

## Bundle Finance and Performance OPEN 14 May 2024

### Agenda attachments

- ITEM 0 Open FPC Agenda –14 May 2024
- 0 09:30 – OPENING ITEMS
- 1 Chair’s welcome, apologies, and confirmation of quorum
- 2 Board Member Register of Interests  
*Board Member Register of Interests*
- 3 Minutes of last Meeting 19 March 2024  
ITEM 03 2024-03-19 OPEN F and P Minutes
- 4 Action Log and Matters Arising  
ITEM 04 Action Log (Public) FPC
- 5 09:35 – Operations Quarterly Update  
ITEM 05 Operations Quarterly Report for Committees 23-24 Q4
- 5.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION
- 6 09:55 – Integrated Medium Term Plan (IMTP) End of Year Position 2023/24 and Forward Assurance Plan for 2024/25  
ITEM 06 Year End 2324 Position and Forward Assurance Plan for 2024-25  
ITEM 06a Appendix 2 – IMTP Delivery Assurance Report STB April 2024
- 7 10:10 – Digital Reporting  
ITEM 07 Digital Reporting May 2024  
ITEM 07.1 Digital Reporting May 24\_ Open FPC
- 8 10:20 – Digital Plan Refresh 2024 – 2029  
ITEM 08 Digital Plan Refresh – 2024 – FPC
- 9 10:50 – Information Governance Toolkit [Verbal]
- 9.1 10:55 – COMFORT BREAK
- 10 11:10 – Commissioning Intentions EMS and NEPTS  
ITEM 10 24-25 Commissioning Intentions SBAR FPC May 2024
- 11 11:20 – Clinical Assessment Software – Update [Verbal]
- 12 11:30 – Financial Position for Month 12, 2023/24  
ITEM 12 Finance Report Month 12 23-24 FPC May 2024
- 13 11:40 – Financial Position for Month 1 [Presentation]  
FPC – 14 May 2024 – M1 Final
- 14 11:50 – Financial Sustainability Programme Update  
ITEM 14 Financial Sustainability Programme Report May 2024
- 15 12:00 – Policies for Approval  
*15.1 Purchase Card Policy*  
*15.2 Waste Management Policy*  
*15.3 Data Quality Policy*  
ITEM 15 Policies for Committee Approval – FPC 140524  
ITEM 15.1 Purchase Card Policy V1.14  
ITEM 15.2 Waste Management Policy V1.12 230424  
ITEM 15.3 Data Quality Policy v0.11 260424
- 15.1 12:10 – COMFORT BREAK
- 16 12:25 – Environment, Decarbonisation and Sustainability Update May 2024  
ITEM 16 Environment, Decarbonisation, and Sustainability Update May 2024
- 17 12:35 – Monthly Integrated Quality and Performance Report  
*17.1 Review of Metrics*  
ITEM 17 MIQPR SBAR FPC March April 2024  
ITEM 17.1 Annex 1 MIQPR FPC March April 2024
- 18 12:50 – Risk Management and Board Assurance Framework  
ITEM 18 Executive Summary Risk Management Report FPC 140524
- 19 13:00 – Audit Tracker  
*The ICT Contract Management IA has been removed as it was presented at the March FPC Meeting.*

ITEM 19 SBAR Audit Tracker to Committees – Q4 Reporting – May–June Reporting – FPC – FILE REPLACED

ITEM 19A Annex 1 – Audit Tracker FPC – Internal Audit Recommendations

ITEM 19B Annex 1 – Audit Tracker FPC – External Audit Recommendations

20 13:10 – Cycle of Business for 2024/25 and Cycle of Business Monitoring Report

ITEM 20 SBAR for FPC on Cycles of Business 24–25

ITEM 20.1 FPC Cycle of Business 2024–25

ITEM 20.1a FPC Cycle of Business Notes

ITEM 20.2 Cycle of Business Monitoring Report

20.1 CONSENT ITEMS

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

21 Committee Highlight Report (March 2024)

ITEM 21 Finance and Performance Committee Highlight Report March 2024

21.1 13:15 – CLOSING ITEMS

22 Reflection & Summary of Decisions and Actions

23 Any Other Business

24 Date and Time of Next Meeting; 16 July 2024 – 09:30



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## MEETING OF THE OPEN FINANCE AND PERFORMANCE COMMITTEE

Held on 14 May 2024 from 09:30 to 13:20

Meeting held virtually via Microsoft Teams

*Break between Open and Closed Meetings – 30 Minutes; Closed meeting to commence at 13:50*

### AGENDA

No.	Agenda Item	Purpose	Lead	Format	Time
<b>OPENING ITEMS</b>					
1.	Chair's welcome, apologies, and confirmation of quorum	Information	Joga Singh	Verbal	5 Mins
2.	<a href="#">Board Member Register of Interests</a>	To Declare Conflicts	Joga Singh	Verbal	
3.	Minutes of last Meeting 19 March 2024	Approval	Joga Singh	Paper	
4.	Action Log and Matters Arising	Review	Joga Singh	Paper	
5.	Operations Quarterly Update	Assurance	Lee Brooks	Paper	20 Mins
<b>ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION</b>					
6.	Integrated Medium Term Plan (IMTP) End of Year Position 2023/24 and Forward Assurance Plan for 2024/25	Assurance	Rachel Marsh	Paper	15 Mins
7.	Digital Reporting	Assurance	Jonny Sammut	Paper	10 Mins
8.	Digital Plan Refresh 2024-2029	Assurance	Jonny Sammut	Paper/Presentation	30 Mins
9.	Information Governance Toolkit	Assurance	Jonny Sammut	Verbal	5 Mins



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No.	Agenda Item	Purpose	Lead	Format	Time
<b>COMFORT BREAK – 15 Minutes</b>					
10.	Commissioning Intentions EMS and NEPTS	Assurance	Rachel Marsh	Paper	10 Mins
11.	Clinical Assessment Software – Update	Assurance	Liam Williams	Verbal	10 Mins
12.	Financial Position for Month 12, 2023/24	Assurance	Chris Turley	Paper	10 Mins
13.	Financial Position for Month 1	Assurance	Chris Turley	Presentation	10 Mins
14.	Financial Sustainability Programme Report	Assurance	Angela Lewis	Paper	10 Mins
15.	Policies for Approval		Julie Boalch		10 Mins
	15.1 Purchase Card Policy	Approval	Chris Turley	Paper	
	15.2 Waste Management Policy	Approval	Chris Turley	Paper	
	15.3 Data Quality Policy	Approval	Jonny Sammut	Paper	
<b>COMFORT BREAK – 15 Minutes</b>					
16.	Environment, Decarbonisation and Sustainability Update May 2024	Assurance	Chris Turley	Paper	10 Mins
17.	Monthly Integrated Quality and Performance Report	Assurance	Rachel Marsh	Paper	15 Mins
	17.1 Review of Metrics				
18.	Risk Management and Board Assurance Framework	Assurance	Julie Boalch	Paper	10 Mins



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No.	Agenda Item	Purpose	Lead	Format	Time
19.	Audit Tracker	Assurance	Alex Payne	Paper	10 Mins
20.	Cycle of Business for 2024/25 and Cycle of Business Monitoring Report	Approval	Julie Boalch	Paper	5 Mins
<b>CONSENT ITEMS</b>					
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.					
21.	Committee Highlight Report – 19 March 2024	Information	Julie Boalch	Paper	-
<b>CLOSING ITEMS</b>					
22.	Reflection & Summary of Decisions and Actions	Discussion	Joga Singh	Verbal	5 Mins
23.	Any Other Business	Discussion	Joga Singh	Verbal	
24.	Date and Time of Next Meeting 16 July 2024 - 09:30	Information	Joga Singh	Verbal	

### Lead Presenters

Name	Position
Julie Boalch	Head of Risk/Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Angela Lewis	Director of People and Culture
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Joga Singh	Chair and Non-Executive Director
Jonny Sammut	Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources
Alex Payne	Corporate Governance Manager
Liam Williams	Executive Director of Quality and Nursing

## UNCONFIRMED MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE (OPEN SESSION) HELD ON 19 MARCH 2024 VIA TEAMS

**Meeting started at 09:30**

**PRESENT:**

Joga Singh	Non-Executive Director and Chair of Committee
Peter Curran	Non-Executive Director
Professor Kevin Davies	Non-Executive Director
Bethan Evans	Non-Executive Director

**IN ATTENDANCE:**

Hugh Bennett	Assistant Director Commissioning and Performance
Julie Boalch	Head of Risk/Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Alexander Crawford	Assistant Director of Planning and Performance (Item 19/24 only)
Paul Hollard	Non-Executive Director (Item 19/24 only)
Fflur Jones	Audit Wales
Navin Kalia	Assistant Director of Finance and Corporate Resources
Angela Lewis	Director of People and Culture (left after item 22/24)
Rachel Marsh	Executive Director of Strategy, Planning and Performance (Joined for item 19/24 only)
Trish Mills	Director of Corporate Governance/Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Jonny Sammut	Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

**16/24 PROCEDURAL MATTERS**

The Chair welcomed all to the meeting, especially Peter Curran as a new Member and reminded attendees that the meeting was being audio recorded. Members noted that any declarations of interest were contained within the Trust's Register of Interests.

## Apologies

Apologies were received from Rachel Marsh who was attending the meeting for item 19/24 only.

## Minutes

The minutes of the open session held on 15 January 2024 were considered by the Committee and confirmed as a correct record.

## Action Log

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

Action Number; 02/24: *Joint Emergency Services Interoperability Programme (JESIP) Assurance Visit. Lessons learned from the JESIP visit to the Trust in November 2023 to be included in the next update report. Lee Brooks advised that the action plan was currently being developed based on the findings from the report.* It was noted that while responding to the report is not mandatory, but it is a valuable opportunity to incorporate the learnings from it. The action plan will be developed through the Senior Operations Team and Senior Leadership Team with updates provided to the Committee as part of the Emergency Preparedness Resilience and Response Annual Report. Therefore, if the Committee agreed this proposed approach, that will be implemented. The Committee agreed with this approach and agreed to close the action.

Action Number: 02/24a: *Ambulance Care - Eligibility Criteria. Further information was requested, and it was agreed that following the Strategic Transformation Board meeting on 15 January 2024, more information would be known, and this would be provided to Members.* Details had been included in a report to the Trust Board on 25 January 2024. Action Closed.

Action Number: 02/24b: *Volunteer Car Drivers. Further detail was sought by a Committee Member on the number of Volunteer Car Drivers and whether the target of 51 had been reached.* The following response was given during the meeting of 15 January 2024: The Operations Directorate were confident that they will be able to achieve the additional 51 Volunteer Car Drivers by the end of February 2024. Good progress was being made and two courses have been held already. Action Closed.

Action Number 02/24c: *The Committee sought reassurance that the overtime reduction in EMS was not exacerbating the problem of system pressures and ambulance delays. Would reducing the overtime availability affect the capacity and ability to respond to emergency requests.* The following information was given during the meeting of 15 January 2024: The Operations Directorate review Unit Hours Production (UHP) on a daily and weekly basis and the overtime reductions during that period were focused and more efficient in that the need for overtime was monitored and efforts were focused on maintaining a good UHP. The Committee were assured that UHP was maintained as good levels overall during the period. Action Closed.

Action Number 09/24: *IMTP 2024-27 - Progress in Developing the plan. The Trust was waiting on feedback from some targeted engagement that had been undertaken with patients and the public. The Committee requested a more detailed understanding of what that targeted engagement had involved in a future update report.* Hugh Bennett advised the Committee that details were contained in the IMTP item later in the meeting. Action Closed.

**RESOLVED: The**

- (1) Minutes of the meeting held on 15 January 2024 were confirmed as a correct record; and**
- (2) Action log was considered and updated as described.**

**17/24 OPERATIONS QUARTERLY UPDATE – QUARTER THREE 2023/24**

Lee Brooks explained there was no further updates to provide in relation to the report, as it was presented at the last meeting of the Committee in January

**RESOLVED: The update was noted.**

**18/24 INTEGRATED MEDIUM TERM-PLAN (IMTP) 2023- 2026 – Q3 DELIVERY AND ASSURANCE**

Hugh Bennett provided an update as follows:

1. Emergency Medical Services (EMS) Operations Programme: This is due to close soon and was largely complete with further Human Resources data being awaited.
2. The Ambulance Care Programme was progressing well, however there was one red rated deliverable which related to the Non-Emergency Transport (NET) Centre re-roster as current funding does not provide a new roster within current operating hours.
3. The Non Emergency Patient Transfer Services (NEPTS) roster has been paused due to funding issues.
4. Urgent Care Service, this was making positive progress in terms of tightening scope of practice.
5. Gateway to Care Programme: The main focus was on the CAS replacement, and this was currently on track.
6. The 111 booking and pathway work is currently showing as an amber status due to interim technology led delays.

7. Clinical Transformation Programme: This was mostly on track, there were some issues with independent prescribing caused by the lack of supervisory support for trainee Advanced Paramedic Practitioners (APP).
8. Financial Sustainability Programme and income generation, this continues to progress well and budget balancing was on track.
9. The Administrative Review Action Plan continues to progress well.
10. Enabling Programmes: There is ongoing work with Equality Impact Assessment (EQIA) training, TU partnership, and employee offer development.
11. All planned activities with the National Data resource programme was complete.
12. The upgrade to the 999 telephony platform was due to go live mid-April 2024.

Overall, progress is being made across various programmes, with some challenges and areas needing attention, particularly in funding and support for certain initiatives.

#### Comments:

The report indicates that a meeting with a preferred bidder took place in February to initiate commercial market analysis work, an update on this was requested. Angela Lewis explained that a bidder has been identified and appointed as the supplier for the Financial Sustainability Programme. This decision was made at the beginning of February, and they were given a tight six-week window to deliver recommendations. Their task primarily involves examining market options and assessing viability. They will be presenting their findings to the Executive Leadership Team this Thursday, allowing for in-depth discussions on options, risks, and the viability of advancing the income generation aspect of the Financial Sustainability Programme. This presentation marks a crucial step in the process, as it will provide the team with the necessary information to make informed decisions moving forward.

Members recognised that digital literacy remains a significant challenge and it was crucial to address this issue to ensure that all staff within the Trust have the necessary skills and knowledge to effectively utilise digital tools and technologies. Further details were sought on any training and support programmes which can be implemented to improve digital literacy across the organisation. Angela Lewis explained it was about maximising its use and effectiveness in the workplace. The Trust has identified and was addressing these gaps in digital literacy as a priority, especially considering that there may be demographic factors at play as well. Focusing on training and support initiatives targeted at improving digital skills across all levels of the organisation will help bridge these gaps and empower employees to leverage technology effectively in their work.

Following a query on the single sign on portal NADEX, Jonny Sammut explained that simplifying the sign-on process is indeed a significant aspect of improving digital accessibility and usability within the organisation. It was essential to identify areas where

current practices may be lacking or could be enhanced to streamline the sign-on experience for users. The continued collaboration and strategic planning will be key in ensuring that this objective is effectively integrated into the overall digital strategy refresh and successfully implemented across the Trust. Liam Williams added that by establishing a unique identifier at the pre-registration level, it becomes feasible to construct a comprehensive database for the broader health sector. Currently, there is a significant focus on this matter within Digital Healthcare Wales. (DHCW)

Members acknowledged that despite the many challenges this was a positive report, all the red areas related to a lack of resources to address them.

The Committee raised a concern about the impact of upcoming changes in legislation on the flexible work policy and questioned whether the Trust was prepared for potential influxes of applications or any related issues arising from the change. Angela Lewis responded to the query by mentioning the extensive publicity efforts surrounding the upcoming changes in legislation regarding flexible work. She highlighted that promoting flexibility has been a priority within the Trust's Integrated Medium-Term Plan (IMTP). Additionally, she expressed confidence in the Trust's readiness for the changes, attributing it to ongoing efforts to address barriers and promote flexibility.

**RESOLVED: That the Finance & Performance Committee**

- (1) Noted the overall delivery of the IMTP detailed in the report.**
- (2) Noted the update against the ministerial priorities that are relevant to the Trust in Appendix 1 of the report.**

**19/24 INTEGRATED MEDIUM-TERM PLAN (IMTP) 2024-27 – FINAL VERSION, INCLUDING FINANCIAL PLAN**

Rachel Marsh presented the report and drew the Committee's attention to the following:

The plan reflects the Trust's progression towards its long-term strategic goals. She emphasised the potential for strategic choices to facilitate the Trust's evolution towards a new Clinical Response Model.

The plan outlines the specific strategies for meeting each of the commissioning intentions provided to the Trust. Additionally, like last year, there are Ministerial Priorities that will be addressed as well.

Rachel Marsh highlighted the Trust's goal of reducing the number of patients requiring Emergency Department (ED) visits. She also mentioned ongoing discussions with Commissioners during the plan development process, expressing anticipation of support from them, although formal confirmation is pending.

Furthermore, she mentioned the efforts to transition the plan into a three-year framework, with actions outlined for each year. While year one actions are more detailed, there is a sense of progression over the three-year period.

### Financial Plan

Chris Turley provided additional context regarding the three-year Integrated Medium Term Plan (IMTP) and the focus of the financial plan on the 2024/25 financial year. He emphasised the detailed nature of the financial plan, which is primarily centred on the upcoming year due to annual budget allocations and government perspectives. He highlighted the fortunate position of starting from a balanced financial standpoint without underlying deficits.

Chris Turley further mentioned the necessity of delivering commissioning intentions and transformational work within the allocated budget, with the resulting savings requirement. He noted that the financial plan has been shared and discussed over the past few months at various Trust Board and Committee meetings.

### Comments:

Members expressed concern about potential discrepancies between the Trust's priorities and those of the broader healthcare system. The challenge of aligning with evolving Ministerial Priorities was acknowledged along with the difficulty in predicting future changes.

Members emphasised the need to address systemic challenges alongside the Trust's ambitions and queried how the team is managing this balancing act. Rachel Marsh highlighted potential actions outlined in the main plan, including investments in remote clinicians, additional Advanced Paramedic Practitioner (APPs), and digital solutions. She commented these investments would enable the Trust to deliver solutions more efficiently.

Rachel Marsh acknowledged that while the Trust can act within its current resources, it operates within a healthcare system under significant pressure. She highlighted discussions with Health Board Chief Executives about collaborative efforts and embedding strategic plans emphasising the importance of partnership with Health Boards for pathway development and other initiatives. Despite positive discussions, she recognised that system pressures will continue to impact the Trust's ability to achieve all desired outcomes.

The Committee queried if the Trust had been able to gain any traction in promoting a different approach to reporting metrics and potentially reconsidering how they were measured. Rachel Marsh indicated that while the Trust had not explicitly discussed metrics reporting in recent meetings with the Emergency Ambulance Services Committee (EASC), it has committed to revisiting the topic in April or May.

Members expressed a significant concern about the demand placed on Rachel Marsh and other team members across the Trust to deliver the plan. Rachel Marsh explained that the expansion of the Trust necessitates corporate support for frontline staff. While significant

investment has been directed towards frontline personnel, there is now a need to bolster corporate support to accommodate this growth. Therefore, several posts will be supported to fulfil this requirement.

With regards to the risk in terms of revenue, members inquired about the assumption of the award of a 3.67% pay uplift and the potential implications if the full amount is not passed on; allied to this there was assumed funding for various items which are assumed to be funded elsewhere, such as the implications of the Manchester Arena Inquiry, and questioned the risk of these not being funded. Furthermore, with respect to the plan's mention of additional posts, the Committee sought clarification on whether the implications of these additional posts are included in the revenue budget.

Chris Turley explained that the plan had been developed since the announcement of the 3.67% uplift, before Christmas. Throughout this period, various scenarios were considered, including best case, worst case, and most likely case scenarios, to assess the impact on the plan. Contingency plans were created to analyse the potential impacts if the uplift passed through had been lower than 3.67%. This involved evaluating the costs and choices associated with delivering on commission intentions. These analyses helped identify potential challenges and adjustments needed to meet financial objectives.

Chris Turley clarified that the other items mentioned as unfunded in the plan are not currently committed to, and their funding will depend on the submission of business cases for funding. The plan acknowledges the level of stretch and savings required to achieve balance within the given resource envelope. If funding for these items is not secured, it is expected that no expenditure will be committed to them. Overall, he emphasised that the plan adopts a cautious approach regarding expenditure on unfunded items and will only proceed with them if adequate funding is secured.

Members expressed concern about the potential implications of the ambulance vehicle fleet not being fully funded in the capital plan, particularly regarding the maintenance budget. They sought assurance regarding any risk analysis conducted for such a scenario. Chris Turley responded by acknowledging the importance of considering the worst-case scenario and conducting risk analysis. He stated that while the Trust had not explicitly conducted a risk analysis for the fleet not being fully funded, it had engaged in broader discussions about the potential impacts of the capital plan not being fully realised. This included considerations of the maintenance budget and the ability to deliver on planned projects. He further added the need to be mindful of such risks and to ensure that the Trust remains flexible and prepared to address challenges as they arise. Chris Turley expressed confidence regarding the current state of the fleet revenue budget. However, he indicated that if next year's capital programme for fleet is not at the requested level, there may be additional impacts to consider in the financial plan for the 2025-2026 period.

In terms of other capital funding, Chris Turley highlighted several estate capital priorities that the Trust is aiming to deliver. These priorities involve either submitting cases to the government for funding or prioritising within their own discretionary annual capital allocation. However, due to limited resources, there will always be some priorities that cannot be addressed. The plan aims to continue the progress made in allocating resources

to these priorities, especially during times when additional funding was available, such as during the COVID-19 pandemic.

Following a query on the capital prioritisation process, Chris Turley indicated that feedback on a long list of proposals against the remaining budget of £2.27 million had been received. The outcome of this process would be presented at an Executive Finance Group meeting, where they would seek approval for the selected schemes. He gave assurance that the process had resulted in a balanced allocation of funds, with a small contingency held for unexpected expenses.

Following a query in terms of patient engagement, Liam Williams, commented that the Trust was expecting Ministerial guidance on patient engagement to be issued in the next six weeks. This guidance will set out expectations stemming from the Civica system, which will aid the Trust in conducting outreach efforts. One of the challenges faced this year was from an information governance perspective, particularly in contacting patients who had used 111 and 999 services but did not receive a face-to-face response. Despite the progress made in aligning this work with regulatory frameworks and reporting, there were still difficulties in achieving community outreach at scale using digital, data-driven insights mechanisms rather than relying on sporadic community events. The Patient Experience Community Involvement (PECI) Team collaborates closely with Health Boards, ensuring joint engagement in terms of information sharing and working together at events or community opportunities.

Rachel Marsh highlighted some inconsistencies in graphics and tables in the document, which need further refinement to ensure alignment and clarity. Additionally, she mentioned the importance of reflecting on deliverability and providing more detail on confidence levels and assurance mechanisms for achieving the objectives outlined in the plan. There will be further details from EASC later in the morning, which might require some adjustments but are not anticipated to result in major change.

The Committee were comfortable endorsing the paper in its current form, subject to any necessary final editing.

**RESOLVED: The Committee:**

- (1) NOTED the progress made in developing this year's IMTP;**
- (2) ADVISED of any further assurance required during the final stages of the planning cycle.**
- (3) ENDORSED the IMTP 2024-27 for submission to Trust Board at its meeting on 28 March 2024 for approval, subject to any final editing.**

**20/24 WAST INITIAL 2024-25 REVENUE BUDGET**

Chris Turley commented that the current position is better than last year's. Last year, there was significant movement in the financial plan, which led to challenges in bringing the

budget paper through the Finance and Performance Committee before it went to the Trust Board.

Chris Turley further commented that the initial revenue budget serves as a starting point. It reflects the financial plan outlined in the Integrated Medium-Term Plan (IMTP) and is currently fully consistent with it. However, certain aspects of the budget may undergo changes as the year progresses, particularly in terms of resource allocations from central reserves. These changes are expected due to factors such as non-pay inflation and other additional costs outlined in the plan. While some costs are known and will be funded accordingly, others require further clarification regarding when they will occur and how they will impact the budget. At present, a portion of the budget is held centrally in reserves, but the goal is to reduce this reliance as decisions are finalised in the coming weeks. Despite the challenges of finalising the budget in parallel with the financial plan, upcoming discussions should provide more clarity, allowing for a more detailed allocation of resources to match anticipated costs.

Going forward, Chris Turley will meet with the Chief Executive as the Accountable Officer of the Trust and each of the delegated budget holders. In these meetings, delegated budgets will be discussed in detail. This process ensures that individual senior budget holders in the Trust accept the budget delegated to them from the Chief Executive. Additionally, the allocation of reserves will be done in advance of these meetings so that budget holders are very clear about the level of funding they must deliver within their budgets.

Given that the paper is developed in parallel with the financial plan, there is some repetition of key assumptions, risks, and delivery considerations. These aspects are very similar to what has been seen within the main financial plan document within the IMTP. The plan is to seek the Finance and Performance Committee's endorsement of this today, to then take it to the Trust Board next week for final approval of this initial revenue budget ahead of 1 April 2024.

#### Comments:

The Committee recognised that for future years, there is a recognition that achieving savings becomes increasingly challenging as cumulative savings are made. It is not as simple as finding more and more savings indefinitely.

Regarding the specific point about the 2024/25 plan, a significant portion of it involves pay vacancy management and corporate savings. This area will likely continue to be a focus in future years as well. Chris Turley explained it was a complex issue with savings categorisation, especially when considering recurring but variable savings like pay vacancy management. While these savings are not consistently in the same budget lines, they do materialise across the Trust over time. There is a debate about whether to classify them as recurring or non-recurring savings, as they are recovered in some form but not consistently in the same areas. This presents challenges in accurately pinpointing which budgets will be reduced by these savings. It is an ongoing discussion that requires careful consideration and balancing between different reporting perspectives and practical

budget management.

Chris Turley added there were no significant changes to the plan at this point. However, he would remain vigilant for any developments that could impact the plan, and if necessary, would communicate these changes to the Board before seeking their approval.

**RESOLVED: The Committee endorsed the initial 2024/25 revenue budget, building on the WAST Financial Plan included in the IMTP and recommended it for onward approval at Trust Board on 28 March 2024.**

## **21/24 FINANCIAL POSITION FOR MONTH ELEVEN 2023/24**

Chris Turley provided the Committee with a PowerPoint presentation on the financial position for month eleven and drew attention to the following points.

The Trust was currently reporting a break-even position having submitted the month 11 position last week indicates progress in staying on top of current financial reporting requirements while also preparing for the next fiscal period.

Continued Risks: Despite reaching this stage in the fiscal year, there may still be ongoing risks that need attention. These risks pertain to various aspects of financial management, such as budget execution, revenue collection, expenditure control, or external factors impacting financial performance.

The Committee were made aware of the significance of certain invoices that have been submitted, particularly for technical items. These invoices carry greater value than usual because they include costs related to losses and depreciation. It is essential to remember that these figures are not just typical adjustments but rather reflect specific expenses incurred throughout the year.

While addressing the delivery of savings is paramount, it is worth noting that the Trust has historically performed well in meeting other statutory targets, such as those related to public sector payment policy.

The Trust has received final confirmation from Welsh Government (WG) regarding full coverage for the 2023/24 pay award. This confirmation reinforces previous assurances and exemplifies how assurances have been provided regarding the funding mechanisms for covering costs.

There was an assumption regarding a low-risk request from WG to ensure that any costs resulting from the Airwave contract extensions are fully funded. This assumption has been confirmed, and funding has been received for the capital elements associated with this contract.

At the beginning of the year, there is often a reasonable level of risk due to uncertainties and unknowns. These uncertainties are reflected in the assumptions within the plan. However, moving through the year these assumptions become clearer or are supported by

funding, and the associated risks tend to diminish. By the year-end, many of the risks identified earlier may have been resolved or mitigated.

Chris Turley commented that the Trust has successfully achieved its savings plan for the year, even surpassing it in some areas. This overachievement will have a positive impact on the future financial outlook. He referred to the table in the presentation which gave details of the delivery of these savings, showing variations across different areas but generally indicating success in meeting or exceeding targets.

While the capital plan for the year was set at £22.5 million, the actual spend up to month 11 has only reached around £10 million. There are specific reasons for this, including the implementation of the new 111 system, and the scheduled delivery of new vehicles and equipment. For example, the implementation of the new 111 system required a tight timeline for delivery, resulting in costs being incurred later in the year. Similarly, the delivery of new vehicles and equipment was scheduled for March, aligning with planned expenditure. Additionally, factors such as delays in tendering processes have contributed to the timing of the capital spend.

The Trust has recently received further correspondence from WG regarding the fleet business case submitted for 2024/25, asking for further details prior to their final decision on funding. This business case outlines the request for approximately £24 million to fund the replacement of 157 vehicles. Some of this funding is meant to cover the shortfall from this year. While the Trust did not anticipate receiving the full amount this year, it is still awaiting confirmation from WG regarding the funding allocation for fleet replacement in the 2024-2025 financial year and was actively engaging with WG to finalise this matter.

Comments:

Following a query regarding further clarity on balancing finances, Chris Turley explained that whilst there is not a specific reserve set aside for financial risks, there is a statutory duty to balance finances over a three-year period. This means that any surplus in one year could potentially offset a deficit in another year, ensuring overall financial stability over time. It should also be understood there may be some flexibility within the balance sheet to manage certain elements, although these adjustments would be small and immaterial from an audit perspective. Overall, while there may not be explicit reserves designated for specific risks, there are mechanisms in place to maintain financial equilibrium over time and manage any unforeseen fluctuations within the budget.

**RESOLVED: The month eleven financial update was noted.**

## **22/24 FINANCIAL SUSTAINABILITY PROGRAMME**

Angela Lewis presented the Committee with an update on the Financial Sustainability Programme (FSP) which set out the current position as at quarter four.

In line with the savings plan that supports the IMTP, gross savings of £6.08m have been achieved against a year-to-date target of £5.462m. Whilst the challenge of finding

cumulative costs year on year was recognised, the real achievements in terms of a collective response from across the organisation to drive efficiency was celebrated.

There has been significant progress and achievement, which was commendable considering the collective effort involved. The involvement of staff in suggesting savings schemes highlights the importance of a collaborative approach to achieving financial sustainability.

The emphasis on income generation and exploring commercial viability options has shown that the Trust has a forward-thinking strategy to diversify revenue streams and mitigate financial risks. While progress has been made, it's acknowledged that challenges remain, and there is a recognition of the need to be more creative in addressing them.

The work on income generation and commercialisation is critical to take the financial sustainability programme to the next level and the support of Trade Union Colleagues with this work was also recognised. It was agreed that this would be a priority area for the Committee in 2024/25.

Additionally, the emphasis on income generation and exploring commercial viability options highlights a proactive approach to financial sustainability.

Comments:

The Committee queried the possibility of exploiting commercial opportunities within the existing resource envelope, which may involve identifying immediate opportunities that can be pursued with minimal additional resources, leveraging existing assets and capabilities. Angela Lewis advised that it is essential to critically assess the Trust's current capabilities and determine if they align with the income generation goals. While there may be immediate opportunities that can be pursued with minimal additional resources, it is also crucial to recognise when additional investment is needed to achieve sustainable income generation. The Trust continues to discuss potential challenges and the need for collaboration with Trade Union colleagues. Engaging stakeholders and seeking their input can be instrumental in navigating cultural shifts and ensuring alignment with the Trust's goals. Chris Turley raised the point about ensuring that efforts in income generation do not detract from core responsibilities as an NHS provider. It is essential that the Trust strikes the right balance and prioritises activities that align with the core mission and obligations to patients and communities.

**RESOLVED: That the Committee noted the update.**

## **23/24 MONTHLY INTEGRATED QUALITY AND PERFORMANCE REPORT – JANUARY/FEBRUARY 2024**

Hugh Bennett presented the report and drew attention to the following points.

The increase in demand, particularly evident in the higher call volumes, presents a significant challenge. While performance in certain areas like Priority one times remains

good, it is essential to address the impact of increased demand on other aspects of service delivery, such as Priority two and Priority three response times.

The issue of handover delays leading to prolonged ambulance turnaround times is particularly concerning. These delays not only affect the ability to respond promptly to emergencies but also impact staff workload and patient outcomes. Efforts are underway to address this issue, including the implementation of new processes and seeking staff feedback on potential solutions.

Additionally, the focus on enhancing capacity through recruitment and resource allocation is crucial, especially considering the ongoing pressures faced by the service. While there are areas where performance falls short of targets, such as call abandonment rates and consul and close rates, it is evident that concerted efforts are being made to improve these metrics.

Comments:

Members discussed the performance which is within the gift of the Trust to influence such as staff Personal Appraisal Development Reviews (PADR), and statutory and mandatory training and were reassured that whilst performance is not where the Trust would want it to be, given the pressured time of the year the reporting covered and abstractions due to the Clinical Assessment System (CAS) replacement work and training, it was somewhat anticipated.

The point was made that the establishment for 111 is not sufficient currently to meet the out of hours demand which impacts on call abandonment rates. Management will continue to make the case for a demand and capacity review in this area.

Lee Brooks responded to a comment regarding service delivery in oncology adding there had been a significant improvement in oncology services, achieving a plus 70% performance level. This progress is especially commendable considering the challenges faced during the winter period. The investment made to bolster capacity in oncology reflects a strategic use of financial resources to address service needs effectively. It is evident that proactive measures, such as winter investments, have contributed to enhancing service delivery in oncology. This positive outcome underscores the importance of strategic planning and resource allocation to meet the evolving demands of healthcare delivery.

A point was raised regarding the cause and effect relationship between the Trust's performance metrics and the well-being of staff. While the patient-related indicators appear relatively positive, there are concerns about the health and well-being metrics, particularly regarding mental health and sickness absence. Regarding the reduction trend in mental health issues despite the absence of data for January and February, it raises questions about the statistical validity of such claims. Similarly, the lack of figures for sickness absence in February also raises concerns.

Hugh Bennett acknowledged the time lag in obtaining sickness data, often resulting in delays in its release and subsequent amendments. He mentioned the February figure of 8.89%, indicating a high sickness absence rate. Despite challenges in data management, Hugh Bennett highlighted the abundance of information available within the Trust, characterising it as a "number-rich environment." However, he acknowledges the complexity of navigating through this vast amount of data to identify key trends and issues.

Regarding the health and well-being metrics, he commented that the pressure within the system could be contributing factors. He indicated that the impact of shift overruns on individuals' personal lives may also be influencing staff health and well-being.

Lee Brooks highlighted the correlation between health and well-being metrics, such as sickness absence, and the workplace staff experience and attendance. He acknowledges the pressures existing within the system and suggests a reasonable assumption of connectivity between these factors.

Regarding sickness absence, Lee Brooks reiterated the Trust's efforts to achieve a target of 6%, acknowledging the challenges in reaching this target consistently. Despite being off target, he was pleased to see a sustained upward trend over the winter months, indicating ongoing attention to staff well-being.

Trish Mills provided an update on sickness figures discussed during a recent Executive Leadership Team meeting. She mentions that the figures for January were 8.89% and for February were 8.41%, indicating improvement. Additionally, she noted a positive trend in turnover and a reduction in mental health-related absences to 2.23% in January. Trish Mills advised that the People and Culture Committee's comprehensive approach to assessing health and well-being was an ongoing focus.

The Committee sought further detail in respect of the 111-call answering performance expressing concerns about potential funding reductions anticipated from April, coinciding with the implementation of a new call system. Hugh Bennett mentioned that these concerns have been raised with Commissioners and the WG about the potential impact on performance due to funding reductions. He suggested that discussions may be needed to determine what is considered patient safe given the constraints of the current funding situation. Additionally, he referred to the demand and capacity review, which was initially postponed but may be revisited with the involvement of new Commissioners starting from 1 April 2024.

**RESOLVED: The Committee considered the January/February 2024 Integrated Quality and Performance Report and actions being taken and determined that it provided sufficient assurance and noted the update on the current position.**

24/24

**STRATEGIC DEMAND AND CAPACITY REVIEW – VERBAL**

A verbal update was given by Hugh Bennett on progress with the Strategic Demand and Capacity Review. The timeframe the review to be presented at the Emergency Ambulance Services Committee (EASC) had changed given their transition to a new Joint

Commissioning Committee and a full update will be provided to this Committee later in the year. The Committee were reassured that work was ongoing on the review in the meantime. The Committee noted that a written update report would be presented at the next Committee meeting on 14 May 2024.

**RESOLVED: The update was noted, and the Committee also noted that a written update report would be presented at the next meeting on 14 May 2024.**

## **25/24 VALUE BASED HEALTHCARE REPORT**

Alexander Crawford outlined several key workstreams that the Trust has been focusing on, facilitated by a working group of colleagues. These workstreams include outcome measures, patient-reported experience, patient-level information costing, evaluation methodologies, business case development, and the use of a value-based lens for investments. He further mentioned upcoming discussions on prioritising spending for the next year and ongoing work on benchmarking.

Regarding patient-reported outcome measures, he pointed out the challenges in collecting data for emergency frontline services compared to elective procedures. However, efforts are being made to assess patient outcomes along pathways, particularly in areas like stroke and heart failure. The Trust is also exploring data linkage to improve outcome measure collection.

The issues related to patient engagement, information governance with Civica, and delays with the 111 system should be noted as ongoing challenges. Plans for the patient level information and costing system are being adjusted, with expectations of providing valuable insights into the Trust's cost base at a patient level.

A project framework incorporating evaluation and business case processes is being developed to ensure a consistent approach to project implementation and impact measurement. Benchmarking work is temporarily on hold but will be revisited in the future.

Looking ahead, Alex Crawford emphasised the need for executive alignment on key priorities related to value-based healthcare and addressing WG expectations. A steering group will be established to oversee these initiatives and ensure proper resource allocation.

Comments:

The Committee sought further detail on the governance and accountability when considering value-based healthcare. Alex Crawford explained the process involved of bringing the value-based healthcare initiative through the Strategic Transformation Board, which includes Executives and is linked to the IMTP (Integrated Medium Term Plan) deliverables.

**RESOLVED: The Committee noted the position and progress made in developing value-based healthcare in the Trust.**

Trish Mills provided an overview of the annual review conducted by the Committee, highlighting its methodology and outcomes. The review involved using surveys to gather opinions on good practices and areas for improvement.

Although there was an improvement in the return rate compared to the previous year, there were still challenges in receiving responses. The results and comments were themed around focus, engagement, team working, and effectiveness.

There are discussions about improving the timeliness of papers and clarity on the metrics presented in reports. Additionally, there are proposed changes to the committee's terms of reference to streamline processes and ensure alignment with the organisation's strategic objectives.

The importance of the committee's effectiveness, which is assessed based on various factors such as meeting regularity, engagement, adherence to work programmes, and reporting was acknowledged.

Proposed changes to the terms of reference included moving information governance and information security responsibilities to the Quality Patient Experience and Safety Committee (Quest) Committee and clarifying the roles of other committees in reviewing new plans and strategies.

Trish Mills advised that the draft -Annual Report presents a proposed assessment of the committee's effectiveness, which members will have the opportunity to agree with or provide feedback on. She mentions that this assessment is based on various factors beyond just the survey results, including the committee's meeting regularity, level of engagement, the quality of discussions during meetings, and the effectiveness of pre-meeting preparations such as setting the agenda. This holistic approach ensures a comprehensive evaluation of the committee's performance and effectiveness.

Trish Mills highlighted that clarity has been provided regarding the roles of different committees within the Trust. Specifically, the Audit Committee is responsible for shorter-term implementation assurance of the Quality and Performance Management Framework (QPMF) whereas the Finance and Performance Committee has responsibility for oversight of the QPMF effectiveness, once implemented. This delineation ensures that each committee has a clear understanding of its specific responsibilities and areas of focus within the Trust's governance structure.

Trish Mills concluded by outlining the committee's priorities for the upcoming year, which include overseeing the digital plan, monitoring potential commercialisation streams, and addressing information governance and security issues. The Committee considered and supported the following priorities:

1. The development and approval of the Digital Plan.

2. Oversight of the potential commercialisation streams in the Financial Sustainability Programme.
3. Focus on the new elements of its terms of reference relating to Information Governance and Information Security.

**RESOLVED: The Committee**

- (1) Reviewed and approved the draft Annual Report.**
- (2) Reviewed and endorsed any further changes to the terms of reference;**
- (3) Confirmed the proposed changes to operating arrangements in response to issues raised in questionnaires as set out in the draft Annual Report; and**
- (4) Set priorities for the Committee for 2024/25.**

**27/24 WASTE MANAGEMENT UPDATE**

Chris Turley drew out the following points:

Upcoming changes to waste legislation in Wales requires the Trust to robustly recycle waste into additional segregated waste streams. These changes include civil action for non-compliance. The new waste regulations (as a provision under the Environment (Wales) Act 2016) will come into force on 4 April 2024.

To comply with his new legislation the current external waste contract has been amended to provide the required additional waste streams. Contract negotiations have been positive and a robust contract management regime set. Changes to external bin provision started in February but may take until the middle-end of April to complete.

The audit of Trust waste management processes took place in April 2022. The audit found limited assurance of compliance to waste management requirements and compliance with Welsh Health Technical Memorandum (WHTM) 07-01 health care waste. Ten recommendations were made, of which three remained as outstanding.

1. Recommendation 501 – Writing of a Waste Policy
2. Recommendation 505a – Waste transfer to hospital sites
3. Recommendation 505(b)- Clinical waste transfer

In respect of recommendation 501, Chris Turley provided an update on the Waste Management policy, indicating that it was in its final stages and would be presented at the upcoming Committee meeting. He assured that any remaining issues, whether internal or external, regarding the finalisation of the policy had been addressed. Therefore, he proposed closing recommendation 501 once the policy was had been through the appropriate governance mechanism. With regards to recommendations 505a and 505b, Chris Turley explained there were more challenges encountered with these, primarily due to the nature of the recommendations requiring collaboration with external parties or relying on their responses. However, he stressed that the Trust had exerted all possible

influence and efforts to address the issues within its control. Recognising the limitations and the ongoing nature of the challenges, he proposed closing these two items in the next cycle of updates to the internal audit tracker. This decision was based on the understanding that the Trust had fulfilled its obligations to the extent possible and that keeping these items open indefinitely on the tracker would not be productive. While acknowledging that this decision was more of an executive function, he expressed his desire for Committee input on the matter.

Furthermore, Chris Turley elaborated that the risks underlying some of the issues addressed by the recommendations were being managed in a different manner. Although the recommendations may not have been fully compliant with their original wording, the Trust had taken steps to mitigate and manage the underlying risks effectively.

Looking ahead, Chris Turley highlighted the importance of being more explicit in internal audit reports regarding when recommendations would be considered closed, especially in cases involving requests or responses from external parties. He commented on the need to clearly outline the steps taken to address recommendations and to indicate when they would be closed based on interactions with other stakeholders. He suggested refining the approach to closing recommendations in future internal audit reports to provide clearer insights into the Trust's actions and interactions with external parties.

Comments:

The Committee recognised and understood that external influences beyond the Trust's control can significantly impact outcomes. The Committee expressed their support for the rationale as mentioned above by Chris Turley to close two audit actions; Recommendation 505a – Waste transfer to hospital sites and Recommendation 505(b)- Clinical waste transfer from the 2021-2022 period as they transition into the 2024-2025 plan. They acknowledged the significant internal effort put into these audits and noted the importance of providing clear closure on actions.

Trish Mills agreed with the rationale for closing these two audit items. She mentioned that this audit was conducted in the 2021/22 period, and now they are moving on to the 2024/25 plan, indicating a significant progression. The Trust has invested a considerable amount of internal resources in addressing these issues. Trish Mills expressed appreciation for Chris Turley's clarity in outlining the criteria for closing actions, as sometimes it can be challenging to determine. She stressed the importance of providing assurance to the Audit Committee that these issues have been effectively closed. Trish Mills mentioned that while it may require some back and forth, with the support of the Committee and Internal Audit colleagues, it was hoped to successfully close these older actions.

Felicity Quance offered her support for the decision to close the recommendations, highlighting the passage of time since they were initially raised, and the internal work undertaken to assess their progress. She mentioned that waste management was conducted across multiple NHS organisations simultaneously. Interestingly, she noted that

she recently closed off similar recommendations for another organisation where they had done as much as they could internally, and now the responsibility has shifted elsewhere.

**RESOLVED: The Committee**

- (1) NOTED this update, in relation to waste management changes and infrastructure put in place to manage change.**
- (2) NOTED the internal audit recommendations and any remaining challenges in terms of some of their closure.; and**
- (3) SUPPORTED the closure of the two actions. Recommendation 505a – Waste transfer to hospital sites and Recommendation 505(b)- Clinical waste transfer.**

28/24

**RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK**

Julie Boalch explained that the purpose of the report was to provide assurance in respect of the management of the Trust's principal risks, specifically the eight risks that are relevant to the committee's remit for oversight and additionally the Trust's two highest scoring risks which are assigned to the Quality, Safety & Patient Experience Committee (QuEST) for oversight.

Julie Boalch explained that each risk has been updated as of 7 February 2024, with no significant changes in ratings. However, she assured the committee that controls, assurances, and mitigating actions have all been reviewed and updated as necessary. Progress and areas needing attention were highlighted in the accompanying report. She further mentioned that all risks are currently undergoing appropriate review and governance processes.

Comments:

It was noted this update had been discussed at the last Audit Committee meeting.

**RESOLVED: The Committee considered the contents of the report.**

29/24

**INTERNAL AUDITS**

The Committee recognised that the following Internal Audits had been presented at the last Audit Committee meeting:

**Decarbonisation** – Chris Turley mentioned that the final report was presented and discussed at the Audit Committee, including the management actions and responses to each recommendation. Some recommendations have already been addressed, while others are in progress. He emphasised the clarity provided on how and when recommendations will be closed off, within the Trust's control.

Members queried clarity on the management response at 2.1 of the audit. Felicity Quance highlighted the concern regarding the level of detail in reporting the Decarbonisation Action Plan, which wasn't observed during their review. She

acknowledges that the Trust is now working to strengthen this aspect, but at the time of their audit, the evidence provided did not meet their expectations.

**Vehicle replacement** – Chris Turley identifies an area flagged in the report concerning a more limited assurance, specifically related to a technical breach of standing orders regarding contract approvals. He explained that this issue does not pertain directly to vehicle procurement but rather to evolving organisational practices regarding contract approvals following board level expenditure commitments. He explained the need to implement an additional step in the approval process to ensure full compliance with the scheme of delegation within the standing orders. Trish Mills explained that the Trust had developed a governance practice note specifically addressing the recommendation regarding non-compliance with Standing Orders. This note has been shared with relevant stakeholders, including Internal Audit colleagues and Audit Wales, to ensure clarity and alignment with the Trust's approval processes.

**Strategy Development** – Hugh Bennett outlined the three main recommendations in the report:

Update the long-term strategy: This recommendation suggests considering updates to the long-term strategy, particularly in light of potentially implementing a new clinical response model. This aspect is covered in the Integrated Medium Term Plan (IMTP), and a reassessment of the strategy may be needed at that point.

Complete work on the engagement plan: Currently, engagement efforts are ongoing with the Consultation Institute. Once this work is finished, there will be an engagement delivery plan put in place, followed by a period of pause and reflection. This phase is anticipated to be crucial in the first six months of the next year.

Enhance benefits and reporting: The need for improved benefits and reporting, which is related to various programs within the Trust. An initial review of these programs is planned for April and May, with a new benefits framework expected to be implemented in Q1/Q2.

**ICT Contract Management** – Jonny Sammut outlined the details of the recommendations and the progress being made. These are primarily focused on the contract register, decision-making processes, availability of notes from supplier meetings, application to all ICT contracts, and management of end-of-term reviews and assessments. The aim is to take a balanced view considering the size of the contracts, as the Trust deals with many.

**RESOLVED: The updates on the Internal Audits: Decarbonisation, Vehicle replacement, Strategy Development and ICT Contract Management were noted.**

## **30/24 DIGITAL REPORTING: 1 APRIL 2023 TO 29 FEBRUARY 2024**

Jonny Sammut provided the following key highlights for the Committee's attention:

Increased Demand on Records Team: There has been a significant increase in demand on the records team over the last two years, despite having only two full-time equivalent (FTE)

records officers. This will be addressed as part of discussions on the digital strategy plan refresh.

Data and Analytics Turnaround: While there has been improvement in the pace of work, there was still a backlog that required attention.

