report, the Panel were provided with additional material, in particular CCTV footage and footage from the body-worn video cameras of police officers.[174] In light of that material, they looked again at the issue of survivability and produced a second report dated 30th March 2020.[175] Of John Atkinson, they said:

> *"[He] sustained multiple secondary blast injuries with an overall high burden of injury …*
>
> *The PM [post-mortem] photos and medical imaging demonstrate severe leg injuries; these leg injuries were associated with severe compressible bleeding.*
>
> *The video demonstrates catastrophic and continuing external bleeding; this appears amenable to treatment outside hospital.*
>
> *Based on the video footage, witness statements, and the above information, we believe, John Atkinson could have potentially survived in this situation with earlier treatment (application of effective bilateral tourniquets).*

169 INQ015996/18 [not published]
170 INQ025413/21 [not published]
171 INQ025413/20 [not published]
172 161/3/6-4/23
173 INQ025413/21 [not published], INQ015996/18 [not published]
174 161/80/18-81/2
175 INQ032039 [not published]

> *However, the post-mortem noted a pre-existing cardiac condition that reportedly reduced the chances of survival given the burden of injury. This reduction in chances of survival due to the pre-existing cardiac condition is a matter not within the expertise of the panel."*[176]

18.163 In a third report dated 24th March 2021, the Panel clarified that the change of language from *"potentially survivable"* in the first report to *"could have potentially survived"* in the second report was deliberate.[177] They explained that it *"reflects a strengthening of our opinion that timely medical intervention – the application of effective bilateral tourniquets – could have made a material difference for John Atkinson"*.[178]

18.164 However, the Panel's opinion as to survivability in John Atkinson's case continued to have a proviso. Throughout their reporting, the Panel made it plain that their opinion on survivability in his case was contingent upon the significance of his pre-existing ischaemic heart disease. In that regard, the Panel responsibly drew attention to the fact that the significance of that condition to survivability was outside their combined expertise.[179]

The expert cardiological opinion

18.165 For that reason, I instructed Surgeon Commander Rees to provide his opinion on the significance of John Atkinson's pre-existing heart disease.

18.166 Surgeon Commander Rees is an expert in cardiology, general internal medicine and pre-hospital emergency medicine. He works as a consultant cardiologist within Barts Heart Centre, at St Bartholomew's Hospital in London, and undertakes regular duties with an air ambulance service. He also has military experience, having undertaken combat deployments including working in a field hospital in Afghanistan, and worked as a consultant leading the Medical Emergency Response Team, often treating those injured in explosions.[180]

18.167 Surgeon Commander Rees gave evidence to the Inquiry.[181] He agreed with Dr Carter that the problems in John Atkinson's heart and coronary artery found in the post-mortem examination were not a consequence of the explosion but instead were pre-existing.[182] John Atkinson had lived with the blockage in his artery for a substantial period prior to 22nd May 2017, and the scarring to his heart was pre-existing and likely the result of a heart attack at some point in the past. John Atkinson's medical records contained no reference to any history of heart problems, let alone to a heart attack. Surgeon Commander Rees found this unsurprising. He explained that cardiology recognises the concept

176 INQ032039/3 [not published]
177 INQ041014/13 [not published]
178 INQ041014/13 [not published]
179 161/81/3-84/4
180 161/19/14-21/9
181 161/19/4-65/15
182 161/28/1-29/6

of a silent heart attack in which the patient is wholly unaware that anything untoward has happened. Moreover, even where the patient has symptoms, they may mistake them for something trivial and make no report of them.[183]

18.168 Notwithstanding that the problems in John Atkinson's heart and coronary artery identified on the post-mortem examination appear not to have caused him any or any significant difficulties in life, Surgeon Commander Rees agreed with Dr Carter that the findings were notable. However, he did not consider that they had made a contribution to John Atkinson's death.[184] His opinion was in three parts.

18.169 First, he did not think that the presence of ischaemic heart disease contributed to John Atkinson's blood loss.[185]

18.170 Second, he did not think that the ischaemic heart disease made any material contribution to the cardiac arrest at 23:47.[186] The disease that was identified during the post-mortem was minor and was not interfering with John Atkinson's ability to conduct a normal life. He had what Surgeon Commander Rees described as a stable *"bystander"* disease.[187] Surgeon Commander Rees stated:

> *"[We] also know from the post-mortem that the area of scarring is very small, so he was left with the vast majority of his heart muscle able to function perfectly normally. What we also know from the post-mortem is that his other major cardiac arteries, his main heart arteries, were entirely normal and free from disease. So, in all likelihood, they were functioning perfectly well. So, in the context of having a very small area of scar, a very small area of narrowing in a relatively unimportant heart artery, I think the relative contribution of ischaemic heart disease here is actually very small, and the primary contributor to his very sad deterioration is the degree of hypovolaemic shock that we outlined earlier. I think that's by far the most significant contributor to him ending up in a state of cardiac arrest, and I think the role of ischaemic heart disease here is very small or negligible in terms of its overall contribution to deterioration to the point of cardiac arrest."*[188]

18.171 Third, ischaemic heart disease did not contribute to the inability to resuscitate John Atkinson once he went into cardiac arrest. The deciding factor on resuscitation was John Atkinson's state of hypovolaemic shock.[189] Surgeon Commander Rees considered that John Atkinson's survival after the cardiac arrest at 23:47 was *"extremely unlikely"*.[190] That event marked the *"point of no*

[183] 161/29/16-31/20
[184] 161/35/21-36/13
[185] 161/33/4-18
[186] 161/33/19-35/20
[187] 161/34/14-35/20
[188] 161/34/24-35/18
[189] 161/35/21–36/8
[190] 161/56/3-11

return".[191] Electrical activity detected at about 00:00 on 23rd May 2017, as John Atkinson was in the ambulance on his way to hospital[192] was likely to have been intermittent and not reflective of a fully functioning heart. In no sense was it a return to the activity of a normal heart.[193]

18.172 The evidence of Surgeon Commander Rees was measured, clear and persuasive. I accept his opinion that John Atkinson's ischaemic heart disease did not make any material contribution to his death. That removes the proviso that the Blast Wave Panel of Experts applied to their own opinion. That is of significance to the issue of survivability in the case of John Atkinson.

18.173 Surgeon Commander Rees was clear that his role was to address the cardiological aspects of the case. He recognised that the Blast Wave Panel of Experts were able to draw upon a broader range of expertise. In those circumstances, he considered that he ought to defer to them on the issue of survivability.[194] In my view, he was right to do so.

Survivability

18.174 In respect of John Atkinson's survivability, I heard further evidence from the pathologists and the Blast Wave Panel of Experts. They did not give evidence one after another, as is usual, but instead concurrently in a process sometimes referred to as 'hot-tubbing'. I used this approach on a number of occasions during the oral evidence hearings and found it an effective way of getting to the core of the expert issues.

18.175 The pathologists who gave evidence were Dr Lumb and Professor Crane. As I explained earlier in this Part, I instructed them to review the post-mortem evidence for each of the twenty-two killed in the Attack in light of all of the medical, scientific and available video evidence. Dr Lumb is a consultant forensic pathologist on the Home Office register and led the team that carried out the post-mortem examinations of those who died in the Attack.[195] Professor Crane was the State Pathologist for Northern Ireland between 1990 and 2014 and is currently Professor of Forensic Medicine at Queen's University Belfast.[196]

18.176 Dr Lumb and Professor Crane were clear that Dr Carter's initial view that John Atkinson's ischaemic heart disease might have made a contribution to a death that was principally caused by blood loss from leg wounds was entirely reasonable on the basis of what she knew.[197] They were not critical of Dr Carter's original conclusion and nor am I. Dr Carter highlighted an important issue that

191 161/57/23-58/3
192 159/29/11-30/6
193 161/56/4-58/3
194 161/42/17-43/9
195 176/109/19-112/8
196 161/2/16-24
197 161/116/10-117/25

undoubtedly required further investigation. However, Dr Lumb and Professor Crane had access to more evidence than Dr Carter, including the opinion of Surgeon Commander Rees.

18.177 In light of all of that evidence, Dr Lumb and Professor Crane had no doubt that John Atkinson's death was caused by the leg injuries he sustained and that the pre-existing heart disease from which he suffered played no part.[198]

18.178 I accept that evidence. It means that the issue of survivability becomes focused on whether anything more could have been done to stem the bleeding from John Atkinson's leg injuries. It was this bleeding that led, ultimately, to his death.

18.179 Professor Bull and Colonel Clasper of the Blast Wave Panel of Experts gave evidence on the issue of John Atkinson's survivability. They set out the views of the Panel as a whole. Professor Bull is a bioengineer. He heads the Department of Bioengineering and the Centre for Blast Injury Studies at Imperial College London. The Centre brings together experts in medicine, engineering and other areas of science to investigate blast injuries.[199] Colonel Clasper is a consultant orthopaedic surgeon with considerable experience of major injuries in both a civilian and military context. He is a Visiting Professor within Professor Bull's department at Imperial College London and Clinical Lead for the Centre for Blast Injury Studies.[200]

18.180 Colonel Clasper explained how the views of the Blast Wave Panel of Experts on the survivability of John Atkinson had developed. He confirmed that the position of the Panel in light of all of the evidence, including the opinion of Surgeon Commander Rees, was that John Atkinson *"could have potentially survived"* his injuries.[201]

18.181 Colonel Clasper agreed with Surgeon Commander Rees that there was *"no coming back from"* the cardiac arrest at 23:47.[202] He explained the timeline in John Atkinson's case by reference to the footage the Blast Wave Panel of Experts had seen.[203] A belt had been applied as a tourniquet to John Atkinson's right leg within five to six minutes of the explosion.[204] It was the view of Colonel Clasper that the member of the public who applied this makeshift tourniquet, Ronald Blake, *"did brilliantly"*.[205] Nonetheless, despite the heroic efforts of Ronald Blake, John Atkinson continued to lose blood.[206] If additional early steps, in particular the application of bilateral tourniquets by properly qualified first responders, had been taken to stop or slow his blood loss, then that would probably have delayed John Atkinson going into a state of hypovolaemic shock

198 161/116/4-118/5
199 150/3/3-4/1
200 161/65/24-67/21
201 161/78/2-85/12
202 159/16/24-17/3, 161/92/7-10
203 161/85/18-89/10
204 158/13/4-23, INQ023493T/21
205 161/87/14-88/17
206 161/86/11-87/13

and that, in turn, would probably have delayed the cardiac arrest, or even prevented it altogether.[207] Colonel Clasper stated the following in answer to questions:

> *"Q. If this course had been delayed so that John had reached hospital in a state in which he was not in cardiac arrest, in your view would that have made a difference?*
>
> *A. Yes.*
>
> *Q. What difference do you think it would have made?*
>
> *A. He had other severe injuries, but I think if he'd got to hospital without having had a cardiac arrest, given that the team were prepared for him, I think there's a high chance he would have survived. I can't give you an estimate of exactly how high, but I think it's a high chance."*[208]

18.182 The fact that there was a *"high chance"* that John Atkinson would have survived if he had reached hospital prior to his cardiac arrest does not mean that that necessarily could have been achieved and does not mean that survival was, on a sensible analysis of what could be achieved, probable. Colonel Clasper was pressed on this important issue.[209]

18.183 In response, he described a *"platinum 10 minutes"* during which the best prospect of stemming significant bleeding exists.[210] However, Colonel Clasper was clear that it was not the case that intervention after ten minutes was incapable of making a difference.[211] His evidence, which represented the views of the Blast Wave Panel of Experts as a whole, was clear (with emphasis added):

> *"Q. … bearing in mind John goes into cardiac arrest … 1 hour and 16 minutes after the explosion and his injuries, bearing in mind that we know he was conscious and able to speak, what is your view about the window during which an intervention* ***would have made*** *a difference to John's survivability?*
>
> *A. I think there was a window up to about 40 minutes after the incident."*[212]

18.184 Later, he extended that period up to 45 minutes.[213]

18.185 I accept this evidence of Colonel Clasper. I therefore assess the issue of survivability on the basis that, if an intervention sufficient to slow substantially or stop bleeding had been undertaken before 23:16, that is, up to 45 minutes post-explosion, John Atkinson would probably have survived. That is because he would have arrived at hospital before his cardiac arrest.

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207 161/92/7-23
208 161/93/11-23
209 161/94/2-96/11
210 161/91/4-13
211 161/94/2-10
212 161/94/11-25
213 161/108/18-110/4

18.186 My conclusion is that such an intervention should have occurred in one or both of two ways.

18.187 First, medical tourniquets should have been applied to both of John Atkinson's legs and haemostatic dressings applied to his wounds[214] well before 23:16. ETUK staff should all have been competent to use such treatments and equipped to do so. They were not or at least not sufficiently. Responsibility for that failure rests with the management of ETUK, namely Ian Parry, and SMG, who should have ensured that the event healthcare provider was competent. More NWAS paramedics should have been in the City Room before 23:16, as I explained in Parts 10 and 14 in Volume 2-I. If that had occurred, it is likely that they would have identified the need for urgent treatment and/or evacuation of John Atkinson. That did not occur. Responsibility for that failure rests with NWAS. Such treatment would, I am satisfied, have enabled John Atkinson to arrive at hospital prior to having a cardiac arrest and would probably have saved his life.

18.188 Issues also arise about whether the firearms officers and unarmed police officers should have provided such treatment. In future, they should do so, where the circumstances permit. However, for reasons I will address in Part 20, I am not critical of GMP or BTP for the fact that their officers did not do so on the night of the Attack.

18.189 Second, John Atkinson should have been evacuated from the City Room promptly. His evacuation in fact started at 23:17[215] and he did not arrive in the Casualty Clearing Station until 23:24,[216] following an extraction which, through no fault of those engaged in it, was entirely unsatisfactory. If firefighters had been in the City Room shortly after 22:45, as I have concluded in Parts 10 and 15 in Volume 2-I ought to have been the case, John Atkinson would have been prioritised for evacuation. If more ambulances had been present at the Victoria Exchange Complex shortly after 23:00, as I have also concluded in Parts 10 and 14 in Volume 2-I ought to have been the case, John Atkinson would have received treatment and would have been transported to hospital shortly after that time. Either way, he would have reached hospital before having a cardiac arrest and is likely to have survived.

18.190 In his opening remarks at the beginning of the oral evidence hearings, Counsel to the Inquiry explained that I would examine whether there were any inadequacies in the emergency response. I have found that there were. He went on to say that, if those inadequacies, or any one of them, led to the loss of even a single life, that would be entirely unacceptable. They did. John Atkinson would probably have survived had it not been for inadequacies in the emergency response.

[214] 161/37/10-22, 161/98/8-14

[215] 158/38/14-40/7

[216] 158/54/9-19

THE CONTENT OF WHAT FOLLOWS IS PARTICULARLY DISTRESSING. IT CONTAINS DETAIL ABOUT THE NATURE OF THE INJURIES SUSTAINED BY SAFFIE-ROSE ROUSSOS AND HER CAUSE OF DEATH

Saffie-Rose Roussos

18.191 I heard expert evidence about the cause of the death of Saffie-Rose Roussos over the course of three days between 1st and 3rd December 2021. There was a significant disagreement between, on the one hand, the members of the Blast Wave Panel of Experts and, on the other hand, some of the additional experts I instructed. The former ultimately considered that there was no possibility that Saffie-Rose Roussos would have survived whatever treatment she had received. The latter felt that survival was not an impossibility with the best treatment. No one will benefit from a detailed recitation of that evidence, which was harrowing. Instead, I propose to record my conclusions, setting out the reasons for those conclusions in summary form. Even that will inevitably be distressing to read.

18.192 Dr Lumb performed the post-mortem examination on Saffie-Rose Roussos on 24th May 2017.[217] He identified 69 external injuries in addition to internal injuries. The internal injuries involved extensive damage to the musculoskeletal and vascular systems of Saffie-Rose Roussos, injuries to her lungs and liver, and internal bleeding.[218] In their work, the Blast Wave Panel of Experts utilised an internationally recognised system called the New Injury Severity Score. They did so by reference to the post-mortem report of Dr Lumb, the post-mortem photographs and the results of the computerised tomography (CT) scan that was undertaken, which included a reconstruction. This work ascribed a greater number of injuries to Saffie-Rose Roussos than Dr Lumb had, not because of any error on his part, but as a result of differences of description. Applying the New Injury Severity Score, the Panel identified that Saffie-Rose Roussos had suffered a total of 103 injuries that were *"scorable"*[219] against that system. They stated: *"Graphically, this can be described as equivalent to the energy of more than 15 handgun bullets."*[220]

18.193 In considering the injuries that were causative of the death of Saffie-Rose Roussos, or potentially so, the experts focused on three categories of harm: the fractures to her pelvis and legs; the damage to her vascular system; and the damage to her lungs.

217 176/45/14-21

218 176/53/4-71/8, 176/71/13-103/15

219 176/208/4-5, 177/61/6-62/16, 177/63/3-64/3

220 177/63/22-64/3, 177/66/16-20

Fractures to the pelvis and legs

18.194 Saffie-Rose Roussos sustained extensive fractures to her pelvis and legs.[221] These were the consequence of bolts penetrating her body and striking bone and/or bolts penetrating her body and depositing energy into the bone as they passed by.[222] I see no value in describing these injuries further given that all of the experts agreed about the severity of the injuries sustained.[223] Dr Lumb described the fractures as *"extremely severe"*.[224] All of these fractures, the experts agreed, will have bled.[225]

Vascular injury

18.195 The evidence identified four potential areas of significant vascular injury to Saffie-Rose Roussos: the popliteal arteries (the arteries behind the knees which extend upwards and into the thighs); the vessels in the area of the acetabulum (hip joint) on the left side; and the femoral arteries and associated vascular structures in the left thigh and the right thigh.[226]

18.196 The experts were agreed that there was vascular injury and consequent bleeding in the popliteal arteries.[227] However, there was a dispute as to the existence of vascular injury and/or its severity in the area of the acetabulum and in the left and right thighs. The members of the Blast Wave Panel of Experts expressed the firm view that such injuries were present and were serious.[228] They supported their opinion by reference to a presentation by Lieutenant Colonel Ballard, a consultant radiologist with considerable military and civilian experience.[229] Dr Wellings, also a consultant radiologist, agreed with the Panel.[230] Conversely, Lieutenant Colonel Park, Dr Davies and Mr Vasireddy, additional experts I instructed, all considered that there was no significant vascular injury in these areas. They did so on the basis that, in their experience, the presence of such injuries would have caused Saffie-Rose Roussos to die through blood loss much more quickly than in fact occurred.[231]

221 176/96/7-98/1, 177/50/10-20, 177/61/6-62/16, 177/78/4-17, 177/88/4-19, 177/199/8-200/5, 177/224/11-226/22, 177/231/14-234/18, 178/162/15-164/7, 178/167/3-9

222 176/97/21-98/1

223 176/102/10-21, 176/ 168/17-170/13, 176/171/11-172/12, 177/77/15-78/17, 177/224/11-226/22

224 176/97/7-20

225 176/115/4-21, 176/174/13-177/1, 176/208/18-209/10, 177/92/5-18, 177/152/10-20, 177/224/11-226/22, 177/233/14-235/10, 178/163/4-164/7, 178/167/3-18

226 176/61/17-22, 176/48/16-49/4, 176/89/13-93/7, 176/98/8-21, 176/100/11-101/13, 176/102/22-103/10, 176/110/12-114/13, 176/170/14-23, 176/180/22-183/11, 176/183/15-185/21, 176/190/16-193/22, 176/194/7-196/16, 176/197/6-198/25, 176/199/20-201/11, 176/204/2-206/18, 177/67/10-70/16, 177/78/22-79/25, 177/82/16-90/10, 177/93/2-96/14

227 176/199/20-201/11, 176/201/22-205/20, 176/205/22-206/18, 177/67/10-70/20, 177/233/14-235/16, 177/235/11-236/19, 178/110/19-111/21, 178/158/1-22

228 176/178/3-183/11, 176/183/15-185/21, 176/190/16-196/16, 176/197/6-198/25, 177/82/16-83/12

229 176/123/10-124/14, 177/17/22-18/20, 177/131/17-132/2

230 176/181/6-183/11, 176/183/15-184/9, 176/184/10-185/21, 176/194/24-195/9, 176/196/9-16, 176/199/20-201/11, 176/204/24-205/20

231 178/85/2-86/7, 178/76/23-81/10, 177/222/11-224/17, 178/1/21-6/17

18.197 On each side of this dispute were experts of high quality, each of whom had considerable relevant experience and each of whom, I have no doubt, was trying to help me to reach the right conclusion. However, both sides cannot be right.

18.198 On balance, I preferred the opinion of the Blast Wave Panel of Experts and Dr Wellings about the nature and extent of the vascular injuries. That is for the following two reasons.

18.199 First, I will consider the conclusions to be drawn from the CT scans. Computerised tomography (CT) scans combine a series of X-ray images taken from different angles around the body with computer processing, to create cross-sectional images of the body. CT scanning is of considerable diagnostic value in living patients. In the context of the Attack, CT scanning assisted the pathologists to identify where bolts had penetrated the body and the structures they had struck.

18.200 CT scanning may take a number of different forms.[232] One form is known as contrast CT scanning. This involves the introduction into the body of a dye known as a contrast medium. In a living patient, this is pumped around the veins and arteries of the body by the heart, enabling the vascular system to be seen on the CT scan.[233] A second form of CT scanning is known as full-body CT scanning. This does not involve the introduction of a contrast medium. It enables the musculoskeletal system to be seen on the scan but not the vascular system.[234]

18.201 Dr Lumb and his team carried out full-body scans of Saffie-Rose Roussos and the others who died, rather than contrast CT scans. As the radiologists agreed, there were good reasons why this was the correct approach.[235] The process of contrast CT scanning slows the post-mortem process and creates risks for those carrying it out. At the time, there were no clear indicators that it was necessary to carry out such scanning. In any event, the equipment to enable it to be done was not readily available. Even today, post-mortem contrast CT scanning is very much the exception and Dr Lumb described it as an area of research in forensic pathology.[236]

18.202 Although I am not at all critical of the decision to carry out only a full-body CT scan, the consequence is that the CT scanning of Saffie-Rose Roussos does not show her vascular system.[237] That means that the scanning alone does not establish definitively whether she had sustained significant vascular damage in the area of her acetabulum and in the left and right thighs.[238]

232 176/46/22-47/4
233 176/47/15-50/23
234 176/47/5-14
235 176/46/22-51/15, 176/124/15-127/12
236 176/47/10-51/15, 176/124/15-127/12
237 176/124/23-125/7
238 176/46/25-51/15, 176/112/7-114/13

18.203 However, the radiologists Lieutenant Colonel Ballard and Dr Wellings considered that the CT scans were of assistance in determining whether vascular damage had occurred in those areas. They pointed out that the scans showed that Saffie-Rose Roussos had sustained penetrating injuries in each of the relevant areas with consequent fracturing.[239] It was their view that such injuries must have had cavitating effects.[240] Such effects are, as Colonel Clasper of the Blast Wave Panel of Experts explained, rarely seen in civilian practice.[241] They involve a high-velocity projectile entering the body, transferring energy into the body, tearing and distorting the tissues, and creating a cavity beyond the wound track.[242] Lieutenant Colonel Ballard and Dr Wellings explained that these cavitating effects must have caused significant vascular damage to Saffie-Rose Roussos. In their view, it was not possible for such extensive damage to have been caused to the bone and soft tissue in these areas without the underlying blood vessels also having sustained significant damage.[243]

18.204 I accept that analysis.

18.205 Second, I will consider the conclusions to be drawn from the post-mortem examination. At the time of that examination, Dr Lumb reported on the vascular injury to the arteries behind the knees of Saffie-Rose Roussos.[244] This was a reference to the popliteal arteries, which the experts agreed were the location of vascular damage. After completing his post-mortem report, Dr Lumb was asked whether he was able to say whether there had also been vascular damage in the thighs. In response, he explained that the thighs are *"richly vascular"*.[245] He expressed the strong view, based upon what he observed on his examination, that there was significant vascular damage to both thighs, describing such damage as *"inevitable"* in relation to the left thigh and *"almost certain"* in relation to the right thigh.[246] He described the injuries to Saffie-Rose Roussos's legs as *"very severe"* and capable of causing death on their own.[247] Professor Crane agreed that these injuries were sufficient on their own to cause death.[248]

18.206 I accept the evidence of Dr Lumb as to the presence of significant vascular damage in the thighs. It comes from the expert who actually carried out the post-mortem examination, supported by the opinion of a pathologist of long experience and undoubted expertise.

239 176/117/18-221/20
240 176/117/18-221/8
241 177/58/4-59/12
242 177/59/13-23
243 176/180/22-185/21
244 176/89/3-93/12, INQ004704/18-19 [not published]
245 176/75/7-13
246 176/89/18-93/12
247 176/100/11-101/7
248 176/101/20-22

18.207 I gave careful consideration to the views of the experts who expressed the competing opinion that Saffie-Rose Roussos had sustained no significant vascular damage save behind the knees.[249] Their experience is substantial, and their views were expressed with force and conviction. While I accept that they may have had different experience on which to draw, the overwhelming burden of the evidence demonstrated that significant vascular injury causing bleeding was present in each of the areas I have described.

18.208 The fact that Saffie-Rose Roussos did not die sooner through blood loss is explicable by reason of the following factors: she is likely to have bled rapidly in the period just after sustaining her injuries but then more slowly as her blood pressure dropped;[250] her blood vessels may not have fully bled immediately or all of the time due to various mechanisms about which the various experts agreed;[251] Saffie-Rose Roussos's age will have made her more resilient;[252] and there is real-world experience of people with serious vascular injury surviving for the same length of time Saffie-Rose Roussos remained alive.[253]

18.209 Colonel Clasper of the Blast Wave Panel of Experts gave evidence on this final point.[254] As I have set out, he is a consultant orthopaedic surgeon with particular knowledge and experience of injuries caused by explosions. He explained that the experience of the military is that a femoral artery injury does not always cause death swiftly. There is experience within the military of those with Saffie-Rose Roussos's burden of injury, including femoral artery injury, surviving for longer than 40 minutes, indeed for over an hour in some cases. Hence, the fact that Saffie-Rose Roussos survived for a little over one hour does not, in the view of Colonel Clasper, make her *"an outlier"*.[255] I accept his evidence.

18.210 For these reasons, I am satisfied that Saffie-Rose Roussos sustained significant vascular damage not only to the arteries behind her knees, but also in the area of her hip joint and in both thighs. Furthermore, I consider that these injuries were extremely serious.

Injury to the lungs

18.211 The experts agreed that Saffie-Rose Roussos had suffered lung damage as a result of the explosion, significantly worse on the right side than on the left.[256]

249 178/160/1-4, 178/4/20-6/17, 178/157/4-169/13, 178/227/18-230/16

250 178/243/5-22, 178/240/15-242/17, 178/244/11-22

251 178/240/15-244/22

252 177/97/25-98/25, 177/218/23-220/12, 178/34/3-15, 177/154/20-156/8, 175/236/8-237/19, 175/244/19-246/13, 176/22/8-24/15

253 177/93/2-96/14, 177/155/19-156/8

254 177/93/2-96/14

255 177/93/2-94/20

256 176/77/20-79/1, 176/85/18-87/5, 176/146/7-147/16, 176/158/18-161/17

18.212 The strong view of the Blast Wave Panel of Experts was that the cause of this lung damage was a condition known as blast lung.[257] They explained that an explosion has a number of effects. The first is known as the primary blast.[258] This is best described as a shock wave which surges out from the seat of the explosion. The interaction of this shock wave with the human body is capable of causing injury to the air-containing organs, such as the lungs, airway and bowel. Injury to the lungs is characteristic and, where it occurs, is known as blast lung.[259] Such injury involves disruption of the structures of the lung, causing bleeding and a subsequent inflammatory reaction.[260] It becomes progressively worse, is very dangerous and may be fatal, in particular where there is otherwise a high burden of injury.[261]

18.213 At one stage, I had understood that there was a dispute as to whether the damage to the lungs of Saffie-Rose Roussos was the result of blast lung. As a result, I asked Professor Crane to consider that issue. He was a consultant forensic pathologist during much of the period of the Troubles in Northern Ireland and therefore has considerable experience of deaths as a result of explosions.[262] He examined photographs of the lung tissue of Saffie-Rose Roussos.[263] He expressed the opinion that she had sustained *"severe primary blast lung injury to the right lung"*.[264] On the left there was also, in his view, blast lung, but not as extensive or serious as on the right.[265] Dr Lumb agreed with Professor Crane.[266]

18.214 In light of the clear and unequivocal evidence of the pathologists, Dr Davies, who was on the other side of the survivability debate, realistically accepted that the damage to the right lung was severe and that a significant part of the cause was blast lung.[267]

18.215 On the basis of all the evidence I heard, it is my view that Saffie-Rose Roussos had severe damage to her right lung and some, but less extensive, damage to her left lung and that the cause of both was blast lung.

18.216 Although this fact was established by the evidence, an issue remained about the severity of the consequences of this for the ability of Saffie-Rose Roussos to survive. In particular, Lieutenant Colonel Park was unconvinced that the lung injury, serious though she accepted it was, had an effect on Saffie-Rose Roussos's ability to breathe to the extent that her life was imperilled by it.[268]

[257] 176/215/15-218/7
[258] 177/24/8-26/5
[259] 177/25/4-27/7
[260] 177/120/17-121/25
[261] 177/122/8-124/5
[262] 176/87/6-21
[263] 176/82/10-14
[264] 176/85/18-86/7
[265] 176/86/8-87/5
[266] 176/87/22-88/5
[267] 178/130/5-133/24
[268] 178/134/2-135/25 (Dr Davies), 178/141/13-152/11 (Lieutenant Colonel Park)

She and Dr Davies attached importance to the footage from the body-worn video camera of, in particular, Police Constable (PC) Leon McLaughlin.[269] They stated that they had been unable to detect in that footage any significant respiratory impairment on the part of Saffie-Rose Roussos and were of the view that the lung damage did not, therefore, have any significant physiological effect in the period before her death.[270]

18.217 I have viewed the footage. I do not consider that it establishes the point advanced by Lieutenant Colonel Park. Furthermore, the opinion of Lieutenant Colonel Park and Dr Davies is at odds with the evidence of lay witnesses who saw Saffie-Rose Roussos in the period before she was transported to hospital. That evidence is consistent with Saffie-Rose Roussos experiencing difficulties breathing.[271] PC McLaughlin gave evidence that, while Saffie-Rose Roussos was on the pavement on Trinity Way, her breathing was *"quite shallow, quite laboured"*.[272] Bethany Crook, an off-duty nurse who was with Saffie-Rose Roussos for a 14-minute period[273] prior to her departure for hospital, expressed her concerns about the breathing of Saffie-Rose Roussos. She explained that there were times when it was very shallow and times when it was *"very pronounced and exacerbated … that is an indication to me medically, in my training, that tells me that she's having difficulties breathing"*.[274] The lay witness evidence, in my view, was consistent with the effect that blast lung would generally be expected to produce, namely respiratory difficulties.

18.218 I consider that the evidence overall demonstrated that the damage to the lungs of Saffie-Rose Roussos was so severe that it must have significantly compromised her ability to get oxygen to her tissues, which was necessary for her to sustain life. This ability had already been compromised by her blood loss from the injuries to her pelvis and legs and to her vascular system.

Overall burden of injury

18.219 In all of the circumstances, I am satisfied that the views of the Blast Wave Panel of Experts about the disputed areas of injury, and about the severity of those injuries, were correct.

18.220 It is important to understand, as I explained at the beginning of this section, that these injuries formed just a part of what happened to Saffie-Rose Roussos. Overall, as all the experts agreed, she suffered an extremely high burden of injury.[275] It is also important to recognise that all of those injuries were affecting Saffie-Rose Roussos at the same time and, as Dr Lumb explained, will therefore have had a compounding effect upon each other.[276]

269 178/142/15-144/3
270 178/147/16-151/11
271 177/139/9-142/16
272 175/19/3-5
273 175/59/14-25
274 175/73/16-76/6
275 177/14/17-15/5 (Blast Wave Panel of Experts), 178/124/14-125/24 (Dr Davies)
276 176/98/22-100/2, 177/61/6-63/2

18.221 Alan Hepper was a member of the Blast Wave Panel of Experts. His background is in engineering. He is a Fellow with the Defence Science and Technology Laboratory, where his main responsibilities are for issues related to human vulnerability, injury assessment and injury modelling. He undertakes research on the effects of weapons, including bombs, on the human body in order to aid improvements in treatment.[277]

18.222 Alan Hepper carried out an assessment of the burden of injury sustained by Saffie-Rose Roussos, using the New Injury Severity Score system.[278] This allocates a score to the three principal injuries suffered by a victim of trauma. These scores are then added together to provide an overall measurement. On the basis of her three principal injuries, the New Injury Severity Score produced a result of 41 in the case of Saffie-Rose Roussos.[279] This is in itself a high score, and those on the database used by Alan Hepper who shared the same score, and had one or more injuries in common with Saffie-Rose Roussos, had generally, although not invariably, died.[280] Alan Hepper emphasised, however, that 41 may not reflect the overall burden of Saffie-Rose Roussos's injuries because she had sustained many more than three injuries; he explained that some of those other injuries were very serious in their own right.[281]

18.223 Care needs to be taken before drawing conclusions from a statistical tool such as the New Injury Severity Score. However, the Blast Wave Panel of Experts emphasised that they had not used the New Injury Severity Score as the foundation for their opinion about Saffie-Rose Roussos's survivability. Instead, once they had formed the view that her injuries were unsurvivable, they used the New Injury Severity Score as a check.[282] In my view, that was an appropriate approach and the New Injury Severity Score result was of some, albeit limited, weight in my conclusions.

Survivability

18.224 The important question at the end of all of this evidence is whether the injuries sustained by Saffie-Rose Roussos were ones that she could have survived with different care and treatment.

18.225 In their first report, the Blast Wave Panel of Experts expressed the view that the injuries sustained by Saffie-Rose Roussos were *"unlikely to be survivable"* with current advanced medical treatment.[283] The Panel explained that the term *"unlikely to be survivable"* described:

277 177/21/12-22/25
278 177/45/12-48/6
279 177/47/22-48/6
280 177/48/17-52/9
281 177/47/22-48/24
282 177/4/6-9/12, 177/45/12-50/9, INQ100090/1 [not published]
283 INQ025364/23 [not published], 177/161/15-162/21

> *"... individuals whose injuries were so severe that even if that same advanced and comprehensive medical treatment was initiated immediately after injury, we would not expect that person to survive, but at that point we could not say survival was impossible."*[284]

18.226 In their second report, the Panel reviewed their conclusion in relation to Saffie-Rose Roussos and found that her injuries were *"unsurvivable"*.[285] Colonel Mahoney explained this term:

> *"[I]t meant that we felt the injuries were so severe that even if the most comprehensive and advanced medical treatment was initiated immediately after injury, we believe that survival was impossible."*[286]

18.227 It follows that the Panel were initially unable to exclude the possibility of survival in the case of Saffie-Rose Roussos but then six months later felt confident in doing so. This change was naturally of concern to her family and those who represent them and led to the instruction by me of the additional experts to whom I have referred.

18.228 The Panel were pressed in evidence on their change in opinion.[287] They explained that their first report made clear that it was a preliminary report that was always intended to be subject to any further evidence that was received.[288] What had changed between the first and second report was that the Panel had received the footage from the CCTV and body-worn video cameras, as was recorded in Appendix 1 to that second report.[289] That led Colonel Mahoney to conclude that Saffie-Rose Roussos had become *"very sick, very quickly"* with respiratory distress that was, he believed, a combination of lung injury and blood loss.[290] In turn, that led the Panel to conclude that Saffie-Rose Roussos had suffered from blast lung, as outlined in paragraphs 18.211 to 18.218, which conclusion I have found to be correct.

18.229 It was appropriate that the Blast Wave Panel of Experts were pressed to explain their change in position. However, having heard their evidence, I am clear about what happened. The Panel expressed a preliminary opinion, making plain that they would review that opinion if further evidence was provided. Further evidence was provided of a type regarded by the Panel as significant. That altered the Panel's opinion and they said so. Not only was their approach understandable, it was also entirely responsible.

18.230 That does not mean, however, that the final conclusion of the Blast Wave Panel of Experts that survival was impossible is correct.

284 150/68/9-16
285 INQ032039/3-4 [not published], 177/15/16-16/23
286 150/67/7-68/8
287 177/163/10-181/8
288 INQ025364/2 [not published]
289 INQ032042/5 [not published]
290 177/173/15-174/19

18.231 Even though I accept that the Blast Wave Panel of Experts were right about the nature and extent of the injuries suffered by Saffie-Rose Roussos, I do not consider that the evidence enables me to say that she had absolutely no chance of survival if the most comprehensive and advanced medical treatment had been initiated immediately after injury.

18.232 Lieutenant Colonel Park, Dr Davies and Mr Vasireddy were experienced and impressive experts. Their evidence about what consultants in pre-hospital emergency medicine can achieve out of hospital was striking.[291] The evidence of their experiences means that I cannot exclude the remote possibility that Saffie-Rose Roussos would have survived, notwithstanding the severity of her injuries, if she had received treatment from an experienced consultant in pre-hospital emergency medicine immediately, followed by swift evacuation to hospital and expert treatment there.

18.233 While I have recognised the dangers involved in seeking to apply statistical data, I noted that within the database utilised by Alan Hepper, one individual who sustained blast lung of a severity comparable to that sustained by Saffie-Rose Roussos survived, notwithstanding that this person had a total New Injury Severity Score of 66, significantly higher than that given by Alan Hepper to Saffie-Rose Roussos.[292] While I recognise that the score of 41 given to Saffie-Rose Roussos was described as conservative,[293] this finding seems to me to underscore why I should not conclude that Saffie-Rose Roussos had no prospect of survival at all. Colonel Mahoney was asked about this example in the database.[294] His answer did not persuade me that my analysis is flawed.

18.234 I make clear that what I am postulating is a remote possibility of survival. On the evidence that I have accepted, what happened to Saffie-Rose Roussos represents a terrible burden of injury. It is highly likely that her death was inevitable even if the most comprehensive and advanced medical treatment had been initiated immediately after injury.

[291] 177/211/25-245/19, 178/1/1-239/17
[292] INQ100090/3 [not published]
[293] 177/47/25-48/16
[294] 177/146/4-147/6

Part 19
Understanding what happened and why

Introduction

19.1 During the Inquiry's oral hearings, I heard evidence from 267 witnesses, many of whom were called during the hearings relating to the emergency response. The hearings relating to the response took place between January and October 2021. Additionally, the accounts of many other witnesses involved in the response were read out or summarised. Behind that witness evidence was a very substantial body of documentary, audio and video material which had been assembled, organised and reviewed. I also received opening and closing statements, both written and oral, on behalf of Core Participants, including each of the bereaved families and the emergency services.

19.2 Having received and considered all this information, I have been able to reconstruct what happened on the night of 22nd May 2017 and to do so in considerable detail. This has enabled me to identify what went wrong.

19.3 The complexity of this process and the necessity to await the conclusion of the criminal trial of HA, coupled with some delay to the start of the oral evidence hearings by reason of the COVID-19 pandemic, meant this has taken considerable time. Over five years will have passed since the Attack by the time that Volume 2 of my Report is published.

19.4 In the course of the oral hearings, I received evidence from a number of very senior members of the emergency services. A number of these people stated that the process of the Inquiry had caused them to identify areas for improvement that had not previously been identified and to implement or start to implement change as a result.

19.5 For example, Sarah-Jane Wilson, the Head of North West Fire Control (NWFC), began her evidence by telling me that, following her review of the Inquiry's evidence:

> *"I would like the Inquiry to know that I have followed almost all of the evidence that has been given to the Inquiry. I have also worked through the documents and evidence on the Inquiry's portal, which is something I did before the Inquiry started and have continued to do ever since ...*

> *It has become very clear to me that on the night of the Attack, North West Fire Control did not manage communications in the way that would have been expected of them by the public and by the Fire Service. The control room was responsible for significant failures in the management of information throughout that night …*
>
> *I have personally asked for those failures to be fully set out in a sequence of communications which North West Fire Control has provided the Inquiry with."*[1]

19.6 Later in Sarah-Jane Wilson's evidence, the following exchange took place:

> *"Q. … has information come to light by reason of the Inquiry, which is relevant to North West Fire Control's way of operating?*
>
> *A. Yes, sir."*[2]

19.7 Deputy Chief Constable (DCC) Ian Pilling gave evidence on behalf of Greater Manchester Police (GMP). The following exchange took place during his evidence:

> *"Q. … has the process of the Inquiry led to further relevant information coming to GMP's attention?*
>
> *A. Yes, it has."*[3]

19.8 DCC Pilling gave an example later in his evidence. He was asked about the gap in police officers' knowledge about how other emergency services operate and why it took until February 2021 to create training materials to address this. His answer was significant: *"I think it's probably a realisation of the gravity of the problem as we started to look at the evidence from the Inquiry."*[4]

19.9 He also observed: *"[O]ne of the things that I've taken away from this Inquiry so far is around Plato and it needing a good dose of looking at."*[5]

19.10 Assistant Chief Constable (ACC) Sean O'Callaghan gave evidence on behalf of British Transport Police (BTP). He was asked about changes which had been identified. This exchange followed:

> *"Q. And some of what you have already said is as a result, as I understand it, of what has come out in the Inquiry?*
>
> *A. Absolutely, yes."*[6]

1 135/3/14-4/1
2 135/94/4-8
3 130/169/19-170/1
4 130/207/6-18
5 130/217/1-7
6 139/62/13-16

19.11 The Inquiry followed a number of earlier evidence-based investigations into what happened and why. Some commentators have questioned why it required a public inquiry to uncover some of these issues.

19.12 In this Part, I review why some of what went wrong only emerged as a result of the work of the Inquiry. The purpose is to show where areas for improvement in the emergency response to tragedies such as the Attack can be identified, without the need for a process as complex and lengthy as this Inquiry.

Record of events

Written notes

19.13 There was a requirement imposed by some organisations for written notes or decision logs to be kept relating to the response to the Attack. For example, firearms commanders were expected to keep a record of their decisions.[7] Under the third edition of the Joint Operating Principles (JOPs 3), *"decision-makers"* were required to *"record the rationale and information sources for their tactical decisions"*.[8] Police officers operated under a general expectation to keep notes in their pocket notebooks. North West Ambulance Service (NWAS) expected its commanders to keep a decision log. Greater Manchester Fire and Rescue Service (GMFRS) expected its officers to record decisions in a log or, where this was not possible, to record notes later and within 24 hours of an incident.[9]

19.14 A firearms officer gave evidence that advice had been given that those officers should *"just … produce duty statements at [the] time that we were there at the incident, et cetera, but not in detail. At a later date we would give a detailed statement when requested to."*[10] This was not an assertion that I investigated in detail. However, if it accurately reflects the approach taken, it should be reviewed by GMP. The reason may be because of concern about the wellbeing of officers who had just been through a very traumatic experience, but detailed notes should normally be made as soon as is reasonably practicable.

19.15 Making accurate notes forms an important first stage in the recording of what happened and why decisions were made. The need for accuracy cannot be overstated. Inaccurate notes can be worse than no notes: they are presumed to paint an accurate picture but will have the opposite effect. It is through the making of accurate notes that errors will be identified and improvements to what worked well noted.

19.16 The timing of record-making is critical to achieving accuracy. NWAS, for example, required a decision log to be completed within 72 hours of an incident.[11] There may be good reason for this. It may be a national standard. However, in my view, this is too long a period to ensure accuracy. NWAS should reflect on this. Unless there are compelling reasons justifying a delay, such records should be completed within 24 hours of an incident.

19.17 Ideally, the making of such records should be prioritised so they are completed by the point of command handover. As JOPs 3 stated: *"[D]ecision logs can be used to assist future decision-making and ensure clarity of understanding of*

[7] 108/27/4-28/5, INQ029139/35
[8] INQ008372/16
[9] INQ026714/30-31 at paragraphs 135-137, INQ026738/20 at paragraphs 127-131, INQ025614/6-7 at paragraphs 38-39
[10] 102/82/7-16
[11] INQ012848/72, INQ014791/1

what will be a rapidly developing and complex situation."[12] I see no reason why this statement of principle should be confined only to Major Incidents in which Operation Plato has been declared. It should be applied to all Major Incidents.

19.18 In Parts 14 and 15 in Volume 2-I, I set out occasions when inaccurate notes were made about the content of important telephone calls. I do not repeat them here. These notes were capable of obscuring the truth of what happened on the night of the Attack. It was only the fact that recordings of the calls existed that enabled the inaccuracies to be exposed and corrected.

19.19 Investigators, judges and other decision-makers have long regarded contemporaneous notes as a more reliable source of evidence than recollections repeated after discussions with others have taken place. As a result, it is all the more essential that accurate notes are made.

19.20 I recommend that all emergency services involved in the response to the Attack reflect on their approach to note-taking during and immediately following Major Incidents with a view to improving the current practice. I recommend that the Home Office, College of Policing, National Ambulance Resilience Unit and Fire Service College ensure that all commanders responding to a Major Incident are trained on the importance of recording their key decisions and rationale.

19.21 In the case of those who are responding at the scene, the timely taking of notes will be less practicable. For people in these roles, audio and/or visual technology can provide vital support. In saying this, I am not seeking to confine the use of audio and/or visual technology to those who attend a scene. They are the people who are likely to derive the most benefit from a recording but those remote from the scene, for example Strategic/Gold Commanders, will also see an advantage, as ACC Deborah Ford acknowledged.[13]

Audio and/or visual recordings

19.22 In Part 13 in Volume 2-I, I addressed the position of firearms officers and body-worn video. I will not repeat that here, but it forms an important part of what I say next.

19.23 Two of the most important pieces of evidence received by the Inquiry came from Dictaphone recordings. One was made by Chief Inspector Mark Dexter of GMP,[14] the other by Inspector Dale Sexton of GMP.[15] These recordings were an invaluable source of information for my investigation. They captured important conversations by those individuals. They allowed me to reach conclusions about how busy the people recorded on them were. They permitted me to make informed judgements

[12] INQ008372/16
[13] 106/20/13-23
[14] INQ025409
[15] INQ024325

about how challenging the environments were. They revealed something of the stress levels people were operating under. To some extent, they enabled the listener to put themselves in the situation that was being recorded.

19.24 There was inconsistency across the emergency services in relation to the use of Dictaphones. There were a number of important witnesses in command roles who had immediate access to a Dictaphone but did not use it, or used it for only a short period of time.[16] There were also some in significant roles who did not have access to a Dictaphone on the night of the Attack.[17]

19.25 I have considered whether those individuals or their organisations should be criticised for this. I have concluded that it is more appropriately treated as an opportunity for improvement. The lack of a recording of what individuals said and heard did not impact on the quality or nature of the response to the Attack, but it may have had an impact on the ability to learn lessons.

19.26 There was no evidence to suggest that the use of a Dictaphone would have any adverse effect on any individual's performance. If anything, knowing that everything that is said is being recorded may lead to a person acting more deliberately and thoughtfully. It may also mean in certain circumstances that a written log is less important, given that a complete record will be captured through an audio recording. This will free up time to focus on more important command activities.

19.27 As technology advances and costs reduce, it may be that body-worn video equipment is regarded as a viable alternative to Dictaphones. A number of police officers who responded to the Attack were issued with such equipment as part of their tour of duty that day. This audio and video footage formed a vital part of reconstructing what happened in the City Room in particular. The content was often too distressing to play publicly. I have viewed a good deal of it. It enabled me to understand better how terrible an environment the City Room was in the period immediately after the Attack. The body-worn video recordings have been the subject of very detailed analysis.

19.28 I recommend that the Home Office, College of Policing, National Ambulance Resilience Unit and Fire Service College ensure that all those who may be required to take up a command position are issued with a means to record what they say, hear and, where appropriate, see. It may also be that key personnel within control rooms would benefit from having such equipment available for activation in the event of a Major Incident. Training should be given to all who are issued with such technology on the circumstances in which it should be used and the importance of its use. Exercises should include the use of contemporaneous recording devices in order to simulate how they will be used in practice.

[16] 115/25/7-15, 121/57/17-58/11

[17] 104/77/1-78/25

19.29 It is important to make clear that I do not regard the use of audio and visual recording equipment to be a complete substitute for the timely taking of notes. A recording of what occurred will not always capture why an individual made a given decision. Accurately capturing the rationale behind commanders' decision-making is important.

Conversations not conducted in person

19.30 Generally, radio transmissions and calls to control rooms on the night of the Attack were recorded. Collating these recordings was a substantial undertaking. Once this important work had been undertaken, these recordings formed a vital part of understanding how information moved within and between organisations.

19.31 However, as I set out in Part 15 in Volume 2-I, there were a significant number of conversations between senior GMFRS personnel which were conducted by mobile phone.[18] The participants in these calls had different recollections as to what was said in a considerable number of those discussions.[19] This required me to resolve disputes of fact, if that was possible, before I could identify where improvements might be made.

19.32 This only serves to underline the need for audio and/or visual recordings for commanders and other key personnel.

[18] 132/167/5-25

[19] 132/167/5-25, 121/51/3-23, 121/88/4-20

Debriefs

19.33 A number of debriefs took place following the Attack. Some were termed *"hot debriefs"*.[20] These were proximate to events and were intended to capture raw impressions of what had occurred. There were also more formal debrief processes where individuals completed questionnaires and attended debrief meetings.[21]

19.34 The debrief process provides an invaluable opportunity for organisations to understand what may have gone wrong and how improvements in their practices can be made. They must be conducted constructively and candidly. Given the importance of joint working, the debrief process of Major Incidents involving more than one emergency service should be overseen by the local resilience forum.

19.35 Particular care will need to be taken for debriefs following Major Incidents which may give rise to a criminal investigation. In these circumstances, the investigators will need to provide input on the management of those areas which might prejudice the investigation.

19.36 Operation Newtown was the name given by GMP to the response to the Attack. In a document dated 16th June 2017, GMFRS Deputy Chief Fire Officer Paul Argyle, Chair of the Greater Manchester Resilience Forum (GMRF), set out the principles, scope and process that were to be adopted for the Operation Newtown debrief.[22] There were two stages. The first comprised a *"strategic multi-agency debrief"* undertaken by GMRF and *"tactical organisational debriefs"* conducted by individual GMRF member organisations.[23] The two elements were conducted in parallel. The second stage took place at multi-agency level and aimed at testing the findings, developing the learning and making recommendations.[24]

19.37 A large number of Operation Newtown debrief questionnaires were completed during July 2017. Each questionnaire required the person completing it to identify what aspects of the multi-agency response did not go well, what aspects did go well and any key recommendations that they had.

19.38 Operation Manteline was the name given by GMP to the criminal investigation into the Attack. Debrief questionnaires were also completed within Operation Manteline.[25]

[20] 121/131/12

[21] For example, INQ000790, INQ041168, INQ022376, INQ000788

[22] INQ012576/1-4

[23] INQ012576/4

[24] INQ012576/1-4

[25] For example, INQ041168 (Inspector Sexton's debrief questionnaire)

19.39 It is important that I acknowledge that an enormous amount of work went into all of the debrief processes following the Attack. I detected no lack of willingness by those who participated to get to an understanding of what went wrong, what went well and what recommendations might be made. However, I was struck by the lack of critical detail in the content of some of the debrief questionnaires prepared by witnesses who were called to give evidence. It is essential that everyone who needs to complete a debrief questionnaire is encouraged and supported to be constructive, objective, open and comprehensive.

19.40 ACC O'Callaghan was asked about the effectiveness of BTP's debrief process and whether it was effective in revealing problems. His answer was that *"[t]here's certainly work still to be done in that area"*.[26] He agreed that there was a danger that a debrief process could be defensive. This is an understandable reaction which is difficult to overcome. ACC O'Callaghan stated that BTP had retained an external consultant to ensure that BTP's review of what has emerged from the Inquiry is robust.[27]

19.41 I have a concern that the debrief processes following the Attack did not reveal several of the issues that they should have. It is beyond the scope of the Inquiry's terms of reference for me to conduct a minute examination of why this was the case.

19.42 I recommend that each emergency service involved in the response to the Attack seek to understand why the issues considered in Volume 2 of my Report were not identified sooner. This is intended to be a constructive exercise aimed at improving the current system. I recognise that the answer to some may simply be attributable to the highly detailed and forensic process that the Inquiry has been able to undertake, but not all.

[26] 139/62/17-63/21

[27] 139/62/17-63/21

Witness statements

19.43 Operation Manteline took witness statements from those with evidence relevant to the criminal investigation. Inevitably, there was a substantial overlap between what was relevant to that investigation and the Inquiry's terms of reference.

19.44 For good reason, the focus of the criminal investigation was not on command decisions on the night of the Attack. As a result, witness statements were not taken from emergency services commanders until requests were made for them by me once I had been appointed as the Coroner for the inquests. This meant that many key witnesses did not make witness statements until several years after their involvement in the Attack. This included three people whose decisions I have needed to scrutinise in detail: the GMP Force Duty Officer (FDO), the NWAS Operational Commander and the GMFRS duty National Interagency Liaison Officer (NILO).

19.45 For those witnesses who did not have recourse to comprehensive notes made at the time, this was unsatisfactory. Even where a recording exists, the rationale behind decision-making was not always captured. To take one example to illustrate this point: Inspector Sexton's first witness statement was dated 6th December 2019.[28] This was two and a half years after the Attack. As DCC Pilling observed, *"it obviously would have been more helpful"* if Inspector Sexton's full account had been captured earlier than this.[29]

19.46 I recommend that the Home Office, College of Policing, National Ambulance Resilience Unit and Fire Service College take steps to ensure that all emergency services understand the importance of obtaining comprehensive accounts from commanders as part of the debrief process. This will not necessarily need to occur following every Major Incident. A threshold will need to be identified for this to be triggered. As a minimum, I would expect it to occur as a result of every terrorist attack and any Major Incident which results in death.

[28] INQ029021

[29] 131/49/2-13

Kerslake Report

19.47 In July 2017, the Mayor of Greater Manchester set up an independent review chaired by Lord Kerslake.[30] The review was into Greater Manchester's preparedness for and emergency response to the Attack. Participation in the work of the review was voluntary. A substantial number of people who gave evidence to me also provided accounts and information to Lord Kerslake's team.