Digital Contributions to Progress on IMTP: Updates on key digital projects include the data linkage project, out-of-hospital cardiac arrest pilot project feeding into the National Data Repository (NDR), CAS replacement project, and the 999 telephony upgrade planned for April.

Digital Experience and Champions Work: Progress on this has been slower due to resource constraints, primarily driven by the focus on the CAS program.

Resource Strain: There is continued strain on resources, particularly in informatics, prompting a six-week pause to identify internal efficiencies.

Strategy Refresh Work: This was progressing well, with a presentation to the Executive Leadership Team planned for mid-April, followed by presentation to this committee on 14 May 2024 and to the Trust Board for awareness on 30 May 2024.

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

**31/24 CYCLE OF BUSINESS MONITORING REPORT**

The report was noted for information.

**RESOLVED: The Committee noted the report.**

**32/24 REFLECTION: SUMMARY OF DECISIONS AND ACTIONS**

Reflections of the meeting were given.

**Meeting concluded at 13:02.**

**Date of Next Meeting: 14 May 2024.**

**ACTION LOG - CURRENT  
FINANCE AND PERFORMANCE COMMITTEE**

<b>Minute Ref</b>	<b>Date</b>	<b>Agenda Item</b>	<b>Action Note</b>	<b>Responsible</b>	<b>Due Date</b>	<b>Progress/Comment</b>	<b>Status</b>
Minute: 24/24	19 March 2024	Strategic Demand and Capacity Review	An update would be provided to the Committee in the form of a written report.	Rachel Marsh	14 May 2024	Update for 14 May 2024 A verbal update will be provided on the status of the report	Open



GIG  
CYMRU  
NHS  
WALES

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

## OPERATIONS DIRECTORATE QUARTERLY REPORT FOR COMMITTEES 2023-24 Q3 (Jan – March 2024)

### National Operations & Support

#### **Manchester Arena Inquiry (MAI)**

Progress on the MAI workstream continues toward completion of the outcome. The Chairman of the Inquiry has set out that each organisation including all ambulance Trusts should review their capacity to respond to a mass casualty incident, make recommendations to their NHS commissioners relating to additional resources and that commissioners must then give urgent and close consideration to these recommendations. Having undertaken a series of workshops and evidence gathering exercises, including data modelling, three reports will be produced which will detail:

- Our Capability to Prepare
- Our Capability to Respond
- Capability of Specialist Assets

These three reports will recommend what additional resources are required to effectively plan and respond to a mass casualty incident in Wales. This will form a financial submission which will then work through the governance route between May and July 2024. This will include Operations Senior Leadership Team, the Executive, Board Development, Finance and Performance Committee and finally Trust Board. All of these will be held in closed sessions. To aid familiarisation for trade unions partners prior to Board Development and Committee meetings, colleagues will be invited to attend the Operations Senior Leader Team consideration of papers.

Welsh Government and EASC have been briefed during the process and are set to receive the final submission on completion of the internal governance route.

#### **Community Welfare Responders (CWR)**

There are currently 8 active teams of CWRs across Wales, operating as part of the Connected Support Cymru (CSC) initiative. We held our first CWR onboarding event in February with a number of volunteers invited to attend the recruitment courses in February and March in Cardiff and Swansea respectively.

January saw the first webinar for CSC reaching out to stakeholders for recruiting partner organisations. This was well attended, and a list of over 180 expressions of interest has been collated

with some of these volunteers offered places on the Cardiff and Swansea training courses. The initial phase of CSC will focus on growing numbers of CWR responders. Support Officers are also supporting the awareness courses for the role out of LUSCII technology in care homes across North Wales.

### **NHSCT Grant Award**

Following the funding from NHSCT in June 2023, the Volunteering team was able to recruit Support Officer posts to support the on-boarding and operational support for CWR responders. These posts were recruited to in January 2024 and will undertake stakeholder engagement as well as being involved in LUSCII projects in Care homes. As part of the NHSCT bid, observation kits for volunteers have been funded to enable this new role to become operational.

## **Resourcing, EMS Coordination and Quality**

### **Accredited Centre of Excellence (ACE) status with the International Academies of Emergency Dispatch (IAED)**

The Trust has fallen below the standard for centre of excellence accreditation set by the IAED for the last reporting period (quarter). This is because the non-compliance of random 999 call audits finalised at 8.7% for the quarter which is above the 7% threshold set by the IAED. Broken down by month between January and March 2024, this equated to 7%, 10% and 9% non-compliance respectively. An analysis of the issues impacting compliance, and an accompanying action plan has been developed between Operations Quality and EMS Coordination, and this is being considered at Senior Operations Team (SOT) on 23 April 2024 before formal escalation to Senior Leadership Team (SLT). Colleagues should further anticipate these outputs also being shared within our quality meeting structures. The Operations Quality department has been working closely with the IAED to identify the issues and develop actions to make improvements. Following approval, the action log will be submitted to the IAED as part of the requirement set by the IAED Remediation & Revocation Policy. The process allows the Trust 3 months to return to compliance and a further 3 months if not achieved within the first 3 months.

### **HM Coroners**

EMS Coordination/Operations Quality received an influx of coroner request during Q4 which has resulted in an increased backlog of statements. Capacity within Operations Quality (OQ) has been realigned where possible to support with the construction of statements and a robust QA process is in place to ensure that accurate statements can be reviewed and signed by the Service Managers/Head of Service for serving to HMC. Whilst 9 of the outstanding 30 coroner statements have breached the requested return date, these are all at some point in the QA process. All other outstanding statements are not yet due, and the OQ team is completing these alongside other investigations (concerns and nationally reportable incidents (NRIs) etc.).

## **Resource - Relief Planning Pilot**

During Q4, relief planning pilot progressed to a 5 week notice period for shift allocation across all areas of operations. The group have met to review the impact and are pleased to report that annual leave compliance in line with resourcing policy has improved in comparison to the same position last year. To further support the pilot and staff it was agreed that the remaining staff would be afforded an extended deadline of last week in April to increase compliance or discuss mitigating circumstances with line manager. The agreement in partnership is to commence allocating leave to the remaining non-compliant staff by resourcing prior to publication of rosters which will align with the next phase of the pilot during Q1 to provide a 6 week notice period for shift allocation.

## **MIST Booking contractual hours (CPD) monitoring.**

During Q4, the MIST booking process has been reviewed in collaboration with Education and Development, EMS and Ambulance Care. The process now incorporates Resourcing approving bookings to ensure compliance with working time regulations and resourcing policy as well as capturing MIST hours contribution to contractual hours monitoring (CPD hours). Further work is ongoing to expand the process to capture the remaining CPD hours afforded to EMS and ACA2 colleagues.

## **Work Management Portal**

Workflow/Request system (Work Management Portal) is in early stages of development utilising O365 as a platform. Once development and testing is complete in Q1/2, this will introduce a centralised web based work request system that will enable staff and management to track progress on resourcing work/information requests (replace emails). It will also provide insight, data, and intelligence on resourcing departmental demand to identify areas for both system and service improvement, automation, and quality. It will promote the Resourcing brand as one team servicing four operational functions and will be a move forward in providing resilience and equity of service across the functions.

## **Estates**

Plans for Estate work in Llangunnor were signed off in March 2024 with a view to complete the estates strategy in Q2 of 24/25. The estates plan in the North was also signed off in March 2024 with a delivery quarter of Q3 following the feedback from capital management colleagues. We do however stay alert to lesser contractor availability in North Wales which we understand could impact the timeline.

## **Call Handler Recruitment**

As part of the recruitment process, a total number of 29 staff members were recruited in January 2024 with a plan to further recruit in Q2 24/25. This additional capacity within EMSC has resulted in capacity being over established in our EMD function rectifying the position previously reported.

## **Culture**

Culture initiatives including regular drop-in sessions for staff are now regularly offered. The engagement with staff offers the opportunity to engage with Service Managers and Head of Service directly with the intention of promoting a positive culture within the CCC and EMS Coordination.

## **Demand and Capacity**

The restructure of the EMSC leadership was agreed in principle at ELT in January 2024. The restructure will bring EMSC in line with other Directorates within Operations. The new leadership model will also support the delivery of the demand and capacity recommendations from ORH. The recommendations include a Single Allocator Model, Boundary changes and Roster review for the DCM's and Dispatcher teams. The OCP is expected to commence in Q1 and it is exciting to see, for the first time in WAST, the potential for a management and support structure with role opportunities at all levels offering a career pathway within EMSC.

## **Operations Quality OCP**

The Operations Quality (OQ) OCP has concluded, and final job evaluations and recruitment have begun. Interviews have been scheduled for the Locality Manager, OQ post which will have some of the coroner responsibility for the department/directorate alongside the Service Manager, OQ. The Support Officer and third Learning & Development Coordinator posts are awaiting approval on Trac, and the Quality Improvement Manager and Quality Audit Manager posts are awaiting job evaluation. It is anticipated that once these posts are in place, the department will have the capacity to push forward with the required SOP reviews.

## **Emergency Medical Service**

### **Challenges**

#### **Lost Hours to Handover**

Delayed transfer of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service with timely response to calls. The total amount of lost hours in January 2024 were 26,985, February 2024 at 23,896 and March 2024 at 23,403. The impacts of these delays and associated system pressures are regularly discussed at Committee and Trust Board.

#### **Red and Amber Performance**

As we notice a continued very poor position in transfer of care delays, this is ultimately being translated into a deteriorating Red performance and delayed response to our most critical patients. On the whole, the Red performance continues to fall well short of 65% in all Health Board areas. This is under constant scrutiny within the EMS Response and EMS Coordination teams to improve the level of response in this area.

The Amber median trend has remained relatively constant; however, recent deterioration has been evident. A reduction in handover delays would support our response to these patients and prevent escalating through the Clinical safety Plan (CSP) with further response implications to this category of patients, especially amber 2 patients.

## **General Update**

### **Quality & Support Days**

These days have proven invaluable in supporting operational staff in the promotion of key indicators and expectations relating to many elements of quality behaviour within Trust premises, on ambulance vehicles, and relating to the member of staff personally.

The subject areas covered include seat belt and safety harness use, Dress Code Policy, IP&C, and cultural awareness. These days are supported by all grades of operational manager/leader and further promote visibility to staff.

An MS Form is completed for each interaction with an operational crew or station visit during the support day which serves to provide assurance of compliance against the requirements.

Three Q&S days have been held so far, with all aspects of the Operations leadership teams involved. Themes and trends are to be collated and fed back through the senior leadership team.

### **End of Shift OVERRUNS**

While it is noted that the level of investigation of over 2 hour end of shift overruns have improved, along with the uptake of utilising the options available to reduce the end of shift overrun, work progresses on a number of initiatives to further reduce end of shift overruns to support the wellbeing of staff. Despite rising handover delays in recent months, the average length of overrun has remained a levels lower than 12-15 months ago.

### **Financial Savings Plan 2024/25 Overtime Allocation**

The 2023/24 FSP concluded successfully with original savings assumptions mainly achieved and overtime allocation following suit. The new savings requirements have been announced for the 2024/25 period with similar savings assumptions modelling almost complete. To support the routine day-to-day overtime allocation an 'Overtime Allocation SOP' has been approved and currently in use to support this now business-as-usual process.

## Ambulance Care

### IMTP

#### UCS Transformation Plan

An action plan was implemented in March 2024 to oversee delivery, numbers, and the development of rosters for consultation and work was completed to develop a new code set for Urgent Care Service. Communications were completed and issued alongside engagement sessions. The recommendations will be presented to ELT in April 2024.

### General Update

#### Recruitment

The Ambulance Care OCP which commenced in 2023 has recently seen all the positions recruited into. This will allow Ambulance Care to now progress with the service improvements the new structure was designed to achieve.

#### CMP (Capacity Management Plan)

An updated Capacity Management Plan has recently been approved by the Executive (following engagement with commissioners) enabling greater capability to manage the thousands of patient journey requests. Go live is scheduled for May 2024.

## Integrated Care - CSD

### Challenges

#### Integration of Systems

The integration of the telephony system within CSD involved various complexities, including ensuring smooth integration with existing systems, providing adequate training to staff, adjusting operational procedures, and ensuring accuracy in reporting. These challenges likely arose due to the intricacies involved in transitioning to a new system while maintaining uninterrupted service and data accuracy. Despite the overall challenges faced by the service, additional BI reporting has given additional metrics to support intelligence and reporting.

## **Capacity and Leadership support**

Sufficient leadership support for operational activities has posed some challenges due to a high volume of staff on sickness absence and/or those on supported return to the workplace. To bridge this gap and to offer members of the wider team an opportunity for professional growth we have implemented an Operation Manager development programme which has been well received.

## **Inbound Contact Centre Concept**

Traditionally focused on outbound calling, the solidification of an inbound contact centre concept in CSD has grown significantly in this quarter. CSDs Remote Clinical Support for Newly Qualified Paramedic crews, Community Responders, as well as the pilot to support Police colleagues potentially facing long waits on scene has taken considerable reorganisation of "on duty" activity. Focus on managing call answering in a timely manner has led to the creation of a specialist desk to deal with this inbound work. However, this has taken core staff away from the traditional role of Consult and Close and with other roles such as Screening and Enhanced Screening in escalation alongside the commitment to 24/7 Red Review provision has meant that our ability to significantly improve on our Consult and Close percentage has been challenged.

## **IMTP**

### **Consult and Close**

The Consult and Close rate rose in the quarter but did not exceed 14.3%. Work continues with staff and teams to focus on activity levels to improve triage rates. Work continues on the use of ECNS to reduce triage durations. The service is also committed to offering the provision of a 24/7 Red Review and Remote Clinical Screening during high levels of escalation.

### **ECNS**

The process to improve clinical outcomes in ECNS is in place with auditors and practice educators to identify and support those whose outcomes/conversions are comparatively lower. Guidance was released in Q4 to improve the efficiency of the ECNS triage process to optimise time taken per triage.

## **General Update**

### **PTAS**

A video was completed in collaboration with ABUHB and CVUHB health boards to increase the use of PTAS to consult and close. As part of the strategy to move away from a local SOP to a guidance document used by Health Boards, The SOP has been removed with a view to be updated and circulated as a Guidance document to disseminate.

## Integrated Care – NHS 111 Wales

### Challenges

#### **Demand Levels & Operational Productivity**

NHS 111 Wales call demand in Q4 was 10% up on Q3. Recent weeks have continued to see higher demand than we saw for much of December. This level of demand is 14.6% above the level the service is resourced to answer.

Through Q4 we have seen 9-10% of our staff abstracted consistently for CAS replacement training. Despite those abstractions we answered 9% more calls in Q4 than we did in Q3. The increase in calls answered despite higher abstractions can be attributed to the use of agency call handling resources and the introduction of virtual queuing. The level of calls answered in Q4 was 5.6% above funded levels.

#### **Workforce capacity**

Recruitment was curtailed during the SALUS implementation period and again during the CAS replacement project. Consequently 111 is under established and this is impacting operational production. Plans are in place to return to full establishment through Q1 and Q2.

### IMTP

#### **Dental Services Transformation**

The funded operating model for four health boards has been built and is confirmed following work with Health Boards, Six Goals Programme and the Chief Dental Officer for Wales. This model will be going live on the 30<sup>th</sup> April 2024 along with the replacement CAS. Unfunded activity for the remaining health boards has now been ended following a phased and agreed roll back of those services.. The development of "Once for Wales" options in the unfunded areas continues with Health Boards and the Six Goals Team. This work is included as part of the Operations Transformation work outlined in the 24-27 IMTP.

#### **Increased Available Pathways**

A pathway to enable WAST 111 staff to pass calls to 111 Press 2 teams was will go live as part of the rollout of the new CAS system at the end of April 2024.

A trial of direct booking from 111 to Urgent Primary Care Centres in two Health Boards commenced in this quarter. Referral volumes have been lower than expected however this has been predominantly attributed to a very narrow inclusion criteria. In the next quarter we will work with HBs and other stakeholders to broaden the criteria.

## General Update

### **CAS Replacement Project**

Significant focus and effort has been focussed on the replacement CAS solution. The solution remains on track for go live on the 30<sup>th</sup> of April 2024.

Considerable activity has taken place across Operations, Digital and QSPE Directorates to ready the technical infrastructure, train our people and re-design every process within 111.



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<b>AGENDA ITEM No</b>	<b>6</b>
<b>OPEN or CLOSED</b>	<b>Open</b>
<b>No of ANNEXES ATTACHED</b>	<b>2</b>

**Integrated Medium Term Plan (IMTP)  
End of Year Position 2023/24 and forward assurance plan for 2024/25**

<b>MEETING</b>	Finance and Performance Committee
<b>DATE</b>	14 May 2024
<b>EXECUTIVE</b>	Rachel Marsh - Executive Director of Strategy, Planning and Performance
<b>AUTHOR</b>	Alexander Crawford - Assistant Director of Planning and Transformation Heather Holden – Head of Transformation Gareth Taylor – Senior Project Manager
<b>CONTACT</b>	Heather.holden@wales.nhs.uk

**EXECUTIVE SUMMARY**

The purpose of this paper is to provide Finance & Performance Committee with the end of year position on actions in the IMTP 2023-26, including the Ministerial (now Cabinet Secretary) Priorities set by Welsh Government, and outlined in Appendix 1 (SBAR).

**RECOMMENDED:**

**That the Finance & Performance Committee:**

- 1. Notes the overall delivery of the IMTP detailed in this paper and appendices.**
- 2. Notes the approach to IMTP delivery and assurance reporting set out in this paper.**

**KEY ISSUES/IMPLICATIONS**

The end of year position for the IMTP is largely positive given the scale of ambition within our IMTP set against the challenging financial position in NHS Wales last year, and the need to deliver the Financial Sustainability Programme and significant savings. Those areas where work was off track but ongoing (**AMBER**) by year end have been rolled over where required into either IMTP workstreams or into directorate plans for delivery in 2024/25.

The following workstreams were significantly off track (**RED**):

- NET Centre re-roster, as current funding does not provide a new roster within current operating hours. This rolls over to the new financial year and has been raised with commissioners.
- Work to increase consult and close rates remains at 14% and did not achieve 17% by Year End. This will be a key focus of our work in 2024/25 on a future clinical service model set out in the IMTP 2024-27.
- Independent prescribing, due to the and a lack of supervisory support for TAPPs and APPs, as the APP Clinical Supervision infrastructure remains **AMBER** but features as a priority in next year’s IMTP.



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Appendix 1 sets out more detail for the end of year position. Appendix 2 sets out the full assurance summary report that was received at Strategic Transformation Board (STB) in April.

Appendix 1 also sets out the future arrangements for IMTP delivery and assurance as well as the milestones that will be assessed going forward against the Cabinet Secretary priorities and the actions we are taking that align to those priorities.

The next Committee update in July 2024 will provide a detailed outline of the Transition Plan to implement WAST's Future Clinical Service Model, an update on overall IMTP delivery and assessment against the ministerial (or Cabinet Secretary's) priorities.

### REPORT APPROVAL ROUTE

Strategic Transformation Board 8<sup>th</sup> April 2024

### REPORT APPENDICES

Appendix 1 SBAR: IMTP End of Year Position, forward assurance plan and Cabinet Secretary Priorities

Appendix 2 STB Assurance Report April 2024

### REPORT CHECKLIST

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

## Appendix 1

### IMTP End of Year Position, forward assurance plan and Cabinet Secretary Priorities

#### Situation

1. The paper reflects on delivery during FY23/24 and **notes the ongoing work to restructure the existing delivery programmes and determine the Future Clinical Services Model that will be implemented during 2024/25** as part of the overall IMTP delivery in the 2024-27 IMTP. This includes setting out how the plan has addressed the ministerial priorities (for the now Cabinet Secretary) and the milestones set out in the templates submitted to the Minister alongside the IMTP.

#### Background

2. WAST submitted its previous IMTP (2023-26) to WG on 31st March 2023 following Board approval. Welsh Government recently approved WAST's IMTP on 12th September 2023. Following approval, the Director General issued accountability conditions on which our approval is based on 2nd October 2023. The approval conditions were largely financial with papers on finance and value reported through Finance & Performance Committee regularly throughout the year. The Committee also received updates on the requirement assure the Board that we had actively worked to deliver our commitments made against the (then titled) Minister's priorities for the NHS, alongside detailed assurance reports on our delivery against our IMTP.
3. We submitted our latest iteration of the IMTP for 2024-27 on 28<sup>th</sup> March 2024 following Board approval the same day.
4. The requirement set out within Welsh Government (WG) planning guidance was to submit clear narrative plans set over three years, showing clear progression over those three years, together with templates setting out how organisations would deliver against the Health Minister's (now Cabinet Secretary's) key priorities for the NHS and aligned to a Minimum Dataset (activity and performance trajectories, workforce plans and financial plan). These priorities are:
  - Enhancing care in the community, with a focus on reducing delayed pathways of care;
  - Primary and Community Care, with a focus on improving access and shifting resources into primary and community care;
  - Urgent and Emergency Care, with a focus on delivery of the 6 goals programme;
  - Planned Care and Cancer, with a focus on reducing the longest waits;

- Mental Health, including CAMHS, with a focus on delivery of the national programme.
5. We addressed the last 4 priorities as being most relevant to WAST in the IMTP within its appendices and will report on these against the milestones set out below in future IMTP assurance reports to the committee.

***IMTP Assurance arrangements: Looking Back – 2023/24***

6. As noted in the FPC paper dated 7<sup>th</sup> July 2023, a single reporting line was established that tracked IMTP Deliverables into defined IMTP Delivery Programmes or Enabling Workstreams, and ultimately into STB. Within each programme, individual actions were grouped into work packages for 2023/24, to enable more detailed tracking at project/workstream level, and higher-level tracking through Programme Boards and STB.
7. Other IMTP-related actions were managed via alternative routes such as Local Delivery Plans or Capital Management Board (list not exhaustive). These were reported discreetly upwards to the relevant Senior Leadership Team.

***IMTP Assurance arrangements: Looking Forward – 2024/25***

8. Work is currently underway to redefine and redesign our Clinical Service Model for the future with a series of workshops planned early in May to scope and define our new clinical model. To enable delivery of the new model, it will be vital that we transition to a more integrated organisation-wide Transformation Programme that brings together our existing programmes of work into a single-holistic programme.
9. Reflecting on the current IMTP Delivery Programmes, we recognise that the scope of these has changed over time to encompass some tactical service changes and business-as-usual operations. Scope creep is very common in programme management and whilst not unexpected, it has made monitoring and assurance increasingly challenging as the portfolio has expanded. **The development of our Future Clinical Service Model provides an opportunity to refresh our approach to management of transformation and wider service changes and improvements within the IMTP and we will be moving towards a more structured approach that distinguishes between the ‘level’ of change and how this is managed and monitored locally and organisationally.**
10. The team are currently developing a framework for the delivery and assurance of the complete IMTP portfolio and will be presenting this at Strategic Transformation Board on the 20<sup>th</sup> May, along with a high-level transition plan to demonstrate how this will be achieved. Following approval of the revised framework and delivery and assurance structure we will develop a detailed transition plan and will support each of the existing IMTP Delivery Programmes and Enabling Workstreams to adopt

these new arrangements, ensuring this is carefully managed to avoid delivery disruption.

### ***Impact of the transition***

11. At each stage of transition, **we will ensure that there is a clear line of delegation for IMTP deliverables**, but these may change materially in terms of ownership, and potentially in their prioritisation.
12. During Q1 and Q2 we expect to operate a dual approach to reporting whilst changes are embedded. This is likely to mean that rather than getting a single IMTP Delivery & Assurance report, these may vary in terms of the format and frequency.
13. In many cases, changes will be more superficial such as naming conventions, or there may be a requirement for Terms of Reference to be reviewed, ownership, objectives, and the organisation of milestones. **Importantly, our IMTP deliverables will remain unchanged, but the process and organisation of these deliverables may be revised.**
14. We expect the transition to commence in Q2 and to be finalised early in Q3.

### **Assessment**

15. The following section of the paper sets out the IMTP end of year position for 2023/24.

#### **Transformation Programmes – Year End Position**

##### **During 2023/24 the defined IMTP Delivery Programmes were:**

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

##### **The defined IMTP Enabling Programmes for FY23/24 were:**

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

It should be noted that the Inverting the Triangle (ITT) Programme was not included within the summary of IMTP Delivery Programme work packages.



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## EMS Operational Transformation – End of Year Position

### Overall RAG Status: **AMBER**

- The EMS Response Roster Review closure and evaluation report will be presented to EMS Programme Board on the 29<sup>th</sup> April 2024, before being presented to STB on the 20<sup>th</sup> May 2024. This presents a slippage against previous timelines.
- The rightsizing of EMS Response is **AMBER**. The EMS Operations Programme aims to run a post-roster change relief gap temporarily as agreed by WAST CEO in consultation with TU Partners.
- The EMS Control Reconfiguration Project is currently recorded as **GREEN** for Year End across all four workstreams as work well underway to implement recommendations. Working Group being established and the Project Board resume on the 12<sup>th</sup> April which will form an essential component of the EMSC Reconfiguration. To continue with Organisation, Change Processes.
- CHARU work is also rated **Amber** based on recruitment numbers and closure report yet to be presented (Programme Board 29<sup>th</sup> April 2024).

## Ambulance Care Transformation – End of Year Position

### Overall RAG Status: **AMBER**

- 1 **RED** deliverable relates to the NET Centre re-roster as current funding does not provide a new roster within current operating hours. This rolls over to the new year and has been raised DAG.
- Implementation of the new NEPTS roster pan-Wales remains paused, whilst funding to support is identified. 12FTEs in the NET Centre Project is also paused as no funding from commissioners to progress. **PAUSED**
- The Urgent Care Service (UCS) Demand and Capacity review is now complete and transition planning now underway. **COMPLETE**
- As noted previously, project manager appointed for the UCS Transformation Plan Transition Planning will continue into 2024/25. **AMBER**
- Transfer and discharge project is continues to assess options following discussion with commissioners regarding ORH D&C modelling. Transfer Demand modelling to be carried over as 2024/25 deliverable, and further engagement was undertaken during workshop in April 2024. **GREEN/AMBER**
- Implementation plan regarding improved performance parameters for NEPTS completed with actions underway. Rollout due Q1 2024/25
- The Quality Assurance agenda continues to move forward, approved by Ops SLT 12 December and CQGG on 29 Jan 24.
- Opportunities to expand the ambulance car service sought; none identified, decision to close the project noting that a case be developed should opportunities emerge at a later date. **CLOSED**
- The NEPTS Operational Improvement Plan remains **AMBER** with work still ongoing with delays resulting from HB capacity.
- The roll out of the refresh of the ambulance care fleet mix is on track. **GREEN**

## Gateway to Care Transformation – End of Year Position

### Overall RAG Status: **GREEN/AMBER**



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- Re-rostering call handlers and clinicians remains paused pending funding, and work to develop clinically confident and competent workforce remains ongoing despite elements paused due to the CAS replacement system.
- CAS replacement work on track to achieve 30<sup>th</sup> April deadline.
- Work to increase consult and close rates remains at 14% and did not achieve 17% by Year End. **RED**
- Improvements to the 111.Wales website are also currently **GREEN** as funding received and external stakeholders re-engaged.
- Remote clinical support strategy closure report accepted at G2C Programme Board.
- 111 booking and pathway work currently **GREEN**.
- Resource currently impacting G2C/Power BI dashboard development and remains **AMBER**

### Clinical Transformation – End of Year Position

**Overall RAG Status: GREEN**

- 1 **RED** remains and relates independent prescribing due to the and a lack of supervisory support for TAPPs and APPs, as the APP Clinical Supervision infrastructure remains **AMBER** but features as a priority in next year's IMTP.
- APP Navigator and APP Dispatch Criteria workstreams currently **GREEN**
- Optimising Conveyance workstream all **GREEN** however the 6 Goals clinical elements are being monitored as continued engagement but financial constraints in HBs are impacting. Pre-dispatch Outcome Risk Stratification also now transitioned to BAU. **COMPLETE**
- All work within the Clinical Intelligence Assurance Group remains **GREEN**. The development of the Clinical Audit Plan has been **CLOSED** as this is now business as usual.
- Older Persons and Falls workstream remains **GREEN**. SBUHB domiciliary care provider evaluation currently underway.
- Funding for Mental health response vehicle approved for AB. Pilot completed, and evaluation to follow. Evaluation report to follow. Currently **GREEN**
- Evaluation Report on the impact of mental health providers has been completed, and work progressing on dashboards. Currently **GREEN**
- Evaluation report on RITA tablets also undertaken and further work on the impact of environment on NEPTS vehicles to continue into 2024/25.
- Connected Support Cymru work 20 week community welfare feasibility welfare project complete, however feedback on business case remains outstanding. SBRI and LUSCII contract ended 31<sup>st</sup> March. **AMBER**

### Financial Sustainability Programme

#### 1. Income Generation

**Overall RAG Status: GREEN/AMBER**

**Overall Position Against Savings Target: GREEN** (Exceeding Financial Forecast)

- **Commercial Structures and Long-term Planning** report completed and presented to ELT Away Day. Workshop conducted and recommendations taken on board. Plan for 2024/25 now underway. **GREEN**
- **Income Generation Schemes** - new scheme submission and communications plan to be implemented in 2024/25 **AMBER**
- **Commercial and Financial Mindsets** work will continue into 2024/25 alongside the commercial structures and long-term planning, as a workstream **AMBER**



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## 2. Achieving Efficiency

**Overall Project RAG Status: GREEN/AMBER**

**Overall Position Against Savings Target: GREEN** (Exceeding Financial Forecast)

- **Reviews.** Administrative & Corporate Services Review Action Plan underway. Contains 13 **should do** and 6 **must do** recommendations that will be implemented throughout 2024/25. Interviews are underway, following completed discussion packs. Next step is to complete Summary Reports for all 44 Business Areas. **GREEN**
- **Short Term Savings Opportunities** - Number of schemes proposed, assessed, and delivered in 2023/24, including Leasing Cars, Fuel Savings, and Consumables Waste. Overall savings target met, and revised set of scheme 'themes' determined with £6.4m 2024/25 Financial Plan. **GREEN**
- **Long Term Savings Opportunities** - Larger programmes of work such as RPA to be initiated in 2024/25 following release of funding + recruitment of developers. Programme of work to be led by digital, but reported into the Financial Sustainability Programme. Work on behaviours to be discussed at Leadership Symposium in April 2024. **GREEN**
- **Process Efficiencies** collated in Year End Review Document. Those delivered and those to be delivered (with timelines) **GREEN**

### Overall

- Last reporting period has seen substantial work on the commercial strategy. Report completed and presented to ELT Away Day. ELT content with outputs of report and acknowledgement that work to be undertaken over next reporting year. Workshop conducted and recommendations taken on board. Project Planning for 2024/25 now underway.
- 2024/25 Financial Plan considers an addition £6.4m savings plan and increase of approximately £400k on the last financial year.
- A 2023/24 Gateway Review Session undertaken in March 2024 and to be presented following Year End. Queries regarding ongoing purpose and direction of FSP considered alongside lessons learnt from 2023/24. Agreed focus across Income Generation will be on the commercial structures following direction from ELT

## Enabling Programmes – End of Year Position

### People & Culture

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

#### CULTURE

On track overall (**GREEN**), however there is an **AMBER** status against

- **Develop and articulate our target culture:** due to rollout of EQIA training due to limited training capacity
- **Refresh TU partnership working arrangements:** ACAS action plan has now been developed and agreed in partnership with TUPs. Implementation of the plan is underway, but timelines have been updated in the context of IA.

#### CAPACITY

**Develop our employee offer: GREEN**



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

1. **Shift Overruns** – ED Holding Area Survey completed and results was presented to STB on the 26th of February 2024 – some positive signals from the survey and STB has asked the Operations teams to consider the next steps for 2024/25 in the IMTP as this remains a commitment to staff.
2. **Flexible Working Policy** – Developments around flexible working include,
  - a. Reviewing current policy.
  - b. Establishing a clear understanding of current processes and impacts of flexible working arrangements across frontline services.
  - c. Reviewing current research for frontline flexible working across NHS& Emergency services.
  - d. Engaging with the wider Ambulance Sector to understand flexible working practices across the UK.
  - e. Developing coaching / process material.
  - f. Exploring ESR functionality for requesting and recording agreed / declined flexible working requests.
  - g. Engaging with WAST colleagues to understand perceptions and views on flexible working options and evaluate after changes are implemented.
  - h. Continuing to establish a pathway of support for Carers within the organization.
3. **Digital Experience** – Work ongoing with the EqlA process, in order to make this more digitally accessible. Regarding Digital Literacy Skills, the development of accredited and non-accredited education programmes is underway, as is the implementation of LMS365. Also within this commitment is the expansion of Learning Launchpad content. There will be further work on simplified access to digital tools through the refresh of the Digital Plan set out in next years' IMTP.

## CAPABILITY

### Promote personal responsibility: GREEN/AMBER

On track overall, however, there remains a **RED** status against Apprenticeship provision, due to inability to draw down previously secured funding (income), the financial implications of which have been highlighted. These financial implications have been partially mitigated by residual funding but will be considered next financial year.

## Digital

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

### National Data Resource Programme Support: GREEN/AMBER

- All planned activities are complete, however longer-term funding has not been agreed which poses a potential risk. Current funding forecast remains lower than anticipated and may impact two data engineering posts within Health Informatics.

### Upgrade 999 Telephony Platform: AMBER

- Voice recorder is currently being upgraded, also needs a new version of Callpilot installing and configuring that will need testing, with the aim to go live mid-April.

### Digital Experience of Staff: AMBER



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- **AT RISK:** Meetings ongoing work on hold due to CAS replacement taking priority on resources, impacting capacity. CAS Go Live 30<sup>th</sup> April 2024

#### **Operations Communication Programme: GREEN**

- The NEPTS National Mobilisation Application (NMA) has passed Service Acceptance testing and is deployed on 3 vehicles as part of a live pilot, with plans to increase this to 5. Conclusion of the pilot will be achieved once the Trust is adequately assured the platform is suitable for operational deployment.
- The MDVS project is still seeking to conclude deployment across all vehicle types in Q2 2024. Nearing completion in mid-April 2024.

### **Fundamentals (including Risk Management) – End of Year Position**

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

#### **Risk Management: AMBER**

- Risk Management Framework in draft – approved by Audit Committee March 2024 and recorded as **GREEN**, however programme of training and Board risk education rolled over into 2024/25 IMTP. Framework endorsed by Trust following approval.

#### **Welsh Language Policy: GREEN**

- Translation service is currently in operation with further comms to follow in May 2024.
- More than just words year 1 report submitted to WG. Year 2 development of a Welsh Language Workforce Strategy as part of the overall WAST Strategic Workforce Plan. To be completed by 31 March 2024.
- Welsh Language Standards work focusing on development of a Welsh Language Standards Compliance dashboard.

#### **Quality Management System Implementation: AMBER**

- Working Safely Plan closed and closure report to be shared.
- Quality Management System Group meetings being held and attended for each service area. QPMF Self-Assessment pilots concluded end of Q3 and review due to be completed in Q4, however winter pressure knock-on has rolled deliverable into 2024/25.
- DoQ e-learning launched and Siren pages updated
- Communications strategy drafted to launch DoQ e-learning across Organisation. Developing packages for supervisory/leadership roles.
- MIQPR now available via SIREN SharePoint as and Phase 2 of Always On Reporting launched mid April 2024.
- Board Training Day for DoQ and CoC due June 2024.
- Further comms during April CEO Roadshows.

### **Forward View – IMTP Assurance 2024/25**

16. Following final publication of the IMTP, the Transformation and Planning teams have been working with transformation programme SROs and leads for enabling and fundamental workstreams to formally document the priority work linked to the IMTP for delivery during FY24/25.

17. As noted earlier in the report, May and June will see restructuring around the existing and future clinical service model. As such,

- Projects and workstreams are being redefined, including their scope, in line with the new Clinical Service Model.
- Milestones have been provisionally agreed for delivery during Q1, based on the IMTP and any rolled over from 2023/24, however workstreams may be re-aligned following the change of structure.
- Project/workstream progress will be monitored by the Transformation and Planning teams by way of progress against agreed milestones as per previous years.
- By exception reports will continue to STB in May 2024, due to the interim period between reporting structures. This will highlight any risks or issues for noting/action.
- This report will also include the agreed next steps following the Clinical Service Model planning workshops in May 2024 for the next quarter.
- The quarterly written assurance report will be shared with Finance & Performance Committee for information as per previous years.
- Following the May STB, Written and Verbal updates will be provided at every alternate STB; meeting minutes will be shared with Finance & Performance Committee for information if applicable.

18. In addition to establishing a revised IMTP assurance process for FY24/25 (in line with the new Clinical Service Model), the Transformation Support Office (TSO) has also re-commenced work with Verto 365 to deploy a centralised project portfolio management system.

19. As noted in the End of Year Report presented to FPC in July 2023, this system is used extensively across NHS Wales and presents an opportunity to strengthen and streamline our IMTP assurance reporting. The project is currently in the defining stage, and discovery work is underway to develop a prioritised requirements list.

20. The first iteration of the system will focus on two core pillars of the Future Clinical Service Model – Remote Integrated Care Service (RICS) and Urgent Community Response Service. These workstreams are being prioritised due to the scope of the facilitated workshops in May, as this will provide an opportunity to input the workshop outputs into the new system. Further iterative rollout will be planned in tranches throughout FY24/25.

21. We will continue to produce written assurance reports as the system is designed, tested, and deployed, but will be reviewing our assurance reports in line with Verto 365 adoption.

## **Forward View – Assurance against the Cabinet Secretary’s priorities 2024/25**

22. WAST submitted eight templates covering plans against four of the Cabinet Secretary’s priorities for NHS Wales. These cover how we engage across community services, provide support to planned care, but importantly how we align to the Six Goals programme for Urgent and Emergency Care and how we will approach our response to patients with mental health needs. In 2024/25 we will also be required to develop a ‘Six Goals’ delivery plan. Whilst we have set out in the templates submitted to WG many areas across the six goals where we can implement change, these are already factored into the scope of the work to develop a future clinical services model, and will undoubtedly also feature in the six goals plan. Therefore we will aim to reduce the burden and duplication of reporting through our assurance mechanisms into STB and the Committee.

23. The following table sets out the key areas for WAST against the priorities, and the milestones to be achieved in quarter 1.

<b>Cabinet Secretary Priority</b>	<b>Area for WAST</b>	<b>Milestones Q1</b>
Primary and Community Care, with a focus on improving access and shifting resources into primary and community care	111 Skill Mix	<ul style="list-style-type: none"> <li>Group established to consider and develop scope for 111 MDT skill mix</li> </ul>
	111 Pathways	<ul style="list-style-type: none"> <li>Dental access improved in 4x health boards by end of Q4</li> <li>Strengthened links into primary care / Out of Hours in. Urgent Primary Care Centre access by end of Q4</li> <li>Medicines management pathways in place by end of Q4</li> </ul>
	999 Pathways: Falls & Frailty	<ul style="list-style-type: none"> <li>Level 1 falls - Assessment of the demand &amp; capacity modelling undertaken</li> <li>Level 2 falls - Undertake evaluation of our existing services</li> </ul>
	999 Pathways: Digitised pathways	<ul style="list-style-type: none"> <li>Evaluate the effectiveness of the new digital solutions to make referrals to existing pathways and usage</li> </ul>
	999 Pathways: Connected Support Cymru (CSC)	<ul style="list-style-type: none"> <li>Recruitment of key roles to support CSC delivery (dependent on outcome of business case)</li> <li>Commenced recruitment of internal volunteers</li> <li>Testing ‘ambulance in a box’ in Care Homes in AB &amp; BCU, evaluate and conclude forward plan</li> </ul>



**GIG**  
CYMRU  
**NHS**  
WALES

Ymddiriedolaeth Brifysgol GIG  
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Welsh Ambulance Services  
University NHS Trust

Cabinet Secretary Priority	Area for WAST	Milestones Q1
Urgent and Emergency Care, with a focus on delivery of the 6 goals programme	Goal 2: New 111 System	<ul style="list-style-type: none"> <li>• Full implementation of new CAS system 30th April</li> <li>• Decommission old system</li> </ul>
	Goal 2: 111 website & symptom checkers	<ul style="list-style-type: none"> <li>• Scoping exercise to review requirements of a 111 website – and develop options appraisal accordingly</li> </ul>
	Goal 2: 111 re-roster	<ul style="list-style-type: none"> <li>• No Q1 milestone</li> </ul>
	Goal 3: <ul style="list-style-type: none"> <li>• Develop the remote clinical assessment speciality</li> <li>• Develop a fully remote working clinician offer (operations/training/digital)</li> <li>• Develop Pre-Dispatch Outcome Risk Stratification Tools linking CAD &amp; ePCR data</li> <li>• Roll out of new integrated (111/clinical support desk) care model</li> <li>• Connected support Cymru</li> <li>• Extend use of video/ phone consultation</li> <li>• Urgent On-Scene Community Response</li> </ul>	<ul style="list-style-type: none"> <li>• Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report</li> </ul>
	SDEC Pathways	<ul style="list-style-type: none"> <li>• Re-establish ICAPs with Health Boards (subject to JCC commissioning arrangements)</li> <li>• Complete data quality assurance of end destination in CAD to ensure SDEC referrals fully captured</li> </ul>
	Goal 4: CHARU	<ul style="list-style-type: none"> <li>• Complete CHARU recruitment by end Q2</li> <li>• Improve utilisation rate to modelled benchmark by end Q2 (work ongoing during Q1)</li> </ul>
	Goal 4: Rural variation	<ul style="list-style-type: none"> <li>• Complete CHARU recruitment by end Q2</li> <li>• Continue process of targeted recruitment and process of smoothing i.e. aligning SIP to establishment by end Q2</li> <li>• Build rurality results from 2023 EMS Demand &amp; Capacity Review by end Q2</li> <li>• Agree Implementation Plan with commissioners by end Q2 (work ongoing during Q1)</li> </ul>

Cabinet Secretary Priority	Area for WAST	Milestones Q1
	Goal 4: Sickness reduction in EMS and EMSC	<ul style="list-style-type: none"> <li>Ongoing continuation of managing attendance and implementation of the health and wellbeing plan throughout year</li> </ul>
	Goals 5 & 6: Transfer and Discharge model	<ul style="list-style-type: none"> <li>Engagement on modelled options for transfer services with health boards commenced</li> <li>Implementation of new MTPS protocols within the Computer Aided Dispatch (CAD) system designed to allocate transfer resources more effectively</li> </ul>
Planned Care and Cancer, with a focus on reducing the longest waits	Roster review of NEPTS Ambulance Care Assistants	<ul style="list-style-type: none"> <li>No specific milestone in Q1</li> </ul>
	Enhanced hub for oncology patients	<ul style="list-style-type: none"> <li>Establish expected outcomes &amp; principles to develop enhanced oncology service</li> </ul>
	Quality assurance of external providers	<ul style="list-style-type: none"> <li>No specific milestone in Q1</li> </ul>
Mental Health, including CAMHS, with a focus on delivery of the national programme	Develop and implement a referral pathway for 111 Press 2 teams	<ul style="list-style-type: none"> <li>Completion of 111 CAS system implementation to aid improvement in 111 press 2</li> </ul>
	Mental Health Response Vehicles	<ul style="list-style-type: none"> <li>Collating and presenting evidence from pilot within AB, discussing outcomes and options for further pilots</li> </ul>
	Right Care Right Person	<ul style="list-style-type: none"> <li>Engaging with Police Services in Wales, NHS partners, Local Authorities and third sector providers on changes affecting response to people in crisis</li> </ul>
	Mental Health Practitioners in CSD	<ul style="list-style-type: none"> <li>Assess demand and capacity plan outlining future needs for the team and training requirements (as part of overall demand and capacity work for the future clinical service model)</li> </ul>

## Recommendation

### 24. That the Finance & Performance Committee:

- **Notes the overall delivery of the IMTP detailed in this paper and appendices.**
- **Notes the approach to IMTP delivery and assurance reporting set out in this paper.**

Welsh Ambulance Services NHS Trust

# IMTP Delivery Summary

## Year-End Summary



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Ymddiriedolaeth GIG  
Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust

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IMTP Delivery  
Version 1.0  
Released: April 2024

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by Transformation Support Office  
Gareth.taylor3@wales.nhs.uk



# IMTP Delivery Programmes

- [EMS Operations](#)
- [Ambulance Care](#)
- [Gateway to Care](#)
- [Clinical Transformation](#)
- [Financial Sustainability](#)
- [IMTP Enablers & Fundamentals](#)



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# EMS Operations Programme

Hugh Bennett

# EMS Operations Programme



Report Month:	Current RAG	Previous RAG	STB Action Required	SRO:	Hugh Bennett
March 24	Amber	Amber	For Noting and updated RAG for part 1 evaluation from Amber to Red. Currently in the process of drafting a closure report for the programme.	Business Partner:	-
				Project Manager:	Richard Baxter
Objectives	Current Position		RAG	Work to be completed	
EMS Response Roster Review	<b>Complete part 1 evaluation:</b> Currently waiting for ORH information, in particular, if any tweaks are recommended to the December 21 ++ keys. This will enable completion of the closure and evaluation report, which is drafted. TU partners feedback has been fed into the draft report, but it is envisaged that a meeting with them will be required before final version to STB.		R	1. Take to EMS Operational Programme Board on 29 <sup>th</sup> April 2024 for approval. 2. Take to STB in May 2024.	
	<b>Rightsizing following roster changes:</b> Run a temporary relief gap as agreed by WAST CEO and Trade Union Partners. Due diligence of the USC scope of practice project has identified they need to revisit these numbers. This work will be completed in February 24.		A	Final run round these numbers and then agreement on how to apply in practice.	
EMSC Reconfiguration Project	<b>EMSC Restructure:</b> EMSC Management team met following the ORH Demand and Capacity review Sept 2023 to understand how the structure set out in a presentation to the Executive Leadership Team in November 2021 could be changed to provide a robust management structure while remaining within the existing financial envelope. Taking cognisance of some of the recommendations from the ORH report (Single allocator model, roster review and desk requirements) a new management structure was developed and submitted for comments. Further funding was made available by ELT, which ensured that the establishment of the EMSC operations remained unchanged and the new structure was signed off by SLT and ELT. This provides a robust structure that meets the need to support staff, while also providing a level of operational cover that meets the needs of the Manchester Arena Inquiry recommendations.		G	The EMSC Restructure requires a number of job descriptions to be finalised. This work is already underway in conjunction with People Services. Working group will be set up lead by Gill Fleming once the necessary building blocks finalised. The Project Board resume on the 12 <sup>th</sup> April which will form an essential component of the EMSC Reconfiguration. To continue with Organisation, Change Processes.	
	<b>EMSC Roster Review Workstream:</b> The first phase of the Roster Review process for EMSC was completed for Emergency Medical Dispatch (Call Takers) and the second phase started in 2023, but was paused due to a withdrawal of TUPs from any Roster review processes. When the issues that led to the pause were resolved it was decided to pause the work until the ORH refresh of the 2019 work had been completed to ensure that the most recent data informed any future roster keys. This was completed in September 2023 and following a broader review of the recommendations from that report together with a EMSC Senior Management Team review of the management structure, it was agreed that this would form part of the agreed approach to EMSC reconfiguration. The working group will take into consideration the ORH Report dated September 2023 and will consult with staff on a new roster that takes into account the demand on the service. The working meeting have recommenced on 12 <sup>th</sup> April 2024. The project team are currently working on the draft of Core Principles.		G	It is envisaged that the draft of the Core Principles will be taken Project Board on 12 <sup>th</sup> April. Following this the working group will commence work on the roster that aligns with the new roster keys.	
	<b>Boundary Changes Workstream:</b> The Desk / boundaries realignment featured in the original ORH demand and capacity review in 2019 and has been updated following the initial project working group discussions last year. In September 2023 ORH refreshed their 2019 work with new data points and this report will now form the basis of discussions around desk and boundary realignment to ensure that there is an equity of work across desks, but also that there a natural flow of patients to the appropriate Emergency departments. This work is a dependency within the overarching EMSC Reconfiguration work and links to both the Roster review, Single Allocator Model and Management Restructure.		G	The working group meeting recommenced on 14 <sup>th</sup> March and is focusing on the specific items aligned on the ORH report in 2023 including issues such as individual divisional areas, development plans, communication strategy and technical group meetings.	
	<b>Single Allocator Model:</b> A recommendation from the 2019 ORH D & C review and again in 2023 was to move to a single allocator model. This has been incorporated into the new EMSC Structure signed of by SLT and ELT. This model involves working in a different way to the current model within EMSC, but the transition is envisaged to be smoother as Support Coordinators have been factored into the new structure that will Support the allocator with tasks, whilst the Allocator maintains overall responsibility for the area they are managing. As this involved a change to the status quo a Working Group under the direction of the Project has been formed and will be lead by a manager within EMSC. It should be noted that this Working group has a dependency with the Roster Review Group and the Desk / Boundaries Group. Contact has been made with other Ambulance Trust about benchmarking on service that current us this model.		G	The working group meeting will commence on 3 <sup>rd</sup> April and will look at exploring the fundamental differences between the existing and future operating model. The working group will develop an understanding of the mechanics for both the response coordinator and support coordinator roles. This will ensure that that the practical application of these roles in the future operating model as clearly defined and agreed. Other Ambulance Trusts are well versed in this model and there may be scope to learn from other Trusts.	
Cymru High Acuity Response Unit (CHARU) Workstream	Target of 153 with 101.7 staff in post including 12.69 WTE SP contribution. Vacancy rate at 38.61 FTEs. 11 people are waiting for the next training to be delivered at the beginning of May due a course being postponed due to NHS industrial actions. Following EMS Operational Transformation Programme Board on 02.02.2024 it was agreed that a Closure Report will be brought to the next Programme Board in April 24 and the Task and Finish Group will then transfer to a steering group and be over seen by the Senior Operations Team (SOT).		A	1. Continue to recruitment to target. 2. Completed Closure Report and Present to Programme Board on 29 <sup>th</sup> April 2024.	



# Ambulance Care Programme

Mark Harris

# Programme Summary Q4



Report Month:	Current RAG	Previous RAG					SRO:	Mark Harris
Mar-24	Amber	Amber						
<b>NEPTS Roster Project (MH)</b>								
Implement the new roster pan Wales (NEPTS)						P	• Paused, potential for 2024/5 for funding to support implementation.	
<b>NET Centre Project - AO</b>								
Seek funding for 12 FTEs for planning and day control as per the NEPTS D&C						P	• No funding identified	
Re Roster NET Centre (c/f from 22/23)						R	• Current funding doesn't provide for operating hours or relief. Reviewing operational opening hours. Discussed at DAG, roll forward.	
<b>Urgent Care Transformation – MH</b>								
Complete the UCS demand and capacity review						C		
Review the recommendations from the D&C review						C		
Develop a transformation plan for UCS						A	• Recruitment underway 1st EMT course for ACA2's, transformation into 24/25	
<b>Transfer &amp; Discharge - AC</b>								
Understand commissioning response to proposed high level concept on All Wales T&D Model						A	• Working on final options. Following discussions with commissioners	
Review modelling of transfer demand to determine scope of any business case						G	• Development of model into 24/25 deliverables	
Work collaboratively with NCCU on any business case						NS	• Further engagement opportunity at Vision workshop (NCCU position) April 24	
Develop an implementation plan (subject to commissioning)						NS		
<b>Transport Solutions – KH (Interim pending new Head of Service for Ambulance Care Co-ordination)</b>								
Implement refreshed performance parameters that focus on improving patient and customer experience						C		
Revising and implementing the new eligibility criteria (subject to further dialogue with Commissioners & WG)						A	• Capacity Management Plan approved by EMT on 13/12/2023 – RAG Updated from Red to Amber, roll out Q1 24/25	
<b>NEPTS Plurality Model – AE (Interim)</b>								
Continue to drive forward the Quality Assurance agenda						A	• Present to CQGG 25/03/24, roll out Q1 24/25	
Identify opportunities to expand use of the ambulance car service						C		
<b>CAD – AE (Interim)</b>								
Establish cross Organisational project to consider the requirements of systems to support service delivery for patients						A	• Meetings with Cleric & MIS to understand options, also EMAS	
Completion of BJC for a new CAD system						NS		
<b>NEPTS Operational Improvement</b>								
Review resource downtime (previously referred to as post-production lost hours)						C		
Work with a local hospital to maximise the usage of the discharge lounge, to reduce cancellations.						A	• Capacity in HBs delaying progress, continued engagement.	
Finalise the National Standardised guidance and risk assessments.						C		
Continue to roll out the refresh of the ambulance care fleet mix						G		



# Gateway to Care Programme

Rachel Marsh

# Gateway to Care Programme Summary



Objectives	Milestone Status				Current Position
	Q1	Q2	Q3	Q4	
<b>Deliver a safe and high-quality service, providing an excellent patient experience</b>					
Re-roster call handlers and clinicians	G	G/A	P	P	Paused Pending funding - progress paused - project still very much required
Develop clinically confident and competent workforce	G	G	P	P	Elements of project on hold due to 111 CAS Replacement System
<b>Access to high quality remote clinical assessment</b>					
Identify opportunities to increase consult & close rates from the 999's	G	G	A/R	R	60% of consult and close action plan delivered Will not reach 17% due to multiple issues: 1. Resourcing 2. Telephony reporting (Lack Off) - (Delayed) 3. High triage durations
Develop a clinical specialty educational and career framework for Remote Clinical Decision-making (RCDM)	G	G	A	A	- Awaiting an update on the WAST apprenticeship - Led by People and culture team - Advance Practice Education – 111 & CSD Group established and required to review use of additional skill set, role design advance Practitioner B7, and HR aspect. Next steps currently being mapped out, JDs in draft and review of structures for these new roles in review. - Work still to start on the newly qualified nurse option - 'What does this look like' (Put on hold due to competing on priorities - Likely to be put on hold until May 24)
Develop a remote clinical support strategy	G	G	C	C	Closure report accepted at G2C
<b>Seamless transfer of callers to further specialists or face to face assessment</b>					
Implement 999 Triage system Emergency Communication Nurse System (ECNS)	A	A	A	A	Implementation of text and email functionality in ECNS continues to be pursued with the Supplier (Amber). A range of options have been explored and a potential solution identified. WAST ICT are currently configuring a unique SMS presentation ID (Alpha Sender) and testing will be arranged with the Supplier.
Implement the new 111 system	G	G	G	G	All 3 system components [C3, ECNS and CPSS] are now live in their respective training environments - training courses for all 3 systems are in progress. ICT Systems are being implemented along with additional works including Adastra ITK and Remote Worker.
Develop and expand direct booking and pathway opportunities within CSD and 111	G	G	G	G	Pause on pilot due to some changes to the model - looking to commence Dec/Jan Direct booking into UPCC's trial due to start December in Cardiff - agreement to expand into BCU. January for HD. Agreed UPCC's are more suitable for 111 patients than SDEC. Funding has been agreed to continue 111 press 2, awaiting on Capita to complete model.
<b>Increasing numbers using digital frontend to meet patient's routine and urgent care needs / More people accessing 111 as their preferred port of call to meet their healthcare needs</b>					
Deliver an improved Directory of Services	A	G	P	P	No Current funding continuing conversations with 6 GOALS team.
Improve 111.Wales website, and enable better digital self-service	A	A	P	G	Short term funding has been received to finance: 1. The development of the dental element on the website. 2. Re-engaged the company Evolution to obtain a number of key project specification to secure additional funding as part of a business case
<b>Standardise information architecture and common approach to data and analytics</b>					
Develop a data dashboard for G2C/Power Bi reporting to drive decision making through data and analytics	A	A	A	A	Digital team working through backlog of dashboard requests so an interim solution may be required using reports available through the MIQPR which is currently being developed.





# Clinical Transformation Programme Andy

Andy Swinburn

# Programme Summary



IMTP Objectives	Milestone Status				Position
	Q1	Q2	Q3	Q4	
<b>Optimising Care Group – Advanced Clinical Practice</b>					
Evaluate the APP Navigator and if appropriate look to expand via a spread and scale	A	G	G	G	On track, APP Nav continued development into 24/25 plan
Review the APP dispatch criteria to maximise skillset to patient need	G	G	G	G	PDSA 4 completed, continue into next stages of development 24/25
Develop WAST Principles of Advanced Practice document	G	R	A	A	Implementation Plan agreed for supervision to support, roll over
Evaluate the impact of the Independent Prescribing programme	R	R	R	R	Lack of supervisory support for TAPPs and APPs; roll over
<b>Optimising Care Group – Optimising Conveyance</b>					
Deliver the WAST clinical elements of the 6 Goals	G	A	G	C	Continued engagement but financial constraints impacting and commissioning arrangements, track under 6 goals going forward
Digitalisation of current and future pathways and referrals	R	G	G	G	Ongoing testing, further work with Welsh Portal 24/25
Develop Pre-Dispatch Outcome Risk Stratification Tools linking CAD & ePCR data	R	G	G	C	Now BAU
<b>Clinical Intelligence Assurance Group</b>					
Deliver Clinical Indicator Plan and design a suite of future Clinical Indicators	A	G	G	G	Continued development of future clinical indicators
Develop and deliver the existing Clinical Audit plan	A	G	G	C	Now BAU
Deliver a comprehensive PowerBI Dashboard providing organisational clinical assurance	G	G	G	G	Continued development of dashboards
Improve the integration and linkage of WAST clinical data (ePCR)	G	G	G	G	Further work with DHCW
<b>Older Persons &amp; Falls</b>					
Evaluate Powys Care Home PDSA and consider opportunities for spread and scale	A	G	G	G	SBUHB domiciliary care provider evaluation
Expand the Falls & Frailty Response (inc. Level 1 and 2) across Wales	R	R	G	G	
<b>Mental Health &amp; Dementia</b>					
Pilot use of Mental Health Response Vehicles	G	A	A	G	ABUHB Pilot completed, evaluation to follow and roll over
Write Evaluation Report of the impact of Mental Health Practitioners in Clinical Support Desk	G	G	G	G	Completed; further work on dashboards and ECNS progressing to develop further
Establishing optimal configuration for dementia friendly ambulance environments	G	G	G	G	Evaluation of RITA tablets undertaken, pilots of environments on NEPTS vehicles, further work into next year
<b>Connected Support Cymru</b>					
Collaborate with SJAC to deliver a 20-week community welfare response feasibility project	N/A	A	G	G	20 week complete, evaluation underway
Explore opportunities for further upscaling and investment	N/A	G	Y	Y	Awaiting feedback on business case
Deliver 'testing' phase of the Small Business Research Initiative	N/A	A	Y	G	Contract between SBRI and LUSCII due to end 31 <sup>st</sup> March



# Financial Sustainability Programme

Angie Lewis

# Financial Sustainability Programme



Report Month:	Previous Milestone RAG	Current Milestone RAG	Current Financial RAG	FY23/24 Target	STB Action Required	SRO:	Angie Lewis
March 2024	Amber	Green/Amber	Green Exceeding Financial Forecast	Green Exceeding Financial Forecast	STB to note ELT direction on commercial direction following Report presented to ELT on 22 <sup>nd</sup> March 2024	Workstream Chair:	Navin Kalia / Liz Rogers
						Project Manager:	Gareth Taylor
Objectives	Upcoming Key Milestones			RAG	Current Position		
Achieving Efficiency	Reviews			G	Interviews are underway, following completed discussion packs. Next step is to complete Summary Reports for all 44 Business Areas.		
	Short Term Savings Opportunities			G	Number of schemes proposed, assessed, and delivered in 2023/24, including Leasing Cars, Fuel Savings, and Consumables Waste. Overall savings target met, and revised set of scheme 'themes' determined with £6.4m 2024/25 Financial Plan		
	Long Term Savings Opportunities			G	Larger programmes of work such as RPA to be initiated in 2024/25 following release of funding + recruitment of developers. Programme of work to be led by digital, but reported into the Financial Sustainability Programme. Work on behaviours to be discussed at Leadership Symposium in April 2024.		
	Process Efficiencies			G	Process efficiencies being collated in Year End Review Document. Those delivered and those to be delivered (with timelines)		
Income Generation	Commercial Structures and Long-term Planning – <i>Scope potential dedicated structure for delivery and oversight of commercial opportunities</i>			A	Report completed and presented to ELT Away Day. Workshop conducted and recommendations taken on board. Plan for 2024/25 now underway.		
	Income Generation Schemes – <i>Identify, scope, determine viability of ideas and schemes for delivery</i>			A	Continued scoping of potential additional income schemes. New scheme submission and communications plan to be implemented in 2024/25		
	Commercial and Financial Mindsets – <i>Identify, assess, and deliver opportunities for commercial and financial training and Development:</i>			A	This work will continue into 2024/25 alongside the commercial structures and long-term planning, as a workstream		
Additional Progress					Forward View		
<ul style="list-style-type: none"> <li>Last reporting period has seen substantial work on the commercial strategy. Report completed and presented to ELT Away Day. ELT content with outputs of report and acknowledgement that work to be undertaken over next reporting year. Workshop conducted and recommendations taken on board. Project Planning for 2024/25 now underway.</li> <li>2024/25 Financial Plan considers an addition £6.4m savings plan and increase of approximately £400k on the last financial year.</li> <li>A 2023/24 Gateway Review Session undertaken in March 2024 and to be presented following Year End. Queries regarding ongoing purpose and direction of FSP considered alongside lessons learnt from 2023/24. Agreed focus across Income Generation will be on the commercial structures following direction from ELT</li> </ul>					<ul style="list-style-type: none"> <li>In February's STB, the Financial Sustainability Programme expected to deliver the following by next STB,                             <ul style="list-style-type: none"> <li>A finalised Financial Sustainability Delivery Framework – completed following comment.</li> <li>A finalised review of current structures – Gateway Review session undertaken and report being drafted for review in May</li> <li>A finalised Financial Scheme Tracker for FY 2024/25 - completed</li> <li>A finalised review of commercial opportunities – completed and presented to ELT</li> </ul> </li> </ul>		





# IMTP Enablers & Fundamentals

- [People & Culture](#) – Angie Lewis
- [Digital](#) – Leanne Smith
- [Fundamentals](#) – Trish Mills and Liam Williams

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



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# People & Culture



<b>Report Month:</b>	<b>STB Action Required</b>	<b>Executive Lead:</b>	Angie Lewis
<b>April 2024</b>	N.B. The People & Culture portfolio is monitored through a local Directorate Plan, with actions aligned to IMTP Objectives. The Directorate Plan has been reviewed and updates provided by exception.	<b>Business Partner:</b>	Sarah Davies

Objectives	Q1	Q2	Q3	Q4	Current Position
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**Culture** – *Create an environment where colleagues have autonomy in their work, feel a sense of belonging, and are confident to make decisions, put forward ideas and raise concerns*

Develop and articulate our target culture	G	G/A	A	A	CSD - Phase 1 of cultural review underway. Team culture survey completed, 121s with management team completed. Further stakeholder meetings are scheduled in April 24. EMSC- Team culture survey completed in March 24. Currently in process of scheduling follow-up site visits/ focus groups between Director of P&C and teams. HART programme start postponed to April 24.
Sustain our focus on improving wellbeing	G	G	G	G	On track and on target overall.
Increase levels of psychological safety	G	G	G	G	On track and on target
Improve disciplinary and resolution processes	G	G	G	G	On Track and on target
Refresh TU partnership working arrangements	A	A	A	A	Senior partnership session delivered and good feedback. LPF level sessions in coming weeks. Output of the sessions will be reviewed for next steps. Creating a list of activities for TUPs for shadowing requirements and will review with TUPs.
Amplify employee voices	G	G	G	G	On track and on target

**Capacity** – *Ensure we have the right people in the right roles, at the right time, with the right skills, to enable WAST to realise its ambitious service redesign plans*

Develop our employee offer	G	G	G	G	On track and on target
Improve organisational onboarding processes	NS	NS	G	G	On Track and on target regarding developing onboarding process.
Improve people related policies and processes	G	G	G	G	On Track and on target
Develop Strategic Workforce Plan	G	G	G	G	On Track and on target
Deliver Managing Attendance Programme	G	G	G	G	On Track. Further work to be undertaken via Deep Dive and streamlining.

**Capability** – *Ensure our people are suitably skilled and qualified, can work at the highest level of their scope of practise and are comfortable to make decisions within their control.*

Build on our learning and development offer	G	G	G	G	On Track and on target
Promote personal responsibility	G	G/A	A	A	On track overall, however there is a <b>Red</b> status against increasing Apprenticeship provision, due to inability to draw down previously secured funding (income), the financial implications of which have been highlighted.
Improve talent management approach	NS	NS	N/S	N/S	Not yet started
Enhance change capacity and expertise	G	G	G	G	On Track and on target
Respond to legislative changes	G	G	G	G	On Track and on target



# People & Culture - Commitments

<b>Report Month:</b>	<b>STB Action Required</b>	<b>Executive Lead:</b>	Angie Lewis
<b>March 2024</b>	None	<b>Business Partner:</b>	Sarah Davies

Commitments	Q1	Q2	Q3	Q4	Current Position
<b>Digital Experiences</b>					
<ul style="list-style-type: none"> <li>EqIA: making this more digitally accessible</li> <li>Digital Literacy Skills: development of accredited and non-accredited education programmes</li> <li>Implementation of LMS365</li> <li>Expansion of Learning Launchpad content</li> </ul>	G	G	G	G	On track and on target
<b>Shift Overruns</b>					
ED Holding Survey completed and results to be presented to STB 26 <sup>th</sup> February 2024	A	A	A	A	
<b>Flexible Working</b>					
<ul style="list-style-type: none"> <li>Review current policy</li> <li>Establish a clear understanding of current processes and impacts of flexible working arrangements across frontline services</li> <li>Review current research for frontline flexible working across NHS&amp; Emergency services</li> <li>Engage with wider Ambulance Sector to understand flexible working practices across UK</li> <li>Develop coaching / process material</li> <li>Explore ESR functionality for requesting and recording agreed / declined flexible working requests</li> <li>Engage with WAST colleagues to understand perceptions views on flexible working options and evaluate after changes are implemented</li> <li>Continue to establish a pathway of support for Carers within the organisation</li> </ul>	G	G	G	G	On track and on target



Report Month:	STB Action Required		
March 2024	N.B. Digital (including HI) is a critical enabler for many FY23/24 IMTP actions and is reported through relevant programme boards. An update has been provided against the digitally-led IMTP objectives.		<b>Executive Lead:</b> Jonny Sammut
			<b>Business Partner:</b> Rhonwen Jones
Objectives	Upcoming Key Milestones	RAG	Current Position
<b>National Data Resource Programme</b>	<b>National Data Resource (NDR) Programme Support:</b> <ol style="list-style-type: none"> <li>Confirm FY23/24 funding to progress longer-term NDR activities</li> </ol>	G/A	<p><b>AT RISK: Funding and Resource as longer-term funding has not been agreed</b></p> <p><b>IG</b> -an overarching Joint Controllership Agreement drafted by DHCW to cover sharing of data from Health Boards and Trusts into the NDR. This is draft version, undergoing review by both WAST and DHCW IG. Once agreed, this is expected to form the basis for all data flows into the NDR with legitimate purpose and lawful basis, offering efficiency to subsequent sharing endeavours. Once this approach is confirmed, the IG for the OHCA project will be finalised. <b>NDR data feeds:</b> initial use case continues to focus on the OHCA dataset. A proof of concept of the data pipelines completed and tested with dummy data, with a small amount of work remaining to productionise the flow from WAST to DHCW's NDR once the IG is agreed. Following transfer to the NDR, the dataset will be supplemented with Health Board data by DHCW before onward sharing with the Welsh Cardiac Network and the University of Warwick for the national registry. <b>Cloud Migration:</b> work has slipped slightly, picked back up in May following the conclusion of the "pause &amp; improve" period currently happening across the wider Health Informatics team. <b>Funding:</b> still remains a risk as the total investment for NDR in 2024/25 will be lower than originally anticipated and agreement is yet to be reached on Trust and Health Board allocations from DHCW. This puts at risk the funding for two members of the Health Informatics data engineering team</p>
<b>Operations Communications Programme</b>	<b>Mobile Data Vehicle Solution (MDVS):</b> <ol style="list-style-type: none"> <li>Integration CRS/MDVS</li> <li>Testing due to complete/pending outcome.</li> <li>Finalise application testing and pilot for NEPTS fleet</li> <li>Commence Mass Deployment</li> </ol>	G	Deployment of the MDVS solution into the EMS fleet is nearing completion with c470 vehicles installed and operating on the new technology. The NEPTS Live Pilot has been expended to 12 vehicles, though some road map developments are required the MDVS project is seeking to exit pilot testing and move to deployment from April 15th, assuming a positive decision at Project Board. Though some delays have occurred as a result of NEPTS application development the project remains on track to conclude installations by Q2 2024.
<b>999 Platform Upgrade</b>	<b>Upgrade 999 Telephony Platform:</b> <ol style="list-style-type: none"> <li>Supplier readiness (level of confidence) to test 999 platform solution during Q2</li> <li>Q2 - testing Jul/Aug 999 platform solution</li> </ol>	A	Still waiting on new version of call pilot plus implementing a solution to call playback. Likely to be mid – late May.
<b>Digital Experience of our Staff</b>	<b>Digital Single Sign on</b> <ol style="list-style-type: none"> <li>Nadex Integration</li> </ol> <b>User Experience Assessment</b> <ol style="list-style-type: none"> <li>Supplier Microsoft (Android)</li> <li>Supplier Apple (iPAD)</li> </ol>	A	<b>AT RISK:</b> Meetings due to be arranged. Ongoing work on hold due to CAS replacement taking priority on resources, impacting capacity.

# Fundamentals



Report Month:	STB Action Required				
March 2024	N.B. These portfolios are monitored through local Directorate Plans, with actions aligned to IMTP Objectives. Directorate Plans have been reviewed and updates provided by exception				<b>Executive Lead(s):</b> Trish Mills/Liam Williams
					<b>Business Partner(s):</b> Deborah Kingsbury/Rhonwen Jones
Objectives	Milestone Status				Position
	Q1	Q2	Q3	Q4	
<b>Risk Management</b>					
Develop and deliver a risk management framework including policy and procedures	G	G	G	G	Policy submitted to, and approved by, Audit Committee in March 2024. Following this the framework was endorsed by Trust Board
Transition to a strategic BAF reflecting strategic objectives and risks	NS	NS	NS	A	Consultant appointed and work progressing during Q4 in relation to advice on best practice and knowledge share.
Develop and deliver programme of training and education for the Trust	NS	NS	NS	R	Work due to commence Q3/Q4 - rolled over into 2024/25 IMTP
Deliver Board education on risk management	NS	NS	NS	R	Work due to commence Q3/Q4 - rolled over into 2024/25 IMTP
<b>Welsh Language</b>					
Centralised translation service	G	G	G	G	Translation service is operational. Comms to further promote the service to be issued during May 2024. Work progressing in setting up translation service support with NWSSP via MOU to deal with overflow and for use of their translation memory software which will make the translation service more efficient.
More than just words 2022-27 action plan	G	G	G	G	The WAST Strategic Workforce Plan has successfully outlined actions for implementation within the Welsh language theme. With board approval anticipated in May 2024, we will proceed to develop an implementation plan dedicated to executing these actions effectively.
Welsh Language Policy	A	G/A	G/A	G/A	Policy in draft – this policy will focus on the positive steps the Trust can take to develop our use of Cymraeg - approval due 2024.
Delivery of the Welsh Language Standards	G	G	G	G	Annual Report completed and approved at Trust Board on 28/09/23. Development of a Welsh Language Standards Compliance dashboard.



# Fundamentals

Report Month:	STB Action Required					
March 2024	N.B. These portfolios are monitored through local Directorate Plans, with actions aligned to IMTP Objectives. Directorate Plans have been reviewed and updates provided by exception	<table border="1"> <tr> <td><b>Executive Lead(s):</b></td> <td>Liam Williams</td> </tr> <tr> <td><b>Business Partner(s):</b></td> <td>Rhonwen Jones</td> </tr> </table>	<b>Executive Lead(s):</b>	Liam Williams	<b>Business Partner(s):</b>	Rhonwen Jones
<b>Executive Lead(s):</b>	Liam Williams					
<b>Business Partner(s):</b>	Rhonwen Jones					

Objectives	Milestone Status				Position
	Q1	Q2	Q3	Q4	
<b>Quality, Safety, &amp; Patient Experience</b>					
Working Safely Plan	G	C	N/A	N/A	Programme now Closed. Closure Report to be shared with members. Confirming reporting arrangements with Estates / Fleet. SQT (Senior Quality Team meeting has it on work program).
Quality Management System (QMS) Implementation	A	A	A	G	<p>Quality Management Group regular meetings being held and attended for each service area. QPMF Self-Assessment pilots were not completed as expected, updated self-assessment now received from resource team but EMSC still outstanding due to winter pressures followed by organisational change processes..</p> <p>ISO9001 clause analysis cross reference with QPMF and DoQ QMS quadrants – draft local template referred to QPMF steering group for decision on progression.</p> <p>Current publicly available metrics aligned to H&amp;C Quality standards and referred to QPMF Steering group</p> <p>DoQ E-learning launched and Siren sharepoint pages updated – completion rates will now be monitored via QMG</p> <p>Developing training packages for supervisory/leadership roles.</p> <p>Phase 2 of MIQPR always on reporting expected to launch April 15<sup>th</sup> 2024</p> <p>Annual report currently being drafted.</p> <p>Decision pending from QPMF steering group on frequency of externally facing Always On reporting which will launch after 1<sup>st</sup> annual quality report.</p> <p>Board training day for DoQ and DoC now scheduled for June 2024</p> <p>CEO roadshow will include stand for DoQ to further communicate responsibilities to wider team.</p>



# Infrastructure (by exception)

Chris Turley



<b>AGENDA ITEM No</b>	<b>7</b>
<b>OPEN or CLOSED</b>	<b>Open</b>
<b>No of ANNEXES ATTACHED</b>	<b>1</b>

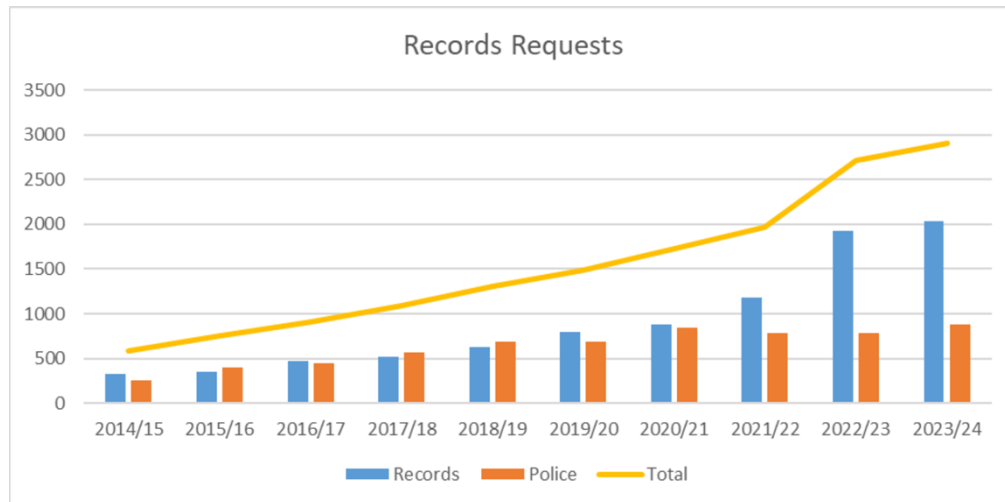
**DIGITAL REPORTING**

<b>MEETING</b>	Finance & Performance Committee
<b>DATE</b>	14 May 2024
<b>EXECUTIVE</b>	Jonny Sammut, Director of Digital Services
<b>AUTHOR</b>	Leanne Smith, Assistant Director of Digital
<b>CONTACT</b>	<a href="mailto:leanne.smith4@wales.nhs.uk">leanne.smith4@wales.nhs.uk</a>

**EXECUTIVE SUMMARY**

1. This report brings to the committee Digital Key Performance Indicators (KPIs) relating to Data & Analytics, ICT Systems, Digital services, projects & programmes, and progress against the IMTP items with Digital involvement.
2. The data in this report refers to the period of 1<sup>st</sup> April 2023 to 31<sup>st</sup> March 2024 unless otherwise indicated. April 2024 is not included here due to the timing of this paper meaning the complete month of data was not available. By the July 2024 meeting of the Finance & Performance Committee, all data for Q1 2024/25 should be available and we will begin to be able to begin monitoring seasonal trends / annual changes.
3. Key points of note from this report include:
  - a. In March, the average turnaround for non-trivial data requests spiked at 37 days. This is because the **Data & Analytics** team have operated with a "pause" on all new requests for the past 6 weeks, focusing on the 111 CAS replacement programme along with a small list of other key priorities. In parallel they have conducted a rapid cycle of improvement as part of a radical tactic to address the challenges the team face around mismatched demand and capacity. A summary of the outcomes of this tactic will be circulated to ELT in the coming weeks showcasing a number of improvements made to the function's efficiency (e.g. streamlined processes), productivity (e.g. clearer priorities and an enhanced request process to empower the team to prioritise requests locally) and collaboration (transparency of our work list – a new tracker is available on Siren for all requesters to view progress of their request). The team now will resume with Business as Usual, positioned ready to support the 2024-27 IMTP.

- b. **Records Requests** continue to be received at a sustained high level and in Q4 of 2023/24 were increased even on levels from earlier in the year. Total annual requests for records, including Subject Access Requests, coroner and Police requests (but not including internal requests for ePCRs) is currently 45% on 2021/22 levels and more than 12% on 2022/23 levels:



- c. For our ICT **System Availability Metrics** March data has not been included as this is currently a manual metric calculation process, and there is limited capacity within the team to collate this intel due to focus on the 111 CAS replacement project and go-live. The full year of data will be available by the next meeting, with a reflection on trends and a more efficient way of continued monitoring.

4. In terms of Digital's contribution to initiatives enabling the 2023/24 IMTP:

- a. The **111 CAS Replacement** initiative been supported by many members of Digital, across ICT and Data & Analytics and IG. Go-live went ahead on 30<sup>th</sup> April 2024 as planned.
- b. The **Data Linkage** project continues to progress, with the RAG changing from Amber to Green since the last reporting period. The Out-of-Hospital Cardiac Arrest dataset - which will be consumed via the National Data Resource (NDR) analytics platform and shared with the NHS Wales Executive / Cardiac Network and national registry – has successfully been tested with new pipelines. DHCW and WAST are collaborating on a Joint Controller Agreement to address the Information Governance Requirements and enable flow of the live data.

- c. Focus has returned to the **111 Website** following some funding support. A rapid vision & strategy development project is currently underway (with cross-directorate leadership), helping collate views from across the Trust and stakeholders, commissioners and service users on the purpose and vision of the website. The delivery team will produce a strategy report in the next month to support WAST's development of a longer-term business case for this online service.
  - d. The **Q&PMF reporting** project moved from ~75% to 100% complete since the last reporting period, following the successful delivery of v1 of the Monthly Integrated Quality Performance Report (MIQPR). This concludes the commitment for 2023/24, but further efforts to support development of MIQPR v2+ and the Q&PMF more broadly will be captured under the 2024/25 IMTP.
  - e. Although the **Digital Experience** and **Digital Champions** initiatives have not officially progressed at pace this year, there have been many supporting activities, such as automation of processes, engagement with colleagues (clinical and operational) and existing suppliers (e.g. Microsoft and Apple) to improve workplace experience for our people. These projects do feature in the proposed Digital Plan and more deliberate efforts will be made in the coming years in support of the People & Culture plan.
5. The spotlight for this reporting period focuses on the Mobile Data Vehicle Solution (MDVS) Installation Project:
- a. The installation of the MDVS solution across the **EMS fleet** is all but concluded, with a small number of outstanding vehicles – such as new fleet being introduced in 2024) and those currently off the road due to vehicle faults. Plans are in place to capture these before concluding installation activities and project wrap-up.
  - b. **NEPTS** installs have begun with 30 vehicles being installed per week, with a target for completion by the end of June 2024.
  - c. **Training** compliance is tracking lower than expected for this point in the plan, with Operational Management Teams asked to engage staff and promote the need to complete training.
  - d. The latest **dashboard** can be found on Siren at the following link which is refreshed weekly:  
<https://nhswales365.sharepoint.com/sites/AMB-Intranet-Digital-Services/SitePages/Mobile-Data-Vehicle-Solution.aspx>

**RECOMMENDATION: The COMMITTEE are asked to NOTE the contents of the accompanying report and the trends in metrics presented.**

### KEY ISSUES/IMPLICATIONS

6. The pace of the 111 CAS replacement project has meant adjustment to the 2023/24 Digital Plans, and further development of the system over the course of Q1-Q2 2024/25 will require ongoing Digital support which will impact team availability.

### REPORT APPROVAL ROUTE

Digital Leadership Group – w/c 29<sup>th</sup> April 2024

### REPORT APPENDICES

Main report – 'Digital Reporting May 24\_Open FPC'

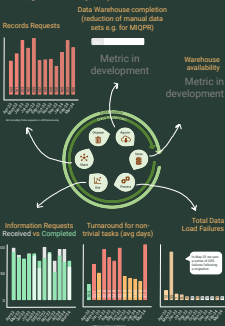
### REPORT CHECKLIST

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

## Digital: Data & Analytics

### Data Lifecycle

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



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

## Digital: ICT Systems

### System availability metrics

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

Definitions based on industry standards  
 ~12.22 mins downtime ~193 99%  
 ~4.22 and ~0.2.8 mins ~199 99%  
 ~0.2.8 mins downtime ~199 9%

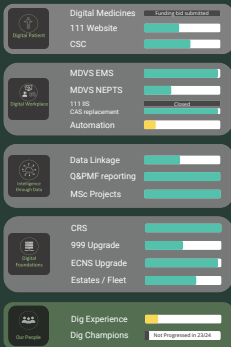


## Digital: Service Provision

Quality, efficiency, and stakeholder feedback: MAR 24



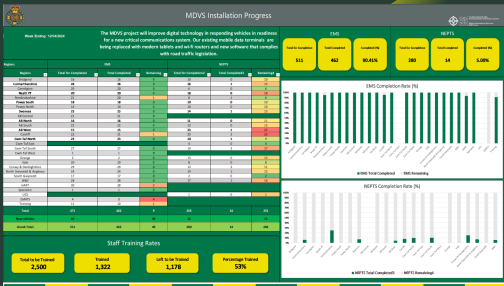
## Digital Contribution 23/24



See IMTP trackers (STE) for action & milestone based progress. RAG and progress based on LDP. Last updated 5th March 2024 by DLG

## Digital: Spotlight

Mobile Data Vehicle Solution (MDVS) Installation Project





<b>AGENDA ITEM No</b>	<b>8</b>
<b>OPEN or CLOSED</b>	<b>Open</b>
<b>No of ANNEXES ATTACHED</b>	<b>5</b>

**DIGITAL PLAN REFRESH 2024-2029**

<b>MEETING</b>	Finance & Performance Committee
<b>DATE</b>	14 <sup>th</sup> May 2024
<b>EXECUTIVE</b>	Jonny Sammut, Director of Digital Services
<b>AUTHOR</b>	Jonny Sammut, Director of Digital Services Leanne Smith, Assistant Director of Digital Services: Data & Analytics Aled Williams, Assistant Director of Digital Services: ICT Keith Williams, Head of OCP Jon Hopkins, Head of Informatics Jon Whitehead, Systems Implementation Manager
<b>CONTACT</b>	<a href="mailto:Jonny.sammut@wales.nhs.uk">Jonny.sammut@wales.nhs.uk</a>

**EXECUTIVE SUMMARY**

1. This report brings to the Finance & Performance Committee, a refreshed long term Digital Plan for WAST.
2. The Digital Directorate comprises of 72.4 WTE over 3 core operations, each with a range of specialist technical and non-technical functions within them.
3. A review of existing WTE and our current demand was conducted and based on the current trajectory, the function would have remained at a 'standstill' without further intervention. The review revealed that we have an approximate 'Business-As-Usual' resource shortfall of 9.0 WTE.
4. Global industry benchmarks suggest that investment in digital transformation range from a modest 3% to a more aggressive 10% of their total revenue (across all sectors). The revenue (pay) allocation for the Digital directorate at WAST last financial year was; £3,529,759, which represents a total of 1.2% of WASTs total revenue (C£290m).
5. The refresh of our digital plan aims to align with the Integrated Medium-Term Plan, Welsh Government directives, and NHS Wales' urgent care strategy, focusing on regulatory compliance, enhancing patient outcomes, and optimising resources. This strategic evolution underscores our commitment to innovation and excellence, ensuring our digital infrastructure not only meets current healthcare needs but is agile enough to embrace future technological



advancements, thereby improving health outcomes for the communities we serve.

6. Adopting the VMOST (Vision, Mission, Objectives, Strategies, Tactics) framework, our refreshed Digital plan ensures strategic alignment across all levels, setting a clear Vision as the guiding star for digital transformation, aimed at empowering our ambulance service with innovative technology for improved healthcare standards. This approach, supported by five key pillars—Everyday Essentials, Security, Safety & Cyber, Digital Pioneers, Transformation, and Data, Information, and Insight—provides a comprehensive and balanced strategy to drive operational excellence, security, innovation, and data-driven decision-making.
7. Over the past six months, the Digital Directorate engaged with the organisation to identify the true digital service needs, resulting in a comprehensive list of 77+ projects aligned under four mission statements—Technology, Overcoming Challenges, Operating Model, and People—geared towards improving care, fostering a digital-savvy workforce, and enhancing operational efficiency. A structured prioritisation mechanism aligns these projects with strategic health frameworks and objectives, ensuring each initiative contributes effectively to Wales' healthcare goals and optimises investment, with detailed project tranches available in appendices for reference.
8. To refresh our digital plan, we have adopted a 'Digital Tranches' approach, enabling precise resource allocation and strategic investment sequencing, enhancing project tracking and ROI, and ensuring alignment with our objectives for a nimble, impactful digital evolution over the next 5-10 years, detailed in Appendices D and E.
9. Two new functional areas are to be deployed; the Digital Transformation function and Chief Clinical Information Officer (CCIO) role, both which are pivotal in WAST, driving innovation and operational efficiency through strategic digital technology use, while ensuring clinical needs and patient care are at the forefront of health IT initiatives.
10. Four options were proposed using the 'Digital Tranches' for sequential implementation to the executive leadership team, with 'Option 2' selected as a preferred option for balancing operational integrity and digital growth, entailing an investment in foundational enhancements and innovative projects.



11. A summary of the cost options presented to the executive leadership team can be seen in the following grid:

Option	Revenue £000s	Capital £000s
Option #1	409	0
Option #2	1,376	196
Option #3	2,416	1,121
Option #4	0	0

12. Failure to invest in the refresh of the WAST digital plan would lead to inadequate digital capabilities, increased cybersecurity vulnerabilities, operational inefficiencies, missed synergies with NHS Wales' objectives, insufficient workforce development, non-compliance with the IMTP, innovation stagnation, resource misallocation, diminished patient experience, cost inefficiencies, inadequate response to demographic shifts, and loss of talent.

13. In shaping our digital plan refresh, we prioritised a comprehensive, forward-looking approach aligned with our commitment to serving the people of Wales, enhancing digital inclusivity, pursuing environmental sustainability, fulfilling our socio-economic duties, and adhering to data and AI ethics. These foundational considerations are directly mapped to our strategic initiatives.

14. In our digital plan refresh, establishing new Key Performance Indicators (KPIs) tailored to strategic pillars and mission statements is essential for efficiently monitoring progress, enabling precise measurement of our digital transformation's success, these will be developed and deployed in due course.

**15. The Finance & Performance committee are asked to:**

- a. Approve the digital pillars outlined in the 'digital vision and pillars' section, as a framework for this plan.**
- b. Acknowledge the investment option selected by the executive leadership team and the digital tranche's recommendation provided in the 'recommendation' section.**
- c. Acknowledge the additional investment amount to the digital services budget for 2024/25 financial year.**
- d. Agree a commitment to actively engage in discussions about horizon initiatives and the 'art of the possible'.**
- e. Support the Digital Plan for onward review at Trust Board**



### KEY ISSUES/IMPLICATIONS

16. Failure to invest in and refresh the WAST digital plan presents 12 identified risks, including inadequate digital capabilities, increased cybersecurity vulnerabilities, operational inefficiencies, and potential non-compliance with IMTP, which collectively threaten to undermine patient care, staff workflows, and the Trust's ability to meet future healthcare demands.

17. Investment Secured ~ £1.376m (Revenue) & £196k (Capital)

### REPORT APPROVAL ROUTE

- Digital Leadership Group – 19<sup>th</sup> April 2024
- Executive Leadership Team – 8<sup>th</sup> May 2024
- Finance & Performance committee – 14<sup>th</sup> May 2024
- (Planned) – Trust Board – 30<sup>th</sup> May 2024

### REPORT APPENDICES

Appendix A – Digital Directorate Overview (in report)  
Appendix B – WTE Overview (in report)  
Appendix C - Digital Structure Diagrams (in report)  
Appendix D - Digital Projects – Summary (in report)  
Appendix E - Digital Tranches Tables (in 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)	Y	Financial Implications	Y
Environmental/Sustainability	Y	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	Y
Health Improvement	NA	Socio Economic Duty	Y
Health and Safety	NA	TU Partner Consultation	NA



## INTRODUCTION

1. The digital landscape within the healthcare sector has undergone rapid evolution over the past few years, driven by technological advancements, shifting patient expectations, and the increasing necessity for efficient healthcare delivery. The Welsh Ambulance Services NHS Trust (WAST), as a critical tranche of Wales' healthcare infrastructure, has made significant strides in embracing digital technologies to enhance service delivery, patient experience and operational efficiency. However, the fast-paced nature of digital innovation and the evolving challenges in healthcare necessitate a proactive and strategic refresh of our digital plan.
2. The current digital strategy, while having served us well, requires a comprehensive review and update to ensure that the Trust continues to provide exceptional patient care, meets the rising demand for healthcare services, and addresses the complexities of the healthcare environment in Wales. This proposal aims to outline the need for a digital plan refresh, focusing on enhancing digital patient experiences, improving patient safety, reducing harm, leveraging data analytics for improved service planning and delivery, and ensuring robust cybersecurity measures to protect patient data and Trust operations.
3. In doing so, we align with the Welsh Government's 'A Healthier Wales: Our Plan for Health and Social Care, (2018)' which emphasises the importance of a transformative approach to healthcare, prioritising prevention, early intervention, and the integration of services. Refreshing our digital plan will not only enable us to meet these strategic objectives but also position the Welsh Ambulance Services NHS Trust as a leader in digital healthcare innovation.
4. This proposal will detail the rationale behind the digital plan refresh, its objectives, key tranches, implementation roadmap, financial/tranche options, and the anticipated benefits to our people, patients and partners and the broader healthcare system in Wales.
5. Often when we think of 'Digital', we think of outputs, such as tools, hardware, software, but when we instead position digital as the opposite of analogue, and see it as an *experience*, we see what value investment in Digital could bring. 'Digital' is the organisation of knowledge, it is automation, it connects systems, intelligence and people, and can open up (and speed up) pathways and make recommendations.



6. In WAST, the Digital Directorate comprises of 3 core operations, each with a range of specialist technical and non-technical functions within them. A detailed list of these can be seen in **Appendix A**.
7. Understanding the current setup of the digital directorate and their workload allocation is crucial for several reasons:
  - a. Firstly, it provides us with a clear picture of our digital capabilities, identifying strengths and areas for improvement. This insight is fundamental to ensuring our digital plan refresh aligns with our operational realities and leverages our current strengths while addressing gaps.
  - b. Secondly, knowledge of the current workload allocation helps us identify potential for efficiency gains, opportunities for reallocating resources to higher priority areas, and areas where investment in additional resources or technologies may be required. This understanding ensures that our digital plan refresh is both realistic and achievable, setting a solid foundation for the successful implementation of new digital initiatives aimed at enhancing service delivery and operational efficiency within the Welsh Ambulance Services NHS Trust.
  - c. Since the launch of our digital strategy in 2020, we have made significant strides in transforming our organisation's digital landscape. This journey has seen the successful implementation of several key initiatives aimed at enhancing operational efficiency, improving digital engagement, and fostering a culture of innovation. These accomplishments mark important milestones in our ongoing commitment to digital excellence. However, it is clear that our ambitions stretch far beyond what we have achieved so far. The digital world is rapidly evolving, with new technologies, user expectations, and competitive pressures emerging at an unprecedented pace. This realisation serves as a crucial backdrop for our discussion on the necessity of refreshing our digital plan. It is essential to acknowledge that while we have made progress, we have not fully realised our digital aspirations.
8. The Digital directorate is comprised of **72.4 WTE**. This is the establishment position which will include existing vacancies. A full breakdown of these roles can be seen in **Appendix B** and a view of the current Digital structure can be seen in **Appendix C**.
9. A review of existing WTE and our current demand has been conducted and based on the current trajectory, means that the function will remain at a 'standstill' in terms of addressing demand and leaves WAST open to significant risks.



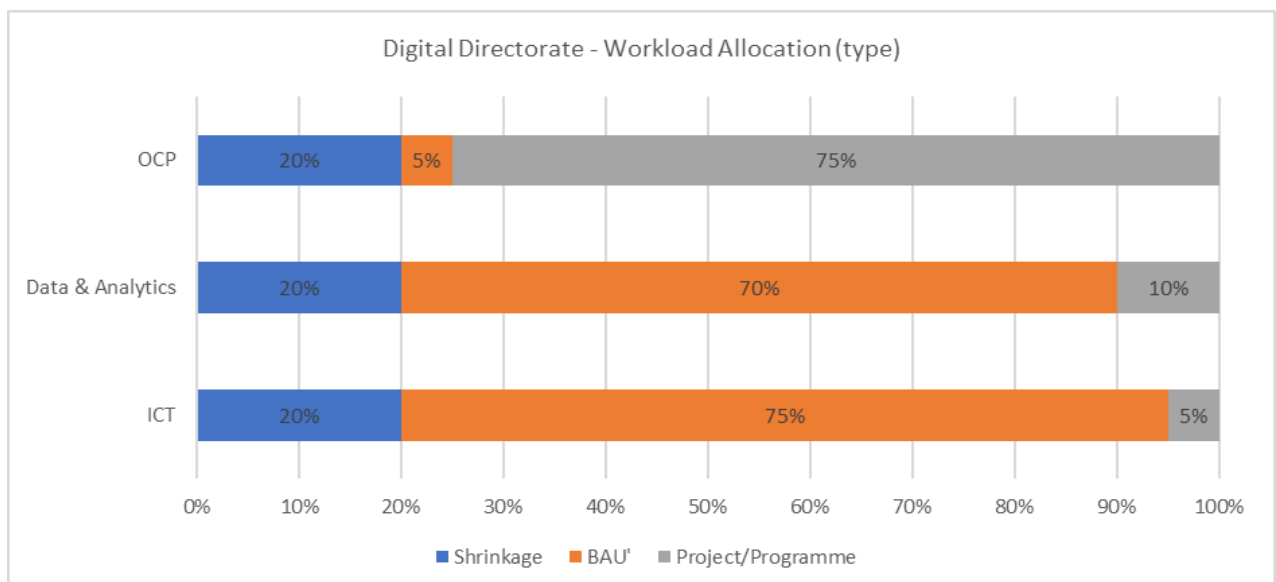
10. This review revealed that we have an approximate shortfall of **9.0 WTE** which are required to provide the current 'base' level of digital services to the organisation. The gaps in 'Business-As-Usual (BAU)' service provision are across these functional areas:

- a. Cyber Security
- b. Data Quality
- c. Records Management
- d. Information Governance
- e. Business Intelligence (Informatics)

11. It is important to note that the digital directorate holds a range of crucial legal and regulatory responsibilities, ensuring compliance with regulations such as data protection laws like GDPR and the Data Protection Act, alongside managing information governance effectively. It is tasked with securing personal and sensitive data against unauthorised access and breaches, while maintaining data integrity and cyber security. This function is vital for safeguarding privacy, preventing legal repercussions, and protecting the organisation's reputation at the patients we serve.

12. As we start to outline the new digital plan and the opportunities that this brings, it is important that we understand that we have gaps in our current baseline provision. Any recommendation that outlines growth in our capabilities must and will include a recommendation to address these gaps too.