19.48 Lord Kerslake adopted a *"Fair Notice"* procedure before reporting. This followed the information-gathering stage. On 9th March 2018, Chief Constable Ian Hopkins wrote in response to the Fair Notice letter which he had received on behalf of GMP. In the course of that response, Chief Constable Hopkins stated: *"Relevant emergency service partners were informed of the declaration of Operation Plato."*[31] The letter went on to assert:

> *"GMP can evidence that GMFRS, NWAS and the military were informed of the Plato declaration, via specified routes, within a few minutes of its declaration. These are the only partners specified in JOPS. We are not clear why this was not then communicated within these organisations, if this was the case.*
>
> *...*
>
> *... [the FDO] was able to complete his key tasks, including the notification of Operation Plato."*[32]

19.49 Chief Constable Hopkins stated in evidence that the content of this letter was *"a very grave error"*.[33] I agree. He explained that a team had been established run by DCC Pilling. The information had come from that team. He also pointed out that, on the next working day, an email correcting this error was sent to Lord Kerslake by DCC Pilling.[34]

19.50 There was no opportunity for Lord Kerslake to be misled by this error due to the timely correction. What is of more concern to me is that, more than nine months after the Attack, the senior leadership of GMP had not realised that the FDO had not communicated the Operation Plato declaration to other emergency services. That was a highly significant fact which should have been identified by GMP at an early stage. GMP should have put greater effort into understanding why it had happened. Both Chief Constable Hopkins and DCC Pilling should have immediately known the letter to Lord Kerslake was incorrect.

19.51 On 27th March 2018, Lord Kerslake delivered his report.[35]

30 INQ000009/14-17
31 INQ000633/2
32 INQ000633/3
33 134/183/24-185/13
34 134/183/24-185/13
35 INQ000009

19.52 I am grateful to Lord Kerslake and his team for making available the material collected as part of his process. It has assisted my investigation. I see my work as building on his review. With the powers, time, evidence and assistance available to me, I have been able to examine the response in much greater detail.

Media interviews

19.53 On 22nd May 2018, the BBC broadcast a documentary entitled *Manchester: The Night of the Bomb*.[36] In the course of the programme, interviews given by emergency responders from BTP and NWAS setting out their account of events of the night of the Attack were played. The transcripts of the interviews were provided to the Inquiry.[37] They formed the basis of some of the questions asked during the oral evidence hearings. I am grateful for the co-operation I received from the BBC in relation to those transcripts being made available.

19.54 Representatives of the bereaved families raised issues about *Manchester: The Night of the Bomb*. Three issues in particular were raised. First, there was concern about *"the inclusion … of graphic footage of the scene of the attack, from which [bereaved families] were able to identify their loved ones as they lay dead, and about which they received no warning"*.[38] Second, there was concern about whether it was appropriate for any emergency responder to have assisted in the making of the documentary at all. Third, there was a concern about the timing of the participation: it occurred when it was known that an investigation into the adequacy of the response would occur.[39]

19.55 ACC O'Callaghan, on behalf of BTP, apologised for the involvement of BTP in this documentary.[40]

19.56 In relation to the second concern, it was submitted to me on behalf of the bereaved families: *"The lesson to be learned is that greater communication with bereaved families is necessary when consideration is given to participation in documentaries and other media coverage following fatal incidents."*[41]

19.57 Freedom of the press is an essential part of our democracy. It is not appropriate for me to seek to define the circumstances in which the media should interview emergency service personnel. Nor is it for me to suggest standards in relation to what material can or cannot be included. The Independent Press Standards Organisation provides some general guidance. However, having seen firsthand the upset this particular documentary caused, it is clear that consultation with bereaved families in fatality cases is capable of reducing any distress which may be caused.

[36] INQ024284T
[37] INQ024278T/26-28
[38] INQ042546/45-46
[39] INQ042546/46
[40] 139/91/9-92/7
[41] INQ042546/47

Period of the inquests and Inquiry

Introduction

19.58 In August 2018, I was appointed by the Lord Chief Justice and the Chief Coroner as the nominated judge to sit as the Coroner to conduct inquests into the deaths of the twenty-two people who died as a result of the Attack. Following a ruling I made in 2019, the Inquiry was established. The matters which were the subject of that ruling will be dealt with in Volume 3 of my Report.

19.59 Both as a Coroner and as a Public Inquiry Chairman, I was granted powers enabling me to carry out a full investigation. Paragraph 5 of the Inquiry's terms of reference set out the scope of my investigation in this area of the Inquiry.[42]

Support from Operation Manteline

19.60 Supporting me in this investigation was a team of GMP officers from Operation Manteline. These officers were not involved in GMP's response to the Attack beyond the criminal investigation. The part of the Operation Manteline team supporting the inquests and subsequently the Inquiry was headed by Detective Superintendent Teresa Lam. Detective Inspector (DI) Michael Russell was responsible for those who gathered, collated and analysed the hundreds of hours of audio-visual material.[43]

19.61 I am indebted to Detective Superintendent Lam, DI Russell and all those within their team. I received an extraordinary level of support and co-operation. I pay particular tribute to the work that was undertaken in reconstructing the period post-explosion. It was of a highly distressing nature. It was painstaking and protracted work. It enabled the clearest possible understanding of what happened to each of those who was killed following the detonation.

Getting to the truth

19.62 As I have set out above, there had been numerous reviews and debriefs aimed at identifying what happened on the night of the Attack. For that reason, some may have thought the Inquiry was going to be a re-analysis of already well-established facts. This proved not to be the case.

19.63 The forensic process of the Inquiry brought to light many new pieces of information which either had not previously been known or the importance of which had not previously been realised.

[42] Appendix 1 in Volume 1

[43] 19/223/2-11

19.64 A stark example of this was in relation to the important first decision within NWFC. Based upon what the panel was told, Lord Kerslake's report states:

> *"On being told on the telephone by GMP at 22:35hrs that 'there had been an explosion and that a bomb has exploded', the North West Fire Control operator initially acted in accordance with the action plan for 'EXPLOSION' and created an incident log. Following the plan's instructions, they then opened the action plan for 'BOMB'."*[44]

19.65 Lord Kerslake's report goes on to identify that the first action of the 'Bomb' action plan was to contact the duty NILO, which is what in fact occurred.[45]

19.66 This account of what happened was maintained in witness statements submitted to me.[46] On 19th August 2020, in its opening statement, NWFC stated: *"Contrary to what is said in some of the material and evidence gathered, the control room operators at NWFC did not 'open' the action plan for 'BOMB – GENERAL'."*[47]

19.67 Further witness statements were provided in support of NWFC's position.[48] These confirmed that the 'Bomb' action plan was never consulted and that the decision to contact the NILO was made without reference to any particular action plan.[49]

19.68 It is most unfortunate that it was not until days before the oral evidence hearings began that the correct state of affairs was identified. I commend those responsible for identifying it and drawing it to the Inquiry's attention. However, whether or not a particular action was based on an existing plan formed an important part of establishing what happened. It is remarkable that it took over three years for this misconception to be dispelled.

19.69 As I have said, the above represents what is a stark example of an important factual revelation emerging after an extended period during which the opposite had been asserted. There were many other developments which I do not rehearse here. I do not raise this particular example with a view to criticising those who had previously been wrong in their recollection. I raise it because it further underlines the importance of accurate record-keeping about what was done and why. It also demonstrates the need for early, objective analysis of the known facts.

Post-Attack changes

19.70 On 30th January 2020, I issued a ruling directing that each of the public body and corporate Core Participants serve a statement setting out the changes which had been made since the Attack.

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44 INQ000009/95 at paragraph 3.152

45 INQ000009/96 at paragraphs 3.153-3.154

46 INQ023881/6 at paragraph 4.9, INQ023877/31 at paragraph 7.3, INQ032856/3 at paragraph 2.2

47 INQ035485/15 at paragraph 10.1

48 INQ035438/1-2 at paragraph 8, INQ035440/1 at paragraph 6

49 INQ037079/7-8 at paragraph 17, INQ035440/1 at paragraph 6

19.71 Statements setting out post-Attack changes were served before the start of the oral evidence hearings, in April to June 2020.[50] I found these statements instructive. They demonstrated that there was a genuine commitment to improvement on the part of each of the emergency services.

19.72 My investigation did not involve a detailed analysis of the efficacy and appropriateness of the changes that have already been made. Its focus was on what the position was in May 2017. For this reason, I have deliberately refrained from commenting on whether any of the issues I have identified have yet been addressed, whether in full or in part.

19.73 In Volume 1, I identified particular recommendations as ones which I intended to monitor. In January 2022, I heard evidence in relation to those 'monitored recommendations'.[51] This evidence provided an opportunity for those who were the subject of monitoring to share their experience of making necessary improvements with a view to sharing their learning widely.

19.74 As I will set out in Part 21, I will adopt the same approach to particular recommendations that I make in Volume 2.

Approach to learning as a result of the Inquiry

19.75 I was particularly impressed by the evidence I heard from GMP and BTP about the structures that have been put in place in order to extract and disseminate learning as a result of the Inquiry.[52]

19.76 As those efforts may be of more general application to emergency services, I comment on them further below.

GMP

19.77 Towards the end of 2019, DCC Pilling set up a team within GMP whose task was to review all the recommendations identified from the Attack and from debriefs. The purpose was *"to ensure [GMP] could assure [itself] that the appropriate progress had been made"*.[53] This team was called *"the Arena Recommendations Review Team"*.[54] DCC Pilling identified the need for this team when he began to prepare his statement for the Inquiry.

19.78 DCC Pilling stated that, out of the work of the Arena Recommendations Review Team, GMP developed what it termed the Organisational Learning Board. DCC Pilling explained:

> *"What I was conscious of was that given the volume of [the debriefs and reviews], that the organisation wasn't always pulling them all together and spotting common threads. And the purpose of the organisational learning*

[50] For example, INQ033298 (DCC Pilling), INQ032849 (Gerard Blezard)
[51] 187/1/5-239/5, 188/1/5-35/13
[52] INQ033298 (GMP), 139/1/18-106/6 (BTP)
[53] 131/13/2-11
[54] 131/13/12-16

> *board … was twofold: first of all, to ensure that we have an effective scanning process across all those threads … The other was to have more of a lessons learning ethos within the whole organisation and encourage … an approach more towards learning lessons."*[55]

19.79 I was impressed by DCC Pilling's commitment to embedding learning within GMP. Establishing a structure of organisational learning officers across all districts and departments in GMP represented a step change for the better. He stated:

> *"[M]y ethos is that most … learning should take place at a low level, it is a localised piece of learning, but equally some learning will be more strategic and it is issues such as that which are brought to the organisational learning board."*[56]

19.80 I recommend that GMP share its approach with other police services through the National Police Chiefs' Council.

BTP

19.81 ACC O'Callaghan gave evidence as part of the process of monitoring recommendations made in Volume 1. In January 2021, following the oral evidence hearings relevant to Volume 1, BTP created the *"SABRE programme"*. SABRE is an acronym which stands for *"situational awareness, briefing, response and events"*.[57]

19.82 ACC O'Callaghan explained the genesis of the SABRE programme in this way:

> *"British Transport Police started the journey of correcting some of the wrongs as early back as when the Kerslake Inquiry was sitting and started developing some of those streams at that point. And then as further streams were picked up through this Inquiry, they were added to that programme, and those combined pieces of work are what became the SABRE programme."*[58]

19.83 A number of those workstreams related to issues with BTP's involvement in the emergency response. I take two examples from within one of those workstreams to illustrate the approach taken by BTP. First, BTP recognised that there was *"a lack of familiarity"* with the Major Incident Manual.[59] I have set out my conclusions in relation to this in Part 13 in Volume 2-I. This led to BTP making changes in its approach.

19.84 Second, BTP developed its approach to the use of tourniquets. ACC O'Callaghan told me: *"I have now changed my position on [tourniquets] having listened to or watched [Brigadier Hodgetts'] evidence and indeed watching … the video*

[55] 131/20/14-21/1
[56] 131/21/12-17
[57] 187/178/3-12
[58] 187/180/8-15
[59] 187/194/23-195/2

on the citizenAID website."[60] He went on to say that he had met with Brigadier Timothy Hodgetts and that BTP had recommended all frontline BTP officers be issued with, and trained in the use of, tourniquets.[61] I shall return to the issue of tourniquets in Part 20.

19.85 I commend BTP's approach to learning from the Inquiry. I was impressed by ACC O'Callaghan's commitment to change.

19.86 I recommend that BTP share its approach with other police services through the National Police Chiefs' Council.

Warning letter process

19.87 I am required by Rule 13 of the Inquiry Rules 2006 to send a warning letter to any person who may be the subject of explicit or significant criticism. Rule 15 requires that a warning letter should state what the criticism or proposed criticism is; contain a statement of the facts that are considered to substantiate the criticism or proposed criticism; and refer to any evidence which supports those facts.

19.88 I was concerned at the outset of the Inquiry that the requirements of the warning letter process may impact on the timetable for publication of my Report. The requirement to identify every potential criticism and supporting evidence is onerous. It means that warning letters can only be issued when the drafting of the report is well advanced. The responses to warning letters can be lengthy and complex. All this increases the risks of delay while issues are reviewed and the Report updated. That has happened at this stage of the Inquiry.

19.89 I have nonetheless found the warning letter process a useful one. As I noted in Volume 1, I have not taken into account fresh evidence or new arguments that were provided in warning letter responses and which could have been, but were not, put forward during the Inquiry's evidence hearings or in written and oral submissions.

19.90 I have adopted that general approach because it is not the purpose of Rule 13 to provide those who may be criticised with an opportunity to reopen matters in order to justify their conduct or to advance submissions that could have been made openly, on notice to the Inquiry and other Core Participants and subject to submissions, but were not.

19.91 Over the course of an inquiry's investigation, the importance of matters may change. New issues may arise. That is how inquiries work. They are not the same as an adversarial process where the issues should be clear before the hearing starts. In an inquiry, issues and proposed criticisms may come into focus only when the report is written. If they have not been explored in evidence, that is

[60] 139/42/4-7

[61] 187/184/16-186/4

a factor I have had in mind when deciding whether or not it is fair and appropriate to make a particular finding. The warning letter process has ensured I have been able to raise matters as potential criticisms which have not been fully explored in evidence and allow an opportunity for a response before I decide whether to include them in my Report. I consider that to be a fair process and one that is essential to enable me to prepare a comprehensive report.

19.92 I understand that any person or organisation warned that they may be criticised in a public inquiry report may be distressed by this. I also understand that, where a person does not believe they should be criticised, this distress may be greater. It is important that those subject to potential criticism have the opportunity to respond.

19.93 I have found it particularly helpful to be told in an objective, dispassionate way why a proposed criticism is said not to be justified. That is a reasonable and proper use of the warning letter process. Some of the responses to warning letters were phrased in this helpful way; others were not.

19.94 Throughout the Inquiry's public hearings, every organisation committed to assist me in the search for the truth. I am grateful to all those who approached the warning letter process constructively. However, I am concerned that the attitude of others as expressed during a confidential process may stand in the way of further change.

19.95 I considered carefully whether to disclose the warning letter responses after the publication of this Report. I have decided not to do so but it is an important reason why I intend to monitor certain recommendations from this Report. It will ensure that everyone considers and reflects on the conclusions in the Report in a constructive manner and with the intention of ensuring that the same mistakes are not made again.

Part 20
The Care Gap

Introduction

20.1 In the event of a mass casualty incident, the public expect ambulances to travel to the scene quickly and in large numbers. The public also expect that, once on the scene, paramedics will attend to casualties immediately, with treatment starting within minutes of the incident occurring. The evidence demonstrates that, following the current approach, this is unlikely ever to be achieved. That is the case for at least four reasons.

20.2 First, the reality of the resourcing of ambulance services around the UK is that ambulances do not wait around for a Major Incident to occur. In the event of a mass casualty incident, it is inevitable that all, or at least most, ambulances in the geographical area of the incident will already be engaged in dealing with other events. That is likely to lead to a delay in the deployment to the scene of the number of ambulances and ambulance personnel needed to deal comprehensively with the incident.

20.3 Second, even when ambulance personnel begin to arrive at the scene of a mass casualty incident, the treatment of casualties is unlikely to commence immediately. Long-established policy within the ambulance service is that the first paramedic on the scene of a Major Incident will become the acting Operational Commander.[1] In that role, they are instructed not to treat casualties.[2] Instead, the acting Operational Commander is expected to assess the scene and pass a METHANE message to the control room, then seek to establish command and control, before co-ordinating with incident commanders from the police and fire and rescue services.[3] All of that takes time.

20.4 Third, once the command structure at the scene is in place, the expectation is that triage will commence. The nature of a mass casualty incident is that the needs of the casualties will almost certainly exceed the capacity of the paramedic resource initially available. The seriousness of the injuries may well vary considerably. Established practice is that it is vital that those in most need of medical intervention are identified quickly. This is the purpose of triage. It should be undertaken before any treatment, except for urgently required life-saving interventions. Once again, this takes time.

[1] INQ032665/36-37, INQ032665/44
[2] INQ013422/2
[3] INQ032665/44

20.5 Fourth, where the mass casualty incident causes the police to declare Operation Plato, that is likely to have an impact on the time it takes for the treatment of casualties in any hot or warm zone. That is so even though the current Joint Operating Principles (JOPs) provide greater flexibility for forward deployment than was the position in 2017.

20.6 Witnesses explained that the consequence of these factors is that, in a mass casualty incident, it is inevitable that there will be a delay in paramedics and/or other healthcare staff arriving at the scene and commencing treatment.[4] During the Inquiry, this period was described as 'the Care Gap'.

20.7 I heard from witnesses with the expertise and experience to assist me on two issues: first, how is the Care Gap to be made as short as possible? And, second, how are we to achieve a situation in which those who are present at the scene before professional clinical staff arrive are able to provide vital life-saving interventions?

20.8 One witness, Philip Cowburn, the Medical Advisor to the National Ambulance Resilience Unit (NARU), summarised these two issues as *"narrowing the gap"* and *"filling the gap"*.[5] I will use these terms but I consider that there are some matters relating to treatment that do not fall neatly into either category. I will deal with the issues in the following order: matters that will narrow the gap; matters relating to treatment during the gap; and matters that will fill the gap.

[4] 68/20/10-25, INQ041868/7 at paragraph 26, INQ042671/1 at paragraph 5

[5] INQ042711/8

Narrowing the gap

Introduction

20.9 If the Care Gap is to be made as short as possible, ambulances and specialist ambulance resources need to reach the scene of a mass casualty incident without delay. Ambulance personnel need to work collaboratively with their colleagues from the other emergency services. Specialist resources will be required and many witnesses advocated a consultant-led response.[6]

20.10 Where the incident is terrorist in nature and of a type such that Operation Plato has been declared, the affected area needs to be zoned accurately and the hot and warm zones need to be shrunk as quickly as possible. All casualties, whatever zone they are in, must be triaged and treated promptly and evacuated to hospital as speedily as possible. That includes the triage, treatment and evacuation of those in the hot zone.

Ambulance service resources generally

20.11 Getting ambulance personnel to casualties quickly in the event of a mass casualty incident is an obvious way of shortening the Care Gap. For that to happen, ambulances need to be available to deploy immediately and in sufficient numbers. Currently, that does not normally happen. That is because, around the UK, ambulance services are always *"playing catch-up"*: at any moment each ambulance in the country will be dealing with an incident, with other emergencies building up behind that incident in order of priority.[7]

20.12 Ambulance services generally do not have any spare capacity within their frontline resources. As the Ambulance Service Experts noted: *"They are normally stacking emergencies with multiple emergencies waiting to be assigned to a particular ambulance."*[8] This means that, in the event of a mass casualty incident, it is likely that the number of ambulances necessary for the care and treatment of the casualties will not be available to attend immediately or anything like immediately.

20.13 The night of the Attack on 22nd May 2017 is an example of that. Of the 319 North West Ambulance Service (NWAS) vehicles available that night, only seven were able to deploy straightaway,[9] far fewer than was needed. The Ambulance Service Experts considered that, with the existing resources available to ambulance services and current levels of demand, such a situation would almost inevitably be replicated if a similar incident were to occur again anywhere in the country. I was informed that, over the course of the last ten years, the demand on

[6] 192/22/13-28/21, 192/85/11-86/19, 192/133/14-134/19, 192/137/11-140/1, 192/151/11-153/15, 192/227/7-19
[7] 144/24/14-25/13
[8] 145/120/7-11
[9] INQ040952/1

ambulance services has doubled, with the trend of increasing demand continuing.[10] So, this problem is only going to get worse if left unchecked. That is a very concerning state of affairs.

20.14 Ensuring that ambulances reach the scene of any mass casualty incident swiftly is a critically important part of making the Care Gap as short as possible. Not only do ambulances contain the personnel and equipment able to provide many life-saving interventions, but they are also the vehicles by which casualties are best transported to hospital. If ambulances do not attend the scene quickly and in sufficient numbers, lives will be lost.

20.15 It is not for me to dictate to central government or to the NHS how finite resources should be spent. However, I consider that all ambulance service trusts should review their capacity to respond to a mass casualty incident. Having done so, they 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.[11] The Department of Health and Social Care (DHSC) should give urgent consideration to any recommendations made by the trusts and the NHS commissioners.

Ambulance service specialist resources

20.16 Connected with this review is the issue of specialist ambulance service resources.

20.17 Where the mass casualty incident is the result of a terrorist attack, there may be sound reasons why only those with specialist skills and equipment should be deployed forward, at least initially. Ambulance services introduced Hazardous Area Response Team (HART) operatives to address this issue.[12] As I explained in Part 14 in Volume 2-I, a HART crew comprises specially recruited personnel who are trained and equipped to provide the ambulance response to high-risk and complex emergency situations.

20.18 They are able to work in dangerous areas during or after a terrorist attack. They are therefore vital to making the Care Gap as short as possible in such a situation. There may be respects in which the training of HART operatives could be improved. Furthermore, strong voices have advocated the view that the clinical response to a terrorist attack should be consultant-led. I will address those issues below. None undermines the importance of HART in narrowing the gap.

20.19 Given the importance of HART in any response to a terrorist attack, it was concerning to hear evidence that this specialist resource is not always available to respond as swiftly as expected. Keith Prior is the Assistant Chief Ambulance Officer in the West Midlands. He is also a Director of NARU,

[10] INQ042167/5 at paragraphs 27 and 28

[11] INQ042167/5-6 at paragraph 28, 188/44/13-46/16

[12] 144/218/2-10

which works nationally on behalf of each ambulance service trust in England to provide a co-ordinated approach to emergency preparedness, resilience and response.[13] He gave evidence that ambulance services around the country are *"struggling"* to maintain the minimum levels of HART staff.[14] He said that, of all the ambulance service trusts, only one is able to achieve that minimum level routinely.[15]

20.20 Keith Prior's view was that there are not sufficient numbers of HART personnel.[16] He explained that NARU's view is that there needs to be an increase in the membership of HART if a proper response to an incident such as the Attack is to be achieved.[17] Also, he considered that there is currently a lack of understanding on the part of ambulance commanders about what HART can provide in the response to a terrorist attack.[18] NARU has been taking steps to address this lack of understanding, but Keith Prior explained that more remains to be done.[19] I accept the evidence of Keith Prior that these are real issues that need to be addressed.

20.21 The Ambulance Service Experts identified an increasing tendency in recent years for HART resources to be deployed for less serious calls. They describe this as a problem[20] and observe that the deployment of HART to a Major Incident should be mandatory.[21] I agree that, in the event of any Major Incident, it is highly undesirable that HART should be delayed in attendance by being engaged in another incident that does not require specialist resources.

20.22 I recognise that steps are being taken to increase certain other specialist resources of the ambulance service. However, HART operatives have particular skills and capabilities that would be invaluable in the event of a terrorist attack.

20.23 The review of resources I identified at paragraphs 20.11 to 20.15 should encompass an assessment of whether each ambulance service trust has an adequate number of trained specialist personnel to respond effectively to a mass casualty incident.[22] On the evidence I heard, the numbers are currently not sufficient.

20.24 DHSC and NARU should also 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.

[13] 190/1/19-3/17
[14] 190/11/25-13/1
[15] 190/11/25-12/21
[16] 190/12/22-13/1
[17] 190/13/2-7
[18] 190/14/24-16/8
[19] 190/17/8-18/8
[20] INQ042167/9 at paragraph 33
[21] INQ042167/9 at paragraph 35
[22] INQ042167/5-6 at paragraph 28, 188/44/13-46/16

20.25 As part of that, DHSC and NARU 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.

20.26 NARU has developed new national standards and training courses for ambulance commanders.[23] Their purpose is to improve standards and standardise command competence. I welcome that.

20.27 I recommend that DHSC and NARU 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, and on the importance of getting ambulance personnel to casualties without delay.

Joint Operating Principles

20.28 At the time of the Attack, the third edition of the *Responding to a Marauding Terrorist Firearms Attack and Terrorist Siege: Joint Operating Principles for the Emergency Services* (JOPs 3) was in force.[24] In Parts 11 and 12 in Volume 2-I, I addressed the detail of that edition of JOPs and its position in a hierarchy that involves the *Joint Doctrine: The Interoperability Framework* (the Joint Doctrine)[25] above it, and, below it, at a national level, the Counter Terrorism Policing Headquarters (CTPHQ) Operation Plato guidance,[26] and, at the local level, Greater Manchester Police's (GMP's) Operation Plato plans.[27] JOPs 3 dealt with the response to a Marauding Terrorist Firearms Attack. This addressed zoning and the fact that, as of 2017, specialist resources such as HART were able to enter the Operation Plato warm zone, but not the Operation Plato hot zone.[28] For that reason, zoning is of importance to the Care Gap. Casualties will almost inevitably be present in the Operation Plato hot zone. The quicker this zone is shrunk and then reclassified to warm or cold, the quicker the casualties within it will be treated. Similar and connected considerations apply to the Operation Plato warm zone. Casualties are also likely to be in that location. Shrinking and then reducing the warm zone to cold will enable a broader range of emergency responders to enter and therefore speed up the treatment of casualties there as well.

20.29 Since the Attack, changes have been made to JOPs. The fourth edition was issued in November 2017. Then, in 2019, there was a shift away from the concept of a Marauding Terrorist Firearms Attack to the broader concept of a Marauding Terrorist Attack. That led the edition numbering to restart.

[23] 190/14/24-18/9
[24] INQ008372/1
[25] INQ004542
[26] INQ013767 (2012 guidance), INQ016688 (refreshed guidance)
[27] INQ040146 (SOP 47 v.4), INQ039970 (SOP 47 v.5), INQ029178 (Whittle Plan)
[28] INQ008372/13

In March 2019, the first edition of the Marauding Terrorist Attack Joint Operating Principles was issued. In December 2020, a second edition was issued.[29] That is the edition currently in force (the current JOPs).

20.30 Chief Inspector (CI) Richard Thomas was the Head of Specialist and Counter Terrorism Armed Policing Capabilities at CTPHQ in 2017. He remained in that post as a civilian when he gave evidence in January 2022.[30] His evidence gave rise to issues of operational sensitivity so it was necessary for some of it to be heard in a restricted session. However, CI Thomas confirmed in open evidence that the current JOPs and the current CTPHQ Operation Plato guidance simplify the description of each zone. They provide greater clarity in relation to the deployment of both non-specialist and specialist resources into zones.[31] The evidence overall indicates that the current JOPs provides not just greater clarity but also greater flexibility to commanders in relation to the forward deployment of both non-specialist and specialist resources.[32]

20.31 This greater clarity and flexibility is desirable. However, the evidence revealed that some senior emergency service commanders continue to lack confidence that the approach contained in the current edition of JOPs will necessarily work to produce a better outcome. Mark Hardingham is Chair of the National Fire Chiefs Council, which provides advice to government about matters that have a bearing on fire and rescue services and which seeks to provide the professional voice for those services.[33] He explained that the National Fire Chiefs Council considers that JOPs ought to include specific reference to the Care Gap and the steps commanders need to take to minimise the gap.[34]

20.32 NARU also considers that JOPs would benefit from improvement.[35] The substantive changes NARU considers should be made are as follows.[36]

20.33 First, greater emphasis should be placed in JOPs on the rapid deployment forward of all emergency services to save lives. Rather than waiting for the ideal conditions to deploy forward, the presumption should be to deploy forward. In particular, the need to deploy specialist paramedics and doctors into hazardous areas, where that is necessary to assist casualties, must be prioritised.

20.34 Second, the emergency services need to work together to align their perception and understanding of risk. Overall, there needs to be a greater tolerance of risk across the emergency services.

[29] 141/102/12-22
[30] 60/1/12-2/14
[31] 141/104/10-23
[32] 189/56/18-57/6, 189/141/9-142/8, 190/7/3-10
[33] 189/133/23-134/21
[34] 189/142/13-145/13
[35] 190/7/11-8/6
[36] INQ042707/1-2

20.35 Third, in the aftermath of a terrorist attack, the possibility of a secondary device will often, if not always, exist. The presumption should be on deployment unless there is a proper basis for believing that a real risk of a secondary device exists. JOPs should make clear that this is the position. A hypothetical chance should never prevent deployment.

20.36 NARU's points, all of which have force, highlight an issue that featured throughout the emergency response evidence. That issue is: how is a situation in which commanders from different emergency services assess risk differently to be addressed? The Joint Doctrine and the current JOPs assume that commanders will agree both the risk and the forward deployments that are appropriate based on that risk. The evidence I heard reveals that this assumption may not be correct. The different emergency services may have different appetites for risk, and certainly individual commanders may do. The emergency response to the Attack demonstrates how this is capable of creating a problem and a delay in deploying responders forward.

20.37 To give just one example, shortly before 01:00 on 23rd May 2017, a Joint Emergency Services Interoperability Principles (JESIP) huddle took place between CI Mark Dexter, the GMP Ground Assigned Tactical Firearms Commander; Stephen Hynes, the NWAS Operational Commander; and Station Manager Andrew Berry, the Greater Manchester Fire and Rescue Service (GMFRS) National Interagency Liaison Officer. The GMFRS Chief Fire Officer, Peter O'Reilly, participated by telephone. The issue of zoning was the focus of the discussion. It is impossible to listen to the recording of that discussion without concluding that, even at that late stage, nearly two and a half hours post-detonation, there was no joint understanding of risk across the three emergency services.[37]

20.38 In the course of the evidence, the question of whether this situation should be resolved by JOPs giving one of the commanders a trump card or casting vote was examined.[38] I am satisfied that there would be significant problems in doing so in a formal sense. However, I am also satisfied that there should be a working assumption that in certain situations particular commanders should take the lead and that their views should prevail, unless there is a compelling reason not to follow them.

20.39 For example, in an Operation Plato situation, the views of the police commander about which resources can and cannot be deployed into particular areas should be followed, unless there is a compelling reason not to do so. The current JOPs has sought to achieve greater clarity in relation to this situation. However, the evidence I heard indicates that if clarity has been achieved in the document itself, that clarity has not been communicated adequately to those who will actually have to respond to events such as the Attack.

[37] INQ040657/67-71

[38] 146/36/14-43/1

20.40 Decisions about zoning and the forward deployment of specialist and non-specialist resources will be critical to the treatment of casualties in an Operation Plato situation. They will be capable of dictating whether lives are or are not saved. In the circumstances, the Home Office, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS), the College of Policing, the Fire Service College, NARU and JESIP should review and, as necessary, update the Joint Doctrine and JOPs. The following matters should be considered in that review.

20.41 First, 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.

20.42 Second, achieving a situation in which risk appetite, by which I mean the understanding, acceptance and management of risk, is common across the three emergency services.

20.43 Third, achieving a situation in which deployment forward of specialist resources is the presumption, to be displaced only in the presence of a properly evidenced basis for not deploying resources forward.

20.44 Fourth, 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.

20.45 Fifth, achieving a situation in which the three emergency services all use the same terminology to describe the Operation Plato hot, warm and cold zones and all have a common understanding of those terms. That need also arises in Major Incident situations in which Operation Plato is not declared. In the same way, a situation must be achieved in which the three emergency services work jointly, using common terminology and sharing an understanding of those terms.

20.46 I recommend that the Home Office, HMICFRS, the College of Policing, the Fire Service College, NARU, individual police services and JESIP review what changes need to be made to the CTPHQ Operation Plato guidance and Major Incident Plans in order to achieve those aims. This calls for an urgent response.

High-fidelity training

20.47 The observations I have just made relate to the extent to which JESIP can help to reduce the Care Gap. In Part 21, I will make some further and more general recommendations in relation to JESIP, the Joint Doctrine and JOPs. However, changing policy and guidance is not, of itself, enough. The changes need to become embedded in those who may actually be called upon to respond in the event of an Operation Plato situation. That requires training and multi-agency exercising.

20.48 In her evidence, Lieutenant Colonel Dr Claire Park, a consultant in pre-hospital care and critical care and anaesthesia who has worked closely with the firearms teams of the Metropolitan Police Service,[39] described her involvement in the design and delivery of Major Incident training. She explained that this involves the use of simulated casualties, designed to test whether those with particular injury patterns get the required treatment when they need it. It explores whether deaths could have been prevented.[40] It also helps to prepare those who will be required to respond to a mass casualty incident for the significant assault on their senses that the incident will involve.[41]

20.49 Lieutenant Colonel Park described this as *"high-fidelity"* training.[42] I consider such training to be vital. The Home Office, CTPHQ and the College of Policing 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.

20.50 Training is not enough. Areas for improvement need to be identified and change implemented. The local resilience forums have an important role to play in this, as do each of the individual emergency services and the control rooms. Training is not an end in itself. One of the important purposes of training is to drive change, and that needs to be understood across the emergency services.

Embedding medics with police firearms officers

20.51 I heard evidence about the approach taken by nine other countries to the Care Gap. Each of those countries faces a substantial terrorist threat. I am grateful for the level of co-operation I received. It was necessary for me to hear most of this evidence in a restricted session because to have heard it in an open session may have assisted terrorists to mount further or more deadly attacks in the countries concerned. I have taken that evidence into account in the conclusions I have reached. I set that evidence out in my Report to the extent that it is responsible to do so.

20.52 On the face of it, an effective way of narrowing the Care Gap would be to embed doctors with the police firearms officers who can enter an Operation Plato hot zone. That would involve the doctors deploying into an area where the most seriously injured casualties were likely to be. This would get around all of the delays and difficulties created by the designation of zones. Such doctors would need to be highly skilled and trained so as to enable them to carry out triage, emergency treatment and evacuation in circumstances of extreme danger and stress.

[39] 178/67/7-69/20

[40] 191/85/21-86/20, 192/61/17-64/16

[41] 191/86/25-87/15

[42] 191/85/21-88/13

20.53 This is what happens in France, where doctors are embedded with police firearms teams with the job of entering the highest-risk areas, akin to our Operation Plato hot zones. I am able to say this without breaching operational sensitivity because the work of the counter-terrorism unit of the French National Police is public knowledge. That team is known as RAID. This stands for Recherche, Assistance, Intervention, Dissuasion, which translates into English as Search, Assistance, Intervention, Deterrence.[43]

20.54 France has experienced much violent Islamist extremist terrorism. In the course of the evidence relating to security for the Arena, I heard about the events of the night of 13th November 2015, when ten ISIS terrorists launched co-ordinated attacks in Paris. Three men went to the Stade de France, where France and Germany were playing football. Each man was wearing an explosive device.

20.55 Each of the attackers detonated their device and died. A passer-by was killed and others injured. Within minutes, further terrorists armed with automatic weapons launched an attack at sites in the city centre, murdering nearly 40 people. Shortly afterwards, a further group of terrorists arrived at the Bataclan theatre, armed with military-grade firearms and wearing explosives vests. They shot dead three people outside and then entered the theatre, opening fire on the crowd.

20.56 It was during this phase of the Paris attacks that RAID was engaged. Members of the RAID team entered the Bataclan along with commandos of a second police team, the Brigade de Recherche et d'Intervention. This translates into English as the Brigade for Research and Intervention. They did so in order to neutralise the threat, just as police firearms officers would do in a comparable situation in the UK. The difference in France is that embedded within each RAID team is a highly trained physician.

20.57 In 2015, Dr Matthieu Langlois was the Chief Physician of RAID. On 13th November, he formed part of the RAID team that entered the Bataclan. He entered the theatre along with his RAID colleagues and a fellow medic from the Brigade de Recherche et d'Intervention, Dr Denis Safran. As other members of the teams sought out and engaged the terrorists, the two doctors performed triage in the combat zone.[44]

20.58 They carried out what is described in an article in the journal *Critical Care* as *"salvage therapies"*.[45] Tourniquets were applied to 15 patients and a further 15 underwent wound compression with haemostatic dressings; two patients received subcutaneous morphine and two received tranexamic acid (TXA); two thoracic exsufflations were performed. All this occurred in the combat zone.[46]

[43] 191/4/21-5/4
[44] 191/34/22-37/7
[45] INQ042566/1
[46] 191/37/12-38/19

20.59 Having completed the salvage therapies, the doctors set about managing the evacuation of the injured to hospital, stopping in an area in the entrance to the theatre where additional treatments could be undertaken if absolutely necessary to prevent death before arrival at hospital. All of the casualties were evacuated even before the threat had been neutralised.[47] What was achieved was remarkable.

20.60 I heard evidence from Dr Langlois. I am grateful to him for being prepared to assist me. He qualified as an intensive care anaesthetist in 2000 and thereafter worked in the accident and emergency department of a major hospital in Paris. In 2008, he joined RAID, initially alongside his existing responsibilities as a hospital consultant. In 2012, he became the Chief Physician of RAID. In that post, he was responsible for the selection and training of RAID's members and for its operational management. He developed the tactical response plan of RAID and led the tactical emergency care during all counter-terrorism interventions in France between 2012 and 2021, of which, sadly, there were many.[48] He was able to speak from a position of considerable authority.

20.61 Dr Langlois explained that RAID doctors are carefully selected to ensure that they have the physical and psychological qualities necessary to enable them to act effectively in situations of extreme stress.[49] Following selection, the doctors are highly trained and thereafter undergo regular further training and take part in exercising.[50]

20.62 In the event of a terrorist attack such as that which occurred at the Bataclan, the RAID doctors deploy into the area that broadly equates with an Operation Plato hot zone, along with and at the same time as those whose role it is to neutralise the threat. The doctor will triage the casualties and carry out any life-saving interventions that are needed. The casualties will then be extracted to a 'forward casualty nest' at the edge of the hot zone, where the risk is acceptable and the casualties can be reassessed. Further treatment can be provided here if necessary to save life before the casualty is extracted to the 'casualty collection point' in the green, safe zone and then on to hospital.[51] The casualty will stop at these points prior to hospital only if absolutely necessary to ensure that they are able to survive the extraction.[52]

20.63 The French describe this as the casualty flow. It is designed to get the casualty from the hot zone to treatment at hospital as quickly as possible.[53] I will consider at paragraphs 20.88 to 20.96 what lessons can be learned from the approach in France, which is not unique, to the issue of evacuation to hospital.

47 191/31/2-6
48 INQ042478/1
49 191/6/9-20
50 191/7/17-8/3
51 191/13/4-21/2
52 191/20/24-25/2
53 191/19/7-20/23

20.64 At an early stage, it seemed to me that an obvious way of narrowing the Care Gap was for the UK to adopt a RAID-style model. However, the evidence has persuaded me that the situation is by no means as straightforward as I had thought and hoped. There are a number of cogent reasons why such a model may not transfer across to the UK. It is not possible for me to explain all of those reasons in an open report, but I can say the following.

20.65 In the UK, Armed Response Vehicles provide the primary response to no-notice incidents such as a terrorist attack. Firearms officers have neutralised the threat during most recent terrorist attacks in the UK. There has been substantial investment in the development of a significant Armed Response Vehicle network. It is not practicable to embed a doctor within each Armed Response Vehicle team. That is a summary of evidence given by CI Thomas in a restricted evidence session on 17th January 2022.[54] There was widespread agreement with his view from other witnesses. Lieutenant Colonel Park has, as I have explained, substantial experience working with the Metropolitan Police Service firearms teams. John Lawrie is a research analyst with expertise in counter-terrorism; he conducted the analysis into the approach taken by different countries to the Care Gap. Both agreed with CI Thomas.[55]

20.66 Counter Terrorist Specialist Firearms Officers (CTSFOs) provide a specialist firearms capability in counter-terrorism and organised crime operations. They will deploy in support of Armed Response Vehicles at incidents if the initial Tactical Firearms Commander decides that their specialist skills and/or equipment would be of value. Because Armed Response Vehicle officers provide the primary response to no-notice incidents, including Marauding Terrorist Attacks, it is unlikely that a CTSFO team with an embedded clinician would form part of the initial response during the critical stages of the golden hour, the first hour of the emergency response.[56] Indeed, it is almost inevitable that the CTSFO teams would arrive after HART operatives. Although on the night of 22nd May 2017, the CTSFOs did in fact arrive at the Arena before HART, Lieutenant Colonel Park agreed that this is contrary to what could reasonably be expected to occur in general. Normally, they would arrive later.[57]

20.67 CTPHQ maintained that embedding doctors with CTSFOs would therefore bring no material benefit to the response to a terrorist attack and that clinical care is best provided under the control of the NHS and ambulance services.[58] CTSFOs, CTPHQ asserted, would be of no assistance in the early stages of an incident because they would be unlikely to be there. By the time a CTSFO doctor arrived, work should already be under way by HART operatives.

[54] 191/27/8-30/16 [restricted]
[55] 192/29/2-7, 188/69/9-70/7 [restricted], 188/73/14-19 [restricted]
[56] 191/30/8-16 [restricted], INQ042637/5
[57] 192/27/7-14, 192/29/21-30/4, 192/30/23-31/10
[58] 191/31/23-32/22 [restricted]

20.68 CTPHQ's position was that if a greater level of skill and training is required of HART, that is a matter for DHSC, the NHS and ambulance services. The level of HART skill highlights an important issue, to which I will turn in paragraphs 20.86 and 20.87.

20.69 A number of further practical issues with embedding doctors within police firearms teams were expressed by other witnesses. Philip Cowburn of NARU, for example, explained that he does not consider there to be, currently, a sufficient number of doctors with expert skills in pre-hospital emergency medicine within the UK to provide a cadre of embedded doctors. He points out that pre-hospital emergency medicine is a relatively new sub-speciality in the UK, compared with France.[59] It is his view that it is vital to find a way of getting experts in pre-hospital emergency medicine forward quickly, but he considers that a RAID-style model is not the way of achieving this.[60]

20.70 The best place for someone with severe injuries to be treated is in hospital. The quicker they get there, the better. Sometimes, it will be necessary for that person to receive treatment at the scene to enable them to survive to hospital. First responder interventions, namely haemorrhage control and airway opening,[61] may suffice and most people can be trained to do those.[62] I will turn to that issue in further detail at paragraphs 20.149 to 20.159. However, more sophisticated treatments may be required, such as bridging interventions like chest decompressions or gaining intravenous access to provide analgesia, and these must be done by a healthcare professional.[63]

20.71 Sometimes, the patient will not survive to hospital unless given enhanced care interventions at the scene.[64] Such interventions typically involve addressing internal bleeding. They include the use of advanced techniques such as chest decompressions and thoracotomy. These can be carried out only by those with a high level of skill and training, normally consultants in pre-hospital emergency medicine.[65]

20.72 Accordingly, it is clear that, if all of those capable of surviving a mass casualty incident are to be given the greatest chance of doing so, clinicians able to provide all three levels of intervention must reach them urgently. On the evidence I heard, the adoption of a RAID-style model is not necessarily the solution. However, I am not satisfied that we have reached the stage in the UK at which such an approach should be discounted altogether.

[59] 192/232/2-19
[60] 192/232/2-233/14
[61] 191/99/11-101/5
[62] 192/1/20-24
[63] 192/2/18-3/18
[64] 192/22/13-23/21
[65] 192/24/2-9

20.73 Lieutenant Colonel Park considered that a RAID-style model was worthy of further examination[66] and John Lawrie agreed.[67] It was clear to me that CI Thomas was dubious but accepted that further consideration might be of value.[68]

20.74 Given the very considerable benefits that RAID brought to the response to the Bataclan attack and to other terrorist attacks in France, I consider that this model, or parts of it, should not be rejected until more work has been done. For example, while I accept that it will not be feasible to embed doctors in all Armed Response Vehicle teams, and while it is unlikely to be appropriate to embed doctors in all CTSFO teams, there may be value in doctors being embedded in one or the other type of team in some locations or on some occasions. As is perfectly obvious, some locations and/or occasions may represent more attractive targets for terrorists.

20.75 I recommend that CTPHQ 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 if so, how that could be achieved. CTPHQ should also review the experience of other jurisdictions that embed medics with police firearms officers, such as 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.

Alternatives to embedding doctors with police firearms officers

20.76 I recognise that the result of that further consideration may be that a decision is made that doctors should not be embedded with police firearms teams. It is therefore necessary to consider other ways in which a consultant-led response to a terrorist attack can be achieved. Two proposals were explored in the evidence, which merit consideration.

20.77 First, around the country, a number of air ambulance organisations operate. Most within England are charities and the extent to which they have links to the NHS varies between the organisations. In Wales and Scotland, air ambulance services are entirely state-funded.[69] The air ambulance organisations form part of the UK's frontline emergency response service, providing life-saving treatment to those in urgent need of pre-hospital emergency medicine.

20.78 I understand that most of these organisations provide a consultant-led pre-hospital emergency medicine response rapidly, either by helicopter or, where more appropriate, by rapid-response car.[70] Most are therefore able to provide the three levels of intervention to which I have referred, namely

66 192/66/16-70/11
67 188/74/9-75/10 [restricted], 188/83/6-8 [restricted]
68 191/35/2-5 [restricted]
69 190/121/22-122/12
70 190/90/24-91/13, 190/105/20-24

first responder interventions, bridging interventions and enhanced care interventions. These interventions are the ones that will save the greatest number of lives in a mass casualty situation.

20.79 Many witnesses considered that air ambulance organisations have a role to play in narrowing the Care Gap in a mass casualty situation resulting from a terrorist attack. Those witnesses included Dr Andrew Curran, Medical Director of the North West Air Ambulance Charity,[71] Dr Thomas Hurst, Medical Director of London's Air Ambulance Charity,[72] Dr Gareth Davies, who has been responsible for the medical governance of a number of air ambulance organisations, including London's Air Ambulance Charity,[73] and Lieutenant Colonel Park, who has considerable experience of a number of air ambulance operations.[74] They represented a body of opinion with considerable experience and authority on the point.

20.80 Dr Hurst was unequivocal: air ambulance organisations have a valuable role to play in a situation such as that which occurred on 22nd May 2017. That role includes, he considers, both providing life-saving interventions to casualties and providing leadership and advice to the ambulance personnel present at the scene.[75] Lieutenant Colonel Park further explained the value of air ambulances and those who staff them. She described how they *"add a very significant decision-making capability on scene, are less likely to be overwhelmed by the critically injured patient, and are used to dealing with multiple seriously injured patients simultaneously and making rapid decisions during evolving events"*.[76]

20.81 I accept this evidence. I also accept that, for air ambulance operations to make the contribution that they plainly are capable of making in the aftermath of a terrorist attack, and, indeed, to any mass casualty incident, some things need to change.

20.82 Dr Curran explained that air ambulance provision is not available 24 hours each day in every part of the UK.[77] He considers that this is inequitable and that there should be 24-hour pre-hospital emergency medicine provision in all parts of the country.[78] Dr Hurst agreed.[79]

20.83 Witnesses generally made clear that air ambulance personnel, with some exceptions, are not usually trained in entering or equipped to enter the zones of greatest danger in the event of an Operation Plato incident.[80] If they are to

[71] INQ042646
[72] INQ042684, 190/89/8-17
[73] INQ042597, 192/123/15-124/7, 192/140/2-141/3
[74] INQ042598, 192/32/24-37/6
[75] 190/96/4-97/6
[76] INQ042598/13 at paragraph 75
[77] INQ042646/3 at paragraph 10
[78] INQ042646/3 at paragraph 14
[79] 190/95/4-96/8
[80] 192/86/13-87/9, INQ042684/2 at paragraph 7

perform this role, they will require training and equipment. They would have to be trained with the other emergency services that will deploy in response to a terrorist incident.

20.84 I was impressed by the dedication and resourcefulness of those who staff the air ambulances in this country. Most in England are charitable organisations, but they all have a potentially important role to play in the response to a terrorist attack. They are capable of providing the kind of rapid consultant-led response that will be needed. Lieutenant Colonel Park explained that London's Air Ambulance had deployed in the emergency response to the terrorist attack at Fishmongers' Hall on 29th November 2019 and had been able to make a significant contribution.[81] That evidence supported me in my view about the potential value of this resource.

20.85 I recommend that DHSC, NHS, NARU, ambulance service trusts, Air Ambulances UK, CTPHQ and JESIP consider how air ambulance organisations might be integrated into the emergency response to a terrorist attack. I further recommend that those organisations consider what training and resources would be required to integrate air ambulance organisations into the emergency response to a terrorist attack. I regard these as potentially important improvements in the emergency response to a terrorist attack and work needs to be done to achieve them urgently.

20.86 Second, it was explained to me that it is possible to train some HART operatives up to the level of providing bridging interventions.[82] However, it is unlikely that they could be trained to provide complex interventions such as the use of a thoracotomy.[83] Such training would not provide a complete solution to the problem. Despite that fact, this is an issue worth considering.

20.87 DHSC and NARU should consider further training of HART personnel so that at least one member on every HART deployment has the ability to deliver most enhanced care interventions.

Evacuation to hospital

20.88 In dealing with the approach of RAID in France, I explained that the focus is on the quickest evacuation from the scene to hospital at the expense of treatment, unless that treatment is necessary to enable the casualty to reach hospital alive.

20.89 The current system within the UK ambulance services is based heavily on the idea that triage will take place a number of times and in different places. At its most basic, our current model involves primary triage. This is also known as

[81] 192/33/15-34/4, 192/44/21-45/7

[82] 192/228/16-231/20

[83] 192/229/18-231/21

'triage sieve'. Primary triage will take place where the casualty is located or at the Casualty Collection Point. It will be followed by secondary triage, or 'triage sort', at some safer location, usually the Casualty Clearing Station.[84]

20.90 Primary triage involves the casualty being given a designation from P1, the most seriously injured, to P3, walking wounded. Treatment should be given only if vital to save life: for example, the application of a tourniquet to stem catastrophic bleeding or the opening of an airway.[85] Those who have died should also be identified during this process.[86] Secondary triage involves the reassessment of the casualty using a more sophisticated method of observation and the application of a wider range of treatments.[87] All of this occurs before the casualty is even in an ambulance. The events of the Attack demonstrate that this process may cause significant delays in casualties arriving at hospital.

20.91 Some countries take a different approach and have a much stronger emphasis on the rapid evacuation of casualties to hospital. France falls into that category.[88] At least one other country has an even stronger focus on evacuation: prioritising the extraction of casualties without delay and with no deference to zoning.[89]

20.92 This is a complicated issue. The evidence I heard does not provide a complete answer. The emphasis in the UK is on ensuring that there are no hold-ups when a casualty arrives at hospital. There was a detailed system in Manchester to ensure that casualties arrived at the most suitable hospital for their treatment and that the hospitals had time to prepare for their arrival. In almost every case, this system as designed worked well on the night of the Attack.

20.93 Arrival at the most suitable hospital is, however, different from arriving at that hospital at an appropriate time. On 22nd May 2017, there were lengthy delays in some casualties arriving at hospital. It may be that other countries deal with the evacuation of casualties to hospital more effectively than the UK does, with their emphasis being on getting casualties to hospital, using whatever vehicles are available, as soon as possible rather than waiting until hospitals are ready.

20.94 One practice that I was told about concerned me. It was explained to me that more ambulances than there were casualties requiring transportation to hospital were needed at a scene before transportation could take place. This is because when the first ambulances arrive at the scene of a Major Incident, all of the paramedics are required to leave their ambulances and go to assist with treating casualties in the Casualty Clearing Station. That leaves no one to drive or look after patients on the journey to hospital: the ambulances remain empty and parked. It is necessary to wait for further ambulances containing paramedics

[84] 144/134/18-137/25
[85] 144/136/22-137/4, 68/99/16-100/8
[86] 110/38/1-12
[87] 144/137/5-7
[88] 191/18/4-20/3
[89] 188/58/8-60/13 [restricted]

who are not required to assist in the Casualty Clearing Station to arrive before any patient can be moved to hospital. If none of the ambulances is double-crewed, it will take more ambulances to arrive before transportation begins.

20.95 This does not seem to me to be a satisfactory system, as it builds in additional delay. This delay is made even more severe when ambulance services around the country are already running at, or beyond, their full capacity and it may take a very long time for sufficient additional ambulances to arrive. In evidence I explored whether it were possible for other people, such as police officers, to drive ambulances to reduce the number of paramedics required. I was told that this was not possible, but it seems to me that there must be a workable solution to this problem.

20.96 In the circumstances, I recommend that DHSC, the Faculty of Pre-Hospital Care, the College of Paramedics and NARU review the current model 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.

Early scene triage tool

20.97 Philip Cowburn has expertise and experience in a number of areas of relevance to the Care Gap. He is a long-serving consultant in emergency medicine at a busy inner-city emergency department and trauma Team Leader at a major regional trauma centre. He was involved in setting up and developing the Great Western Air Ambulance Charity and has been Acute Care Medical Director of a regional ambulance service for over ten years. He was actively involved in the development, education and governance of HART and now oversees the medical component of those teams from a national perspective. He has worked as medical adviser and clinical governance lead to specialist police teams within the South West for 15 years. He has been Medical Advisor to NARU since 2021.[90]

20.98 At paragraph 20.90, I explained the existing approach to triage. Philip Cowburn told me in evidence that many clinicians in his area of practice had developed a concern that these existing triage tools were *"slow and cumbersome"*.[91] What was required, they considered, particularly in a mass casualty situation, was something that was very rapidly deployable.[92]

20.99 NHS England oversees the budgeting, planning, delivery and day-to-day operation of the commissioning side of the NHS in England. Part of NHS England's role involves ensuring that the NHS is properly prepared for dealing with an emergency. NHS England developed the Emergency Preparedness,

[90] 192/214/17-219/5

[91] 192/219/13-25

[92] 192/219/25-220/2

Resilience and Response Framework to provide a structure within which all NHS-funded organisations could meet the requirements of the Civil Contingencies Act 2004, among other requirements.[93]

20.100 As part of that work, NHS England established a group to consider whether a fresh approach to triage was needed. That was a sensible step. Philip Cowburn was appointed to lead this group. Lieutenant Colonel Park is a member of the group and also gave evidence to me about its work.[94] The group has benefited from contributions from experienced military and civilian clinicians in pre-hospital and Major Incident management and from academic experts in the field.[95]

20.101 When Philip Cowburn gave evidence to the Inquiry, he explained that an early scene triage tool had emerged from the work of his group. This was described by him as a simple concept, designed to enable the identification, at speed and by people under stress, of those casualties whose lives are truly at risk. Its purpose is to improve upon and replace primary triage.[96]

20.102 Lieutenant Colonel Park explained in evidence that this tool is based on six main principles: it is simple to use; it prioritises the use of first responder interventions, namely haemorrhage control and airway opening; it removes the requirement to take physiological measurements; it prioritises those with penetrating torso trauma for early evacuation; it does not allow any person other than a healthcare professional to label a casualty as dead; and it involves a straightforward system for the tagging of casualties involving the use of coloured cards to provide visible identification of the priority of patients.[97]

20.103 The evidence I heard about what happened in the City Room left me in no doubt that effective triage is vital in a mass casualty situation. It will narrow the Care Gap. That is for the obvious reason that in such circumstances there will be patients who will die unless treated promptly, and others, although in need of treatment, whose survival is not at immediate risk. The early identification of the time-critical casualties will enable effective prioritisation. It will make sure that those who need treatment urgently receive it.