13. As the Digital directorate has a range of operations and functional areas, it's important to note the current workload allocation type split, which is based on a manual review of workload demand. This outlines that across the Digital directorate, only 4.2 WTE are available for project work that sits outside of the ringfenced OCP programme resource.



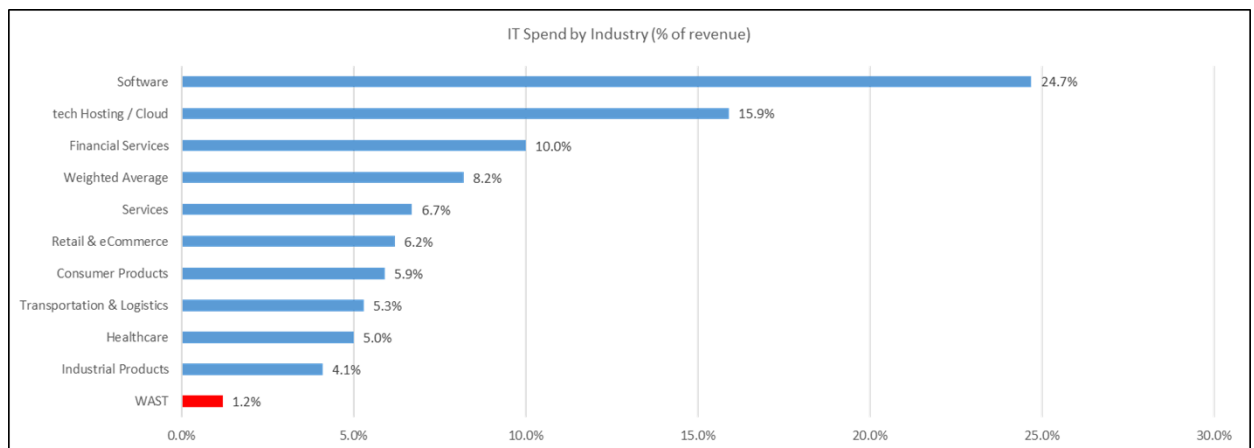


GIG  
CYMRU  
NHS  
WALES

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

## DIGITAL INVESTMENT BENCHMARKING

- The market standard for the percentage of overall revenue that an organisation should spend on their digital healthcare function varies widely and is influenced by numerous factors, including the size of the organisation, its strategic priorities, and the specific healthcare segments it operates within. Global industry benchmarks suggest that healthcare organisations are increasingly investing in digital transformation, with expenditures ranging from a modest 3% to a more aggressive 10% of their total revenue.
- The revenue (pay) allocation for the Digital directorate at WAST this financial year was; £3,529,759, which represents a total of **1.2%** of WASTS total revenue (C£290m).
- Looking at a report produced by Flexera in 2020 which was centred on the state of technology spend across various markets, when introducing WAST into this it's clear to see that we fall some way behind in terms of our investment into digital services.



## RATIONALE FOR A DIGITAL PLAN REFRESH

- The current WAST Digital Strategy was set in 2020, focusing on empowering digital patients, building a digital workplace, leveraging intelligence through data, and establishing strong digital foundations. These aims were designed to enhance patient care, improve operational efficiency, and ensure data-driven decision-making, all underpinned by a commitment to cybersecurity, data protection, and sustainable technological advancement.
- As we refresh our digital plan, it is paramount to recognise the imperative need to align our initiatives with the Integrated Medium-Term Plan (IMTP), the Welsh Government's directives for the ambulance service, and NHS Wales' direction for urgent and emergency care. This strategic realignment is not merely a response to evolving external mandates but a proactive step towards



ensuring that our digital infrastructure and services are at the forefront of healthcare innovation, efficiency, and patient care. The rationale for this refresh centres around three pivotal themes: compliance with regulatory and strategic frameworks, enhancement of patient outcomes, and the optimisation of resources.

19. **Compliance with regulatory & strategic frameworks:** alignment with Welsh Government and UK Government strategic direction and regulatory requirements for information and cyber security, as well as privacy and accessibility, ensures our digital initiatives maintain the trust and confidence we have come to earn from the public and our service users. In a changing regulatory landscape, which needs to consider advancements in AI and medical devices, it is critical that the theme of compliance is included by design in our digital efforts.
20. **Enhancement of Patient Outcomes and Patient Safety:** The Welsh Government's strategic direction for the ambulance service underscores the importance of digital transformation in enhancing responsiveness, reducing wait times. The NHS Wales' strategy for urgent & emergency care is therefore pivoting to a more integrated and digital-first approach, including digital platforms to facilitate patient access and employing predictive analytics to manage patient flows. Additionally, the Integrated Medium-Term Plans (IMTP) outline a clear roadmap for healthcare services, emphasising the need for digital technologies to support clinical decision making and facilitate a seamless patient experience. Refreshing our digital plan ensures our technological advancements are in harmony with the IMTP and positions us to effectively respond to future healthcare challenges and opportunities. This refresh of our Digital Plan will bolster patient safety by integrating advanced technologies that enhance real-time decision-making, ensure faster and more accurate emergency responses, and facilitate seamless communication between on-scene paramedics and hospital staff, ensuring patients receive the most appropriate care as swiftly as possible.
21. **Optimisation of Resources:** This alignment with the IMTP and NHS Wales' and Welsh Government's direction also allows for enhanced interconnectivity between primary, secondary and tertiary care services. Our aim is to utilise real-time data analytics, telehealth solutions, and mobile applications to increase patient access, reduce bottlenecks, improve triage and deliver a more coordinated and informed care experience. This approach will not only streamline operations, but improve efficiency and effectiveness of the ambulance services.



22. **The rationale for refreshing our digital plan is clear:** to align with the strategic visions laid out by the IMTP, the Welsh Government, and NHS Wales. By doing so, we aim to enhance the quality, efficiency, and delivery of healthcare services, ensuring that our digital infrastructure not only meets the current needs of our patients and staff but is also poised to adapt to future advancements in healthcare technology. This strategic refresh is a commitment to innovation, excellence, and the continual improvement of health outcomes for the communities we serve.
23. **Supports the 2030 vision for WAST:** In aligning the refreshed digital plan with the vision for 2030 set forth by WAST, we remain committed to pioneering digital innovation that enhances patient care, streamlines operations, improves communication and fosters a culture of excellence. Our plan envisions embedding new technologies to enhance and improve a seamless, patient-centric experience, ensuring that individuals across Wales receive timely and effective care when they need it most. Through robust data analytics and data linking protocols, we will transform the way we access and manage information across the trust. This strategic realignment underscores our dedication to advancing the Welsh Ambulance Service's vision for 2030, positioning us at the forefront of healthcare innovation in Wales.
24. **Supports our People & Culture plan:** In refreshing our digital plan, we can ensure it aligns with the WAST People and Culture Plan. Our primary objective is to foster a connected and empowered workforce while enhancing the overall people experience. Embracing the principles of autonomy and culture, our refreshed digital plan seeks to empower employees by providing them with the digital tools and platforms necessary to excel in their roles. Through targeted training and development initiatives, we will aim to enhance both the capacity and capability of our workforce to effectively leverage digital technologies in their daily operations. Moreover, by promoting a culture of innovation and continuous learning, we will strive to create an environment where employees feel valued, supported, and inspired to contribute to the organisation's success

## DIGITAL VISION & PILLARS

25. In the process of refreshing our digital plan, the Digital directorate have adopted the VMOST (Vision, Mission, Objectives, Strategies, Tactics) approach, this provides a structured and strategic framework that ensures alignment across all levels of the digital directorate.
26. The VMOST framework starts with establishing a clear and compelling Vision statement, which acts as the north star for our digital transformation journey. This Vision sets out a long-term aspiration for what we aim to achieve through digital innovation, guiding decision-making and prioritising initiatives that contribute to our overarching goals. The benefits of setting a Vision statement



are manifold. It not only inspires and motivates the team by providing a shared purpose but also helps in communicating our digital ambitions both internally and externally, ensuring our stakeholders are aligned and engaged. Moreover, a well-articulated Vision statement serves as the foundation upon which mission statements, specific objectives, strategies, and tactics are built, ensuring a coherent and unified approach to achieving our digital goals.

27. This coherence is critical in navigating the complexities of healthcare technology and in making informed choices about where to allocate resources for maximum impact. By embracing the VMOST approach, our digital directorate is better positioned to drive forward meaningful and sustainable digital transformation that aligns with our overall strategic ambitions and the evolving needs of the healthcare landscape. Our vision statement was created by the function, for the business and is as follows:
28. ***“Empowering our ambulance service with cutting-edge, user-friendly technology, we unite digital brilliance with health data to enable and enhance our services. Committed to excellence for patients, colleagues and partners alike, our digital community leads with trust, innovation, and seamless experiences—empowering decisions, driving outcomes, and setting new standards in digital healthcare, every time, everywhere.”***
29. Incorporating five key pillars into the refresh of our digital plan offers a robust framework that ensures comprehensive and balanced attention to all critical aspects of digital transformation. These pillars will enable us to further develop and monitor our missions, objectives, strategies and tactics as we get into the delivery of the key work programmes and are intended as a simplified front to present back to the organisation. These pillars are:
  - a) **Everyday Essentials** - focuses on ensuring that fundamental digital tools and infrastructure are reliable, user-friendly, and accessible to all users, forming the backbone of patient centric and daily operations.
  - b) **Security, Safety & Cyber** - prioritises the protection of digital systems, patient data, and the network against cyber threats, establishing trust and compliance with legal standards.
  - c) **Digital Pioneers** - encourages innovation and the adoption of emerging technologies, fostering a culture of continuous improvement and experimentation.
  - d) **Transformation** - is about rethinking and redesigning processes and services with digital technology to improve efficiency, patient care, and adaptability in the face of change.
  - e) **Data, Information, and Insight** - emphasises the strategic use of data, analytics and visualisation to inform decision-making, enhance service delivery, and provide actionable insights for better outcomes.
30. Together, these pillars ensure a balanced focus on operational excellence, innovation, security, and the strategic use of data, driving forward a comprehensive and future-ready digital plan.



## DISCOVERY - PROJECTS

31. The digital directorate have spent the last six months reaching out to the wider organisation to discover and understand the true needs and demands of digital services. This has led to the establishment of a single 'long-list' which contains 77 projects and programmes of varying size, complexity, cost and benefit. Some of which can be progressed as 'BAU' work, some which require additional funding above the baseline to progress.
32. Following the VMOST approach ran as a directorate, these 77 projects fit into the following four mission statements. These mission statements play a critical role in bridging the gap between our organisation's overarching strategy and the concrete digital services actions needed to achieve it;
- A. **Technology** - Our mission is to empower our patients and colleagues with user-friendly, durable technology that improves care access and monitoring, through seamless integration, in-house innovation, and comprehensive training, ensuring everyone can confidently embrace and benefit from our digital healthcare solutions.
  - B. **Overcoming challenges** - Our mission is to foster a cost-effective and connected healthcare ecosystem that empowers our staff through continuous education, leverages advanced technology to meet the challenges of an ageing population, and drives staff retention and engagement. We strive for smart recruitment and clear communication to ensure sustainability and a positive return on investment, while fully embracing the clinical vision of WAST and nurturing a culture of ownership and innovative change.
  - C. **Operating Model** - Our mission is to harmonise our approach by adopting a unified model, ensuring robust hardware and seamless interoperability across NHS systems, fostering collaboration, and automating processes for around-the-clock 24-hour service. We're dedicated to empowering patients with self-care tools, enhancing staff knowledge, and supporting innovation while maintaining operational excellence. Our focus is on learning from data to guide future advancements, improving inter-departmental communication, and promoting resource sharing between emergency services, all to advance patient care and service self-sufficiency.
  - D. **People** - Our mission is to elevate our workforce into a community of digitally literate subject matter experts by focusing on recruitment that meets our specific needs and investing in comprehensive training programs. We will foster a culture of excellence and collaboration, simplifying service access and driving digital inclusion. By upskilling our team with the latest technologies, establishing strong ties with educational institutions, and nurturing digital champions, we commit to growing our capacity to innovate and enhance the user experience across our services.



33. As we undertake the refresh of our digital plan, it was vital to incorporate a structured prioritisation mechanism that cross-references our extensive project portfolio against key strategic and operational frameworks. By aligning projects with the Local Delivery Plan and the Integrated Medium-Term Plan (IMTP), we ensure that our digital initiatives are directly contributing to the current and emergent health care needs, as well as the broader strategic objectives outlined for Wales.
34. Furthermore, by evaluating each project against our Long-Term Strategic Objectives, we maintain fidelity to our vision for the future, ensuring that short-term gains do not detract from our long-term goals. The prioritisation of projects based on their urgency, size, scale, complexity, and dependencies enables us to quantify required resources more efficiently and capitalise on opportunities for synergy between projects.
35. This multi-faceted prioritisation approach not only enhances the strategic alignment and impact of our digital projects but also optimises our investment. The recommendations provided under the 'digital tranches' section have been compiled utilising this approach.
36. The tranches and corresponding projects can be seen in **Appendix D**, with a summary view in **Appendix E**.

#### PROPOSITION: DIGITAL 'TRANCHE' OPTIONS

37. In our pursuit to refresh the digital plan, we propose structuring the implementation of projects and programmes into a series of 'Digital Tranches'. This tranche-based approach offers numerous advantages, facilitating more nuanced discussions and informed decision-making around priority and investment.
38. By breaking down the overarching plan into digestible tranches, the Board can evaluate and direct resources with greater precision, ensuring that each tranche aligns with our strategic objectives and delivers value at every stage. This phased deployment allows for agility in adapting to emerging trends and technologies, enables thorough review and refinement of projects based on real-time feedback and outcomes, and ensures that the most critical initiatives receive the attention and funding they need without delay.
39. 'Digital Tranches' will not only enhance our capacity to track progress and ROI more effectively but also ensure transparent and strategic sequencing of investments over the coming 5-10 years, thereby optimising impact and accelerating our digital evolution.



40. A total of 5 'Digital tranches' have been identified from the project long list, the items which require 'above baseline' funding are available to be seen in **Appendix E**. The digital tranches have been compiled utilising the VMOST approach and broader cross-referencing/prioritisation exercises outlined earlier in this paper. It is proposed that the tranches in their current format and grouping, offer the most efficient approach to delivery in terms of resources and digital specialisms required.
41. A series of tables have been provided in **Appendix D**, which outline each project under an tranche, the proposed outcome/benefit and anticipated revenue and capital costs have also been documented in these tables.
42. It's imperative to address the projects and programs that aren't selected for development in the current cycle. These initiatives, while not prioritised at this time, remain valuable assets within our strategic portfolio. To ensure their continued relevance and potential for future implementation, a comprehensive annual review process will be undertaken to assess their alignment with evolving organisational objectives, technological advancements, and stakeholder needs. Projects and programs that aren't selected for immediate development will be carefully catalogued and stored in a centralised repository (backlog), maintaining their visibility and accessibility for future consideration and selection, in particular when other work items conclude.

## NEW FUNCTIONAL AREAS

43. To deliver our refreshed digital plan, the establishment of specific functional areas within the directorate is pivotal. Two critical areas which are currently missing that demand attention are 'Digital Transformation' and the 'Chief Clinical Information Officer (CCIO)' function. These areas are essential for several reasons:

### Digital Transformation

44. The Digital Transformation function within WAST would serve as a critical catalyst for change, aiming to leverage digital technologies to fundamentally reshape business operations, culture, and patient experiences. This function is designed to drive innovation, efficiency, and competitiveness in an increasingly digital world. The purpose and remit of a Digital Transformation function encompass several key areas:

#### Strategic Direction

- **Vision and Leadership:** Establish a clear vision for how digital technologies can transform the organisation. Provide leadership and direction in integrating this vision into the broader business strategy.



- **Alignment with Business Goals:** Ensure that digital transformation initiatives are closely aligned with the organisation's overall objectives, enhancing its ability to achieve its goals through technological innovation.

#### Innovation and Development

- **Adoption of Emerging Technologies:** Identify, assess, and implement emerging digital technologies that can offer performance advantages, improve operational efficiency, and / or enhance patient experience.
- **Product and Service Innovation:** Drive the development of new digital products or services, or the enhancement of existing offerings, to meet changing patient and staff needs and expectations.

#### Process Optimisation

- **Business Process Reengineering:** Analyse and redesign business processes to improve efficiency, reduce costs, and improve product or service quality through digital solutions.
- **Automation and Efficiency:** Implement tools and technologies for automating routine tasks and processes, thereby freeing up valuable resources for more strategic initiatives.

#### Culture and Capability Building

- **Digital Literacy and Skills Development:** Promote digital literacy across the organisation, ensuring that staff are equipped with the skills and knowledge necessary to thrive in a digital environment.
- **Cultural Change:** Foster a culture of innovation, agility, and openness to change, encouraging experimentation and the adoption of digital-first mindsets.

#### Stakeholder Engagement and Collaboration

- **Internal Collaboration:** Work closely with various departments and functions to ensure that digital transformation efforts are integrated and aligned with specific needs and priorities.
- **External Partnerships:** Engage with external partners, including technology providers, industry groups, and other organisations, to stay abreast of digital trends and opportunities.
- **Blue Light Partners:** Engage with other emergency services across the Welsh footprint to develop strategic solutions together.

#### Governance and Risk Management

- **Digital Governance:** Establish frameworks and policies for managing digital initiatives, ensuring that they adhere to regulatory requirements and ethical standards.
- **Risk Management:** Identify and mitigate risks associated with digital transformation projects, including cybersecurity threats, data privacy concerns, and technology adoption challenges.

#### Digital Performance Measurement

- **Metrics and KPIs:** Develop and monitor key performance indicators to assess the impact of digital transformation efforts on the organisation's performance.



- **Continuous Improvement:** Foster a continuous improvement mindset, using data and feedback to refine digital strategies and initiatives over time.

45. The Digital Transformation function is essential for guiding and executing the strategic use of digital technologies across WAST. Its purpose is to drive enduring cultural change that enhances operational efficiency, patient experience, and competitive positioning, all while navigating the risks and challenges inherent in digital innovation.

### **Chief Clinical Information Officer (CCIO)**

46. The role of the Chief Clinical Information Officer (CCIO) is pivotal in bridging the gap between clinical practice and information technology to enhance patient care and health service delivery. The CCIO combines clinical expertise with an in-depth understanding of digital technologies and data, ensuring that health IT initiatives support clinical needs, improve patient outcomes, and contribute to the digital transformation of the NHS. The purpose and remit of the CCIO function encompass several key areas across multiple service lines:

#### Clinical Leadership in IT

- **Advocate for Clinical Needs:** Represent the interests and needs of clinicians in the development and implementation of IT strategies, ensuring that these initiatives support clinical workflows, effective utilisation and generation of data, patient care, and safety.
- **Clinical Governance:** Oversee the integration of clinical governance principles into health IT projects, ensuring that patient care is safe, effective, and centered on patient needs.

#### Strategy and Policy Development

- **Strategic Planning:** Contribute to the development of the NHS's digital strategy, aligning IT projects with clinical priorities and the overall vision for healthcare improvement.
- **Policy Formulation:** Participate in the creation of policies related to health informatics, data management, and the ethical use of digital technologies in clinical practice.

#### Digital Transformation and Innovation

- **Champion Digital Solutions:** Promote the adoption of digital technologies that have the potential to transform healthcare delivery, including electronic health records (ePCR), telemedicine, mobile health applications, and data analytics.
- **Innovation Facilitation:** Encourage and support innovative uses of technology within clinical settings, fostering a culture of innovation among healthcare professionals.



### Stakeholder Engagement

- **Collaboration:** Work closely with IT professionals, healthcare staff, and management to ensure that digital initiatives are well-integrated into clinical practice and aligned with organizational goals.
- **Communication:** Serve as a key communicator, articulating the value of IT investments to clinical staff and ensuring that the benefits of digital transformation are understood and embraced across the NHS.

### Education and Training

- **Capacity Building:** Lead efforts to enhance digital literacy among clinical staff, ensuring they have the necessary skills to effectively use digital tools and systems in their daily work.
- **Continuous Learning:** Advocate for and facilitate ongoing education and training opportunities related to health IT and digital health innovations.

### Data Governance, Regulation and Quality

- **Data Stewardship:** Ensure the quality, accuracy, and security of clinical data within digital systems, promoting high standards of data governance.
- **Regulatory responsibilities:** responsible for ensuring FIHR and DCB are in place and to a good standard.
- **Information Utilisation:** Advocate for the effective use of clinical information to improve patient outcomes, support research, service transformation, and inform public health initiatives.

### Change Management

- **Lead Change Efforts:** Guide and support the implementation of new technologies and processes within clinical settings, addressing challenges and managing resistance to change.
- **Evaluate Impact:** Monitor and assess the impact of digital initiatives on clinical practice, patient outcomes, and operational efficiency, using insights to drive continuous improvement.

47. The CCIO role within the NHS is crucial for ensuring that digital strategies and technologies are leveraged effectively to enhance clinical care, patient experience, and the operational efficiency of health services.

48. By combining clinical insights with an understanding of information technology, the CCIO helps to navigate the complex intersection of healthcare and IT, driving forward the digital transformation agenda in a way that is aligned with the core mission of the NHS and WAST.

49. Importance in the Directorate

- a) Incorporating these functions within the directorate ensures that digital strategy is not only about the adoption of technology but also about transforming the organisation to better meet the enduring needs of its stakeholders.



- b) The digital transformation function provides the strategic framework and execution capability, while the CCIO ensures that clinical considerations are at the heart of digital initiatives. Together, they create a balanced approach to digital strategy, one that recognises the importance of technology in driving organisational performance and the central role of clinical excellence in delivering healthcare outcomes.

## SELECTED OPTION

50. We have carefully curated a series of 'Digital Tranches' (**Appendix E**) as a part of our strategic digital refresh, each designed to sequentially address our critical needs while propelling us towards our overarching digital objectives. These tranches have been selected based on their potential to deliver impactful benefits aligned with our strategic pillars, and they represent a mix of foundational enhancements and innovative leaps.

51. This strategic sequencing was presented to the executive team for consideration, with a formal request to discuss, refine, and agree upon the proposed order. The ordering has been developed to ensure that we maintain operational integrity while also seizing opportunities for transformational change. It is paramount that we reach consensus on the priority of these tranches to facilitate a clear, executable roadmap and to align our collective efforts toward a cohesive digital future.

52. The options for strategic sequencing were as follows:

a. Option 1

- i. Address BAU gaps – no strategic growth.
- ii. Total Revenue Cost (£000s): 409
- iii. Total Capital Cost (£000s): £0

**b. Option 2 (Preferred)**

- i. Address BAU gaps plus, Tranche 1.
- ii. Implement new functional areas: Transformation & CCIO
- iii. Total Revenue Cost (£000s): 1,376
- iv. Total Capital Cost (£000s): 194

c. Option 3

- i. Address BAU gaps plus, Tranches 1 & 2.
- ii. Implement new functional areas: Transformation & CCIO
- iii. Total Revenue Cost (£000s): 2,416
- iv. Total Capital Cost (£000s): 1,121

d. Option 4 (least preferred)

- i. Do nothing.
- ii. Total Revenue Cost (£000s): £0
- iii. Total Capital Cost (£000s): £0



## COSTS

53. An estimated cost summary of each option can be seen in the following table:

Option	Revenue £000s	Capital £000s
Option #1	409	0
Option #2	1,376	196
Option #3	2,416	1,121
Option #4	0	0

54. The formal recommendation from the digital function is '**Option 2**'. this is the preferred choice, giving a balance of maintaining operational integrity and growth in digital service offering. Based on the preferred option, 'option 2', the cost breakdown between the BAU gaps, new functional areas and tranches 1 & 2 are outlined below. This option was supported by the Executive Leadership team in May 2024 following review and discussion.

55. A revenue cost breakdown of addressing the '**BAU Provision**' Gap across the broader digital function is as follows:

Functional Area	Role	Band	Salary (gross) £000s
ICT Delivery	Cyber Specialist	Band 6	45
Business Intelligence	FOI Analyst	Band 6	45
Business Intelligence	Developer	Band 7	56
Data Quality	Data DQ Analyst	Band 5	36
Data Quality	DQ Specialist	Band 6	45
Records Management	Records Officer	Band 3 (x2 WTE)	60
Information Governance	IG Officer	Band 7	56
Information Governance	Junior IG Officer	Band 6	45
<b>Total:</b>			<b>388</b>

56. A Revenue cost breakdown of the **new CCIO function** is as follows:

Functional Area	Role	Band	Salary (no fringe)
CCIO Function	CCIO	Band 8c	90
<b>Total:</b>			<b>90</b>

57. A Revenue Cost breakdown of the **Digital Transformation function** related to 'digital tranche 1' is as follows:



Primary Focus (Year 1)	Role	Band	Salary £000s
E-Timesheets	Project Manager	Band 6	45
E-Timesheets	Developer	Band 7 (x2)	112
RPA Deployments	RPA Developer	Band 7 (x2)	112
RPA Deployments	Business Analyst	Band 6	45
All Projects	AD: Digital Innovation & Development	Band 8d uplift	20
Digital Literacy	Digital Skills Facilitator	Band 4	30
111 Website (Subject to Commissioning approval)	TBC	Band 8a (x2)	130
111 Website (Subject to Commissioning approval)	TBC	Band 7 (x2)	112
111 Website (Subject to Commissioning approval)	TBC	Band 6 (x2)	90
Simplified Sign-On	Specialist Digital Engineer	Band 6	45
111 Visual IVR, Surveillance Drone & NEPTS Cancellations AI Bot	Digital Innovation Developer	Band 7 (x2)	112
All Projects	Tester	Band 6	45
<b>Total:</b>			<b>898</b>

58. A estimated Capital / Non-pay breakdown for 'Digital Tranche 1' is as follows:

	24/25 £000s	25/26 £000s	26/27 £000s	27/28 £000s	28/29 £000s
Maintenance costs of 111 website (Subject to commissioning approval)	40	40	40	40	40
Additional costs associated with new 111 CAS	124	124	124	124	124
Drone & flight equipment	12	-	-	-	-
Visual IVR interop model	20	-	-	-	-

59. It's essential to acknowledge that these estimates of costs for the digital tranches are subject to various uncertainties and variables, including technological advancements, market changes, and unforeseen challenges



during implementation. While every effort is made to provide accurate projections, it's prudent to maintain flexibility and anticipate the need for adjustments as the project progresses.

60. As we begin to deliver against our refreshed digital plan, it's crucial to acknowledge potential roadblocks that could impact our trajectory. Firstly, the realisation of our vision is significantly contingent upon our ability to bolster our teams with top-tier talent. Given the current volatility in the job market, this recruitment activity may face unforeseen delays, potentially affecting our delivery timelines. Secondly, as we innovate and roll out new products and initiatives from our digital delivery tranches, it is imperative that we concurrently review our ICT support infrastructure. This will ensure that we not only launch new tools and products but also maintain the capability and capacity to offer unwavering support for these innovations. Balancing our service delivery with robust ICT support is essential for sustainable growth and for maintaining the high standard of service our users expect.
61. Investment in digital healthcare will significantly impact the wider health system in Wales, offering key benefits such as improved patient outcomes through enhanced data analytics services, and increased operational efficiency by automating administrative processes and facilitating seamless information flow between care providers. This strategic shift not only promises to elevate the standard of patient care but also aims to ensure a more sustainable, resilient, and accessible healthcare system across Wales.

## RISKS

62. If investment and the refresh of the WAST digital plan were not agreed upon by the business, the following risks may arise:
- **Inadequate Digital Capabilities:** Without investment, the Trust may struggle to keep up with the necessary digital capabilities to meet both current and future healthcare demands.
  - **Cybersecurity Vulnerabilities:** Without the implementation of the updated plan, there could be increased exposure to cyber threats and data security breaches, jeopardising patient data and trust in the Trust's services.
  - **Operational Inefficiencies:** Lack of investment might lead to continued operational inefficiencies and the inability to streamline operations or leverage new technologies for better patient care.
  - **Missed Synergies:** The absence of a refreshed plan could lead to missed opportunities for synergy between the Trust's digital projects and the broader strategic objectives of NHS Wales.



- Insufficient Workforce Development: Failure to invest in the digital refresh could result in a workforce that lacks the necessary digital literacy and skills to adapt to new technologies and processes.
  - Non-compliance with IMTP: The Trust risks non-compliance with the Integrated Medium-Term Plan (IMTP), which could affect funding and regulatory standing. In particular the following IMTP commitments:
    - SO01 – Providing the right care and advice every time.
    - SO03- Being at the forefront of innovation & technology.
    - More services will be accessible
    - Our future workforce will be agile, highly skilled and capable.
    - We will transform the way we access and manage information.
  - Innovation Stagnation: Without a commitment to digital innovation, the Trust might fall behind in healthcare technology, missing out on advancements that could enhance patient care and staff workflows.
  - Resource Misallocation: A lack of strategic refresh may lead to continued misallocation of resources, not aligning with the most critical areas of need within the Trust.
  - Diminished Patient Experience: Without investment in the digital plan, the opportunity to enhance patient experiences through technology may be lost, potentially impacting patient satisfaction and outcomes.
  - Inefficiencies over time: the lack of investment may lead to higher costs, as outdated systems become more expensive to maintain & less effective.
  - Inadequate Response to Demographic Shifts: As the population ages, the Trust might not be equipped to handle the shift in healthcare needs without a modernised digital approach.
  - Loss of Talent: with investment from the UK and Welsh Government (particular in the South Wales and South East regions) to attract more technology business and talent, the Trust risks increased difficulty in recruiting digital, data and technology professionals to manage even the core requirements and services.
63. Addressing these risks requires careful consideration of the proposed digital plan refresh and a commitment to invest in the Trust's digital future. Failure to invest will result in these risks becoming issues, some of which would be complicated and costly to undo.



## CONSIDERATIONS

64. In the development of our digital plan refresh for Finance & Performance committee consideration, several key considerations have informed our work and strategic thinking to ensure the plan is comprehensive, forward-looking, and aligned with our organisational values and external obligations. These considerations were made through the design of our plan and we remain committed to keeping these at the heart of all we do. These considerations include:

- **The People We Serve:** Recognising our responsibility towards the people of Wales, our plan is designed to foster sustainable development, ensuring that our digital initiatives contribute positively to the economic, social, environmental, and cultural well-being of future generations.
- **Strategic Direction of the Organisation:** Our digital plan is closely aligned with the overall strategic direction of the organisation, supporting our mission to deliver high-quality patient care and to innovate in response to the changing healthcare landscape. It supports our goals of improving healthcare outcomes, enhancing patient experience, and ensuring operational efficiency.
- **Digital Inclusivity and Equality:** Central to our plan is the commitment to digital inclusivity, ensuring that all individuals, regardless of socio-economic status, disability, race, or age, have equal access to our digital services. This commitment informs our approach to the design, principles and deployment of digital solutions, emphasising user-friendly interfaces, multilingual support, and accessibility features.
- **Environment and Sustainability:** Our digital initiatives are developed with an acute awareness of their environmental impact. We aim to leverage digital technologies to reduce our carbon footprint, such as by minimising the need for physical travel through telehealth services and optimising resource use in our operations. Sustainability principles guide our choices in technology, infrastructure, and operational practices.
- **Socio-Economic Duty:** We recognise our broader socio-economic duty to contribute positively to the communities we serve. This involves not only ensuring equitable access to our digital services but also leveraging our digital transformation efforts to stimulate local economies, create employment opportunities, and support education and training in digital skills within our communities.
- **Data and AI Ethics:** In embracing data-driven solutions and AI, we are committed to upholding the highest standards of ethics. This involves



rigorous adherence to data protection laws, ensuring transparency, accountability, and fairness in our AI systems.

65. These considerations are foundational to our strategic thinking and have been integral in shaping a digital plan that is not only ambitious and innovative but also responsible and inclusive, ensuring we meet the needs of today's population while paving the way for a sustainable and equitable digital future.
66. The projects outlined in the recommendation section above can be directly mapped to our strategic commitments as well as our corporate risks, this is summarised in the following grid:

<b>Project</b>	<b>Benefit</b>	<b>Strategic &amp; IMPT Link</b>
E-Timesheets	Improved staff morale, reduced manual calculation errors and efficiency gains in process	All staff will have access to the most appropriate technology to undertake their role.
Robotic Process Automation (RPA)	Increased operational efficiency and reduced manual workload through the implementation of automated processes, allowing staff to focus on higher-value tasks.	SO03 - Being at the Forefront of Innovation & Technology
111 Website Development	Increased accessibility and usability of the 111 website for a diverse user base	SO01 - Providing the right care and advice every time
Simplified Sign-on	'Streamlined user access with a simplified sign-on process, reducing complexity and improving overall user experience and security	SO03 - Being at the Forefront of Innovation & Technology
111 Visual IVR	Streamlined and simplified the user journey for 111 services through visual IVR technology. This includes a proven benefit of circa 20-25 seconds saving per call.	More services will be accessible using digital and virtual platforms  SO01 - Providing the right care and advice every time
Surveillance Drone	Enhanced situational awareness through aerial surveillance for safer more efficient access to certain scenes.	SO03 - Being at the Forefront of Innovation & Technology  SO01 - Providing the right care and advice every time



GIG  
CYMRU  
NHS  
WALES

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

NEPTS Cancellations Chatbot	Improved scheduling efficiency and reduced cancellations through AI-driven optimisation.	SO03 - Being at the Forefront of Innovation & Technology
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## MEASURES OF SUCCESS

67. In the context of our digital plan refresh, it is imperative to highlight the critical importance of setting our digital Key Performance Indicators (KPIs) under each of the strategic pillars and mission statements set through our VMOST approach. This reset will be vital to ensure that our progress towards achieving the objectives of the digital plan is monitored in an efficient, clear, and easily digestible manner.
68. By establishing new KPIs that are specifically tailored to the refreshed plan, we will be able to measure our true success more accurately across various dimensions of digital transformation, including but not limited to operational efficiency, patient satisfaction, digital inclusivity, and cybersecurity. These KPIs will be reported to our Finance and Performance Committee regularly.
69. The development of these new KPIs will commence following the selection of the preferred 'digital tranche' approach outlined earlier in this paper. This approach ensures that the KPIs are directly relevant to the specific initiatives and projects under each pillar, aligning measurement with our strategic priorities and the phased implementation plan.
70. Our deliverables and progress against more detailed plans will be managed and reported through our IMPT and Local Delivery Plans (LDPs).
71. By doing so, we will be able to track progress, identify areas for improvement more swiftly, and make data-driven decisions that enhance the overall impact of our digital transformation efforts. Moreover, clear and relevant KPIs will enable transparent reporting to the board, finance and performance committee, stakeholders, and the wider community, fostering accountability and trust in our digital journey.
72. People will continue to be at the heart of how we measure our digital success. User experience will be gauged through regular surveys and real-time feedback mechanisms, focusing on ease of use, satisfaction, and engagement levels with our digital platforms. Finally, the adoption of new technologies will be measured through quantitative data such as adoption rates, usage patterns, and the rate of completion of onboarding processes for new digital tools.

## HORIZON



73. In the dynamic landscape of digital healthcare, the importance of maintaining active dialogue around horizon initiatives cannot be overstated. Keeping these future-focused discussions at the forefront, enables WAST to stay ahead of the curve in adopting innovative solutions that enhance patient care and improve operational efficiency.
74. By engaging in ongoing conversations about the "art of the possible," we help foster a culture of innovation and flexibility, encouraging all stakeholders to think beyond the immediate challenges to envision transformative digital healthcare solutions.
75. This proactive approach not only prepares us for the rapid technological advancements in healthcare but also inspires cross-functional teams to collaborate in creating impactful, forward-thinking strategies. The benefits of such discussions extend to anticipating patient needs, optimising healthcare delivery, and ultimately, leading the way in setting industry standards for excellence in digital healthcare services.
76. Whilst a selection of projects will be taken forward this financial year (24/25) – it is important that we keep focused on the remaining projects in the long-list and ensure these are given the right level of focus and discussion, when funding and resource opportunities present.
77. As part of our commitment to maintaining alignment with our long-term corporate strategy, this digital plan refresh outlines a comprehensive plan extending up to the year 2029. It is designed to ensure continual synergy between our overarching corporate goals and the extensive list of digital deliverables we aim to achieve. This approach not only facilitates a coherent and unified direction for our digital initiatives but also guarantees that our digital efforts are consistently enhancing our core business strategies.

## RECOMMENDATION

78. The formal recommendation from the digital function is '**Option 2**'. this is the preferred choice, giving a balance of maintaining operational integrity and growth in digital service offering. This option was supported by the Executive Leadership team upon review.

### **18. The Finance & Performance committee are asked to:**

- a. **Approve the digital pillars outlined in the 'digital vision and pillars' section, as a framework for this plan.**
- b. **Acknowledge the investment option selected by the executive leadership team and the digital tranche's recommendation provided in the 'recommendation' section.**



GIG  
CYMRU  
NHS  
WALES

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

- c. Acknowledge the additional investment amount to the digital services budget for 2024/25 financial year.**
- d. Agree a commitment to actively engage in discussions about horizon initiatives and the 'art of the possible'.**
- e. Support the Digital Plan for onward review at Trust Board**

## NEXT STEPS

- 79. Following FPC endorsement, the next milestone will be to obtain approval from the Trust Board on 30th May 2024, for both the digital plan refresh and the digital tranches ordering. This will mark a significant achievement in our journey, aligning organisational governance with our digital ambitions.
- 80. Finally, upon receiving the green light from the Trust Board, we will proceed to formalise the plan, producing a succinct and comprehensive plan document. This document will serve as a blueprint for our digital transformation, and it will be widely communicated across our business to ensure everyone is informed, engaged, and aligned with our digital future.



## APPENDIX A – DIGITAL DIRECTORATE OVERVIEW



### ICT

- **Network and Telecoms:** Management of the organisation's network infrastructure to ensure reliable and secure communication channels.
- **Airwave:** Oversight of the Airwave communication system, critical for secure and effective communication between ambulance staff and emergency services.
- **Service Desk:** Providing IT support to resolve technical issues and ensure smooth operations for all digital tools and systems.
- **Engineering:** Maintenance and development of IT systems and infrastructure to support operational needs.
- **Contract Management:** Managing agreements with IT vendors and service providers to ensure quality and cost-effectiveness.
- **ICT Projects:** Leading digital projects to improve services and operational efficiency through innovative technology solutions.
- **SQL Engineer:** Managing and optimizing SQL databases to support data-driven decision-making and operational performance.
- **Cyber Security:** Protects information systems from cyber threats, ensuring data privacy and compliance.



### Data & Analytics

- **111 Web Development:** Creating and maintaining web applications for health advice via the 111 Wales NHS Service
- **Data Engineering:** Building and maintaining the infrastructure for data collection, storage, and retrieval.
- **Data Warehousing:** Managing centralised repositories of integrated data from multiple sources.
- **Information Analysts:** Analysing data to provide insights that support decision-making and improve services.
- **Data Quality:** Ensuring the accuracy, completeness, and reliability of data within the system.
- **Records Management:** Organizing, maintaining, and protecting company records for easy retrieval and compliance.
- **Information Governance:** Establishing policies and procedures to ensure data is handled securely and in compliance with legal and ethical standards.



### Operational Communications Programme

- **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).
- **Mobile Data Vehicle Solution (MDVS):** Implements technology in vehicles for real-time data exchange and communication.
- **Programme Management:** Oversees the planning, execution, and governance of all communication-related projects.
- **Control Room Solution (CRS):** Enhances the efficiency and effectiveness of control room operations with advanced technology.
- **Emergency Services Network (ESN):** Develops the new communication network to support critical voice and data services for emergency services.



## APPENDIX B – WTE OVERVIEW

Operational Area	Function	Current WTE	Current Gap to provide provision full
ICT	Networks & Telecoms	x1 B8a x3 B7	
ICT	Service Desk	x1 B8a x1 B5 x6 B4	
ICT	ICT Delivery	X1 8a X1 B7 (SQL) X1 B7 (Specialist) X1 B7 (CAD) X1 B7 (ePCR) X1 B7 (Security) X1 B7 (Engineer) X4 B6 (Engineer) X7 B5 (Engineer) X5 B4 (Engineer) X1 B6 (Security)	Gap estimated x1 WTE (Security) (1 B6)
ICT	ICT Team Lead (Airwave)	1 x 8b	
ICT	Contracts Management	X1 B8a	
ICT	EPCR Clinical Lead	X1 B8a	
ICT	Projects	X1 B8a	
Data & Analytics	Service Delivery & Development	X2 B7 X1 B6	
Data & Analytics	Business Intelligence (Informatics)	X1 B8a X2 B7 (Analyst) X2 B7 (Warehouse) X4 B6	Gap estimated x2 WTE (1B6, 1 B7)
Data & Analytics	Data Quality	X0.4 B6	Gap estimated x2 WTE (1B5, 1B6)
Data & Analytics	Records Management	X1 B7 X1 B5 X2 B3	Gap estimated x2 WTE (2 B3)
Data & Analytics	Information Governance	X1 B7 X2 B6 X1 B3	Gap estimated x2 WTE (1 B8a, 1 B6)
OCP	Programme	X1 B8a X1 B7 X3 B6 X2 B4	



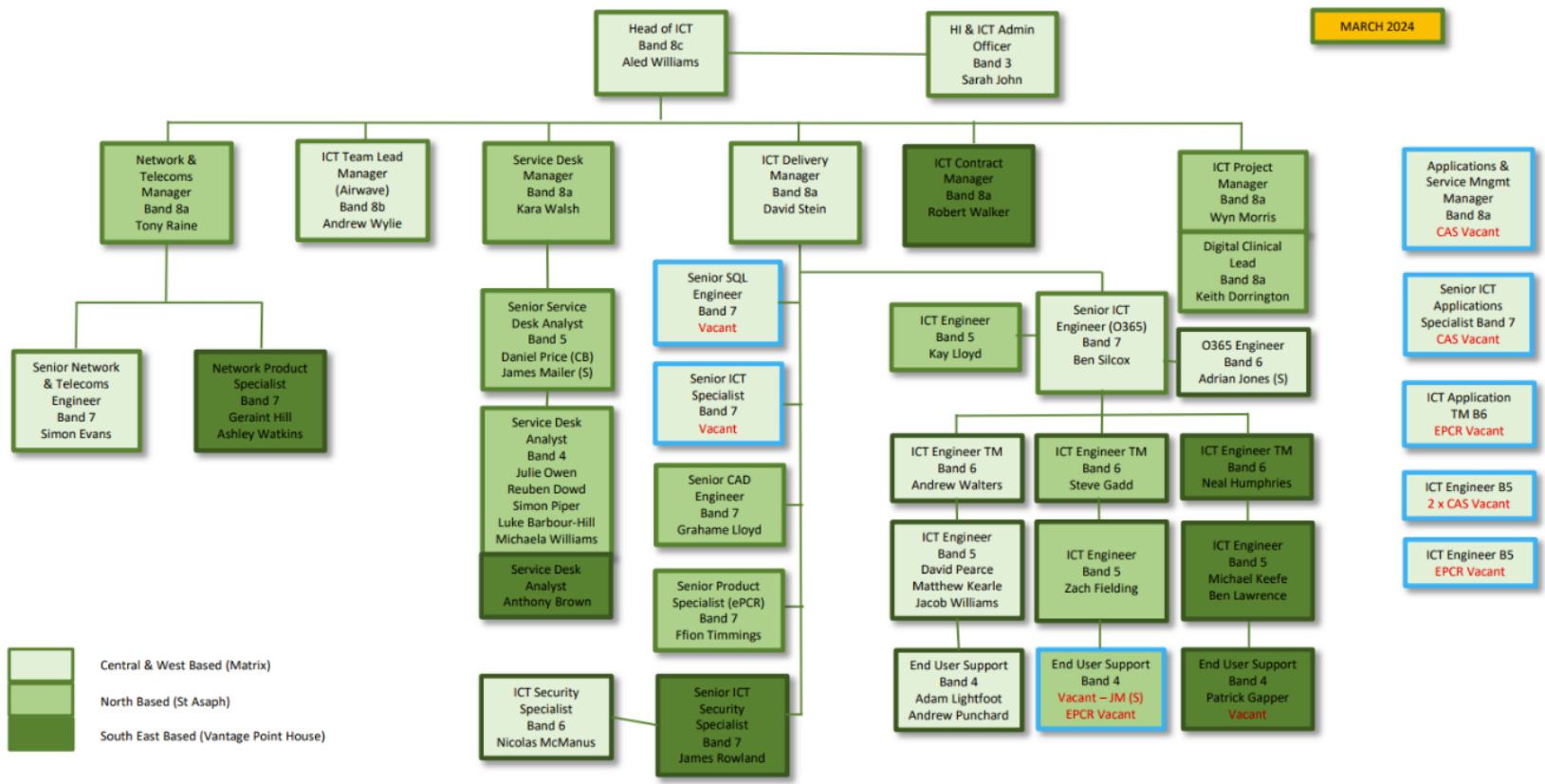
## APPENDIX C – DIGITAL STRUCTURE DIAGRAMS



### Welsh Ambulance Services NHS Trust ICT Department

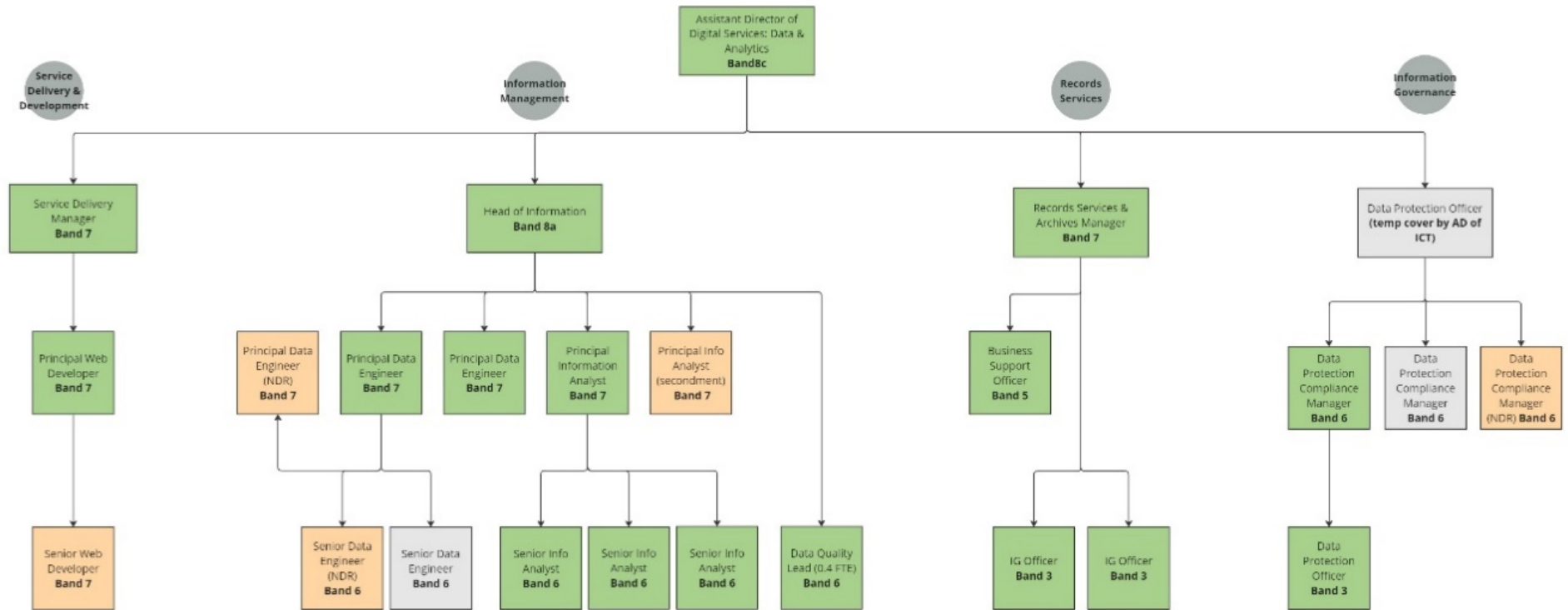


MARCH 2024





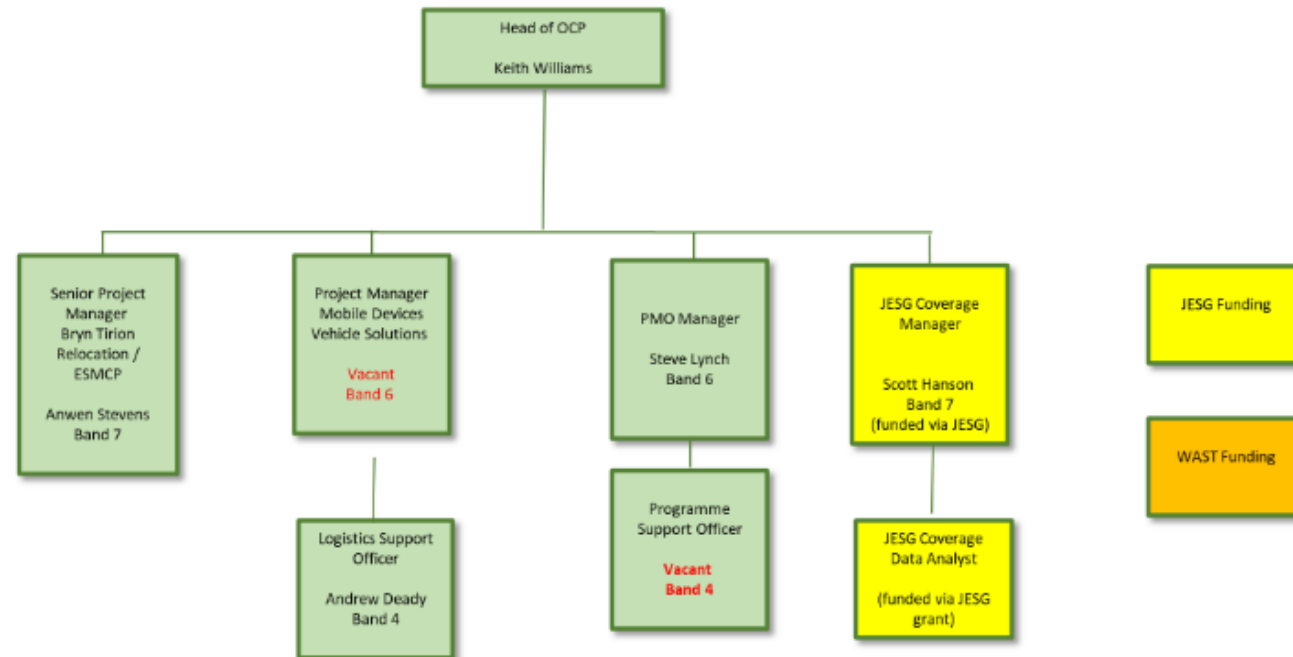
# Health Informatics



- Filled permanent post
- Fixed term or non-recurrent post
- Vacancy

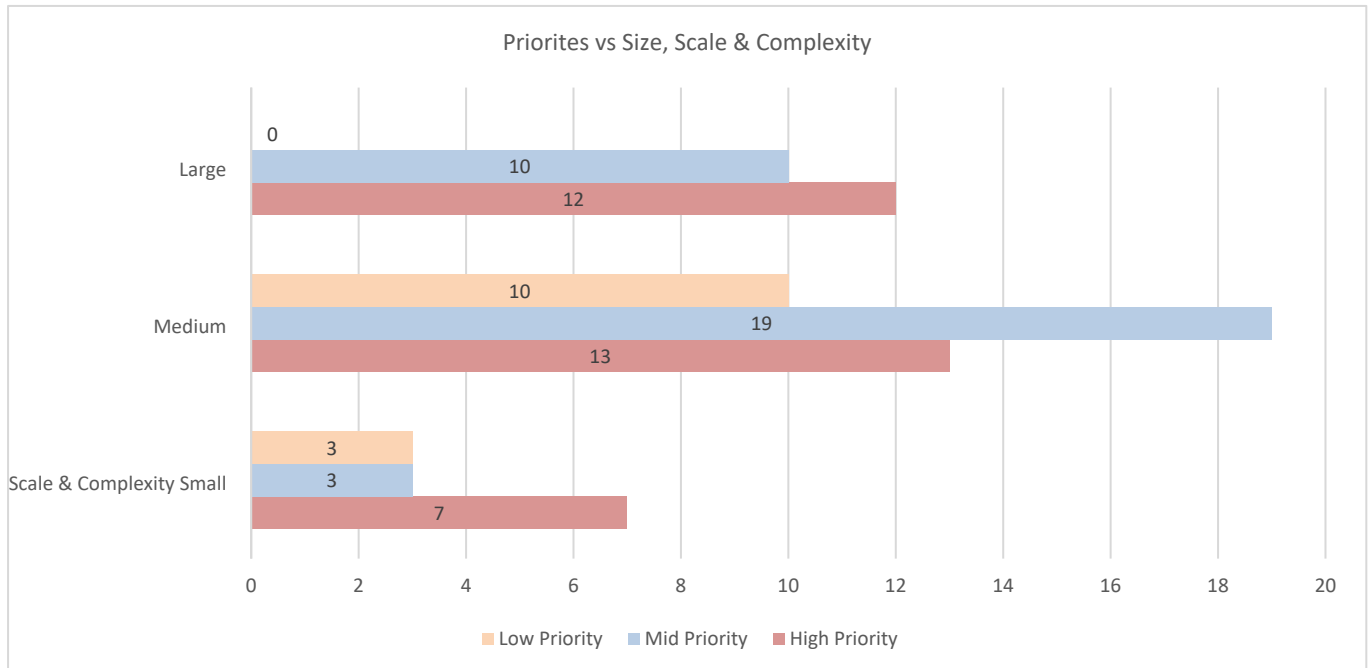


## Welsh Ambulance Services NHS Trust Operational Communications Programme (ESMCP)





## APPENDIX D – DIGITAL PROJECTS - SUMMARY





## APPENDIX E – DIGITAL TRANCHE TABLES

### Tranche #1

<b>Project:</b>	<b>Outcome/ Benefit</b>	<b>Capital Cost £000s</b>	<b>Revenue Cost £000s</b>	<b>Est. Project Length</b>
E-Timesheets	Improved staff morale, reduced manual calculation errors and efficiency gains in process		177	12 months
Robotic Process Automation (RPA)	Increased operational efficiency and reduced manual workload through the implementation of automated processes, allowing staff to focus on higher-value tasks.		157	12 months
111 Website Development	Increased accessibility and usability of the 111 website for a diverse user base	164	332	12 months
Simplified Sign-on	'Streamlined user access with a simplified sign-on process, reducing complexity and improving overall user experience and security		45	6 months
111 Visual IVR	Streamlined and simplified the user journey for 111 services through visual IVR technology. This includes a proven benefit of circa 20-25 seconds saving per call.	32	112	12 months
Surveillance Drone	Enhanced situational awareness through aerial surveillance for safer more efficient access to certain scenes.			
NEPTS Cancellations Chatbot	Improved scheduling efficiency and reduced cancellations through AI-driven optimisation.			