20.104 On hearing the evidence, I regarded the development of the early scene triage tool as significant. That was particularly so because it was explained to me that the intention is that this tool be used by all first responders, not just paramedics.[98]

93 13/2/20-4/3
94 192/47/5-54/20
95 INQ042789/6-7
96 192/219/19-221/20
97 192/52/15-53/21
98 192/54/4-55/7, 192/220/22-221/20

20.105 At the time when he gave evidence, Philip Cowburn's expectation was that major progress would be made in relation to the development of this tool during 2022. In fact, progress was expected both in relation to the early scene triage tool and in relation to the issue of triage more generally.[99]

20.106 As a result, in July 2022, I sought an update from Philip Cowburn.

20.107 Philip Cowburn provided me with a comprehensive report in writing on 3rd August 2022. This sets out a proposal for major change in the approach to triage at the scene of a Major Incident.[100]

20.108 A concept called the Major Incident Triage Tool has been devised. This tool, which will be known as MITT, was field-tested in August 2021. The testing used both quantitative gauges and qualitative gauges. The former involved identifying how long triage had taken. The latter involved asking what those who had used the new tool in the field test thought of it. MITT proved to be superior to the existing system for triage on both gauges. It is proposed that MITT entirely replace the existing approach of primary and secondary triage. That proposal has the support of NHS England.[101]

20.109 While Philip Cowburn's group regarded MITT as a significant improvement on the existing procedures, the group identified an additional need. In the event of a mass casualty situation, there was a risk of responders being overwhelmed by the sheer number of casualties that they needed to triage. What was needed, the group concluded, was an additional tool that was capable of being applied rapidly and by a broader range of responders in a mass casualty situation.[102] This is the early scene triage tool that Philip Cowburn explained was under development at the time when he gave evidence.

20.110 Work has progressed since then. What the group has now devised is both quick and easy to use. It is designed to provide an element of control and structure to the inevitable confusion that will ensue in the early stages of a Major Incident. Importantly, it can be used by any responder with the ability to provide first responder interventions, not just the staff of an ambulance service.[103]

20.111 Based on the material currently available, it appears to me that Philip Cowburn's group has identified a triage tool that allows the rapid assessment of multiple casualties, while prioritising life-saving interventions. Those interventions are ones that must be delivered quickly to maximise the survival of critically injured patients. The working title of this new tool is 'Ten Second Triage'. If that name endures, it will be known as TST.[104]

99 192/222/20-224/8
100 INQ042789
101 INQ042789/5-6
102 INQ042789/6
103 INQ042789/7
104 INQ042789/9

20.112 If all first responders present in the City Room on the night of the Attack had been trained in TST, it would have made a difference. Triage would have been much more efficient.

20.113 The early indications are that TST has the support of the representative bodies of the ambulance service, police, fire and rescue service, and military. By the time Volume 2 of my Report is published, a field test based around a terrorist attack will have been undertaken in relation to TST. As part of that field test, the relationship between MITT and TST will be assessed. I cannot prejudge the outcome of that field test, but it is important that, once the field test has concluded, NARU and the representative bodies of the other emergency services should analyse what has been learned as quickly as possible and implement change swiftly.[105]

20.114 The work of Philip Cowburn's group has been guided by experts in the field. It has been undertaken to a standard of excellence. Philip Cowburn's report to me indicates that the emergency services have expressed a commitment to implementing MITT and TST.

20.115 I recommend that the representative bodies of the emergency services review the proposals of Philip Cowburn's group urgently and, in the event that they agree that they represent an improvement on the existing approach to triage, implement them as soon as possible. The bodies to whom I direct this recommendation are: the College of Policing, the College of Paramedics, the Fire Service College, the National Police Chiefs' Council, the National Ambulance Resilience Unit and the National Fire Chiefs Council and also, given its oversight role, the Home Office.

[105] INQ042789/9

Other matters relating to treatment

Introduction

20.116 As I have explained, a number of issues were raised during the evidence that do not strictly fit into either narrowing the gap or filling the gap. Instead, they relate to the treatment of those injured in a mass casualty incident.

20.117 Those issues are: analgesia; blood; freeze-dried plasma; and TXA. It is convenient to deal with them at this point in my Report before turning to the steps that need to be taken to fill the Care Gap: in other words, the steps that need to be taken to empower those who happen to become caught up in the aftermath of a terrorist attack.

Analgesia

20.118 Lea Vaughan was one of two HART operatives who entered the City Room during the critical period of the response.[106] Following the Attack, she prepared a PowerPoint presentation. The purpose of this was to provide training, although no such training was in fact provided.[107]

20.119 In a section of the presentation headed *"Problems faced"*,[108] she identified an issue that was subsequently explored at various stages in the evidence. Lea Vaughan confirmed that no analgesia was provided to those in the City Room. She considered that it would have been highly desirable to have been able to give analgesia to casualties, but she explained that, once given, it requires the casualty then to be monitored. This prevents the paramedic from moving on to another patient.[109] In other words, the provision of analgesia causes delay.

20.120 Christopher Hargreaves, the HART operative who entered the City Room with Lea Vaughan, echoed her views.[110]

20.121 Both HART operatives considered that steps need to be taken to identify a form of analgesia that can be given to casualties in a situation like the one that existed in the City Room. That analgesia must not delay the work of paramedics in dealing with others.

20.122 Lieutenant Colonel Park had a clear and well-informed view about this issue. She explained that, where a casualty is gravely injured, analgesia has a number of benefits. Relieving pain has its own humanitarian value, but it also assists in evacuating casualties who might otherwise not be able to be moved. There is a further way in which pain relief can assist. Splinting a limb and applying traction

106 INQ035612/258-259
107 79/15/4-17/22
108 INQ022850/12
109 79/36/3-24
110 112/183/18-184/22

can reduce bleeding. However, these can be very painful processes. Providing adequate pain relief enables these processes to happen when otherwise they might not be possible.[111]

20.123 Lieutenant Colonel Park recognised the difficulty with administering intravenous analgesia as described by Lea Vaughan but explained that the British Army had found a solution. All soldiers now deploy with fentanyl lozenges, which are sometimes called fentanyl lollipops.[112] Fentanyl is a strong opioid painkiller, used to treat severe pain, even in children. Lieutenant Colonel Park described lozenges that simply dissolve in the patient's mouth. Studies in the US military and also within London's Air Ambulance have found fentanyl lozenges to be practical and safe and to provide effective pain relief even for those with extremely serious injuries.[113]

20.124 The British Army is able to provide fentanyl lozenges to its soldiers because of a dispensation within the regulatory framework. No such dispensation exists for ambulance services; not even HART operatives are able to deploy with fentanyl lozenges.[114] It was clear to me that Lieutenant Colonel Park regarded that situation as anomalous, as did Philip Cowburn.

20.125 Philip Cowburn explained that the inability of those in civilian practice to use fentanyl lozenges was a *"massive hindrance"* in dealing with a mass casualty incident.[115] In writing following his evidence, he expressed the view that fentanyl lozenges or sufentanil sublingual tablets are ideal for mass casualty situations. They are rapidly absorbed, they can be self-administered or easily given and they do not require supervision of the casualty.[116]

20.126 Philip Cowburn regards a situation in which the military can use such analgesia while paramedics and other pre-hospital care professionals cannot as incongruous and unacceptable. He considers that the current situation deprives those injured in a mass casualty incident of the safe and effective analgesia to which they are entitled.[117] I found his views and those of Lieutenant Colonel Park persuasive.

20.127 Some of those awaiting evacuation from the City Room were conscious and in severe pain. If effective pain relief can be provided to such casualties without harming their chances of survival or the overall rescue effort, it should be. Both Lieutenant Colonel Park and Philip Cowburn consider that this can be achieved and each speaks from a position of authority and experience.

111 192/21/6-16
112 192/15/4-17/2
113 192/17/3-20
114 192/17/21-18/20
115 192/231/9-13
116 INQ042711/6
117 INQ042711/6

20.128 I recommend that DHSC, the Home Office and the Medicines and Healthcare products Regulatory Agency (MHRA) give urgent consideration to whether the regulatory regime should be altered to enable this to occur. If the decision is that it should, I recommend that NARU consider urgently whether the use of fentanyl lozenges should be rolled out to all HART and other specialist operatives as part of their basic equipment and quite possibly to paramedics more generally.

Blood

20.129 Obviously, where a casualty has suffered an injury that has caused a catastrophic or heavy bleed, the priority must be to stop the bleeding. The evidence made that very clear; it is, in any event, common sense. However, as the circumstances of the Attack make clear, effective action to stop a bleed may not occur. Also, not all catastrophic haemorrhages can be easily controlled.[118] Instinctively, it would therefore seem sensible that ambulances should carry blood or blood products to replace lost volume and help maintain life until the casualty's arrival at hospital.

20.130 The evidence, however, demonstrated that, in practice, a situation in which all frontline ambulances carry blood or blood products cannot be achieved. That is so for a variety of reasons explained by a number of witnesses, all of whom agreed. Among those witnesses were Dr Timothy Smith, an Associate Medical Director of NWAS and an Enhanced Pre-Hospital Care Consultant with the North West Air Ambulance Charity,[119] Philip Cowburn of NARU[120] and Lieutenant Colonel Park.[121]

20.131 Two principal objections arise, one clinical and the other logistical.

20.132 First, the clinical objection. Pre-hospital blood transfusion is a recognised practice within the UK. However, the decision whether to administer blood is complex and is one that must usually be made by a senior doctor. Lieutenant Colonel Park told me that the decision whether or not to transfuse a patient is sometimes difficult, even for a senior clinician.[122]

20.133 It is right that some specialist paramedics are able to deal with this procedure, having received advanced training. However, it is not feasible to train all paramedics in the administration of blood replacement. Philip Cowburn explained that frontline paramedics would be likely to encounter a situation in which a patient required pre-hospital blood less than once a year.[123]

118 192/234/1-16
119 INQ042524
120 192/234/1-252/20
121 192/56/4-60/18
122 192/58/4-59/11
123 192/238/1-239/17

20.134 While I acknowledge that he was indicating a view that was not based on research, Philip Cowburn's considerable experience entitles him to express the opinion that training all such personnel would be disproportionate, particularly since there are other ways of dealing with the issue. I have already dealt in paragraphs 20.76 to 20.87 with one of the other potential ways of dealing with the issue, namely having a consultant-led clinical response to a terrorist incident. Below, in paragraphs 20.139 and 20.140, I will deal with another potential way of dealing with the issue, namely the use of freeze-dried plasma. Other witnesses agreed that it was not feasible to train all ambulance personnel or even all specialist staff in the administration of blood.[124] I accept their common view.

20.135 Second, the logistical objection. The challenges involved in the movement of blood in the pre-hospital environment are significant. It is not necessary for me to go into the detail of this, but, in simple terms, blood must be stored in particular circumstances and then heated prior to use. This requires bespoke equipment, which is expensive.[125] More importantly, it takes time to prepare.[126] Procedures are established for air ambulances to carry and transfuse blood[127] but there simply are not the resources available to scale this up so that all or most ambulances have the same capacity.[128]

20.136 Significant issues arise in relation to the traceability of blood products and also, importantly, the scale of supply. Philip Cowburn explained that blood is a precious resource and that having blood in frontline ambulances would give rise to a significant risk of wastage that might result in lives being lost in a hospital environment.[129] Dr Hurst of London's Air Ambulance Charity agreed.[130]

20.137 On the evidence, I accept that equipping all frontline ambulances, or even just all HART vehicles, with blood is not feasible.

20.138 Philip Cowburn's view was that the solution is not to equip all ambulances with blood or blood products, but instead to ensure that there exist mobile resources, such as air ambulances, that possess suitably qualified and equipped staff to transfuse blood into those patients who need it.[131] This provides a yet further reason for ensuring that a consultant-led response occurs as soon as possible. I have already recommended that ways of achieving this must be considered.

[124] INQ042524/12 at paragraph 30, 192/238/25-241/23, 192/60/12-18, 192/144/17-145/4
[125] 192/242/21-243/25
[126] 192/234/21-25
[127] 192/246/24-247/16, 192/250/23-252/20, 190/106/8-20
[128] 192/143/24-146/13
[129] 192/244/1-16, 192/246/16-23
[130] 190/106/21-107/6
[131] 192/246/16-247/16

Freeze-dried plasma

20.139 While he does not consider that HART should carry blood or blood products, Philip Cowburn believes that consideration should be given to all HART operatives carrying freeze-dried plasma.[132] Freeze-dried plasma is a solution to which water is added in order to reconstitute it. It is then warmed. While it does not carry oxygen, this plasma replaces volume and has an impact on clotting, although not to the same extent as whole blood.[133] Overall, it has the potential to benefit those who have experienced catastrophic blood loss in a mass casualty incident.

20.140 I recommend that DHSC, the Faculty of Pre-Hospital Care, the College of Paramedics and NARU consider whether all HART operatives should be deployed with freeze-dried plasma and trained on its use. This recommendation is dependent on the benefits of the use of plasma being confirmed by research. In considering this recommendation, regard should be had to the following article published online in *The Lancet Haematology* on 7th March 2022: 'Resuscitation with blood products in patients with trauma-related haemorrhagic shock receiving prehospital care (RePHILL): a multi-centre, open-label, randomised, controlled, phase 3 trial'.[134] This article addresses the benefits of the use of pre-hospital blood products generally.

Tranexamic acid

20.141 TXA is a medication that helps blood to clot. It is useful in a number of situations, including in treating blood loss caused by major trauma.[135] TXA was administered to some of those injured in the Attack.[136] It was also used in the response to the Bataclan attack.[137]

20.142 Intravenous administration of TXA may be difficult in patients lacking sufficient volume of blood. It takes approximately ten minutes to administer, during which period the paramedic must remain with the patient. That will cause delay in the treatment of other patients in a mass casualty situation. Both problems could be solved by the use of intramuscular as opposed to intravenous TXA.[138]

20.143 Philip Cowburn considered that a review should be carried out into whether frontline ambulances should carry intramuscular TXA.[139] I agree. I recommend that the review be undertaken by DHSC, the Faculty of Pre-Hospital Care, the College of Paramedics and NARU.

[132] 192/249/4-250/22
[133] 192/248/8-249/3
[134] INQ042724
[135] 161/68/14-69/6
[136] 138/120/19-25, 159/8/20-24
[137] 191/38/10-15
[138] 192/252/21-253/18, 192/259/4-260/4
[139] 192/252/21-253/6

Filling the gap

Introduction

20.144 It is inevitable that members of the public will be caught up in the aftermath of a terrorist attack. The government advice for those embroiled in such a situation is *"Run, Hide, Tell"*.[140] Run: run to a place of safety. Hide: it is better to hide than confront. Tell: tell the police by calling 999.

20.145 Nothing I say in this Part of my Report is intended to undermine that advice. However, experience from the UK and around the world demonstrates that some members of the public choose not to run and hide, but instead to remain at the scene and help. Others will run towards danger to provide their assistance. These people are sometimes known as zero responders or immediate responders.[141]

20.146 The Attack showed that people other than members of the public, such as event medical staff or unarmed police officers, will also run to the scene of a terrorist attack and that police firearms officers are likely to attend quickly.

20.147 The evidence reveals that it is vital that all of those who choose to be present in the aftermath of a terrorist attack in any of these ways are able to provide what I have referred to already as first responder interventions.

20.148 Lieutenant Colonel Park explained the concept of first responder interventions and their significance.[142] An obstructed airway or a catastrophic bleed may kill within minutes, long before professional clinical care is likely to arrive.[143] These conditions may be capable of management by the application of simple techniques, which any member of the public can be taught. In my view, there needs to be widespread education about what those techniques are. That will save lives.

Educating the public

20.149 We need to ensure that as many members of the public as possible have the skills needed to provide first responder interventions so that if they wish to provide life-saving assistance they can. I am satisfied that much work is already being done to achieve this, but more can and should be done.

20.150 The charitable sector has done extraordinary work to bring the need for better public education to the forefront. I heard from Brigadier Timothy Hodgetts.[144] Since he gave evidence, Brigadier Hodgetts has been appointed

140 INQ042678 at paragraph 7
141 188/38/17-23
142 191/99/11–101/5
143 191/98/6-9
144 68/1/24-114/12

as the Surgeon-General of the UK Armed Forces, the most senior medical officer within the armed forces, and he now holds the rank of Major General. He is also Chair of Trustees of citizenAID, a position he has held since that charity's inception.[145]

20.151 Brigadier Hodgetts explained that the aim of citizenAID is to provide the public with the knowledge to enable people both to keep safe in deliberate attack situations and to prioritise and treat the seriously injured. citizenAID is designed to empower the public to save lives in the critical minutes before the emergency services are able to attend: in other words, during the Care Gap.[146] Its work and that of other charities is invaluable. The website of citizenAID can be found at https://www.citizenaid.org/.

20.152 While I welcome the work of citizenAID and other charities in this regard, it is the state that has the primary responsibility for ensuring that members of the public have the knowledge necessary to save lives in a mass casualty incident.

20.153 I acknowledge that counter-terrorism policing has introduced its own initiative. The National Counter Terrorism Security Office has commenced work to encourage employers to train their employees to understand the basics of first aid.[147] That is to their credit, but much more needs to be done. I recommend the following.

20.154 First, the young must have the skills needed to provide life-saving interventions in a mass casualty situation. 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.[148] I agree that this is necessary. The Department for Education should ensure that it continues.

20.155 I understand that children and young people are not currently taught to deal with catastrophic bleeds or airway impairment.[149] I consider it vital that training in such matters is provided to young people. This training should be received before they leave secondary school; the earlier it can responsibly be provided, the better. The Department for Education should consider extending the National Curriculum requirement on first aid to incorporate this.

20.156 I recommend that the Department for Education give consideration to including training in all first responder interventions in the National Curriculum.

20.157 Second, until children and young people have all been educated in first responder interventions, there will be a gap. Those who have already left school may lack the necessary skills. That situation needs to be addressed. The public at large cannot be forced to undertake training in first aid interventions. However,

145 68/2/2-7
146 68/19/8-20/13
147 189/83/22-89/6
148 INQ042678/5 at paragraph 10
149 192/100/2-101/19

something needs to be done to encourage greater awareness within the general population of what can be done to save lives in situations such as the Attack and indeed more generally.

20.158 I recommend that the Home Office consider a public education programme and the introduction of a requirement into law, perhaps through regulations issued under the Health and Safety at Work etc. Act 1974, that employers have a duty to train all employees, or certain categories of employees, in first responder interventions.

20.159 I emphasise that everything that can reasonably be done to educate the general population in first responder interventions should be done.

Control rooms

20.160 The operators within control rooms are able to provide guidance to members of the public who telephone seeking assistance. For example, North West Fire Control had guidance documents providing advice relating to certain risks.[150] These documents enabled operators to provide assistance to callers confronted by building fires, incidents involving collapsed or collapsing structures, wildfires, flooding and acid attacks. Operators were encouraged to deploy this guidance by way of a series of prompts provided by their systems. That is all sensible.

20.161 As the circumstances of the Attack reveal, in the aftermath of a terrorist attack, the control rooms of all the emergency services will receive multiple calls. Control Room Operators may have a valuable contribution to make in providing guidance on first responder interventions. Such advice is capable of empowering those uninjured members of the public who choose to remain in the aftermath of a terrorist attack by providing them with the assistance they require in order to help the casualties.

20.162 I recognise that Control Room Operators working for the ambulance services already have skills and/or training in this regard, but I consider that there is value in those who work in the control rooms of all three emergency services having the ability to provide advice on basic trauma care. I recommend that the College of Policing, the Fire Service College and National Fire Chiefs Council consider devising training packages for operators within police and fire and rescue service control rooms that achieve this aim, and that DHSC and NARU take steps to ensure that the existing training for ambulance service operators is fit for this purpose.

20.163 Those who work in control rooms should not seek to subvert the government's *"Run, Hide, Tell"* message, but experience shows that many members of the public will in fact choose to stay and help. Control Room Operators are well placed to provide them with guidance.

[150] INQ042676/1 at paragraph 4

Training of unarmed police officers

20.164 I will next turn to the position of unarmed police officers. I will address the position of firearms officers at paragraphs 20.175 to 20.183.

20.165 Often, unarmed police officers will arrive at the scene of a terrorist attack before the professional clinical response. The response to the Attack is an example of that. Officers of British Transport Police (BTP) were within the Victoria Exchange Complex when the bomb was detonated.[151] Within minutes of the explosion they had rushed to the City Room, entering within about two minutes.[152] GMP officers arrived at the scene within a short time of their armed colleagues. By 22:48, GMP unarmed officers had entered the City Room.[153]

20.166 Police officers such as these should be able to provide first responder interventions, including applying a tourniquet and opening an airway. However, the evidence I heard reveals that the unarmed officers generally lacked the skills to deliver the help they desperately wanted to provide. The footage I watched from body-worn video cameras of the unarmed officers and the evidence more generally demonstrates that the officers were frustrated by their inability to do more to help.

20.167 All unarmed police officers should be trained to provide first responder interventions. I heard evidence from a series of police officers of Chief Officer rank. In light of that evidence, I believe that there has now developed an understanding that this is so.

20.168 It is not necessary for me to rehearse all the evidence I heard on this issue. I will, however, refer to the evidence of Assistant Chief Constable Iain Raphael, the Director for Operational Standards in the College of Policing.[154] The College of Policing is the body that sets the standards for policing and develops guidance and policy for policing. That involves the College setting standards for the training of police officers, including in first aid.[155]

20.169 ACC Raphael explained that the College of Policing was undertaking a review of its First Aid Learning Programme (FALP) and that there is an expectation that, from January 2023, the first aid training of all police officers will include training in first responder interventions. This will include the application of tourniquets and the opening of airways.[156] Some police services, including GMP, have improved their training in this regard ahead of the conclusion of the review.

151 INQ035612/3
152 INQ035612/14-16
153 INQ035612/112-113
154 192/165/14-17
155 192/166/1-169/22
156 192/183/13-187/24

20.170 To assist the review and with a view to ensuring that expectation becomes reality, I recommend that the Home Office and the College of Policing ensure that all newly recruited and existing police officers and all frontline police staff, such as Police Community Support Officers (PCSOs), are trained in first responder interventions. That training should be provided urgently.

20.171 The evidence I heard left me unconvinced that the amount of time allocated to first aid training under the current system is sufficient to allow for proper instruction in these new skills. Each police service must ensure that adequate time is allocated to training in this crucial topic. The Home Office and the College of Policing should regularly assess and appraise the training on first responder interventions given by each police service to ensure that it is of an appropriate quality and that adequate time is allocated to it.

20.172 I have already referred to TST, the 'Ten Second Triage' tool. Philip Cowburn and Lieutenant Colonel Park consider that this tool should be capable of use by unarmed police officers and firearms officers.[157] The aftermath of the Attack demonstrated that police officers would have benefited from training in the use of this tool. It would have enabled them to identify those in greatest need of help and to prioritise them for treatment or to direct paramedics to them, if paramedics had been there in sufficient numbers.

20.173 I recommend that the College of Policing ensure that it includes training in TST in its first aid training programme when, and if, it is adopted. This is even more important while paramedics and unarmed police officers have different views as to the degree of risk that it is acceptable to take.

20.174 I recommend that the College of Policing keep the national first aid training for all officers, including firearms officers, under continual review with a view to continuous improvement.

Firearms officers: Care Under Fire

20.175 In her evidence, Lieutenant Colonel Park explained the concept of Care Under Fire.[158] Every soldier in the British Army is taught that, when a fellow soldier is shot on the battlefield, the uninjured soldiers should return fire in order to neutralise or manage the threat, but then as soon as possible provide first responder interventions for their injured colleague.[159]

20.176 While the concept is known as Care Under Fire, it obviously applies to other situations in which a soldier is dealing with a threat. For example, it follows from the evidence I heard that where a soldier has been injured by an Improvised Explosive Device (IED), their colleagues would be expected to provide them with life-saving interventions alongside dealing with any secondary device.

[157] 192/47/22-50/24, 192/219/13-221/20

[158] 191/99/11-105/8

[159] 191/101/6-102/10

20.177 I heard evidence that police firearms officers within the UK have been trained in first responder interventions.[160] Members of Armed Response Vehicle teams will commonly respond at an early stage to a terrorist attack. On the night of the Attack, the first firearms officers had entered the Arena itself by 22:43, just over ten minutes after the explosion.[161]

20.178 The view of senior police officers is that such firearms officers should provide Care Under Fire, giving that term its broad meaning. Matthew Twist is Deputy Assistant Commissioner (DAC) within Specialist Operations, which is part of National Counter Terrorism Policing.[162] He explained that he would expect Armed Response Vehicle officers, as they sought to neutralise a threat, to be considering whether they were able to start providing care to the injured.[163] CI Thomas expressed similar views.[164]

20.179 I do not doubt that DAC Twist and CI Thomas, each of whom was experienced and expert, expressed their genuinely held views. However, on the evidence I heard, I do not believe that the firearms officers who formed Armed Response Vehicle teams on the night of the Attack had a sufficient understanding that part of their role was to provide Care Under Fire.

20.180 The firearms officers who initially attended the Arena provided no treatment to any casualty. Indeed, the only firearms officers who provided any treatment did not arrive at the scene until 23:09, 38 minutes after the explosion.[165] They helped to treat a casualty on the raised walkway at 23:12 and a casualty in the City Room at 23:25.[166] I do not criticise the firearms officers, who behaved bravely that night. Rather, I am identifying an apparent disconnect between the expectations of senior officers and the understanding on the ground.

20.181 Lieutenant Colonel Park, who is heavily involved in the training of the armed assets of the Metropolitan Police Service, confirmed that, although firearms officers are trained in basic life-saving interventions, the need to provide those interventions in the response to a terrorist incident is not well enough understood by those officers.[167] The events of the night of the Attack suggest that Lieutenant Colonel Park is right.

20.182 The capacity of firearms officers to provide first responder interventions will help to fill or shorten the Care Gap because they will generally be on the scene at a very early stage. It is important that they should understand that, having neutralised the threat or having established that there is no threat, they should where possible provide basic life-saving interventions to casualties. I do not

160 191/22/9-25/3 [restricted]
161 INQ035612/75
162 189/54/1-10
163 189/117/17-119/4, 189/126/15-128/19
164 191/56/11-24 [restricted]
165 INQ042686/1
166 INQ042686/1-3
167 191/102/11-105/8, 192/80/22-83/12

believe that this is currently adequately understood by the firearms officers on the ground. I recommend that the College of Policing and CTPHQ ensure that this important issue is urgently addressed in the training of all firearms officers.

20.183 Lieutenant Colonel Park raised the prospect that firearms officers might be deployed with analgesia.[168] She pointed out that a number of police services had been trialling methoxyflurane, a non-opioid painkiller used for the emergency relief of moderate to severe pain.[169] She stated that consideration ought to be given to rolling this out nationally.[170] Given the early stage at which firearms officers are likely to reach those most seriously injured in a terrorist incident, and given the likelihood that many they encounter will be in pain, this proposal has obvious value. The College of Policing and CTPHQ should review whether firearms officers should be deployed with and trained to use analgesia as part of providing Care Under Fire.

Training of firefighters

20.184 There was widespread agreement that firefighters have a vital role to play in the event of a terrorist attack. They have particular skills in the evacuation of casualties and those skills need to be maintained. They also have first aid skills. I consider that they should be trained to provide first responder interventions. This particularly applies to the specialist resources of the fire and rescue services who may be deployed forward in an Operation Plato situation. But, as with the police, this should also be the position with all firefighters. The National Fire Chiefs Council expressed the view that this was necessary.[171] I agree.

20.185 I recommend that the National Fire Chiefs Council and the Fire Service College take steps to devise a training scheme that educates all firefighters in first responder interventions. The National Fire Chiefs Council and the Fire Service College should ensure that the training scheme is implemented first to specialist responders, then to all other firefighters. This should be applied nationally. Finally, the National Fire Chiefs Council and the Fire Service College may find it helpful to consult with the College of Policing when considering the scheme since it is apparent that the College of Policing has already undertaken a good deal of work in relation to this issue as part of its review.

20.186 Philip Cowburn and Lieutenant Colonel Park considered that TST should also be capable of being used by firefighters.[172] There is no doubt that there will, in the future, be situations in which casualties would benefit from firefighters having the knowledge that this tool would give them. Accordingly, I recommend that the National Fire Chiefs Council and the Fire Service College consider including training in this tool in its first aid training programme.

168 192/19/3-9
169 192/19/11-15
170 192/19/11-21/5
171 189/149/16-152/17
172 192/54/4-55/2, 192/219/13-221/20

Training of event staff licensed by the Security Industry Authority

20.187 Many events will require the presence of stewards and other security staff and some of those personnel will require a licence issued by the Security Industry Authority (SIA). That body is the subject of examination and recommendations in Parts 3 and 8, respectively, of Volume 1 of my Report.

20.188 Not every member of security personnel is required to be registered by the SIA, so no recommendation I make to the SIA can ensure that every such member of staff is trained in first responder interventions. However, every single additional person who has the necessary skills is capable of making a difference. I consider that all SIA staff should have those skills.

20.189 I recommend that the SIA take steps urgently to devise a training scheme in first responder interventions that educates all of those licensed with it, both existing licensees and applicants for a licence. The SIA may find it helpful to consult with the College of Policing in this, since it is apparent that the College has already undertaken a good deal of work in this regard. I also recommend that the SIA take steps to encourage the security industry generally to ensure that even those members of staff who do not require an SIA licence develop skills in basic trauma care.

20.190 The Home Office has a working group with the SIA.[173] I recommend that the Home Office take the action available to it to ensure that all of those licensed or to be licensed by the SIA have appropriate first aid training as I have described it.

Event healthcare services

20.191 This section can be dealt with briefly because, although important, there was widespread agreement across all Core Participants about what was required.

20.192 In Part 16 in Volume 2-I, I set out why the provision of event healthcare services at the Arena on 22nd May 2017 was inadequate. I have little doubt that such serious shortcomings occurred elsewhere at other venues. I fear that they continue to happen. At least in part, they were and are the result of inadequate regulation by the state. That needs to be remedied.

20.193 There should be regulation that addresses the following.

20.194 First, a standard should be set for the level of event healthcare services that are required for any particular event. The evidence does not enable me to state what that standard should be, but the standard will inevitably have regard to the size of the crowd likely to attend an event and the profile of the event.

[173] 188/100/13-101/21

20.195 I recommend that DHSC consider what that standard should be. I do not consider that it is a standard that should be contained only within guidance. Serious consideration should be given to putting it on a statutory footing. The consequences of failing to meet the standard could be fatal.

20.196 Second, the standard should be capable of enforcement by a regulator. The Care Quality Commission (CQC) is the principal regulator of the health and social care sector. Clear and compelling evidence was given by Dr Edward Baker, the Chief Inspector of Hospitals at the CQC.[174] He stated that the CQC considers that it is the appropriate body to regulate this area of activity.[175] The CQC has made this point to DHSC in plain terms, but there have been delays in implementing the necessary changes.[176] In my view, these changes should happen urgently.

20.197 I recommend that DHSC give urgent consideration to making the necessary changes in the law so as to enable the CQC to carry out the work it wishes to undertake in this important area.

20.198 Third, regulation of this area should have teeth. Those who provide event healthcare services may be responsible for the lives of very many people. If they breach the standard of services that the state decides to impose, there is a strong argument that there should be both civil and criminal consequences.

20.199 I recommend that DHSC consider, together with the CQC, whether the consequence of breaching the standard of provision for event healthcare services should be penal, including the possible imposition of custodial sentences.

20.200 All of these matters should be considered as a matter of urgency.

20.201 I recognise that some time is going to pass before the change I recommend is implemented. In the meantime, the licensing regime has a role to play. I acknowledge that this is not a complete answer because not all venues will be subject to licensing requirements. Even where they are, changing existing licences is not straightforward.

20.202 I recommend that the Department for Levelling Up, Housing and Communities 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 to meet existing conditions.

[174] 190/125/3-11

[175] 190/127/6-15, 190/131/23-132/5

[176] 190/133/11-135/18

Ambulance Liaison Officer

20.203 Jeremy Cowen is an Emergency Planning Officer with the Northern Ireland Ambulance Service. He has a special interest in event and venue safety, and experience and expertise in that area. He provided a witness statement to the Inquiry.[177] It contains his informed views about how the Care Gap should be addressed. I am grateful to him for the valuable contribution he has made to the Inquiry's work.

20.204 Among Jeremy Cowen's suggestions was that, where a particular risk threshold for an event is reached, an Ambulance Liaison Officer should be physically present. That person will be a member of the ambulance service. In the event of a Major Incident, the Ambulance Liaison Officer should be able to gain good situational awareness quickly and therefore pass an early METHANE message. The Ambulance Liaison Officer will also be able to initiate the ambulance service's Major Incident Plan.[178]

20.205 It seems to me that the Ambulance Liaison Officer may be able to perform the role of NWAS Operational Commander until someone dedicated to that role arrives. I have no doubt that, on the night of 22nd May 2017, an Ambulance Liaison Officer would have made a valuable contribution to the emergency response.

20.206 There was considerable support for the view of Jeremy Cowen. Keith Prior made clear that NARU agreed that Ambulance Liaison Officers are capable of providing real benefit.[179] The Ambulance Service Experts agreed in principle that Ambulance Liaison Officers are a good idea.[180] I also agree.

20.207 The Ambulance Service Experts explained that work remains to be done to make sure that Ambulance Liaison Officers work in practice. In my view, two broad issues need to be addressed. First, there needs to be a mechanism by which the threshold at which an Ambulance Liaison Officer must be present at an event is identified. The most important factor will be the number of attendees, but there are likely to be other factors of relevance such as audience profile. Second, there needs to be a mechanism by which a requirement to appoint an Ambulance Liaison Officer in appropriate circumstances can be imposed on venue operators.

20.208 I recommend the following. In the first instance, DHSC and NARU should consider the scope of the role of an Ambulance Liaison Officer and issue guidance to ambulance services. The Home Office and DHSC should consider how the threshold for a requirement that an Ambulance Liaison Officer be present is to be identified.

177 INQ041868
178 INQ041868/6
179 190/40/1-41/1
180 144/71/22-76/24

20.209 If this scheme is going to work, ambulance services will need to be prepared to make members of their staff available to fill the role of Ambulance Liaison Officer. The resources of ambulance services are already stretched. The Home Office, DHSC and NARU should consider how this situation is to be resolved. It is likely, it seems to me, that venue operators will need to fund the presence of an Ambulance Liaison Officer where one is required. The Home Office should also consider how the presence of an Ambulance Liaison Officer in appropriate circumstances can be made mandatory. It may be that this should form part of the Protect Duty, which I deal with extensively in Volume 1 of my Report, or part of the regulation of event healthcare services.

Equipment

20.210 Another aspect of ensuring preparedness in the event of a terrorist attack is making sure that those who will provide assistance have the equipment they need. That applies to zero responders, to paramedics including members of HART, to police officers whether armed or unarmed, to event medical service providers and to others who may fill the Care Gap. The evidence revealed that, at the moment, there is a risk that some or all of these groups may lack the equipment they require in the event that a mass casualty incident occurs.

Public Access Trauma kits

20.211 The concept of Public Access Trauma (PAcT) first aid kits was explained by DAC Twist in his evidence.[181] The idea is that they are available in publicly accessible locations and contain the equipment that would be required to provide first responder interventions. The kits also provide basic instructions. They are designed for ready use, even by untrained members of the public.[182] These are plainly an excellent idea.

20.212 CTPHQ has been working with others, including charities, to promote these kits. I commend both CTPHQ and the charities for that work, but so important is this equipment that more needs to be done.

20.213 I recommend that DHSC consider the equipment that ought to be included within a PAcT kit. It is not clear to me that the CTPHQ kit necessarily contains all the equipment that might be used by a zero responder to carry out first responder interventions. In particular, while it does contain tourniquets and instructions, it is not clear to me that it contains instructions and equipment to enable an airway to be opened.

[181] 189/84/5-89/6, INQ042442

[182] 189/86/4-87/6

20.214 Brigadier Hodgetts described a *"grab bag"* that citizenAID makes available.[183] While he was envisaging something that might be used by the organiser of an event as opposed to a member of the public, he described things such as a stretcher that might usefully be included.[184] The contents of PAcT kits need to be given further consideration.

20.215 I recommend that the Home Office and DHSC consider how a situation is to be achieved in which PAcT kits are available in all locations in which they are most likely to be needed. It may be that this is something that can be addressed as part of the Protect Duty, or alternatively as part of the work that I have recommended DHSC undertake to ensure that there is an appropriate standard imposed on those who provide event healthcare services.

20.216 Ultimately, how this is to be achieved is a matter for government. But it is clearly a matter of importance. I do recognise the difficulties in balancing the need for public accessibility against the risks of theft or vandalism which sadly exist. Such risks will need to be accommodated in the government's plans, but my expectation is that such issues will have arisen in many other contexts, such as publicly available defibrillators and emergency throwlines, and solutions may be available.

20.217 Connected with PAcT kits, which allow equipment to be available permanently within publicly accessible locations, DAC Twist raised the concept of *"drop bags"*.[185] These are, as I understood it, essentially the same as PAcT kits, but they are designed to be carried by members of Armed Response Vehicle teams and dropped as they enter the scene of a terrorist attack. The aim is that they will then be used by members of the public in the same way as PAcT kits. NARU supports their introduction[186] and I agree that they are a good idea. DAC Twist explained that they are already in use in a number of police service areas, with full implementation expected by 1st October 2022.[187] I hope very much that implementation by that date will be achieved.

Hazardous Area Response Team equipment

20.218 As I have explained, Lieutenant Colonel Park described treatments called *"bridging interventions"*.[188] These are interventions that a member of the public would not be able to perform.[189] They require specialist skills and equipment. They involve the splinting and carrying out of traction on broken limbs.[190] This is an important procedure because it reduces the casualty's pain, enabling them to be moved, and also because it reduces bleeding, which can cause death.[191]

183 68/71/22-72/21
184 68/72/3-5
185 189/89/7-90/11
186 190/39/10-15
187 189/89/15-25
188 192/2/22-3/18
189 192/2/15-21
190 192/3/11-14
191 192/3/21-4/10

20.219 Lieutenant Colonel Park explained that members of HART would not commonly take into hazardous areas equipment that enables them to carry out bridging interventions.[192] It was her view that consideration should be given to the specialist resources of ambulance services carrying such equipment into those zones.[193] I agree. I recommend that DHSC, the Faculty of Pre-Hospital Care, the College of Paramedics and NARU 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.

Stretchers

20.220 Once triage and any treatment needed for immediate life-saving purposes, such as the application of a tourniquet or airway release, has been undertaken, casualties need to be evacuated. The means by which this is done is relevant both to the speed at which it will occur and to the safety and comfort of the casualty. What happened on the night of the Attack was unacceptable, with casualties carried away from the City Room on unstable advertising hoardings. The Home Office, DHSC, 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 number are always available for use by the emergency services and in appropriate locations in the event of a mass casualty incident.

20.221 In 2019, Dr Langlois and colleagues in France carried out an assessment of the types of stretcher that best enable rapid extraction of casualties in mass casualty incidents.[194] The results of that analysis are informative. They are publicly available and should be read by all of those who may have responsibility for the response to any mass casualty incident, including a terrorist attack.

20.222 The technology may have moved on since the work of Dr Langlois and his colleagues, and, in any event, different types of stretcher may be appropriate to different kinds of environments. I consider that work ought to be undertaken in the UK in order to identify the type of stretcher that is of greatest utility in the event of a mass casualty incident. That work should be undertaken by DHSC, with input from other bodies as DHSC considers appropriate. The product of that research should be rolled out to all those with responsibility for the response to a mass casualty incident, including a terrorist attack, whether in the public or private sector.

[192] 192/11/16-24

[193] 192/11/25-13/21

[194] INQ042572

Part 21
Volume 2 conclusions and recommendations

21.1 There are three sections to Part 21. The first section will set out my overall conclusions. These are drawn from across Volume 2. The second section will list my Recommendations. The third will identify my approach to monitoring the progress of particular Recommendations I make in Volume 2 (Monitored Recommendations).

21.2 The Monitored Recommendations are all in areas where substantial progress can be made during the period I have set for monitoring them.

21.3 The fact that I have not listed a Recommendation as a Monitored Recommendation does not mean that it should not be the subject of prompt attention. There is a great deal of work that needs to be done to address the issues I have identified, which include systemic issues. All those with a responsibility to keep the public safe need to address areas for improvement as a matter of urgency.

Conclusions

21.4 As I said in the Preface to this Volume of my Report, in the immediate aftermath of the Attack on 22nd May 2017 there were heroic acts by numerous people. These were members of the public who were in or around the Arena; people who worked at the Arena or in the Victoria Exchange Complex; and members of the emergency services who went into the City Room in the early stages. These people ignored the risks to their own safety to try to do what they could to help the dying and the injured. They had no protective clothing but they went into the City Room, even though they must have realised that they were putting themselves at risk in doing so. Those acts were acknowledged by me during the Inquiry and I do so again now in this conclusion. Everyone who heard the evidence has great respect and admiration for the people who acted so bravely.

21.5 While not overlooking those acts, I have inevitably been concerned with determining what went wrong and why things went wrong, and making recommendations to try to ensure that they do not go wrong again.

21.6 The evidence I have heard revealed that a great deal went wrong in the emergency response to the Attack on 22nd May 2017.

21.7 Previous tragedies had not resulted in necessary change being implemented. Each of the emergency services had drawn up plans. Those plans had been created with the intention of ensuring that people affected by a terrorist attack would receive the greatest possible assistance. However, on 22nd May 2017, those plans were not known by everyone who should have known about them. Many of those who did respond to the explosion, the non-specialists, had little or no knowledge of the plans that had been devised. But when the plans were known about, they were not always as clear as they might have been. And when they were clear, they were not always properly understood. And when they were known and understood, they were not always put into practice.

21.8 Some of the failures that occurred in the emergency response were down to mistakes made by individuals. It is understandable that individuals under the immense pressure and stress that a terrible incident such as a bombing creates will make mistakes. It is all the more important in those circumstances that there are checks and balances in place. These will ensure that all the things that need to be done have been done, and that the right decisions have been made.

21.9 The almost universal response from senior commanders during the Inquiry's oral evidence hearings was that it was not their job to ensure that their subordinates had done what they ought to have done. Again that is understandable: checking up on others takes time and may show a lack of belief in the abilities of subordinates. Nevertheless, it is necessary. In at least two of the emergency services, there were single points of failure. Had checks been made by more senior officers as they took up their position in the command structure, serious omissions could have been quickly rectified.

21.10 The response to the explosion started well. Greater Manchester Police (GMP) directed firearms officers in numbers to the site of the explosion. They were quickly able to establish that there were no armed terrorists in the City Room and, by placing armed guards on the entrances to that location, were able to ensure that none could enter. Unarmed and unprotected British Transport Police (BTP) and GMP officers were quickly on the scene doing what they could.

21.11 From that start, it ought to have been possible to get medical assistance to the injured in the City Room speedily. This would have allowed victims to be removed safely on stretchers to the station entrance; from there they could have been put into ambulances and taken to hospital, where they would have received the best treatment.

21.12 That is not what happened.

21.13 One of the most emotional and upsetting parts of the Inquiry was listening to the evidence of people in the City Room, both rescuers and the injured, who heard the sirens of the ambulances outside and expected to see paramedics arriving imminently, and then hearing of their despair when so many fewer than they reasonably expected actually arrived in the City Room. The failure of the paramedics to arrive in numbers was a terrible disappointment to the injured and the rescuers in the City Room, who did not have the skills to triage the injured and give them the life-saving medical help they might need prior to being moved. Paramedics had these skills. The injured were desperate for help, not realising that decisions that had been made meant they would not see paramedics in the City Room in the numbers hoped for and expected. I set out in Part 17 of my Report the experiences of the injured and those with the deceased in the City Room as they waited in vain for help to arrive.

21.14 Three paramedics went into the City Room to carry out triage and any life-saving interventions that had to take place before the injured were moved. No stretchers were taken from the ambulances to assist with the removal of the injured. Instead, police officers and members of Arena staff and the public carried the injured along the raised walkway and down a series of stairs to the entrance hall of the station on anything they could find. Advertising hoardings, crowd barriers and tables were used. It was a painful and unsafe way of moving the injured. On the station concourse, a treatment centre was set up where the other paramedics re-triaged and gave much-needed treatment to the injured, including stabilising them sufficiently for the trip to hospital.

21.15 The situation was undoubtedly difficult, but the evacuation of the City Room would have worked much better for everyone if there had been a more co-ordinated response. No one wanted the injured and dying to suffer more than they needed. Everyone involved in the emergency no doubt thought that they were doing their best. In some cases, and for reasons I set out in my Report, their best was not good enough.

21.16 Members of the fire and rescue services are trained to give assistance in circumstances such as those in the City Room. They would have been of great help. They have stretchers that are suitable for use in such situations. Their absence was significant, as they could have provided very substantial assistance in the safe removal of the injured from the City Room. The fact that most of the members of the other emergency services did not notice that Greater Manchester Fire and Rescue Service (GMFRS) officers were not there helping in the rescue suggests a lack of appreciation of the part that fire and rescue services can and do play. If the Joint Emergency Services Interoperability Principles (JESIP) had been fully embedded in the muscle memory of responders, that would not have happened.

21.17 The suggestion was made during the Inquiry's oral evidence hearings that the reason GMFRS did not turn up and North West Ambulance Service (NWAS) did not go into the City Room in numbers was because they were risk averse.

21.18 None of the firefighters I heard from were risk averse. Rather, I heard from a number of very angry firefighters who were ashamed of the fact that they did not get to join in the rescue. They desperately wanted to get involved. I am also satisfied that paramedics would have gone into the City Room, if asked to do so, in order to carry out their work of saving lives.

21.19 It is one thing to take risks on your own behalf, but it is quite another for a commander to send people under his or her command into a situation where they may be at risk of death or serious injury. There needs to be an assessment of that risk before others are potentially placed in danger. None of the commanders I heard from was risk averse for his or her own safety, but some were for the people who might be put at risk by carrying out their orders. All members of the emergency services take risks in the course of their work, and do so willingly, but the extent of that risk needs to be properly assessed by commanders before committing rescuers forward. Evaluating the degree of risk that is acceptable is very difficult. Detailed guidance and assistance needs to be available.

21.20 The best risk assessment is a joint risk assessment between all the emergency services that are on scene. They need to pool their knowledge. While no service is bound to accept the risk assessment of another, it is important that they listen to the views of others. Where one rescue service has more situational awareness than others, there would need to be a good reason for that assessment not to be accepted by everyone. BTP and GMP had the best situational awareness of the risk of working in the City Room as unarmed police were in there in numbers without any special protection. The GMP Operational/Bronze Commander's view was that it was safe enough for rescuers without special protection to work there. He was right, but nobody from GMP or the other emergency services asked for his opinion. Firearms officers who were present also thought it was safe enough for such rescuers to be present. Their views were not sought. The only paramedic present in the first 44 minutes thought the same.

21.21 Other inquiries, inquests and investigations have emphasised the importance of the emergency services working together to provide the best result for the injured. Detailed policies, such as JESIP, have been devised, and people trained to put them into practice.

21.22 JESIP emphasises the need for co-ordination, either by locating commanders at the same place and, if that is not possible or is still to happen, by having effective communication between all the emergency services. Manuals have been written on what is needed to make JESIP work; everyone is meant to be trained on the principles. JESIP still failed on 22nd May 2017. Commanders did not co-locate. There was no effective communication. This is not the first incident in which JESIP has failed.

21.23 At one stage during the hearing of evidence, the failures on the night and the failures in JESIP in the past led me to suggest that it should be abandoned.

21.24 However, it was the evidence from all of the witnesses at the Inquiry hearings that the application of the principles of JESIP was the best way to assist the injured and get them treated quickly. I accept that it is, in light of that evidence, but it is necessary to ensure that JESIP works in practice and not just in theory. I have made recommendations in my Report about how to achieve this. More training, more practice, and the right sort of practice, are needed. Lessons need to be learned when things go wrong in exercises or in a real emergency, and change implemented as a result. Most importantly, individual emergency services must not operate alone. They must respect and understand the contribution that can be made by other emergency services and they must respect the views of others, particularly when it comes to assessing risk.

21.25 The failure of JESIP on 22nd May 2017 meant that those who were having to make decisions assessing risk did not receive information from those who were in the best position to provide the necessary situational awareness to assess that risk. That should not have happened.

21.26 Had there been good communication and co-location on 22nd May 2017, many of the problems that did arise would not have.

21.27 The evidence heard at the Inquiry has led me to the view that necessary changes were not always identified and implemented as the result of past mistakes, partly because the debrief processes were not as effective as they might have been, and even when shortcomings were identified they were not always put right. In the Inquiry, I heard evidence of exercises where things had gone wrong that were similar to the things that went wrong on 22nd May 2017. This needs to be improved, and I have made a number of recommendations, which I hope will, if accepted, result in improvements.

21.28 There were problems with the debriefing process after 22nd May 2017. It was alarming to hear evidence that the Chief Constable of GMP had informed Lord Kerslake, during his review of the preparedness for and emergency response to the Attack, that GMP could demonstrate that Inspector Dale Sexton had notified

the other emergency services of the declaration of Operation Plato. That was incorrect. Inspector Dale Sexton had not done so. The Chief Constable was not deliberately trying to deceive Lord Kerslake; it was what he had been told. It is difficult to understand how that had happened on such a crucial issue.

21.29 What I hope was a constructive part of this Inquiry dealt with what I described as 'the Care Gap'. There will always be a time lag between the emergency having happened and the arrival of the emergency services that are able to assist the casualties. That is a critical time when lives can be lost if no action is taken to save casualties. This makes it essential that as much help as possible can be provided on site by people who are in the vicinity and prepared to help. This means that it is vital that establishments of a similar size to the Arena have a reasonable number of adequately trained and equipped medical staff on hand to give emergency care, to bridge the gap before the ambulance service and the fire and rescue service can arrive. Standards need to be laid down and enforced to ensure that this happens. There needs to be liaison between site operators and event healthcare staff and the ambulance service to co-ordinate their responses to an emergency. The in-house healthcare provision at the Arena on 22nd May 2017 was inadequate.

21.30 Police officers, who are often first on the scene, should have trauma training so that they can provide life-saving treatment and do not find themselves in the position that the unarmed officers did on 22nd May 2017. They wanted to provide assistance to casualties but they did not have the necessary training to do so. The same applies to members of the public, who found themselves wishing they had greater first aid skills. Encouragement should be given to the public generally to acquire the skills needed to help casualties who are in a life-threatening condition. The National Curriculum should include education in first responder interventions and there ought to be incentives to those who have left school to develop those skills.

21.31 I have considered in my Report whether different procedures can be adopted by the emergency services themselves to reduce the effect of the Care Gap. The emphasis in the present system is on ensuring that hospitals are ready for the patients before sending them there. I heard about other countries, such as France, where they operate a different system, aiming to get the injured to hospital as soon as possible by whatever means they can.

21.32 It is important that we do not close our eyes to new ideas. There is still much work to be done on reducing, as far as possible, the Care Gap and its consequences. The witnesses I heard giving evidence about the Care Gap were very impressive. There is a great deal of innovative thinking going into the reduction of the problems caused by the Care Gap. It is very important that the ideas coming out of the new research are considered with an open mind.

21.33 The most important issue in the Inquiry has been whether a more effective rescue effort could have saved the lives of any of those who died. I deal with that question in Part 18 of my Report and I invite readers to read that to get the full detail. As can be seen, I have concluded that one of those who died, John Atkinson, would probably have survived had the emergency response been better. In the case of Saffie-Rose Roussos, I have concluded that there was a remote possibility that she could have been saved if the rescue operation had been conducted differently. The evidence was conclusive that there was no possibility that any of the others could have survived the murderous actions of SA.

21.34 While we do need to consider whether we should move to different systems to get the injured to hospital more quickly, I accept that the draft hospital dispersal plan activated by NWAS worked well. It meant that casualties were sent to the specific hospital best equipped to deal with their particular injuries, and staff were there waiting to receive them. Despite this, I was concerned about the time it took to get patients to hospital. The evidence of the injured, who seemed to wait for a very long time in the City Room and then in the station entrance before going to hospital, was very moving and telling.

21.35 A constant criticism of some of the emergency services during this Inquiry has been that they were defensive and, rather than join in a genuine search for what went wrong, they tried to insist that everything they did was correct and, where something went wrong, to blame it on others. If criticism is unjustified, then it does not help a search for the truth simply to accept it. Conversely, it is a natural human reaction to try to avoid blame for some terrible disaster and find some explanation that excuses it, even if it puts the blame on someone else. The real test will be whether action is taken to put right what went wrong, and not just in the short term but until the terrible threat of terrorism has been eradicated.

21.36 I believe that I have got to the truth of what happened on that dreadful night. I have certainly had assistance from many clever, hardworking and motivated people to do so. I am very grateful to them all. I also hope fervently that what comes out of this Inquiry will make a difference, and I ask all those concerned with what happens next to ensure that it does.

Recommendations

21.37 I set out below the recommendations I make arising out of my investigation into the emergency response on 22nd May 2017 (the Recommendations).

21.38 Against each Recommendation I have added a cross-reference. These are mostly to paragraphs within specific Parts of Volume 2, and sometimes to statements from the Emergency Response Experts. These cross-references are intended to assist the reader, and any organisation to which the Recommendation is directed, to understand the issue the Recommendation is seeking to address. The cross-referencing is not exhaustive and each one of the Recommendations should be understood in the context of Volume 2 as a whole. All organisations should, in any event, review the whole of Volume 2 in order to identify what I consider is required of them.

Issues arising at a local level in Greater Manchester

Greater Manchester Resilience Forum

R1	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

British Transport Police

R2	British Transport Police should ensure that all its Inspectors are trained to undertake the Bronze Commander role in the event of a Major Incident.	12.98 to 12.106
R3	British Transport Police should review its procedures to ensure the prompt appointment of a Bronze Commander during a Major Incident.	12.98 to 12.106
R4	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.	12.98 to 12.106

R5	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.	12.107 to 12.113
R6	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.	12.112 to 12.113
R7	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.	19.13 to 19.42
Greater Manchester Police		
R8	Greater Manchester Police should ensure that its role cards are always immediately accessible to the officers who are to perform those roles.	12.173
R9	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.	12.200 to 12.202
R10	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

R11	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 Officer.	12.235
R12	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.	12.303 to 12.310
R13	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.	19.13 to 19.42
North West Ambulance Service		
R14	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
R15	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
R16	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
R17	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
R18	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.	12.480
R19	North West Ambulance Service should train its Operational Commanders on the appropriate practice for relieving another of command and being relieved of command.	12.480

R20	North West Ambulance Service should ensure that non-specialist ambulance personnel are involved in multi-agency exercising.	12.500
R21	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
R22	North West Ambulance Service should ensure that its commanders are adequately trained in the use of operational discretion.	14.214
R23	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
R24	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
R25	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
R26	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
R27	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
North West Fire Control		
R28	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).	12.554 12.749
R29	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.	12.602 12.749

R30	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.	12.602 12.749
R31	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.	15.407
R32	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.	15.309 to 15.315
R33	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.	15.172
R34	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.	15.210 to 15.211
R35	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.	19.13 to 19.42
Greater Manchester Fire and Rescue Service		
R36	Greater Manchester Fire and Rescue Service should ensure that its commanders are adequately trained in the use of operational discretion.	12.654 to 12.655
R37	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.	15.215 15.568

R38	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.	15.172
R39	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.	19.13 to 19.42
Counter Terrorism Policing Headquarters		
R40	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.	13.643
SMG		
R41	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.	16.30
R42	SMG should ensure that the healthcare service provider at the Arena has a strong working relationship with North West Ambulance Service.	16.74 to 16.75
R43	SMG should ensure that the healthcare service provider at the Arena has adequate staffing and skill levels for every event at that location.	16.19 to 16.22
R44	SMG should review its approach to the provision of healthcare service equipment at the Arena to ensure that adequate equipment is always available.	16.54 to 16.63

Issues arising at a national level

Joint Doctrine and Joint Operating Principles

R45	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.	20.40 to 20.45
R46	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
R47	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 Unity, individual police services and JESIP should develop a nationally agreed format for all plans, placing JESIP at their centre.	INQ042283/3

Multi-agency preparedness		
R48	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
R49	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 multi-agency exercises is effective to capture the lessons that need to be learned.	12.749 to 12.758
R50	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
R51	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
R52	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
Multi-agency communication		
R53	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

R54	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.	12.679 to 12.683 INQ042283/6
R55	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
R56	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
R57	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.	20.160 to 20.163
Planning by police services		
R58	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.	12.309 to 12.310
R59	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.	12.309 to 12.310
R60	All police services should ensure that they have robust version control arrangements in place for all plans.	INQ042283/2 12.303 to 12.310

The funding of police services		
R61	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.	12.143 to 12.148
Operation Plato		
R62	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.	12.315 to 12.316
R63	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.	INQ042283/5

R64	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.	12.362 13.585
R65	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.	12.336 to 12.347 13.486
R66	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.	13.250
Common terminology		
R67	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
R68	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.	20.46

R69	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.	20.45
R70	Those organisations should consider what changes need to be made to Major Incident plans in order to achieve those aims.	20.46
Action cards		
R71	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

Gold and Silver Control Rooms and Strategic Co-ordinating Group meetings		
R72	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.	13.505
R73	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.	INQ042283/4
Embedding medics with police firearms officers		
R74	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.	20.75
R75	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.	20.75
Role of air ambulance services		
R76	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
R77	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

Police command structure		
R78	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.	13.461 13.497 13.540
R79	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.	13.548
Use of explosives detection dogs		
R80	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.	13.359 to 13.364
Notification of pre-planned events		
R81	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.	13.491
R82	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
R83	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.	14.100

Record-keeping		
R84	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.	19.22 to 19.29
R85	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
R86	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
R87	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
R88	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
R89	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.	19.14
R90	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.	13.316

Police training and training records		
R91	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.	INQ042283/4-5
R92	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 INQ042283/4
First aid		
R93	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.	20.170 to 20.174
R94	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.	20.170 to 20.174
R95	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.	20.170 to 20.174
R96	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.	20.175 to 20.182
R97	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.	20.183

Local resilience forums at a national level		
R98	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.	INQ042283/1 12.78 to 12.81
R99	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
R100	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.	12.21 12.44 to 12.61
R101	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.	12.21 12.44 to 12.61
R102	The Home Office should consider how local resilience forums are to be funded consistently and sufficiently to enable them to do their important work.	12.39
R103	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.	12.40
R104	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.	12.74 to 12.77
Ambulance services at a national level		
Resources		
R105	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

R106	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
R107	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
Hazardous Area Response Team (HART)		
R108	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 INQ042167/9
R109	All ambulance service trusts should undertake training and exercising with neighbouring ambulance service trusts to ensure that cross-border support is efficient and effective.	INQ042167/10
R110	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.	20.26 to 20.27 14.214
R111	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

New triage tools		
R112	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
R113	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
Other matters relating to ambulance services		
R114	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.	14.101 to 14.104
R115	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
R116	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 INQ042167/6-8

R117	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
R118	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.	20.118 to 20.128
R119	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
R120	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
R121	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
R122	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
R123	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
R124	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.	INQ042167/11

R125	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 Liaison Officers		
R126	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
R127	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
R128	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
R129	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
Fire and rescue services at a national level		
R130	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.	20.184 to 20.185
R131	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.	INQ042111/6

Event healthcare services at a national level		
R132	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.	20.194 to 20.195
R133	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 law to enable the Care Quality Commission to become the regulator for this sector.	20.196 to 20.197
R134	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.	20.198 to 20.199
R135	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.	16.57
R136	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
R137	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.	20.201 to 20.202
R138	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.	16.63, 20.209 and 20.215

R139	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.	14.187 to 14.188
Security Industry Authority		
R140	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.	20.189
R141	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.	20.189
The public		
R142	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.	20.154
R143	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.	20.155 to 20.156
R144	The Home Office should consider the introduction of a public education programme to educate the public in first responder interventions.	20.158

R145	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.	20.158
Public Access Trauma kits		
R146	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.	20.213
R147	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.	20.215
Stretchers		
R148	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
R149	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

Monitored Recommendations

21.39 Of the Recommendations I have made above, I indicate below those I propose to monitor. The numbering is not intended to indicate importance or priority.

21.40 I have grouped the Volume 2 Recommendations together thematically. The effect of this is that there are Monitored Recommendations, which comprise more than one of the Recommendations I made above. This means that some reporting organisations are only expected to report back against specific Recommendations within a Monitored Recommendation. I have identified below which organisations I expect to address each Monitored Recommendation.

21.41 As I did for Volume 1, I shall take a staged approach to monitoring the Recommendations arising out of Volume 2.

21.42 First, I will require an update as to progress from those reporting against the Monitored Recommendations. This will be due approximately three months after the publication of Volume 2. Responses will be added to the Inquiry's website.

21.43 Second, I will require witness statements from named individuals within each reporting organisation. Each statement will be required approximately six months after the publication of Volume 2. The witness statements will be added to the Inquiry's website.

21.44 Third, the Solicitor to the Inquiry will inform those who made the witness statements, as well as all Core Participants, which of those witnesses I intend to hear live evidence from. I will permit a brief window for submissions to be made on this.

21.45 Fourth, I will receive live evidence from those witnesses from whom I consider I should hear. I anticipate hearing that evidence during the summer of 2023.

21.46 The Solicitor to the Inquiry will contact those organisations who are the subject of the Monitored Recommendations and provide exact dates for each stage and to assist in the identification of the individual who can provide witness evidence.

21.47 As I said in Volume 1, it should be understood that I intend to scrutinise what has been done in response to the Monitored Recommendations and use all of the powers available to me, if required, to achieve transparency and accountability.

Monitored Recommendations		Reporter
MR10	**British Transport Police** Recommendations R2, R3, R4, R5, R6, R7	• BTP
MR11	**Greater Manchester Police** Recommendations R8, R9, R10, R11, R12, R13	• GMP
MR12	**North West Ambulance Service** Recommendations R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27	• NWAS
MR13	**North West Fire Control** Recommendations R28, R29, R30, R31, R32, R33, R34, R35	• NWFC • GMFRS
MR14	**Greater Manchester Fire and Rescue Service** Recommendations R36, R37, R38, R39	• GMFRS
MR15	**SMG** Recommendations R41, R42, R43, R44	• SMG
MR16	**Operation Plato** Recommendations R62, R63, R64, R65, R66	• Home Office • College of Policing • CTPHQ
MR17	**Use of explosives detection dogs** Recommendation R80	• Home Office • HMICFRS • CTPHQ • College of Policing
MR18	**First aid** Recommendations R93, R94, R95, R96, R97	• College of Policing • Home Office • CTPHQ
MR19	**New triage tools** Recommendations R112, R113	• NARU

Monitored Recommendations		Reporter
MR20	**Other matters relating to ambulance services** Recommendations R114, R115, R116, R117, R118, R119, R120, R121, R122, R123, R124, R125	• DHSC • NARU • Faculty of Pre-Hospital Care • College of Paramedics • MHRA
MR21	**Event healthcare services at a national level** Recommendations R132, R133, R134, R135, R136, R137, R138, R139	• DHSC • CQC • DLUHC • Home Office • NARU

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Appendix 9: List of abbreviations

Organisations

ACPO	Association of Chief Police Officers
ACPO (TAM)	Association of Chief Police Officers (Terrorism and Allied Matters)
BTP	British Transport Police
CQC	Care Quality Commission
CPS	Crown Prosecution Service
CTPHQ	Counter Terrorism Policing Headquarters
CTPNW	Counter Terrorism Policing North West
DHSC	Department of Health and Social Care
DLUHC	Department for Levelling Up, Housing and Communities
ETUK	Emergency Training UK
GMFRS	Greater Manchester Fire and Rescue Service
GMP	Greater Manchester Police
GMRF	Greater Manchester Resilience Forum
HMG	Her Majesty's Government (prior to 8th September 2022)/ His Majesty's Government (from 8th September 2022)
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (prior to 8th September 2022)/His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (from 8th September 2022)
HMPPS	Her Majesty's Prison and Probation Service (prior to 8th September 2022)/His Majesty's Prison and Probation Service (from 8th September 2022)
LFB	London Fire Brigade
LFRS	Lancashire Fire and Rescue Service
MHRA	Medicines and Healthcare products Regulatory Agency
MPS	Metropolitan Police Service
NARU	National Ambulance Resilience Unit
NWAS	North West Ambulance Service
NWCTU	North West Counter Terrorist Unit
NWFC	North West Fire Control
SIA	Security Industry Authority

Individuals

SA	Salman Abedi
HA	Hashem Abedi

Ranks and roles

ACC	Assistant Chief Constable
ACSO	Assistant Commissioner Specialist Operations
CI	Chief Inspector
CTSFO	Counter Terrorist Specialist Firearms Officer
DAC	Deputy Assistant Commissioner
DC	Detective Constable
DCC	Deputy Chief Constable
DCI	Detective Chief Inspector
DCS	Detective Chief Superintendent
DI	Detective Inspector
DS	Detective Sergeant
EMT	Emergency Medical Technician
EMT-A	Emergency Medical Technicians Advanced
EMT-B	Emergency Medical Technicians Basic
FDO	Force Duty Officer
NILO	National Interagency Liaison Officer
PC	Police Constable
PCSO	Police Community Support Officer

Other

AMPDS	Advanced Medical Priority Dispatch System
CSCATTT	Command and Control; Safety; Communication; Assessment; Triage; Treatment; Transport
CT	computerised tomography
CT2	Counter-Terrorism Policing Part 2
FALP	First Aid Learning Programme
FCP	Forward Command Post
HART	Hazardous Area Response Team (NWAS)
HQ	Headquarters
IED	Improvised Explosive Device
JESIP	Joint Emergency Services Interoperability Principles
JOPs	Joint Operating Principles
MEN	Manchester Evening News
METHANE	Major Incident; Exact Location; Type of Incident; Hazards; Number of Casualties; Emergency Services (see Figure 23 in Part 11 in Volume 2-I)
MIMMS	Major Incident Medical Management and Support
MITT	Major Incident Triage Tool
PAcT	Public Access Trauma (first-aid kit)
PDA	pre-determined attendance

PPE	personal protective equipment
PTSD	post-traumatic stress disorder
RAID	Recherche, Assistance, Intervention, Dissuasion team
REBOA	resuscitative endovascular balloon occlusion of the aorta
RVP	Rendezvous Point
SOP	Standard Operating Procedure
SORT	Special Operations Response Team
TATP	triacetone triperoxide
TST	Ten Second Triage
TXA	tranexamic acid

Appendix 10: Key events in the emergency response – chronology

A10.1 In this chronology, I have recorded the key events of the emergency response on 22nd and 23rd May 2017. My intention is that this chronology will give a reader an understanding of how the different emergency services' responses developed over time and in relation to each other.

A10.2 The considerable assistance given to me by Operation Manteline has meant that many of the timings have been checked and confirmed against the evidence. There are other timings where such a check has not been possible. In relation to these, I have recorded the most likely time based upon the surrounding evidence.

Key

- British Transport Police (BTP)
- Greater Manchester Police (GMP)
- Greater Manchester Fire and Rescue Service (GMFRS)
- North West Fire Control (NWFC)
- North West Ambulance Service (NWAS)
- Emergency Training UK (ETUK)

Time	Event
22nd May 2017	
22:31	**GMP** received its first 999 call from a member of the public.[1]
22:32	**NWAS** received its first 999 call from a member of the public.[2]
	The first emergency responder, **BTP** Police Constable (PC) Jessica Bullough, entered the City Room.[3]

[1] 52/125/14-126/13, INQ023493T/19-22
[2] 52/127/22-128/11, INQ015293T
[3] 52/131/16-22, INQ035612/14

Time	Event
22nd May 2017	
22:34	The first **BTP** patrol vehicle arrived at the Victoria Exchange Complex on Station Approach.[4]
	The first **ETUK** medic, Elizabeth Woodcock, entered the City Room.[5]
	GMP Inspector Dale Sexton became aware of the Attack and simultaneously became **GMP** Tactical/Silver and Strategic/Gold Commander.[6]
	GMP Inspector Michael Smith was informed of the Attack by **GMP** Control.[7]
	NWFC received its first notification of the Attack from **GMP**.[8]
22:36	Director of **ETUK**, Ian Parry, entered the City Room.[9]
22:37	**NWAS** Control notified **NWFC** of the Attack.[10]
22:38	During the call with **GMP**, **NWFC** created an incident log which sent a pre-alert to **GMFRS** Manchester Central Fire Station.[11]
	NWAS on-call Tactical Commander Annemarie Rooney was informed of the Attack.[12]
22:39	**BTP** Force Incident Manager, Inspector Benjamin Dawson, declared a Major Incident.[13]
	GMP Temporary Superintendent Arif Nawaz (Night Silver) was informed of the Attack by **GMP** Force Duty Supervisor Ian Randall.[14]
22:40	**NWFC** informed the **GMFRS** duty National Interagency Liaison Officer (NILO), Station Manager Andrew Berry, of the Attack. Station Manager Berry instructed **NWFC** to mobilise **GMFRS** crews to Philips Park Fire Station as a muster point.[15]
	GMP Inspector Sexton granted Firearms Authority and assumed the role of Initial Tactical Firearms Commander and Strategic Firearms Commander.[16]
	NWAS Tactical Commander Annemarie Rooney telephoned **NWAS** Strategic Commander Neil Barnes to notify him of the Attack and left a voicemail message.[17]

4 52/133/21-134/7, INQ035612/21
5 52/134/10-14, INQ035612/22
6 INQ007214/8
7 102/176/21-177/13, INQ018514T/4
8 122/177/24-178/7, INQ001231/2
9 52/145/2-6, INQ035612/43
10 53/4/12-5/9, INQ001218/1
11 122/177/21-179/9, 69/133/22-134/15, INQ008376/3
12 115/114/12-20, INQ015353T
13 92/58/12-60/13, INQ002000/30
14 99/193/10-19, INQ018839T/5-6
15 53/9/14-24, INQ001198
16 INQ029021/10
17 115/14/19-16/9, INQ014791/4

Time	Event
22nd May 2017	
22:41	**NWFC** received its only 999 call from a member of the public.[18]
	First two **GMP** Armed Response Vehicles recorded on Station Approach.[19]
	BTP informed **NWAS** that it had declared a Major Incident.[20]
	NWAS Tactical Commander Annemarie Rooney informed **NWAS** Consultant Paramedic Daniel Smith of the Attack.[21]
22:42	**GMP** PC Troy Tyldesley and PC James Dalton entered the Victoria Exchange Complex. They were the first firearms officers to do so.[22]
	First **NWAS** paramedic, Patrick Ennis, arrived outside the Victoria Exchange Complex in a rapid response vehicle.[23]
22:43	**GMP** firearms officers PC Lee Moore and PC James Simpkin conducted a 'raw check' of the City Room[23]
	BTP nominated the Fishdock car park as a Rendezvous Point.[24]
	NWAS informed **BTP** that it was sending crews to Manchester Central Fire Station.[25]
22:44	**BTP** Chief Superintendent Allan Gregory was informed of the Attack by **BTP** Senior Duty Officer, Chief Inspector (CI) Antony Lodge.[26]
	GMP Operational/Bronze Commander, Inspector Michael Smith, arrived at the Victoria Exchange Complex.[27]
22:45	**NWAS** declared a Major Incident.[28]
22:46	**GMP** Operational Firearms Commander, PC Edward Richardson, entered the City Room.[29]
22:47	**GMP** Inspector Sexton declared Operation Plato.[30]
	GMP Operational/Bronze Commander, Inspector Michael Smith, entered the City Room.[31]

18 123/149/10-12, INQ001165
19 53/14/4-18, INQ035612/67
20 53/14/20-15/7, INQ028932/9-11
21 110/79/25-80/19, INQ014791/4
22 INQ035612/78, 102/85/6-22
23 76/62/14-63/8
24 74/97/1-8, INQ028932/15
25 INQ015145T
26 93/106/9-107/10
27 53/24/12-20, INQ035612/89
28 53/27/11-28/22
29 INQ035612/101-103
30 53/36/2-17, INQ024325/1
31 102/191/10-192/1, INQ035612/113

Time	Event
22nd May 2017	
22:50	**NWAS** Advanced Paramedic Patrick Ennis entered the Victoria Exchange Complex.[32] Within seconds, he informed **NWAS** Control that all ambulances should come to Hunts Bank.[33]
	GMP PC Grace Barker approached **NWAS** Advanced Paramedic Patrick Ennis and advised all **NWAS** paramedics to go to "*the booking office*".[34]
	NWAS Consultant Paramedic Daniel Smith instructed **NWAS** Control to maintain Manchester Central Fire Station as the Rendezvous Point.[35]
22:51	**GMP** Control informed **NWAS** Control that all available ambulances should go to "*Hunts Bank*".[36]
22:52	**GMP** CI Mark Dexter assumed the role of Ground Assigned Tactical Firearms Commander and agreed that **GMP** Temporary CI Rachel Buckle would become the Tactical Firearms Commander at **GMP** Headquarters (**GMP** HQ).[37]
	GMP Strategic/Gold Commander, Assistant Chief Constable (ACC) Deborah Ford, was informed of the Attack by **GMP** Tactical/Silver Commander, Temporary Superintendent Nawaz.[38]
	GMFRS duty Group Manager Dean Nankivell was informed of the Attack by **NWFC**.[39]
22:53	**NWAS** Advanced Paramedic Patrick Ennis entered the City Room for the first time.[40]
22:54	**NWAS** Advanced Paramedic Patrick Ennis sent a METHANE message to **NWAS** Control.[41]
	First **GMFRS** Manchester Central Fire Station appliance arrived at Philips Park Fire Station.[42]
	GMP Counter Terrorist Specialist Firearms Officers arrived at the Victoria Exchange Complex.[43]
22:55	First **GMP** Tactical Aid Unit of eight officers, led by Sergeant Kam Hare, entered the City Room.[44]

32 53/45/15-23, INQ035612/130
33 INQ035612/132, INQ032872T
34 76/78/10-79/12
35 INQ015056T
36 INQ015139T/1, INQ015139T/2
37 106/146/9-21
38 105/39/17-21, 104/38/20-39/8
39 INQ001224
40 INQ035612/143
41 INQ015070T
42 INQ004284/4
43 53/61/20-62/6
44 INQ035612/151, 78/46/18-49/7

Time	Event
22nd May 2017	
22:56	**BTP** Gold Commander, ACC Robin Smith, was informed of the Attack by **BTP** CI Lodge.[45]
22:57	Saffie-Rose Roussos was carried out of the City Room on a makeshift stretcher.[46]
22:58	First **NWAS** ambulance arrived at the Victoria Exchange Complex.[47]
	Saffie-Rose Roussos was carried out of the Victoria Exchange Complex onto Trinity Way.[48]
	BTP Force Incident Manager, Inspector Dawson, received a METHANE message from **BTP** Sergeant David Cawley.[49]
22:59	**NWAS** Consultant Paramedic Daniel Smith arrived at the Victoria Exchange Complex.[50]
23:00	**NWAS** Control instructed all vehicles responding to the Attack to go to Hunts Bank.[51]
23:03	**NWAS** Consultant Paramedic Daniel Smith appointed himself **NWAS** Operational Commander.[52]
23:06	Saffie-Rose Roussos was placed into **NWAS** Ambulance A344,[53] which departed from the Victoria Exchange Complex 11 minutes later.[54]
	GMFRS Group Manager Ben Levy received a pager message from **NWFC** notifying him of the Attack.[55]
	Six **NWAS** ambulances at Manchester Central Fire Station set off in convoy for Hunts Bank.[56]
	First **NWAS** HART operatives from the HART crew based in Greater Manchester arrived on Hunts Bank.[57]
	NWAS HART crew covering Cheshire and Merseyside agreed with **NWAS** Control to mobilise to the incident.[58]

45 94/102/18-103/6, INQ041119/3
46 174/34/13-15
47 53/73/1-7, INQ035612/162
48 174/39/2-8
49 INQ032071
50 53/74/19-75/7, INQ035612/169
51 INQ015093T
52 INQ035612/194
53 174/65/6-16
54 174/89/1-2
55 121/154/20-156/23
56 81/84/15-88/6
57 INQ040616/4
58 81/115/15-118/6

Time	Event
22nd May 2017	
23:07	The first casualty arrived at the Casualty Clearing Station following evacuation from the City Room.[59]
23:08	GMFRS Chief Fire Officer Peter O'Reilly was informed of the Attack by GMFRS Group Manager Nankivell.[60]
	NWAS ambulances travelling from Manchester Central Fire Station began to arrive at Hunts Bank.[61]
23:10	GMP Tactical/Silver Commander, Temporary Superintendent Nawaz, arrived at the Silver Control Room in GMP HQ.[62]
23:11	NWAS HART operatives Simon Beswick, Christopher Hargreaves and Lea Vaughan convened on Station Approach.[63]
23:12	NWAS Tactical Commander, Annemarie Rooney, arrived at the Silver Control Room in GMP HQ.[64]
	BTP Chief Superintendent Gregory notified BTP Superintendent Kyle Gordon of the Attack and appointed him as BTP Bronze Commander.[65]
23:13	Two NWAS HART operatives, Christopher Hargreaves and Lea Vaughan, entered the Victoria Exchange Complex.[66]
23:15	NWAS HART operatives Christopher Hargreaves and Lea Vaughan entered the City Room.[67]
	GMP Strategic/Gold Commander, ACC Ford, arrived at GMP HQ.[68]
	NWAS Tactical Commander Annemarie Rooney was briefed by GMP Tactical/Silver Commander Temporary Superintendent Nawaz that a suicide bomber was responsible for the Attack, that there were 20 fatalities including the bomber, and that it was not a shooting incident.[69]
23:17	John Atkinson was carried out of the City Room on a makeshift stretcher.[70]
23:18	GMP Tactical Firearms Commander, Temporary CI Buckle, arrived in the Silver Command Room at GMP HQ.[71]

[59] INQ041266
[60] 132/1/22-3/10, INQ004348/66
[61] 81/84/15-88/6
[62] 104/52/15-19
[63] 77/25/4-/26/8
[64] 115/122/6-7, INQ014791/5
[65] 93/168/25-169/12
[66] 53/98/10-25, INQ035612/252
[67] INQ035612/258
[68] 105/86/13-16
[69] 115/122/6-124/5
[70] 155/40/11-13
[71] 100/131/18-20, INQ029004/5

Time	Event
22nd May 2017	
23:20	**GMP** Force Duty Supervisor, Ian Randall, left **GMP** Control to set up the Silver Command Room at **GMP** HQ.[72]
23:23	**NWAS** Operational Commander Daniel Smith provided a METHANE message to **NWAS** Control.[73]
	NWAS Ambulance A344 carrying Saffie-Rose Roussos arrived at the Royal Manchester Children's Hospital.[74]
	GMP Ground Assigned Tactical Firearms Commander, CI Dexter, arrived at the Victoria Exchange Complex.[75]
23:24	John Atkinson arrived at the Casualty Clearing Station.[76]
23:25	**GMFRS** Group Manager Carlos Meakin arrived at Philips Park Fire Station.[77]
	GMP Ground Assigned Tactical Firearms Commander, CI Dexter, entered the City Room for the first time.[78]
23:26	Georgina Callander was carried out of the City Room on a makeshift stretcher.[79]
23:28	Georgina Callander arrived at the Casualty Clearing Station.[80]
23:34	**BTP** Chief Superintendent Gregory took over as Silver Commander from **BTP** Inspector Dawson.[81]
23:35	**GMFRS** Group Manager Levy arrived at Philips Park Fire Station.[82]
23:39	Georgina Callander was placed into **NWAS** Ambulance A347,[83] which departed from the Victoria Exchange Complex one minute later.[84]
	The last living casualty was evacuated from the City Room.[85]
23:40	**GMFRS** duty Assistant Principal Officer, Area Manager Paul Etches, was the first to arrive at the **GMFRS** Command Support Room.[86]
	GMFRS Station Manager Berry arrived at Philips Park Fire Station.[87]

72 99/175/11-12
73 53/106/20-107/11, INQ034313/1
74 174/92/6-9
75 53/108/17-24, INQ035612/302
76 155/54/9-11
77 121/83/23-84/7, INQ004300/3
78 INQ035612/310
79 155/28/16-21
80 155/29/10-11
81 92/124/1-9
82 121/190/10-11
83 155/34/11-13
84 155/35/21-22
85 54/8/11-12
86 129/189/16-20
87 119/195/22-196/11, INQ004300/1

Time	Event
22nd May 2017	
23:41	GMFRS Group Manager Nankivell arrived at the Command Support Room.[88]
23:43	NWAS Cheshire and Merseyside HART leader Ronald Schanck arrived at Manchester Central Fire Station.[89]
23:44	In a call to NWFC, GMP requested the attendance of a GMFRS NILO in the Silver Control Room at GMP HQ.[90]
23:45	GMP Superintendent Craig Thompson arrived at GMP HQ.[91]
	GMFRS Group Manager Levy informed GMFRS Station Manager Berry that he was now the Incident Commander.[92]
23:47	BTP PC Philip Healy and Police Dog Mojo entered the City Room.[93]
23:48	NWAS Ambulance A347 carrying Georgina Callander arrived at Manchester Royal Infirmary.[94]
23:49	GMFRS Chief Fire Officer O'Reilly and GMFRS Group Manager John Fletcher arrived at the Command Support Room.[95]
23:50	John Atkinson was placed into NWAS Ambulance A368,[96] which departed from the Victoria Exchange Complex ten minutes later.[97]
	NWAS Deputy Director of Operations, Stephen Hynes, arrived at the Victoria Exchange Complex on Station Approach.[98]
23:54	GMFRS Station Manager Berry requested a Forward Command Post from GMP and was told it was the Boddingtons car park.[99]
23:56	BTP CI Andrea Graham was identified on CCTV for the first time at the Victoria Exchange Complex, walking along the raised walkway towards the City Room.[100]
23:57	Stephen Hynes replaced Daniel Smith as NWAS Operational Commander.[101]
23:58	GMP Silver Control Room Operators used the proposed multi-agency control room talk group to see which other agencies were listening. NWFC replied to say that it was.[102]

88 INQ004300/4
89 81/119/6-9
90 54/7/17-24
91 108/26/19-27/3
92 122/14/22-15/5
93 54/10/22-11/8, INQ035612/392
94 155/38/15-17
95 128/49/19-50/8
96 159/18/2-6
97 159/29/8-10
98 54/14/5-11, INQ035612/405
99 54/13/3-19
100 54/19/21-20/15, INQ035612/419
101 54/20/16-21/1
102 54/22/15-23/4

Time	Event
23rd May 2017	
00:00	**GMP** Temporary Superintendent Nawaz handed over tactical/silver command to **GMP** Temporary Superintendent Christopher Hill.[103]
00:02	First **GMFRS** appliance arrived at Manchester Central Fire Station.[104]
00:05	**GMFRS** NILO, Station Manager Michael Lawlor, arrived at **GMP** HQ.[105]
	GMFRS Station Manager Berry arrived at Manchester Central Fire Station.[106]
00:06	**NWAS** Ambulance A368 carrying John Atkinson arrived at Manchester Royal Infirmary.[107]
00:15	**GMP** Tactical/Silver Commander, Temporary Superintendent Hill, informed **GMFRS** Station Manager Lawlor that Operation Plato had been declared.[108]
	GMFRS Group Manager Levy instructed **NWFC** to record him as Officer in Charge (Incident Commander) and enquired whether Operation Plato had been declared. **NWFC** said that it had not.[109]
00:18	**GMP** Force Duty Officer Inspector Sexton handed over the Tactical Firearms Commander role to **GMP** Superintendent Thompson.[110]
	GMP Tactical/Silver Commander, Temporary Superintendent Hill, informed **NWAS** Tactical Commander Annemarie Rooney that Operation Plato had been declared.[111]
	GMFRS Station Manager Lawlor informed Group Manager Fletcher of the Operation Plato declaration.[112]
00:30	**NWAS** Strategic Commander Barnes arrived at the Silver Control Room at **GMP** HQ.[113]
00:36	First **GMFRS** fire appliance arrived at the Victoria Exchange Complex on Station Approach.[114]
00:38	**GMFRS** Station Manager Berry arrived outside the Victoria Exchange Complex.[115]

[103] 104/208/5-7
[104] INQ004284/13
[105] INQ026726/1
[106] INQ004284/14
[107] 159/30/7-12
[108] INQ026726/2
[109] INQ001204/1
[110] 98/1/24-2/8, INQ024325/50-51
[111] 115/133/24-134/20, INQ014791/9
[112] 128/81/14-19, INQ004348/37
[113] 115/49/7-10
[114] 54/40/19-24, INQ035612/469
[115] 54/41/6-22, INQ035612/470

Time	Event
23rd May 2017	
00:54	**GMP** CI Dexter declared the scene was "*warm going cold*" in conversation with **GMFRS** Station Manager Berry and **NWAS** Operational Commander Stephen Hynes.[116]
	NWAS Tactical Commander, Annemarie Rooney, informed **NWAS** Operational Commander, Stephen Hynes, of the Operation Plato declaration.[117]
00:57	**GMP** Temporary Superintendent Hill declared a Major Incident on behalf of **GMP**.[118]
01:16	**GMP** Strategic/Gold Commander, ACC Ford, agreed with **BTP** Gold Commander, ACC Robin Smith, that **GMP** was the lead agency in the response.[119]
01:23	**BTP** Bronze Commander, Superintendent Gordon, arrived at the Victoria Exchange Complex.[120]
01:53	**BTP** CI Susan Peters arrived at **GMP** HQ and assumed the role of Silver Control liaison.[121]
02:10	**GMFRS** Chief Fire Officer O'Reilly arrived at **GMP** HQ.[122]
02:50	The last casualties were transported from the Casualty Clearing Station to hospital by ambulance.[123]
04:15	A Strategic Co-ordinating Group meeting was held at **GMP** HQ following the arrival of all Strategic/Gold Commanders.[124]

116 INQ040657/69-70, INQ035612/522
117 115/140/19-23, INQ014791/11
118 INQ022399/11
119 94/133/15-136/4
120 95/66/9-16
121 INQ002000/102
122 INQ026726/2
123 INQ041266
124 105/206/4-14

Appendix 11: Emergency Response Experts

A11.1 I will set out below a summary of the relevant expertise of those who assisted me in relation to the emergency services response. It reflects the position when they gave evidence in 2021.

Fire and Rescue Expert

Matthew Hall

A11.2 Matthew Hall served in the Royal Navy before joining the London Fire Brigade (LFB) in 1990. While holding the rank of Station Manager between 2002 and 2005, he became an instructor for the Institution of Fire Engineers[1] and qualified as a Tactical/Silver Commander.[2]

A11.3 He was part of the Special Operations Group at LFB[3] before being seconded to the Department for Communities and Local Government in early 2006 to assess the operational service delivery of the UK Fire and Rescue Service. Later that year, he became Staff Officer to the LFB Deputy Commissioner.[4] In 2008, he was promoted to Group Manager and led on a number of special projects, such as strategic response arrangements and Strategic/Gold Commander training.[5]

A11.4 From 2011 to 2014, he was the National Interagency Liaison Officer (NILO) Co-ordinator.[6] He delivered NILO training courses as an Associate of LFB Enterprises Limited between 2016 and 2019. In his last two years of service with LFB, he was part of the Technical and Service Support Unit, focusing on the development of technology for equipment and more efficient emergency responses.[7]

A11.5 During his service, he conducted the review into the emergency response to the Marchioness disaster on behalf of LFB[8] and was involved with the review following the 7/7 attack.[9] Ahead of the 2012 Olympics, he was the UK Fire and Rescue Service representative in the multi-agency joint operational group for Marauding Terrorist Firearms Attack response. He led on the development and delivery of the role of the Fire and Rescue Service within the National Olympic Co-ordination Centre, contributing to Joint Operating Principles at the time.[10]

1 142/4/24-5/14
2 142/5/20-23
3 142/6/5-7
4 142/7/4-13
5 142/7/4-8/1
6 142/8/8-13
7 142/9/13-21
8 142/5/15-19
9 142/6/8-11
10 142/8/14-9/7

A11.6 He retired as Deputy Assistant Commissioner in 2016. Since then, he has provided multi-agency and interoperability training to a variety of bodies, including government departments and the armed forces.[11]

Ambulance Service Experts

Christian Cooper

A11.7 Christian Cooper served as an ambulance officer and paramedic for the Great Western Ambulance Service between 2000 and 2007. He was Resilience Manager for the South West Strategic Health Authority until 2009. In 2009, he became the Hazardous Area Response Team and Specialist Operations Manager for the Great Western Ambulance Service.[12]

A11.8 From 2013, he was the Head of Quality and Improvement for the National Ambulance Resilience Unit.[13] At the time of giving evidence to the Inquiry in September 2021, he was the National Head of Operations for the Unit. In this role he had responsibility for overseeing the development of the national and contractual standards that apply to ambulance trusts, to enable them to respond effectively to Major Incidents.[14]

Michael Herriot

A11.9 Michael Herriot worked in nursing between 1976 and 1980[15] before becoming a paramedic for the East Sussex Ambulance Service. By 1995, he was the Assistant Chief Ambulance Officer for the Scottish Ambulance Service.[16]

A11.10 Between 1995 and 1997, he worked at the Home Office Emergency Planning College[17] as a course director.

A11.11 Since April 1997, he has been the Associate Director for Special Operations and Emergency Planning at the Scottish Ambulance Service, where he is responsible for special operations and emergency planning.[18]

[11] 142/10/8-18
[12] 144/3/9-21
[13] 144/3/22-24
[14] 144/4/9-18
[15] 144/5/1-3
[16] 144/5/6-8
[17] 144/5/9-11
[18] 144/5/12-15

Policing Experts

Scott Wilson

A11.12 Scott Wilson was a Detective Superintendent in Counter-Terrorism Command for the Metropolitan Police Service (MPS) between 2008 and 2010.[19] On promotion to Detective Chief Superintendent in 2010, he became the Head of Emergency Planning. This role included preparing for the London Olympics in 2012.[20]

A11.13 He was the Head of the MPS Intelligence Bureau between 2013 and 2014.[21] Between 2014 and 2018, he was the National Co-ordinator for Protect and Prepare, having strategic oversight of the National Counter-Terrorism Security Office and leading the policing response to high-risk threats. During this time, he worked domestically and internationally, setting up an international team in 2015 following the terrorist attacks in Tunisia.[22]

A11.14 In his role as National Co-ordinator, he conducted a full review of police strategies and capabilities, including firearms capacity, command and control, and protective security.[23] He developed the national police counter-terrorism awareness campaigns from 2014 to 2018 and operated as the strategic lead for Operation Temperer.[24] He was responsible for the management of counter-terrorism exercising[25] and co-authored the third edition of the Joint Operating Principles in January 2016.[26]

A11.15 He was one of the Senior Investigating Officers for the Glasgow Airport attack in 2007 and the Senior Identification Manager for the London Bridge attack in 2017.[27] He retired from the MPS as a Detective Chief Superintendent in 2018.[28]

Iain Sirrell

A11.16 Iain Sirrell began his career with the MPS in 1988, transferring to North Yorkshire Police in 1992 before retiring from the MPS as a Chief Inspector in 2018. He was the Police Training College Manager between 2006 and 2008.[29]

A11.17 He was a control room Force Incident Manager from 2008 until 2010 and from 2013 to 2016. During this time, he also qualified as a Silver Commander and made major changes to the control room in relation to its counter-terrorism response.[30]

19 146/2/19-21
20 146/2/22-3/5
21 146/3/6-8
22 146/3/9-20
23 146/3/21-25
24 146/4/8-15
25 146/4/21-23
26 146/5/18-20
27 146/5/5-13
28 146/2/13-18
29 146/6/5-12
30 146/6/12-21

A11.18 He was occupationally trained as a counter-terrorism security co-ordinator and had responsibility for command and control in a national counter-terrorism programme for police and military exercises.[31]

Ian Dickinson

A11.19 Ian Dickinson had a long career in policing, rising to the rank of Deputy Chief Constable in Lothian and Borders Police before retiring as Assistant Chief Constable.[32]

A11.20 He has substantial experience in strategic command, having been the Deputy National Co-ordinator for counter-terrorism in Scotland. He was in post as a Strategic Commander at the time of the Glasgow Airport attack in 2007.[33]

A11.21 He now works at the Emergency Planning College, along with Scott Wilson and Iain Sirrell. As part of the Cabinet Office Civil Contingencies Secretariat, the Emergency Planning College delivers training courses from an operational, tactical and strategic level to local authorities and emergency services in the UK and internationally.[34]

Supporting research analyst

John Lawrie

A11.22 John Lawrie is a researcher and analyst who supported Matthew Hall in the preparation of his expert reports into the response of the Greater Manchester Fire and Rescue Service to the Attack.[35]

A11.23 He worked in law enforcement for 25 years and was engaged in specialist roles for the majority of that time. He held the positions of Staff Officer, Contingency Planner and Emergency Planning Officer. He has been a firearms instructor[36] and has delivered firearms command and control processes to police services since the 1990s.[37]

A11.24 He has been a Tactical Advisor in two national forces as well as in the National Crime Agency, the Regional Crime Squad and the London Flying Squad.[38] He was engaged in operations throughout one of the busiest periods of counter-terrorist operations in the UK.[39]

[31] 146/6/22-25
[32] 146/7/9-18
[33] 146/7/21-8/3
[34] 146/8/11-22
[35] 142/11/12-19
[36] 142/11/24-12/7
[37] 142/12/12-14
[38] 142/12/7-11
[39] 142/12/15-18

A11.25 For a number of years, he researched and authored cross-government reports as an intelligence analyst in Whitehall. He has acted as a delegate to the United States, the Middle East and Europe. John Lawrie now operates as a consultant, specialising in threat, risk, and political and religious extremism. He is a keynote speaker on UK NILO courses and has given lectures to the European Commission.[40]

A11.26 During his time as an intelligence analyst, he specialised in firearms, weapons-effects and ballistics, and terrorist tactics and training. In partnership with the Home Office, he worked with all three emergency services supporting investment in the preparation for terrorist attacks.

[40] 142/12/19-13/11

Appendix 12: Medical and Survivability Experts

A12.1 I will set out below a summary of the relevant expertise of those who assisted me in relation to the injuries which were sustained by those who died. It reflects the position when they gave evidence in 2021.

Forensic pathology

Philip Lumb

A12.2 Dr Philip Lumb is a Home Office-registered forensic pathologist.[1] He was Lead Pathologist in response to the Attack, with responsibility for co-ordinating the team of pathologists in the early stages of the investigation.[2]

A12.3 Before 2017, Dr Lumb was regularly involved in planning and preparation for the pathological response to mass casualty incidents.[3] He was involved in the response to the Selby rail disaster in 2001 and the inquests into the Hillsborough disaster.[4]

Jack Crane

A12.4 Professor Jack Crane is a medical doctor and forensic pathologist.[5] He was State Pathologist for Northern Ireland between 1990 and 2014.[6] He is a Professor of Forensic Medicine at Queen's University Belfast.[7]

Blast Wave Panel of Experts

Mark Ballard

A12.5 Lieutenant Colonel Dr Mark Ballard is a Lieutenant Colonel in the Royal Army Medical Corps[8] and a Fellow of the Royal College of Radiologists.[9] He has deployed to Afghanistan as both a general duties medical officer and a consultant radiologist.[10]

1 149/105/24-25
2 149/110/4-24
3 149/108/7-109/1
4 149/109/2-10
5 161/2/16-18
6 161/2/19-21
7 161/2/22-24
8 176/117/22-24
9 176/118/5-6
10 176/118/16-22

A12.6 Since 2013, he has been a consultant radiologist at the Queen Elizabeth Hospital, Birmingham.[11] He was the Consultant Adviser in Radiology to the British Army between 2015 and 2019 and has consulted for the Ministry of Defence since 2019.[12]

A12.7 Lieutenant Colonel Ballard has published and lectured nationally on the topics of ballistic injuries, blast images and tourniquets.[13] He is a contributor to the NHS England clinical guidelines on Major Incidents and mass casualty events.[14]

Anthony Bull

A12.8 Professor Anthony Bull is a bioengineer and Head of the Department of Bioengineering at Imperial College London, where he leads the Centre for Blast Injury Studies. The Centre is cutting-edge in its interdisciplinary approach to conducting research. With embedded military and medical personnel, it is the only centre of its kind.[15]

A12.9 Professor Bull has extensive experience in trauma research and was awarded a fellowship with the Royal Academy of Engineering in 2014. He is a member of the World Council of Biomechanics.[16]

Jonathan Clasper

A12.10 Colonel Professor Jonathan Clasper was a serving officer with the British Royal Army Medical Corps until 2019.[17] He was a consultant in orthopaedic surgery at Frimley Park Hospital until 2021[18] and is a Fellow of the Royal College of Surgeons of Edinburgh and London.[19]

A12.11 He is a visiting professor in bioengineering at Imperial College London and Clinical Lead for the Royal British Legion Centre for Blast Injury Studies.[20] He has extensive operational experience of military trauma, having treated and researched injuries from the military conflicts in Iraq and Afghanistan.[21]

Alan Hepper

A12.12 Since 2002, Alan Hepper has been an engineer at the Defence Science and Technology Laboratory,[22] where he undertakes research to understand the effect of injuries from military weapons.[23]

[11] 176/117/25-118/4
[12] 176/118/7-12
[13] 176/119/2-6
[14] 176/119/7-9
[15] 150/3/3-23
[16] 150/4/2-7
[17] 161/66/2-8
[18] 161/66/12-15
[19] 161/66/9-11
[20] 161/66/16-21
[21] 161/67/10-15
[22] 177/21/14-21
[23] 177/21/22-22/3

A12.13 He has provided expert witness evidence to the Special Investigation Branch of the Royal Military Police[24] and contributed to the evidence in the inquests into the 7/7 attack and Birmingham bombings in 1974.[25]

Peter Mahoney

A12.14 Colonel Professor Peter Mahoney joined the Territorial Army in 1980[26] and is a member of the reserve forces.[27] He has deployed to Iraq and Afghanistan, where he was involved in the clinical management of casualties with blast and ballistic injuries.[28]

A12.15 He is a consultant in anaesthesia with fellowships in pre-hospital care and anaesthesia. He has obtained a PhD in defence and security[29] and a postgraduate diploma in forensic investigation.[30]

Cardiology

Paul Rees

A12.16 Surgeon Commander Dr Paul Rees is a consultant in cardiology, general internal medicine and pre-hospital emergency medicine[31] at the Barts Heart Centre in St Bartholomew's Hospital, London. He performs intervention and cardiology duties as part of a high-volume 24-hour heart attack centre team.[32]

A12.17 He is a Surgeon Commander in the Royal Navy,[33] with three years' experience as a submarine medical officer.[34] He has deployed with a Commando Brigade in Iraq and served in Afghanistan, where he worked in the field hospital and as a consultant leading the Medical Emergency Response Team.[35]

A12.18 He regularly undertakes flying duties with the East Anglian Air Ambulance. He is also Co-lead for the British Cardiovascular Interventional Society focus group on out-of-hospital cardiac arrests.[36]

[24] 177/22/4-7
[25] 177/22/11-15
[26] 150/4/25-5/4
[27] 150/4/14-16
[28] 150/5/4-7
[29] 150/4/21-23
[30] 150/5/8-9
[31] 161/19/16-18
[32] 161/19/21-20/3
[33] 161/19/19-20
[34] 161/20/15-18
[35] 161/20/19-24
[36] 161/20/6-12

Radiology

Richard Wellings

A12.19 Dr Richard Wellings graduated as a medical doctor in 1982 and became a consultant in 1993.[37] He is a consultant radiologist at the University Hospital of Coventry and Warwickshire[38] and a Fellow of the Royal College of Radiologists.[39]

A12.20 He is an honorary clinical lecturer at the University of Warwick.[40] He has peer-reviewed articles in relation to radiology and has published on the subject for the Royal College of Physicians.[41]

Pre-hospital care and orthopaedic trauma surgery

Aswinkumar Vasireddy

A12.21 Mr Aswinkumar Vasireddy is a pre-hospital care consultant involved in the management of critically injured patients, and has led on the complex trauma referral system for five years.[42] He is also an orthopaedic fellow and trauma surgeon at King's College Hospital, specialising in the management of complex trauma.[43]

A12.22 He works as a research lead and lectures at the Institute of Pre-Hospital Care at London's Air Ambulance. He is an honorary clinical lecturer in the Medical School at Queen Mary University of London.[44] Mr Vasireddy teaches nationally and internationally in orthopaedics and general and pre-hospital trauma care.[45]

A12.23 He is a non-executive director for an NHS trust and has memberships with the British Orthopaedic Association and the Orthopaedic Trauma Societies of the UK and USA.[46] He has also completed core training in anaesthesia, intensive care and emergency medicine.[47]

[37] 176/120/23-121/1
[38] 176/120/20-22
[39] 176/121/4-6
[40] 176/120/17-19
[41] 176/121/10-21
[42] 177/213/3-14
[43] 177/212/15-21
[44] 177/213/15-25
[45] 177/214/11-14
[46] 177/214/1-10
[47] 177/214/22-215/1

Pre-hospital care and emergency medicine

Gareth Davies

A12.24 Dr Gareth Davies is a consultant in emergency medicine and pre-hospital care.[48] He was Medical Director of London's Air Ambulance from 1996 to 2018, with responsibility for the care and treatment strategies of over 40,000 seriously injured patients.[49] During this time, he attended and provided medical treatment at numerous Major Incidents.[50]

A12.25 He is the Co-developer and Convenor of the Royal College of Surgeons' pre-hospital and resuscitative thoracotomy course. Dr Davies also led the team which delivered the resuscitative endovascular balloon occlusion of the aorta (REBOA) initiative.[51] He has contributed to national working groups on trauma and major incidents[52] and has published over 60 peer-reviewed papers.[53] He lectures in pre-hospital care at Queen Mary University of London.[54]

Claire Park

A12.26 Lieutenant Colonel Dr Claire Park is a consultant in pre-hospital care, critical care and anaesthesia in the British Army. She has deployed to Afghanistan three times as a member of the Medical Emergency Response Team and to North Africa with a small forward surgical team.[55]

A12.27 She was the Clinical Governance Lead for the Medical Emergency Response Team between 2013 and 2016.[56] She has held consultant roles within the NHS and was the Major Incident Lead with London's Air Ambulance. She was also the Post-incident Lead for the Fishmongers' Hall and London Bridge attacks.[57]

A12.28 She is a consultant in critical care and trauma at King's College Hospital[58] and provides clinical governance to the MPS and the National Police Clinical Governance Panel.[59]

48 178/59/24-60/1
49 178/60/4-13
50 178/62/8-63/6
51 178/63/12-24
52 178/63/16-18
53 178/66/6-8
54 178/66/23-25
55 178/67/7-25
56 178/68/1-3
57 178/68/8-15
58 178/68/22-24
59 178/69/15-19

Appendix 13: Acknowledgements

A13.1 I wish to acknowledge my gratitude to the members of the Greater Manchester NHS Resilience Hub. It was set up in response to the Attack in 2017 to co-ordinate care and support for thousands of children, young people and adults whose mental health or emotional wellbeing was affected. That is a role the Hub continued to perform throughout the Inquiry. It provided tireless assistance to witnesses, families and others to support them through the traumatic evidence that was heard about the Attack and the emergency response. I am greatly indebted to them.

A13.2 The Inquiry was assisted by many contributions from members of the public who followed the evidence and provided helpful insights on aspects of the hearings. I wish in particular to thank those who took the time to contact the Inquiry and share their own experiences with my team. I would especially wish to thank Jeremy Cowen, whose experiences of working as a paramedic provided an important contribution to the evidence I heard on the Care Gap and the recommendations I have made.

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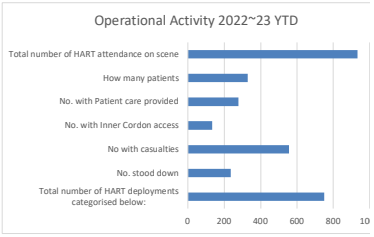
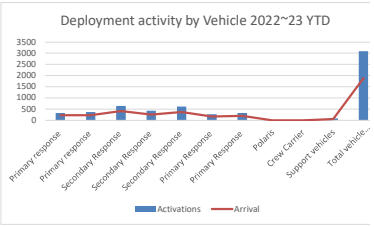
Welsh Ambulance Services NHS Trust	April 2022 to March 2023	Full Year	
WAST HART KPI report			
Date team went live:	**July 1st 2012**		
Personnel in post - please quote WTE	**Target**	**Achieved**	**Notes**
Total number of operatives & team leaders currently appointed to HART (out of 42)	41		
No. paramedic operatives	39		
No. technician operatives	2		
No. paramedic team leaders	7		
No. USAR trained paramedics	39		
No. female operatives	7		
No. female team leaders	2		
Admin Support	1		
Manager	1		
HART Trainer	1		
Other (please state in Notes column)	1		Stores person
Turnover - please quote WTE			
No. current operative vacancies	1		
No. current team leader vacancies	1		
No. personnel who have left HART since appointments for this team began	20		
No. of personnel who have left in 2022 -23 reporting period	2		
Absence in reporting period			
No. shifts where < 4 on duty	8		
No. hours absence due to HART work related ill health/injury	705		
No. hours absence due to other ill health/injury	5486.02		
No. hours unauthorised absence	351.7		
No. hours authorised absence (special leave / compassionate / study etc)	468.9		
No. WTEs who have been on maternity/paternity leave during past 12 months	1		
No. WTEs who have been on secondment during past 12 months	516.15		reported in hrs on the sheets
Operational Activity 2020 -21 reporting period			
Total number of HART deployments categorised below:	750		Deployment = a job allocated and team member(s) mobilised. Any calls that indicated potential need for HART capabilities - inc. bariatric calls.
No. stood down	235		
No with casualties	555		
No. with Inner Cordon access	134		
No. with Patient care provided	277		
How many patients	329		
Total number of HART attendance on scene	933		
Deployment Activity by Vehicle 2020 -21 reporting period	**Activations**	**Arrival**	**Call Sign**
Primary response	330	217	WH51
Primary response	371	224	WH52
Secondary Response	641	410	WH14
Secondary Response	429	254	WH11
Secondary Response	615	372	WH12
Primary Response	266	160	WH61
Primary Response	327	189	WH71
Polaris	15	4	WH41
Crew Carrier	4	1	WH31
Support vehicles	85	57	WS02/03/WH81
Total vehicle deployments	3083	1888	**61.2%**
Training 2020 -21 reporting period			
No. of ongoing training hours delivered (not national courses)	11370.25		39.25 hours per week for 6 staff times 13 weeks
No. of training hours delivered - national courses	607.7		
No. of ongoing training hours cancelled (not national courses)	466.5		
No. of local multi-agency exercises attended	10		
No. of national multi-agency exercises attended	2		
Accidents/Untoward Incidents - 2020 -21 reporting period			
No. of untoward incidents reported	0		
No. of SUIs investigated	0		
No. of RIDDOR incidents	1		





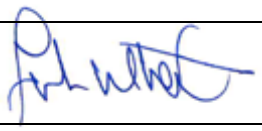
Special Operations Response Team (SORT)	**Target**	**Achieved**	**Notes**	**Skillset of total**		
				CBRNe	*SFR*	*AIT*
No. of SORT Supervisors in post	3	3				
SORT Staff in CW	50	49	Remained static since last recruitment Awaiting the SORT enhancement uplift alinged to Opt 12	43	5	34
SORT Staff in North	50	45		40	8	34
SORT Staff in SE	50	46		35	17	31

Epishuttle	
Total trainied	71
Percentage	51%


300

Llywodraeth Cymru
Welsh Government

HEALTH EMERGENCY PLANNING ANNUAL REPORT FOR 2022

Name of NHS Organisation	**Welsh Ambulance Services NHS Trust**	**Date**	**February 2023**
Signature of Chief Executive Officer			

Planning and Preparation

1. **Please provide the name and position of your nominated Executive level lead for civil contingency/emergency preparedness arrangements.**

   Lee Brooks, Executive Director of Operations

2. **Please provide the name and position of your nominated Executive level business continuity lead if different from the above.**

   As above

3. **Please provide the name and position of your officer(s) who has lead day to day responsibilities for your civil contingencies/emergency preparedness arrangements and, if different, the name and position of the officer with day-to-day responsibility for your business continuity arrangements.**

   Judith Bryce, Assistant Director of Operations, National Operations & Support
   Clare Langshaw, Head of Service, EPRR & Specialist Operations
   Jason Fenard, Service Manager, EPRR & Specialist Operations

YES ☐ **NO** ☐

4. **Please provide the name and position of the officer in your organisation responsible for PREVENT activities (normally delivered as part of Safeguarding)**

Nikki Sims, Head of Safeguarding

5. When was your business continuity arrangements for maintaining critical services last considered and adopted by your Executive Board?