**Tranche #2**

<b>Project:</b>	<b>Outcome/ Benefit</b>	<b>Capital Cost £000s</b>	<b>Revenue Cost £000s</b>	<b>Est. Project Length</b>
Communications & Network Improvements	Ongoing improvements to communications and network, including integration of sim cards on vehicles into 1 (from 6)	100	80	
Device Architecture	Improvements, consolidation and ongoing management of devices		50	
Video Triage / Video Calls	The deployment and adoption of video triage technology for our CSD and 111 services	50	60	
Smart Stations Programme	Looking at IoT sensors to drive behaviour change (e.g. closing doors/windows or bin emptying, power management etc.)	300	200	
Digital Business Partners	To support with day to day planning at a directorate level with regards to Digital provision		120	
Artificial Intelligence	A programme of works to deploy AI onto key areas, for example AI to manage low acuity clinical stack in CSD as a clinical decision making support tool	200	150	
Point of Care Testing	A programme to identify key point of care testing opportunities which can be supported by the correct digital tools, an example is troponin testing	150	60	
111 Conversational AI	Deployment of Conversational AI onto the 111 website to allow patients to self-serve	50	80	



	repeat prescriptions, saving significant call volume into the service			
Integration into NHS App	Identifying key opportunities to integrate into the NHS app, for example clear link to Conversational AI for repeat prescriptions		80	
All-Wales Directory of Service (DOS)	Deployment and enhancement of our DOS to create an all-Wales offering integrated within each health service reducing channel confusion - supporting gateway to care		60	
Natural Language Processing	Use of NLP to identify service improvement opportunities and real time alerting (eg "bomb" or "gun" auto-dispatching HART to near scene); LS: lots of applications including Learning from Deaths (in progress)	75	100	



### Tranche #3

<b>Project:</b>	<b>Outcome/ Benefit</b>
SMS Reminders & Communications	2 way chat in particular for NEPTS - this could include text to cancel a journey and reminders
Improved technical testing	Improved testing regime (including UAT and Regression testing)
Role based access	Improvement to role based access across the trust
ISO 27001 Accreditation	Achievement and maintenance of ISO27001 Accreditation
Resilience and security desktop exercises and programme	Improved testing and programme to ensure readiness and resilience in the event of any major incident and outage
Forced Device Compliance	Development of force device compliance protocols across the trust
Digitally enabled vehicles	This includes digital monitoring devices (e.g. diesel monitoring or seat belt adherence)
Revenue Generation / Software Development / Commercial Offering	Creation of a software development team with a view of commercialising products. A key example here may be the development of an audit tool (both corporate, vehicle and H&S)
Virtual Ward Monitoring	This could include key features such as respiratory monitoring utilising AI to curate real time alerts
Predictive & what-if modelling (including digital twin)	This could be used to support resource planning as well as clinical decision making
Integration with Alexa / Google Hub	Integration of our digital services with voice enabled technology (identifying where this could be used internally too, e.g. Stock management)
Development of Synthetic Data Sets	To support system testing and development (avoids the use of PII)
ePCR notifications to GP	Integration of the ePCR notifications directly with GP system for real time notification and transfer of key data
GRS Replacement	Replacement and improvement of the GRS System
Integrated contact centres	Options to enable integrate contact centres technology when required
New Content Management System (CMS)	CMS for 111 and other Web Applications
RFID Asset Tracking	RFID Asset tracking for medical equipment, this links into automated stock control
Data Science Programme (inc. advanced modelling)	The programme to deploy data science capability in the trust, this includes advanced analytics, predictive modelling, and machine learning/deep learning capabilities



Integrated Service Line BI	Merge of all service line data into single dashboard view (9s 1s and NEPTS)
Shared Care Record Wales	A single record to show all emergency, primary and secondary care records in real time through one portal

#### Tranche #4

Project:	Outcome/ Benefit
Enhanced out of hours support provision	An option to expand the out of hours support to move from critical system to major system
VR / Augmented Reality	Enhanced use of VR and Augmented reality for our CSD/Road staff to get eyes on/monitor patients and/or enhanced training usage
VC Pathways with ED	VC Pathways with ED Consultants could prevent hospital admittance
CAD replacement/integration	Opportunities to integrate CADs and refresh software
Interoperability Programme	An ongoing programme of work designed to look for interoperability opportunities, for example Violence and Aggression markers automatically passing between NEPTS and 9s CAD
Digital First 111	Using the Digital First 111 as the front door to all digital services from a patient perspective - ongoing programme of works
Affiliate Programme	Creation of super users and business partners, that are able to self-serve development in a supported way, this includes published data sets for access
Population Health Analytics Programme	Development of a programme of work centred on population health, this includes informing personalised care (wearables, vitals etc) and risk stratification and pathway design



### Tranche #5

<b>Project:</b>	<b>Outcome/ Benefit</b>
Technical Personas	Deployment of developer and non-developer admin right personas to support key innovation development
Integration of Large Language Models (LLM) into the organisation	This could include variations of Chat GPT or Microsoft co-pilot
Data Integration Programme	A project/s set to identify key data integration opportunities across Wales (both with public data and private data e.g. "experian-mosiac")
JESG Single Resource View	Development of joint emergency response live resource deployment to support management of major incidents
Immutable Backups	An immutable backup should be unchangeable and able to deploy to production servers immediately in case of ransomware attacks or other data loss.

<b>AGENDA ITEM No</b>	<b>10</b>
<b>OPEN or CLOSED</b>	<b>OPEN</b>
<b>No of ANNEXES ATTACHED</b>	<b>0</b>

<b>24/25 COMMISSIONING INTENTIONS</b>
---------------------------------------

<b>MEETING</b>	Finance and Performance Committee
<b>DATE</b>	14 May 2024
<b>EXECUTIVE</b>	Rachel Marsh – Executive Director of Strategy, Planning & Performance
<b>AUTHOR</b>	Hugh Bennett - Assistant Director, Commissioning & Performance
<b>CONTACT</b>	<a href="mailto:Hugh.Bennett2@wales.nhs.uk">Hugh.Bennett2@wales.nhs.uk</a>

<b>EXECUTIVE SUMMARY</b>
<p>The purpose of this report is to provide Committee with a short overview of the 2024/25 commissioning intentions process and how they feed into the Trust’s planning cycle, in particular, the Integrated Medium Term Plan (IMTP).</p> <p>The report also covers arrangements for in year monitoring of progress against the commissioning intentions.</p> <p><b>RECOMMENDATION</b> Committee is asked to: -</p> <ul style="list-style-type: none"> <li>• <b>Consider</b> whether the arrangements, as set out, give assurance that the commissioning intentions are being appropriately built into the planning of the Trust and are performance managed in year.</li> </ul>

## SITUATION

1. The Trust's three main patient pathways (111, 999 and Ambulance Care) are commissioned services. As part of the commissioning arrangements the Trust works to "commissioning intentions", provided each year by the commissioners.

## BACKGROUND

2. From the 01 Apr-24 the Trust has been commissioned for 111, 999 and Ambulance Care by the Joint Commissioning Committee (JCC). This arrangement is very new, but 999 services have been commissioned since 2015, Non-Emergency Patient Transport Services (NEPTS) since 2018 and 111 since 2023.
3. As part of the commissioning process, commissioners provide commissioning intentions, their expectations of what they want to see delivered in each year, linked to the funding received.

## ASSESSMENT

### Development of Commissioning Intentions

4. The Trust receives draft commissioning intentions each autumn. These are then discussed internally, including at Executive Leadership Team (ELT), and a formal response is sent by the Trust to the commissioners. There is then normally a process of dialogue and negotiation before the intentions are finalised in Q4. ELT consider the 2024/25 commissioning intentions as supportive of the Trust's strategic ambitions.

### IMTP 2024-27

5. During late Q3 and early Q4 Strategy, Planning & Performance establishes specific IMTP planning meetings with commissioners.
6. The commissioning intentions are built into the IMTP main document as well as being specifically referenced in detail in IMTP Appendix 1 Challenges & Opportunities. The following table is an extract from Appendix 1:-

WAST response to commissioning intentions

Commissioned Service	Summary of Priorities	Metrics	Response in this IMTP
111	<ul style="list-style-type: none"> <li>Continue to review <b>“what good looks like”</b>.</li> <li>Continue to review <b>workforce skill mix</b> and rations of call handlers to clinicians.</li> <li>Identify opportunities for <b>enhanced clinical practice</b>.</li> <li>Support the <b>Six Goals Programme</b> e.g. urgent dental, palliative care etc.</li> <li>Collaborate on <b>national reviews</b> e.g. a “rapprochement”</li> <li>Complete the <b>111 CAS replacement</b> and start to realise benefits from it.</li> <li>Undertake a review of the <b>111 digital platform</b>.</li> <li>Review calls, dispositions and outcomes, including self care, <b>number of touchpoints</b>, flows into UPCC, GMS etc.</li> <li>Keep under review <b>effectiveness of IVR</b> messaging.</li> <li>Keep under review <b>demand and the capacity</b> (including productivity).</li> <li>Ensure 111 is reflected in WAST’s <b>strategic workforce plan</b>.</li> <li>Ensure <b>good workforce planning arrangements</b>.</li> <li>Undertake a <b>workforce training review</b>.</li> <li>Undertake a <b>roster review</b>.</li> <li>Continue to develop a <b>staff education matrix</b> to ensure it aligned with agreed service model, in particular, the new 111 CAS.</li> <li>Reduce <b>sickness absence</b>.</li> </ul>	<p>WAST produces a monthly report to the 111 DAG and a bi-monthly WAST 111 Provide Report to the Interim 111 Board, which detail the key metrics that WAST is focused on. These include:-</p> <p><u>Our Patients</u></p> <ul style="list-style-type: none"> <li>&lt; 5% <b>call abandonment rate</b>.</li> <li><b>95% calls answering within 60 seconds</b>.</li> <li><b>90% of P1 patients to start their definitive clinical assessment</b> within one hours of the end of the first contact.</li> <li>90% of P2 patients to start their definitive clinical assessment within two hours of the end of the first contact.</li> <li>90% of P3 patients to start their definitive clinical assessment within four hours of the end of the first contact).</li> <li>National Reportable Incidents.</li> <li>Datix as a % of total call volume.</li> <li><b>Themes and trends from quality metrics</b>.</li> </ul> <p><u>Our People</u></p> <ul style="list-style-type: none"> <li><b>Staff in post v commissioned establishment</b> for call handlers and clinicians.</li> <li>Abstractions (benchmark 30.7%).</li> <li><b>Sickness absence</b> (IMTP ambition 5.99%).</li> <li><b>Clinical Advice Line</b> usage rate by call handlers (lowest benchmark 20%).</li> <li><b>Shift fill compared to predicted demand</b></li> <li>Developing <b>advanced practice</b> within 111</li> </ul> <p><u>System Contribution</u></p> <ul style="list-style-type: none"> <li><b>Calls stopped at source i.e. by WAST</b>.</li> <li><b>Calls referred to alternative pathway</b>.</li> <li>Calls referred to 999/ED (18% the 2023 average)</li> </ul> <p><u>Financial</u></p> <ul style="list-style-type: none"> <li>Maintaining the <b>core staff in post</b> (call handlers and clinicians) <b>inside the core commissioning control</b> total of 190 FTEs and 101 FTEs.</li> </ul>	<p>WAST responded to the draft 111 commissioning intentions, which were signed off at 111 Board in Jan-24. The Trust sees the commissioning intentions operating at three levels:-</p> <p><u>Transition</u></p> <ul style="list-style-type: none"> <li>The 111 commissioners wanted the Trust to focus on “stability” in 2023/24. The 111 service is much more stable with the abandonment rate being achieved for six consecutive months.</li> <li>Clarity on the commissioning framework for 111</li> <li>Also there is <b>no agreed demand &amp; capacity review</b>, which identifies the level of capacity (including efficiencies) to deliver the WG targets.</li> <li>The Trust will be working to lower commissioned control totals for call handlers and clinicians in 2024/25, which will have some impact on performance.</li> <li>Subject to funding by commissioners the Trust wants the <b>roster review</b> (including demand &amp; capacity element) <b>to be undertaken</b></li> <li><b>‘Confident and Clinically Competent Workforce Programme’</b></li> </ul> <p><u>Transformation</u></p> <ul style="list-style-type: none"> <li>The immediate transformation focus in 2024/25 will be on the <b>implementation of the new 111CAS</b> and starting to realise the business case benefits.</li> <li>A related focus will be on ensuring the workforce plan supports this delivery.</li> <li>The Trust will also focus on <b>completing a business case on options for the 111 digital platform</b> and how it can add greater value.</li> <li>The Trust will continue to <b>actively support the Six Goals Programme</b> e.g. urgent dental etc.</li> <li>The Trust will continue to work with commissioners and DHCW on a <b>set of 111 ASIs</b>.</li> <li>The Trust will engage with the <b>Duty of Quality</b> through a work plan developed from its self-</li> </ul>

7. The Trust’s response to the commissioning intentions is effectively Trust Board approved as part of the approval process for the IMTP. The commissioners explicitly approve the commissioning intentions at their relevant committees.

In Year Monitoring

8. Once approved the commissioning intentions are monitored in year on a quarterly basis, with a RAG rated draft quarterly return sent to commissioners, which is then scrutinised informally before being formally scrutinised at the relevant commissioning committee.

9. The commissioning intentions progress is also reported to Strategic Transformation Board, chaired by the Trust’s CEO.

10. The commissioning intentions in year progress is not explicitly reported to Committee/Trust Board, but implicitly they form part of the IMTP Deliverables, which are reported each quarter to Committee/Trust Board.

Assessment

11. The Trust has a strong track record of delivery and is in routine monitoring with Welsh Government i.e. the lowest level. Whilst there is no room for complacency, given the issues around patient safety and staff well-being, the Trust has established mechanisms for aligning the commissioning intentions with its IMTP planning process and strong mechanisms for in year reporting.

**RECOMMENDATIONS**

Committee is asked to: -

- **Consider** whether the arrangements, as set out, give assurance that the commissioning intentions are being appropriately built into the planning of the Trust and are performance managed in year.

REPORT APPROVAL ROUTE	
Date	Meeting
03rd May 2024	Executive Director Strategy, Planning & Performance
14 <sup>th</sup> May 2024	Finance & Performance Committee

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

<b>AGENDA ITEM No</b>	<b>12</b>
<b>OPEN or CLOSED</b>	<b>OPEN</b>
<b>No of ANNEXES</b>	<b>1</b>

<b>Financial Performance as at Month 12 – 2023/24</b>
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<b>MEETING</b>	Finance & Performance Committee
<b>DATE</b>	14 May 2024
<b>EXECUTIVE</b>	Chris Turley (Executive Director of Finance & Corporate Resources)
<b>AUTHORS</b>	Edward Roberts (Head of Financial Business Intelligence & Capital Planning) Steph Taylor (Assistant Head of Capital Planning)
<b>CONTACT</b>	Chris.Turley2@wales.nhs.uk

<b>EXECUTIVE SUMMARY</b>
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This paper presents to the Committee the Financial Performance Report of the 2023/24 financial year, as at Month 12 (March 2024) / year end.

The Committee is asked to review, comment, note and receive assurance on the financial position of the Trust for 2023/24, subject to audit and ahead of the Trust Board presentation of the 2023/24 accounts in July 2024.

**RECOMMENDED that the Committee:**

- a) **Notes** and gains **assurance** in relation to the Month 12 (and therefore draft 2023/24 year end) revenue and capital financial position and performance of the Trust as at 31<sup>st</sup> March 2024;
- b) **Notes** the delivery of the 2023/24 savings plan, and the context of this within the overall financial position of the Trust.

### KEY ISSUES/IMPLICATIONS

Key highlights from the report for the Committee to note are:

- The Trust is reporting a small revenue surplus (£85k) as a M12, and which will be the basis for the draft accounts for the 2023/24 financial year (subject to audit);
- Capital expenditure is fully spent;
- In line with the financial plans that support the IMTP, gross savings of £6.546m have been achieved against a target of £6.000m;
- Public Sector Payment Policy is on track with performance, against a target of 95%, of 96.4% for the number, and 98.5% of the value of non NHS invoices paid within 30 days.

### REPORT APPROVAL ROUTE

- EMT via sharing this paper – 8<sup>th</sup> May 2024

### REPORT APPENDICES

***Appendix 1 – Saving details***

### REPORT CHECKLIST

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

**WELSH AMBULANCE SERVICES NHS TRUST  
FINANCE & PERFORMANCE COMMITTEE**

**FINANCIAL PERFORMANCE AS AT MONTH 12 2023/24**

**INTRODUCTION**

1. This report provides the Committee with a summary of the revenue financial performance of the Trust as at 31<sup>st</sup> March 2024 (Month 12 2023/24 and therefore the draft 2023/24 year end position), along with an update on the final 2023/24 capital programme spend, both of which are subject to audit.

**BACKGROUND**

2. The key points to note in relation to the **delivery of the Statutory Financial Targets for 2023/24** (1<sup>st</sup> April 2023 – 31<sup>st</sup> March 2024) are that:
  - The revenue financial position reported is a small **underspend against budget of £0.085m**, (subject to audit).
  - In line with the financial plans that supported the submitted Annual Plan within the IMTP for this financial year, gross savings of £6.546m have been achieved against a target of £6.000m, thus an **over achievement against the plan set at the opening of the financial year**.
  - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 96.4% for the number, and 98.5% of the value** of non-NHS invoices paid within 30 days.
3. Any risks previously reported were continued to be reviewed and fully assessed right up to the year end, however there are now no reported financial risks included in the draft year-end position, subject to audit.

**REVENUE FINANCIAL PERFORMANCE**

4. The table below presents an overview of the financial position for the period 1<sup>st</sup> April 2023 to 31<sup>st</sup> March 2024.

Revenue Financial Position for the period 1st April - 31st March				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
<b>Income</b>	<b>-306,061</b>	<b>-306,061</b>	<b>-305,163</b>	<b>898</b>
<b>Expenditure</b>				
Pay	222,100	222,100	218,680	-3,420
Non-pay	59,237	59,237	62,292	3,055
<b>Total pay &amp; non-pay expenditure</b>	<b>281,337</b>	<b>281,337</b>	<b>280,972</b>	<b>-365</b>
<b>Depreciation &amp; Impairments / interest payable &amp; receivable</b>	<b>24,724</b>	<b>24,724</b>	<b>24,106</b>	<b>-618</b>
<b>Total</b>	<b>0</b>	<b>0</b>	<b>-85</b>	<b>-85</b>

### Treatment of Covid-19 spend

- In light of the lack of clarity around the funding methodology for the expenditure the Trust has now removed this and thusly the income assumptions from the Covid-19 costs previously included up to month 6. As previously reported, this has not had an adverse impact on the Trust's year end position.

### Income

- Reported Income against the initial budget set to Month 12 shows an underachievement of **£0.898m**.

### Pay costs

- Overall, the total pay variance at Month 12 is an underspend of **£3.420m**. As has been previously reported, much of this is in line with that expected given the in year variations accepted in terms of income, and is therefore offset by the non pay and income variations.

### Non-pay Costs

- The overall non-pay position at Month 12 is an overspend of **£2.437m**.

### Savings

- As Committee members will recall, the 2023/24 financial plan identified that a minimum of **£6.000m** of savings, cost avoidance and cost containment measures were required to achieve financial balance in 2023/24. This is a significant increase in that which has been able to be achieved in the recent past, and especially over the last couple of years.
- As at Month 12 for the financial year 2023/24 the Trust achieved total savings of **£6.546m** against a target of **£6.000m**, an over achievement against the target of **£0.546m**.

11. **Appendix 1** provides an overview of Month 12 performance by thematic and organisational / directorate levels.

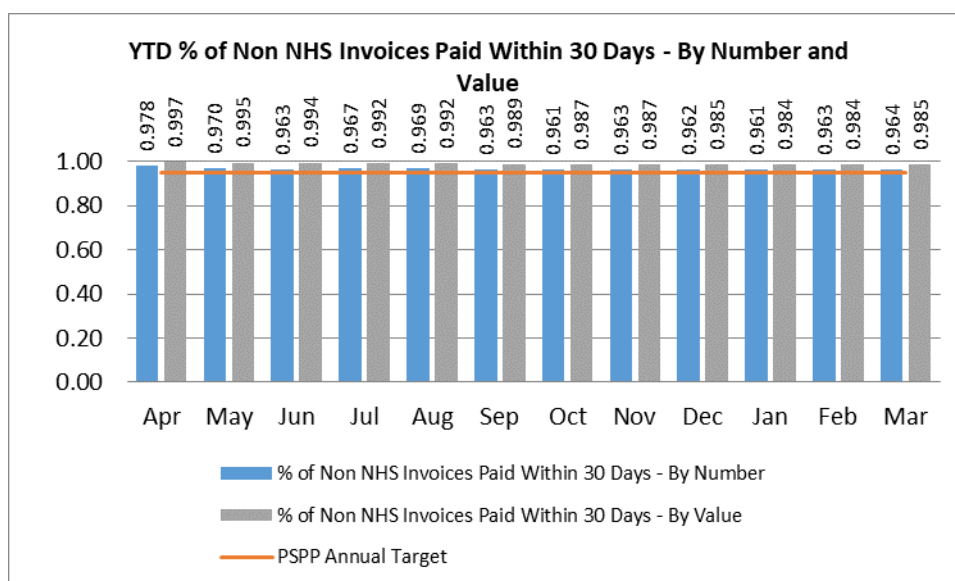
12. On top of this, a series of highlight reports have again been developed that provide the detail of savings delivery at thematic levels. The highlight reports present financial information which is supported by a narrative that denotes progress and identifies actions for the full delivery of our savings plans. Whilst shared locally at a detailed level to inform budgetary decisions, these highlight reports are always also available to Committee members for review, should they wish to receive them.

13. The key points drawn from these are;

- Workforce, efficiencies and transformation has achieved savings / cost containment of £1.075m, over-achieving cumulative target by £0.452m;
- Fleet savings totalling £0.016m has been achieved, under-achieving cumulative target by £0.126m;
- Through management of non-operational vacancies, £2.774m has been saved which exceeds the cumulative target to date by £0.174m;
- There are a number of local schemes in directorates, some of which are attracting additional income rather than reducing costs and savings totalling £0.814m has been achieved, over-achieving cumulative target by £0.201m;
- Estate savings totalling £0.128m has been achieved, achieving cumulative target;
- Digital savings totalling £0.258m has been achieved, over-achieving cumulative target by £0.038m;
- Procurement efficiencies has achieved savings of £0.250m, under-achieving cumulative target by £0.250m
- Income generation totalling £1.232m has been achieved, over-achieving by £0.057m.

#### **PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)**

14. Public Sector Payment Policy (PSPP) compliance up to Month 12 was **96.4%** against the **95%** WG target set for non-NHS invoices by number and **98.5%** by value.



## RISKS AND ASSUMPTIONS

15. There are currently no remaining or expected financial risks to the reported draft year end position (subject to audit).
16. Whilst there are no presented risks to the year end financial position, the number and total value of financial risks we have managed this financial year is clearly greater than in recent years, which in itself raised the level of risk in relation to the continuing delivery of our statutory financial duties. This included, as Committee members will recall, a greater level of income variation much later into the financial year, which needed to be managed. When all this is then considered alongside continuing significant service pressure and the likely balancing of this risk against patient safety, quality, and experience, it is clear that, this has been a challenging financial year, despite the good financial performance as at Month 12. This must also be seen in the context of the progressing the delivery of the financial plan for 2024/25, despite the additional funding uplifts which have been made available for the coming financial year.

## 2023/24 CAPITAL PROGRAMME

17. At Month 12 the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2023/24 is **£21.931m**. This includes **£17.610m** of All Wales Approved schemes and **£4.321m** for Discretionary schemes.
18. It should be noted that, unlike previous financial year ends, WG didn't provide the facility to broker under and overspends between schemes and between years as has been the case in the past. Whilst this always had a neutral impact bottom line, it will now result in some smaller adjustments between schemes in 2024-25.
19. Whilst the majority of schemes delivered to budget there were a few known underspends which the Trust had planned for and discussed with WG, these

included underspends on ESMCP schemes and an underspend on the 2023-24 Vehicle replacement programme, this was offset with the acceleration of the 2024-25 Fleet BJC in relation to the minimum number of replacement defibrillators the Trust would need to replace, this however will need to be repaid/ recovered in the 2024-25 reporting.

20. The Trust achieved the CEL target of £21.931m, with a very small underspend against plan of £10.06 (*subject to audit*). Below is a summary of the year end capital position, which shows the small adjustment between discretionary and All Wales schemes of circa £8k:

	Actual £'000	Plan £'000
<b>All Wales Capital Programme:</b>		
<b>Schemes:</b>		
ESMCP - Control Room Solutions	610	610
111 Project Costs	(1,130)	(1,130)
Additional 111 CAS system - Project Costs	4,159	4,159
Ambulance Replacement Programme 22-23	5,991	5,991
MDVS	1,411	1,411
Efab - Infrastructure	381	381
Efab - Decarbonisation	569	569
Ambulance Replacement Programme 23-24	5,462	5,462
Protective Equipment for Hazardous Incidents	242	242
DPIF for Improvements to NHS Wales Cyber Security (WAST) - FL-DPIF-WAST-Cyber-2023-24-1	94	94
Emergency Medical Services Computer Aided Despatch System (CAD) – Contingency funding	480	480
Ty Maes y Gruffydd building at Cefn Coed Hospital asset transfer to Swansea Bay	(667)	(667)
<b>Sub Total</b>	<b>17,602</b>	<b>17,602</b>
<b>Discretionary:</b>		
I.T.	1,000	1,000
Equipment	829	829
Statutory Compliance	0	0
Estates	2,462	2,462
Other	38	38
Unallocated Discretionary Capital	0	0
<b>Sub Total</b>	<b>4,329</b>	<b>4,329</b>
<b>Total</b>	<b>21,931</b>	<b>21,931</b>
Less NBV reinvested		
<b>Total Funding from WG</b>	<b>21,931</b>	<b>21,931</b>

21. A detailed report on the final 2023-24 Capital programme will be shared through the Capital Management Board for governance purposes.

22. As is expected with projects finishing so close to the year end some schemes have slipped which will result in a need to fund from the 2024-25 discretionary allocation, however it is hoped the impact of this will be minimal due to expected VAT recoveries.

## **2023/24 YEAR END & PLANNING FOR 2024/25 AND BEYOND**

23. Finalisation of the Accounts and audit work continues in respect of the 2023/24 Trust Annual Accounts. The draft accounts were submitted to WG and Audit Wales, as per the issued guidance, on 3<sup>rd</sup> May 2024, with the audited accounts to be presented to Audit Committee on 15<sup>th</sup> July 2024 ahead of seeking final approval of these at Trust Board on 25<sup>th</sup> July 2024.
24. The 2023/24 year-end audit will again be conducted virtually, maximising the use of technology and building on the experiences of the previous 4 years' audits.

### **RECOMMENDED that the Committee:**

- c) **Notes** and gains **assurance** in relation to the Month 12 (and therefore draft 2023/24 year end) revenue and capital financial position and performance of the Trust as at 31<sup>st</sup> March 2024;
- d) **Notes** the delivery of the 2023/24 savings plan, and the context of this within the overall financial position of the Trust.

## Appendix 1

### Welsh Ambulance Services NHS Trust

#### Savings Performance by Directorate Level 3 23-24

Reporting Month 12

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Chief Executive Directorate	137	11	-8	-19	137	64	-73	137	64	-73
Corporate Governance	32	2	4	2	32	39	7	32	39	7
Digital Directorate	478	0	0	0	478	642	164	478	642	164
Finance and Corporate Resources Directorate	1,655	149	193	45	1,655	1,550	-105	1,655	1,550	-105
Medical & Clinical Services Directorate	296	18	14	-4	296	285	-11	296	285	-11
Operations Directorate	1,857	232	203	-29	1,857	2,587	730	1,857	2,587	730
Partnerships & Engagement Directorate	50	3	-12	-15	50	60	10	50	60	10
People & Culture	735	60	81	21	735	536	-199	735	536	-199
Planning and Performance Directorate	83	6	-5	-11	83	63	-20	83	63	-20
Quality, Safety and Patient Experience Directorate	477	39	10	-29	477	554	77	477	554	77
Trust Reserves	200	20	-13	-33	200	167	-33	200	167	-33
<b>Totals</b>	<b>6,000</b>	<b>539</b>	<b>467</b>	<b>-72</b>	<b>6,000</b>	<b>6,546</b>	<b>546</b>	<b>6,000</b>	<b>6,546</b>	<b>546</b>

### Welsh Ambulance Services NHS Trust

#### Savings Performance by Theme 23-24

Reporting Month 12

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Digital	220	0	0	0	220	258	38	220	258	38
Estates	128	11	11	0	128	128	0	128	128	0
Fleet	142	14	6	-8	142	16	-126	142	16	-126
Income	1,175	184	101	-83	1,175	1,232	57	1,175	1,232	57
Local Schemes (Non Pay)	613	67	76	9	613	814	201	613	814	201
Management of Non Operational Vacancies	2,599	152	190	38	2,599	2,774	174	2,599	2,774	174
Procurement Efficiencies	500	55	20	-35	500	250	-250	500	250	-250
Workforce Efficiencies & Transformation	623	56	63	7	623	1,075	452	623	1,075	452
<b>Totals</b>	<b>6,000</b>	<b>539</b>	<b>467</b>	<b>-72</b>	<b>6,000</b>	<b>6,546</b>	<b>546</b>	<b>6,000</b>	<b>6,546</b>	<b>546</b>

#### Key

- negative = under recovered  
+ positive = over recovered

Welsh Ambulance Services University NHS Trust

# Finance & Performance Committee

## Update on Month 1 2024/25 financial performance

14<sup>th</sup> May 2024



GIG  
CYMRU  
NHS  
WALES

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

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Version 1.0  
Released: 14/05/2024

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by Finance & Corporate Resources Directorate

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## Update on Financial Performance – Month 1 2024/25

- Due to limited reporting requirements for Month 1, the amount reported within this presentation is reflective of the information provided to Government.
- The month 1 reports will be submitted to Welsh Government at 12pm today, Tuesday 14<sup>th</sup> May 2024;
- The cumulative year to date (at Month 1 end of April 2024) revenue financial position reported is an underspend against budget of £0.019m;
- The I&E forecast for 2024/25 is one of breakeven;
- The Capital plan is being progressed and current planned expenditure of £21.672m is forecast to be fully spent by the end of the financial year (this now includes the recently confirmed c£12.828m of funding towards the 2024/25 Fleet BJC);
- In line with the financial savings plans that support the IMTP, gross savings of £0.663m have been achieved against a year-to-date target of £0.569m;
- Public Sector Payment Policy is on track with cumulative performance to month 1, against a target of 95%, of 97.3% for the number of non-NHS invoices paid within 30 days.



# Financial Performance by Directorate

## Comments:

- Budget sign off meetings for 2024/25 in the diary
- Most directorates in line with budget plan for Month 01 2024/25;
- FinCoR surplus relates to in part to interest receivable in month being in excess of budget;
- Partnership & Engagement Directorate is underspent by £4k due to staffing vacancies;
- Some additional costs per IMTP remains to be fed into delegated budgets, based on profiling of spend / actual spend incurred ytd

Financial position by Directorate @ 30th April 2024	Year to date			
	Budget	Actual	Variance	Variance
	£000	£000	£000	%
Chief Executive Directorate	157	160	3	2.0%
Corporate Governance	38	38	- 0	-0.1%
Partnerships & Engagement Directorate	42	38	- 4	-8.6%
Operations Directorate	16,032	16,047	16	0.1%
Finance and Corporate Resources Directorate	3,037	2,986	- 51	-1.7%
Planning and Performance Directorate	193	195	3	1.5%
Quality, Safety and Patient Experience Directorate	426	428	2	0.4%
Digital Directorate	902	909	7	0.7%
People and Culture Directorate	412	417	5	1.2%
Trust Reserves	11	12	1	8.2%
TRUST INCOME	- 21,471	- 21,471	- 0	0.0%
Medical & Clinical Services Directorate	223	222	- 0	-0.1%
<b>Overall Trust Position</b>	- 0	- 19	- 19	

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

# Key assumptions/risks in Month 1

- At Month 1 the key assumptions underpinning the year-to-date financial performance, remain broadly in line with that within the 31st March approved IMTP/Trust Board financial plan and budget set;
- In particular:
  - The ability to deliver a minimum of c£6.421m in savings and efficiencies in year. This equates to c2.2% of the Trusts discretionary income;
  - The recovery of all of the income assumptions in the financial plan including growth predictions and that the current changes in commissioning have no wider impact on the Trust financially, including in relation to how it is currently funded for EMS, NEPTS services;
  - No other developments, enhancements or cost increases not currently funded within budgets will be able to be progressed until a confirmed funding source for them is found, or an agreed equivalent value of cost is stopped or reduced elsewhere. These include
    - i. Any costs relating to any proposed banding change for EMT / technician level posts;
    - ii. Any costs, capital or revenue, emerging from the recommendations of the Manchester Arena Inquiry, and
    - iii. Any and all costs associated with the recently submitted Connected Support Cymru business case, other than that already confirmed through Charitable grants.

# Key assumptions/risks in Month 1 (cont'd)

- Despite an element of additional funding provided, some cost elements are still hard to predict through the 2024/25 financial year (and beyond) and may remain volatile, with a clear indication from WG that no further funding will follow in year in 2024/25 to manage any such variations;
- The ability to manage in year cost pressures as they arrive, within the small contingency the Trust continuities to hold, as per the IMTP / 2024/25 financial plan.

# Main risks as at Month 1 – as reported to WG

- Total assessed risks being reported at Month 1 are shown below, given we are only in month 1 and have a balanced IMTP the risks recorded below are all categorised as low risk. However these need to be captured and continually monitored.
- Not captured in the below table is the pay award funding for 2024/25 as this is assumed to flow at cost to WAST and that the recurrent cost of the 2023/24 pay award will be mapped to the JCC to pass through to the Trust. All of this has previously been confirmed as such by WG.

	FORECAST YEAR END	
	£'000	Likelihood
PIBS	(1,000)	Low
Winter Pressure	(1,000)	Low
Energy and Vehicle fuel prices	(1,000)	Low
Non achievement of identified savings	(1,000)	Low
Costs associated with revised EMT / Technician level posts		Low
Costs (Revenue and Capital) emerging from the Manchester Arena Inquiry		Low
Costs associated with the recently submitted Connected Support Cymru Business Case		Low

# Current Schemes – Month 1 Savings



Savings overachieved by £94k to date



C8.9% of annual plan phased YTD of which c10.3% actually achieved against plan



Forecast achievement is currently c£6.421m,

Savings Performance by Directorate Level 3 24-25										
Reporting Month	1									
	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Chief Executive Directorate	139	12	11	-1	12	11	-1	139	138	-1
Corporate Governance	36	3	3	0	3	3	0	36	36	0
Digital Directorate	508	42	38	-5	42	38	-5	508	400	-108
Finance and Corporate Resources Directorate	1,350	77	157	80	77	157	80	1,350	1,713	363
Medical & Clinical Services Directorate	250	21	21	0	21	21	0	250	148	-102
Operations Directorate	2,601	286	292	6	286	292	6	2,601	2,607	6
Partnerships & Engagement Directorate	46	4	4	0	4	4	0	46	46	0
People & Culture	589	49	57	8	49	57	8	589	457	-132
Planning and Performance Directorate	83	7	7	0	7	7	0	83	51	-32
Quality, Safety and Patient Experience Directorate	479	40	46	6	40	46	6	479	485	6
Trust Reserves	340	28	28	0	28	28	0	340	340	0
<b>Totals</b>	<b>6,421</b>	<b>569</b>	<b>663</b>	<b>94</b>	<b>569</b>	<b>663</b>	<b>94</b>	<b>6,421</b>	<b>6,421</b>	<b>0</b>



- Capital funding at Month 1 has been confirmed as £21.672m of which £5.455m is via discretionary capital funding with £16.217 via All Wales Capital Funding.
- The breakdown of the current confirmed All Wales Capital funding is shown below, which now includes that which is being funded for the fleet replacement programme in 2024/25 (only confirmed by WG last week) It should also be noted that the amount provided is circa half (52.6%) of the amount requested via the submitted BJC (£24.388m), therefore further urgent prioritisation works have now commenced, linking into existing workstreams, to ensure maximum value and benefit from that which has been able to be funded.



All Wales Capital Scheme	£000
ESMCP - Control Room Solutions	427.00
Efab - Infrastructure	303.00
Efab - Fire	333.00
Efab - Decarbonisation	596.00
MDVS	1,730.00
Fleet 24-25	12,828.00
<b>Total</b>	<b>16,217.00</b>

Welsh Ambulance Services University NHS Trust

# Finance & Performance Committee

## Update on Month 1 2024/25 financial performance

### Questions and discussion



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NHS  
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Ymddiriedolaeth Brifysgol GIG  
Gwasanaethau Ambiwlans Cymru  
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<b>AGENDA ITEM No</b>	<b>14</b>
<b>OPEN or CLOSED</b>	<b>Open</b>
<b>No of ANNEXES ATTACHED</b>	<b>0</b>

**Financial Sustainability Programme Position Paper**

<b>MEETING</b>	Finance and Performance Committee
<b>DATE</b>	14 May 2024
<b>EXECUTIVE</b>	Angela Lewis, Director of People and Culture Chris Turley, Executive Director of Finance & Corporate Resource
<b>AUTHOR</b>	Gareth Taylor, Project Manager
<b>CONTACT</b>	Email: <a href="mailto:gareth.taylor3@wales.nhs.uk">gareth.taylor3@wales.nhs.uk</a>

<b>EXECUTIVE SUMMARY</b>
<ol style="list-style-type: none"> <li>1. This paper sets out the Year End Position of the Financial Sustainability Programme and highlights key areas of progress against key schemes within Achieving Efficiency and Income Generation. It also sets out key areas of focus for 2024/25 and highlights the lessons learnt that will be embedded into the 2024/25 Programme.</li> <li>2. As of M12 FY2024/25, there is an overperformance of £546,000 against the established planned total (YTD) of £6m.</li> <li>3. As noted in previous Finance &amp; Performance Committee updates based on the 2% savings requirement from Welsh Government (of total turnover), £6.4m of potential savings opportunities have been targeted, and earmarked for delivery in 2024/25.</li> </ol> <p><b>RECOMMENDATION:</b> <b>Finance and Performance Committee is asked to note the content of this Year End Report.</b></p>

<b>REPORT APPROVAL ROUTE</b>		
<b>WHERE</b>	<b>WHEN</b>	<b>WHY</b>
FSP Lead Executives	29/04/2024	For Noting
Finance & Performance Committee	14/05/2024	For Noting

<b>REPORT APPENDICES</b>
None.

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

## 1. Context

1.1. This paper sets out the Year End position for the Financial Sustainability Programme and highlights key areas of progress against key schemes within Achieving Efficiency and Income Generation.

1.2. A targeted savings target of £6m was set for the 2023/24 financial year, a £1.7m uplift on 2022/23. This target was surpassed by £546,000.

1.3. The challenging financial climate within the public sector continues the need for all public sector organisations to deliver sustainable recurrent savings especially based on reducing costs. As a result, the savings target (2% of turnover, set by Welsh Government, increases to £6.4m for 2024/25.

1.4. Following the finalisation of the 2024/25 Financial Plan to supplement the 2024-27 IMTP submitted to Welsh Government in March 2024, a review session was undertaken on the direction and objectives set for 2024/25.

1.5. The result is a set list of potential areas of focus for 2024/25 to enable delivery of key targets.

1.6. While there is an evident overperformance against the established 2023/24 savings target, there has been an opportunity to scope and assess the challenges that presented over the year, along with opportunities to learn and mitigate as we head into a new financial year.

1.7. As a long-term workstream, the FSP will continue to evolve as outlined later in the paper.

## 2. Current Areas of Focus

2.1. As noted in the March 2024 FPC update, Achieving Efficiency has focussed on four key areas of delivery.

- **Service and Provision Reviews:** This area looks to provide an evidence-base for long-term efficiency across the organisation by undertaking an audit of Administrative and Support Staff provision, and an audit of Service provision across the organisation which will establish the basis for an annual review process.
- **Short-term Efficiency Savings:** Identify, scope, and deliver opportunities for cash-related savings in the short-term, contributing to the FY23/24 financial savings target.
- **Long-term Efficiency Savings:** Identify, scope, and deliver opportunities for long-term cash-related savings, contributing to targets beyond the FY23/24 financial savings target.
- **Process Efficiencies:** Identify, scope, and deliver opportunities for non-cash-related savings opportunities.

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

- **Income Generation Schemes:** *Scope and deliver 'small-wins' to support the delivery FY23/24 financial savings target.*
- **Commercial Structures and Long-Term Planning:** *Scope potential dedicated structure for delivery and oversight of commercial opportunities beyond 23/24 and to support long-term financial sustainability.*
- **Commercial and Financial Mindsets – Training and Development:** *Explore opportunities for commercial and business training and embed a culture of commercial capability across the organisation.*

### 3. Achieving Efficiency

#### 3.1. Service & Provision Reviews

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

3.1.2. ADLT continue to take forward recommendations from the Administrative and Corporate Services Review and have developed a 22-point Action Plan accordingly, which (as of March 2024) there remains 6 workstreams designated **must do**, with a further 13 designated as **should do**. The remaining 3 workstreams are designated **could do** or will not do.

3.1.3. The Service Review is also underway and at time of writing, all data collection has now completed following the dedication of approximately 70 hours of interviews across 57 service areas. Following this, the development of initial summary reports will be assessed by a group of key colleagues.