The Business Continuity Policy was approved in 2019 and is being reviewed 2023. A Business Continuity Assessment report was presented for review by the Finance and Audit Committee in June 2022.

6. Do your business continuity arrangements include response arrangements for maintaining critical services in the event of a major power outage

YES ☒ **NO** ☐

7. Do your business continuity arrangements include written procedures for responding to a cyber-attack/ICT incident impacting across the organisation

YES ☒ **NO** ☐

8. Does your organisation have written procedures that may be needed to respond to a change in threat level to critical?

YES ☒ **NO** ☐

9. When was your organisation's Lock Down arrangements last worked through or tested?

Dates	Details of what was undertaken
	The EMS-C (control rooms) have lockdown processes that work mainly when there are potential infection outbreaks. These ran through COVID. There are no emergency lockdown procedures in place for threats at WAST sites.

Major Incident/Emergency Plan(s)

10. When was your Major Incident/Emergency Plan(s) last considered and formally adopted by your Executive level Board?

The revised Incident Response Plan (v1.1) went through the Senior Operations Team, Senior Leadership Team and Assistant Director Leadership Team in October 2022 when it was then accepted by the Executive Management Team.

11. When was your Major Incident/Emergency Plan(s) last updated to reflect any organisational changes and essential plan contacts updated?

WAST Incident Response Plan v1.1 reviewed and updated in October 2022 and reflects lessons identified internally and externally and changes in guidance and terminology.

12. Do you have resilient activation systems, action cards and suitably trained and equipped staff to provide for a 24-hour emergency response?

YES ☒ **NO** ☐

If NO, what are the gaps and how are these being addressed?

13. Do your emergency planning arrangements take account of any roles or responsibilities placed on your organisation as set out in the "Mass Casualty Incident Arrangements for NHS Wales" document, agreed by Chief Executives?

YES ☒ **NO** ☐

If NO, what are the gaps and how are these being addressed?

14. Does your organisation have robust arrangements for reviewing emergency plans that take account of lessons from incidents and exercises (including following the process set out in the NHS Wales Lessons Identified Register?

YES ☒ **NO** ☐

Training, Testing & Implementing Arrangements

15. Please provide the dates when your organisation tested its emergency plans, as required, through:

a. Carrying out a communications/activation test every six months. Please provide details below

Dates	Details of communications/activation test undertaken
Weekly	Weekly internal testing undertaken using Everbridge, this system is the system that would be utilised during a MI to alert WAST staff
Monthly	Monthly airwave tests (scheduled) north and south (separately) plus no-notice hailing tests monthly
6 monthly MI Communication test	6 monthly MI Communications test to all Health Boards and Trusts, across Wales to test the cascade of the MI declaration by WAST.
4th April 2022	BAE Systems Activation test (4th April and 21st June – 4th Aril had significant issues so re-run required on 21st June. Monmouthshire Council, Gwent Police, SWFRS, WAST, ABUHB and PHW).
20th July 2022	Eastman Activation test – Newport Council, Gwent Police, SWFRS, WAST, ABUHB and PHW)
4th Oct 2022	Ex Bluestone pt1 (4th Oct 2022) – suspect package exercise, BCU received a warning, passed information to the police, cascaded to other services, services noted their initial actions

b. Carrying out a tabletop training exercise within the last year. Please provide details below

Dates	Details of tabletop training exercise
9th March	Ex Joshua – Cyber and ICT Disruption ex via Teams

2022	
11th May	Exercise Daybreak– Vale of Glamorgan COMAH site (Bakerlite) – Tactical commander and comms officer as players.
14th September	Exercise Hordeum – Felindre WTW (lower tier COMAH site) – no WAST players but provided METHANEs and CSCATTT to act as injects from WAST on scene
21st September	Exercise Azoti – BOC COMAH site – Tactical commander and comms officer as players.
5th Oct 2022	Ex Bluestone pt2 – BCU suspect package exercise, *postponed*
9th Nov 2022	Ex Drift – COMAH ex via Teams at Operational and Tactical (WAST Tactical participated)
16th Nov 2022	WAST Seasonal Planning ex via Teams with department leads
PDG exercises	Exercise First Steps (CBRNe) Ops Manager and Duty Control Manager – 3 courses run, 2 supported fully by WAST Exercise Priority Zones (MTA NILO) 48 courses run, 39 supported by WAST Exercise First call (MTA) OM and Control room Staff, 26 Courses 23 course supported by OM, some CCC attendance PDG T and E Calendar 2022-23 GH

c. Carrying out a major live or simulated exercise within the last three years. Please provide details below

Dates	Details of major live or simulated exercises undertaken
20th March 2020	Ex Vosa – Hazmat exercise with NWFRS and WAST, operational commander.
24th Sept 2020	Ex Zephyr - crash at Airbus, SORT and Commanders
15th October 2020	Ex Hightower – fire in block of flats. Frontline staff and Operational commander attended
26th May 2021	Ex Tonna – Hybrid of live and table top, multiagency, all command levels
22nd Sept 2021	Ex Weekend Warrior (Cardiff Airport) Simulation of light aircraft collision with escort car on runway. WAST Operational Commander and crew involved. Tactical commander also took part at station, receiving updates via radio from Operational Commander.
25th May 2022	Celtic Consolidation – Full live play including CCC, ODU, full command structure, SORT, HART
15th Sept 2022	Ex Largo – multiagency MTA ex (operational and tactical) at Principality
21st Sept 2022	CBRN North - *postponed* until March 2023 due to Queen's passing
28th Sept 2022	Ex Reflect – Crash at Airbus, SORT, MERIT (requal) and Operational Commander plus EMRTS
6th October 2022	Ex Lion – COMAH ex (Puma), crew, Op Commander, Loggist
26th October to 7th December	HART Rapid exercises. 6 exercises every Wednesday from 26th October to 7th December. All HART Teams involved as well as Operational Commanders taking overall command and functional roles.

2022	
27th October 2022	Ex Eirias - *postponed* until Q1 2023 (part of the mass cas exercise programme, north version of Dan y Graig)

16. Apart from COVID-19, have you implemented any of your emergency plans in response to any other incident in 2022?

YES ☒ **NO** ☐

a. If YES, what was the nature of the incident?

21/01/2022	BCI	CAD outage (PSBA failure)
14/02/2022	MI Standby	Tata Steel leak
09/06/2022	BCI	Issues with planned upgrade re CAD
19/07/2022	MI Standby	BCI due to pressures escalating to Standby
04/08/2022	BCI	Cyber attack on Adastra
11/12/2022	BCI	High demand
18/12/2022	Critical	High demand exceeding BCI

10/09/2022 Op Dragon, although not an incident, Op Dragon required extensive multiagency working and partner co-operation.

b. Were post-event reports produced for these incidents? YES ☒ **NO** ☐

c. If post incidents reports were produced, have these been shared with the health emergency planning network and any lessons identified uploaded on the Wales NHS Lessons Identified Register?

Lessons have been identified internally and mainly refer to internal processes which are not applicable to wider learning. They are entered onto the WAST Organisational Learning Spreadsheet as recommendations and actions and monitored by the Senior Operations Team.

Multiagency lessons or areas of good practice can be added to JOL, this is reflected on the OLS.

17. Have you undertaken an assessment of staff training needs in relation to your emergency plans?

YES ☒ **NO** ☐

If YES, please provide further information

Staff joining the Trust did not have MI training and relied on information gained from experienced colleagues, this was identified through Trust Structured debriefs and a training needs assessment identified that new starters, either joining from universities or from other ambulance, needed MI training. All responding staff coming into the Trust, either via an induction course or part of the EMT training, now attend a major incident training day delivered by the EPRR team,

Through Trust debriefs it was identified that staff needed an easy to access way to refresh their MI training. An e-learning major incident training package, and online JESIP package is now available to all staff, to ensure that these products are used and therefore addressing the identified learning need, the EPRR team is able to request a report from ESR on the number of staff who have completed these learning packages and this will be incorporated into the 2023/24 assurance procedures.

Commander courses are delivered by the EPRR team, in line with the NARU standards, The EPRR

team works with the Heads of Service, EMS to assess the need for initial foundation courses for new commanders. Refresher courses are delivered for commanders at all levels of command every 3 years to ensure the commanders are current and up to date with command developments. In 2022 all commanders undertook the refresher training, 2 of the tactical commanders were deferred to 2023 due to long term illness, all other commanders passed the competency assessment in command, 3 operational commanders were provided with additional support to ensure their CPD was compliant, and all commanders were assessed as compliant by the end of December 2022. The 2023 assurance program has begun with refresher dates being set and CPD being reviewed from March. Between these refresher courses the EPRR team assesses additional training needs and delivers additional training as required. An example of this is the new Triage Tools that will need to be delivered to all staff in 2023/24 and the training sessions provided to commanders via familiarisation sessions on changes to the WAST Clinical Safety Plan and JOPs for MTAs.

In light of the recommendations from the Manchester Arena Inquiry report, the Trust has recognised that further exercising opportunities are required to ensure WAST commanders are able to refresh their command skills. A review of training and exercising needs is scheduled to commence in March 2023, which includes a proposal for all staff to complete a questionnaire checking their knowledge. This will give them a training opportunity during completion and inform EPRR as part of a gap analysis in the training and exercising within the Trust.

18. Do you have a staff training programme to support your emergency plans?

YES ☒ **NO** ☐

If YES, please provide further details e.g., number of staff trained in Gold, Silver, and Bronze roles; emergency planning online training package.

All responder staff attend a major incident day as part of their induction or EMT course. An awareness session is provided for Ambulance Care staff.

Commanders are required to complete a series of courses and an ongoing CPD. Individual commander's achievement against their personal command CPD is reviewed annually by the EPRR team to ensure they achieve the required standards in line with the WAST Command policy. This was completed for 2022 and except for those commanders on long term sick leave, all WAST commanders were compliant.

Command Courses that commanders are required to attend and pass, where appropriate include:

- WAST foundation courses for Operational, Tactical and Strategic command levels (course applicable to the role)
- WAST foundation command course for EMSC Operational and Tactical commanders
- JESIP multiagency course
- NARU course relevant to the command level (operational and tactical)
- All Wales Silver (for Tactical Commanders)
- All Wales Gold (for Strategic Commanders)

All HART Operations Managers and 2ICs (deputies) are trained as Operational Commanders.

Duty Control Managers (DCM) in the Clinical Contact Centres all attend an Operational EMSC Commander course and a JESIP course. Progress is still to be made on ensuring EMSC Operational Commanders attend a JESIP course, however EMSC managers have given assurance that those commanders who have not attended a JESIP course, will be available to attend in 2023. National Delivery Managers within the ODU attend a Tactical EMS Command course. Their role is not to attend a scene, but to give command direction for the first 30 to 40 minutes of an incident as such, they are not included in the following figures.

Operational: 174
Tactical: 43

Strategic: 17

National Interagency Liaison officers are trained at Operational, Tactical and Strategic command levels, but maintain their substantive CPD at Tactical command. The Trust currently has 9 trained NILOs, with 2 more being planned.

Communications

19. Have relevant NHS organisations and partner agencies been consulted about any role they may have in your emergency plans?

YES ☒ **NO** ☐

20. Is there a mechanism for discussing and co-ordinating health emergency planning arrangements internally within your organisation?

YES ☒ **NO** ☐

21. If yes, please provide details of your internal mechanism for co-ordinating your emergency planning arrangements – for example: contingency/risk group structure, emergency preparedness strategy, EP work plan etc.

Internally the following forums are utilised to ensure a joined up approach is achieved.

- EPRR Action plan working group meetings are held every 6 weeks, reporting to the EPRR & Specialist Operations Group
- EPRR Organisational Lessons Identified group meetings are held every month, reporting to the EPRR & Specialist Operations Group
- EPRR LRF overview meetings are held every month, reporting to the EPRR & Specialist Operations Group
- Business Continuity Steering Group – quarterly meeting chaired by Locality Manager EPRR and attended by BC Leads from all departments, reporting to the EPRR & Specialist Operations Group
- EPRR and Specialist Operations Group meetings are held every month, reporting to the Assistant Director of Operations (ADO), National Operations & Support
- Head of Service EPRR & Specialist Operations, attends the Senior Operations Team to ensure EPRR matters are raised within the wider Trust, this group reports to the Senior Leadership Team.
- ADO National Operations & Support attends the Senior Leadership Team meetings to ensure EPRR matters are raised within the wider Trust, this group reports to the Executive Management Team (EMT).
- From the EMT the Executive Director of Operations ensures that EPRR matters are shared within the EMT and the Chief Executive Officer of the Trust.
- The Executive Director of Operations attends the Finance and Performance Committee of the Trust board, this ensures that EPRR matters can be shared at the Trust board level. There is a schedule of work for this committee in which EPRR matters are included.

21 Is there a mechanism for discussing and co-ordinating your emergency planning arrangements externally with Wales NHS and with other organisations, including within the LRF area?

YES ☒ **NO** ☐

If YES, please provide further details on how this is done.

The EPRR team provide representation to all 4 of the LRFs and wider groups including:

- Health and Social Services Group
- Wales Resilience Partnership Team
- Wales Resilience Partnership Forum
- Emergency Planning Advisory Group (EPAG)
- Pre Hospital Group
- Mass Casualty Group
- Wales Prepare and Protect Board
- CONTEST Cymru Board
- Local CONTEST Boards
- Prepare Delivery Group
- All Wales Learning and Development group
- NHS Wales Learning and Development Group
- EPRR Delivery Group (UK Ambulance Services)
- EPRR Group (UK Ambulance Services)
- National Business Continuity Group (UK Ambulance Services)
- Local JESIP group meetings (feeding into L&D)
- LRF Executive (Strategic) Groups
- LRF Coordination Groups (and relevant sub-groups)

22. If applicable, who represents your organisation at the Local Resilience Forum meetings?

Executive level:
All LRFs – Clare Langshaw, Head of Service, EPRR & Specialist Operations

Coordinator level:
South Wales and Gwent LRFs – Scott Walker, EPRR Manager S&E
Dyfed Powys LRF – Mathew Jones, EPRR Manager C&W
North Wales LRF – Joanne Hodson, EPRR Manager North

Subgroup level:
South Wales and Gwent LRFs – Scott Walker
Dyfed Powys LRF – Mathew Jones and Deian Thomas
North Wales LRF – Joanne Hodson and Nia Hughes

As Chair of the NWLRF Risk Group, a representative of WAST, Joanne Hodson also attends the All Wales Risk Group.

Assessment

23. What more can be done to improve your organisation emergency preparedness arrangements?

The WAST EPRR team has undergone a number of changes post holders over the past year and is now in a position where the majority of the positions are filled. This has allowed the team opportunities to look at new ways of working and identify gaps within the team capabilities when working to meet the Trust's duties under the CCA.

An assessment of the needs of the WAST EPRR team has highlighted that the team currently covers all four LRFs with 3 EPRR managers placing pressure on the team to deliver its obligations under the CCA and impacts on the team's ability to fully engage with the LRFs across Wales.

We continue to work with Counter Terrorism Policing Wales to undertake counter terrorism multiagency exercising schedules as per the PDG exercise plan. Work continues with the LRF Training and Exercising group to ensure WAST is integrated in multiagency training with LRF partners.

A review of the Manchester Arena Inquiry report has highlighted that the Trust needs to assess its ability to respond to incidents. This includes its preparedness and the ability of the EPRR team to deliver sufficient internal exercising across the Trust for its commanders and frontline staff. In recognition of this, the Trust is working to secure a 12-month seconded EPRR position to assess, review and make recommendations on the direction the Trust should take, in meeting its CCA responsibilities, in light of the Manchester Arena Inquiry report.

24. Are you satisfied that your organisation is fulfilling principles required by the Civil Contingencies Act 2004 as described below?

Overall WAST is meeting its obligations under the CCA, however this is not being achieved with the robustness that WAST would like to undertake these duties, due to the limitations within the EPRR team as detailed above.

	YES	NO	If no, please say why
1) Assess risks to inform your contingency arrangements	X		
2) Put in place Emergency Plans	X		
3) Put in place Business Continuity Management arrangements	X		
4) Share information with other organisations to enhance co-ordination and efficiency	X		
5) Cooperate with other organisations to enhance co-ordination and efficiency	X		
6) Have appropriate arrangement to warn, inform and advise the public/others, including in an emergency	X		

25. When submitting the completed report, please include an electronic copy of the following:

- **your current Major Incident /Emergency Plan(s)**

  The attached is the redacted version of the IRP, with the response to a MTA type incident redacted, if a full copy is required, this is Official-Sensitive.

- **an organisational chart setting out your organisation's emergency preparedness structure**
- **an organisational chart setting out your organisation's emergency response structure.**

Completed and signed Report forms with any attachments to be returned by 10th February 2023

By email to:

Copied to: Matthew.Evans027@gov.wales

HM Government

The UK Government Resilience Framework

December 2022

HM Government

The UK Government Resilience Framework

December 2022

This information is also available on the GOV.UK website:
https://www.gov.uk//government/publications/the-uk-government-resilience-framework

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Foreword from the Chancellor of the Duchy of Lancaster

These are unsettled and troubling times. Russia's brutal invasion of Ukraine; the wide ranging impacts of the COVID-19 pandemic; increasing signs of the impact of climate change; and constant and evolving cyber challenges are recent examples of an evolving threat picture.

We live in an increasingly volatile world, defined by geopolitical and geoeconomic shifts, rapid technological change and a changing climate. This context means that crises will have far reaching consequences and are likely to be greater in frequency and scale in the next decade than we have been used to. We have a responsibility to prepare for this future.

This challenge is not unique to the United Kingdom but faced by countries around the world. However, we must act now to bolster the United Kingdom's resilience and ensure we have plans to prepare for and mitigate a wide range of risks when they arise on our shores, ensuring that we can face the future with confidence.

We have bold and comprehensive plans to build resilience to specific risks. We have launched our Net Zero Strategy, the National Cyber Strategy and the British Energy Security Strategy, all of which tackle some of the most pressing challenges we face. We are also refreshing our Integrated Review to ensure that the UK's security, defence, development and foreign policy strategy is keeping pace with the evolving environment.

But alongside these plans, we need to strengthen the underpinning systems that provide our resilience to all risks. This UK Government Resilience Framework is our plan to achieve this.

The core of the Framework is built around three fundamental principles: that we need a shared understanding of the risks we face; that we must focus on prevention and preparation; and that resilience requires a whole of society approach.

This Framework is a broad and tangible set of actions. It is the first step in our commitment to develop a wide and strategic approach to resilience. We are committed to working with partners, industry and academia from across the UK to implement this Framework but also as we continue to develop our approach.

A strong resilience system – including UK Government departments, devolved administrations, local authorities, emergency services and the private and voluntary and community sectors – is more important than ever.

Working together to build our national resilience will mean we are better equipped to tackle the challenges that come our way, ensuring businesses grow, our communities thrive and citizens can build a brighter future.

Rt Hon. Oliver Dowden CBE MP | Chancellor of the Duchy of Lancaster

UK Government's Approach to Resilience

1. The professionalism and commitment of the people who contribute to the UK's resilience is extraordinary and we have a well established framework for civil protection in the UK. But the last few years have exposed the need to build on these strong foundations and strengthen our resilience in order to better prevent, mitigate, respond to and recover from the risks facing the nation. That is why the UK Government committed, in the *Integrated Review*,[1] to a new Resilience Strategy.

2. The framework is the first articulation of how the UK Government will deliver on a new strategic approach to resilience. It is based on three core principles:

   - A developed and shared **understanding of the civil contingencies risks** we face is fundamental;
   - Prevention rather than cure wherever possible: a greater emphasis on **preparation and prevention;** and
   - Resilience is **a 'whole of society' endeavour,** so we must be more transparent and empower everyone to make a contribution.

3. This framework focuses on the foundational building blocks of resilience, setting out the plan to 2030 to strengthen the frameworks, systems and capabilities which underpin the UK's resilience to all civil contingencies risks. The framework's implementation window reflects the UK Government's long term commitment to the systemic changes needed to strengthen resilience over time and matches the commitments made in the Integrated Review. Delivery has already begun and we are making quick progress on our commitments with 12 expected to be completed by 2025 (see *Annex B*).

4. It proposes measures and investment to enable the UK's resilience system to prevent risks manifesting or crises happening where possible. But, while prevention is a key principle, it cannot replace careful and effective management of emergencies as they occur. Some risks are inherently unpredictable, or manifest in unpredictable ways – whether over a wide geographic area, or as a result of a wide range of triggers and/or other risks. For example, we cannot stop substantial rainfall from causing flooding, or entirely eradicate the risk of cyber threats from hostile actors. For this reason, this framework also proposes actions to improve response and preparation for risks and ensure that partners throughout the system are able to play their part fully. There will be a shift away from simply dealing with the effects of emergencies towards a stronger focus on prevention and preparation for risks.

1 Global Britain in a Competitive Age: the Integrated Review of Security, Defence, Development and Foreign Policy

5. This is just the starting point for the UK Government's ambitions on resilience. We have already introduced new structures at the heart of the UK Government to focus on resilience and ensure decisions are made with an eye on the challenges we might face. The new Resilience Directorate in the Cabinet Office will drive the implementation of the measures set out in this framework and develop our ongoing resilience programme. This will include building on the National Security Risk Assessment (NSRA) to consider the chronic vulnerabilities and challenges that arise from the geopolitical and geoeconomic shifts, systemic competition, rapid technological change and transnational challenges such as climate change, health risks and state threats that define contemporary crises.

6. This work will bring together and complement the bespoke plans and programmes of work which manage individual risks and build cross cutting capabilities that underpin resilience across Government. This includes:

   - The UK Government 10 Point Plan for a Green Industrial Revolution[2] and the Net Zero Strategy[3] set out a clear vision for how the UK Government will transform the production and use of energy, in a decisive shift away from fossil fuels. The British Energy Security Strategy[4] accelerates this plan, in a series of bold commitments which put Great Britain at the leading edge of the global energy revolution. The Energy Security Strategy will deliver a more independent, more secure energy system and support consumers to manage their energy bills. That Strategy sets out how the UK Government will enhance the use of wind, new nuclear, solar and hydrogen, and support the production of domestic oil and gas in the near term.

   - The UK was among the first countries to legislate for climate adaptation and the Climate Change Act provides a strong framework for the UK Government. This includes commitments to produce a UK Climate Change Risk Assessment[5] to identify risks, followed by a National Adaptation Programme[6] to address those risks every five years. The UK Government fully recognises the scale of the challenge of adapting to climate change, and is developing a Third National Adaptation Programme (NAP3) which will set out how we will meet that challenge. Having undertaken the Third Climate Change Risk Assessment, the UK Government is committed to significantly increasing efforts to respond to identified risks and opportunities in NAP3.

   - The UK Government has developed a Supply Chains Resilience Framework[7] which highlights 5 areas to explore when building resilience in supply chains. The framework aims to provide a useful guide for both public and private sector organisations in considering potential actions aimed at mitigating risks and vulnerabilities in their supply chains.

2 The ten point plan for a green industrial revolution – GOV.UK
3 Net Zero Strategy: Build Back Greener – GOV.UK
4 British energy security strategy – GOV.UK
5 UK Climate Change Risk Assessment 2022 – GOV.UK
6 Climate change: second national adaptation programme (2018 to 2023) – GOV.UK
7 Supply chain resilience – GOV.UK

- In 2021, the UK Government published the National Cyber Strategy,[8] building on the National Cyber Security Strategy 2016-2021 and the Integrated Review. A key pillar of the strategy focuses on "building a resilient and prosperous digital UK". Through this pillar, the Cyber Strategy aims to improve understanding of cyber risk, prevent and resist cyber attacks more effectively, and strengthen resilience at the national, and organisational level, to prepare for, respond to and recover from cyber attacks.

7. This framework focuses on drawing together the many actors and programmes across the resilience system. The framework primarily outlines action for England and the UK Government in areas where responsibilities are reserved to the UK Government. All four nations of the United Kingdom share the same goal – to protect our citizens from the impacts of crises – and resilience encompasses both reserved and devolved matters. Where elements of the resilience system are overseen by the UK Government, the UK Government is committed to work in partnership with the devolved administrations (DAs). Significant elements of resilience are wholly the responsibilities of the devolved administrations. The resilience arrangements in each part of the UK are set out in *Annex A*.

8 National Cyber Strategy 2022

Executive Summary

8. This framework focuses on the UK's ability to anticipate, assess, prevent, mitigate, respond to, and recover from known, unknown, direct, indirect and emerging civil contingency risks.[9] It is applicable to building resilience to risks that have a domestic source, and those that have their roots overseas (but which would impact the UK). In this context, the framework uses 'resilience' to refer to an ability to withstand or quickly recover from a difficult situation, but also to get ahead of those risks and tackle challenges before they manifest.

9. The framework is guided by the three core principles which characterise the UK Government's strategy for resilience:

   - **A developed and shared understanding of the civil contingencies risks we face is fundamental:** it must underpin everything that we do to prepare for and recover from crises. The risks that impact our prosperity and stability are complex and dynamic, and they pose more profound structural and societal questions. We need to adapt the resilience system to face these and incentivise risk-based decision making around our new understanding. This will start with the actions outlined in this document around practical steps to improve our risk system;

   - **Prevention rather than cure wherever possible:** resilience-building spans the whole risk cycle so we must make sure we focus effort across the cycle, particularly before crises happen. It is more cost effective to invest in risk prevention and building resilient systems that can withstand crises rather than to rely solely on having the world's best crisis response systems. Accomplishing this means putting resilience at the heart of our decision making and investment, well beyond areas that are explicitly focused on emergencies. This framework sets the direction for actions we are already taking to improve the system, with the new standing resilience function in the UK Government taking forward sustained work to identify issues that require action to prevent or mitigate risk; and

   - **Resilience is a 'whole of society' endeavour,** so we must be more transparent and empower everyone to make a contribution. We need to prepare and respond to emergencies on a whole of system, whole of society scale. This means organising society in a coherent, resilience-focused way, but also taking a much broader focus on resilience. This includes how we structure the centre of the UK Government, what we expect of businesses, the local tier, voluntary organisations, community groups, and the public.

10. This framework represents a package of measures to broaden and strengthen the resilience system centred on six themes: risk, responsibility and accountability, partnership, community, investment and skills. For each theme this framework aims to demonstrate how our proposals will deliver tangible changes and benefits for those

9 This framework specifically focuses on civil contingencies risk and the HM Treasury Orange Book supports the UK Government to identify and manage a very broad range of risks, including, but not limited to technological, economic, legal and reputational risks.

working in the resilience system and the public. A list summarising the actions we will take is at *Annex B*.

11. By 2030:

- Our understanding of national and local **risks** will be dynamic, driven by data and insight where appropriate, and informed by the best UK and international expertise and experience. Within the UK Government there will be clear ownership of all risks, including complex and catastrophic risks, underpinned by sharpened governance and accountability. The UK Government will communicate about risk in an accessible, actionable and transparent way, so that everyone understands the risks they should plan for and how to protect themselves. Decision making on risk by ministers and officials will be informed by dynamic and expert data and insight, and will take into account underlying vulnerabilities in communities impacted by risks.

- In every part of the resilience system, **responsibilities and accountability** will be clear, coordinated, and coherent. The crisis management and resilience capabilities within the UK Government will be overhauled and strengthened. Local Resilience Forums in England will be strengthened and enhanced, in recognition of the vital role they play in resilience. The UK Government will have the emergency powers we need to act decisively in a crisis. Standards will be introduced throughout the public sector, to drive continuous improvement in preparedness.

- **Partnerships** with the private sector and experts will be strengthened to deliver and inform vital work on resilience. To support a new way of partnership working with the private sector, the UK Government will provide guidance on risk in order to help the private sector to meet new standards on resilience. These standards will be enforced through regulation only in the highest priority cases. The UK Government will build on existing structures to draw in external expertise and challenge to ensure that our approach is based on wide ranging knowledge and experience. The UK Government will continue to show leadership on resilience through international fora and through strong bilateral relationships, recognising the risks we face are part of an interconnected world. This will include providing support to international partners to build their own resilience, and working together to tackle risks before they manifest.

- A strengthened partnership with the Voluntary and Community Sector will support them to maximise their contribution to resilience at local and national level. Recognising the importance of protecting **communities** from the impacts of emergencies and crises, the UK Government will strengthen standards for statutory responders in England to consider community resilience as an essential part of their work. Support for vulnerable groups will be improved through better guidance for the local tier, and through work with the operators of essential services to identify and support vulnerable customers in an emergency.

- Resilience **investment** decisions in the UK Government will be underpinned by a shared understanding of risk and priorities, allowing a better and more efficient use of our capabilities and resources. Models of funding for Local Resilience Forums (LRFs) in England will be reviewed to ensure they are appropriate to the expectations placed upon them. The UK Government will incentivise further investment in resilience by the private sector through sharing better information on risk, to inform

investment decisions. Better information on risk will also help communities and households to decide how to invest in their own preparedness.

- A new Resilience Academy built out of the Emergency Planning College and **skills** and training pathway will ensure that all those who work on resilience have the capability and knowledge they need to play their part. A reinvigorated National Exercising Programme will test preparedness throughout the resilience system.

12. This work will be driven by the UK Government's new standing resilience function, the Resilience Directorate, and delivery has already begun. There are many actions in the framework that the Government is committed to delivering in the next year, including the first annual statement to Parliament on civil contingency risk and resilience, launching the UK Resilience Academy and appointing a Head of Resilience.

13. The UK Government is committed to working in partnership with the devolved administrations to implement change across the four nations where appropriate. The direct scope of the framework is action for England, UK Government departments and in areas where responsibilities in Scotland, Wales and Northern Ireland are reserved to the UK Government. Nevertheless, there are clearly areas where alignment and shared objectives will deliver a better result for the four nations. The end of each chapter outlines the applicability of the proposals across the UK.

Our action plan: **Risk**

On risk, we are already taking action by:

Refreshing the National Security Risk Assessment (NSRA) process, so it will look over a longer timescale, include multiple scenarios, look at chronic risks and interdependencies and use the widest possible range of relevant data and insight alongside external challenge.

Creating a new Head of Resilience, to guide best practice, encourage adherence to standards, and set guidance.

By 2025, we will:

Clarify roles and responsibilities in the UK Government for each NSRA risk, to drive activity across the risk lifecycle.

Conduct an annual survey of public perceptions of risk, resilience and preparedness.

Introduce an Annual Statement to Parliament on civil contingencies risk and the UK Government's performance on resilience.

Develop a measurement of socio-economic resilience, including how risks impact across communities and vulnerable groups – to guide and inform decision making on risk and resilience.

By 2030, we will:

Make the UK Government's communications on risk more relevant and easily accessible.

14. The starting point of all resilience work is understanding risk. In this framework we use 'risk' to refer to civil contingency risk.[10] A risk can be any event that poses a serious threat to safety and security of livelihoods either locally or nationally, this can include, amongst others, threats to lives; health; critical infrastructure; economy; and sovereignty. These risks can be acute (e.g. flooding and terrorist attacks) or chronic (e.g. an enduring health emergency or serious and organised crime).

15. In all parts of the resilience system, we are driven by the risks we face. Those risks determine which capabilities we need, which skills we need to develop, who we need to work with, how we invest our money, how we act in a crisis, and how we best recover from crises and emergencies. Some risks are well understood and are relatively easy to measure and predict, whilst others currently remain unknown and can only be identified in advance through sustained research and analysis across multiple fields of expertise. For this reason, we will always need to consider the right balance between risk-specific capabilities and cross-cutting capabilities to ensure we can be as prepared as possible for the widest possible range of risks. This framework focuses on the cross-cutting capabilities that are delivered through the resilience system, with risk-specific capabilities addressed through work being conducted across the UK Government and by partners.

16. The risks that influence our prosperity and stability are complex, evolving, and sometimes uncertain and this raises profound structural and societal questions. The UK Government needs to adapt the system to face these and incentivise risk-based decision making. To achieve this, we will make the UK Government's risk assessment more dynamic and insight- and foresight-led, taking greater account of complex, cascading and chronic risks. Central to this will be working closely with LRFs in England as well as wider partners to ensure they can make full use of these new assessments.

17. Alongside the framework for approaching civil contingency risks outlined here, the UK Government will work with the Government Risk Profession and the Government Risk Centre of Excellence to ensure appropriate cohesion and collaboration with the broader risk management community across the UK Government and the wider resilience sector. The Head of the Government Risk Profession will work closely with the new Head of Resilience, introduced later in this chapter. Further, the approach to assessment of civil contingency risk outlined in this chapter will complement broader risk management practices in the public sector, as outlined in the HM Treasury Orange Book.[11]

10 Primarily those that are outlined in the National Security Risk Assessment (NSRA), and its public counterpart the National Risk Register (NRR). Risks are also reflected locally in the Community Risk Registers (CRRs) of the four nations of the UK. All of these draw together the most significant risks from a range of more specialised assessments. The risks covered in the NSRA and NRR include malicious and non-malicious risks, and threats and hazards respectively. In this context we do not consider wider risks (such as financial, organisational or social), except where these are direct impacts of a civil contingency emergency. For example, the overall resilience of the NHS is not a civil contingency risk, but the impact of a civil contingency emergency on the operation of the NHS is in scope.

11 The Orange Book

Risk Assessment

18. Understanding civil contingencies risk is essential to everything we do, and our risk assessment methodology and processes are how we do this. Most risks are, by their nature, dynamic and hard to predict. We cannot therefore always perfectly predict how risks develop and manifest. But as the global risk picture evolves, and the impacts become more interconnected and complex, the way that we assess risk must also evolve. Assessment must be based on a wide range of relevant data, information and insight, and must be carried out on a timeline that bears proportionate relation to how risks develop.

The National Security Risk Assessment

19. **The National Security Risk Assessment (NSRA) will remain the main tool for assessing the most serious civil contingencies risks facing the UK.** The NSRA assesses, compares and prioritises the top national level risks facing the UK, focusing on both likelihood of the risk occurring and the impact it would have, were it to happen. This remains an invaluable tool for policy makers and operational leaders to form contingency plans for a wide range of scenarios that might impact on a national or local level.

20. In the last year, the UK Government has led the most substantial review of the NSRA since its inception (in the early 2000s), in conjunction with the Royal Academy of Engineering. Although the fundamentals of the NSRA remain solid, we have identified a set of significant and ambitious changes to ensure the NSRA is comprehensive, robust and incorporates extensive expert challenge. **The UK Government's ambition is to create an NSRA process which readily invites external challenge from experts, academia, industry and the international risk community. Relevant information from the NSRA, sensitivity permitting, will be openly available to the public.** By doing this we can maintain the UK's reputation as exponents of best practice in national risk assessment. To achieve this, the UK Government will work to make sure that the NSRA:

    - Includes clearer separate consideration of the interplay between **acute and chronic risks** as they require different planning and responses and are not equally measured through an identical process. Currently both are included in the assessment. However, we will do more to differentiate our approach to these two categories of risk in order to aid better planning. Linked to this, risks with significantly different planning and/or responses in their different manifestations will be represented by **multiple scenarios in the NSRA,** to aid planning against a wider range of possible impacts. Across all risks under the NSRA, we will improve how we factor in **consideration of impacts and vulnerabilities** to produce more accurate overall judgements.

    - **Uses the widest possible range of relevant data and insight.** For example, the National Situation Centre will expand the data sources on which the NSRA risk assessment is based. The UK Government will also increase the role of external expertise in the NSRA process.

- **Lengthens the timescale over which risks are measured.** It is currently over a two year period for most risks but we will look to measure some risks over a five year period where appropriate, while still providing a robust assessment of likelihood. We will identify the most efficient way to visualise risks measured over different timescales on the same matrix.

21. Further to these changes, in the longer term the UK Government will move towards making the NSRA a more live and interactive product, in order to provide resilience practitioners and policymakers at national and local levels with better risk assessment to inform their work. The benefits of this approach will be reflected in the National Risk Register (NRR), which is the publicly available counterpart of the NSRA and is important in communicating about risk with resilience practitioners.

Wider UK Government Risk assessment

22. While the NSRA remains our core centralised risk assessment tool, it is not the only government product that helps us to understand the civil contingencies risks we face. Looking beyond the timescales of the NSRA, there are forward-looking projects such as the Government Office for Science's Resilience Foresight project,[12] which identifies long-term governance, economy, social, technology and environmental trends that impact on risk and resilience, while its Trend Deck[13] sets out the broader evidence, trends and context for policy makers. The GO-Science Futures Toolkit[14] and Institute of Risk Management Horizon scanning: A Practitioner's Guide[15] show how trends can be used in foresight approaches to anticipate change and reduce uncertainty. The UK Government will use these tools within our risk and resilience planning to extend our risk horizon scanning and to improve the long-term resilience of government policy. We will also consider the value in making these or similar products available to key resilience partners to support their own risk and resilience planning.

23. The UK Government has many centres of risk assessment expertise spread across departments, agencies and arm's length bodies. One example is the Committee on Climate Change, an independent, statutory body, established under the Climate Change Act 2008 which advises the UK Government and devolved administrations on greenhouse gas emissions targets and climate risks and opportunities. It also monitors progress in achieving UK Government and devolved administration carbon budgets and emissions targets and implementing adaptation policies. We can and will do more to ensure that all these and wider sources of information and expertise are fed into our understanding of risk in a more coordinated and effective way. In addition to the commitments around the NSRA, the UK Government **will work towards sharing risk assessment with partners throughout the resilience system (including those outside of government) as our default position,** accepting that there will still be times when sensitive information will have to remain within government.

12 Resilience to long-term trends and transitions to 2050 – GOV.UK

13 Trend Deck Spring 2021 – GOV.UK

14 Futures toolkit for policy-makers and analysts – GOV.UK

15 Horizon Scanning: A Practitioner's Guide

Risk Ownership

24. The UK Government's ownership model on risk must ensure that all civil contingencies risks are appropriately and effectively managed and funded through all parts of the risk cycle. Effective and clear ownership of risk is not only important in a crisis, but also in planning for and recovering from it. It is vital that the government understands risks, how they might manifest, what impacts they have and which capabilities are available to tackle them.

25. **The UK Government will continue to use the Lead Government Department model to guide risk ownership, but there will be further clarification of roles and responsibilities for complex risks.** Currently, NSRA risks are primarily owned and managed within Lead Government Departments (LGDs), although LGDs must work with a range of departments and regulators to make sure they are well understood, managed and invested in across the risk lifecycle. Additional coordination or support comes from the Cabinet Office at times of crisis, particularly when the impact of a risk crosses sectors or is particularly geographically widespread. This model works well in principle, and in practice, in the vast majority of cases. But there are also limitations of the LGD model, particularly where risks become more complex, meaning that their impacts can cross departmental and sectoral boundaries. For example, the response to COVID-19 demonstrated the challenge for a single part of government leading on an emergency which reached deeply into all parts of the economy and society, and required leadership from all parts of government. Although there was an understanding of the risk of pandemic flu, treating it as a health emergency meant that there was limited planning outside of the healthcare sector.

26. To ensure, therefore, that all risk continues to be fully owned and managed, the UK Government will clarify roles and responsibilities for all NSRA risks. This is not a radical change to the LGD model and will continue to be underpinned by the core principles of subsidiarity and local leadership. However, we will review existing LGD responsibilities, ensure responsibilities are placed with those best placed to discharge them and provide clarity in accountability and responsibility for the small number of risks where ownership is less clear (e.g. where they currently span departments or are cascading risks). This will help the Cabinet Office and departments to support each other more effectively. For many risks, this will simply formalise and complement existing roles and responsibilities for owning risk, however for some risks we may need a bespoke model and for a small number of complex or catastrophic risks we may need a change to roles and responsibilities. This work will not create conflict with other duties or impinge on regulatory independence, particularly risks are owned by a department or Arms Length Body that has regulatory responsibilities for aspects of the risk cycle or for responders and other involved parties.

27. LGDs will continue to be responsible for driving activity across the risk lifecycle, including with other LGDs where relevant, and coordinating across government and partners as needed – particularly when it cuts across departmental boundaries. While good collaboration will continue to be vital, departments will need clear levers to ensure that they can take action.

28. While the LGDs are responsible for ensuring there are adequate plans and capabilities to manage their NSRA risks, as part of our efforts on risk ownership, the UK

Government will create a new Head of Resilience role to provide leadership for this system. This new role will guide best practice, support adherence to resilience standards, and test planning in a meaningful and proportionate way to support the LGD model. The Head of Resilience will complement the existing role of the National Security Advisor (NSA). The UK Government will ensure that a Head of Resilience will not duplicate or cut across the responsibilities of existing senior officials or LGDs but will provide leadership for the system. They would also not cut across the responsibilities of the devolved administrations, but would work with them in partnership.

Risk Communications

29. Working out how to appropriately tailor risk communications and the sharing of information on risk is complex. In some cases it can be important to share information in a broadly consistent way across all groups, in other cases different partners and groups will need different information about different risks. Similarly the levels of detail that will be needed or expected will vary. As an example, large corporations may need detailed and technical advice on cyber security, but this advice would be of no practical use to most individuals, who would be better served by general advice on good online security behaviours. Specialist advice is already available for many sectors and organisations. For example, the Emergency planning and response for education, childcare, and children's social care settings guidance[16] sets out how educational and childcare settings should plan for and deal with emergencies, and focuses on minimising the amount and length of any disruption to education or childcare.

30. Government communications on risks should draw on evidence-based principles for communications in an emergency; be transparent, accessible, diverse in platform, and tailored for the diverse audiences that we need to reach; as well as being designed in consultation with different socio demographic, vulnerable and at-risk groups who will require tailored approaches. They should also draw on 'trusted voices', recognising that those partnerships are often the best way of reaching audiences.

31. The UK Government will improve its communication of risk, focussing on personalisation (for organisations and individuals) as a means to ensure that organisations and individuals have access to relevant, actionable information. We will work closely with both national and local partners to develop and deliver these messages, as well as supporting partners to develop and deliver their own communications campaigns. The UK Government will not only communicate about the risk itself, but also the impacts of the risk so people better understand what they may actually see or experience, and the action that people can take to protect themselves and their communities. The UK Government will also be clear about the reasons why government cannot be transparent in discussing all risks, such as for reasons of commercial sensitivity or national security.

32. Vulnerable and at-risk groups and communities are often most impacted by risk materialisation, as seen in the current rise in the cost of living. The UK Government will develop appropriate communications on civil contingencies risks for disproportionately affected populations, engaging with these groups to better understand their barriers

16 Emergency planning and response for education, childcare, and children's social care settings – GOV.UK

to action and developing co-produced materials for use in risk planning and response. Working with local and national partners and those in these communities will be crucial to this. Developing tailored communications will also include how to avoid stigmatising particular communities.To support the UK Government's risk communications and ensure they are appropriately targeted, the UK Government will conduct **an annual survey of public perceptions of risk, resilience and preparedness** that uses a representative sample of the population. This will ensure the risk communications strategy is built on an understanding of how aware the public is of the risks we face and how prepared they are for emergencies.

33. The UK Government will increase public accountability on risk, to ensure that risks continue to be adequately assessed and prepared for. This will start with the introduction of an **Annual Statement to Parliament** on civil contingencies risks and our performance on resilience. This Statement will include the government's understanding of the current risk picture, performance on resilience and current state of preparedness. This will represent a shift in our transparency on risk, and will complement the more technical risk information provided to practitioners. It will also provide a public baseline for work on civil contingencies across the public and private sectors.

34. The UK Government will develop proposals to make our communications on risk personalised, and more relevant, actionable and easily accessible. Currently, advice from the UK Government on specific risks is available through a range of gov.uk pages which are successful in their own right, but are not necessarily easily accessible beyond their defined target audiences and do not give a holistic view when considering whole-of-society risks. UK Government departments also deliver communications campaigns on the risks that they own. For example, the FCDO's *Travel Aware* campaign provides easily accessible and dynamic travel advice, and its reach is increasing annually. However, this means that organisations and citizens who are not already formally part of the resilience system, or are not proactively searching for information on a risk, may find it difficult to access the information that is useful to them.

35. Making advice on risk more directly accessible to the public will not only improve the visibility of information on risk, but will also include an element of personalisation so that individuals, households and organisations have actionable information on how they can prepare for the risks that might impact them. There are already some examples such as *Ready Scotland*,[17] a Scottish Government website, providing relevant and actionable information for citizens and businesses in Scotland.

36. The **National Risk Register (NRR)** remains an important way for the government to communicate about risk with resilience practitioners. The NRR is the publicly available counterpart of the NSRA, aimed at providing detailed information for those with formal contingency planning responsibilities at a national and local level. The UK Government will reform the NRR, and include more information from the NSRA to make it more useful to practitioners and ensure this product is shared proactively with them and the wider public. The UK Government will also ensure the NRR is usable by local resilience partners, Small and Medium-sized Enterprises and community VCS

17 Ready Scotland

organisations, by better detailing the common types of disruption that could impact their business continuity.

37. The National Risk Register is complemented by **Community Risk Registers (CRR),** which are produced by the local tier. CRRs are based on the NSRA, risk assessments in the devolved administrations (such as the Scottish Risk Assessment and the Northern Ireland Civil Contingencies Risk Register), and the NRR, but focus on the risks that are the highest priority in each local area. The production and use of CRRs is the responsibility of local resilience partners (including LRFs). However, as set out in the *CCA Post Implementation Review 2022*[18] and as part of the wider strengthening of LRFs in England, the UK Government will strengthen the requirements around the production of the CRR so that responders consider community demographics, particularly vulnerable groups. As a first step, the improvements made to the NSRA and NRR should in turn make CRRs more dynamic and better aid local contingency planning. The UK Government will continue to review how it can support local responders to better communicate risks to the communities they serve and to tailor communications.

Using data to better embed risk in decision making

38. The UK risk picture is constantly changing. Modern technology means that we are better able to keep up, and to gather, analyse and visualise vast amounts of data to better understand and protect our vulnerabilities and identify how and where civil contingencies risks may manifest. It is important that decision-makers and experts have access to the right information at the right time during an emergency. This requires us to continue to improve our understanding of data flows, ownership, and interoperability as part of our preparedness. But quality matters as much as quantity, and the UK Government will continue to make improvements in the data and analysis that supports our decision making on risk, in advance of and during a crisis. The UK Government will also use external experts to test and challenge thinking on risk and resilience (more detail in the *Partnerships* chapter).

The National Situation Centre

39. The National Situation Centre (SitCen) within the Cabinet Office has been established to bring data, analysis and expertise together for crisis management. Announced as part of the *Integrated Review*,[19] and drawing upon lessons learned from the COVID-19 pandemic, the SitCen has accelerated the UK Government's journey of modernisation and use of data and wider information and insight. The UK Government will continue to deliver a step change in the use of data to assess risk and support the UK Government's crisis response. By continuing to develop the National Situation Centre, we will continue work in proactively identifying, monitoring and managing risks. Framed around the NSRA, the SitCen brings together expertise and a range of government, international, local, national and commercial data feeds to provide a holistic picture. The unique value of the SitCen is its ability to understand the intersection of multiple risks

18 Civil Contingencies Act 2004: post implementation review report (2022) – GOV.UK

19 Global Britain in a Competitive Age: the Integrated Review of Security, Defence, Development and Foreign Policy

and provide insights at pace due to its preparatory work and automated data pipelines. Key to this is the SitCen's data map, which can visualise how data feeds, risks and impacts interact.

40. The SitCen started operating on 30 September 2021 and has already made a step change in the speed at which data is drawn together, analysed and made available across the government. During the UK Government's response to Russia's invasion of Ukraine in early 2022, the SitCen acted as a central point for data, insights and analysis on international, national security and domestic implications.

41. A focus on continuous capability development and innovation is core to SitCen's future evolution. In terms of internal systems, greater automation is a near term goal, leading to use of machine learning techniques to create models capable of testing, refining and expanding linkages between data sets, which may ultimately pave the way for the creation of digital replicas of the real world, known as digital twins or synthetic environments. Looking more broadly it is important that we consider the wider systems in which we operate and the partners who both act as key sources of data and information and who may come to be key users of outputs and analysis. Our ambition is to be able to draw in relevant data points from across the private and public sector, including Local Resilience Forums in England where we will support them in building their capacity and capability as a key part of their strengthening.

42. This is underpinned by the SitCen's data strategy, which maps public and private sector data against the NSRA risks. This supports more effective and rapid deployment of data during crisis response, as well as improving resilience by identifying and addressing data gaps. The SitCen regularly convenes a cross-government network of crisis data experts to support this, and to promote resilience through best practice for using data in crisis response.

Social Vulnerability

43. With the UK facing an increasingly complex risk landscape, it is critical that the UK Government is able to fully utilise all available information both before and during crises. If we are to improve resilience across the whole of society and make targeted interventions during crises, we must ensure we understand which groups are acutely vulnerable to local and national risks.

44. Improving the use and sharing of data, analysis and insight will allow us to improve our understanding of how different groups and communities might be affected by emergencies and give planners and responders the information they need to understand and serve their communities at all stages of the resilience cycle.

45. The UK Government has always known that risks do not impact communities equally across the UK for a wide variety of factors. Recently, we have seen that the impacts of COVID-19 had a disproportionate impact on ethnic minority and low income groups. Plans and preparations must reflect this and enable us to better plan, prepare, respond and recover from crises.

46. To support that, the UK Government, with input from Local Resilience Forums in England and wider partners, will **develop a measurement of socio-economic resilience** and vulnerability to key civil contingencies risks, including how civil

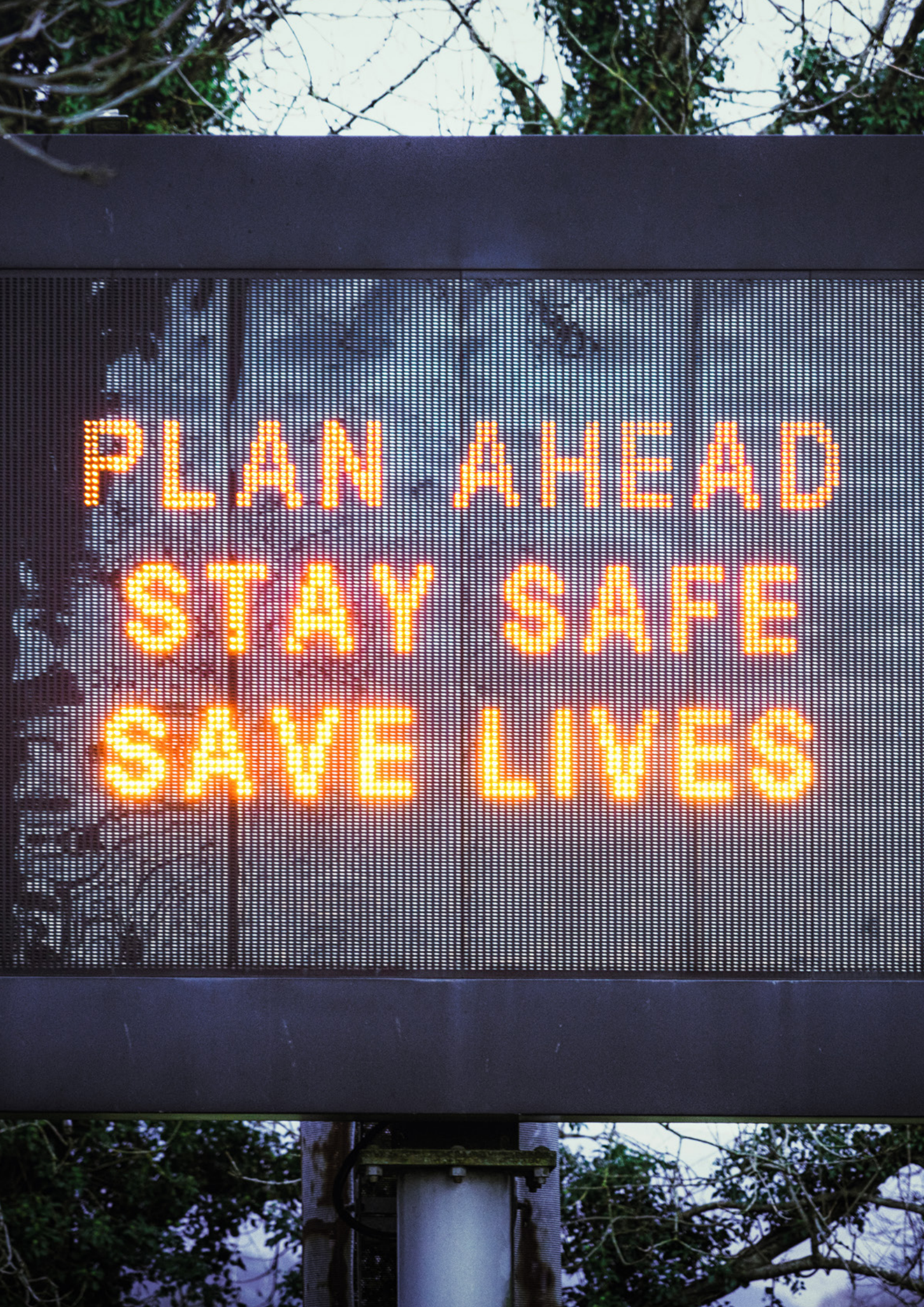
contingency risks and emergencies impact across communities and vulnerable groups, to guide and inform decision making on risk and resilience. This measurement will need to be driven by a nuanced view of vulnerability and the factors that can cause vulnerability, and will be informed by behavioural and social science evidence. This tool will use new and existing data to **provide a snapshot of the key characteristics of local areas,** and build the evidence base on how risks and emergencies have impacted across communities and vulnerable groups and assess where there may be particular vulnerabilities to civil contingencies risks. The devolved administrations will also be encouraged to participate where beneficial. The tool will:

- Support the UK Government LGDs in understanding **how the implications of their risks materialising will impact communities differently** and ensure that their prevention and planning takes into account these differentiations.
- Offer a key tool in **developing targeted communications strategies** and offer a degree of personalisation in the risk information available to the public.
- Be **an open tool that LRFs in England and the wider local tier and voluntary and community sector** will be able to use to support their own work.
- **Enable stress-testing of national (LGD) contingency plans** and be able to add depth to exercising through the National Exercise Programme (see *Skills* chapter).

Applicability across the UK

Some of the actions proposed in this, and the following chapters, will be the responsibility of the UK Government, some will be the joint responsibilities of the UK Government and the devolved administrations, and some wholly the responsibilities of the devolved administrations. At the time of publication, it is anticipated that:

- The DAs will remain involved in the production of the NSRA, and will continue to use it to inform their own activity.
- The principle of risk transparency is shared with the DAs, but for specific products the decision on transparency will sit with existing owners.
- Changes to risk ownership and governance within the UK Government will not directly change any arrangements inside the DAs, although the UK Government will be mindful of any adjustments needed in working practices as a result of these internal developments.
- The Annual Statement to Parliament on civil contingencies risk will be produced by the UK Government, and will cover risks that impact reserved competencies and international risks. In this context, it will refer to joint working with the DAs on these risks.
- Improvements to risk communications will be developed by the UK Government and will be accessible to residents in all four nations. These will also draw on advice provided by the DAs.
- The proposed measure of Social Vulnerability will draw on ONS data covering all four nations and will be an open tool, accessible to the DAs. The UK Government would welcome additional data from the DAs.


PLAN AHEAD
STAY SAFE
SAVE LIVES

Our action plan:
Responsibilities and Accountability

On responsibilities and accountability, we are already taking action by:

Strengthening UK Government resilience structures by creating a new resilience function to deliver longer term capability building and risk mitigation to work alongside the UK Government's crisis management infrastructure.

By 2025, we will:

Expand the scope and use of standards and assurance in the public sector to support better contingency planning and risk management.

Run a pilot across three key pillars of reform to significantly strengthen Local Resilience Forums (LRFs) in England: Leadership, Accountability, and Integration of resilience into the UK's levelling up mission.

By 2030, we will:

Expand the scope and use of standards and assurance in the public sector to support better contingency planning and risk management.

47. The approach to resilience within the UK public sector is driven by the efforts of UK Government departments, arm's length bodies and agencies, devolved administrations, local authorities, LRFs and a wide range of responders. The extensive efforts of the private and voluntary and community sectors are covered in the *Partnerships* chapter. In planning, preparing, responding and recovering from emergencies it is essential for each part of the system to understand their role and specific responsibilities.

48. Our strategic approach will continue on the basis of where responsibility and accountability lies in the system, but this framework will further clarify and develop the roles and responsibilities of the UK Government, LRFs and the wider Local Tier, all Category 1 and 2 responders and the Military. In some cases this framework outlines new or strengthened roles and responsibilities and makes those accountable for resilience more visible to local communities. The responsibilities of the devolved administrations in resilience will remain unaltered, but the UK Government will continue to support a strong and clear understanding throughout the resilience system of the vital role that the devolved administrations play in the UK's resilience. The framework underpinning UK resilience is the Civil Contingencies Act (CCA) 2004 and this together with clearer expectations will enable all parts of the system, across the whole resilience cycle, to work together with renewed clarity and confidence.

UK Government

49. The UK Government will continue to provide leadership across the resilience cycle, but its responsibilities will be clarified and, in some cases formalised, to provide clarity to other partners. The Lead Government Department (LGD) model will continue to guide responsibilities on resilience, as covered in the *Risk* chapter. The devolved administrations will continue to lead on devolved areas of resilience policy and practice.

Crisis Management in the UK Government

50. We will significantly overhaul UK Government resilience structures to ensure that we can draw on world class capabilities and resources during an emergency, whilst in parallel delivering longer term capability building and risk mitigation. This will ensure that we have dedicated resource across the risk cycle from assessment, prevention and preparation to response, recovery and lessons capture.

51. Throughout numerous domestic and international crises – the Salisbury attack, the Russian invasion of Ukraine, terrorist attacks, and floods – the UK Government has proven its ability to quickly stand up a world class response. However, this range of recent emergencies has naturally tested our existing arrangements. While we have been able to successfully provide an effective response, there is no room for complacency. We need to continue to build our collective resilience, bolstering our existing strengths and preparedness and continue to strengthen our ability to anticipate, prevent, prepare, respond and recover from emergencies.

52. To do this, we have refocused our work on prevention and preparation by creating a dedicated function for resilience, the Resilience Directorate, to focus on the prevention and mitigation of both acute and chronic risks rather than only dealing with the consequences of crises.

53. The new Resilience Directorate sits at the heart of UK Government and takes a strategic approach to economic and societal resilience, overseeing how we are tackling both acute and chronic risks in order to make the UK a stable and safe place to live and work. It drives the implementation of the measures set out in this framework and also works across government to develop a programme of action to bolster critical cross cutting capabilities, building on successful work to date such as supply chain resilience. It gives the UK Government the opportunity to properly focus on major challenges, anticipating and properly preparing for the crises of the future.

54. The new Resilience Directorate works alongside the UK Government's crisis management infrastructure, which has been developed over many years, and is highly regarded internationally. This separate crisis management function – COBR Unit – leads the UK Government's response to acute emergencies and drives further professionalisation of emergency management in government. Delivery capacity and capability will be uplifted by crisis teams and resources that are composed of crisis professionals, with the time and resource to prepare and exercise their capabilities, to ensure that they can respond whenever needed. Key to this is the need to make sure that while the Cabinet Office must have the right crisis structure, ownership of risk and crisis roles must also be clear between departments. The new approach to risk ownership outlined in the *Risk* chapter will be part of this ongoing management of risk within government, but our new crisis structures also makes sure that this ownership is reflected in protocol and responsibilities during an emergency.

55. The UK Government will **continue to invest in our crisis response infrastructure** at the centre of the UK Government, to maintain the momentum of improvements in the use of data and technology, alongside maintaining the necessary security to protect discussions appropriately. The system is designed to be flexible and has been repeatedly adapted to meet a changing risk landscape with subsidiarity at its core. The UK Government Concept of Operations (CONOPs)[20] describes the UK response model and this will be updated to reflect this framework shortly after publication. The Cabinet Office Briefing Rooms (COBR) remain the key mechanism through which the UK Government responds quickly to emergencies that require decisions urgently. A resilient environment for strategic decision-making during crises, COBR brings people together to respond to domestic and international emergencies affecting UK interests. The UK Government has already launched a new National Situation Centre in 2021 to enhance our data analysis and visualisation capabilities. The UK Government also brought a series of planned infrastructure improvements in COBR into service to better support decision making discussions.

56. The UK Government will continue to maintain a number of specialist central crisis management capabilities, across the command, control and communications (C3) spectrum. A current example of this is the Resilient Satellite Network (RSN) which provides an alternative form of communication during a scenario when terrestrial communication has been disrupted. The system is placed in Police HQs, certain UK Government departments and Civil Contingency offices across the four nations. Consequently, the system ensures stable communications with those who lead crisis response in the most challenging scenarios.

20 The central government's concept of operations – GOV.UK

57. The UK Government will shortly introduce a new system of Emergency Alerts. This system is already used internationally, and is expected to launch in early 2023. It will allow government organisations and emergency responders to send alerts, with a distinctive message appearance and tone, to every compatible mobile device (over 85% of 4G/5G smartphones released since 2015) within a chosen geographical area at very short notice (typically seconds), providing a highly flexible capability for informing and where appropriate prompting rapid action from the public in the vicinity of a life-threatening incident. Their key attributes are speed of delivery and versatility – they can be used in any life-threatening situation where the public need to be given life-saving information.

Formalising UK Government Departments' Responsibilities

58. There are excellent examples of partners throughout the system working together openly and seamlessly during an emergency, but too often we have found that this is dependent on individuals or informally agreed ways of working. While this can be effective, we need greater assurance that we can depend on vital links between local and national partners working effectively. For most parts of the resilience system there are duties to set expectations about how essential parts of the system carry out their roles to the necessary standard, which in turn ensures that the system as a whole can function.

59. The UK Government should not be an exception to this. One of the functions that UK Government departments must carry out is to effectively share appropriate information with the local tier. While some information is sensitive and this should continue to be protected, there is more we will do to share information about risk with all our partners. But supporting and guiding contingency planning in local areas goes beyond just sharing aspects of the NSRA. At any point in an emergency – whether it is as a risk is starting to materialise, or when recovery efforts begin – it is essential that the local tier is able to access the information it needs in order to make informed local decisions. Too often, we have heard that the UK Government is slow to keep local responders informed in an emergency, which hinders efforts on the ground.

60. **The UK Government will consider a range of options for improving this and develop an action plan to deliver these,** including by developing proposals for formalising duties on UK Government departments, particularly in respect of working with Local Resilience Forums and wider local responders in England on resilience across the whole resilience cycle. Any new duty would be subject to an impact assessment, to ensure that it did not place a counterproductive burden on the UK Government department and would not alter the fundamental roles of either the UK Government or the devolved administrations on resilience.

61. In addition, as part of a renewed effort to improve working between the UK Government and local partners, all UK Government departments must make sure that they have appropriate fora and mechanisms for working with local responders, and that all guidance is up to date and effective.

The Local Tier & Local Resilience Forums

62. The multi-agency work across planning, preparation, response and recovery at the local level will continue to be the building block of the UK's resilience. All risks and emergencies and their impacts are local; only some are regional or national. The 38 Local Resilience Forums (LRFs) in England, the four LRFs in Wales, three Regional Resilience Partnerships (RRPs) in Scotland and Emergency Preparedness Groups (EPGs) in Northern Ireland play a critical role in bringing local responders, such as the emergency services, together to plan and prepare for emergencies. They are supported by the common framework for multi-agency working provided by the CCA drawing together individual Category 1 and 2 responders.[21]

63. In England, the LRF multi-agency model plans and prepares for risks and emergencies; leads multi-agency response and recovery activity through the standing up of Strategic Coordination Groups and Recovery Coordination Groups; and coordinates support for communities. The recent Post Implementation Review of the CCA[22] made clear that the core principles of subsidiarity and local leadership remain critical. However, we must recognise that expectations and pressures on local resilience structures have grown significantly over recent years, and that this is unlikely to change in the future.

64. The UK Government remains fully committed to working closely with the devolved administrations to ensure integration of respective approaches, share best practice and learning, and ensure strong cross-border collaboration – delivering on our duty to protect citizens in every part of the UK. The devolved administrations have their own established and effective local resilience partnerships, and these will not be impacted by the planned strengthening of English LRFs.

65. Building resilient places and communities will be critical in our mission to Level Up and drive growth across the United Kingdom. Risks, emergencies, and disruptive events can damage local economies and limit new investment, reducing the potential of areas to take advantage of the opportunities of levelling up and the new global Britain. We also see that disruptive events can affect different areas in different ways, with the most vulnerable often the most severely affected. Empowering local areas and communities to build their resilience, including providing appropriate additional support to the most vulnerable, will enable our places and communities to be better prepared and able to respond to and recover from emergencies. This in turn has the potential to reduce the overall impact, disruption, and cost of adverse events, as well as reducing key vulnerabilities in communities and places.

21 Category 1 responders are organisations such as the Local Authorities, the Police Force, Fire and Rescue Service, Ambulance Service, some NHS bodies, Environment Agency and Maritime and Coastguard Agency. Category 2 responders are organisations such as Electricity and Gas Network Operators, water and sewerage undertakers, telephone service providers, railway, port and airport operators and the Health and Safety Executive.

22 Civil Contingencies Act 2004: post implementation review report (2022) – GOV.UK

The ambition for change in England

66. In recognition of the central, and growing, role of LRFs and to ensure that all parts of England can anticipate, prevent, prepare for, respond and recover from risks and emergencies, the UK Government will work to **significantly strengthen LRFs.** There are three key pillars to this reform: Leadership, Accountability, and Integration of resilience into the UK's levelling up and growth mission and wider local policy and place making. Recognising the scale of this change, the UK Government will work closely with the sector and begin with a programme of piloting and trailblazer projects.

67. The aim is to empower LRFs, local partners and local leaders to consider, drive and improve resilience across the places for which they are responsible. They will be given a clear mandate to support the building of more resilient communities and places that are best able to adapt and respond to, and recover from risks, emergencies and disruptive events and to take full advantage of the opportunities of levelling up. This will include identifying those communities most vulnerable to key risks and addressing these vulnerabilities to build their resilience.

Leadership of LRFs in England

68. As the role and expectations on LRFs have grown to meet the varied challenges of recent years, so too has the role of LRF Chairs. For many years LRFs have been led to great effect by committed senior leaders drawn from a variety of responder organisations, including the Police, Fire Service and Local Authorities. This has typically been as part of a wider role within their organisations that included a range of other duties and responsibilities. The UK Government will work with LRFs and their members to **ensure LRF leaders have the resources, capacity, and capability to sustain this work** as they engage with an ever more challenging risk landscape and drive resilience in their areas.

69. It is critical to the success of LRFs that senior leaders from the organisations outlined in the CCA and beyond continue to take a key leadership role in the work of LRFs. It is equally vital to ensure that LRF Chairs have the capacity and capability to lead LRFs in delivery of the strengthened roles and responsibilities we are proposing. They will need the time and space to fully embed themselves and their LRFs in wider local structures – including working in close partnership with locally elected democratic leaders and the full range of senior leaders across local government and responder organisations. To best enable this, **the UK Government will work with the sector to pilot evolving the nature of the LRF Chair role, including considering a full time permanent role occupied by an appropriately qualified and experienced individual who will become the Chief Resilience Officer (CRO) for each LRF area.** The LRF CRO should be provided with the resources, support, mandate and levers to bring together the full range of partners to drive and enhance resilience in their areas and we will work with the sector to consider how best we can do this. The LRF CRO will be distinct from the UK Government Head of Resilience role discussed in the *Risk* chapter, with both having complementary leadership roles across the resilience system.

70. The UK Government will set clear expectations for LRF Chief Resilience Officers to lead the building of resilience and delivery of resilience activity in their areas and **they will be accountable to executive local democratic leaders.** This will **give these democratic**

leaders a clear role in ensuring effective delivery of resilience activity, including integrating resilience into wider local delivery and levelling up.

71. As set out in the 2022 Post Implementation Review of the CCA,[23] at present the fulfilment of the duties of the Act by Category 1 and 2 responders remains fit for purpose. However, we recognise that the evolving risk landscape, and the ambition to strengthen LRFs in England may require future consideration and may necessitate future changes to underpinning legislation and regulatory frameworks.

Accountability for LRFs in England

72. **Strengthening the accountability and assurance across LRFs** in England will ensure local leaders have key tools to drive the building of resilience and multi-agency collaboration in their communities. **Clear mechanisms and expectations for accountability between LRF Chief Resilience Officers and executive local democratic leaders** will make LRFs more accountable to the communities that they serve and provide a mechanism for **local communities to hold local leaders to account for driving and delivering resilience.**

73. To support this, we will consider the best way to develop a means of stronger assurance of LRF collective delivery in England, including auditable frameworks, to set and drive standards and support local places to develop their resilience whilst providing assurance of levels of resilience across the LRF system and England as a whole. We will build the assessment of resilience activity into the inspection and audit regimes of individual responders, working closely with the relevant assurance and inspection bodies. **Alongside this we will establish clear mechanisms for the assurance of the multi-agency activity at LRF level.** This will give local leaders new information and tools to understand the impact of their work, identify areas for improvement or mitigate risk or vulnerability by targeting resilience activity.

74. The introduction of new assurance activity will contribute to continuous improvement in emergency management, provide further opportunities to celebrate and share good or best practice and crucially address emerging risk through early mitigation measures or prevention activity. Alongside this it will enable the UK Government to consider the level of support that may be required (before, during or after an emergency) to assist the local level at any stage of the resilience cycle.

Integration of Resilience into Local policy and place making in England

75. The UK Government needs to build a solid foundation of resilient communities and places, drawing on the full range of national and local levers. This means **placing resilience at the heart of levelling up and wider place making.** This will ensure that all areas can take advantage of the opportunities this affords, tackle key vulnerabilities, and minimise the potential for risks and emergencies to stop areas achieving their full potential. The UK Government will **empower the new LRF CRO and the local elected leaders work across the full range of local policy making and delivery** to make the

23 Civil Contingencies Act 2004: post implementation review report (2022) – GOV.UK

building and delivery of resilience central to wider place making, including other key policy areas such as Net Zero and Build Back Better.

76. **Resilience will be included as a key aspect of the local devolution deals in England** being delivered as a part of levelling up, with local areas taking formal responsibility for building and delivering local resilience. The UK Government will work with areas not preparing a devolution deal **to integrate resilience into wider delivery** including, as appropriate, working with Police, Fire and Crime Commissioners to make resilience the third strand of community safety. Alongside this we will consider the case for making Combined Authorities and Mayoral Combined Authorities Category 1 Responders.

77. The UK Government will encourage and facilitate stronger collaboration between regions and across the four nations to maximise the opportunities for shared learning, insight, and cooperation. Similarities between areas are not just geographical and we will link places, even if they are at opposite ends of the country, to share good practice.

78. The UK Government will work with LRFs to strengthen data, intelligence and analysis capacity and capability. This will support them to make the best use of data to target activity and measure success as well as being a vital tool in response and recovery. Central to this will be ensuring appropriate sharing of UK Government data and information and building strong links with the National Situation Centre.

Civil Contingencies Act 2004 and Emergency Powers

79. Emergencies can require quick action, and they require powers to allow us to take that action. They require government, responders and businesses to work with partners in a way that they would not normally. When dealing with crises, actual or potential, it is vital that we have the powers we need to take decisive action.

80. The Civil Contingencies Act (CCA) 2004 will continue to be the legislative basis for the UK's resilience frameworks.[24] The CCA sets out a framework for emergency preparedness. It provides a definition of 'emergency', sets out arrangements for multi-agency working at the local level, and provides emergency powers to allow the UK Government to make temporary legislation in the most serious of emergencies. The Act is made up of two parts:

    - Part 1: local arrangements for civil protection, establishing a statutory framework of roles and responsibilities for local responders.
    - Part 2: allows for the creation of temporary special legislation in an emergency without prior parliamentary scrutiny.

81. Under the CCA, there are two groups of responders that have defined responsibilities. Category 1 responders are those that have a statutory duty to plan for emergencies and put those plans into action when an emergency occurs. Category 2 responders

24 In Northern Ireland the CCA currently only applies to the PSNI and MCA as Category 1 responders and certain telecommunications operators as Category 2 responders.

are obliged to cooperate with and share information with local responders to aid planning activity.[25]

82. The CCA was subject to statutory review in 2022, and this review recommended some amendments to primarily Part 1 of the Act and found that Part 2 remains fit for purpose with no need for fundamental alterations. The review identified three areas in which the Act should be further strengthened.

83. Firstly, there is a need for enhanced accountability for the multi-agency preparedness activities conducted by local resilience arrangements. To support this, the UK Government will clarify the statutory and non-statutory guidance around accountability where these components come together in the planning and emergency response stages. New methods for accountability and assurance for resilience will continue to be considered as part of the measures to strengthen LRFs.

84. Secondly, while the CCA sets out expectations on responder organisations clearly, it does not ensure adherence to those expectations. As part of the wider strengthening of the roles and responsibilities of LRFs, the UK Government will consider putting the Resilience Standards that apply to responder organisations in England onto a statutory footing, and will require categorised responders to publicly state how they are meeting their obligations under the CCA. An impact assessment will be done as part of those considerations to ensure no counterproductive burden is placed on responders.

85. Thirdly, the definition and scope of Category 1 and 2 responders (see above) remain effective, and there is not yet a case for expanding or changing the duties of either category. However, the statutory review of the CCA recommended adding two new Category 2 responders (the Met Office and Coal Authority). Likewise, as part of the wider strengthening of LRFs we will look at strengthening the requirement to produce a Community Risk Register (CRR) to require responders to consider community demographics (particularly vulnerable groups) in preparing and communicating their CRR, to further consider how emergencies impact on communities.

86. The review also recommended bringing the legislation up to date with current local responsibilities. The role of the Regional Nominated Coordinator in England, originally added to the Act to aid coordination, will be removed. Instead, we will focus our efforts on working through existing local structures and reporting mechanisms.

87. **The emergency powers under the CCA remain fit for purpose.** The primary conditions placed on their use need to be maintained to prevent misuse of the power and ensure that, wherever possible, any legislation required to respond to an emergency goes through Parliament in the normal way. The UK Government has shown we can introduce emergency specific primary legislation to tackle risks but we will consider the need for new non-legislative options to ensure we can act effectively in an emergency.

88. The UK Government will continue to use **sector-specific legislation** to tackle risks, as they develop and after they have become emergencies, maintaining the CCA powers as an important option of last resort.

25 Civil Contingencies Act – Category 2 Responders: overview of sectors and emergency planning arrangements

The Devolved Administrations

89. All four nations of the United Kingdom share the same goal – to protect our citizens from the impacts of crises. Resilience encompasses both reserved and devolved matters. This means that some elements of the resilience system are overseen by the UK Government and it is important that the UK Government works in partnership with the devolved administrations (DAs) as reserved issues may impact devolved responsibilities. Significant elements of resilience are wholly the responsibilities of the devolved administrations.

90. Crises do not always fall neatly within the boundaries between the four nations of the UK and all four nations have their own Administrations, their own local structure and resilience partners, and their own emergency services. The resilience system must respect these differences, whilst making sure that when crises do spread across the UK every part of the system can come together to tackle it. The UK Government is committed to working in partnership with the devolved administrations to implement change across the four nations where appropriate, to ensure that citizens in every part of the UK are protected from crises.

91. Where they have responsibility, the **devolved administrations will continue to drive resilience activity in their nations, and in partnership with the UK Government, where it has responsibility wherever appropriate.** Whilst much of resilience is devolved, we can derive great collective strength and resilience from fostering and building on strong joint working and mutual support. This can range from the active sharing of new ideas to enhanced protocols for cross border and cross-regional support in times of heightened risk or when responding to or recovering from emergencies. We also recognise that similarities in areas are not always bound by the nearest neighbour and we will link places that reflect the local picture even if they are at opposite ends of the country to share good practice.

92. In order to maximise cooperation on a four nations basis, there will be periodic ministerial level meetings on resilience, informed by quarterly senior official quad meetings and regular official-level contact, as part of a joint governance process.

The Armed Forces

93. Over the last few years, the armed forces have become one of the most familiar public faces of an emergency. In addition to its primary role of protecting the UK, its citizens and interests, the military can also contribute to domestic resilience through MACA (Military Aid to the Civil Authorities), allowing civil authorities to request military aid during crises. Under this process, they have driven ambulances, rescued households from floods, administered vaccines and much more. The military can provide essential specialist skills and deploy a volume of personnel at short notice across the UK. But the Armed Forces are facing pressure as risks multiply and diversify both at home and overseas, and they cannot be the first port of call whenever an emergency hits. **The armed forces will continue to play a vital supporting role to the civil authorities in resilience, but will not be asked to take on an enhanced role.**

94. Record numbers of personnel have been deployed on MACA operations in recent years, with approximately 34,000 servicemen and women (about 21% of the UK's

Armed Forces) deployed to support the UK pandemic response. However, alongside the increase in demand for MACA, the re-posturing of Defence and the need to meet increased persistent overseas threat means that requests for military assistance will need to continue to meet a high bar for authorisation. Utilising the Armed Forces in domestic resilience tasks comes with a cost: both financial for the requesting UK Government department or Devolved Administration, and to the Armed Forces in the military capability diverted from its primary role of protecting the UK's national interests.

95. The UK Government will continue to work towards maximising the effectiveness of civilian organisations, with a view to reducing reliance on the Armed Forces. Therefore a more strategic application of MACA will be required in the future as requests for MACA should be an instrument of last resort[26] and only used when:

- There is a definite need to act and the tasks the Armed Forces are being asked to perform are clear;
- Other options, including mutual aid, commercial alternatives and the voluntary sector have been discounted;
- The civil authority lacks the necessary capability to fulfil the task and it is unreasonable or prohibitively expensive to expect it to develop one; or
- The civil authority has all or some capability, but it may not be available immediately, or to the required scale, and the urgency of the task requires rapid external support from the MOD.

96. The military will remain an ultimate guarantor of national security and resilience in emergencies, however, utilising our Armed Forces for non-emergency, routine tasks where the military do not play a specific and defined role should be seen as an indication of policy failure, inadequate resilience planning or chronic underinvestment. There will be a shift to deliver some MACA through locally-based Reserves and the UK Government will retain existing MACA thresholds and encourage adherence to them.

97. Reserve service personnel already participate in the full spectrum of the UK Armed Forces, including recently in operations in support of the UK Government's COVID-19 response. In the future, as a part of Defence's Integrated Operating model, it is envisaged that the Reserves will play a greater role in resilience operations and MACA. Key to this will be an enhanced relationship between Defence and the employers of Reservists who may be asked to release them for military duties at shorter periods of notice.

Standards and Assurance

98. Good assurance, based on commonly understood standards across the public sector, can help to ensure that work across the resilience sector will have a positive real world impact. The UK Government will **expand the scope and use of standards and assurance across the public sector in England and develop an action plan to deliver this,** to support continuous improvement in risk management and

26 As defined in the Joint Doctrine Publication 02.

preparedness. Although this approach needs to be flexible according to the needs of the sector, without meaningful, robust and standards-based assurance, risk-owning principals, stakeholders and potentially affected parties have no reliable way of knowing whether capabilities and arrangements to respond to risks and impacts are effective. This approach will be supported through an enhanced offer on skills and training, to help all those working on resilience to meet these standards.

99. There are some existing standards and frameworks in England at national and local levels in relation to specific risks and resilience capabilities. For example the National Resilience Standards for LRFs[27] set out expectations of good and leading practice for LRFs, which build on and complement statutory duties under the CCA and other relevant legislation, however there are no current mechanisms for more formal assurance against these standards. More broadly some sectors are regulated and some organisations are inspected but others are not, so arrangements are not complete or coherent at the system level.

100. The UK Government will adopt a **standards-based approach to assurance and develop an action plan to deliver this,** setting out what organisations, partnerships and networks should do, should have and should be able to do in order to manage risks effectively, including those within the NSRA, and competently respond to and recover from emergencies arising from those risks. This will introduce greater rigour, provide greater consistency and transparency in assessments, and enable continuous improvement through identifying lessons to address and good practice to build on. To support this, the UK Government will build upon existing structures to develop **assurance frameworks** that will span departments and agencies, national and local resilience capabilities and arrangements, and encompass Critical National Infrastructure (both public and privately owned) and essential services.

Recovery

101. Recovery is a key stage in the resilience cycle and can have an important role in catalysing regeneration, renewal and future prevention in the aftermath of an incident. Whilst recovery is woven across all areas of the resilience system, there are some additional specific actions that will be taken.

102. Strengthened LRFs and their partners in England will continue to have a central role in the planning for and delivery of recovery activity. Working with the VCS and communities they will put plans and protocols for recovery activity in place and will work with these same stakeholders to deliver recovery activity should incidents occur. This includes ensuring the needs and views of communities are fully considered and understood.

103. The UK Government's LGDs will take responsibility for the provision of clear guidance across government and to LRFs and wider partners on considerations for recovery related to their risks, ensuring appropriate advice and support are available should they be required. This will sit alongside a refreshed set of national recovery standards and updated National Recovery Guidance.[28]

27 National Resilience Standards for Local Resilience Forums

28 National Recovery Guidance – GOV.UK

104. As an initial measure, **the UK Government will also offer guidance to the local tier on how mental health and psychosocial awareness** can be intrinsically factored into recovery work, to support those affected beyond their physical needs.

105. It is absolutely right that UK Government funding is targeted where the highest impact will be made, including investing more in prevention and preparation. It will always be the case however that emergencies will continue to happen. Where communities are impacted by emergencies the default remains for this to be managed locally, however in exceptional instances the UK Government may intervene to provide additional support and coordination.

106. At present financial assistance for recovery activity is usually agreed on a case-by-case basis. To ensure consistency for our partners, and building on the example of the Flood Recovery Framework,[29] we will seek to provide greater clarity and guidance on when and how the UK Government may intervene, and consider if more formal arrangements should be developed to cover recovery from wider risks.

107. We will strengthen the evidence base on recovery, including developing tools for measuring and assessing the efficacy of recovery interventions. Building on this we will aim to enhance our understanding of what works in supporting communities to manage and recover from the impacts of emergencies to inform future policy development and planning.

Applicability across the UK

At the time of publication, it is anticipated that:

- Any statutory duty considered for UK Government departments will not apply in the devolved administrations.
- The proposed strengthening of Local Resilience Forums will only apply to LRFs in England.
- The expanded use of assurance and standards will apply to England and to reserved sectors across the UK. The UK Government and devolved administrations will work together to ensure that approaches are aligned.
- The scope and applicability of the CCA will remain the same. Any new sector-led legislation will be led by the UK Government, in consultation with the devolved administrations on a case-by-case basis.

29 Flood recovery framework: guidance for local authorities in England – GOV.UK

Our action plan: **Partnerships**

On partnerships, we are already taking action by:

Continuing to take international, bilateral and multilateral action and cooperation on risk and resilience.

Continuing to use the UK Government's international action to identify and tackle risks before they manifest.

By 2025, we will:

Grow the UK Government's advisory groups made up of experts, academics and industry experts in order to inform the NSRA. This may include establishing a risk-focused sub-group of the UK Resilience Forum.

By 2030, we will:

Introduce standards on resilience across the private sector, where these do not already exist, adjusted to take into account the current landscape, priorities and needs across and between sectors.

Provide the wider private sector with better guidance on resilience to support contingency planning and risk management.

Build upon existing resilience standards for CNI to create common but flexible resilience standards across CNI, and do more on the assurance of CNI preparedness.

Review existing regulatory regimes on resilience to ensure they are fit for purpose. In the highest priority sectors that are not already regulated, and for the highest priority risks, consider enforcing standards through regulation.

108. The resilience of the United Kingdom cannot depend solely on the ability of the public sector to organise emergency preparedness or lead a response in times of crisis. The private sector already provides many services and much expertise on resilience, and is essential in preparing for and managing long term risks, in addition to their role in responding to crises. Our vision is for a much fuller integration of these private and third sector partner organisations into our resilience frameworks, through a combination of new opportunities, guidance and obligations.

109. We must also look beyond our borders to strengthen our resilience. We live in an increasingly interconnected world. We consume food and goods shipped from the far corners of our planet, and we connect with individuals at home and abroad through technology that is constantly changing. Many risks are global in nature, or require global action. Our lives are therefore often affected not just by our own actions, but by those taken across the world.

Private Sector

110. Businesses, especially those that run essential services and Critical National Infrastructure (CNI), are an active partner in building our resilience. Many sectors and businesses are already well aware of the risks that they face, and actively undertake effective contingency planning. Others are actively involved in increasing the UK's resilience and supporting our preparation for emergencies, such as through the development of vaccines. The UK Government must work with businesses to encourage an active partnership in resilience, and to itself learn from the experiences of businesses. This must be a joint endeavour, with the UK Government doing more, through consultation with businesses, to set standards, and share guidance and information. Although regulation can be a powerful tool in ensuring resilience behaviours, we recognise that it is not always appropriate, and many sectors are already subject to significant regulation. Raising private sector resilience standards may mean that the UK Government asks more of some parts of the private sector, but it will provide the guidance and information on risks that organisations need in order to be able to meet the standards that the UK Government sets.

111. At the core of our private sector is a group of owners and operators that run and protect some of the UK's Critical National Infrastructure.[30] These owners and operators are absolutely vital to the UK's resilience, and we must put our full efforts into ensuring that they can operate without disruption. The UK Government's work on CNI is a unique partnership between the public and private sectors. The UK's CNI is an interconnected system. This interconnectedness brings many benefits but comes with risks, especially the possibility of cascading failures across systems. The vulnerability of these interconnected systems is complex and may be significantly underestimated with the potential for issues to be far reaching.

30 There are currently 13 sectors formally designated as CNI: Communications (sub sectors: Post, Telecommunications and Broadcast), Transport, Civil Nuclear, Chemicals, Defence, Energy, Water, Food, Emergency Services (sub sectors: Police, FRS, Ambulance and Maritime Coastguard), Health, Finance, Government and Space.

112. Many CNI owners and operators already have a high awareness of risk and are forward thinking about resilience; however, with an ever evolving risk landscape, we must be forward thinking on preparedness in CNI. The UK Government will continue to **strengthen the resilience of our CNI,** across the public and private sectors, by building an ever stronger understanding of our risks and interdependencies, and by developing new standards and assurance processes.

113. This chapter sets out an overarching approach to partnership with the private sector. Most of the sectors that make up this area span the four nations of the UK, and many of those span reserved and devolved policy areas. The UK Government will work with the devolved administrations to ensure that the approach across all four nations is joined up and consistent.

Standards and regulation

114. Our aim is that the whole private sector will contribute to UK resilience. But what this will look like will differ depending on the size and type of each organisation, and on the risks to which it is vulnerable. Standards can help businesses work out how they can protect themselves and contribute to UK resilience. The National Infrastructure Commission has recommended that the UK Government should publish a set of standards for energy, water, digital, road and rail services, to be reviewed and updated every five years.[31] The UK Government **will introduce standards on resilience and develop an action plan to deliver these** across the private sector, where these *do not* already exist, to give a clear benchmark on what 'good' looks like for resilience. These standards on resilience will be non-statutory, and **adjusted to take into account the unique sector landscapes, priorities, needs, and interlinkages with other sectors,** to ensure that expectations are appropriate and not overly burdensome or disproportionate to the benefits they can deliver.

115. As part of this, the UK Government will build upon the resilience standards for CNI which already exist to create **common but flexible resilience standards across CNI.** These CNI resilience standards will be non-statutory and will consider malicious and non-malicious risks, and will help ensure a stronger common understanding of the resilience expected particularly between sectors, identify gaps in resilience measures and drive forward improvements.

116. The National Infrastructure Commission also underlines the importance of regular stress testing of resilience standards by regulators. The UK Government accepts this in principle – as reflected in the approach outlined in this chapter – and will ensure that sectors can continue to manage their own strategies, supported by regulators who can make choices about the best way to stress test the way in which resilience standards are met.

117. To make sure that CNI resilience standards are effective, the UK Government will also consider what form of assurance might accompany new standards. In considering what form assurance might take, we will need to balance the value of assurance against any additional burden. However, given the importance of CNI to our overall resilience,

31 2020 Resilience Report

the UK Government will also **do more on the assurance of CNI preparedness and develop an action plan to deliver this,** including where they have a role with local partners and LRFs as Category 2 responders. This will take into consideration the roles, responsibilities and obligations of different stakeholders, including regulators. The outcomes of any exercises and testing are used to better understand vulnerabilities, learn and implement improvements in resilience.

118. Many sectors – particularly CNI – are already subject to regulation on resilience, for example with regards to business continuity or security. Regulators play a key role in linking the priorities and direction of the UK Government and drive improvements to the delivery of resilience. The UK Government will continue to work with regulators to further strengthen key sectors against risk.

119. The UK Government will **review existing regulatory regimes on resilience** to ensure that they are fit for purpose, particularly where these are used to assure CNI sectors. Working with regulators, the UK Government will make adjustments where it is agreed they are needed. For example, aviation is highly regulated across a number of areas, including security, but only some of the largest organisations are subject to regulation on resilience. In sectors such as this the UK Government should ensure that organisations are subject to an appropriate and proportionate level of regulation on resilience. This could mean raising baseline requirements or expanding the scope of who is covered by regulation within sectors. Any new regulation or adjustments to regulation will be led by the Lead Government Department, working with the sector, and we will not seek a one-size-fits-all approach.

120. **In the highest priority sectors that are not already regulated, and for the highest priority risks, the UK Government will consider enforcing standards through regulation.** This regulation could focus on risk assessment, contingency planning and data sharing. It would be aimed at protecting key sectors and assets against high priority risks, but will respect the ability of companies to run as they need, and will not stifle innovation. Any new regulation will strike a balance between the needs of the sector, consumer impacts, and the national need to guard against risk and we will only regulate where we know that the benefits will outweigh any costs.

121. This approach will complement broader efforts to improve the resilience of a significant proportion of the private sector[32] through the use of Resilience Statements, as recommended by the *Independent Review into the Quality and Effectiveness of Audit* in 2019.[33] These new Resilience Statements, to be led by the proposed Audit, Reporting and Governance Authority, will compel company directors to make a public statement about a company's short, medium and long term resilience against a range of organisational risks.

Partnership working

122. To make such standards effective, the UK Government needs to help set businesses up for success. Some businesses are already heavily involved in areas requiring resilience

32 This review focussed on public interest entities across the UK.

33 The quality and effectiveness of audit: independent review – GOV.UK

processes and have developed systems for managing risk and planning for crises. But many have limited or no engagement with the resilience world, and so we must help those businesses to meet the standards that we set. To drive this, **the UK Government will support the wider private sector with better guidance on resilience, and risk assessment information, to support contingency planning and risk management.** Alongside this the UK Government will work with newly strengthened LRFs in England to support them to work with local businesses across the country to engage with resilience as critical parts of their local communities and economies.

123. In order for the private sector to meet standards, the UK Government must improve how we share risk assessment and information with them. The UK Government cannot expect organisations to properly prepare if they do not have the tools to understand which risks they face or how those risks may impact on their businesses. In turn, they must also understand how a lack of resilience in their own business may have wider impacts. For example, there are some goods that we may not instinctively link to UK resilience, but they may occupy an essential place in a vital supply chain. Guidance should not only focus on the risks, but also their potential consequences. Sometimes it is not the root cause of a risk that is important in planning, but the consequence that a business must mitigate. For example, if a business' IT systems headquarters is rendered inaccessible, it is more helpful to have a contingency plan for that situation – whether it is a result of flooding, a pandemic or a security incident. There will always be some risks that require specific responses, but organisations should also be prepared for common consequences.

124. In addition, the UK Government will make training on resilience accessible to businesses, including through the UK Resilience Academy (see *Skills* chapter). The private sector can also be a valuable source of data and information on emerging (or active) risks and their impacts. The UK Government will ensure that, as we provide better guidance and information on resilience and risks to private sector partners, we also draw upon the expertise and data within the private sector to inform our resilience efforts.

125. Understanding risk is particularly crucial for CNI. Here, the UK Government will use the CNI Knowledge Base, a bespoke CNI mapping tool, to identify interdependencies across and within CNI sectors. The CNI Knowledge Base is a visualisation and mapping tool whose data forms the 'Single Source of Truth' for UK CNI. The tool helps users across the UK Government to collaborate to build an evolving picture and collective understanding to assist with the proactive management of sector-specific and cross-cutting risk to CNI. The CNI Knowledge Base will enable a step-change in the way the Government anticipates, prevents and responds to cascading risks that could impact our most essential services. A flagship project, initiated under the 2016 National Cyber Security Programme, it provides a world-leading capability in CNI risk management.

126. Furthermore, the private sector can, and should, be an active partner in planning for and mitigating against the risks the UK faces. For instance, during the COVID-19 pandemic most of the promising innovative COVID-19 vaccines originated from biotech companies or academia, and were ultimately manufactured and sold by major pharmaceutical

companies.[34] The UK Government provided funding and support to the development and distribution of some of these, including the Oxford/AstraZeneca vaccine, which has protected millions of people across the UK.

127. The UK Government commits to **continuing to build partnerships between the public and private sector to improve our collective resilience and to identify opportunities for innovation.** This expands on previous work such as the "100 Days Mission to Respond to Future Pandemic Threats" report[35] (100DM) which the UK initiated during our 2021 Presidency of the G7. The 100DM was developed in collaboration with international organisations, industry chiefs and chief science advisers and presents 25 recommendations to achieve safe and effective diagnostics, therapeutics and vaccines in the first 100 days from the identification of a pandemic threat. Since June 2021, international organisations, governments, industry and philanthropic implementation partners have mobilised and formed strong coalitions to deliver the recommendations.

128. One excellent example of the partnership between the UK Government and the private sector on risk is the Cyber Essentials programme.[36] Run by the National Cyber Security Centre (NCSC), the programme helps organisations to protect themselves against a range of the most common cyber attacks and provides certification to those who pass the assessments. Certification provides reassurance for both current and potential customers and enables organisations to better understand their current cyber security status. For instance, certification is a requirement for UK Government contracts involving the handling of sensitive and personal information. In providing certification, the Cyber Essentials programme also acts as a benchmark for wider good cyber security practice within organisations. We look for further opportunities to build on this type of good practice.

External Expertise

129. Expertise on resilience can be found in all parts of the system, and **we must make sure that the UK Government's policy making and assessment on risk and resilience are informed by as many expert views and evidence as possible.** The Iraq Inquiry[37] demonstrated the danger of basing our decision making on narrow views or groupthink. Although the UK Government already has a solid track record of working with partners across the system, we can formalise this.

NSRA Challenge

130. The refreshed NSRA process will expand our formal mechanism for involving external expertise, with a greater number of experts from a wider range of disciplines and backgrounds. We will look to resolve security and technical factors that can prevent open and transparent conversation between government and external experts. The UK

34 UK Vaccine Taskforce 2020 Achievements and Future Strategy

35 100 Days Mission to respond to future pandemic threats

36 About Cyber Essentials – NCSC.GOV.UK

37 The Report of the Iraq Inquiry

Government will grow our advisory groups made up of experts, academics and industry experts from a diverse range of specialist fields in order to inform the NSRA including establishing a risk-focused sub-group of the UK Resilience Forum.

UK Resilience Forum

131. The UK Government has set up a new UK Resilience Forum (UKRF) to strengthen UK resilience by improving communication and collaboration at a national level on key discussions about risk, emergency preparedness, crisis response and recovery. Established in 2021, the UKRF brings together representatives from the UK Government, devolved administrations, emergency services, responder organisations, the private sector and the voluntary and community sector. This advisory board is aimed at aligning efforts across the system, strengthening relationships between partners, and informing the government's work on its resilience commitments under the *Integrated Review.*[38]

SAGE and scientific advice

132. Scientific advice and expertise are invaluable in how we understand, anticipate, prepare for, and respond to risks. During COVID-19 we saw the essential role that the Scientific Advisory Group for Emergencies (SAGE) played in understanding how the pandemic was evolving, in providing expert science advice to decision makers, and in communicating the risk to the public. The COVID-19 SAGE and its expert sub-groups provided a broad and diverse range of expertise – from multiple institutions and disciplines, including behavioural and social sciences – that allowed for robust, relevant and high-quality science advice to be given to decision makers. Previous SAGEs have provided a critical service to the UK Government across numerous crises, drawing on specialist knowledge and expertise from academia and the private sector and providing evidence-based challenge, advice and analysis for government decisions during an emergency. The diversity of backgrounds and expertise that is drawn upon during active SAGEs can provide broad and data-driven understanding of relevant active emergencies and their impacts, while ensuring diversity of thought. The SAGE model, and its potential subgroups, will continue to play a vital role in supporting government decision makers during active emergencies.

133. Whilst SAGE sits at the UK level providing scientific advice on emergencies, provision also exists to provide advice to local responders. Science and Technical Advice Cells (STACs) provide expert advice to local Strategic Coordination Groups (SCG) to inform the immediate response to an emergency and the management of longer-term consequences. In an emergency, local decision makers and emergency responders must quickly understand the potential impacts on the ground so that they can take timely tactical and operational decisions, for example whether it is necessary to evacuate an area at risk of flooding. STACs bring together science and technical experts from a range of agencies to advise the Gold Commander. The STAC model will continue to play an important and active role in local crisis response operations.

38 Global Britain in a Competitive Age: the Integrated Review of Security, Defence, Development and Foreign Policy

SAGE and STACs are only activated during emergencies that require coordinated science advice and STACs can be activated even if a SAGE is not required, depending on the emergency itself. SAGE Secretariat must liaise and engage with the STAC lead, to facilitate timely knowledge transfer to the local level, and to allow SAGE attendees access to local intel on the incident which could provide critical scientific evidence.

134. Outside of active emergencies, the UK Government draws on robust, relevant and high-quality science and technology advice to understand, prevent, prepare for, respond to, and recover from risks. The UK Government draws on the science capabilities of public sector research establishments such as the Met Office, Ordnance Survey and British Geological Survey for important data and evidence on resilience challenges. The Natural Hazards Partnership is central in bringing together the science community in the resilience space and supports various aspects of resilience work including the NSRA. UK Government departments should continue to invest in research and development to inform their understanding and planning, and also communicate their priority research questions to academia and industry through their Areas of Research Interest publications.

135. Lead Government Departments should actively and regularly draw upon their Chief Scientific Adviser (CSA) to access internal and external science advice and relevant expertise for the risks they own. By proactively drawing upon CSAs and their expert networks, as well as analysis teams and futures expertise within departments and across government, LGDs can ensure evidence-based challenge and analysis of response planning beyond existing policy teams and across a diverse range of expertise. The Government Office for Science also facilitates access to the wider CSA network and external S&T expertise, particularly in response to emerging risks and in preparation for potential SAGE activations. The Government Science and Engineering Profession is working to increase STEM skills across government, including upskilling policymakers' capacity and skills to effectively use evidence and data to provide challenge in policy making.

136. In driving our work on resilience, the Government is committed to inviting expert challenge and input to build its understanding of risk and preparedness. We will remain open to opportunities, in addition to the mechanisms outlined above, to draw in external expertise.

Interconnected World

137. The *Integrated Review*[39] outlines that we are moving towards a more competitive and multipolar world, with growing and diversifying state threats to the UK. Our international allies and partners recognise that mutual support is vital for resilience, and that collective action by like-minded countries is of critical importance.

138. The UK's international connections are vectors for both risk and resilience. Risks do not operate in silos, but are interconnected like our economy, environment and society. Those connections draw risks across borders, reinforce or cause other risks,

39 Global Britain in a Competitive Age: the Integrated Review of Security, Defence, Development and Foreign Policy

and expose the UK to long-term international trends. The same connections are vital for resilience, supporting global action and shared endeavour on the biggest risks, harnessing international expertise, and providing economic diversity. For the UK, resilience is not simply a matter of homeland security; this is a globally-oriented maritime trading nation without a large continental hinterland, and that must shape our strategic approach.

139. Understanding this is integral for both addressing the causes of risk and supporting responses and recovery to any materialisation of risk. The UK Government will continue **to work through multilateral forums to promote global resilience and, in the ever-contested international world that we find ourselves in, we will raise awareness of the importance of resilience in their work.**

140. The UK Government will continue to take a leading role on resilience in many multilateral organisations. This includes in the G7 where, during the UK's 2021 G7 Presidency, the Prime Minister nominated Lord Sedwill to chair an independent G7 Panel on Economic Resilience, which published a report titled 'Global Economic Resilience: Building Forward Better'.[40] The G7 Leaders noted their appreciation of this work in the Carbis Bay G7 Summit Communiqué and outlined that they will continue to work on the issues highlighted by the panel.[41] In 2021, and as outlined later in this chapter, the UK also hosted the COP26 climate conference, during which the Glasgow Climate Pact was agreed. At this critical point in history, it is driving action on international climate change mitigation and adaptation measures. In addition, in June 2022, the UK announced[42] that it will give £25 million to found a new World Bank fund to prevent, prepare for and respond to future devastating pandemics. Furthermore, as a permanent member of the UN Security Council, the UK Government has the influence to advance freedom, peace and security at the highest of global levels.

141. The UK Government will continue to engage **countries bilaterally on resilience,** and we can utilise our international networks to support our engagement. We also call upon our expertise, such as in the Emergency Planning College and military, to support any such collaboration on resilience. In this way, bilateral initiatives can create links below the national level, forming effective partnerships between practitioners and experts that can drive real change.

142. The UK Government will also build capacity and capabilities in low- and middle-income countries around the world to help support improvements to their economies, security and resilience. **By enhancing resilience in these partner nations, the UK will improve the global resilience landscape and ultimately support its own.** The UK Government will continue to support this through our international development work.

40 Global Economic Resilience

41 CARBIS BAY G7 SUMMIT COMMUNIQUE

42 UK supports new international drive to prevent and prepare for future pandemics

Applicability across the UK

At the time of publication, it is anticipated that:

- The standards, or any new regulations proposed in this chapter will be decided on a sector-by-sector basis. Accordingly, they will be led by the UK Government, but in consultation with the devolved administrations where appropriate.
- New guidance should be created for business across the UK and includes best practice. The UK Government will lead this work in consultation with the devolved administrations. The guidance be made available to the devolved administrations, but the devolved administrations will decide how best to communicate it to their partners.
- While representation at existing multi-and bilateral forums will continue to be led by the UK Government, the devolved administrations will continue to lead their own bilateral and international engagement and action, in devolved areas of responsibility.

Our action plan: **Communities**

On communities, we are already taking action by:

Continuing to deepen and strengthen our relationships with the Voluntary and Community Sector (VCS) in England.

By 2025, we will:

Offer better guidance from the UK Government to LRFs and local partners in England, created with local responders, the VCS and communities to support them working with vulnerable groups.

143. We regularly see the generosity of people coming forward to help their communities and the capacity of communities to support those in need: from emergency responders and networks of businesses, voluntary groups and local volunteers, to smaller community groups and individuals who undertake those simple and essential acts of good neighbourliness.

144. Communities[43] include individuals (e.g. members of the public and households), organisations (e.g. businesses or voluntary, community and social enterprise groups), groups (e.g. those with shared characteristics, interests or identities), and associations and networks (e.g. local community, faith and business networks). The UK Government's *Community Resilience Development Framework*[44] sets out that community resilience in England is enabled when the public are supported to harness local resources and expertise to help themselves and their communities to: prevent, prepare for, respond to and recover from disruptive challenges, in a way that complements the activity of emergency responders; as well as planning and adapting to long term social and environmental changes to ensure their future prosperity and resilience.

145. For communities, our 'whole-of-society' approach to resilience means that everyone recognises their role in, takes responsibility and contributes to, the UK's resilience. To achieve this, the UK Government will support greater community responsibility and resilience, driving a cultural shift where everyone who can, is prepared and ready to take action and support themselves during an emergency. This will mean those needing more specific or tailored support can be prioritised.

Voluntary and Community Sector

146. The Voluntary and Community (VCS) sector plays a vital role in the UK's resilience. The UK Government works with many VCS organisations that contribute to our resilience. This includes for example, the Royal National Lifeboat Institute, British Red Cross, St John Ambulance, Neighbourhood Watch and Citizens Advice. In line with the approach outlined in this chapter, **the UK Government will continue to deepen and strengthen its relationships with the VCS in England. The capabilities of the VCS will be better understood and integrated, as appropriate, strengthening resilience at local and national level in England.**

147. The impact of the sector ranges from grassroots and local level right through to providing national and international services working alongside statutory responders. To continue to support the sector, the UK Government will work with strengthened LRFs in England and provide guidance and support for engaging and working with communities and community groups on both acute and chronic risks, so that they become increasingly active partners in building local resilience. The Department for Digital, Culture, Media and Sport is also funding the Voluntary and Community Sector Emergencies Partnership (VCSEP) in England with up to £1.5m, to 2025. This funding

43 Definition of 'communities' informed by the work of: Shaw D and Jordan R (2022) The Renewal of Community Resilience: A new local and national resilience capability? In:The Manchester Briefing on Covid-19

44 Cabinet Office Community Resilience Development Framework

will be used to support and coordinate the voluntary and community sector's input into emergency preparedness, planning and response. Through its partnership and network, the VCSEP will reach thousands of community organisations in order to share insight and build capability at a local and national level.

148. National, regional, local and grassroots VCS and faith-based organisations have been at the forefront of the response to emergencies. Over the last few years, the UK has also seen the emergence of new voluntary sector capabilities, such as the National Emergencies Trust that launched in November 2019 with the aim of collaborating with charities and other bodies to raise and distribute money and support victims at the time of a domestic emergency. The National Emergencies Trust launched its first fundraising appeal in response to COVID-19 and raised close to £100 million, distributing money raised through UK Community Foundations to national and local charities who could then support those most in need.

Supporting partnerships between statutory responders, the Voluntary and Community Sector, and communities in England

149. Building relationships and partnerships is an important component of this framework. The UK Resilience Forum has been established to steer partnerships across the resilience system at the UK level, and includes public, private and VCS organisations. To empower and support greater community responsibility and resilience, communities must be active contributors to resilience planning and part of decision-making processes. The UK Government will continue to support and encourage engagement between communities and local responders, ensuring that the knowledge and skills of the diverse people and organisations that exist in our society are enabled to contribute their fullest to local planning. The UK Government will also consider ways **to enhance the role of citizens** and the VCS as an integrated part of **resilience policy making and planning.**

150. At the local level, successful community resilience approaches are often based on connection and relationships. Deepened partnerships between statutory responders, the VCS sector and communities provide benefits across the board. It will mean that community and voluntary capabilities are better understood and integrated into resilience and emergency management activities. It will also assist local responders in developing a better understanding of their communities and needs and will reduce demand on statutory responder resources during emergencies so they can be focused on those most in need. To support this work, the **UK Government will consider options for measuring and evaluating statutory responder engagement with the VCS and wider community and develop an action plan to deliver this.**

Reducing disparity in the impacts of emergencies

151. The impact of emergencies can be felt by everyone, but some parts of society are more adversely affected. The UK is faced with a wide range of risks that can have a disproportionate impact on vulnerable and at-risk groups and communities. Individuals within these groups and in these areas can experience more significant impacts from

risks and incidents when they happen. They are also more likely to suffer financial hardship either as a direct or indirect consequence of a risk materialising. Health and socioeconomic disparities are also linked and impact on people's ability to reduce risk and respond in emergencies meaning these communities and places may have fewer resources and less capacity to proactively take steps to build their resilience.