### 3.2. *Short Term Savings Opportunities*

3.2.1. Progress within this key area has included 'short-term' wins (including a deep dive into Fuel Efficiencies and consumables spend). While the Consumables pilot has now completed with satisfactory results, the ongoing delivery of savings will transition into the relevant operational areas. The work has transitioned into BAU with continued monitoring, and targeted saving set within the 2024/25

3.2.2. Following the lease and hire car audit mandated by the Achieving Efficiencies Group, work has both mitigated potential areas of Trust Risk surrounding the use of lease and hire cars and reduced avoidable spend. A new process for requesting vehicles was also implemented in November 2023. Following the transition of this work back to BAU, further income generation opportunities are currently being scoped into the new year.

### 3.3. *Long Term Savings Opportunities*

3.3.1. Longer term saving opportunities encompass areas such as Digital. Several opportunities for long term sustainability flow directly from the reviews and will be taken forward as recommendations. These include robotics and process automation among others.

### 3.4. *Process Efficiencies*

3.4.1. As above, several opportunities for long term sustainability flow directly from the reviews and will be taken forward as recommendations via these action plans. These include e-timesheets among others.

3.4.2. Minor process changes already delivered in 2023/24 include a renewed process around Hire & Lease Cars, automated stock replenishment (due to be fully rolled out in 2024/25 and 2025/26, and improved awareness of fuelling processes.

## **4. Income Generation**

### 4.1. *Commercial Structures and Long-Term Planning*

4.1.1. Income Generation has focused on assessing the structures and gaps for delivering on future commercial ventures.

4.1.2. There has been considerable consideration given to risk appetite over the last 12 months by Trust Directors and non-Executive Directors.

4.1.3. Following on from an extensive review of options and the potential viability of increasing income generation / commercialisation, the decision has been made to progress this area of work with increased focus and dedicated resource over the coming year.

4.1.4. In doing so 2024/25 will largely be focussed on developing a substructure, with a clear mission statement of assessing opportunities in enough detail, in order to potentially achieve a position by March 2026 whereby commercial ventures are pursuable. Should the decision be not to pursue then a robust evidence base will be in place to justify the decision.

#### 4.2. *Commercial and Financial Mindsets – Training and Development*

4.2.1. Discussions at STB have acknowledged changes required and identified the need to do more to embed a commercial mindset in a public sector organisation like WAST and will be considered as part of both the remit of any commercial function but will also be managed via engagement and training throughout the year.

### **5. Successes**

5.1. **Scheme Submission:** A number of schemes were proposed and evidenced clear engagement Trust-wide.

5.2. **Communication & Engagement:** 2023/24 evidenced positive engagement with colleagues across the Trust.

5.3. **Stakeholder Engagement:** When in full attendance, stakeholders excelled at driving schemes forward and provided a robust foundational knowledge on which schemes were deemed viable or not. For 2024/25 we will look to expand this core group of stakeholders and expand the knowledge base available depending on the scheme

5.4. **The Role of the FSP:** The core role of the FSP group is to enable financial sustainability, by providing the mechanism to deliver alternative schemes or proposals, as well as providing assurance, and oversight of key areas of enquiry. The FSP group will continue to support the development and implementation of key schemes into 2024/25, assessing any plans, supporting risk management, and target monitoring to ensuring schemes remain financially viable and aligned with the objectives of the IMTP.

5.5. **Assurance:** As noted above the FSP regularly engaged with TU partners throughout the year via schemes or via the Executive Sponsors, as well as providing assurances to Finance & Performance Committee, CEO, Trust Board, ELT, and STB. Work will continue into 2024/25 to ensure governance arrangements are as robust possible.

### **6. Challenges and Lessons Learnt**

6.1. The Financial Sustainability has evolved over the last 18 months, and awareness among WAST colleagues of the significance of sustainability and efficiency has been supported by several key workstreams.

6.2. The Financial Sustainability Programme has been successful in delivering an appetite for change, evidenced by the number of schemes that have been proposed, and while many have been deemed non-viable, it is positive that innovation to drive sustainable change is evident among colleagues.

6.3. As the programmes sets its objectives for 2024/25, it is important to note the challenges faced and lessons learnt. These include,

Area	Summary of Experience	Lesson Learned
Scheme Submission	During 2023/24, schemes were typically submitted verbally, by email, or during group forums, and often consisted of an idea or suggestion only. This method of submission became time consuming to extrapolate the detail and assess the idea.	In light of this, a scheme proposal document was later drafted with a focus on the benefits (financial/quality) and risks. This scheme proposal document can be accessed within the FSP Delivery Framework (Appendix A).  There will also be a portal on Siren to support accurate recording and audit of submissions.
Communication & Engagement	Communication and awareness of the FSP was primarily via word of mouth, outside of typical assurance hierarchies.	In light of, this, regular communication and enhanced engagement throughout 2024/25 will be supported by an increased presence on Siren and a staged approach to communications.
Financial Sustainability/Income Generation	Organisational Maturity	Investing in continuous organisational development and knowledge transfer to ensure WAST remains agile and adaptable to challenges.
Financial Sustainability/Income Generation	Risk Appetite variation across WAST	Implementing mechanisms for transparent communication and collaboration to align risk management strategies with the needs and priorities of different services within WAST.
Financial Sustainability/Income Generation	Risk Reputational Damage	Prioritising transparency, accountability, and ethical conduct in financial decision-making processes to safeguard WAST's reputation and maintain public trust.
Financial Sustainability/Income Generation	Risk appetite vs Risk capacity	Conducting regular assessments of risk exposure and resource capabilities to ensure strategies are realistically aligned to reduce and mitigate risk.

Financial Sustainability/Income Generation	Lack of capacity and headspace to pursue	Streamlining processes, delegating responsibilities, and providing adequate support to alleviate work pressures and create space for planning and implementing.
Financial Sustainability/Income Generation	Disconnect (ELT sometimes unaware of schemes discussed at directorate level)	Enhancing communication channels for information sharing platforms, ensuring that relevant stakeholders are kept informed and engaged in discussions.
Financial Sustainability/Income Generation	Lack of financial acumen	Investing in targeted training and development to build literacy and competency skills among staff at all levels, empowering them to make informed decisions and contribute effectively to financial sustainability.
Financial Sustainability/Income Generation	Lack of commercial expertise	Recruiting or developing talent with specialised expertise and leveraging external partnerships to access additional support to optimise revenue and cost management strategies.
Financial Sustainability/Income Generation	Lack of structures to deliver real income generation	Identify opportunities beyond traditional funding sources, recognise and address gaps and limitations in the existing business model, invest in developing structures and processes to support income generation initiatives. Ensure alignment with WAST mission, values and strategic objectives. Develop robust frameworks.

## 7. 2024/25 Forward Plan

7.1. A communication plan will be enhanced along with a dashboard on SIREN which will improve accessibility, transparency, and engagement. This plan will aim to provide clarity and promote increased engagement and suggestion submission.

7.2. A scheme proposal document has been uploaded to SIREN and will be available to anyone wishing to submit a scheme idea. The key objective for 2024/25 will be to ensure an integrated system working in conjunction with WIIN.

7.3. Achieving Efficiency work will continue to be influenced by the recommendations of the Administrative and Service reviews.

7.4. The main objective of Income Generation will be to set up a commercial function alongside scoping of schemes.

7.5. Both workstreams will look to focus on closer alignment and input from colleagues in operations who lead on and achieving efficiencies agendas

7.6. Plans to achieve greater alignment with Value Based Health Care work to ensure a focus on values and sustainability as per the IMTP.

## **8. Financial Progress**

8.1. As of M12 FY2024/25, there is an overperformance of £546,000 against the established planned total (YTD) of £6m.

8.2. FY2024/25 has identified approximately £6.4m ahead of the new year, with approximately £3.3m of non-recurrent schemes carried over from 2023/24.

## **9. Conclusion**

9.1. Finance & Performance Committee are asked to **note** the content of this Year End Report.

## POLICIES RECOMMENDED FOR COMMITTEE APPROVAL AND ADOPTION

<b>Committee</b>	Finance and Performance Committee	<b>Date of Meeting</b>	14/05/2024
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<b>Presenting Officer</b>	Julie Boalch, Head of Risk/Deputy Board Secretary [Chair of Policy Group]
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Policy Name	Directorate	EqlA	Date of Policy Group	Date of ELT	Points of Note
Purchase Card Policy v1.14	Finance and Corporate Resources	Completed No Issues	23/01/2024	14/02/2024	N/A
Waste Management Policy v1.12	Finance and Corporate Resources	Completed No Issues	23/04/2024	08/05/2024	N/A
Data Quality Policy v0.11	Digital Services	Completed No Issues	23/04/2024	08/05/2024	N/A



GIG  
CYMRU  
NHS  
WALES

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

# Purchase Card Policy

<b>Policy Number:</b>	086	<b>Version No:</b>	1.14	<b>Supersedes:</b>	1.13
<b>Date of Approval:</b>		<b>Review Date:</b>	Three years from date of approval	<b>Impact Assessments Completed:</b>	Yes
<b>Classification of Document:</b>	Finance	<b>Type of Document:</b>	Policy	<b>Approved by:</b>	
<b>Brief Summary of Document:</b>	The purpose of this policy document is to ensure that Purchase Cards (P-Cards) are used as an efficient, secure business tool, strategically aligned with the wider requirements of the business.				
<b>Scope:</b>	This policy applies to all employees of the Trust who have a Purchase Card (P-Card).				
<b>To be read in conjunction with:</b>	N/A				
<b>Owned By</b>	Finance & Performance Committee				
<b>Policy Lead:</b>	Jillian Gill	<b>Job Title:</b>	Head of Financial Accounting		
<b>Trade Union Lead:</b>	Mark Marsden		Trade Union Partner		
<b>Director:</b>	Chris Turley	<b>Job Title:</b>	Executive Director of Finance and Corporate Resources		

**Version Control Sheet**

Version	Date	Author	Summary of Changes
1.0	02/09/2019	Jillian Gill	Initial Draft
1.1	20/11/2019	Jillian Gill	Amendments following Task and Finish Group meeting on 13th November 2019
1.2	21/11/2019	Julie Boalch	Formatting amendments
1.3	28/11/2019	Jillian Gill	Amendments following Policy Group meeting on 26th November 2019
1.4	02/03/2020	Jillian Gill	Amendments following Task and Finish Group meeting on 28th February 2020
1.5	19/10/2021	Julie Boalch	Minor template formatting amendments
1.6	18/01/2022	Jillian Gill	10 f) amended to read 'Electrical goods over £50'. Also updates to finance job titles
1.7	18/01/2022	Julie Boalch	Update to front cover
1.8	20/02/2022	Julie Boalch	Update to EqIA section to include and Welsh Language
1.9	15/11/2023	Jillian Gill	Review of policy prior to re-submission to Policy Group. Amendments include update to DoF role name, minor updates to usage in sections 9 & 11 in part to accommodate and reflect home working arrangements. Change in name of Card Administrator Section 21 and change of TU representative.
1.10	16/01/2024	Julie Boalch / Lisa Trounce / Louise McKenzie	Formatting amendments, new template.
1.11	23/01/2024	Jillian Gill	Typo's identified at policy meeting on 23/01/24. Also change of frequency of review back to every three years as agreed, and correction of Digital Directorate name, together with an update to Task and Finish group members heading to aid understanding.

Version	Date	Author	Summary of Changes
1.12	04/03/2024	Jillian Gill	Update of job titles.
1.13	25/04/2024	Lisa Trounce	Crown badge and Trust logo replaced with new, and header updated to reflect Trust's university status. Version control sheet updated and standardisation of date format.
1.14	26/04/2024	Julie Boalch	Logo on front cover

### Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Counter Fraud	28/10/2019	Carl Window
Information Governance		
Records Management		
EqlA / Welsh Language	28/02/2020	Melfyn Hughes
Estates	N/A	
Environment	N/A	

### Task and Finish Group Members (correct at time of policy writing circa 2019/20)

Name	Job Title
Jillian Gill	Head of Financial Accounting
Tracey Thomas	Financial Services Accountant
Catrin Jones	Debtors Assistant
Angie Roberts	Trade Union Partner
Rhian Watts	Assistant Finance Manager
Nicola Parsons	Assistant Finance Manager
Nick Roberts	Assistant Finance Manager
Stephen Williams	Locality Manager
Susan Gillard	PA to DoF
Emma Oram	PA to DoF
Nyree Mogford	PA to CEO
Phillip Davenport	Claims Investigation Manager
Ian Jones	NWSSP Procurement

**Keywords** Purchase Cards, Card, P-Card

**Policy Approval Route**

Meeting Title	Meeting Date	Purpose/Outcome
Company Payment Card start up meeting (Task and Finish group)	13/11/2019	For information and comment
Policy Group Meeting	26/11/2019	For information and comment
Policy Group Meeting	21/01/2020	For information and comment
WASPT	27/01/2020	For information and comment
Company Payment Card Task and Finish Group	28/02/2020	For information and comment
(process paused due to Covid-19)		
Policy Group Meeting	19/10/2021	For information and comment
EMT	22/12/2021	For information and comment
Policy Group	25/01/2022	To recommend approval
Policy Group	23/01/2024	To recommend approval
Trade Union Partners Team	TBC	To recommend approval
ELT	14/02/2024	To recommend approval
Finance and Performance Committee	19/03/2024	Approval

**Disclaimer:**

If the review date of this document has passed, please ensure that the version you are using is the most up to date either by contacting the document author or by emailing [Amb\\_policies@wales.nhs.uk](mailto:Amb_policies@wales.nhs.uk)

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## 1. INTRODUCTION

Purchase Cards (referred to within the rest of this document as “P-Cards”) are designed to provide the Trust with an efficient and cost-effective method for managing certain types of purchasing requirements.

P-Cards are assigned to individual members of staff who are authorised to make certain types of purchases on behalf of the Trust.

P-Cards streamline the purchasing process by reducing and/or removing the need for reliance upon traditional purchasing routes such as Cheque Requests, and Petty Cash.

P-Cards also reduce the administrative effort associated with the more traditional purchasing routes referred to above.

Where appropriate and specifically allowed for, P-Cards can also provide the Trust with a degree of additional purchasing flexibility and operational resilience. For example, P-Cards can be set up to allow purchases to be made outside of normal working hours.

Typically, P-Cards are designed to manage the following types of purchasing requirement: -

- to enable online payments to be made where alternatives are not possible.
- to provide flexible operational resilience in place of petty cash
- to replace petty cash provision where appropriate.

## 2. POLICY STATEMENT

The Trust is committed to ensuring that its Board members and staff practice the highest standard of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and non-executive members are informed and supported in delivering that aim.

## 3. SCOPE

This policy applies to the whole Trust. It applies to all employees and all non-executive board Members. The term employees include all those who have an employment or honorary contract with the Trust.

## 4. AIM

The purpose of this policy document is to ensure that P-Cards are used as an efficient, secure business tool, strategically aligned with the wider requirements of the business. Specifically, the policy document will ensure that: -

- Robust rules, guidelines, processes, and control mechanisms are established for the use of P-Cards.
- The policy is clear and unambiguous, easy to understand, and is easily accessible.
- P-Cards are used in an appropriate, effective, and controlled manner.
- Obligations and responsibilities for all staff involved in the use or management of P-Cards (Card Administrators, Card Holders, and Line Managers) are clearly defined.
- All staff involved in the use or management of P-Cards are made aware of the potential consequences resulting from the misuse of P-Cards.

## 5. OBJECTIVES

This policy aims to clarify the respective responsibilities of individuals in the discharging of this policy.

## 6. ROLES AND RESPONSIBILITIES

### Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate banking arrangements in place. This responsibility is delegated to The Executive Director of Finance and Corporate Resources.

### Executive Director of Finance and Corporate Resources

The Executive Director of Finance and Corporate Resources is responsible for the effective management of, and compliance with, this policy.

## 7. EQUALITY

The Welsh Ambulance Service NHS Trust is committed to implementing all policies in a way which promotes the fair and equal treatment of all employees and eliminates discrimination on the grounds of race, disability, gender, gender reassignment, age, sexual orientation, religion and belief, language, human rights and the Welsh Language.

This policy applies to all staff. An equality impact assessment has been undertaken and no specific matters relating to equality have been identified. As the policy applies universally to all staff only Part A and B of the equality impact assessment was undertaken.

## 8. OBTAINING A PURCHASE CARD

To make an application please complete the forms at Appendix 1 and Appendix 2 and arrange for your line manager to e-mail the forms together with an indication of their approval to the Card Administrator.

A P-Card will only be issued to an individual once:

1. The P-Card application has been properly completed and approved by the line manager, please refer to the form titled "New Card Holder Application Form" at **Appendix 1. In addition to the completion of Appendix 1, a Barclaycard application form must also be completed. A link to this is included within Appendix 1.**
2. The P-Card applicant provides acknowledgement of having accepted the terms of use within the policy document (see **Appendix 2**).
3. An Authorised Signatory change form has been completed for the P-Card applicant and authorised as appropriate to enable delegated budget to be assigned to the applicant. The financial limit on this must be sufficient to cover the transaction limit requested within **Appendix** Forms and full guidance can be obtained by e-mailing [AMB\\_WAST.ASL@wales.nhs.uk](mailto:AMB_WAST.ASL@wales.nhs.uk)
4. The P-Card application is submitted to and approved by the Card Administrator.

## 9. PERMITTED SPEND CATEGORIES

Your Purchasing card can potentially be used at any Visa supplier outlet, provided your card has been set with the appropriate authorities.

Suppliers that accept your Purchasing Card fall into two categories: -

1. Suppliers who are Visa Purchasing Card capable (special electronic equipment must be installed by the suppliers to have this facility).
2. Suppliers that accept Visa only.

## 10. PROHIBITED TRANSACTIONS

The following spend categories/ activities/ transaction types are prohibited:

- a) Items for personal use or for personal benefit\*
- b) Automotive fuel\*
- c) Alcoholic beverages
- d) Cash
- e) Goods available from Trust catalogue\*
- f) Electrical goods over £50.

- g) IT Equipment, unless purchased by the Digital Department, all such transactions should be addressed to Procurement using appropriate IT procurement forms.
- h) Training fees
- i) Travel and accommodation costs \*

\* *Unless in the situation of urgency or resilience e.g. a) replacement of contaminated clothing, b) fuel card failures, e) items required urgently i) in emergency or exceptional situations*

## 11. RAISING TRANSACTIONS / PLACING ORDERS

In brief the requirements are as follows:

The cardholder personally needs to place the order. This can be in one of four ways:

- Ordering the goods/service by telephone and quoting the card number. Telephone orders should be delivered to a site address and not to the cardholder's private address. \*\*
- Personally, visiting the supplier's premises and signing for the goods.
- Placing orders on a Suppliers web site via the Internet

N.B. where documentation is used for ordering the cardholder should not leave paperwork around displaying the card number.

**In all instances** the cardholder **must** inform the supplier of:

- The full card number and date of expiry.
- The full name of the cardholder (as shown on the card).
- The Company name.

When undertaking transactions by telephone order or over the internet you may be asked to quote the last three digits of the number printed within the signature slip on the reverse of your card (CVV number).

You will also need to quote:

- The full delivery address.
- A clear description of the goods required.

The goods and GRN (and VAT receipt where appropriate) should be marked prior to shipment: -

**“Visa Purchasing Card”**  
**Cardholder's Name and Location/Department**

The supplier needs to send an invoice/VAT receipt and it must be sent **directly to you**. Failure to do this may result in the supplier being paid twice. It is imperative that these invoices/VAT receipts are retained and uploaded onto the online Barclaycard system. Failure to comply will result in WAST not having the evidence to enable the reclaim of VAT on the transaction.

\*\* Exception being in the case of home office and order relating to item for home office use.

### **11.1 Card Declined**

If a transaction is declined refer to your Purchasing Card Administrator. Some potential causes are exceeding monthly card limit, exceeding individual transaction limit, or using a supplier that is within a Merchant Category not allowed by the Company.

### **11.1 Rejection of Goods/Goods Incorrect**

If you reject the goods, ensure that you tell the supplier directly, as it is they who will arrange a credit to your Purchasing Card account. The credit will appear on your monthly statement / cardholder transaction reports and therefore should be entered on your daily log to aid reconciliation. There is no need to await receipt of the Purchasing Card statement before raising the problem with the supplier. If you cannot come to mutual agreement with the supplier, contact your Purchasing Card Administrator.

### **11.2 Incorrect amount billed.**

When checking your monthly statement / cardholder transactions you may identify a transaction that you are not happy with. In these circumstances contact the relevant supplier to seek explanation/adjustment. If the discrepancy remains unresolved contact your Purchasing Card Administrator for further instructions. Further instructions will need to be provided to the Purchasing Card Administrator regarding the transaction dispute settlement process.

### **11.3 Billed but goods not received.**

If you are billed for something that has not been received, contact the supplier to ensure that the goods have been despatched. It is VISA regulations that the transaction is not processed until the goods are despatched. Inform your Purchasing Card Administrator this regulation has been breached.

## 11.4 Missing transactions

Any purchases made just prior to statement date (a date each month) will show up on the following month's cardholder statement / cardholder transaction report. If any transactions do not turn up as anticipated it is possible that the supplier has not yet entered the purchase into the VISA system. In these circumstances contact your Purchasing Card Administrator before taking any action.

## 12. CARD HOUSEKEEPING

### 12.1 Amended cards - change of name.

If you need to amend your name on the card (e.g. because of marriage etc.) contact your Purchasing Card Administrator. The obsolete card should be cut in half across the magnetic strip and then returned to the Purchasing Card Administrator following receipt of the new one.

### 12.2 Card renewals

Line managers should revisit the justification for need on an annual basis and assess whether existing P-Card holders should continue to have cards, these findings should be clearly documented. If it is decided that a card should be withdrawn, the Card Administrator should be contacted.

Your replacement card should be received approximately 14 days before the renewal date. Non-receipt should be advised immediately to your Purchasing Card Administrator.

### 12.3 Security of the card

The card provided to you is to be used by you only and should not be lent to anyone else. It is in the name of the company, and it is your responsibility to ensure that it is retained in a secure location. Remember, cards are to be used for business purposes only.

On receipt of your card, you will be asked to sign an employee agreement form to confirm that you will adhere to the procedure documented please see **Appendix 3**.

### 12.4 Lost/stolen/damaged cards.

If you lose your card or it is stolen or damaged, please advise Barclaycard Customer Services immediately by telephone.

Telephone 0333 202 2051 (Lost or stolen cards – 24 hours and 7 days per week)

Please also complete the lost/stolen/damaged incident report and forward this to the card administrator. This is shown in **Appendix 4**.

### **12.5 General customer services enquiries**

Telephone 0333 202 2051 (Mon – Fri 8am to 8pm, Sat 8am to 6pm)

### **12.6 Job change/department change**

Upon notice of a job change and/or departmental change, advise your Purchasing Card Administrator as soon as possible. A decision will then be made on the need for your continued use of the card.

### **12.7 Leaving employment.**

Upon leaving the employment you must cut your card in half and return it to the Purchasing Card Administrator.

### **12.8 Cardholders liability/credit status**

Whilst the Purchasing Card is embossed with your name, the account and therefore the liability is in the name of your organisation. Consequently, there is no impact on your personal credit status. However, fraudulent use of the card may lead to disciplinary proceedings.

### **12.9 Monthly credit limit**

An initial monthly credit limit has been set for your card as detailed in Appendix 1. If you find that this is insufficient for your needs, contact your Purchasing Card Administrator to discuss a revision. Any revisions would require the authorisation of your line-manager.

### **12.10 Transaction limit**

The maximum permitted transaction limit will need to be agreed between the line manager and proposed cardholder at the application stage and should be set at a level appropriate for the intended usage. Your current limit is shown in Appendix 1. The card should not be used for purchases more than this limit. Attempts to do this will be met

with a decline when authorisation is sought for the transaction. This limit is inclusive of any VAT, carriage charges etc.

## 13. CARDHOLDER TRANSACTION REPORTS

### 13.1. Monthly Reconciliation

1. Finance will download a transaction file from Barclaycard, which lists purchases from 29<sup>th</sup> of the previous calendar month to the 28<sup>th</sup> of the current month. The Bank's software provides a summary report and splits the transaction file into individual cardholder statements.
2. Around the 29<sup>th</sup> of each month, an E-mail notification will be sent by Barclaycard to Cardholders that their transaction statement is available.
3. Cardholder will upload copies of Invoices/VAT Receipts into the online Barclaycard system. This can be undertaken at any point during the monthly cycle.
4. Cardholder will review the statement online, checking for accuracy and applying financial codes from preset drop-down lists before submitting for line manager approval online.
5. Line manager will then receive a notification to approve.
6. Manager reviews transactions online and approves or rejects as appropriate.

**The above should be processed within 5 working days of receipt. If there is any delay, please advise the Purchasing Card Administrator as to the reasons before the end of the reporting period. Failure to comply with this process will result in the card being deactivated.**

## 14. SUSPENSION OR TERMINATION OF A PURCHASE CARD ACCOUNT

The Trust may terminate the right to use a P-Card at any time and for any reason. The relevant P-Card Holder must return a terminated P-Card immediately upon request.

A P-Card may be terminated for the following reasons (these are indicative examples, and this is not an exhaustive list): -

- The P-Card Holder shares the P-Card with someone else.
- The P-Card Holder splits transactions to obtain value higher than the single transaction limit.

- The P-Card Holder uses the card for any transactions which are non-compliant with P-Card Policy.
- The P-Card Holder fails to undertake monthly reconciliations as explained above.

## **15. COUNTER FRAUD**

The Welsh Ambulance Services NHS Trust is committed to taking all necessary steps to counter fraud, bribery, and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively, staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility <https://cfa.nhs.uk/reportfraud> Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

## **16. RECORDS MANAGEMENT**

The Welsh Ambulance NHS Services Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff, and members of the public.

## **17. TRAINING AND IMPLEMENTATION**

No formal training is needed for the implementation of this policy. Support and guidance will however be provided by the finance team as required.

## **18. AUDIT AND MONITORING**

Use of P-Cards and compliance with P-Card policy will be subject to regular audit (both formal and informal).

It is the responsibility of all individuals either directly or indirectly involved in the use or management of P-Cards to conduct regular analysis of all P-Card transactions and to self-audit compliance with P-Card Policy.

Individuals directly or indirectly involved include:

- Card Administrator(s)
- P-Card Holder(s)
- P-Card Line Managers(s)

- Budget Holders
- Procurement Department
- P2P Department

It is the responsibility of all individuals to immediately inform the Card Administrator in writing of all identified instances of P-Card misuse or non-compliance with P-Card Policy.

Each nonconformance will be communicated by the Card Administrator(s) direct to the relevant P-Card Holder and their P-Card Line Manager and will be investigated accordingly.

Audit provisions are intended to identify the following typical examples / indicators of potential / actual misuse, or potential / actual non-compliance with P-Card Policy.

- Unusual transaction patterns e.g. transactions made on weekends/ out of office hours.
- Purchases made in contravention of prohibited spend categories and/or suppliers.
- Unusual increases in P-Card Holder average spend.
- Any instances where it appears that a supplier has processed multiple transactions for a single item to work around single transaction limits.
- Any transaction that has not been coded or which lacks an appropriate description.
- Transactions that have not been validated and approved in a timely manner by both Card Holders and Supervisors.
- Not coding the VAT charge or trying to obtain receipts.

## **19. REVIEW**

This policy will be reviewed every three years or sooner should the Policy Lead or legal requirements deem it to be relevant or required.

## **20. DOCUMENT CONTROL**

This document will be held by the Finance department. Copies of the document will be made available on their intranet page.

## 21. APPENDIX 1 - NEW CARD HOLDER APPLICATION FORM

### Cardholder Specific Details

<b>P- Card holder Name</b>	
<b>P- Card holder work postal address</b> ( <i>address card to be posted to</i> )	
<b>P- Card holder work e-mail address</b>	
<b>Card Administrator:</b>	Sonia Das, Finance and Corporate Resources, Ty Elwy, St Asaph e-mail <a href="mailto:Sonia.Das@wales.nhs.uk">Sonia.Das@wales.nhs.uk</a> Enquiries also to :- Tracey Thomas, Finance, Ty Elwy, St Asaph e-mail <a href="mailto:Tracey.Thomas5@wales.nhs.uk">Tracey.Thomas5@wales.nhs.uk</a>
<b>Transaction Limit:</b>	£
<b>Monthly Card Limit:</b>	£
Please explain reasons why a P-Card is required?	
Will the issue of this card mean that a Petty Cash existing resource will no longer be required? Y/N If so, please name present Petty Cash holder.	
<b>Link to Barclaycard Cardholder Application Form.</b> Please complete online and submit with Appendix 1. <a href="#">e-Payments service.html</a>	
<b>P- Card Line Manager Name</b>	
<b>P- Card Line Manager e-mail address</b>	

**22. APPENDIX 2 – CARDHOLDER AGREEMENT**

If my card application is successful I, ..... as a cardholder I agree to comply with the following terms and conditions regarding my use of the Card.

- a. I have received and understood that I am being entrusted with a corporate charge card and will be making financial commitments on behalf of the Welsh Ambulance Services NHS Trust. Where stipulated and if relevant, I will be using designated suppliers as identified by the Purchasing department.
- b. I understand that the Welsh Ambulance Services NHS Trust is liable to the card provider for all the charges made on the card.
- c. I agree to use this card for the Welsh Ambulance Services NHS Trust business purchases only and agree not to charge personal purchases. I understand that the Trust will audit the use of this card and report and take appropriate action on any discrepancies. *Such action may include disciplinary, or referral for investigation by the Trust’s Local Counter Fraud team.*
- d. I will follow the established procedures for the use of the card. Failure to do so may result in either revocation of my use privileges or any other disciplinary actions, including termination of employment.
- e. I am aware of the Trust’s Purchasing Card Policy and understand the requirements for the Card’s use.
- f. I agree to return the Card immediately upon request or upon termination of employment (including retirement). Should there be any organisational change, which cause my purchasing requirements to change, I agree to return my card and arrange for a new one, if appropriate.
- g. If the card is lost or stolen, I agree to notify Barclaycard immediately by telephone and the Card Administrator as soon as possible thereafter.
- h. I agree to place orders with the vendors listed on the Preferred Vendor List supplied to me (if applicable).

Employees Signature\_\_\_\_\_

Date\_\_\_\_\_

Managers Signature\_\_\_\_\_

Date\_\_\_\_\_

Administrators Signature\_\_\_\_\_

Date\_\_\_\_\_

**23. APPENDIX 3 – LOST/ STOLEN/ DAMAGED INCIDENT REPORT**

<i>Cardholder name</i>	
<i>Department / Contact number</i>	
<i>Card number</i>	
<i>Date lost/stolen</i>	
<i>Location lost/stolen</i>	
<i>Brief report of circumstances lost/stolen</i>	
<i>Date reported to Barclaycard</i>	
<i>Name of contact at Barclaycard</i>	
<i>Date Reported to Card Administrator</i>	

Send this form to the Purchasing Card Administrator as confirmation of your telephone call to Barclaycard Customer Services team.



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Welsh Ambulance Services  
University NHS Trust

# Waste Management Policy

<b>Policy Number:</b>	109	<b>Version No:</b>	1.12	<b>Supersedes:</b>	1.11
<b>Date of Approval:</b>	TBA	<b>Review Date:</b>	3 years from date of approval	<b>Impact Assessments Completed:</b>	Yes
<b>Classification of Document:</b>	Corporate	<b>Type of Document:</b>	Policy	<b>Approved by:</b>	Finance & Performance Committee
<b>Brief Summary of Document:</b>	Management and disposal arrangements for healthcare and non-healthcare waste.				
<b>Scope:</b>	The scope of the waste management policy provides clear direction, guidance and advice to all Trust employees, visitors, volunteers, and contractors involved in the management and disposal arrangements for healthcare and non-healthcare waste.				
<b>To be read in conjunction with:</b>	Policies and standard operating procedures as listed in Appendix A.				
<b>Owning Committee</b>	Finance and Performance Committee				
<b>Policy Lead:</b>	Nicola Stephens	<b>Job Title:</b>	Environment and Sustainability Manager		
<b>Trade Union Lead:</b>	Hugh Parry	<b>Job Title:</b>	Trade Union Partner		
<b>Executive Director:</b>	Chris Turley	<b>Job Title:</b>	Executive Director of Finance & Corporate Resources		

## Version Control Sheet

Version	Date	Author	Summary of Changes
1.0	12/04/2023	Nicola Stephens	Initial document
1.1	14/04/2023	Nicola Stephens	Amendments made after TU review.
1.2	09/07/2023	Julie Boalch	Template formatting
1.3	10/07/2023	Lynne Haddow	Review and approved
1.4	14/02/2024	Lisa Trounce	Initial review / formatting
1.5	20/03/2024	Julie Boalch	Minor amends to scope, key words, roles and responsibilities
1.6	21/03/2024	Nicci Stephens	Minor amendments to roles and responsibilities alongside appendices.
1.7	16/04/2024	Julie Boalch	Minor formatting amendments and removed statement of disciplinary for not complying with Policy. Added comments regarding roles and responsibilities, and introduction to policy. Crown badge and Trust logo replaced with new versions.
1.8	16/04/2024	Nicci Stephens	Minor amendments to formatting, aim and scope.
1.9	16/04/2024	Lisa Trounce	Version number amended on front sheet, removal of comments boxes throughout, minor formatting to version control sheet, and removal of spare lines within document.
1.10	17/04/2024	Nicci Stephens	Minor amendments to formatting, aim and audit.
1.11	23/04/2024	Nicci Stephens	Amendments following Policy Group, including minor spelling, additional terminology, and inclusion of role for training
1.12	23/04/2024	Lisa Trounce	Repositioning of Crown Badge. Some minor formatting. Version number amended in footer.

### Key Words

Waste, Clinical Waste, Non-Clinical Waste, Waste Disposal

### Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Training		
Counter Fraud	10/07/2023	Lynne Haddow.
Information Governance		
Records Management		
EqlA / Welsh Language	14/03/2023	Kat Cobley
Estates		
Environment	12/04/2023	Nicci Stephens
ESMCP		

### Task and Finish Group Members

Name	Job Title
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Louise Coulson	Head of IPC
Jason Fenard	HART Training Manager
Nigel Bannister	Regional Fleet Manager
Andrew Jones	Regional Fleet Manager
Gavin Lane	Regional Fleet Manager
David Holmes	National Fleet Manager
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Chris Moore	Head of Medicines Management
Aled Williams	Head of ICT
Martin Mulholland	Learning and Development Manager
Hugh Parry	Trade Union Partner
Paul Aston Jones	Health and Safety Advisor
Daniel Purnell	Senior Finance Business Partner
Glenn McPeak	Head of Service, EMS (South Central)

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Trade Union Lead – Hugh Parry	14/04/2023	Development of draft
Waste Management Task and Finish Group	14/04/2023	For Review and Approval
Policy Group	25/04/2023	For Review and Approval
Policy Group	23/04/2024	Recommend for Approval
ELT	08/05/2024	Recommend for Approval
Finance and Performance Committee	14/05/2024	Approval

**Disclaimer**  
 If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the [Amb\\_policies.wales.nhs.uk](http://Amb_policies.wales.nhs.uk)

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## 1. INTRODUCTION

The purpose of this policy is to set out the standards required within the Welsh Ambulance Services University NHS Trust (WAST) for compliant, efficient, and cost-effective waste management. This policy signposts readers to associated procedure documents and related WAST policies for procedural advice and guidance on the management of waste.

Large quantities of waste are produced throughout WAST daily. It is therefore essential that the appropriate segregation, transportation, and safe disposal of all waste streams are properly managed.

Comprehensive legislation covers the risks associated with waste for people and the environment. This legislation is enforced by the Natural Resources Wales (NRW), the Health and Safety Executive (HSE) and local authorities. WAST policies and procedures are written to meet current regulatory requirement. Such as, but not limited to:

- Environmental Protection Act 1990
- Scrap Metal Dealers Act 2013
- Waste (England & Wales) Regulations
- Waste (Wales) Measure 2010
- Controlled Waste (England and Wales) Regulations 2012
- Environmental Permitting (England and Wales) Regulations
- Control of Pollution Act 1974
- Hazardous Waste (England and Wales) Regulations
- List of Waste (Wales) Regulations 2005
- The Waste Electrical and Electronic Equipment Regulations
- Waste Batteries and Accumulators Regulations
- The Landfill (England & Wales) Regulations 2002
- The Carriage of Dangerous Goods Regulations 1999
- End of life Vehicle Regulations 2003
- The Waste (CIRCULAR ECONOMY) Regulations 2020
- The Environmental Protection (Single use plastic products) Wales Act
- Workplace recycling Act 2024

This policy provides formal guidance and appropriate direction on good waste management standards and practices for WAST.

## 2. POLICY STATEMENT

WAST considers the safe and effective management of waste as essential to the health and safety of all its service-users, staff, and stakeholders. Responsible waste disposal, waste segregation and recycling are critical to the protection of the environment. WAST will ensure that appropriate policies and procedures are in place to safely handle, segregate, store, transport and dispose of waste. This policy, and supporting procedures, have been developed in line with the requirements of the Health and Safety

at Work Act 1974 and the Welsh Health Technical Memorandum (WHTM) 07 – 01 (Safe Management of Healthcare Waste).

### 3. SCOPE

This policy provides guidance and signposting for compliance, implementation, monitoring, audit, and review of our management system. Demonstrating continual improvement and achievement of our policy aims.

### 4. AIM

WAST has a duty to reduce its environmental impact from waste, and therefore provides guidelines for WAST Staff, volunteers, visitors, and contractors to meet the legal requirements and environmental considerations for waste disposal.

### 5. OBJECTIVES

This policy and associated standard operating procedures, will provide all information required to meet the aims of this policy, by ensuring the waste hierarchy (Figure 1 below) is followed, alongside statutory legal and clinical guidance.

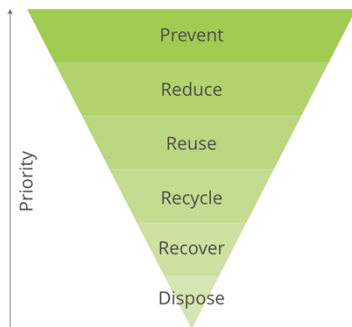


Figure 1: Waste Hierarchy

#### 5.1. Waste Management Flow Chart

To comply with waste management requirements various standard operating procedures (SOPs) and other applicable policies should be read. The Waste Management Flowchart (Figure 2 below) signposts the reader of this policy to the most appropriate applicable document.



Figure 2: Waste Management Flowchart

## 5.2. Master List of Waste (MLW)

The Master List of Waste (MLW) shown in Appendix A, details the correct SOP or policy to review regarding waste and waste disposal.

## 5.3. Standard Operating Procedures (SOP) & Associated Documents

All SOPs and associated documents can be found in Appendix B of this policy or on WAST's Intranet under [Environment & Sustainability](#). These SOPs provide all procedural information on how to follow the waste hierarchy, safely handle, segregate, store transport and dispose of waste in a legally compliant and sustainable way.

## 6. TRAINING AND IMPLEMENTATION

A training needs analysis (TNA) process has been followed, as a gap analysis to identify required knowledge, skills, and abilities. The TNA identified various training levels, via various methods, this includes.

- Waste management training to all staff via [ESR](#) mandatory module.
- Face-to-face [Waste Management Induction Training](#), accessed via the Learning Launchpad on SharePoint; and
- Contractor control procedures.

The TNA can be found in Appendix C.

## 7. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EqIA) form has been undertaken to determine if this policy would adversely affect any groups or people negatively. On completion of Part A and B of the assessment no evidence was found of any adverse, negative impacts. Therefore, it was not necessary to carry out a full EqIA, having recorded a neutral impact. A copy of the completed EqIA forms can be obtained from the policy author if required.

### 7.1 Environmental Standards and Impact Assessment

This policy will put the relevant waste management requirements in place to ensure the correct disposal route is used, reducing the waste to landfill, and increasing recycling. This will in turn reduce CO<sub>2</sub> emissions and therefore reduction WAST's carbon footprint.

WAST has an ongoing commitment to reduce its impact on the environment and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

### 7.2 Counter Fraud

The Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. Staff should report suspected incidents of fraud and

corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively, staff may contact the confidential NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60; or the on-line reporting facility <https://cfa.nhs.uk/reportfraud>. Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

### **7.3 Records Management**

WAST recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

### **7.4 Information Governance**

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its' staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information.

It will enable managers and staff to make appropriate decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high-level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

### **7.5 Health and Safety**

The Management of Health and Safety at Work Regulations 1999 require the Trust to make a suitable and sufficient assessment of the risks to the health and safety of its employees to which they are exposed whilst they are at work, and the risks to the health and safety of anyone else affected by the activities of the Trust.

### **7.6 Infection Prevention Control (IPC)**

WAST is committed to a zero tolerance of preventable Health Care Associated Infections (HCAIs). Actions are prioritised to reduce the risk of HCAIs within the pre-hospital care environment that could impact on the care provided to patients, carers and staff in secondary care and the wider community. Correct healthcare waste disposal supports WAST's IPC objectives.

## 8. ROLES AND RESPONSIBILITIES

### 8.1 Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust complies with this policy and therefore complies with waste legislation and regulations, as directed by UK and Welsh Governments.

### 8.2 Executive Director of Finance and Corporate Resources

The Executive Director of Finance and Corporate Resources is responsible for the effective management of and compliance with this policy. This includes:

- Responsibility for ensuring that this policy is maintained and updated.
- Responsible for ensuring that the appropriate advice and assistance is provided, and that consideration is given to any training and resources implications that are defined.
- To ensure each affected directorates appoint a Policy Lead for their directorate direct waste streams, such as clinical and pharmaceutical waste.
- Reporting to the Finance and Performance Committee, who has oversight of compliance with environmental regulations and targets. To that end an annual waste management update is provided annually to this committee.

### 8.3 Executive Director of Paramedicine

The Executive Director of Paramedicine is responsible for the effective management of, and compliance of, clinical waste management and disposal arrangements. This includes.

- Ensuring training is provided to all applicable staff to identify, and for the safe disposal of, clinical waste.
- Ensure current legislation and guidance is followed by applicable staff.
- Investigate non-compliance of legislation and provide assurance to trust board that all non-compliance matters are actioned and resolved.

### 8.4 Head of Estates and Facilities

The Head of Estates and Facilities is responsible for the effective management of and compliance with this policy. This includes:

- ensuring that a compliant contract is in place with a licensed and authorised waste provider, to dispose of municipal waste.
- ensuring data is gathered for reporting requirements and is kept and recorded efficiently for onward reporting.

### 8.5. Workforce Education & Development.

Are responsible for ensuring that:

- The outcome of the training needs analysis is reviewed, and training packages are put into place, including refresher training.
- They liaise with other departments such as estates and ESR to ensure additional training needs are kept up to date and provided.
- Training outcomes are monitored and recorded, as such would satisfy audit requirements.

### 8.6. Service Managers / Clinical Leads / Locality Managers

Are responsible for:

- Ensuring that new members of staff that join the Trust are made aware of this policy at local induction, and how to access this document specific to their area.
- Understanding the policy process and their role in supporting best practice.
- Working with staff without access to the intranet to ensure they have access to this policy and other waste relevant documentation.
- Monitor waste streams primarily Clinical waste, for compliance to this policy and associated procedures.
- Audit clinical waste and disposal receptacles at least annually and reporting finding to the environment and sustainability manager alongside the waste collection contractor Health Courier Service.

### 8.7. Line Managers

Are responsible for:

- Ensuring that the staff for whom they are responsible are aware of and adhere to this document.

This includes ensuring that:

- Copies of this policy and associated SOPs are readily available and accessible to all staff.
- Information is disseminated on a regular basis, to ensure staff have read and understood the requirements of the trust related to waste management and are aware of any new waste guidance or revisions.
- The identification of specific staff training needs in relation to this policy.
- Systems exist to enable the review, audit, and compliance test adherence to this policy.

### 8.8. All Staff

Are responsible for ensuring that:

- They comply with the provision of this policy and associated procedures, and where requested, demonstrate such compliance.
- Information regarding failure to comply with the policy, for example, lack of training, inadequate equipment, is reported to their line manager and that the incident reporting system is used where appropriate.
- Their practice is in line with policies in use across the Trust and specific to their area of work.
- Information regarding any changes in practice, organisational structure or legislation that would require an urgent review of documents is immediately reported to their line manager.

## 9. AUDIT AND MONITORING

General municipal waste will be monitored and audited on a rolling annual basis at all contracted sites by the incumbent waste contractor, reporting to the Environment and Sustainability Manager.

Clinical waste will be monitored by Locality Managers, with pre-audits completed annually by locality managers or their nominated representatives, with reported findings presented to the Environment and Sustainability Manager. Annual Health and Safety department audits will include the effectiveness of clinical waste disposal.

Other Waste – all other wastes, as indicated in associated SOPs & Policies (See Appendix B), will be monitored by SOP and policy owners. This includes:

- Estates – for municipal and recycling waste.
- Fleet – specific fleet waste, including scrap metals and chemicals.
- ICT – WEEE specific to ICT technology.
- Operations – this includes clinical consumables, uniform and ad hoc purchases.
- Clinical managers- Pharmaceuticals and medications.

All waste information will be collated by the Environment and Sustainability Manger for annual reporting via Finance and Performance Committee.

## 10. APPENDICES

Appendix A – Master List of Waste

Appendix B – SOPs and Associated Documents.