152. The UK Government will continue to take a leading role on resilience in many multilateral organisations. This includes continuing to work with and through the G7 under the Japanese Presidency in 2023 and beyond, building on work started during the UK's 2021 G7 Presidency, when the Prime Minister nominated Lord Sedwill to chair an independent G7 Panel on Economic Resilience, which published a report titled 'Global Economic Resilience: Building Forward Better'. In 2021, and as outlined later in this chapter, the UK also hosted the COP26 climate conference, during which the Glasgow Climate Pact was agreed. At this critical point in history, it is driving action on international climate change mitigation and adaptation measures. In addition, in June 2022, the UK announced that it will give £25 million to found a new World Bank fund to prevent, prepare for and respond to future devastating pandemics. Furthermore, as a permanent member of the UN Security Council, the UK Government has the influence to advance freedom, peace and security at the highest of global levels.

153. When crises happen, people and groups can lose access to vital services. We know that the effects of this loss can, and will, be felt the most by the most vulnerable in society.[45] The UK Government will create a **stronger and more consistent approach for operators of essential services to identify, communicate with, and offer support to vulnerable customers and develop an action plan to deliver this,** and consistency in the sharing of information of vulnerable customers with LRFs and wider relevant local partners in England involved in emergency planning and response. This will include working with relevant operators of essential services to ensure that plans are in place to assist vulnerable customers in an emergency. The UK Government will work with industry partners to develop guidance to support this.

Applicability across the UK

At the time of publication, it is anticipated that:

- Any new guidance for practitioners and communities will be created in partnership between the UK Government and devolved administrations, so that it reflects the resilience arrangements, and needs of organisations and communities across all four nations.

45 Energy Emergencies Executive Committee Storm Arwen Review – Final Report


VOLUNTEER

Our action plan: **Investment**

On investment, by 2030, we will:

Have a coordinated and prioritised approach to investment in resilience within the UK Government, informed by a shared understanding of risk.

Consider options for funding models for any future expanded responsibilities and expectations of LRFs in England.

Offer new guidance to community organisations and individual householders, to help those people to make more informed decisions about investing in their own resilience and preparedness.

154. Building preparedness for risks that may threaten the lives of our citizens, national security, economic prosperity, and societal wellbeing is a critical function of government and understanding of risk should be fundamentally built into our investment decisions and structures. Investing adequately in crisis prevention is more cost effective than merely responding to them, so there needs to be more purposeful links between our investment decisions and our understanding of risk.

155. The UK Government is committed to investing in resilience. It currently invests in a huge range of activities and capabilities that contribute to our resilience, either that are dedicated to resilience or have broader primary aims. For example, having a well functioning national health system is vital to our resilience – but it is not in itself a resilience function.

156. Investment in resilience is not only the responsibility of Governments, but is for the whole of society. This chapter considers four key areas of investment on resilience: public sector and UK Government investment, investment in local resilience and Local Resilience Forums in England, the private sector, and community and individual investment.

157. In the devolved administrations, spending on devolved areas of competence in relation to resilience is the responsibility of those administrations and is not considered here.

Public Sector Investment in Resilience

158. The UK Government spends significant sums on emergencies, with the majority spent on responding and recovering rather than longer term investments in prevention and preparation. When emergencies happen the priority is mitigating the impacts of the event and minimising the effect on the public. The UK Government will continue to spend on recovery as a vital aspect of the emergency management cycle which can ensure improved future preparedness, especially when we draw on 'lessons learned' to shape decisions.

159. Incidents over the last decade have repeatedly demonstrated that the cost of responding to and recovering from emergencies can be significant. This often outweighs the cost of preparing for or preventing such events. Examples include:

- Where there is a risk of flooding, the Environment Agency has helped ensure homes are built in a flood safe way. Every £1 spent advising on flood risk matters in spatial planning applications has saved £12 in future flood damages.[46]
- During Storm Christoph, 49,000 properties were protected from flooding, with fewer than 1200 inundated.
- Improved response arrangements ensured that a Foot-and-mouth outbreak in 2007 caused much less damage (£150 million) than the outbreak in 2001 which cost the UK around £8 billion.[47]

46 Provided by the Environment Agency as part of the Call for Evidence.

47 National Risk Register

160. In future, the UK Government will **drive strategic resilience building to acute and chronic risks through targeted and evidenced prioritisation of investment in prevention and preparation in England.** This does not mean that the other stages of the risk life cycle – particularly response and recovery – will go unfunded, but rather that the UK Government should ensure adequate investment and maximise the impact of that investment across the risk lifecycle. Investment in risk reduction will be essential in easing the investment pressures on resilience activity and capabilities. As part of our risk reduction efforts, the UK Government must also bake resilience into wider government projects and policies.

UK Government investment

161. Resilience building and planning for risk are key responsibilities of the UK Government, and are underpinned by how investment decisions are made. To do this we need to have a shared understanding of how the UK Government invests its money on resilience, in order to ensure that investments are directed where it can make the most impact. This will be informed by a shared understanding of the risks we face, and a shared understanding of our collective risk tolerance.

162. Spending Reviews (SRs) are led by HM Treasury and set multi-year budgets for departments in line with the UK Government's policy priorities. The risk landscape is complex and cuts across departmental boundaries, so it is **important that investment in resilience is considered and coordinated across government.** HM Treasury has prioritised join-up of spending plans where appropriate but as we look to create the most resilient UK by 2030, we can do more to coordinate across the UK government in resilience.

163. To make the most of our considerable investment in resilience, the UK Government must be able to prioritise and coordinate both across departmental lines and across the UK Government and local government. Implementation will be iterative and will take time but the UK Government will begin to **measure and track departmental investment in resilience** across risks, meaning risk owning departments can track investments. On this and other government investments, HM Treasury will continue to ensure that the UK Government is making investment decisions which represent the best value for money. This is particularly important to our overall investment approach as so much resilience activity spans departmental boundaries. Alongside this, it will be crucial to build our evidence base on the impact of civil contingencies risks and emergencies across the country as well as the impact of interventions from the UK Government and our partners. This will allow us to more fully consider outcomes, impacts and value for money assessments in our resilience investment decisions.

164. The risks that we face are not static but change over time and we must also reflect that in how the UK Government invests in risk prevention and preparation. The UK Government needs a clear view of how we are investing across the risk landscape to ensure our investment priorities can flex to the evolving risk picture and we are mitigating risk effectively.

165. The UK Government will take **a coordinated approach to our investment in resilience.** To make strategic investment decisions, we need to understand how current capabilities match up with risks and concentrate investment where gaps are identified.

As a first step, the UK Government will **agree on a working definition of resilience activities and capabilities, and using that, will map current UK Government resilience capabilities.** The UK Government will establish a process to capture current levels of investment across departments and track investment on those capabilities.

166. Once the UK Government has an agreed map of resilience activity and capability, we will **map resilience investment within the UK Government** alongside other funding arrangements (e.g. the Counter-Terrorism ringfence) and against UK Government risk assessments. This will highlight where investment needs to be adjusted, or opportunities to reduce duplication, which the Cabinet Office will work with departments to take action on. This mapping should account for investment outside of government. For example, if a risk receives relatively little funding from the UK Government, but is well funded within the private sector or at a local level, then we should consider whether there is a genuine investment gap or not.

167. This will mean the UK Government can streamline investment in risks and avoid duplication of investment by departments. It will ensure we are making informed investment decisions, which should also be informed by national security and science and technology advice. For example, futures and foresight advice can support forward-looking and long-term investment decisions, enabling investment into emerging technologies and capabilities that could be critical to the UK's resilience. This will ensure we are investing taxpayer money most effectively by evidencing where investment could best meet the needs identified by our risk assessments. We know that the risk picture is dynamic and can change rapidly, and so although our approach to investment should be fundamentally informed by our understanding of risk, it will not be the only factor that we consider.

168. Implementing this will require a continuous and iterative process before it is fully embedded. It must also be a process that includes all government departments that contribute to resilience, and the Cabinet Office and HMT will work together with departments to embed the changes.

Investment in local resilience and Local Resilience Forums in England

169. A country's resilience is built on the actions, choices and investments made by the individuals, organisations, businesses and government which come together to deliver resilience. When considering local resilience funding it is important to recognise that a wide range of core activities, capabilities and functions that may not be explicitly badged as 'Resilience' are crucial to an area's resilience (e.g. core Fire and Rescue Service capabilities).

170. Local resilience structures are devolved, and therefore the changes to LRF funding set out below have been implemented within England. The UK Government is fully committed to ensuring integration and enhancing cross border collaboration and we will continue to work with local resilience leaders and practitioners from Scotland, Wales and Northern Ireland, sharing best practice and ensuring the mutual benefits of these changes can be shared across the UK.

171. As part of our IR commitment to consider strengthening the roles and responsibilities of LRFs in England, the UK Government is carefully considering how LRFs may be appropriately supported and funded into the future. Currently there is no single funding

allocation or funding approach for each LRF and until recently the two main sources of LRF funding in England were:

- **Direct financial contributions from partners:** often in the form of voluntary and locally managed contributions from partner organisations, used to fund staffing and other resources to run a core secretariat function for coordinating the activities of the LRF.
- **In-kind contributions from partners:** LRFs receive a wide range of benefits in kind, provided by the chair organisation and other funders. These benefits are provided to support a core secretariat function. The most common benefits in kind LRFs receive are IT equipment, office and meeting space, training and partner HR and welfare support.

172. In highly exceptional circumstances, some LRFs have also received ad-hoc funding directly from the UK Government to support the delivery of locally led resilience activity tied to specific events, such as planning for the UK's departure from the European Union and the COVID-19 pandemic.

173. In 2021, the UK Government announced £7.5m of funding to LRFs in England as a 12-month pilot project to collect evidence on the potential efficacy, challenges and opportunities of the UK Government providing a degree of central funding to LRFs. The aim of the LRF funding pilot was to enable LRFs to build new capacity and capability and to encourage innovation within the sector, without displacing existing partner contributions. The evaluation of this pilot has indicated that the funding pilot has met its objectives: funding has increased essential capacity and capability across LRFs in England to support the multi-agency coordination of planning and preparation activities, with LRFs recruiting new staff and delivering a wide range of projects in support of specific nationally and locally defined priorities. The evaluation concluded that the evidence available suggests that the pilot funding is likely to represent value for money in the long term and that there is currently no evidence of displacement of partner contributions.

174. Building on the success of the funding pilot, in late 2021 **DLUHC agreed a £22m three-year funding settlement for LRFs in England** starting in the 22/23 financial year. This additional UK Government funding will complement the contributions of partners and will allow LRFs to continue to enhance their strategic coordination capacity and capabilities to reflect the already enhanced expectations the UK Government has of LRFs.

175. We recognise that LRFs need a consistent, sustainable funding model to continue to build the necessary capacity and capability to deliver what the UK Government has grown to expect of them and the proposals set out to further strengthen their role and responsibilities. The UK Government will **consider options for funding models for any future expanded responsibilities and expectations of LRFs.** The UK Government also recognises that funding from the UK Government alone should not be the answer. Over many years LRFs have developed through the contributions of partner organisations to reflect local priorities and ways of working. Any future funding model must build on the principle that funding for local resilience should continue to be provided by the categorised responders of English LRFs alongside any funding from UK

Government. Any direct funding from the UK Government should seek to compliment, not displace or disrupt, these arrangements.

Private Sector investment in resilience

176. There is already significant investment in resilience throughout the private sector. Some of this is direct investment in preparation for or protection from risk – for example, businesses investing in cyber security to protect their assets. Some of this is indirect, as businesses seek to make their supply chains, services or products reliable in order to secure commercial advantage.

177. Ultimately, decisions are taken by private companies based on multiple competing factors: the need to maintain profit margins, manage their reputation or balance decisions against overall operational planning means that private sector organisations do not always put resilience at the heart of their investment decisions. The UK Government will not aim to change or overrule the private sector's right to take these decisions.

178. Not least because the private sector has demonstrated that it can be capable of independently increasing investment in resilience when the need arises – 95% of UK business leaders are aware of the need for investment in wider resilience[48] and following COVID-19 and the vulnerabilities in international supply chains that it exposed, worldwide investment in supply chain management companies increased from $5.9bn in 2020 to $11.3bn in 2021.[49] However, there was a clear immediate commercial alignment with longer term resilience here, whereas businesses may find other emergencies (such as flooding) harder to recognise or quantify.

179. Businesses do make independent investment in risk and resilience when advice is provided by governments – London Gatwick Airport allocated £30m in 2013 to implement the recommendations of a UK Government review into flooding disruption that had affected the airport, including improved flood modelling, and the completion of a bespoke flood warning scheme.[50]

180. This is important because the economic impact of catastrophic events has continued to grow and the estimated resilience investment requirements have grown accordingly as threats such as cybersecurity and climate change increase in severity. There is still an average worldwide gap between the economic cost of a catastrophic event and private sector insurance coverage for costs of over 60%.[51]

181. Private sector investment in resilience differs across sectors, organisations and risks. Although investment decisions must remain the responsibility of sectors and companies, the UK Government **will provide improved guidance for businesses on risk, and support the insurance sector to help protect against specific risks.**

48 PWC Global Crisis Survey 2021

49 After Record Year, Supply Chain Funding Shows No Signs of Breaking Down 2022

50 DfT, Transport Resilience Review: A Review of the Resilience of the Transport Network to Extreme Weather Events 2014

51 GREAT, The Business of Resilience: Summary Report 2022

Insurance

182. When used alongside good preparation and planning, having adequate insurance against risks is an important part of building resilience for individuals and businesses. The UK Government and the insurance industry have worked together in a variety of ways to ensure there is insurance available for individuals and businesses. The Flood Re and Pool Re schemes are the most often cited examples of insurance used by the UK Government in relation to risks and are examples of longer-term government supported reinsurance schemes. This approach can also work in the shorter term. For example, the Film & TV Production Restart Scheme which provided confidence to the UK Film and TV industry to restart productions during the COVID-19 pandemic.

183. Insurance is increasingly supporting resilience in other sectors. Cyber attacks are a key expanding risk to UK businesses and here we can see both the private sector's desire to invest in cyber security, and the importance of governments in aiding and directing that investment. The scale of the threat is significant: 39% of all UK businesses reported a cyber breach or attack in 2022.[52] UK Government support for businesses centres around the creation of the National Cyber Security Centre, which offered support to 777 significant incidents in 2020/21.[53] As the threat has grown, so has interest in guarding against the threat. We have seen an increase in senior business interest in cyber security, from 69% in 2016 to 82% in 2022. The private sector market for cyber insurance has grown in tandem: 5% of UK businesses now have a specific cyber security insurance policy and 38% have cyber security as part of a wider insurance policy.[54]

184. The UK Government, with the devolved administrations, will continue to **explore opportunities to better support the insurance industry and develop an action plan to deliver this,** recognising it is an important way to encourage organisations to take action on risk and ensure that, when a crisis hits, we are all well prepared. However, insurance is not a substitute for good preparation, and both the insurance sector and UK Government have an important role to play in encouraging businesses to have appropriate contingency plans in place as well as adequate insurance.

Community and individual investment in resilience

185. Every level of society has a part to play in building national resilience, including at a community and individual level. In the *Risk* chapter, we set out how the UK Government will make improvements to how it communicates about risk so that communities and members of the public can make informed decisions about managing risks in their local area. Alongside this, the UK Government will work with LRFs in England and local partners to offer **new guidance to community organisations and individual householders, to help those people to make more informed decisions about investing in their own resilience and preparedness.**

52 DCMS Cyber Security Breaches Survey 2022

53 NCSC, Annual Review 2021

54 Cyber Security Breaches Survey 2022

186. Investment in community resilience is a key part of the Levelling Up agenda. The UK Shared Prosperity Fund is a central pillar of the UK Government's ambitious Levelling Up agenda and a significant component of its support for places across the UK. It provides £2.6 billion of new funding for local investment by March 2025, of which £559m is set aside for the adult numeracy programme 'Multiply'. More than £2bn will be made available for places to identify and build on their own strengths and needs at a local level, focused on building pride in place and increasing life chances, and delivered through three investment priorities: communities and place, local businesses and people and skills.

Applicability across the UK

At the time of publication, it is anticipated that:

- The proposals on public sector investment will apply to the UK Government only.
- Guidance to inform and drive private sector, community, and individual investment will be created in partnership between the UK Government and devolved administrations, but individual Administrations will be able to decide how best to communicate the guidance with their stakeholders.
- Work with the insurance industry will be led by the UK Government, with close consultation with the devolved administrations where it impacts devolved responsibilities.

Photo: Kvalifk

Our action plan: **Skills**

On skills, by 2025, we will:

Deliver a new UK Resilience Academy, built out from the Emergency Planning College, making world class professional training available to all that need it.

Deliver a new training and skills pathway to drive professionalism and support all those pursuing a career in resilience.

Reinvigorate the National Exercising Programme to test plans, structures and skills.

187. At the heart of the resilience system are the resilience specialists and many individuals who lend their skills and time to building resilience. The UK Government cannot deliver an ambitious programme of change on resilience without making sure that these people have the required skills and knowledge to draw upon. This chapter focuses on what the UK Government can do to develop skills throughout the resilience system, as well as complement the wealth of expertise and training driven by universities, private institutes and the private sector. Our aim here is to build on this, and support and encourage the upskilling of all those that work in all areas of civil contingency risk and resilience.

188. The declaration on Government Reform in June 2021 set out an ambitious statement for improving how the UK Government delivers for the public. To do this we need the **best people leading and working in government and across the wider resilience sector** to deliver better outcomes for citizens and achieve our ambitions for the country. By doing so, we will also be making the most effective use of the finite resources available.

Resilience skills

189. To deliver this framework, public servants must have both specialist and generalist knowledge, skills, and networks. This will be delivered through the recently published plan by the UK Government Skills and Curriculum Unit (GSCU) to create a Government Campus and new curriculum for civil servants: Better Training, Skills and Networks[55] in January 2021. Developing resilience and crisis management skills, knowledge and networks form part of the new GSCU Campus which will also address wider aspects of risk management. These skills must be rigorous and accessible across the Civil Service, from core universal knowledge to specialist training. We will also consider whether resilience can be reflected more explicitly in the frameworks of government professions. Including resilience in the policy profession standards framework, for example, could raise the baseline competency across the UK Government as part of broader risk management improvement initiatives.

190. Excellent learning and development elevates the effectiveness of all resilience and crisis activity. Investment in knowledge, skills and resilience behaviours needs to be made at the pre-emergency phase, building preparedness and resilience before it is needed, particularly for areas with only a small number of specialists currently practising.

191. The UK Government will build resilience knowledge, skills and behaviours for all in the resilience system through:

- Defining competence standards that align to extant British Standards Institution standards
- Providing appropriate individual training and education, assessment and accreditation and mechanisms to share best practice;
- Providing collective training and exercising; and
- Continual professional development and retention to remain up-to-date.

55 Better Training, Knowledge and Networks: the New Curriculum and Campus for Government Skills

192. This chapter focuses mainly on crisis and response skills and training, as that is where the majority of specialist skills are required in resilience work. Our renewed efforts will require a broadening of skills within specific risk areas. For example, efforts to mitigate or prevent supply chain or climate risks will require specialist skills and knowledge that are specific to that subject.

Professionalisation

193. The UK Government will play a central role in both driving and enabling the development of skills and knowledge of people working right across resilience. To reflect this broad audience with a shared purpose, the UK Government will further strengthen the professionalisation of resilience work through the creation of the UK Resilience Academy and by the creation of training pathways as part of broader risk management learning journeys.

UK Resilience Academy

194. At the centre of our professionalisation offering will be a new **UK Resilience Academy** (UKRA), which will be the heart of a network of similar UK-Government affiliated providers and deliver leadership and learning to all those in the resilience system. This will be built up and out of the Cabinet Office's Emergency Planning College (EPC) which is already partnered with the UK GSCU.

195. Our vision is that the **UKRA will be a physical and virtual campus delivering the scoping, design and delivery of training, wider education, learning and development and exercising for resilience professionals.** It will bring together similar providers into a network, becoming a wider centre of excellence, incorporating concepts and doctrine, training and education, exercise and experimentation, lessons learning and implementation and innovation.

196. The EPC already contains much of the capability and expertise required to deliver this, however it will need a broadened remit to include the private sector covering CNI, the voluntary sector and finance. It will also provide ratified and current mechanisms, methods, materials, and guidance to inform individual citizens in a way that is clear, simple and would benefit their lives. Although our intention is to make the UKRA accessible to as broad a range of partners as possible, attendance at UKRA training will not be a condition for working with the UK Government on resilience, nor will it replace other excellent training partnerships elsewhere in government.

197. In addition to the EPC, there are a number of UK Government affiliated learning and development providers sharing skills, expertise and powerful networks, for example, the UK Leadership College for Government and College for National Security, as well as JESIP, UK Defence Academy and the College of Policing. All make different and essential contributions to the resilience learning and development landscape. Networked to the UKRA, this will create a comprehensive skills and training centre that needs to be promoted and made accessible to all those that have a role in resilience.

Standards and Training pathways

198. Lessons identified from incidents and complex, long-term responses such as COVID-19 have demonstrated that, as well as the need for wider risk management improvement, there is the need to improve coherence of the crisis management system and its overall operational effectiveness.

199. Building on existing good practice across government, the UKRA will work with Lead Government Departments and other learning and development providers to further enhance resilience capabilities and develop a resilience training pathway focusing on;

- The development and recognition of resilience knowledge, skills and behaviours and considering a progressive competence framework for individuals, aligned to relevant guidance, standards, lessons and good practice that is associated with a clear Learning & Development pathway. The UK Government will – in line with the GSCU curriculum for UK Government skills – consider audiences across government who need a wide but less deep grounding in resilience;
- Exploring the use of enhanced capability standards by drawing on existing best-practice. This will establish a ladder for progressive improvement and a yardstick for assessment and assurance; and
- Establishing a network or community of resilience professionals across government to develop, deliver and signpost L&D opportunities; facilitate communications across the network; organise continuing professional development events; and provide a forum for members of the resilience community to share and raise issues relating to professional development and improvement.

200. The resilience training pathway must also link to other risk and resilience training across the UK Government such as business continuity training and risk management.

201. The UK Government will establish a regular UK Resilience Lessons Digest.[56] This will summarise lessons from a wide range of relevant sources to share insights consistently across the UK Government and wider partners. It will coordinate knowledge to promote continual improvement in UK resilience training, exercising, doctrine, standards and good practice. The Lessons Digest will complement existing mechanisms for identifying and implementing lessons, including the JESIP Joint Organisational Learning (JOL) system, methods which drives continuous improvement in multi agency interoperability, and the Home Office Counter Terrorism Exercising (CTX) Team, which captures and monitors lessons from national Counter Terrorism exercises.

National Exercising Programme (NEP)

202. Planning for emergencies cannot be considered reliable until it has been exercised and has been shown to be workable. Exercises have three main purposes: to validate plans; to develop competencies and give them practice in carrying out their roles in the plans; and to test well-established procedures and identify areas for refinement and improvement.

56 Lessons Digest

203. The UK Government will **reinvigorate the National Exercising Programme** to bring together key partners to stress test our plans, structures and skills and embed lessons captured into our doctrine and standards. Previously the NEP focused on civil contingency emergencies caused by natural events (e.g. flooding) or accidents (a plane crash). Following the IR, it is recognised the NEP should also test the UK Government's capacity to manage civil contingencies emergencies caused by,[57] and impacted by[58] malign state activity.

204. To reflect this, the NEP will now be designed to test rigorously the concept of operations from the coordinated central response through the range of lead government department responsibilities and the involvement of the devolved administrations, from government to local responders. The NEP will complement existing resilience exercising conducted by UK Government departments, local authorities and the emergency services for specific risks.

Civil Service Crisis Skills and Resource

205. During a crisis, the Civil Service must be able to draw on the skills and experience that it needs. Within the UK Government and DAs, there are already thousands of crisis management and subject matter experts that can act when an emergency happens. But there are times when a risk impacts so widely, or requires niche or specialist knowledge, that the UK Government needs to be able to quickly access different or additional support. When this happens, we must be able to work with those partners quickly and efficiently, integrating them seamlessly into our response. Some of this knowledge and experience is held by those who used to be civil servants, and some of it is held within the private sector.

206. Rapid re-prioritisation within the Civil Service was required during COVID-19. 40,000 FTEs worked in COVID-19 roles across the Civil Service, covering a hugely diverse range of activity. Whilst some COVID-19 roles were filled through recruitment, many more were filled by existing Civil Servants, through internal redeployment within departments or re-focussing existing roles on the COVID-19 response. The UK Government Resourcing Hub in Civil Service Human Resources facilitated short-term loans between departments, with almost 3,000 individuals moving across government to fill COVID-19 roles. Although there was immense flexibility and capability within government, this is not a sustainable approach, as other work programmes were paused or cancelled as a result of this surge. It was also common for departments to report similar resourcing gaps.

207. One of the success stories of the COVID-19 pandemic was the NHS Reserve. The approach was piloted by eight early adopter Integrated Care Systems in different regions of England, in response to the need to develop an additional emergency preparedness workforce to support surge demand. The early adopter pilots recruited over 17,000 individuals and since August 2020 have on boarded an additional 1,307

57 For example, a Hostile State attacking UK communications infrastructure in support of a military or political objective

58 For example, a Hostile State using cyber to disrupt emergency services operations, or malicious communications to reduce public cooperation with emergency services and authorities in a crisis.

reservists. All remaining Integrated Care Systems are currently working to set up local reserve programmes as part of a national roll-out and these are forecast to grow the national reserve pool by around 10,000 by March 2023.

208. The *Integrated Review* recognised the need for a reserve to enable 'access to people with the right skills, experience and security clearances to form flexible, diverse and multidisciplinary teams'.[59] The 2020 Boardman Review of pandemic procurement also recommended that 'there should be a cadre of retired and current Senior Civil Servants trained for crisis management who can be brought in to head up a crisis team as senior leaders'.[60] The UK Government will continue to consider options to ensure that it is able to quickly draw on the expertise and resources that it needs during a crisis. This will be a common theme across the resilience system.

Applicability across the UK

At the time of publication, it is anticipated that:

- The UK Resilience Academy will be fully accessible to all partners including from the devolved administrations. However, it will not replace any training or skills-building in the DAs, and attendance at UKRA courses would not be compulsory. Similarly, any new training and skills pathway would be available in the devolved administrations, but would not be compulsory or replace existing activities.
- The NEP will work closely with the DAs. While DAs remain responsible for assuring their own contingency plans, the NEP will work with DAs on exercising for scenarios that cross borders and jurisdictions.

59 Global Britain in a Competitive Age: the Integrated Review of Security, Defence, Development and Foreign Policy

60 Findings of the Boardman review into pandemic procurement

Annex A: **The Devolved Administrations and Resilience**

209. In Scotland, Wales and Northern Ireland, where a matter is devolved (such as flood defence), the administration in that nation leads planning, preparation, crisis response and recovery for these areas. In practice, where a crisis in a devolved policy area spans across borders, the relevant devolved administration(s) and the UK Government will work together to respond and recover. This can be further complicated where a risk is a reserved matter (for example, energy policy), but the impacts of that risk (for example, the impact of energy failure on schools) is devolved. Therefore all resilience work between the four nations must include a partnership approach.

210. In each DA, resilience arrangements, systems and processes have developed to reflect local requirements.

211. In Scotland, the Scottish Resilience Partnership (SRP) is a core group of the most senior statutory responders and key resilience partners. The SRP acts as a strategic policy forum for resilience issues. It provides collective assurance to Scottish Ministers, statutory responders and key partners. It also gives advice to the resilience community on how best to ensure that Scotland is prepared to respond effectively to major emergencies. Resilience is delivered through three Regional Resilience Partnerships which are established by regulation. They work with twelve Local Resilience Forums. Guidance on the principles, good practice and guidance on specific resilience matters is set out in a suite of guidance called Preparing Scotland.

212. In Wales, strategic issues of emergency preparedness are considered at the Wales Resilience Forum (WRF) Chaired by the First Minister. The WRF provides a national forum for multi-agency strategic discussion and assurance for Welsh Ministers on civil contingencies and emergency planning. Local Resilience Forums (LRF), like their English counterparts, are the principal mechanism for multi-agency cooperation on resilience. The Welsh Government is currently undertaking a review of Civil Contingencies Governance structures in Wales. This will inform the Welsh Government's approach to strengthening civil contingencies in Wales to enable delivery of the most effective model of multi-agency emergency preparedness and response across Wales.

213. The Civil Contingencies Group (CCG) (Northern Ireland) is the strategic-level multi-agency forum for the development, discussion and agreement of civil contingencies, preparedness and resilience policy for the Northern Ireland public sector. The Northern Ireland Emergency Preparedness Group, as a Sub Group of CCG (NI), oversees the work of the three Emergency Preparedness Groups at the local level and also acts as a conduit to escalate issues to the strategic level. Civil Contingencies guidance and the principles underpinning preparing for, responding to, and recovering from emergencies, are provided in the Northern Ireland Civil Contingencies Framework – Building Resilience Together.

Annex B: **Summary of Framework actions**

The UK Government is already taking action by:

Theme	Actions
Risk	• Refreshing the NSRA process, so it will look over a longer timescale, include multiple scenarios, look at chronic risks and interdependencies and use the widest possible range of relevant data and insight alongside external challenge. The NSRA was updated in 2022 based on the new methodology. • Creating a new Head of Resilience, to guide best practice, encourage adherence to standards, and set guidance.
Responsibilities and Accountability	• Strengthening UK Government resilience structures by creating a new resilience function to deliver longer term capability building and risk mitigation to work alongside the UK Government's crisis management infrastructure.
Partnerships	• Continuing to take international, bilateral and multilateral action and cooperation on risk and resilience. Continue to use the UK Government's international action to identify and tackle risks before they manifest.
Communities	• Continuing to deepen and strengthen its relationships with the Voluntary and Community Sector in England

By 2025, the UK Government is committing to take the following actions:

Theme	Actions
Risk	• Clarify roles and responsibilities in the UK Government for each NSRA risk, to drive activity across the risk lifecycle. • Conduct an annual survey of public perceptions of risk, resilience and preparedness. • Introduce an Annual Statement to Parliament on civil contingencies risk and the UK Government's performance on resilience. • Develop a measurement of socio-economic resilience, including how risks impact across communities and vulnerable groups – to guide and inform decision making on risk and resilience.
Responsibilities and Accountability	• Expand the scope and use of standards and assurance in the public sector to support better contingency planning and risk management. • Run a pilot across three key pillars of reform to significantly strengthen LRFs in England: Leadership, Accountability, and Integration of resilience into the UK's levelling up mission.
Partnerships	• Grow the UK Government's advisory groups made up of experts, academics and industry experts in order to inform the NSRA. This may include establishing a risk-focused sub-group of the UK Resilience Forum.
Skills	• Deliver a new UK Resilience Academy, built out from the Emergency Planning College, making world class professional training available to all that need it. • Deliver a new training and skills pathway to drive professionalism and support all those pursuing a career in resilience. • Reinvigorate the National Exercising Programme to test plans, structures and skills.
Communities	• Offer further guidance from the UK Government to LRFs and local partners in England, created with local responders, the VCS and communities to support them working with vulnerable groups.

By 2030, the UK Government will:

Theme	Strategic deliverable
Risk	• Develop proposals to make the UK Government's communications on risk more relevant and easily accessible.
Responsibilities and Accountability	• Work across three key pillars of reform to significantly strengthen LRFs in England: Leadership, Accountability, and Integration of resilience into the UK's levelling up mission.
Partnerships	• Introduce standards on resilience across the private sector, where these do not already exist, adjusted to take into account the current landscape, priorities and needs across and between sectors. • Provide the wider private sector with better guidance on resilience to support contingency planning and risk management. • Build upon existing resilience standards for CNI to create common but flexible resilience standards across CNI, and do more on the assurance of CNI preparedness. • Review existing regulatory regimes on resilience to ensure they are fit for purpose. In the highest priority sectors that are not already regulated, and for the highest priority risks, consider enforcing standards through regulation.
Investment	• Have a coordinated and prioritised approach to investment in resilience within the UK Government, informed by a shared understanding of risk. • Consider options for funding models for any future expanded responsibilities and expectations of LRFs in England. • Offer new guidance to community organisations and individual householders, to help those people to make more informed decisions about investing in their own resilience and preparedness.

Equalities Considerations of the Deliverables

The Resilience Framework is an outline of, and commitment to, a range of measures and policies that will go through further development and implementation. The equality implications of those will continue to be assessed and monitored accordingly by those leading on development and implementation.

Annex C: **Evidence and Engagement**

214. This annex sets out our approach to building the evidence base for this framework. The ambition was to root the framework in the best available evidence, analysis and expertise, drawing on a diverse range of high-quality sources.

215. To achieve this ambition, the UK Government undertook a systematic programme of engagement, analysis and challenge. The UK Government established new processes and products where these were needed to address gaps and better inform decision-making. Lessons learned during the process will inform our approach at the implementation stage.

Approach

216. This programme was designed to support each stage of the framework development and drafting process. This involved working with government departments and agencies, the UK's overseas networks, and experts, practitioners and partners from the risk and resilience sector. In particular, the UK Government sought to:

- Agree common understandings and agree the scope for the framework.
- Establish the current risk and resilience landscape and identify potential models to follow.
- Identify priority areas for policy development.

Evidence base

217. The framework looked across a range of reports and projects from varying sources to help formulate and inform policy. Amongst others, these included:

- Government departmental reports
  - Integrated Operating Concept (2021)
  - Government Science Foresight Project: Technology and Innovation (2017)
  - BEIS: Storm Arwen Response Interim Review (2022)
- External and government partnership reports
  - The Centre for Long Term Resilience: Future Proof, The Opportunity to Transform the UK's Resilience to Extreme Risks (2021)
  - Civil Contingencies Resilience Strategy for Northern Ireland 2020-2025
  - Greater Manchester Resilience Strategy 2020-2030 (2021)
  - Grenfell Tower Inquiry: Phase 1 Report (2019)
  - House of Lords Risk Committee: Preparing for Extreme Risks, Building a Resilient Society (2021)

- Joint Committee for National Security Strategy: Biosecurity and National Security (2020)
- Joint Committee for National Security Strategy: The UK's National Security Machinery (2021)
- Leeds Beckett University: Research into Community Resilience, A place-based case study approach England, Wales, Scotland and Northern Ireland (2021)
- London Resilience Partnership: Chronic Incident Review (2021)
- Manchester Arena Inquiry Volume 1: Security for the Arena (2021)
- National Audit Office: The Government's Preparedness for the COVID-19 Pandemic: Lessons for Government on Risk Management (2021)
- National Preparedness Commission: Building Better Resilience (2020)
- National Preparedness Commission: Independent Review of the 2004 Civil Contingencies Act (2022)
- National Infrastructure Commission Report: Anticipate, React, Recover, Resilient Infrastructure Systems (2019)
- RAND Europe: Enhancing Defence's Contribution to Societal Resilience in the UK, Lessons from International Approaches (2021)
- Royal Society of Edinburgh: Response to the House of Lords Risk Assessment and Risk Planning Committee Enquiry (2021)
- Royal Academy of Engineering: Resilience, Building UK Capability and Considering Interdependencies.
- St John Ambulance: Ask Us About Our Million Hours, St John People on their Million Hours and how we built a Lasting Legacy of Emergency Resilience (2021)

- International reports and frameworks
  - The Australian Government: Royal Commission into Natural Disaster Arrangements (2020)
  - Government of Canada: Emergency Management Strategy for Canada, Toward a Resilient 2030 (2019)
  - New Zealand Government: National Disaster Resilience Strategy (2019)
  - Norwegian Directorate for Civil Protection: Analyses of Crisis Scenarios (2019)
  - Organisation for Economic Co-operation and Development: Resilience Strategies and Approaches to Contain Systematic Threats (2019)
  - United Nations Office for Disaster Risk Reduction: Sendai Framework for Disaster Risk Reduction 2015-2030 (2015)
- Devolved administrations frameworks
  - Northern Ireland Civil Contingencies Framework (2021)

Engagement

218. The UK Government designed engagement to bring in different perspectives and policy ideas from across the UK and around the world, adapted the programme in light of COVID-19 to make full use of online platforms and issued a public call for evidence.

219. **Public Engagement:** On 13 July 2021, the UK Government launched a public Call for Evidence. Contributions were invited on a range of security, defence, development and foreign policy questions. The UK Government received almost 400 submissions from individuals and organisations. A wide range of individuals and organisations submitted responses, including from industry; non-governmental organisations; international organisations, academia; community groups; think tanks; local government; local resilience forums; insurance companies; business and continuity teams in critical national infrastructure companies; and fire and police organisations. The UK Government reviewed and catalogued the submissions, which were fed into the development of this framework.

220. **Sector Engagement:** During the summer of 2021 the UK Government undertook an extensive programme of engagement and evidence gathered with LRFs in England and their partners. This "Big Resilience Conversation" was extremely well supported by a wide range of partners and we are grateful for their highly positive and constructive engagement.

221. **Experts and Practitioners:** The Call for Evidence was launched publicly on 13 July 2021 via a speech given by the Paymaster General to the Royal United Services Institute. The UK Government subsequently consulted over 1000 stakeholders in a series of engagement events, including businesses, charities, academics and other experts.

222. **Departmental & International Engagement:** a wide range of government departments were consulted, as well as UK missions overseas and our international partners, all of which informed inputs into this framework. The UK Government consulted departments on their areas of policy and delivery responsibility, and also engaged with the UK Delegation to NATO to better understand the role that can be played by multilateral organisations, and held discussions with international delegations.

223. **Devolved Administrations Engagement:** the UK Government engaged with the devolved administrations and territorial offices to understand arrangements in the Devolved Administrations and learn from good practice already in use. This was achieved through a series of regular contact groups and 1:1 engagements with individual administrations.

224. **Parliamentary Engagement:** the UK Government reviewed a number of parliamentary reports to ensure that relevant recommendations were recognised and reflected in this framework. This included the National Security Inquiry Report on Biosecurity and National Security, and the House of Lords Select Committee on Risk Assessment and Risk Planning Report: Preparing for Extreme Risks – Building a Resilient Society. In the process of developing this framework, officials briefed the Parliamentary Accounts Committee.

Challenge

225. The UK Government put in place challenge processes to test our assumptions and emerging thinking during the framework development process. This included ensuring that the analysis of the responses to the call for evidence was led by professional analysts, and having regular challenge sessions to allow the scope and key assumptions of this framework to be challenged at the development stage.

Annex D: **Acronyms and definitions**

Term	Definition
Acute risk	Time-bound, discrete events, for example a major fire or a terrorist attack. Contrast with Chronic risks.
Cabinet Office Briefing Rooms (COBR)	The Cabinet Office Briefing Rooms provide the coordination mechanism through which the UK Government responds quickly to emergencies that require decisions urgently (set out in the UK Government's concept of operations[61]). Ministers and senior officials are brought together in COBR to ensure a common appreciation of the situation and to facilitate effective and timely decision making in responding to domestic and international emergencies affecting UK interests.
Capabilities	In this context, capabilities means the organisations, tools, data, legislation or resources required to respond to risks. There are both specific capabilities, which are needed to manage specific risks, as well as generic ones which can be used to respond flexibly to multiple risks. Specific capabilities could include specialist equipment used to pump water or measure water speed during flood events. Generic capabilities include evacuation and shelter capability, and the emergency services.
Cascading risk	This term refers to the knock-on impacts of a risk that cause further physical, social or economic disruption. For example, severe weather could cause flooding, which then causes damage to electricity infrastructure, resulting in a power outage which then disrupts communications service providers (and so on).
Catastrophic risk	Those risks with the potential to cause extreme, widespread and/or prolonged impacts, including significant loss of life, and/or severe damage to the UK's economy, security, infrastructure systems, services and/or the environment. Risks of this scale would require coordination and support from UK Government. Examples include: the widespread dispersal of a biological agent, severe flooding, or the detonation of an improvised nuclear device.

61 The central government's concept of operations – GOV.UK

Term	Definition
Category 1 and 2 Emergency Responder	The Civil Contingencies Act divides those with duties for emergency preparation and response at the local level into two groups (Category 1 and Category 2 responders), each with different duties. Category 1 responders are those at the core of most emergencies and include: the emergency services, local authorities, some NHS bodies. Category 2 responders are representatives of organisations less likely to be at the heart of emergency planning but who are required to co-operate and share information with other responders to ensure that they are well integrated within wider emergency planning frameworks. They will also be heavily involved in incidents affecting their sector. Category 2 organisations include: the Health and Safety Executive, Highways Agency, transport and utility companies.
Chronic risk	Continuous challenges which gradually erode our economy, community, way of life and/or national security (e.g. money laundering; antimicrobial resistance). Contrast with Acute risks.
Civil contingencies	Planning and preparation for events or incidents with the potential to impact ordinary citizens and their interests.
Civil Contingencies Act (CCA) 2004	The framework for civil protection in the UK. The CCA identifies and establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level. It also allows for the making of temporary special legislation (emergency regulations) to help deal with the most serious of emergencies.
Civil Contingencies Group (Northern Ireland)	The Civil Contingencies Group (Northern Ireland) is the strategic-level multi-agency forum for the development, discussion and agreement of civil contingencies, preparedness and resilience policy for the Northern Ireland public sector.
Compound risk	When two or more events coincide (either in the same place, or at the same time) causing impacts greater than the sum of the individual risks. An example could be flooding impacting an area that is already experiencing a power outage.
Crisis	An event or series of events that represents a critical threat to the health, safety, security, or well-being of a community or other large group of people usually over a wider area.

Term	Definition
Critical National Infrastructure (CNI)	National Infrastructure is those facilities, systems, sites, information, people, networks and processes, necessary for a country to function and upon which daily life depends. It also includes some functions, sites and organisations which are not critical to the maintenance of essential services, but which need protection due to the potential danger to the public (civil nuclear and chemical sites for example). Critical National Infrastructure is a subset of National Infrastructure which, if damaged, would have major impacts on a national scale.
Emergency	An emergency is defined as: • An event or situation which threatens serious damage to human welfare, or to the environment; or • War, or terrorism, which threatens serious damage to security
Hazard	Hazards are non-malicious risks such as extreme weather events, accidents or the natural outbreak of disease. Contrast with Threat.
Local Resilience Forum (LRF)	LRFs are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and other organisations involved in emergency preparedness. These agencies are known as Category 1 and 2 Responders (except in Northern Ireland), as defined by the Civil Contingencies Act. The CCA and the Regulations provide that responders, through the Local Resilience Forum, have a collective responsibility to plan, prepare and communicate in a multi-agency environment.
Local Responder, Local authorities and responder agencies	Local responders and local responder agencies include both category 1 and category 2 responders as defined in the Civil Contingencies Act 2004. In the context of the devolved administrations, this can also refer to national agencies such as the Police Service of Northern Ireland, the Welsh Ambulance Service and the Scottish Fire and Rescue Service.
Military Aid to the Civil Authorities (MACA)	Military operations conducted in the UK and Crown Dependencies involving the employment of Defence resources as requested by a government department or civil authority. This is subject to Defence ministerial approval, either prior to, or at the time of an event.[62]

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Term	Definition
Malicious risk	Risks characterised by deliberate human intent to cause harm or disruption. These risks can come from individuals, groups or States. Examples include: terrorism; serious and organised crime; and hostile activity by foreign states.
National Security Risk Assessment (NSRA)	The NSRA assesses, compares and prioritises the top national level risks facing the UK, focusing on both likelihood of the risk occurring and the impact it would have, were it to happen. It is the main tool for assessing the most serious civil contingencies risks facing the UK.
National Risk Register (NRR)	The NRR is the publicly available counterpart of the NSRA, aimed at providing detailed information for those with formal contingency planning responsibilities at a national and local level.
Non-malicious risk	Risks characterised by natural or accidental causes. Examples include: industrial accidents; extreme weather; and human and animal disease.
Northern Ireland Emergency Preparedness Group	The Northern Ireland Emergency Preparedness Group, is a SubGroup of Civil Contingencies Group (NI) and oversees the work of the three Emergency Preparedness Groups at the local level and acts as a conduit to escalate issues to the strategic level.
Recovery Coordinating Group (RCG)	It is recommended that the Recovery Coordinating Group (RCG) is set up on the first day of the emergency and run in parallel with the Strategic Coordinating Group (SCG). Activation of the Recovery Coordinating Group (RCG) is initiated by the local authority, usually following a request by/agreement with the Strategic Coordinating Group (SCG). The RCG reports into the SCG until the SCG stands down.
Regional Resilience Partnership (in Scotland)	Resilience in Scotland is delivered through three Regional Resilience Partnerships which are established by regulation. They work with twelve Local Resilience Forums.
Resilience	The UK's ability to anticipate, assess, prevent, mitigate, respond to, and recover from natural hazards, deliberate attacks, geopolitical instability, disease outbreaks, and other disruptive events, civil emergencies or threats to our way of life.
Risk	An event, person or object which could cause loss of life or injury, damage to infrastructure, social and economic disruption or environment degradation. The severity of a risk is assessed as a combination of its potential impact and its likelihood. The Government subdivides risks into: hazards and threats.

Term	Definition
Risk appetite	The amount of risk an individual, business, organisation or government is willing to tolerate.
Risk-agnostic	Describes the ability of a capability, process or response to address 'common' impacts of risks (i.e. those impacts that occur across multiple scenarios). For example, major fires, terrorist incidents and flooding are all likely to produce mass casualties; developing capabilities to handle mass casualties is, therefore, a risk-agnostic approach.
Risk life cycle	A conceptual model that breaks the management of a risk down into stages at which different preparatory actions can be taken. The UK Government is using six stages: anticipation, assessment, prevention, preparation, response and recovery.
Scottish Resilience Partnership (SRP)	The Scottish Resilience Partnership (SRP) is a core group of the most senior statutory responders and key resilience partners. The SRP acts as a strategic policy forum for resilience issues. It provides collective assurance to Scottish Ministers, statutory responders and key partners. It also gives advice to the resilience community on how best to ensure that Scotland is prepared to respond effectively to major emergencies.
Strategic Coordinating Groups (SCGs)	Some disruptive events or emergencies require strategic multi-agency coordination at the local level (e.g. a major flood event). This is carried out by a Strategic Coordinating Group (SCG) in England, which can be activated by any responder organisation represented on the LRF. The SCG takes overall responsibility for the multi-agency management of the incident and establishes a strategic framework within which lower levels of command and coordinating groups will work. SCGs are usually chaired by the Police.
Subsidiarity	The principle whereby decisions are taken at the lowest appropriate level, with coordination at the highest necessary level. In practice this means that most incidents are handled within the capabilities of local agencies and responders, without central involvement.
Systemic vulnerability	Economic, societal, environmental and infrastructural factors that make a system more prone or vulnerable to the impacts of hazards or threats.
Threat	Malicious risks such as acts of terrorism, hostile state activity and cyber crime. Contrast with Hazard.
Upstream risk	Risks occurring in or affecting other countries, or in ungoverned spaces (including the oceans, space and cyberspace), which may then evolve to affect the UK.

Term	Definition
Vulnerability	The quality or state of being more prone or exposed to the impacts of hazards or threats. Vulnerabilities could affect individuals, communities, assets or a whole system and may be caused by physical, social, economic and environmental factors or processes.
Wales Resilience Forum (WRF)	In Wales, strategic issues of emergency preparedness are considered at the Wales Resilience Forum (WRF) Chaired by the First Minister. The WRF provides a national forum for multi-agency strategic discussion and assurance for Welsh Ministers on civil protection and emergency planning.

Annex E: **A (brief) history of Resilience**

226. Resilience is a concept that has evolved over the last 100 years. During this time the UK has gradually moved from civil defence (a focus on war risks, with some spillover benefits) to Integrated Emergency Management (IEM, an all-hazards approach driven by risk assessment) to Resilience (preparedness for effects across networked systems). And in each case, embedding change has taken years.

227. Modern emergency powers have their roots in the post-WWI desire to be able to tackle any threat to the state, and to recognise broader civil contingency risks beyond the war. In the period running up to WWII, this early concept of emergency planning remained focussed on security, but did include consideration of critical supply chains and risks to national infrastructure. The expansion of this to include civil contingency risks, and to give local responders official responsibilities came just before the outbreak of WWII, and naturally focussed on protecting local communities from the impacts of war.

228. After the war, civil defence continued to develop to include smaller scale civil crises, including the widespread disruption caused by strikes in the 1970s. But as the risks facing the UK evolved and adapted in the post-war period, so did our approach to tackling them. It would not be until the 1980s that a new concept of IEM emerged, taking a broader risk-based approach to the whole range of hazards that faced the UK. This was adapted further in the early 2000s into a new Resilience approach, partly driven by the 9/11 attacks.

229. Now, IEM and Resilience are systems that are employed across the world. IEM forms the basis of work in most developed countries. The UK was an outlier when it adopted Resilience in the 2000s, but it is now common practice internationally. But the key deficiency with each of these approaches has been the inability to get ahead of problems – to tackle them at source.

230. The UK cannot and should not abandon IEM and Resilience. But expanding the concept of resilience means that **instead of simply recognising that emergencies run across networks and systems, we reduce the risks in those systems in the first place**.

231. This will take a huge shift and this framework is only the start. But just as the UK's drive on Resilience transformed preparedness two decades ago by shifting engagement and focus, this framework provides a starting point to refocus and extend the civil protection system and beyond towards reducing the UK's risk profile and building resilience.

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

AUDIT REPORT

MEETING	Finance and Performance Committee
DATE	17th July 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 audit recommendation tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports are actioned in a timely manner.

2. There are 86 internal audit recommendations assigned to Committee for oversight. 33 are overdue from their agreed completion dates and revised completion dates have been assigned aligned to progress updates and plans to address the recommendations.

3. The Audit Tracker will be revised during the next quarter, and a recommendation made at the September 2023 Audit Committee meeting which will include a revised process for tracking recommendations and a new tracking format.

4. Advice has 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 are due to take place and where actions have been subsumed into detailed work plans or superseded.

5. This approach will be considered more widely in partnership with Internal Audit and Audit Wales ahead of the Audit Committee in September 2023.

6. **The Committee is asked to note the update.**

KEY ISSUES/IMPLICATIONS

As set out above.

REPORT APPROVAL ROUTE
Audit Tracker reviewed by: ADLT – 30th June 2023 EMT – 6th July 2023

REPORT APPENDICIES
Appendix 1 – Audit Tracker (Circulated Separately by e mail)

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

Savings & Efficiencies
Final Internal Audit Report

May 2023

Welsh Ambulance Services NHS Trust

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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2. Detailed Audit Findings 5
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Appendix B: Assurance opinion and action plan risk rating 18

Review reference:	WAST-2223-04
Report status:	Final
Fieldwork commencement:	20 February 2023
Fieldwork completion:	21 March 2023
Draft report issued:	13 April 2023
Draft report meeting:	17 April 2023
Management response received:	12 May 2023
Final report issued:	15 May 2023
Auditors:	Osian Lloyd, Head of Internal Audit Felicity Quance, Deputy Head of Internal Audit Lisa Harte, Internal Audit Manager
Executive sign-off:	Chris Turley, Director of Finance and Corporate Resources
Distribution:	Navin Kalia, Deputy Director of Finance & Corporate Resources Jason Collins, Head of Financial Management
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

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

Executive Summary

Purpose

To review the arrangements in place at the Trust to ensure that savings plans are specific, realistic, and measurable and that monitoring arrangements are effective.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Developing documented guidance to assist staff in developing, assessing, and approving savings plans.
- Providing financial training to reinforce documented guidance.
- Developing templates to ensure savings information is robustly recorded and reported.

Report Classification

Reasonable Assurance

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary[1]

Objectives		Assurance
1	Robust Savings & Efficiencies Plans	Reasonable
2	Reducing Budget to Reflect Savings	Reasonable
3	Appropriate governance arrangements	Reasonable

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1.1, 1.2	Developing Documented Guidance	1,3	Design	Medium
2.1, 2.2	Provision of Financial Training	1	Design	Medium
3.1	Robust Savings Plans	1	Design	Medium
4.1	Robust Savings and Efficiencies Reporting	3	Design	Medium

[1] We do not necessarily give equal weighting to the objectives and associated assurance ratings when formulating the overall audit opinion.

1. Introduction

1.1 The Trust approved the Integrated Medium-Term Plan (IMTP), which incorporates the Financial Plan for 2022/25, at its meeting on 24 March 2022. Developing the Financial Plan was a challenge on the back of the Covid-19 pandemic, and due to the significant cost pressures faced by the Trust. The Plan details that savings and efficiencies of £4.3m are required to achieve financial balance in 2022/23, a 54% increase in the level of savings to achieve from 2021/22. At month 11, savings of £4.026m have been achieved against a target of £3.942m and the Trust continues to forecast that it will deliver the total planned savings by the end of the financial year.

1.2 Recognising the ability to achieve financial balance in future years will be a greater challenge, the Financial Plan details the approach being developed to achieve further financial sustainability, including establishing a programme and workstreams to support the Trust in addressing its current financial challenges and in delivering further strategic development and transformation.

1.3 Embedding a transformative savings plan and regular reviews of savings targets are included as key controls to manage the following major risk (139), "*Failure to Deliver our Statutory Financial Duties in accordance with legislation*" detailed within the Corporate Risk Register.

1.4 Our audit has focused on the 2022/23 financial year, reviewing the arrangements in place to ensure that savings plans are specific, realistic, and measurable and that monitoring and reporting is effective. We did not review the effectiveness of the Financial Sustainability Programme as we plan to address within the 2024/25 Internal Audit plan, nor did we consider budgetary control arrangements as this was covered within the Financial Planning & Budgetary Control audit (issued August 2021: reasonable assurance).

1.5 Additionally, whilst undertaking this audit, we have considered the content of Audit Wales, '*Structured Assessment 2022 – Welsh Ambulance Services NHS Trust*' (January 2023), which included reviewing the Trust's management of its financial resources, including savings and governance arrangements.