Appendix C – Training Needs Analysis

**Appendix A: Master List of Waste (MLW)**

Description	Management Responsibility	Written SOPS & policies in place	European Waste Code
Domestic general	Estates & Facilities	EPGN 008	Various
Domestic recycling	Estates & Facilities	EPGN 008	Various
WEEE	Estates & ICT	EPGN 005 WEEE	Various
Feminine Hygiene	Estates	EPGN 008	18.01.04
Confidential waste	Building management	EPGN 008	20.01.01
Clinical waste Orange Bags	Operations	Healthcare Waste SOP	18.02.01
Clinical waste sharps	Operations	Sharps Policy 2020	18.02.03
Clinical waste yellow Bag	Operations	HCID SOP May 2022	18.02.02
Fleet	National Head of Fleet	Fleet Waste SOP	Various
Pharmaceutical waste	Head of Medicines Management.	Medicines Management Policy 083 Management of Controlled Drugs Policy 063 SOP for CD Destruction V3 (working draft).	18 01 09 <a href="https://www.gov.uk/how-to-classify-different-types-of-waste/healthcare-and-related-wastes">https://www.gov.uk/how-to-classify-different-types-of-waste/healthcare-and-related-wastes</a>
Medical equipment	Localities then Clinical Logistics Hub	Management of Medical Devices Policy	Various
Clinical consumables	Localities	Clinical and Non-Clinical Equipment Disposal SOP	Depends – may just be general waste
Uniform	Localities & Departmental Managers.	Clinical and Non-Clinical Equipment Disposal SOP	15.01.09
Clinical equipment	Station management	Clinical and Non-Clinical Equipment Disposal SOP	Various
Furniture	Station management	Clinical and Non-Clinical Equipment Disposal SOP (Draft)	20.03.07
Asbestos	Estates	EPGN 004	17.06.05*
Old vehicles – RTC Training	Workforce, Education & Development	Fleet Waste SOP	Scrap metals

Training manikins	Workforce, Education & Development	Clinical and Non-Clinical Equipment Disposal SOP	General waste plastics and rubber Various
HART	HART lead	HART Waste Disposal SOP	Various

**10.1. Appendix B – SOPS and Associated Documents**

- EPGN 008
- EPGN 005 WEEE
- Healthcare Waste SOP
- Sharps Policy 2020
- HCID SOP May 2022
- Fleet Waste SOP
- Medicines Management Policy 083
- Management of Controlled
- Drugs Policy 063
- SOP for CD Destruction V3 (working draft).
- Management of Medical Devices Policy
- Clinical and non-clinical equipment disposal SOP
- EPGN 004
- HART Waste disposal SOP

## 10.2. Appendix C - Training Needs Analysis (TNA)

Goal	Roles	Skills/Knowledge	Skills/Knowledge Level	Training requirement recommendations	Recommendations
<b>Domestic Waste - the compliant disposal of domestic waste including general and recycling</b>	Patient facing	Understanding new waste legislation. Understanding consequences of not complying with legislation. Waste segregation methods.	4	Online module	Workforce Education & Development Induction programmes & annual MIST refresher ESR/SharePoint modules, managed, scored and recorded
	Non patient facing	Understanding new waste legislation. Understanding consequences of not complying with legislation. Waste segregation methods.	4	Online module	ESR/ SharePoint modules, managed, scored and recorded
	Volunteers	Understanding new waste legislation. Understanding consequences of not complying with legislation. Waste segregation methods.	3	Training package update	Training module, managed scored and recorded.
	External providers & contractors	External providers and contractors are not to utilise WAST waste streams, as waste costs, emissions and weights are scrutinised by WG	1	Not required.	N/A

<b>Clinical Waste (CAT B) - The compliant disposal of clinical waste both within or external to WAST estate</b>	Patient facing	In depth understanding of waste legislation and disposal requirements	5	Face to face	Via Workforce Education & Development - Induction programmes & annual MIST refresher
	MRD staff	In depth understanding of waste legislation and disposal requirements	5	Face to face	Via Workforce Education & Development - Induction programmes & annual refresher
	Non patient facing	high level overview of requirements	2	Online module	ESR/SharePoint modules, managed, scored and recorded
	Volunteers	Directed understanding of legislation and disposal requirements	4	Training package update	Training module, managed scored and recorded.
	External providers & contractors	External providers and contractors are not to utilise WAST waste streams, as waste costs, emissions and weights are scrutinised by WG. To take this waste WAST must provide a hazardous waste note and quarterly statement of return.	1	Not required.	N/A

<b>Clinical Waste (CAT A) - the compliant disposal of clinical waste both within or external to WAST estate</b>	Patient facing	In depth understanding of waste legislation and disposal requirements	4	Face to face	Via Workforce Education & Development - Induction programmes & annual MIST refresher
	MRD staff	In depth understanding of waste legislation and disposal requirements	5	Face to face	Via Workforce Education & Development - Induction programmes & annual refresher
	Non patient facing	high level overview of requirements	2	Online module	ESR/ SharePoint modules, managed, scored and recorded
	Volunteers	Directed understanding of legislation and disposal requirements	3	Training package update	Training module, managed scored and recorded.
	External providers & contractors	External providers and contractors are not to utilise WAST waste streams, as waste costs, emissions and weights are scrutinised by WG . To take this waste WAST must provide a hazardous waste note and quarterly statement of return.	1	Not required.	N/A

<b>Clinical waste (Sharps) - the compliant disposal of clinical waste both within or external to WAST estate</b>	Patient facing	In depth understanding of waste legislation and disposal requirements	5	Face to face	Via Workforce Education & Development - Induction programmes & annual MIST refresher
	MRD staff	In depth understanding of waste legislation and disposal requirements	5	Face to face	Via Workforce Education & Development - Induction programmes & annual refresher
	Non patient facing	high level overview of requirements	2	Online module	ESR/SharePoint modules, managed, scored and recorded
	Volunteers	Directed understanding of legislation and disposal requirements	3	Training package update	Training module, managed scored and recorded.
	External providers & contractors	External providers and contractors are not to utilise WAST waste streams, as waste costs, emissions and weights are scrutinised by WG. To take this waste WAST must provide a hazardous waste note and quarterly statement of return.	1	Not required.	N/A

**Skills/Knowledge  
Levels**

1	Must not engage with this waste stream
2	Minimal knowledge required
3	Limited knowledge required - overview
4	Medium knowledge required - basic legislation and Trust requirements
5	In-depth knowledge and understanding of legislation and utilisation skills



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# Data Quality Policy

<b>Policy Number:</b>	073	<b>Version No:</b>	0.11	<b>Supersedes:</b>	0.10
<b>Date of Approval:</b>		<b>Review Date:</b>	3 years from date of approval	<b>Impact Assessments Completed:</b>	Yes
<b>Classification of Document:</b>	Corporate	<b>Type of Document:</b>	Policy	<b>Approved by:</b>	Finance and Performance Committee
<b>Brief Summary of Document:</b>	This document is to outline the Trust's intentions and approach to fulfilling its statutory and organisational responsibilities around Data Quality. It will enable staff to make informed decisions around the availability of complete, accurate, reliable and timely data which is important in supporting patient care, clinical governance and management decision making.				
<b>Scope:</b>	This Policy applies to all staff that are directly employed by WAST and encompasses Non-Executive Directors, bank staff, contractors, and all those that it has legal responsibility for such as students and trainees.				
<b>To be read in conjunction with:</b>	Adverse Incident and Hazard Reporting Policy Data Protection Policy Information Governance Policy Records Management Policy Information Security Policy				
<b>Owning Committee</b>	Finance and Performance Committee				
<b>Policy Lead:</b> <b>Trade Union Lead:</b>	Susan Brown Mark Marsden	<b>Job Title:</b>	Data Quality Lead Trade Union Partner Lead		
<b>Executive Director:</b>	Jonny Sammut	<b>Job Title:</b>	Director of Digital Services		

**Version Control Sheet**

Version	Date	Author	Summary of Changes
0.1	27/07/2018	Liam Allsup	Draft Policy
0.2	31/07/2018	Clare Elcock	Amendments
0.3	03/08/2018	Craig Garner	Draft Review
0.4	18/10/2018	Liam Allsup	Amendments from Bleddyn Roberts: Trade Union partner chair
0.5	12/11/2018	Liam Allsup	DQ Policy Working group
0.6	18/02/2019	Liam Allsup	Policy group amendments
0.7	08/04/2024	Susan Brown	Policy group review and refresh
0.8	23/04/2024	Lisa Trounce	Crown badge and Trust logo replaced with new. Scope amended to reflect that contained within Risk Management Policy. Replacement TU Lead named. Minor formatting. Policy Group comments noted.
0.9	24/04/2024	Susan Brown	Policy Group amendments effected: scope expanded, TU Lead updated, TFG members added, removal of references related to invalid PCR numbers as now automated, corrections to some naming conventions (eg PCR, AQI > ASI), outdated paragraph from compliance section removed and replaced with appropriate terminology, audit and monitoring section completed.
0.10	25/04/2024	Lisa Trounce	Minor formatting prior to submission to ELT and Committee. Link to NHS Fraud website referenced in 9.4 corrected. Outdated role title in 10.4 corrected (Ambulance Operations Managers replaced with Service Managers). Key words expanded. Version control updated to reflect amendments made at v0.9
0.11	26/04/2024	Julie Boalch	Colours, logos, footer

**Key Words**

Data, Quality, Fraud, Information, Security, Confidentiality, Protection,

### Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Training		
Counter Fraud		
Information Governance		
Records Management		
EqIA / Welsh Language		
Estates		
Environment		
ESMCP		

### Task and Finish Group Members

Name	Job Title
Susan Brown	Data Quality Lead
Jon Hopkins	Head of Information
Mark Marsden	TU Lead
Sara Williams	Senior Workforce Business Partner
Kathryn Cobley	Head of Inclusion and Engagement

### Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Policy Group	18/02/2019	Review of Initial Draft
Policy Group	16/04/2019	Review post consultation
Trade Union Partners Forum	03/05/2019	Review
WASPT	20/05/2019	Recommend for Approval
EMT	19/06/2019	Recommend for Approval
Finance and Performance Committee	16/07/2019	Approval
HI SMT	26/03/2024	Review
Digital Leadership Group	03/04/2024	Directorate Approval
Policy Group	23/04/2024	Recommend for Approval
ELT	08/05/2024	Recommend for Approval
Finance and Performance Committee	14/05/2024	Approval

**Disclaimer**

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the

[Amb\\_policies@wales.nhs.uk](mailto:Amb_policies@wales.nhs.uk)

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## 1. INTRODUCTION

- 1.1 The Welsh Ambulance Services NHS Trust (the Trust) recognises the importance of data being of sufficient quality to enable robust decision making. This is only possible when the Trust has confidence in the data collection process, and the processes that provide assurance of this.
- 1.2 Complete, accurate, timely data underpins sound decision making at every level in The Trust and contributes to the improvement of both patient healthcare and organisational efficiency.
- 1.3 Good data quality is crucial, this policy is to set out the trust’s data quality principles to ensure processes conform to NHS data standards. these principles will be adopted and supported by data quality procedures.
- 1.4 The Trust therefore has a responsibility to ensure that their data is accurate and is fit for purpose. Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made.
- 1.5 Data Quality (DQ) is a framework for providing assurance on complete, accurate, timely, consistent and valid data to appropriate internal/external stakeholders with the objective of delivering the best possible care and service.
- 1.6 DQ currently includes the following legislation and guidance:
  - Information Governance Policy
  - Data Protection Policy
  - Freedom of Information Procedure
  - Records Management Policy
  - Information Security Policy
  - Adverse Incident Investigation Policy

## 2. POLICY STATEMENT

This Policy sets out the Trust’s approach to DQ management and ensure a robust DQ framework for the Trust is in place for the future management of data.

The Trust has established a policy framework for its Information Governance policy, supported by a set of Information Governance policies and procedures to cover all aspects of Information Governance aligned to relevant legislation and standards.

The key Data Quality Policies and Protocols are:

Information Governance Policy	This Policy provides assurance to the Trust, its staff, partners and the public that information is handled appropriately and in accordance with statutory and legislative requirements.
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Data Protection Policy	This policy sets out how the Trust meets its legal obligations in respect of data protection in order to meet its operational needs and fulfil legal requirements.
Freedom of Information Act	This sets out how the Trust complies with the Freedom of Information Act (FOIA) 2000 and creates openness and transparency of information which is in the public interest.
Records Management Policy	This policy sets out how the Trust manage records through the delivery of standards, guidance and procedures in line with the IG framework.
Information Security Policy	This policy sets out how the Trust complies with stringent legal requirements and provides assurance that data held and processed by the Trust is treated with the highest appropriate standards to keep it safe.
Adverse Incident Information Policy	This Policy sets out principles to encourage incident reporting, initiate investigations where appropriate and learn from adverse events thus maintaining and improving the quality of patient care, reducing or eliminating the risk of loss, damage or injury to patients, staff and others and protecting the Trust's assets and improving the service

This table below explains the terminology used in this policy.

<b>Term</b>	<b>Meaning/Application</b>
<b>SHALL</b>	<i>This term is used to state a <b>Mandatory</b> requirement of this policy</i>
<b>SHOULD</b>	<i>This term is used to state a <b>Recommended</b> requirement of this policy</i>
<b>MAY</b>	<i>This term is used to state an <b>Optional</b> requirement</i>

### 3. SCOPE

This DQ policy **shall** be adhered to by all staff and partners who have access to Trust Data or anyone undertaking work on behalf of the Trust.

The purpose of the policy is to:

- Establish the Trust's commitment to data quality and its approach to ensuring data quality standards are adhered to.
- Inform all staff working for, or on behalf of the Trust, of their roles and responsibilities with regards to data quality.
- Maintain and increase high levels of data quality within the Trust.

The principles contained within this policy **shall** provide a framework for all staff which will facilitate the development of departmental data quality procedures to ensure that data collected and recorded is accurate, fit for purpose and available when required.

This policy **should** be read in conjunction with other related policies and forms an integral part of the Trust's approach to Information Governance. This policy **shall** be supported by a data quality strategy.

This policy covers all aspects of Data Quality within the Trust including but not limited to:

- Patient, client and service user information
- Staff information
- Clinical information
- Telephony information
- Website information
- Geographical information
- Corporate information.

#### 4. AIM

The principles contained within this policy **shall** provide a framework which will facilitate the development of departmental data quality procedures to ensure that data held is accurate, fit for purpose and available when required.

This policy **shall** set out the standards required for data quality and the importance of data standards.

This policy is complemented by a number of Information Governance policies that support Data Quality principles.

#### 5. OBJECTIVES

The aims **shall** be achieved through regular communications, monitoring of policies and procedures to ensure they are fit for purpose and integrity is maintained.

Appropriate reporting and correction processes are in place to ensure that data is being managed appropriately.

Additional policies and procedures **shall** be developed and created to ensure that this policy is implemented throughout the Trust and communicated to all relevant parties.

Staff **shall** be appropriately trained around Data Quality and made aware of the benefits and implications of poor data quality.

## 6. DATA QUALITY

The Trust shall establish, maintain and review policies and procedures for the effective and secure management of all information assets and resources.

Regular reviews and audits **shall** be carried out by the Information Governance (IG) Team and Information Asset Owners to identify good practice and opportunities for improvement.

The Trust **shall** ensure the effective implementation of an information risk framework that identifies information assets and their owners.

Risk assessments **shall** be conducted by Information Asset Owners to ensure appropriate and effective security is in place for each information asset.

Clinical staff **shall** follow Trust procedures for recording data in an accurate and timely manner via paper based or electronic means.

The Clinical Indicators Assurance Group CIAG **shall** be used as the mechanism to monitor the quality of data relating to the electronic patient care record and raise any significant issues with Data Quality recorded in this system.

At the point of collection, staff **shall** validate (using agreed locally procedures) the data they collect from patients, staff and the general public.

The Data Quality team **shall** monitor the Data Quality Incident of Concern Intranet page, this is accessed via LaunchPad and a weekly/monthly exception report. This includes completeness of key fields such as, invalid age inputted onto the Computer Aided Dispatch system (C3). This allows the Data Quality leads to verify data quality with known issues and escalate if they re-occur.

Staff and partners **shall** be informed on policies and procedures that provide guidance for reporting Data Quality inaccuracies and incidents in line with the Trust's Adverse Incident and Hazard reporting Policy.

### 6.1 The Importance of good Data Quality

Having accurate, relevant information that is accessible at the appropriate times is essential to Trust management for business decisions and to the success of the service provided. The Trust processes a vast quantity of data including clinical, personal, performance and financial. In respect of this, it is essential that all employees of the Trust recognise the importance of data quality and their responsibilities in this area.

High quality information leads to better decision making to improve patient care and patient safety, and there are potentially serious consequences if information is not correct and up to date.

Inaccurate data can cause reputational damage towards the Trust and impact the integrity of the assurance and information we provide Stakeholders.

Accurate data quality is crucial to operational processes and to the reliability of business intelligence reporting.

Information produced from patient data is essential for the efficient running of the Trust and to maximise utilisation of resources for the benefit of patients and staff.

The Trust must provide information for other NHS and non-NHS organisations – these organisations depend on the information we provide them and need to have confidence in its timeliness, quality and value.

## 6.2 Implications of poor Data Quality

Poor data quality puts organisations at significant risk of:

- Reputational damage
- Weakening frontline service delivery capabilities
- Incurring financial loss through fines / monetary penalties
- Results in poor decision making around incorrect data
- Inability to provide accurate data to fulfil statutory and legal obligations.
- Inadequate transparency in the data we provide stakeholders
- An inability to deliver on behaviours in line with the Trust's strategic aims
- Issues with joining datasets to provide whole system analysis

## 6.3 Improving Data Quality

The drive to improve and maintain the quality of the Trust's information is underpinned by a range of initiatives:

- Validation as required of Patient Clinical Records.
- Production of Data Quality reports to identify and enable correction of missing data items and errors on a regular basis.
- Monitoring of Data Quality reports produced so they are of sufficient quality and actions are followed up.
- Maintaining the standard of the Trust's Ambulance Service Indicators (ASI's) and Official Statistics.
- Attendance at national information forums to share local and national issues concerning data collection, data quality issues, recording and submission of corporate and patient related data.

- Creation and implementation of a Data Quality Kite Mark which will enable the Trust to make an explicit assessment of the quality of data upon which the performance measurement is based.
- Training and awareness needs to be in place in respect of DQ to make an explicit improvement.
- Data quality needs to be embedded into day-to-day activities and promoted as everyone's responsibility to develop a culture around improving DQ.
- Encourage ownership of data held on systems within Directorates and owners recorded in an Information Asset Register.

#### 6.4 Openness

The Trust recognises the need to maintain an appropriate balance between openness and confidentiality in the management and use of information.

The Trust fully acknowledges its obligation to be publicly accountable; however, the Trust also places importance on the confidentiality and safeguarding of personal information relating to staff and patients and commercially sensitive information.

Corporate information of the Trust **shall** be available to the public in accordance with the Freedom of Information Act 2000.

Awareness and understanding of all staff and partners, with regard to their responsibilities when handling information, **shall** be assessed and appropriate training and guidance provided as necessary.

#### 6.5 Disclosure of Information

The Trust recognises the need to share personal information with partner organisations and other agencies in line with the Data Protection Act and Caldicott principles.

Information sharing policies and procedures **shall** be in place as guidance to enable the Trust to meet its responsibilities regarding the appropriate use, sharing and disclosure of personal information.

#### 6.6 Confidentiality and Data Protection Assurance

The Trust regards all person identifiable information (PII) as confidential except where national policy or law on accountability and openness requires otherwise.

Effective arrangements **shall** be put in place to ensure confidentiality and security of personal and other sensitive information.

#### 6.7 Information Security Assurance

The Trust **shall** promote effective confidentiality and security practice to its staff and partners through policies, procedures and training. This is outlined in the Information Security Policy.

## 6.8 Information Quality Assurance

The Trust recognises that accurate, timely and relevant information is essential to deliver high quality healthcare. As a result, the Trust **shall** establish and maintain policies for information quality assurance and the effective management of records.

Information Asset Owners (IAO's) **shall** take ownership of, and seek to improve, the quality of data within their services.

The integrity and reliability of information **shall** be monitored and maintained to ensure that it is consistent and appropriate for the purposes intended.

## 6.9 Definitions

Data Quality can be defined as having six dimensions, which can be visualised as individual pieces of a Data Quality Jigsaw. When all six pieces are combined to complete the jigsaw a complete picture of the quality of our Trust's data quality can be obtained.

- **VALIDITY** of data refers to whether the submitted data has been provided in the agreed format and, where applicable, is populated with a Trust wide value as defined in the Trust's Data Dictionary.
- **COMPLETENESS** of data refers to whether the submitted data that has been provided is complete – (e.g. is the data field complete or does it contain a null value).
- **CONSISTENCY** of data refers to whether related data items are consistent with one another.
- **PRECISION** of data refers to whether the submitted data has been provided to the necessary level of detail (e.g. the depth of quality assurance to ensure data passed through C3 into Data Warehouse has been adequately analysed).
- **ACCURACY** of data refers to whether all the submitted data is a true reflection of the activity it is intended to reflect (e.g. has an incident that has been submitted to the Data Warehouse actually taken place?)
- **TIMELINESS** of data refers to whether the data has been reported to stakeholders within agreed timescales (e.g. Welsh Assembly Government for AQI's and official statistics) or assessed for validity within an agreed period.



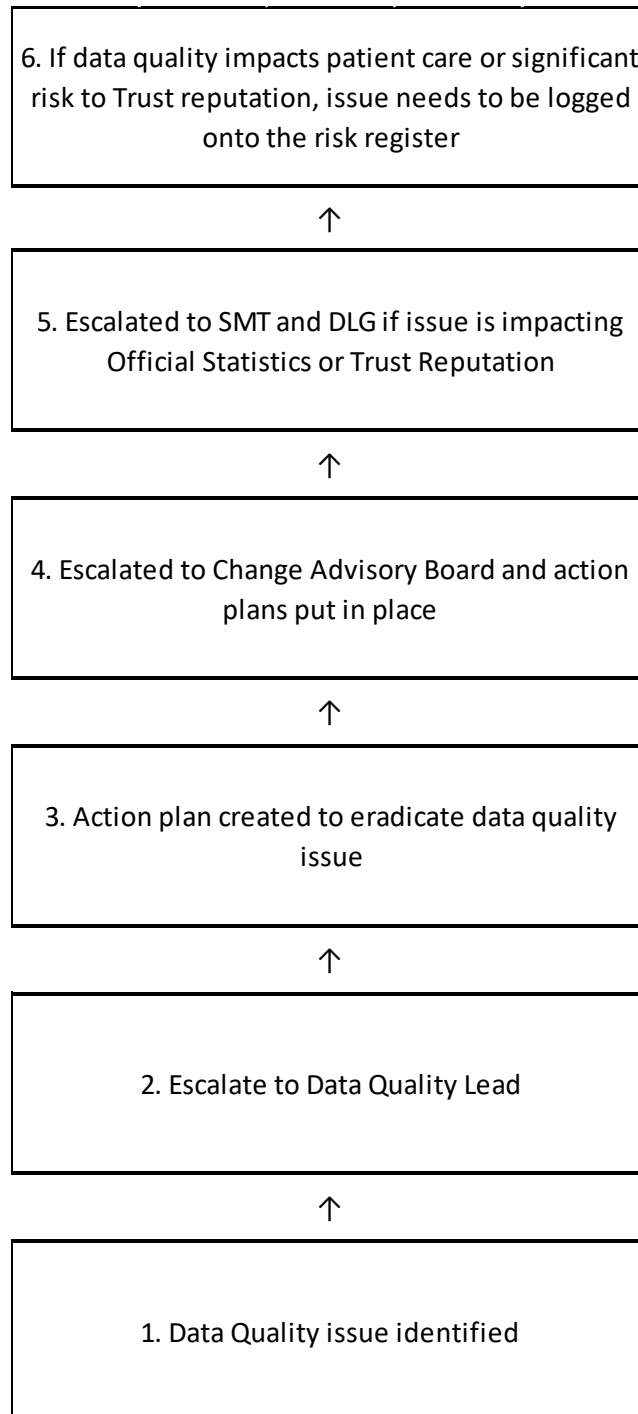
## 7. ESCALATION OF DATA QUALITY ISSUES

### 7.1 Identifying and correcting errors

Errors created by an individual through inaccurate data entry should be rectified as soon as they are discovered. If staff are unable to correct at source, then errors should be escalated to their manager, system administrators and/or the Data Quality lead.

Data Quality issues flagged on the Incidents of Concern page will need to be investigated and amended by the appropriate team member within the Trust. Please see Official Statistics Incident Correction Guide for full guidance.

Where persistent data quality issues need to be raised and escalated, the Trust where possible will go through CAB, SMT, DLG).



## 7.2 Data Quality Reporting and Resolution Process

Systematic errors i.e. where a process or system encourages or allows routine errors to occur, **shall** be identified and escalated by all staff through the agreed formal channel and addressed by the Information Asset Owner with the cooperation of the Data Quality lead.

The Trust and its stakeholders **shall** ensure that high quality data is used in the planning, commissioning, benchmarking and financing of services to support improvement and reporting of initiatives.

The principles set out in this Policy are applicable to any system owned by or managed by the Trust, whether they are paper-based or computer-based.

## 8. TRAINING AND IMPLEMENTATION

Mandatory Information Governance training is provided to all staff which focuses on Data Quality Issues as part of the Trust's ongoing training programme. Specific training **should** be arranged where it is a pre-requisite before access is granted to the Information or systems.

The Data Quality Lead will also provide ad hoc awareness and themed training sessions with teams upon request.

## 9. IMPACT ASSESSMENTS

Policies will not be approved without an Equality Impact Assessment (EqIA) or a Welsh Language Impact Assessment being undertaken as this process has been developed to help promote fair and equal treatment in the delivery of services. It is the responsibility of the Policy Lead to ensure that impact assessments are undertaken during development or review of a policy.

### 9.1 Equality Impact Assessment

In accordance with the Equality Act 2010, all policies will be subject to an EqIA. This enables resources to be targeted effectively and can help to reduce inequalities. The EqIA is a process to find out whether a policy will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights.

Evidence gathered at the initial stages, by undertaking an initial screening, will determine the relevance of policies and how they affect people as service users, members of the public and as employees of the Trust and indicate whether or not a full EqIA is required.

Equality Impact Assessment forms and procedures for completion as part of policy development are available on the Trust's intranet Policy page under [Supporting Documents](#). Further information on the development and value of EqIAs can be found on the Trust's Intranet site and via the following link: [www.eiapractice.wales.nhs.uk/home](http://www.eiapractice.wales.nhs.uk/home).

All finalised policies shall include reference to the EqIA which has been undertaken.

## 9.2 Welsh Language Impact Assessment

Under the The Welsh Language (Wales) Measure 2011 the Trust's Welsh Language Scheme will be replaced by standards. This means that the Trust, when formulating new policies or reviewing or revising existing policies, will be required to assess what effect a policy decision would have on opportunities for persons to use the Welsh language and on treating the Welsh language no less favourably than the English language. Further guidance can be obtained from the Welsh Language Officer.

In order to comply with the Welsh Language Standards and the Trust's Compliance Notice, the Trust is required to publish several policies in Welsh; particularly those that relate to:

- behaviour in the workplace;
- health and well-being at work;
- salaries or workplace benefits;
- performance management;
- absence from work;
- working conditions;
- work patterns

## 9.3 Environmental Standards and Impact Assessment

This policy will put the relevant requirements in place (such as waste management plan, reduction of CO2 emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services NHS Trust ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

## 9.4 Counter Fraud

### **Anti-Fraud and Corruption Concerns**

The Welsh Ambulance Services NHS Trust is committed to taking all necessary steps to counter fraud, bribery and corruption within the Trust. Staff should report suspected incidents of fraud and corruption to the Trust Local Counter Fraud Specialist, who will be happy to discuss any issues or concerns. Alternatively staff may contact the confidential **NHS Counter Fraud Authority, Fraud and Corruption Reporting line on 0800 028 40 60**; or the on-line reporting facility <https://cfa.nhs.uk/report-fraud>

Fraud investigations may lead to disciplinary action and / or prosecution and civil recovery procedures.

## 9.5 Records Management

The Welsh Ambulance NHS Services Trust (WAST) recognises the importance of sound records management arrangements for both clinical and corporate records. The Trusts' records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support

policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public.

## 9.6 Information Governance

Information Governance (IG) is an overarching term used to describe all aspects of information management.

The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

The IG framework ensures that it sets out the high level principles for confidentiality, integrity and availability of information to promote and build a level of consistency across the Trust.

## 9.7 Training

WAST is committed to providing high quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence. Staff are encouraged to discuss any concerns or queries regarding education and training with a member of the Education and Training Team, by telephoning the Learning & Development Hub on 0300 123 2319 or via email at [Amb\\_LDHub@wales.nhs.uk](mailto:Amb_LDHub@wales.nhs.uk)

Mandatory Information Governance training is provided to all staff which focuses on Data Quality Issues as part of the Trust's ongoing training programme. Specific training **should** be arranged where it is a pre-requisite before access is granted to the Information or systems.

The Data Quality Lead will also provide ad hoc awareness and themed training sessions with teams upon request.

Any policy specific training would need to be devised by the Policy Lead and subject matter expert.

## 9.8 Health and Safety

The Health and Safety Team will be responsible for providing advice where a risk is related to Health and Safety. These types of issues are closely linked with risk management and specialist Health and Safety advisers can assist with the conduct of specific and/or specialist assessments.

## 10. ROLES AND RESPONSIBILITIES

### 10.1 Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

### 10.2 Board Secretary

The Board Secretary is responsible for the effective management of, and compliance with, this policy. This includes ensuring that:

- A database of policies and procedures is maintained.
- Policies are approved as part of the Governance framework at the appropriate level in the organisation.
- The documents are accessible to all relevant staff.
- Documents are cascaded appropriately across the organisation.
- All policies are reviewed in a timely manner.

### 10.3 Executive Directors

The Executive Directors are responsible for the effective management of and compliance with this policy. They are responsible for ensuring that all policies within their remit are maintained and updated by liaising with the appropriate policy leads. They are responsible for ensuring that the appropriate advice and assistance is provided to authors and that consideration is given to any training and resources implications that are defined. Each Director will appoint a Policy Lead for their Directorate.

### 10.4 Corporate Governance Manager

The Corporate Governance Manager will act as the Trust's 'Policy Process Manager' and operational gatekeeper with the responsibility for providing guidance, advice and support for the process on behalf of the Trust.

In addition, the Corporate Governance Manager is responsible for:

- Managing the maintenance of the Trust's central Policy tracker and database (including a record of equality impact assessments).
- Facilitation of the Trust's internal Policy Group.
- Managing the Trust wide consultation process for all policies.
- Providing a link between the Policy Group and Employment Policy Sub Group.
- Issuing reminder notices to ensure the timely review of policies.
- Ensuring up to date guidance and documentation regarding the policy process is accessible.

- Publishing policies onto the Trust's internet/intranet sites and working with the Communications Team to ensure comprehensive notification that new policies is maintained across the Trust.
- Maintain an archive of previous versions of any revised or reviewed policies.

### 10.5 Service Managers / Clinical Leads / Locality Managers

Are responsible for:

- Ensuring that new members of staff that join the Trust are made aware of the policy control system at local induction, and how to access Trust wide and local policy documents specific to their area.
- Understanding the policy process and their role in supporting best practice.
- Working with staff without access to the intranet to ensure they have access to relevant documentation.
- Ensuring that local arrangements are established to monitor the receipt and understanding of all relevant Trust documents; thus reducing the risk of misuse of misinterpretation.

### 10.6 Line Managers

Are responsible for ensuring that the staff for whom they are responsible are aware of and adhere to this document.

This includes ensuring that:

- Copies of the Trust policies are readily available and accessible to all staff.
- Information is disseminated on a regular basis, to ensure staff have read and understood the relevant documents and are aware of any new guidance or revisions.
- The identification of specific staff training needs on the implementation of new or updated documents.
- Systems exist to enable the review, audit and compliance testing of all relevant departmental policies as required.

### 10.7 All Staff

All members of staff are accountable for maintaining risk awareness, identifying, and reporting risk as appropriate to their line manager. More specifically they will:

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the Trusts business.
- Report all incidents/accidents and near misses and comply with the Trust's incident and near miss reporting procedures.
- Be responsible for attending mandatory and relevant education and training events.

- Participate in the risk management system, including the risk assessment within their area of work and the notification to their line manager of any perceived risk which may not have been assessed.
- Be aware of and comply with the Trust's Risk Management Policy, processes and associated procedures.

## 11. AUDIT AND MONITORING

There is a requirement of all staff to comply with the provisions of this Policy and, where requested, to demonstrate such compliance.

Monitoring, compliance, and the effective implementation of this Policy will be considered through the ADLT, ELT and from feedback from the Risk Owners and Executive Directors which will ultimately support the risk maturity of the Trust.

Data Quality Lead/Head of Information will regularly monitor to ensure that measures to control Data Quality risks are being fully implemented and remain effective. This includes the regular and continual review of exception reporting and liaising with the Head of Service EMS Coordinator and the Data Protection and Compliance Manager.

Regular reporting to committees and the Information Governance Steering Group on performance monitoring and any risks associated with Data Quality and Trust Reputation.

Internal Audit/Reporting will be undertaken to review any risks.

## 12. REFERENCES

- Information Governance Alliance (2016) Records Management Code of Practice for Health and Social Care 2016: NHS Digital
- Data Protection Act 2018;
- General Data Protection Regulations 2018
- Freedom of Information Act 2000 (FOI);
- Equality Act 2010;
- Information Governance Alliance: Records Management Code of Practice for Health and Social Care 2016;
- Computer Misuse Act 1990

<b>AGENDA ITEM No</b>	<b>16</b>
<b>OPEN or CLOSED</b>	<b>OPEN</b>
<b>No of ANNEXES ATTACHED</b>	<b>0</b>

<b>Environment, Decarbonisation and Sustainability Update May 2024</b>
--

<b>MEETING</b>	Finance & Performance Committee
<b>DATE</b>	14 May 2024
<b>EXECUTIVE</b>	Chris Turley - Executive Director of Finance and Corporate Resources
<b>AUTHOR</b>	Jo Williams – Head of Capital Development Lucinda Wassall – Project Manager
<b>CONTACT</b>	Joanne.williams10@wales.nhs.uk

<b>EXECUTIVE SUMMARY</b>
--------------------------

To provide an update on:

- Decarbonisation Programme Board and other wider governance
- WAST Decarbonisation Action Plan update and NWSSP Decarbonisation Co-ordination Reporting (DCR)
- Internal Audit – Decarbonisation
- Welsh Government reporting – development of the Qualitative report template for submission 14.04.24 and Quantitative Reporting
- EFPMS Reporting
- Capital Investment – EFAB Funding
- Future Car Based Response Vehicle specification design
- Wider Environmental Considerations
- Adaptation Planning

**RECOMMENDATION:**

**Finance and Performance Committee is asked to NOTE this update.**

<b>REPORT APPROVAL ROUTE</b>
------------------------------

Capital Management Board – 18<sup>th</sup> March 2024 – to note  
Finance & Performance Committee – 14<sup>th</sup> May 2024 – to note

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

# **WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST**

## **Finance & Performance Committee**

### **Environment, Decarbonisation & Sustainability Update**

**May 2024**

#### **SITUATION**

1. This paper presents the Finance and Performance Committee with an update on the work being undertaken in support of the Trust's Environment, Decarbonisation and Sustainability work programme.
2. It also provides an update on the detailed reporting against the Trust's Decarbonisation Action Plan.

#### **BACKGROUND**

3. WAST has produced a Decarbonisation Action Plan (DAP) in response to the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan (*NHSW-DSDP*).
4. The plan has a range of actions which frame the Trust's decarbonisation response and spans all directorates across the Trust. It is vital that all areas of the Trust take ownership for the plan and that work across a potentially complex range of actions is organised appropriately to monitor and demonstrate progress.

#### **ASSESSMENT**

##### **Decarbonisation Programme Board and other wider governance**

5. The Programme Board met again on 22<sup>nd</sup> January 2024 and considered a range of updates, including a review of the Decarbonisation Action Plan, DCR reporting and highlight reports from the Transport Project Board and EFAB schemes. A detailed risk register is reviewed at each Programme Board meeting and is regularly updated. New risks have been added regarding PodPoint's withdrawal from the Direct Current (DC) (rapid charging) market and increased diesel emissions outside hospitals. This risk register development is also linked to work on the Corporate Risk Register. Risk 542 is currently in the process of being finalised at a CRR level, and further discussion has recently taken place regarding a high-level summary risk given that a detailed action plan sits below it.

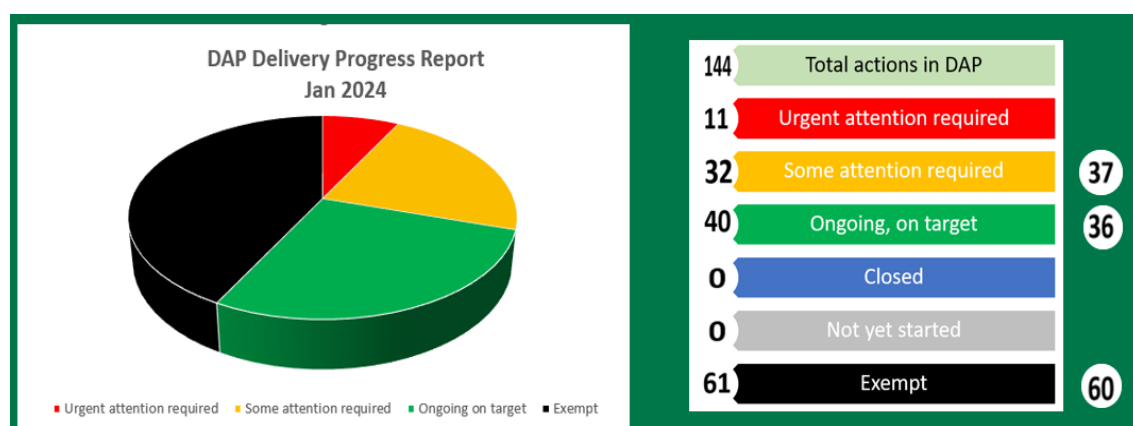
6. The highest rated risks continue to be highlighted within this report. The list below details those risks with a score of 25:
  - a. If there is a failure to secure adequate funding then this would impact on improving the estate/fleet and reducing carbon emissions resulting in an inability to meet the targets set by WG
  - b. If there is a failure to improve/upgrade leased buildings then this would prevent building being brought up to modern standards. This would result in WAST missing DAP targets and the opportunity to lower emissions from a significant part of the estate
  - c. If the Trust does not have the correct resource/skill sets assigned to Decarbonisation projects then they will not deliver the solutions required, resulting in the need to spend additional funding to source these externally and greater overall project costs
  - d. If the Trust is unable to influence NWSSP procurement decarbonisation work, then the Trust will not have control of carbon emissions which come from supply chain. This would result in WAST not reaching identified targets
  - e. If technology is unavailable to change fleet to full electric, then the Trust will be unable to procure ULEVs resulting in targets being unachievable
  - f. If the Trust is unable to deliver all of the actions in the DAP then the emissions will not be reduced resulting in not achieving the Decarbonisations emission targets by 2025 and 2030
  - g. If there is a lack of enough electrical infrastructure or means to upgrade the electrical supply, then the Trust will be unable to install further EV charging capacity resulting in the inability to further progress the charging network and deliver on a full EV fleet.
  - h. The 2018-19 carbon reporting baseline was calculated using differing methods than those currently used to calculate and report emissions. Therefore, it is difficult to understand our current progress, or success against the set baseline.
7. In support of the above, the next Programme Board scheduled for the end of April will consider an escalation plan including assurances that all possible actions are being progressed. It should be noted that other risks are identified at a lower but still significant (15 – 20 score rated) level. The risk register will continue to be reviewed and mitigation action accelerated wherever possible. However, some of the mitigation is outside of WAST control, sitting with industry, partner organisations, Welsh Government or within funding constraints currently being experienced.

### **WAST Decarbonisation Action Plan update and DCR Reporting.**

8. Finance and Performance Committee have received regular reporting on action plan progress since September 2022. The reporting follows the standard Strategic Transformation Board reporting, but given the breadth of actions

within the report, a "Gateway Review" type scale has been deployed to indicate overall programme rating; it is noted that this continues to evolve and is somewhat subjective but helpful in identifying an overall value. From a starting point of Red/Amber, the assessment is now Amber and the progress against several of the actions has been recorded as outlined below.

- The dashboard below outlines the position as reported to the Decarbonisation Programme Board and DCR Team in January 2024, noting that this report is written prior to any further reporting at the end of April Programme Board meeting so there is an element of lag in reporting (however an assurance can be provided that there is no significant change). It can be noted that the number of amber actions has decreased, with a corresponding increase in green actions, with the exception of one action which has moved into the exempt category.



- Work continues on 'deep dive' consideration of both red and amber actions to further explore the ways in which these can be accelerated. It should be noted that a number of challenges still remain regarding estates and infrastructure actions which require investment, alongside fleet (including EV charging) requirements and limitations of AWC vehicle replacement funding.
- NWSSP hold a DAP action relating to the purchase of REGO (renewable) energy via the All-Wales energy contract . The current electricity contract does not include the purchase of REGO energy due to cost, but does include the purchase of renewable energy, including nuclear. The change has now formally been requested through the National Programme Board. Whilst WAST has broadly confirmed support for this (in line, it is understood, with other organisations), we have reiterated concerns regarding targets being changed due to difficulty in delivering them. A number of other, less applicable, targets regarding pharmacy have also been adjusted.
- The reporting above reflects that which was submitted to the DCR Team in NWSSP for Q3 reporting by the deadline of 31<sup>st</sup> January 2024. A further return has also been submitted in advance of the end of April deadline for Q4 aligned to the qualitative reporting submission (see below).

## Internal Audit – Decarbonisation

13. The Internal Audit report has now been finalised and received by the team, and formally at Audit Committee on 1<sup>st</sup> March. The report outlined a limited assurance supported by 3 reasonable and 2 limited objective assurance ratings as outlined below.

### Assurance summary<sup>1</sup>

Objectives	Assurance
1 Governance	Reasonable
2 Localised Strategies	Limited
3 Funding Strategy	Limited
4 Monitoring Reporting and	Reasonable
5 Project Delivery	Reasonable

14. It is acknowledged that the funding strategy is partially outside of WAST control, given the limited availability of AWC funding to support decarbonisation initiatives, and some recent bids have been unsuccessful due to rigid criteria associated with schemes.
15. Management actions against all 4 recommendations have been agreed and will be progressed in the coming months.

## Welsh Government reporting

The deadline for the next round of **Qualitative Report** was 14<sup>th</sup> April 2024. It should be noted that the WG Team have this year identified that DCR reporting should be taken into consideration, therefore the DCR report for Q4 was submitted in support of the Qualitative template. This is in line with the information already summarised above.

16. To note, the template provided did not provide for the granularity of information provided in previous templates, including opportunities to highlight direct support requirements of NWSSP, WG and other health bodies. In the 2022/23 report, the ability to highlight WAST's dependence on support with issues such as handover delays and EV infrastructure was welcomed, and therefore the team has amended the template to complete a similar exercise for the 2023/24 report.
17. In terms of the annual **Quantitative reporting**, the management of Public Sector Carbon Reporting (PSCR) has transitioned from an external consultant to Welsh Government Energy Services. A meeting has been arranged to discuss

additional data reporting requirements, alongside the already significant ask. Reporting of 2023-24 data will start in April with submission in July. This will continue to include the emissions data for medical gasses, which in 2022-23 further exacerbated challenges around reporting against the 2018/19 baseline.

### **EFPMS reporting**

18. Primarily a reporting tool for Estates and Facilities to WG, the Estate, Facilities, and Performance Management System (EFPMS) also includes data for energy, water, and waste. Changes to reporting requirements for 2023-24 has seen the addition of reporting on individual buildings over 1000m<sup>2</sup> (we have 11 buildings within this category), plus the aggregated values of the rest of the estate portfolio. Reporting methodology differs from that of the PSCR, and therefore additional reported data calculation factors are needed, alongside the change of a collective data account to now 12 data sets (11 individual buildings and 1 aggregated report).

### **Capital Investment – EFAB Funding**

19. Delivery of 4 of the 5 WG Estates Funding Advisory Board (EFAB) schemes for 2023/24 is complete, with the fifth scheme due for completion by end of April, and planning has commenced for 2024/25 schemes. As previously noted, the Trust was awarded a proportionally significant amount of the total funding available, with a 30% contribution by WAST within the Capital Expenditure Limit.
20. Schemes range across decarbonisation and infrastructure and an update by scheme is provided below:
  - a. AFSRC Wrexham – Decarbonisation: the scheme which includes PV panels, LED lighting and associated works, and improvements to the existing building was completed by 31<sup>st</sup> March 2024.
  - b. Blaenau Ffestiniog - Decarbonisation: this scheme is now complete with installation of PV panels, an air source heat pump and LED lighting.
  - c. Cardiff Ambulance Station - Decarbonisation: work completed on a scheme to install PV panels on Block B of the Ambulance Station
  - d. Glynneath – infrastructure and decarbonisation: this larger scheme includes re-roofing (including insulation) the station and installing PV panels, installation of an air source heat pump, replacement of doors and windows and redecoration of the station. This will be complete by end of April 2024.
  - e. Bryncethin – infrastructure: this re-roofing scheme is complete
21. The delivery of schemes under the EFAB funding scheme is project managed by the Capital Development and Estates Teams and overseen by the Decarbonisation Programme Board.

## **Wider Environmental Considerations**

22. **ISO14001** – 2023 saw the resolution all non-conformances previously raised through the ISO14001 audits, and therefore retained the Trust’s ISO14001 accreditation. We remain the only ambulance service in the UK to hold this international accreditation. External auditing by BSI of the Trust’s ISO14001 system recommences June 21<sup>st</sup> 2024, however internal audits by the Trust’s Environment and Sustainability Manager begin on April 15<sup>th</sup>.
  
23. **Waste management** – changes to waste management legislation, beginning 4<sup>th</sup> April 2024, has seen a significant reset of Trust recycling requirements. Communications were approved on the 1<sup>st</sup> March 2023 for distribution, and additional internal waste bins purchased, with delivery during March. There are still concerns related to ambulance vehicle waste and the lack of glass waste provision. SOT have been actioned with identifying Waste Champions for sites, to help with the transition. Additional waste legislation in relation to furniture is being scrutinised, and the new legislation is in relation to fire protective chemicals used on soft furniture pre-2019. The use of skips for large scale waste removal of furniture items has been halted due to refusal of waste companies to take these items in this manner.
  
24. The Trust Waste management policy was approved at the March Policy Committee for publication. At the time of writing it is scheduled to be reviewed by ELT in early May and to the Finance and Performance Committee at this meeting for approval.

## **Adaptation Planning**

25. It is anticipated that Welsh Government will be issuing, by the end of the financial year, a toolkit for Adaptation Plan development. This will support the Trust in developing its plans to respond to the impacts of climate change. Whilst the responsibility for Adaptation Planning has not yet been defined, the Assistant Directors Leadership Team is currently considering the ownership of this workstream which is anticipated to sit within either Strategy, Planning & Performance or Operational Resilience.
  
26. It is also recognised that adaptation planning will gain more prominence in future months especially with the Trust’s position in the Wellbeing of Future Generations Act legislation, and it is a positive step that the Trust is considering its proposed processes in response.

## **RECOMMENDATION:**

**Finance and Performance Committee is asked to NOTE this update.**

<b>AGENDA ITEM No</b>	17
<b>OPEN</b>	Open
<b>No of ANNEXES ATTACHED</b>	1

**MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD –  
Mar/April 2024**

<b>MEETING</b>	Finance and Performance Committee
<b>DATE</b>	14 May 2024
<b>EXECUTIVE</b>	Rachel Marsh – Executive Director of Strategy, Planning & Performance
<b>AUTHOR</b>	Hugh Bennett - Assistant Director, Commissioning & Performance Mark Thomas – Commissioning & Performance Manager Melanie O’Connor - Commissioning & Performance Officer
<b>CONTACT</b>	<a href="mailto:Hugh.Bennett2@wales.nhs.uk">Hugh.Bennett2@wales.nhs.uk</a> <a href="mailto:Mark.Thomas12@wales.nhs.uk">Mark.Thomas12@wales.nhs.uk</a> <a href="mailto:Melanie.O’Connor@wales.nhs.uk">Melanie.O’Connor@wales.nhs.uk</a>

**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 **March/April 2024**.
2. Our response times to 999 callers remains of concern with red 8-minute performance at 48% in April 2024 and Amber 1 median at 1 hour and 8 minutes, which the Trust knows leads to avoidable patient harm. The Trust continues to work on actions within its control to mitigate this risk including, for example, maintaining high levels of EA production and fully rolling out the CHARU service. Work continues on an action plan to increase the consult and close rates to the target 17%, as this is modelled to have a significant impact on response times. The Trust lost nearly 23,620 hours to handover in April 2024, and this level of lost capacity is difficult to compensate for, despite all the actions being taken. The 2024/25 budget includes further investment in activities designed to shift demand left and mitigate the impact of handover lost hours.
3. 111 performance is broadly stabilised. Whilst patient demand was 4.8% lower in April 2024, compared to April 2023, it was 18% higher in Q4 2023/24 compared with Q4 2022/23. There is a 4% commissioned reduction in call handlers in 2024/25. The service is in a more resilient place, but if demand

continues to remain at these levels future performance may become a concern. The new 111CAS went live on 30 April 2024 as planned. This new system was delivered at high pace to mitigate a non-delivery issue beyond the Trust's control.

4. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance has been stable, with oncology remaining above target and renal performance achieving its target. Both the NET Centre and NEPTS transport are due to be re-rostered in 2024/25, a key efficiency.
5. The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People & Culture Plan. Sickness absence was 7.67% in March 2024 compared to 8.50% in February 2024. The 23/24 IMTP ambition was to reach 6%. The Trust will continue its focus on sickness absence. It is of note that the EMS abstractions did hit the 30% benchmark in January and February respectively, for the first time since the pandemic; however, there was a slight increase again in March 2024.
6. The Trust continues at pace its programme of transformation, as detailed in its 2024-27 IMTP, which is strategic necessity to mitigate the wider system pressures, in particular, handover lost hours.

**RECOMMENDATION: The Committee is asked to: -**

- **Consider the March/April 2024 Integrated Quality and Performance Report and actions being taken and determine whether:**
  - a) **The report provides sufficient assurance.**
  - b) **Whether further information, scrutiny or assurance is required,**  
**or**
  - c) **Further remedial actions are to be undertaken through Executives.**

**REPORT APPROVAL ROUTE**

09.05.24 Executive Director Strategy, Planning & Performance  
14.05.24 FPC

**REPORT APPENDICES**

Appendix 1 – Top Indicator Dashboard

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

## SITUATION

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the “vital few” key metrics. This report is for **March/April 2024**.