1.6 The key risks considered at this review were:

- Balanced financial position not achieved therefore breaching its statutory duty to break-even;
- Decisions undertaken without sufficient financial scrutiny;
- Corrective action for currently unsustainable services not taken in sufficient time; and
- Savings and efficiencies schemes prove to be detrimental to the quality of service delivery and lead to the failure to meet IMTP objectives.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	4	-	4
Operating Effectiveness	-	-	-	-
Total	-	4	-	4

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

Audit Objective 1: There are robust plans in place to achieve savings and efficiencies targets, which have been assessed to confirm the accuracy of costs and achievable timescales, and with appropriate defined success measures to improve service delivery.

2.3 Historically, the Trust has taken a predominantly 'top-down' approach to identifying savings, but with the Financial Sustainability Programme in place, directorates are increasingly generating ideas for efficiencies. The Trust's Budget Manual emphasises this commitment, *the Trust is committed to a mix of bottom up / top down approach to budget setting by involving managers in the setting and ownership of Budgets*, which follows acknowledged best practice.

2.4 The Finance Directorate has developed a Budget Manual to assist budget holders in carrying out their roles and responsibilities for budgetary control. The Manual briefly refers to the savings and efficiency framework, but there is no detailed guidance to support budget holders through the process and ensure consistency (see **Matter Arising 1**). Having documented guidance would also be beneficial in embedding the Financial Sustainability Programme.

2.5 Providing budget holder training would also assist in clarifying the process and reinforce the need for transformational savings. There has been informal training provided to both finance managers and non-budget holder staff (i.e., Duty Operational Managers) through presentations and discussions on financial processes as part of recent restructures, but there has been no recent formal training (see **Matter Arising 2**). We understand that financial training for both Trust Board and Finance & Committee members has been planned for April 2023.

2.6 The 2022/23 schedule of savings (see Table 1), detailed within the Financial Plan, covers thirteen areas totalling £4.3m. Three areas totalling £1.7m were defined as non-recurring.

2.7 Subsequent reporting of the savings programme (see Table 2) in line with Welsh Government reporting requirements consolidates the thirteen areas into six themes.

Table 1

Schedule of Savings 2022/23 - DRAFT				Rec	Non Rec
	£M	£M	Assumption	£M	£M
Operations					
Workforce Efficiencies	1.80		Overtime, Sickness, Skill Mix, Vacancy Management (non frontline)	1.80	
Uniform	0.03		Utilise 21/22 purchased stock - cfwd benefit / stock control / new uniform supplier from Sept 22	0.03	
Fuel	0.05		Savings from swipe and save / Fuel provider contract	0.05	
M&S Stock Control	0.13		Stock control - minimum / maximum levels	0.13	
Medical Gases	0.02		Reduce cylinder holdings	0.02	
Travel & Subsistence	0.05		linked to overtime reduction	0.05	
Additional Income / External Contracts	0.24		seek to maximise / Contract reviews		0.24
In House Training (previously outsourced)	0.02		ad hoc	0.02	
		2.34			
Vacancy Management (Corporate Departments)		1.30			1.30
Estate utilisation, efficiencies and sustainability impacts		0.33		0.33	
Fleet Maintenance Efficiencies		0.08		0.08	
Non Pay Local Schemes / CIP / budget management (Corporate Directorates)		0.09		0.09	
Balance Sheet Management		0.16			0.16
Current Total Savings Plan		**4.30**		**2.60**	**1.70**

Table 2

	Annual	In Month			Cumulative			Forecast		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Workforce Efficiencies & Transformation	1,969	201	189	**12**	1,767	1,711	**56**	1,969	1,823	**146**
Fleet Efficiencies	81	7	0	**7**	74	6	**68**	81	6	**75**
Management of non operational vacancies (nr)	1,543	88	99	**-11**	1,453	1,838	**-385**	1,543	1,946	**-403**
Fuel	48	4	4	**0**	44	40	**4**	48	44	**4**
Local Schemes (non pay)	325	27	16	**11**	297	171	**127**	325	197	**129**
Estates	334	28	25	**3**	307	259	**48**	334	284	**50**
Totals	**4,300**	**355**	**333**	**22**	**3,942**	**4,025**	**-83**	**4,300**	**4,300**	**0**

2.8 While we were advised that changes have been minimal for 2022/23, there is no clear record of what changes have been made; and while £2.6m was initially identified, the level of recurring savings is not captured in ongoing reporting (see **Matter Arising 3**).

2.9 We were advised that the Director of Finance and Corporate Resources and the Chief Executive met with the relevant director to discuss their annual budgets, which highlighted savings. Evidence was supplied to confirm the correspondence with the directors as well as the meeting dates, but meetings were not minuted. We were informed that set up of an approvals panel is planned to strengthen the assessment and approval of individual plans going forward.

2.10 We reviewed a sample of five savings plans (Finance, Estates, Fleet, Planning & Performance; and Quality Safety & Patient Experience), and while a consistent template was used, enhancements were identified including providing detail for the rationale/ impact of the saving, robust success measures, and demonstrating

alignment to the IMTP (see **Matter Arising 3**). Tightening up on the identification and delivery of savings and efficiencies will be particularly important going forward, recognising the ability to achieve financial balance in future years will be a greater challenge for the Trust.

Conclusion:

2.11 The recording of savings schemes is consistent within directorates but are insufficiently detailed and will not assist in determining the confidence in delivering the savings proposal. This may be symptomatic of a lack of documented guidance to outline the process for developing savings plans. While informal financial training has been provided, the process needs to be formalised to confirm that staff receive training appropriate to their needs. Therefore, we provide **reasonable** assurance.

Audit Objective 2: Review and reporting of operational budgets to confirm these are reduced to reflect the delivery of recurrent savings.

2.12 We reviewed a sample of nine savings schemes (relating to non-pay and vacancy management savings within the directorates of Finance, Chief Executive, Partnership & Engagement, Planning & Performance, and Quality Safety & Patient Experience) and confirmed that they had been removed from the operational budget at the start of the 2022/23 financial year.

2.13 There is no mechanism in place to enable post-evaluation of savings plans to determine benefit realisation and lessons learnt. This would be beneficial to confirm the impact of the savings on service delivery, and understand the reason where savings plans are not being delivered. It is noted that a recommendation, regarding the inclusion of benefit realisation plans within programmes, was included in the IMTP Delivery report (issued February 2023 – reasonable assurance) therefore will not be replicated in this report. Discussions with the project manager confirmed that benefit mapping and lessons learnt were being implemented as part of the Financial Sustainability Programme.

Conclusion:

2.14 Savings have been removed from operational budgets promptly, but there is no benefit realisation plan in place to confirm that the saving plan's outcomes and benefits have been achieved, and identify any lessons learnt. We provide **reasonable** assurance for this objective.

Audit Objective 3: Appropriate governance arrangements are in place for the allocation and oversight of the delivery of savings and efficiencies, including an escalation process where financial sustainability is not achieved/ recovered.

Delivery Oversight

2.15 An appropriate governance framework for approval of the 2022/23 Financial Plan was evidenced – discussed by Finance & Performance Committee (17 March 2022);

endorsed by Executive Management Team (EMT) (21 March); and approved by the Board (24 March).

2.16 With regard to delivery, there is regular oversight of savings and efficiencies achievement by the Board, ADLT (Assistant Director Leadership Team), EMT, Finance & Performance Committee and Welsh Government. The Finance & Performance Committee's terms of reference, approved by Board in May 2022, explicitly refers to their role monitoring achievement of both in-year and recurring cost improvement plans and efficiencies.

2.17 A report to the Chair's Action Meeting in March 2022 detailed that savings performance reporting for the 2022/23 financial year will be incorporated in financial reports to EMT via Executive Finance Group (EFG).

2.18 Both ADLT and Finance & Performance Committee receive a Savings & Efficiency Highlight report that reflects on overall progress with each of the six savings themes, as well as highlighting risks and a thematic action plan to deliver the savings. Report recipients are provided with an overview of the savings programme, but the template could be enhanced by clarifying risks and progress to date, as well as having a robust action to assist with the delivery of the saving (see **Matter Arising 4**).

2.19 Evidence was provided of regular financial reporting to directorates that encompassed progress made against savings schemes – these reports replicate the information reported to Finance & Performance Committee. We did not review meeting notes to demonstrate key actions arising from budget meetings as this had been covered as part of the Finance & Budgetary Control audit (see para 1.4).

Escalation Process

2.20 From review of Finance & Performance Committee meeting minutes, scrutiny of the status of the savings programme was not routinely evidenced. We appreciate that this may be because the Trust is overall overachieving against its programme (see para 1.1), but five of the six saving themes have been consistently underachieving (see Table 3). Achievement of the savings programme is predominantly due to the Trust's reliance on vacancy management, and we note that Audit Wales have previously highlighted risks around this and the Trust's reliance on non-recurrent savings. We also note that the recent industrial action will also have impacted on progress with savings delivery and engagement.

Table 3 – Month 11 overview

Theme	Annual Target	YTD Target	YTD Delivery	YTD Variance		Assessment of delivery (RAG)
	£000	£000	£000	£000	%	
Workforce, Efficiency, Transformation	1,969	1,767	1,711	56	3.2%	
Fleet Efficiencies	81	74	6	68	91.9%	

Management of non-operational vacancies	1,543	1,453	1,838	(385)	(26.5%)	
Fuel	48	44	36	8	18.2%	
Local Schemes	325	297	171	126	42.4%	
Estates	334	307	259	48	15.6%	
Total	**4,300**	**3,942**	**4,025**	**(83)**	**(2.11%)**	

2.21 Furthermore, while there will be discussions operationally and reporting clearly details the performance with schemes, there is not a documented process to define the escalation of savings that are not being achieved in line with target timescales or will not be achieved (see **Matter Arising 1**). This would ensure that prompt action can be taken to prevent the Trust incurring additional financial pressure if savings are not delivered.

Savings Programme

2.22 As the Trust is facing a more challenging financial situation, requiring transformative savings of £6m to be achieved for financial year 2023/24, the Finance & Performance Committee will need to clearly demonstrate their scrutiny and how they are acting as a 'critical friend' to the Trust. In July 2022, the Financial Sustainability Programme was approved to identify 2023-24 savings projects at an earlier stage using two workstreams (covering achieving efficiency and income generation). The Director of Workforce and Organisational Development is the Senior Responsible Officer for the Programme, and a Project Manager has been appointed. At the date of fieldwork, the relevant project management documentation (including a Project Initiation Document) was being developed. Regular updates on the progress with the Financial Sustainability Programme have been reported, including a presentation to EFG in December 2022.

2.23 Further changes are planned to governance arrangements, e.g., putting in place a programme board reporting to the Strategic Transformation Board, so we suggest that a report is taken to Committee to approve any revisions to those originally agreed.

Conclusion:

2.24 There are effective governance arrangements through regular oversight over the savings and efficiencies framework. Enhancements to the reporting templates have been recommended to allow more effective scrutiny and to demonstrate that appropriate action is being taken to realise savings. The Trust is currently overachieving on its overall saving target, due to the continued reliance on non-recurrent items, particularly vacancy management; but there are several savings schemes that are under-achieving. There needs to be a defined process for taking prompt action against underachieving schemes so that it does not impact the

overall financial position. The Trust has recently established a Financial Sustainability Programme to address current financial challenges and to deliver further strategic development and transformation. We provide **reasonable** assurance for this objective.

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Appendix A: Management Action Plan

Matter Arising 1: Developing Documented Guidance (Design)		Impact
The Finance Directorate maintains a Budget Manual, which refers to the savings and efficiency framework as part of the budget setting process. The manual was updated within the last two years, but the document does not detail a date for its next review (this was raised as part of a wider recommendation within the Financial Planning & Budgetary Control audit in 2021/22). There is no further documented guidance to ensure that roles and responsibilities are clear, and that a consistent approach is undertaken when developing, assessing, and approving savings plans. Also, there is nothing documented to confirm the escalation process for any under-achievement of savings and efficiencies. Since May 2022, the Trust has been undertaking a Financial Sustainability Programme with an agreed terms of reference for delivery of governance arrangements. Developing documented procedures will assist in embedding this new approach.		Potential risk of: • Process being managed inconsistently resulting in savings and efficiency schemes not being achieved • Roles and responsibilities are unclear resulting in a lack of accountability and oversight.
Recommendations		**Priority**
1.1	Guidance should be developed to clearly outline: - Roles and Responsibilities (including assessments, approvals, monitoring and reporting arrangements). - Documentation to be used within the savings process to ensure that key elements are included, e.g. impact, risks, success measures, timescales, etc. - Escalation process to be followed (when, to whom and actions to be taken) where savings are not being achieved in line with target timescales.	**Medium**
1.2	The guidance should be communicated to all key individuals involved in the process, and subject to a regular review with the date recorded.	

Agreed Management Action		Target Date	Responsible Officer
1.1	Guidance on roles and responsibilities, documentation and escalation to be developed and shared by Financial Sustainability Programme.	End of July 23	Deputy Director of Finance / FSP Project Manager
1.2	Budget Manual to be updated for 23/24 and then annually reviewed.	End of July 23	Head of Financial Management

Matter Arising 2: Provision of Financial Training (Design)	Impact
Clause 5.2.7 of the Standing Financial Instructions (SFIs) states that it should be ensured, "*that adequate training is delivered on an ongoing basis to assist budget holders managing their budgets successfully*". Section 1.1 of the Budget Manual 2021/22 also details, "*All staff who have been given management responsibility for budgets should receive appropriate training (either formal or on the job), and procedure/ guidance notes. It is the responsibility of the Director of Finance to ensure training is available through the most appropriate medium. E.g. Face to face as part of budget review meetings, workshops, manuals, external training courses etc. In addition, budget managers should ensure sufficient financial management training is received*". While we appreciate that the Covid-19 pandemic and recent industrial action will have impacted, there has been no recent formal financial training provided to budget holders. We acknowledge, however, that this is a Finance objective for the forthcoming financial year (2023/24). Informal training has been delivered through powerpoint presentations, which incorporated the savings programme, and due to recent restructures, some budget holders will have been provided with verbal advice on financial processes. However training requirements need to be closely monitored so that assurance can be provided that all budget holders are proficient.	Potential risk of: • Poor decision-making impacting service delivery and financial sustainability.

Recommendations		Priority
2.1	A formal programme of financial training should be provided to budget holders to allow them to effectively carry out their role.	**Medium**
2.2	Training records should be maintained to confirm attendance, which should be monitored to identify non-attendance so this can be followed up.	

Agreed Management Action		Target Date	Responsible Officer
2.1	Key objective for WAST FM Team (and wider Finance teams) for 23/24 will be to undertake a series of Finance Training to Board Members, Budget Holders and other non-financial staff. This will be delivered by several methods such as face to face training, TEAMS sessions and induction.	End of December 23 (commenced in April 23)	Head of Financial Management
2.2	Schedule of Training and who has attended to be recorded.	End of December 23 (commenced in April 23)	Head of Financial Management

Matter Arising 3: Robust Savings Plans (Design)	Impact
A review of a sample of savings plans (see para 2.10) submitted for financial year 2022/23 identified that the following were not detailed in any of the plans: • the detail over the individual savings proposal nor the rationale to support the business case, instead theme headings were used, e.g. local schemes non-pay, vacancy management, etc; • an assessment of impact to service delivery and success measures that are aligned to the objectives in the Integrated Medium-Term Plan (IMTP) were not detailed; • whether the saving was recurring or one-off nor how it was calculated; and • risks and their impact were recorded, but the same risk and impact was detailed for every savings proposal, and there was no risk assessment to determine the confidence in delivering the proposal. We were informed that set up of an approvals panel is planned to strengthen the assessment and approval of individual plans going forward. While we were advised that changes to the overall savings programme for 2022/23 have been minimal, there is no clear audit trail to record any significant changes made to the programme throughout the year. For example, detailing the reason for the removal or amendments of any savings plans, or rationale for savings amendment from recurring to non-recurring. Outlining a clear rationale along with any perceived risks and impact will also improve decision making.	Potential risk of: • Savings and efficiencies schemes prove to be detrimental to the quality of service delivery and lead to the failure to meet IMTP objectives.

Recommendations		Priority
3.1a	Savings and efficiency plans should be enhanced using SMART criteria to define success and provide realistic timescales.	**Medium**
3.1b	Noting the expected future financial challenges, there should be prioritisation and recording of recurring funding against one-off savings to assist with financial sustainability.	
3.1c	A log should be implemented to enhance the current process recording changes to the savings programme, during the financial year, from that originally approved.	

Agreed Management Action		Target Date	Responsible Officer
3.1a	Will be evidenced by project management principles being applied to every individual savings schemes as it is identified and its ongoing monitoring.	March 24 (as this could be ongoing)	Deputy Director of Finance / FSP Project Manager / Scheme Lead
3.1b	Impact of Non-recurring schemes in 23/24 will be addressed by FSP and as part of WAST Financial Plan for future financial years.		FSP / Deputy Director of Finance
3.1c	Schedule of 23/24 agreed plans and any additions will be controlled through FSP.		FSP / Deputy Director of Finance/Head of FM

Matter Arising 4: Robust Savings and Efficiencies Reporting (Design)	Impact
A Savings and Efficiency Highlight Reporting template has been developed when reporting to the Assistant Director Leadership Team (ADLT) and Finance & Performance Committee. It is a useful tool reporting on progress with individual savings schemes; however, review noted some areas for enhancement that would provide more contextual information and encapsulate SMART criteria clearly detailing progress, significant changes, and providing robust actions to assist with future delivery of efficiencies: • Detailing the progress made with implementation of each savings project since the last performance report was issued, as sometimes it was unclear what progress had been made. • Defining how the risk score was determined (RAG status), which should be aligned to other risk reporting. • Action plans need to be updated providing robust actions to assist with future savings delivery, have action owners, and clear targets when actions will be completed. • Detailing any significant changes to the savings programme since the last performance report was issued.	Potential risk of: • Ineffective reporting arrangements are in place resulting in savings and efficiencies not being sufficiently monitored or scrutinised.

Recommendations		Priority
4.1	Management should consider enhancing the Savings and Efficiency Highlight Reporting template to provide more information on progress made, changes, future actions, and risk scoring.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
4.1	Review of the current monthly savings report.	End of July 23	Head of Financial Management

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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

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

TRUST POLICY REPORT

MEETING	Finance & Performance Committee
DATE	17th July 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 an update to the Committee on the status of the Trust's Policies.

2. The number of Policies within their review date fell below reasonable levels during the Covid-19 pandemic as the policy work plan was largely paused and efforts directed to support the response. This means that most policies have now past their review date; however, it is important to note that these remain our extant policies, they are in use and have not expired. The majority of policies will only require minor changes during the review process as they have already been through robust governance.

3. Whilst it is not possible to provide assurance that all Trust policies comply with current legislation, or that they discharge the Trust's statutory duties; Members can be assured that professionals across the organisation are proactive in identifying legislation or practice changes and updating policies as and when necessary to reflect any significant changes.

4. It is, of course, good practice to review, improve and update our policies in a timely manner and a policy prioritisation exercise is underway to fully assess the Trust's position and outline a priority programme of work to bring the organisation's key policies up to date during 2023/24 and schedule a further work plan over 2024-2026.

5. By way of additional assurance, the Trust's internal controls and policies are tested by the Audit Wales Structured Assessment and through the Internal Audit annual audit plan, both of which are aligned to areas of identified risk within the Trust. Additionally, there is a robust programme of risk management in place that will identify any specific areas that need to be addressed outside of the standard process for the review of policies.

6. The Corporate Governance Team hold a policy risk on the Directorate Register which will be reassessed given the that the Trust has several policies that are past their review date.

This risk is partially mitigated given that these are the Trust's extant policies and will be further mitigated as any required amendments are made, and these are brought through the policy governance process.

7. The Trust's policy governance process is being refreshed in partnership with Trade Union colleagues and includes the review of the Policy on Policies and the process for other documents such as Standard Operating Procedures. It is 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.

8. The EMT agreed proposals to consider extending the current review dates for several non-critical policies that have already been through a robust review process and this will be included in the report for Audit Committee and Trust Board in December 2023 which will also include an overview of the process in selecting these non-critical policies for extension and the 3 year policy work plan for approval.

RECOMMENDATION:

9. **Members are asked to:**
   a) **Consider the contents of the report and the programme of work in development to mitigate risk and bring policies in line with appropriate review dates.**
   b) **Provide a view on any of the policies within Committee's remit that should be included on the priority work plan.**

KEY ISSUES/IMPLICATIONS
10. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
11. The report and associated policy tracker were considered by: • Policy Group – 20th June 2023 • ADLT – 26th June 2023 • EMT – 28th June 2023

REPORT ANNEXES
SBAR Report Annex 1 – Trust Policy List

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

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

SITUATION

1. This paper provides an update to the Committee on the status of Trust Policies as at 20th June 2023 along with proposals to bring them up to date.

BACKGROUND

2. The Policy Group was set up in 2017 to ensure appropriate governance, process and partnership working was applied to the review of existing policies, the development of new policies and to ensure that all policies were dealt with in agreed timelines.

3. Since the Trust's revised policy process was 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 Covid-19 pandemic as policy work was largely paused and efforts directed to support the response. This means that most policies are now past their review date and are overdue for review.

4. Whilst it is not possible to provide assurance that all Trust policies comply with current legislation, or that they discharge the Trust's statutory duties; the Trust can be assured that professionals across the organisation are proactive in identifying legislation or practice changes and updating policies as and when necessary to reflect any significant changes.

ASSESSMENT

5. The Corporate Governance Team has maintained a policy tracker contained at Annex 1. This has been specifically designed to facilitate dynamic reporting dependent on the areas which are of most interest to users, for example reports can be produced by Directorate, type of policy, review date or Policy Lead.

6. The tracker describes the status of all policies and lists those which have been identified as a priority for review to date by working with Directors and their teams as well as reviewing Committee Terms of Reference and cycles of business.

7. In terms of a breakdown of the numbers; the Trust holds 93 polices and, for the reasons set out in this paper, only 13 of those are within their review date – this equates to 14% overall.

8. Additionally, there are 19 all Wales NHS Policies that the Trust has adopted from the NHS Employers Unit and only 1 of these is within its review date - equating to 5%. There are 13 new policies which have been identified for development along with 2 new policies expected from the NHS Employers Unit. These figures and policy reviews are out of the Trust's control as the programme of policy review work sits with NHS Wales.

9. This brings the total number of policies on the policy tracker to 127.

10. There were 49 policies that became due for review during the pandemic; however, there are a number that fell due just before and just after this which will naturally have been postponed given the response to the pandemic.

11. The policy prioritisation exercise which is underway will fully assess the Trust's position and outline a priority work plan to review the organisation's key policies during 2023/24 and schedule a further work plan over 2024-2026.

Policy Work Plan

12. Colleagues have reviewed their directorate lists within the tracker to support the development of a priority schedule and workplan for 2023/24. The Corporate Governance Team will continue to work across the Trust to develop a 3 year work plan to ensure the necessary work is undertaken to enable the Trust to maintain a suite of up to date policies.

13. There is an additional piece of work to be done to review policies in terms of their status and whether these are better suited as Standard Operating Procedures rather than Policy. This will be drawn out in the revised policy governance process.

14. Key Policies identified for priority review in 2023/24 so far are described below; however, this is not a definitive list and others will be included as the work programme is fully established by the Policy Group. The list consists of those policies that sit under the Audit Committee's remit as well as policies that sit within Safeguarding and Health & Safety for example. The EMT reviewed this draft list at its meeting on 28th June 2023.

    1. Assessment, Failure Referral and Appeals Policy
    2. CCTV Policy
    3. Children in Special Circumstances Policy
    4. Counter Fraud, Corruption and Bribery Policy
    5. Data Protection Policy
    6. Driving at Work Policy
    7. Education Programme Policy
    8. Environmental, Estates and Facilities Policy
    9. Equality Policy
    10. Exit Interview Policy
    11. Fire Safety Policy
    12. Flexible Working Policy
    13. Health and Safety Policy
    14. Home Working Policy
    15. HR Starting Policy
    16. Information Governance Policy
    17. NHS Wales Raising Concerns Policy
    18. Occupational Health Policy
    19. People Development Policy
    20. Policy for the Development and Review of Policies
    21. Recruitment and Selection Policy

22. Relocation Expenses Policy
23. Risk Management Policy (new)
24. Safeguarding Children and Adults Policy
25. Staff Immunisation Policy
26. Violence and Aggression Policy

15. It is worthy of note that several policies are already at various stages of the review and development process, as described in the list below, and have been included on the Policy Group Agenda in recent months.

1. Information Security Policy
2. Waste Management Policy
3. Management of High Intensity Service Users (Previous Frequent Caller)
4. Medicines Management Policy
5. Infection Prevention and Control Policy
6. Premises and Vehicle Cleaning Policy
7. NHS Pay Progression Policy
8. NHS Wales Lease Car/Pool Car Policy
9. NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management
10. Clinical Supervision Policy (New)
11. Management of Medical Devices Policy
12. Standards of Business Conduct Policy

16. The EMT agreed proposals to consider extending the current review dates for several non-critical policies that have already been through a robust review process. An extension could be between 6-12 months to support a manageable work plan over the next 3 years and could be applied to policies that fell due just before, during and just after the pandemic period. Work is underway to carry out an assessment of which policies this extension could be applied to facilitate a manageable work plan.

17. A workshop is in the early planning stages and due to be held on the 19th September 2023 to launch the revised policy governance process, which is currently under review, along with a series of communications to support colleagues to undertake the review of existing policies or develop new policies.

RECOMMENDED

18. **Members are asked to:**
    a) Consider the contents of the report and the programme of work in development to mitigate risk and bring policies in line with appropriate review dates.
    b) Provide a view on any of the policies within Committee's remit that should be included on the priority work plan.

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead	Policy Type	Issue Date	Expiry Date	Date Review due to Commence (within 3 months)	Comments
~~Gifts and Hospitality and Declaration of Interest Policy~~ Standards of Business Conduct Policy	1	CORPORATE GOVERNANCE	Trish Mills	Corporate	04/09/18	04/09/21	04/06/21	In the process now
Policy for the Development, Review and Approval of Policies	1	CORPORATE GOVERNANCE	Julie Boalch	Corporate	28/03/19	28/03/21	28/12/20	Under review
Risk Management Policy	1	CORPORATE GOVERNANCE	Julie Boalch	Corporate	01/02/13	01/01/14	01/10/13	Under review
Access Control Policy	8	DIGITAL	Kelly Holding	Corporate	25/10/18	25/04/20	25/01/20	
Access to Personal Information Policy	7	DIGITAL	Judith Birkett	Corporate	25/04/19	25/04/21	25/01/21	
CCTV Policy	2	DIGITAL	Kelly Holding	Corporate	25/04/19	25/04/21	25/01/21	
Confidentiality and Code of Conduct	10	DIGITAL	Kelly Holding	Corporate	23/02/21	23/02/24	23/11/23	
Data Protection Policy	1	DIGITAL	Aled Williams (DPO)	Corporate	15/12/16	15/12/19	15/09/19	
Data Quality Policy	5	DIGITAL	Jon Hopkins / Sue Brown	Corporate	16/07/19	16/07/22	16/04/22	Likely to be a recommendation from the 2023 internal audit for data analysis
Forensic / Digital Evidence Policy	7	DIGITAL	Aled Williams / James Rowlands	Corporate	New	New	#VALUE!	Not yet written - no systems in place yet for forensics
Information Classification Policy	9	DIGITAL	Aled Williams	Corporate	No dates	No dates	#VALUE!	
Information Governance Policy	6	DIGITAL	Kelly Holding	Corporate	25/10/18	25/10/21	25/07/21	
Information Risk Policy	10	DIGITAL	Kelly Holding	Corporate	23/02/21	23/02/24	23/11/23	
Information Security Policy	2	DIGITAL	James Rowlands	Corporate	25/04/19	25/04/22	25/01/22	Currently in review (Feb 2023)
Information Sharing Policy	6	DIGITAL	Kelly Holding	Corporate	New	New	#VALUE!	
Mobile Computing Policy	9	DIGITAL	Aled Williams / James Rowlands	Corporate	No dates	No dates	#VALUE!	Drafted - but most remote working aspects now covered under Info Security Policy
Records Management Policy	8	DIGITAL	Judith Birkett	Corporate	25/10/18	25/10/21	25/07/21	Needs updating to latest GDPR references
Trust Mobile Phone Policy	9	DIGITAL	Aled Williams / Tony Raine	Corporate	01/11/09	01/11/12	01/08/12	Possibly obsolete
Charitable Funds Investment Policy	10	FINANCE & CORPORATE RESOURCES	Jill Gill	Corporate	13/02/20	13/02/23	13/11/22	This policy was approved at policy group in June and will go to the July CFC meeting
Counter Fraud, Corruption and Bribary Policy	6	FINANCE & CORPORATE RESOURCES	Carl Window	Corporate	24/05/18	24/05/21	24/02/21	scheduled within 2023 work plan
Environmental, Estates and Facilities Policy	1	FINANCE & CORPORATE RESOURCES	Susan Woodham	Corporate	16/07/14	16/02/17	16/11/16	
Fire Safety Policy	4	FINANCE & CORPORATE RESOURCES	Susan Woodham	Corporate	17/03/22	17/03/25	17/12/24	A fire safety policy exists and is reviewed, however recent changes to ther team does mean elements of the policy need to be updated.
Fuel Card Policy	9	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	25/04/19	25/04/21	25/01/21	
NHS Wales Lease Car Policy	10	FINANCE & CORPORATE RESOURCES	Angie Evans	Corporate	30/10/19	30/10/22	30/07/22	New All-Wales policy only recently provided and approved by AC in Nov 22 - would assume no review required for another 3 years or until Shared services advise
NHS Wales No PO No Pay (No Purchase Order No Payment) Policy	N/A	FINANCE & CORPORATE RESOURCES	NHS Employers Unit	Corporate	No dates	No dates	#VALUE!	All Wales Policy - T&F group set up across Wales to review start of Sept 23
Overpayments Policy	N/A	FINANCE & CORPORATE RESOURCES	NWSSP / Jill Gill	Corporate	New	New	#VALUE!	All Wales Overpayments Policy review group has been set up with a second meeeting taking place on 28/6 - draft all-Wales policy being compared across bodies with comments being provided back to review group
Pubic Sector Payment Policy - WG	N/A	FINANCE & CORPORATE RESOURCES	TBC	Corporate	01/01/21	NRS	#VALUE!	All Wales Policy - Shared Services Procurement team asked to provide any review dates
Purchase Card Policy	10	FINANCE & CORPORATE RESOURCES	Jill Gill	Corporate	New	New	#VALUE!	Purchase card process in place on a trial basis which will help to inform the final purchase card policy which has been to the policy group for review previously
Tyres and Wheels	10	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	16/07/19	16/07/20	16/04/20	
Vehicle Disposal Policy	8	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	11/03/21	11/03/24	11/12/23	
Vehicle Telematics Policy		FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	10/05/18	10/05/21	10/02/21	
Alternatives to Conveyance Policy		MEDICAL & CLINICAL	Duncan Robertson	Clinical	01/11/10	01/11/11	01/08/11	
Consent to Examination and Treatment Policy		MEDICAL & CLINICAL	TBC	Clinical	25/02/20	25/02/21	25/11/20	
Decontamination of Medical Devices Policy		MEDICAL & CLINICAL	Jon Wilson	Clinical	New	New	#VALUE!	

Dispatch Cross Reference (DCR) Table Policy		MEDICAL & CLINICAL	Grayham McLean	Corporate	23/02/21	23/02/24	23/11/23	
Intellecutal Rights Policy		MEDICAL & CLINICAL	Nigel Rees	Clinical	01/01/17	01/11/18	01/08/18	Will be superseded by all Wales Policy
Management of Controlled Drugs Policy		MEDICAL & CLINICAL	Andy Swinburn / Chris Moore	Clinical	27/07/21	27/07/24	27/04/24	In process now
Management of Frequent Callers Policy		MEDICAL & CLINICAL	Robin Peterson	Clinical	04/09/18	04/09/21	04/06/21	In process now
Management of Medical Devices Policy	1	MEDICAL & CLINICAL	Jon Wilson	Corporate	22/05/18	22/07/18	22/04/18	In process now
Medicines Management Policy	1	MEDICAL & CLINICAL	Chris Moore	Clinical	25/02/20	25/02/23	25/11/22	In process now
NHS Wales Do Not Attempt CPR for Adults in Wales		MEDICAL & CLINICAL	Dr Paul Buss	Clinical	30/10/18	NRS	#VALUE!	
NHS Wales Research and Development Policy NHS Wales		MEDICAL & CLINICAL	Nigel Rees	Corporate	10/05/18	10/05/21	10/02/21	
Non Medical Prescribing Policy		MEDICAL & CLINICAL	Paula Jeffery	Clinical	25/02/20	25/02/23	25/11/22	
Patient Clinical Record Policy		MEDICAL & CLINICAL	Kevin Webb	Clinical	New	New	#VALUE!	
Professional Regulation Policy		MEDICAL & CLINICAL	Andy Swinburn	Employment	10/01/19	10/01/21	10/10/20	
Business Continuity Management Policy		OPERATIONS	TBC	Corporate	24/10/19	24/10/22	24/07/22	
Command Policy		OPERATIONS	Clare Langshaw	Corporate	25/04/23	25/04/26	25/01/26	In process now
~~Emergency Operations Demand Management Policy~~ superseded by Clinical Safety Plan		OPERATIONS	Kate Blackmore	Corporate	19/11/20	19/05/21	19/02/21	
High Risk Record Policy		OPERATIONS	Katie Blackmore	Corporate	16/07/20	16/07/23	16/04/23	
MPDS QA Policy		OPERATIONS	TBC	Clinical	10/01/19	10/01/21	10/10/20	
Quality Assurance Framework for the Clinical Desk		OPERATIONS	TBC	Clinical	01/06/15	NRS	#VALUE!	
Adverse Weather Conditions Policy	8	PEOPLE SERVICES	Bethan Davies	Employment	05/07/18	05/07/21	05/04/21	
Assessment, Failure Referral and Appeals Policy	2	PEOPLE SERVICES	Martin Mulholland	Employment	01/02/16	01/02/18	01/11/17	
Bank Worker Policy	7	PEOPLE SERVICES	Michelle Morse	Employment	New	New	#VALUE!	
Bursary Scheme Policy	10	PEOPLE SERVICES	Sarah Davies	Employment	01/08/16	NRS	#VALUE!	
Colleague Experience / Wellbeing Policy	3	PEOPLE SERVICES	Lynda Bugonovic	Employment	New	New	#VALUE!	
Driving at Work Policy	1	PEOPLE SERVICES	Andrew Morgan	Employment	07/09/21	06/09/24	07/05/24	
Education Programme Policy (RTW)	1	PEOPLE SERVICES	Martin Mulholland	Employment	19/12/12	02/05/18	19/01/18	
Equality Policy	1	PEOPLE SERVICES	Paula Spiteri	Employment	New	New	#VALUE!	
ERDT Appeals Policy		PEOPLE SERVICES	Andrew Morgan	Employment	01/02/17	01/02/19	01/11/18	
ERDT Complaints Policy		PEOPLE SERVICES	Andrew Morgan	Employment	01/02/17	01/02/19	01/11/18	
ERDT Education and Training Maladministration Policy		PEOPLE SERVICES	Andrew Morgan	Employment	01/02/17	01/02/19	01/11/18	
ERDT Equality and Diversity Policy		PEOPLE SERVICES	Andrew Morgan	Employment	01/02/17	01/02/19	01/11/18	
ERDT Fabrication and Falisification Policy		PEOPLE SERVICES	Andrew Morgan	Employment	01/02/17	01/02/19	01/11/18	
ERDT Health and Safety Policy		PEOPLE SERVICES	Andrew Morgan	Employment	01/02/17	01/02/19	01/11/18	
ERDT Learner Induction Checklist		PEOPLE SERVICES	Andrew Morgan	Employment	01/02/17	01/02/19	01/11/18	
ERDT Quality Improvement Policy		PEOPLE SERVICES	Andrew Morgan	Employment	01/02/17	01/02/19	01/11/18	
ERDT RPL Policy		PEOPLE SERVICES	Andrew Morgan	Employment	01/02/17	01/02/19	01/11/18	
Exit Interview Policy	1	PEOPLE SERVICES	Emma Morgan	Employment	01/06/04	01/06/07	01/03/07	
Flexible Working Policy	1	PEOPLE SERVICES	Karen Jones	Employment	10/05/18	10/09/20	10/06/20	
Home Working Policy	1	PEOPLE SERVICES	Karen Jones	Employment	26/03/20	26/03/21	26/12/20	
HR Starting Policy	1	PEOPLE SERVICES	Hilary Caffrey / Anna Stein	Employment	01/10/09	NRS	#VALUE!	
Managing Families and Relatives Working Together Policy	9	PEOPLE SERVICES	Amanda Jones	Employment	10/03/20	10/03/23	10/12/22	
Maternity and Adoption Policy	3	PEOPLE SERVICES	Sophie James	Employment	10/05/18	10/05/21	10/02/21	
NHS Wales Apprenticeship Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	New	New	#VALUE!	
NHS Wales Capability Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	27/06/18	27/06/21	27/03/21	
NHS Wales Disciplinary Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	27/07/17	01/03/20	27/11/19	
NHS Wales Disclosure and Barring Service		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	New	New	#VALUE!	
NHS Wales Email Use Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	04/10/19	26/06/20	04/03/20	
NHS Wales Employment Break Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	27/07/17	01/03/19	27/11/18	
NHS Wales Equality Impact Assessment Guidelines Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	01/10/10	01/09/13	01/06/13	

NHS Wales Internet Use Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	24/05/16	01/01/18	24/09/17	
NHS Wales Managing Attendance at Work		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	16/10/18	16/10/21	16/07/21	
NHS Wales Menopause Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	10/01/19	10/12/21	10/09/21	
NHS Wales Organisational Change Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	10/01/19	01/03/20	10/11/19	
NHS Wales Pay Progression Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	07/07/08	NRS	#VALUE!	
NHS Wales Raising Concerns Policy - Whistleblowing		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	13/03/18	01/01/20	13/09/19	
NHS Wales Recruitment & Retention Payment Protocol		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	27/07/17	01/03/20	27/11/19	
NHS Wales Reserve Forces Training and Mobilisation Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	07/03/16	01/09/19	07/05/19	
NHS Wales Respect and Resolution Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	01/04/21	01/04/24	01/01/24	
NHS Wales Secondment Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	07/03/16	01/09/19	07/05/19	
NHS Wales Social Media Use Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	24/05/16	01/01/18	24/09/17	
NHS Wales Special Leave Policy		PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	13/03/18	01/01/20	13/09/19	
Occupational Health Policy	2	PEOPLE SERVICES	Ceri Bryant	Employment	01/01/14	01/01/14	01/10/13	
Paternity Policy	3	PEOPLE SERVICES	Sophie James	Employment	10/05/18	10/05/21	10/02/21	
People Development Policy	2	PEOPLE SERVICES	Lynda Bugonovic	Employment	New	New	#VALUE!	
Recruitment and Selection Policy	1	PEOPLE SERVICES	Dee U /Charlie Bosher	Employment	25/10/18	25/04/20	25/01/20	
Redeployment Policy	7	PEOPLE SERVICES	Emma Morgan	Employment	25/02/20	25/02/23	25/11/22	
Relocation Expenses Policy	2	PEOPLE SERVICES	Jan Cross	Employment	10/01/19	10/01/21	10/10/20	
Resourcing Policy *		PEOPLE SERVICES	TBC - Prev. Ass. Director Level	Employment	01/03/14	01/06/14	01/03/14	
Rest break Policy *		PEOPLE SERVICES	TBC - Prev. Ass. Director Level	Employment	01/12/14	01/06/15	01/03/15	
Retirement Policy	6	PEOPLE SERVICES	Sara Williams / Hilary Cafrey	Employment	01/08/14	01/08/15	01/05/15	
Shared Parental Leave Policy	3	PEOPLE SERVICES	Sophie James	Employment	10/05/18	10/05/21	10/02/21	
Staff Immunisation Policy	1	PEOPLE SERVICES	Ceri Bryant	Employment	New	New	#VALUE!	
Study Leave Policy	4	PEOPLE SERVICES	Sara Williams / Emma Morgan	Employment	01/06/15	01/06/16	01/03/16	
Transfer Policy *		PEOPLE SERVICES	TBC	Employment	10/03/20	10/03/23	10/12/22	
Work Experience Policy	8	PEOPLE SERVICES	Sara Minahan	Employment	No dates	No dates	#VALUE!	
Working Time Regulations Policy	5	PEOPLE SERVICES	Sara Williams / Emma Morgan	Employment	01/07/04	01/07/07	01/04/07	
Adverse Incident/Hazard Reporting Policy		QS&PE	Jane Palin	Clinical	25/04/23	25/04/26	25/01/26	
Children in Special Circumstances Policy & Procedure		QS&PE	Fiona Davies	Clinical	28/11/17	28/11/20	28/08/20	
Domestic Abuse, Gender Based Violence and Sexual Violence “Ask and Act” Policy		QS&PE	Rhiannon Thomas	Clinical	26/11/19	26/11/21	26/08/21	
Health and Safety Policy	1	QS&PE	Nicola White	Corporate	28/11/17	28/11/20	28/08/20	In process now
Infection Prevention & Control Policy	1	QS&PE	Louise Coulson	Clinical	08/09/20	22/05/21	08/02/21	In process now
Infection Prevention & Control: Sharps Policy		QS&PE	Louise Coulson	Clinical	01/12/20	01/12/23	01/09/23	
Lone Worker Policy		QS&PE	Nicola White	Employment	No dates	No dates	#VALUE!	
Management of Allegations Policy: When an allegation or concern is raised about an Employee or Volunteer		QS&PE	Nikki Harvey	Corporate	27/02/18	27/02/21	27/11/20	
Management of Compensation Claims Policy		QS&PE	Trish Gaskell	Corporate	26/02/19	26/02/21	26/11/20	
Mental Capacity Policy		QS&PE	Steve Clarke	Employment	New	New	#VALUE!	
NHS Wales ANTT Policy		QS&PE	Louise Coulson	Employment - All Wales	25/02/20	25/07/21	25/04/21	
NMC Revalidation and Registration		QS&PE	Helen Rees	Employment - All Wales	04/09/18	04/09/21	04/06/21	
Organisational Learning and Promoting Improvements in Patient Safety Policy and Procedure		QS&PE	TBC	Clinical	01/11/13	01/11/14	01/08/14	
Policy for the Development, Review and Approval of NHS Direct Wales/111Clinical Decision Support Software Changes		QS&PE	Helen Rees	Corporate	New	New	#VALUE!	
Premises and Vehicle Cleanliness Policy	1	QS&PE	Louise Coulson	Clinical	26/11/19	26/11/21	26/08/21	In process now
Putting Things Right Policy		QS&PE	Jane Palin	Corporate	25/04/23	25/04/26	25/01/26	
Safeguarding Children and Adults at Risk of Harm Policy This policy has merged with the Protection of Vulnerable Adults Policy		QS&PE	Nikki Harvey	Corporate	28/11/17	27/11/20	28/07/20	
Safer Handling Policy		QS&PE	Mike Jones	Employment	01/12/20	01/12/23	01/09/23	
Violence & Agression Policy		QS&PE	Nicola White	Employment	04/02/21	04/02/24	04/11/23	

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	25 May 2023
Committee Meeting Date	15 May 2023
Chair	Joga Singh

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. There are no alerts from this meeting.

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** was presented to the Committee. There was good discussion on proposed indicators, and it was agreed that where possible a fuller discussion would take place at a Board development session prior to the July Board to devote more time to this important assurance report.

3. The Committee's **cycle of business for 2023/24** was approved. The cycles will be used to set the agenda and provide predictability to the Trust of the majority of the issues the Committee will see during 2023/24 to discharge its responsibilities under its terms of reference. A monitoring report will be provided to each meeting to track progress against the cycle.

4. The **Operational Update for Q4** was received and members noted that the Royal College of Nurses (RCN) have notified the media and it has been reported that they plan to take industrial action on 6 and 7 June. On that basis the Trust will commence planning using the approach previously established to work with the RCN on derogations.

5. Members **reflected** on the diversity of the agenda which was supported by a more structured cycle of business. Flexibility from the Chair and members in taking some items out of order to allow the free flowing of discussion was effective.

ASSURE

(Detail here assurance items the Committee receives)

6. The **financial performance report as at Month 12 2022/23** was presented with a small revenue surplus reported of £62k (subject to audit), capital expenditure fully spent, and gross savings of £4.392m have been achieved against a target of £4.300m. In addition, the Public Sector Payment Policy is on track with performance, against a target of 95%, of 97.4% for the number, and 97.8% of the value of non NHS invoices paid within 30 days. The Committee congratulated all directorates for achieving this end of year position.

7. The Committee received a presentation on the **financial position for Month 1 2023/24**. The Board will have a detailed paper on the financial position before it for the May meeting. There is a small overspend as at month 1 of £0.008m with the forecast for 2023/24 one of breakeven. Capital plans are being worked through and the private session of this meeting reviewed the current position on this. In line with financial plans gross savings of £0.552m has been achieved against a year to date target of £0.573m. Although slightly underachieved there is good progress. Key assumptions for Month 1 include the funding by Commissioners for 100 front line staff recruited in 2022/23. An update will be provided to the Trust Board, however there is a strong indication that this will be funded for 2023/24.

8. As part of discussion on the Month 1 financial position, a **deep dive on risk 139** was conducted. This risk is *the failure to deliver our statutory financial duties in accordance with legislation*. The risk score is currently 16 (4 x 4) and it was felt that that was appropriate at this point in time but will be regularly reviewed. A key point in time – not just for WAST but for the wider system - will be the Q1 financial position, however monthly detailed finance reports will continue to provide key information to Committee and Board as to the level of risk the organisation is experiencing including elements of non-recurrent as opposed to recurrent funding and how this is being managed financially and operationally. The savings target for 2023/24 remains challenging however the Committee were assured of the commitment from officers to address these, with the Financial Sustainability Programme and Directorate-specific plans looking at all options to close the unidentified savings gap. Whilst difficult choices may need to be made in 2023/24 and beyond, members were encouraged that discussions on the financial position centered around the impact on patient safety and quality.

9. The **Integrated Medium-Term Plan (IMTP) 2022-25** end of year position including the Accountability Conditions set by Welsh Government was received. The Committee reviewed the outstanding actions from 2022/23 which are before the Board at the May meeting, however the teams were congratulated for the significant amount of work that was achieved against the IMTP and ultimately the Trust's strategy, against a backdrop of a very difficult Winter and prolonged industrial action.

10. The **MIQPR** was received for March/April 2023 and is before the Board at the May meeting. Members noted that whilst there had been some improvement in handover delays, 23,000 hours lost in April was still far in excess of what was acceptable, as was 2,700 patients waiting more than 4 hours to be seen in an Emergency Department. The actions to improve response times include those within the control of the Trust and those which rely on system partners. It was noted that the full roll out of CHARU, work on managing red demand differently, and handover delays reducing to Welsh Government targets (15,000 hours lost by end of Q2 and 12,000 by end of Q3) was modelled to provide a 7% improvement in red performance. Members appreciated the actions being taken but

were very concerned with the avoidable harm these delays are causing, even should the Welsh Government targets be met.

11. The Committee has the review of matters relating to **demand and capacity** plans in their remit and an update was received at this meeting. Recent demand and capacity reviews for EMS, NEPTS and 111 were discussed as were current packages of work. Notwithstanding the absence of a formal framework, the Committee was reassured that the Trust's focus on forecasting and modelling, with both external and internal support, was strong and has led to significant transformation work programmes. Consideration will be given to subsuming this into the Quality and Performance Management Framework to enable the Board to receive formal assurance of this business critical process. The 111 demand and capacity review will continue in partnership with the 111 Commissioners in 2023/24.

12. 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 March and April. 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.

13. An update on the Decarbonisation Action Plan (DAP) was received by way of the **Environment, Decarbonisation and Sustainability Update** for April 2023. The DAP has a range of actions which frame the Trust's decarbonisation response and is overseen by the recently formed Decarbonisation Programme Board. Progress against the DAP has moved from a self-assessment of red/amber to amber, with a number of significant schemes completed utilizing All Wales capital funding. In 2022/23 23 hybrid rapid response vehicles were rolled out together with 67 EV chargers over 54 WAST sites. Welsh Government funding has been confirmed to support a range of schemes including decarbonisation initiatives and roofing projects at a number of stations. Notwithstanding the very positive progress, the sheer volume of work, resource and capacity constraints remains of concern for WAST's delivery of the DAP – an issue which all NHS Wales organisations are experiencing, as set out in the recent internal audit on decarbonisation.

14. The **Electronic Patient Care Record (ePCR) Benefits Realisation** report was received which had streamlined the benefits and included a five year plan to realize benefits for ePCR which will now be transitioned to business as usual, and owners identified to take these forward. Assurance on the decommissioning of the digital pen patient clinical report system following an extension to ensure patient information was also provided.

RISKS

Risks Discussed: The principal risks in the remit of the Committee were discussed, as well as risks 223 and 224 and the additional commentary box providing context to the scoring was noted. Risks scores have remained unchanged since the March meeting. The highest risks for this Committee are:

139 (failure to deliver our statutory financial duties in accordance with legislation). See deep dive in the assurance section above.

245 (failure to have sufficient capacity at an alternative site for EMS CCCs which could cause a breach of statutory business continuity regulations) Agreements with respect to the capital programme will have a positive impact on this risk.

458 (a confirmed funding commitment from EASC and/or WG is required in relation to funding for recurrent costs of commissioning)

260 (a significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems)

543 (major disruptive incident resulting in a loss of critical IT systems)

Risk 538 had previously been developed to reflect the possible consequence of a further delay to the implementation Salus, with the risk being further developed to capture the emerging position and differentiate it from the realised issues. A new risk is emerging which relates to the ability to release staff for training on Salus and still have sufficient to meet demand which will affect performance. Discussions are ongoing with Commissioners on the numbers of staff they are able to fund.

New Risks Identified: a new risk (the Trust's inability to provide a civil contingency response in the event of a major incidence and maintain business continuity causing patient harm and death) has been added to the risk register at a score of 15 and members noted that resourcing to address the recommendations has now been identified. Regular updates to the Committee on progress were agreed.

COMMITTEE AGENDA FOR MEETING		
Operations Quarterly Report	Financial position for year end 2022/23 and for month 1 2023/24	Risk Management and Corporate Risk Register
Integrated Medium Term Plan 2022-25 Outturn position and update on IMTP 2023-26	Annual review of key performance indicators	Monthly Integrated Quality and Performance Report
Demand and capacity plans	Quality and Performance Management Framework update	Value based healthcare update
Decarbonisation update	ePCR benefits realisation/PIR	Digipen closure report
Internal audit tracker	Committee cycle of business	

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					
Bethan Evans						
Ceri Jackson						
Chris Turley						
Rachel Marsh						
Lee Brooks	Sonia Thompson					
Liam Williams	Wendy Herbert					
Angie Lewis	Liz Rogers					
Leanne Smith						
Hugh Parry						
Damon Turner						
Trish Mills						

	Attended
	Deputy attended
	Apologies received
	No longer member

AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of APPENDICES	**1**

Committee Priorities and Cycle Monitoring Report

MEETING	Finance and Performance Committee
DATE	17 July 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.

2. With respect to the priorities, discussions are taking place with respect to Audit Committee's oversight of the QPMF, and an update will be provided at the next meeting on the digital strategy and in particular the IMTP 2023-26 elements. 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.

3. There is nothing to escalate on the cycle of business progress.

RECOMMENDATION

4. The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable

REPORT APPENDICES

None

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

COMMITTEE PRIORITIES FOR 2022/23

SITUATION

5. This report updates the Committee on progress against the priorities it set for 2023/24 and progress against the agreed cycles of business.

BACKGROUND

6. 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.

7. 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.

8. 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

9. The Committee priorities, and progress against them is as follows:

Priority	Progress
Focused oversight on the implementation of the digital strategy	• Not yet progressed as a stand-alone item but digital strategy elements included in IMTP 2023-26. • Update being provided to September meeting by Interim Digital Director
Focused oversight on the implementation of the Quality and Performance Management Framework	• A verbal update was provided to the May meeting. Consideration is being given to the Audit Committee having oversight of this framework.

10. There remains a few areas of reporting that are being developed which include:

(a) Report on commissioning
(b) Metrics for digital systems infrastructure

(c) Cyber resilience and cyber security reporting

11. The annual review of the key metrics in the MIQPR was deferred from the May meeting to allow a Board development session to take place on 21 June.

RECOMMENDATION

12. 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 July meeting
IMTP financial plan	STB/EMT	Annually							EDOF	Endorsement	
Value Based Healthcare Report	TBC	Every other meeting							DOF	Assurance	
Assurance paper on PIR process	TBC	One off and then cyclical							EDSPP	Assurance	
Post Implementation Reviews	TBC	As required							Relevant Director	Assurance	No PIRs for July meeting
Monitoring of key projects as requested from time to time	TBC	As required							Relevant Director	Assurance	Salus
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
IMTP for following year	STB/EMT/Board	Annually							EDSPP	Endorsement	
Report on commissioning	TBC	TBC							EDSPP	Assurance	Reporting being developed
Demand and capacity reviews	EMT	Ad Hoc							EDSPP	Endorsement	No reports for July 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
Annual HART KPI report	TBC	Annually							DO	Assurance	
IMTP progress updates	STB/EMT/Board	Each Meeting							EDSPP	Assurance	
QPMF update report	QPMF Steering Group	Bi-annually 22/23									
ESTATES AND FLEET											
Estates and fleet strategy refreshes	TBC	Periodically as required							EDOF	Approval	No refreshes due
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
ENVIRONMENTAL AND SUSTAINABILITY											
Decarbonisation Update	Decarb Programme Board	Every other meeting									
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 due
Metrics for digital systems infrastructure	TBC	Each meeting							DD	Assurance	Reporting being developed
Review/Monitor of digital major projects	TBC	Ad Hoc							Relevant Director	Assurance	Salus
BUSINESS CONTINUITY											
WG Annual Emergency Planning Report	EMT/Board	Annually							EDO	Assurance	
Incident Response Plan Report	EMT	Annually							EDO	Assurance	
Business Continuity Annual Report	EMT	Annually							EDO	Assurance	
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	
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 Director	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
BS - Board Secretary

Cycled for each meeting
Ad hoc item - prompt for agenda setting
Presented as cycled/ad hoc item considered at agenda setting
Deferred