## BACKGROUND

2. This Integrated Quality & Performance Report contains information on key indicators at a highly summarised level which aims to demonstrate how the Trust is performing across four integrated areas of focus: -
  - Our Patients (Quality, Safety and Patient Experience);
  - Our People;
  - Finance and Value; and
  - Partnerships and System Contribution
3. As previously agreed, the metrics which form part of this committee/Board report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust’s plans (IMTP) and strategies. A revised set were agreed for 2023/24. All the updates for the revised set have now been completed, with the exception of: a metric on the duty of candour where we will need to determine our own metric whilst national reporting is agreed; completed symptom checkers; and value indicators for 111/CSD – it is likely that this one will be difficult to determine.

## ASSESSMENT

### Our Patients – Quality, Safety and Patient Experience

4. **Call answering** (safety): the speed at which the Trust is able to answer a 999 or 111 call is a key patient safety measure.
5. **999** call answering times have declined to 34 seconds in March 2024 from 15 seconds in February 2024, not achieving the 6 second target. The 65<sup>th</sup> percentile and median performance remain very good.
6. **111 call answering performance remains broadly stable**, although the call abandonment performance at 10.9% in April and off target (5%). The Trust had almost recruited up to the 198 FTE call handler commissioning control total for 2023/24 with very good levels of production. It should be noted that the Trust is anticipating a reduction in the commissioned level of call handler FTEs next year (-4%). Demand in April 2024 was 4.8% lower than April 2023, but was 18% higher in Q4 2023/24, compared to the same period last year. If this level of demand is sustained, alongside a reduction in capacity, then future call abandonment performance will start to be a concern. In the short term, there

will also be a planned short-term dip in staffing numbers linked to the imminent 111 CAS go live and the need to re-programme training capacity away from new recruits and towards the existing workforce on the new system. This will have some short-term impact on performance, something that has been seen in early May, in particular, through the bank holiday weekend. Detailed analysis is currently being undertaken on the May bank holiday.

7. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 98.4%. Unfortunately, response times for lower priority calls remain some way below target. This drop in performance has been affected by a rise in call demand, but also high clinician sickness absence. Clinician sickness has seen a material deterioration in April, rising to 15.4% compared to 11.8% in March. As with call handling performance, there is likely to be some further deterioration linked to staff abstracted to undertake training for the new system.
8. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for April 2024 was 48%, remaining below the 65% target; however, the Trust is reaching more red patients in 8 minutes, but the denominator (demand) has also grown. The Amber 1 median in March was 1 hour 8 minutes and the Amber 1 95<sup>th</sup> percentile was 5 hours 26 minutes. These long response times have a direct impact on outcomes for many patients.
9. Traditionally the factors which affect response times are demand and capacity (recruitment and lost hours). Recruitment is good, see slide 20 for information on staff in post v establishment, but the lost capacity through handover at hospital remains extremely challenging. The Trust's main focus in the first half of 2024/25 is to implement a material change in how it responds to patient demand by updating its clinical model, before winter. A series of workshops are planned in early May 2024, with additional leadership capacity also being put into this area: both designed to move this at pace. Areas of focus include: -
  - Further investment into the Clinical Support Desk (+23 FTEs);
  - Further investment in APPs (+32 APPs);
  - An updated clinical model that places more emphasis on telephone triage e.g. clinical screening, further work on timebound and planned responses e.g., "Amber Hot" and "Amber Cold";
  - Development of the integrated care model (111 clinicians and CSD clinicians);
  - Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: Connecting Support Cymru, mental health response pilot, Falls response etc.
  - Formal reporting of the 2023 collaborative and independent EMS Demand & Capacity review.

10. The one area of particular focus for recruitment is CHARU: with the Trust recruiting up to the modelled 153 FTEs; and connected to this a focus on CHARU productivity, with on-going analysis work on their contribution (findings positive) etc.
11. As above, the extreme level of lost hours to **handover outside Emergency Departments** remains the critical component of long waiting times and patient safety incidents. 23,614 hours were lost during April 2024. 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. Performance into May has remained very challenging with days where over 1,000 hours are lost.
12. **Ambulance Care (Patient Experience)**: Oncology performance in April 2024 was 73.6%, hitting the 70% target. Renal performance also remains above target at 74.01%. Advanced discharge & transfer journey performance decreased compared to the previous month to 79% and remains below the 95% target. Overall demand for NEPTS continues to increase but remains below pre-pandemic levels. The Trust has a comprehensive Ambulance Care Transformation Programme in place, which includes delivering a range of efficiencies and improvements, for example: aligning clinic patient ready times to ambulance availability and addressing oncology performance. The Trust is expecting to re-roster NEPTS transport in 2024/25 which will better align capacity with demand patterns.
13. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported four NRI's to the NHS Executive in March 2024, a slight decrease from the seven reported in February 2024; and 21 serious patient safety incidents were referred to health boards under the Joint Investigation Framework, which has now been adopted NHS Wales wide. In March 2024 complaint response times improved to 56%, a significant improvement on the 35% recorded in February 2024, but remaining below the 75% target, with cases remaining complex. Reviews of lower graded concerns are being undertaken to ensure proportionate investigations are undertaken. The Trust is currently recruiting to a new structure for the Putting Things Right (PTR) team, which will increase capacity and leadership, including a new Head of Service, who has now arrived.
14. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 72.85% in March 2024, remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system. The return to spontaneous circulation (ROSC) compliance rate increased to 21% in March 2024 compared to 14.7% in February 2024.

15. The Trust is now able to report on call to door times for Stroke and STEMI patients. For March 2024 these highlight call to hospital door times of two hours and 25 minutes for stroke patients and two hours and seventeen minutes for STEMI. Clearly these times are too long and are representative of the longer response times for all calls as a result of the pressures and issues outlined in this report.
16. In April 2024, 7,975 patients **cancelled** their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 170 callers. The Trust believes that 50% of this combined number is unmet demand and is likely to be popping up elsewhere in the system. Anecdotal evidence from health boards supports this view, but data linking planned for 2024/25 is a key enabler to properly evidence this.

Our People (workforce resourcing, experience, and safety)

17. **Hours Produced:** The Trust produced 121,578 Ambulance Response unit hours in April 2024 and delivered an emergency ambulance unit hours production (UHP) of 96%, achieving the 95% target. Key to the number of hours produced are roster abstractions.
18. **Response Abstractions:** EMS abstraction levels increased to 33.49% in March 2024, moving just above the 30% benchmark figure, having achieved the benchmark in January and February. EMS Response sickness abstractions stood at 8.17% (benchmark 5.99%).
19. **Trust sickness absence:** the Trust's overall sickness percentage was 7.67% in March 2024, a decrease on the 8.50% recorded in February 2024. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan. The 7.67% is above the 2023/24 IMTP ambition of 6%, but is a good improvement.
20. **Staff training and PADRs:** PADR rates did not achieve the 85% target in March 2024, but have been steadily improving (78.80%). Compliance for Statutory and Mandatory training increased to 81.89%.
21. **People & Culture Plan:** The Trust launched its People & Culture Plan in April 2023 and workstreams are being delivered around behaviours, in particular, sexual safety, Freedom to Speak Up, 111 culture review, flexible working and the introduction of a staff pulse survey tool. The Executive Leadership Team undertook a pan-Wales round of CEO Roadshows in April 2024. Feedback from attendees will be reviewed.

## Finance and Value

22. **Financial Balance:** The reported outturn performance at Month 12 is a surplus of £85k and the Trust achieved both its External Financing Limit and its Capital Resource Limit.

## Summary

23. The indicators used at this high-level highlight that the 111, EMS and Ambulance Care performance are stable; however, 111 and EMS performance are not where the Trust would want them to be.
24. 111 has seen a clear improvement in performance over the past 12 months and the service is undoubtedly more resilient, however, the current high levels of demand plus a commissioned reduction in call handlers and clinicians may mean that the improved performance comes under pressure in 2024/25. Implementing the new 111CAS may also have a short term impact on performance, as staff familiarise themselves with the new system. The Trust and commissioners will need to keep the level of demand under review: a demand & capacity review is planned for 2024/25.
25. EMS performance has been recognised as challenging for a long time. Transformation of our service offer is a necessity (not an option) for reducing handover lost hours along with handover reduction by health boards. The Trust also needs to continue its focus on core activities like abstractions, production, and utilisation.

## **RECOMMENDATIONS The Committee is asked to: -**

- **Consider the March/April 2024 Integrated Quality & Performance Report and actions being taken and determine whether:**
  - a) **The report provides sufficient assurance.**
  - b) **Whether further information, scrutiny or assurance is required, or**
  - c) **Further remedial actions are to be undertaken through Executives.**

Welsh Ambulance Services University NHS Trust

# Monthly Integrated Quality & Performance Report

March/April 2024

Annex 1 – Top Indicator Dashboard



GIG  
CYMRU  
NHS  
WALES

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

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Annex 1 – Top Indicator Dashboard  
Version 1.0  
Released: May 2024

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by Commissioning & Performance Team



# Section 1: Monthly Indicators / Top Indicator Dashboard



Top Monthly Indicators		Target 2023/24	2 Year Average	Mar-24	Apr-24	RAG	Top Monthly Indicators		Target 2023/24	2 Year Average	Mar-24	Apr-24	RAG			
<b>Our Patients</b>						<b>Health &amp; Well-being</b>										
<b>Timeliness Indicators</b>																
NHS111 Call Handling Abandonment Rates	< 5%	11.4%	13.2%	10.9%	R	Sickness Absence ( <i>all staff</i> )	6.0%	8.88%	7.67%	N/A	R					
111 Clinical Triage Call Back Time (P1)	90%	98.2%	98.0%	98.4%	G	Mental Health Absence Rates	Reduction Trend	2.29%	2.07%	N/A	R					
999 Call Answer Times 95th Percentile	00:06	00:30	00:34	N/A	R	Staff Turnover Rate	Reduction Trend	10.22%	8.73%	N/A	A					
999 Red Response within 8 minutes	65%	49.8%	48.9%	48.0%	R	Statutory & Mandatory Training	>85%	79.06%	81.89%	N/A	A					
999 Amber 1 Median	00:18	01:22	01:22	01:08	R	PADR/Medical Appraisal	>85%	73.18%	78.80%	N/A	A					
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	71.9%	73.7%	73.6%	G	Number of Shift Overruns	Reduction Trend	3849	4010	4000	R					
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	83.7%	86.5%	79.4%	A	<b>Inclusion &amp; Engagement / Culture</b>										
<b>Clinical Outcomes / Quality Indicators</b>						NEPTS % of Total Calls Answered in Welsh						Increasing Trend	1.2%	1.5%	1.6%	R
Return of Spontaneous Circulation (ROSC)	Increasing Trend	18.1%	21.00%	N/A	A	<b>Value</b>										
Stroke Patients with Appropriate Care	95%	76.9%	72.80%	N/A	R	Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	N/A	G					
Stroke Call to Hospital Door Times	Reduction Trend	02:24	2:25	N/A	A	EMS Utilisation Metric (CHARU)	Increasing Trend	30%	28.5%	26.8%	R					
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	42.7%	40.90%	N/A	R	Average Jobs per Shift (All Vehicles)	Increasing Trend	2.38	2.27	2.25	A					
National Reportable Incidents reports (NRI)		5	4	N/A		NEPTS on the Day Cancellations	Reduction Trend	19.8%	19.8%	19.1%	A					
Can't Send & Cancelled by Patient Volumes	Reduction Trend	10,679	11,115	8,799	R	<b>Partnerships / System Contribution</b>										
Concerns Response within 30 Days	75%	35.7%	56%	N/A	A	<b>Inverting the Triangle</b>										
<b>Our People</b>						Successful Consult & Close Outcome						17.0%	13.5%	14.0%	15.0%	A
<b>Capacity</b>						NHS111										
Hours Produced for Emergency Ambulances	95-100%	94%	93%	96%	A	NHS111 Dental Calls	Increasing Trend	6,563	7,277	7,500	A					
						% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department						Increasing Trend	11.4%	11.46%	N/A	A
						Number of Handover Lost Hours						15,000	23,306	23,403	23,614	R
						Consult & Close Volumes by NHS111						Increasing Trend	1,054	946	981	G

**In-Month RAG Indicates =**

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

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

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

TBD: Status cannot be calculated (*To Be Determined*)

# Our Patients: Quality, Patient Safety & Experience

## 111 Call Answering/Abandoned Performance Indicators

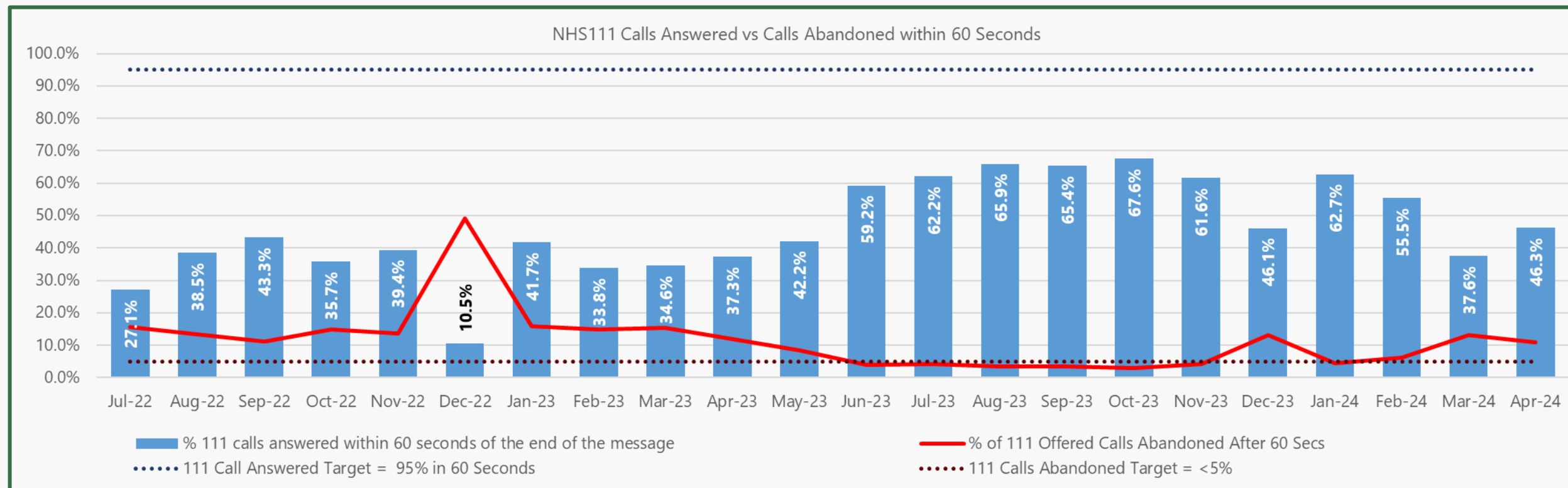
(Responsible Officer: Lee Brooks)

Abandonment Rate

R

FPC

### Influencing Factors – Demand and Call Handling Hours Produced



#### Analysis

The 111-call abandonment rate improved from 13.2% in March 2024 to 10.9% in April 2024 but failed to achieve the 5% target. However, this figure remains lower than the 11.8% abandonment rate seen in April 2023 (demand in April 2024 being 4.8% lower than in April 2023).

The percentage of 111 calls answered within 60 seconds increased, from 37.6% in March 2024 to 46.3% in April 2024, but continues to be below the 95% target (37.3% figure recorded in April 2023). The drop in performance during March 2024 was due to a spike in demand. Demand in Q4 was 18% higher than in Q4 last year, but due to increased efficiencies, improved recruitment and improved rostering, the impact on performance was far less significant than seen during previous months of higher demand.

The new 111CAS system went live on 30<sup>th</sup> April 2024. This was achieved on a very short timeframe, due to circumstances outside of the Trust's control, with the Trust demonstrating agility to put a new system in place at such speed. Launching this system just before a spring bank holiday was less than ideal, but the Trust had no choice. Staff are familiarising themselves with the system, which is having some impact on efficiency at this early stage.

Abstractions due to sickness absence decreased, reaffirming the longer-term downward trend, and overall, 111 abstractions remain lower (better) than benchmark.

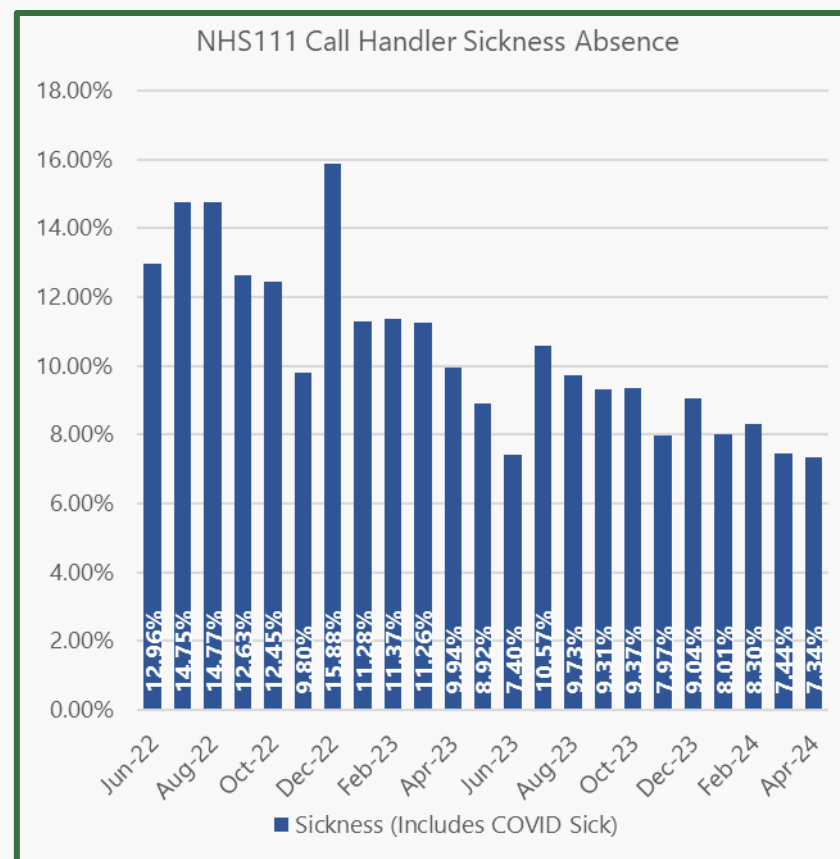
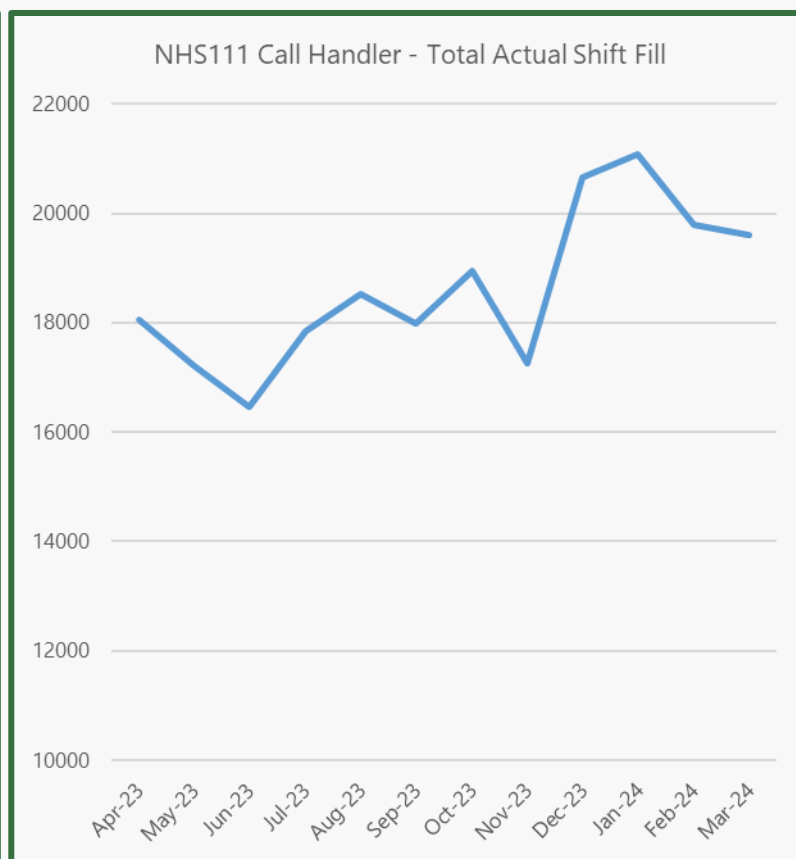
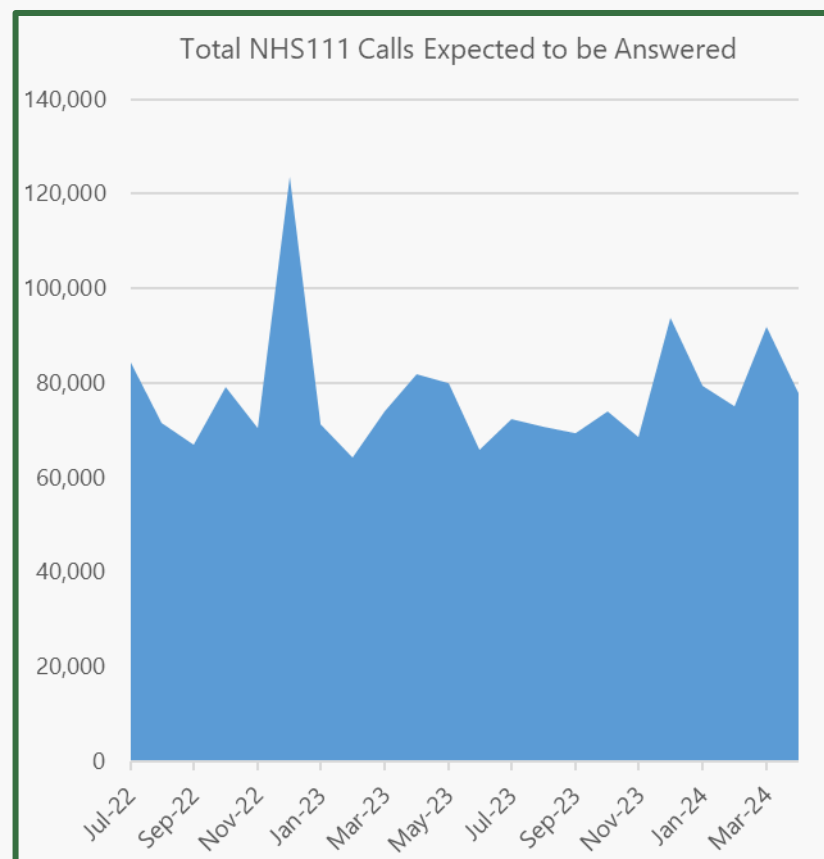
#### Remedial Plans and Actions

The key to improving 111 quality and performance is now twofold:-

- A focus on realising the benefits of the new 111CAS, including a period of transition for our staff onto the new system; and
- A demand & capacity review that takes account of the increased demand the Trust is seeing, what levels of performance commissioners want and the mix of capacity and efficiencies to achieve this.

#### Expected Performance Trajectory

The service is much improved, but with demand increasing in the way it is and the call handlers reducing next year performance is unlikely to improve or hit the commissioned targets.

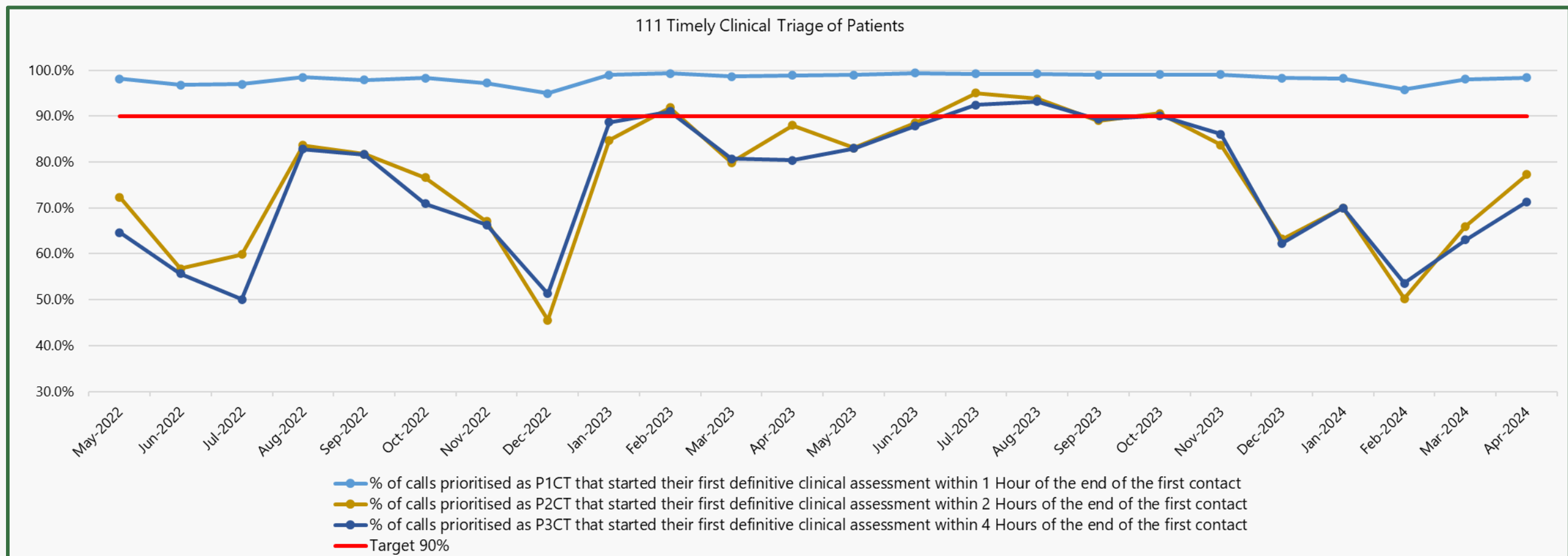


# Our Patients: Quality, Safety & Patient Experience

## 111 Clinical Assessment Start Time Performance Indicators

### Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)



**Analysis**  
The highest priority calls, P1CT, achieved the 90% target once again, recording 98.4% in April 2024.

Lower category calls both improved during April 2024, reversing a previous deterioration in performance, which was primarily due to an uplift in demand, but was also compounded by staff abstractions for new systems training.

P2CT increased from 66% in March 2024 to 77.3% in April 2024, while P3CT increased from 63.1% to 71.4%.

Clinical staff capacity decreased to 9,990 hours during March 2024, a decrease of 904 hours when compared to March 2023 (the Trust is being commissioned for a lower number from April 2024). Clinician sickness absence also increased slightly to 15.40% in April 2024 from the 11.84% reported in March 2024.

Sickness absence management is another core component of capacity and workforce. Current levels within the 111 service, indicate that clinician absence remains higher than target in Apr-24 and further work is required.

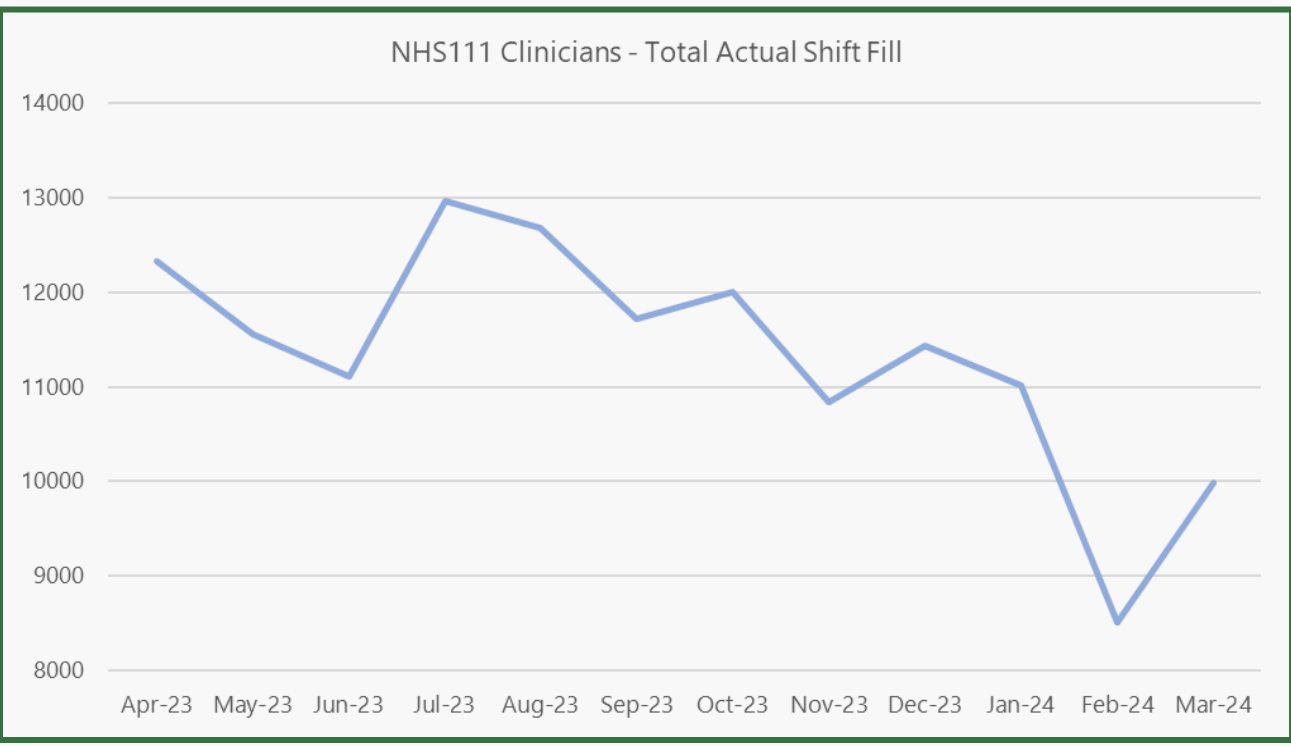
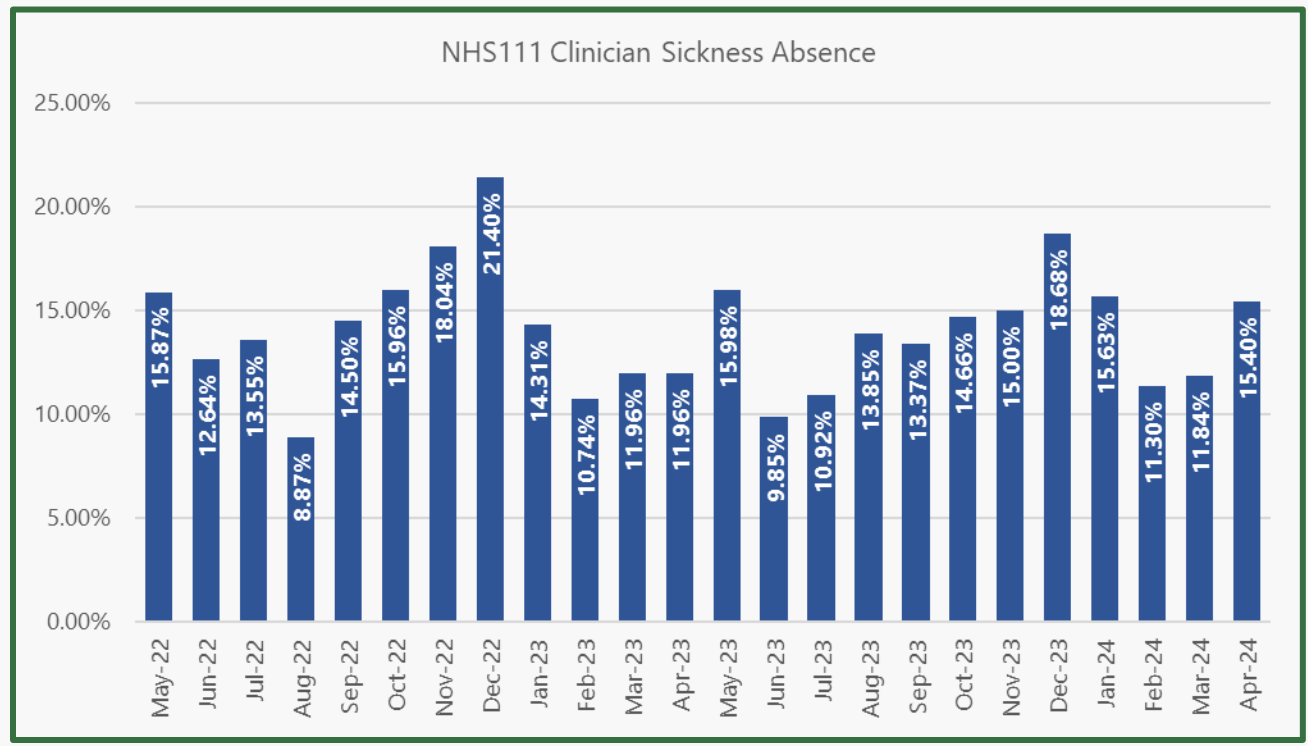
**Remedial Plans and Actions**  
The main focus is the new 111CAS which went live on 30 April 2024. This was implemented at very high pace to mitigate the non-delivery of SALUS.

The new system should deliver a range of benefits for service users and staff and improved performance, but this is not modelled currently.

Sickness levels amongst clinicians remains higher than the Trust would want, but there was a significant improvement in February.

As per the previous slide a demand & capacity review that quantifies the number of clinicians required to meet forecast demand (net of efficiencies) remains key.

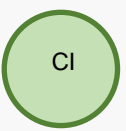
**Expected Performance Trajectory**  
The new 111CAS will bring performance benefits, however, demand is increasing materially, and the number of commissioned clinicians will be lower in 2024/25.



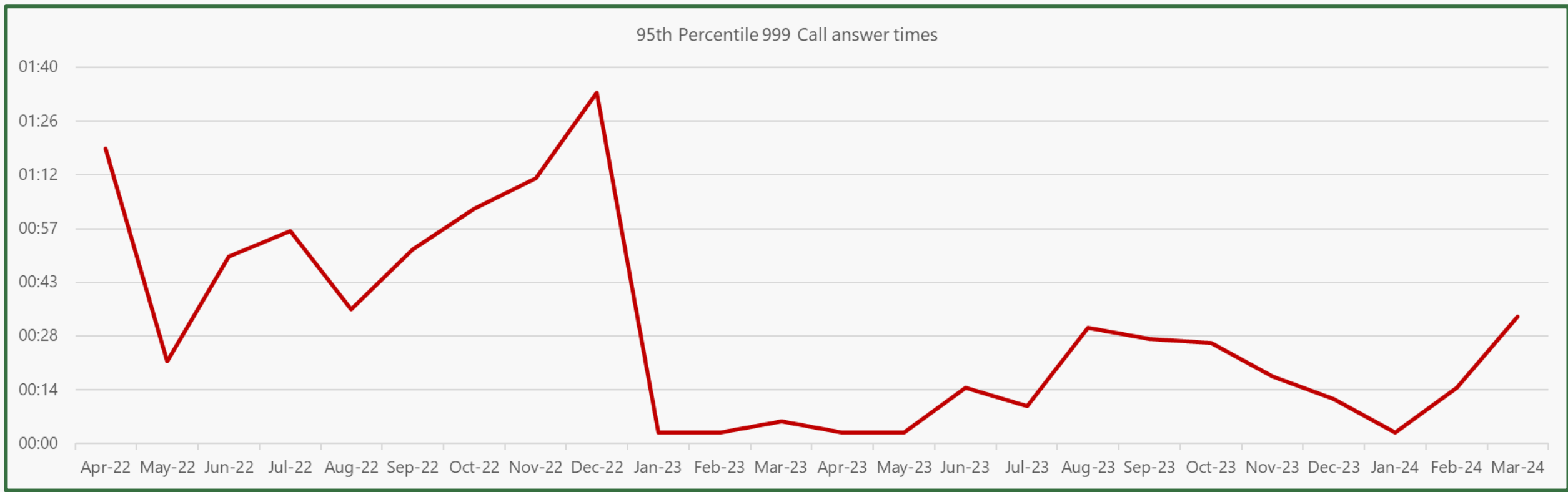
# Our Patients: Quality, Safety & Patient Experience

## 999 Call Performance Indicators

(Responsible Officer: Lee Brooks)



### Influencing Factors – Demand and Hours Produced



#### Analysis

The 95<sup>th</sup> percentile 999 call answering performance increased to 34 seconds in March 2024, up from 15 seconds in February 2024, and not achieving the 6 second target for the second month in a row. The median call answer time for the 999-service remained consistent at 2 seconds.

The Trust received 44,749 emergency 999 calls in March 2024, an increase on the 41,505 calls received during February 2024.

Overall sickness abstractions within EMS Coordination has returned to a downward trajectory after a three month increase at the end of 2023. Sickness decreased to 11.68% in March 2024 from 12.59% in February 2024.

#### Remedial Plans and Actions

- Currently call taker are 22% above establishment (137 FTEs v 112 FTEs)
- There is a future recruitment drive planned for April to August which should provide an additional 36 (if successful in recruiting) which will mitigate against attrition.
- Over establishment has been approved for EMSC by the Executive Director of Operations
- Intelligent Routing Platform is now in operation following configuration changes.
- Three workstreams are being progressed through the EMS Reconfiguration project (see below).

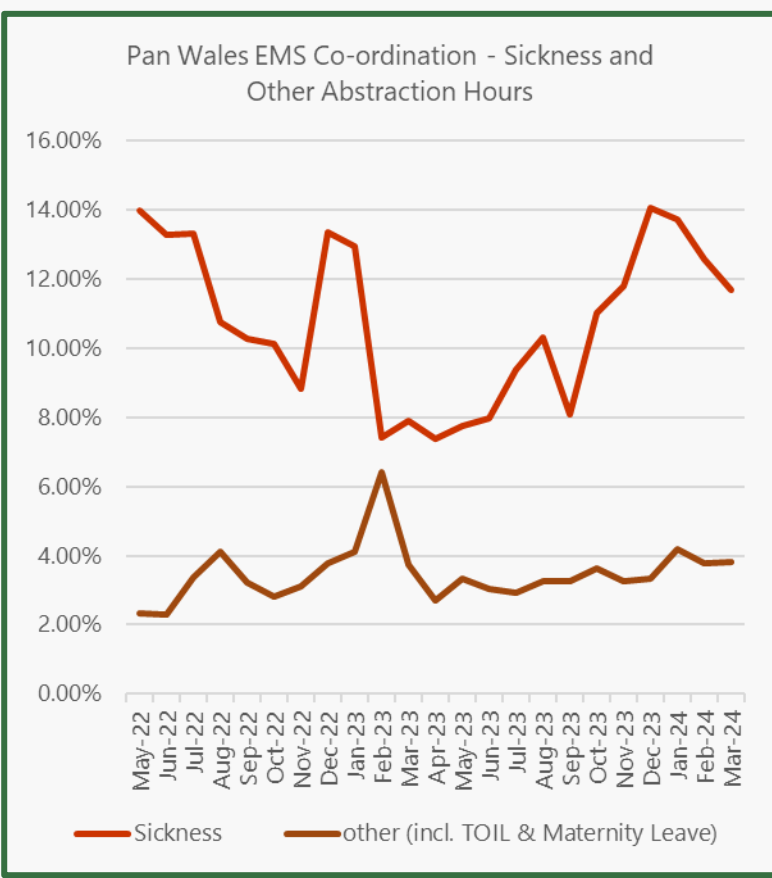
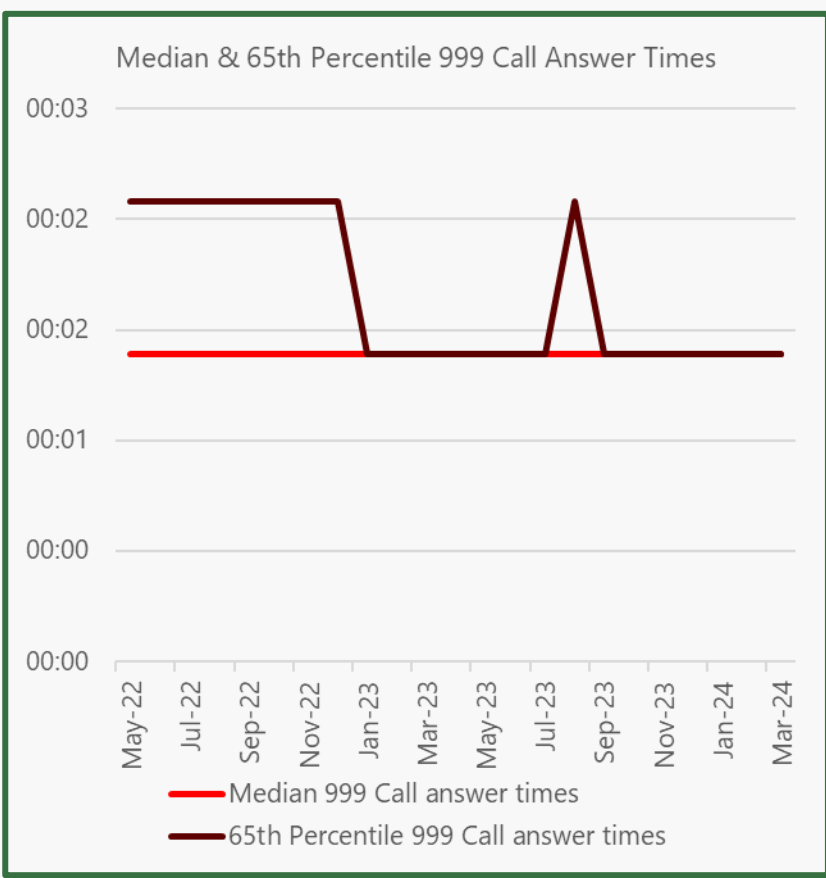
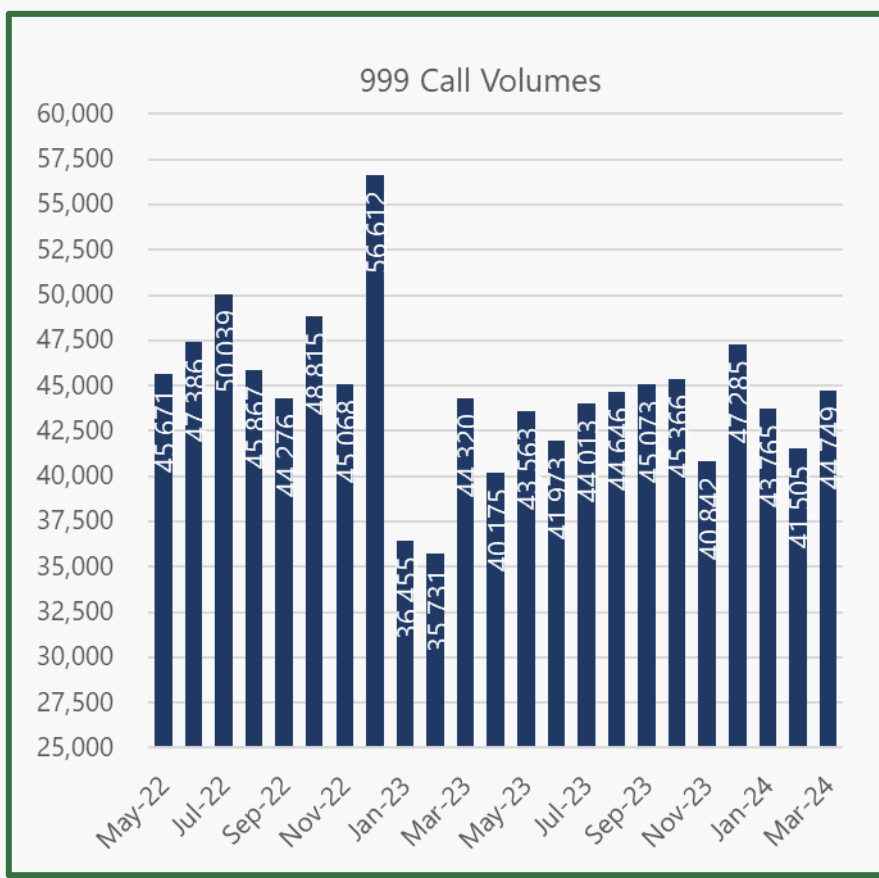
**Roster Review.** Having successfully implemented an EMD roster review in February 23 the project has now progressed to commencing a dispatch roster review for Allocators and Dispatchers. The workstream is now being progressed.

**Boundary changes.** EMS Coordination intend to realign dispatch boundaries to balance workload and pressures for individual dispatch teams. The work-stream is now being progressed.

**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. This workstream is now being progressed.

#### Expected Performance Trajectory

The median and 65<sup>th</sup> percentile are performing very well and are stable. The above changes should provide further resilience. There is some resilience to demand increases, but this needs to be kept under review.

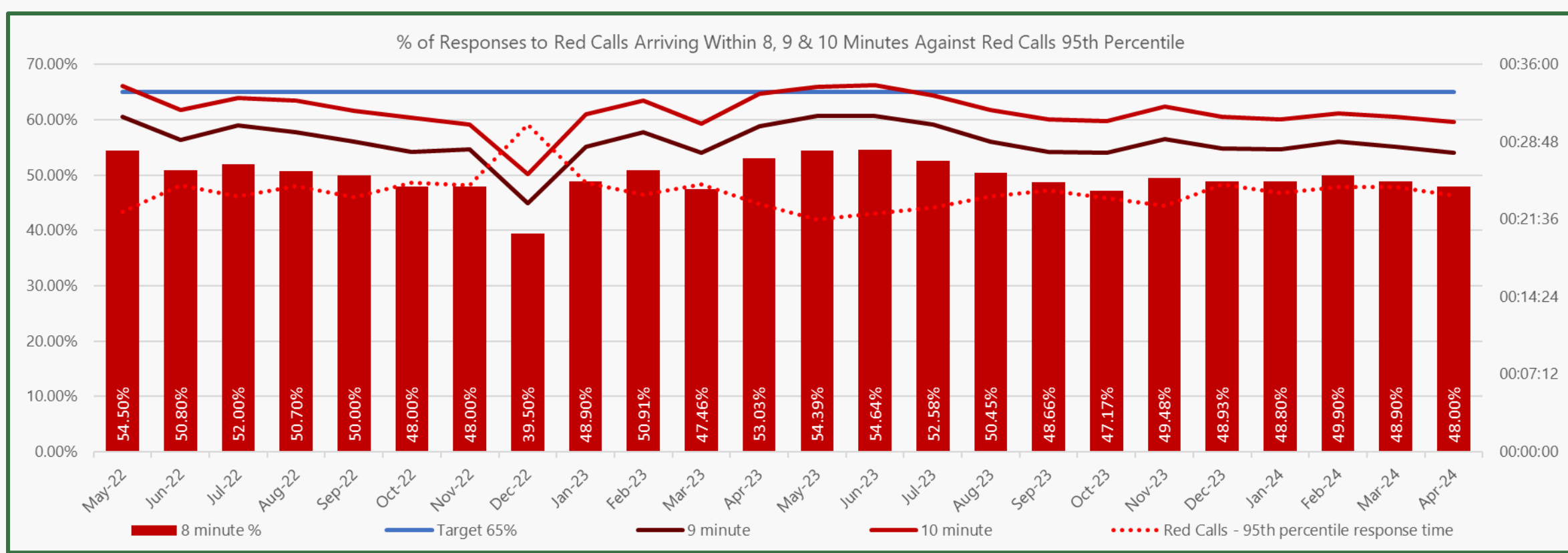
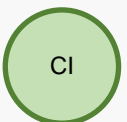


# Our Patients: Quality, Safety & Patient Experience

## Red Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)



### Analysis

Red 8-minute performance continues to remain below the 65% target and decreased marginally during April 2024 to 48%.

Red 10-minute performance for March 2024 was 59.6%, a slight reduction from 60.6% in March 2024.

The bottom right graph shows that as demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for April 2024 being 2,176. This is above the 12-month average (2,243) and would indicate that performance in this area is mirroring the rise experienced in demand during the month i.e. the Trust is reaching more Red calls in 8 minutes, but the denominator is also increasing.

The lower left graph demonstrates the correlation between overall Red performance and hospital handover lost hours. April 2024 (23,614) saw an increase on the 23,082 recorded in April 2023. Despite handover being higher than April 23 the Trust reached 2,176 Red calls in 8 minutes in April 2024, compared to 1,993 in April 2023.

### Remedial Plans and Actions

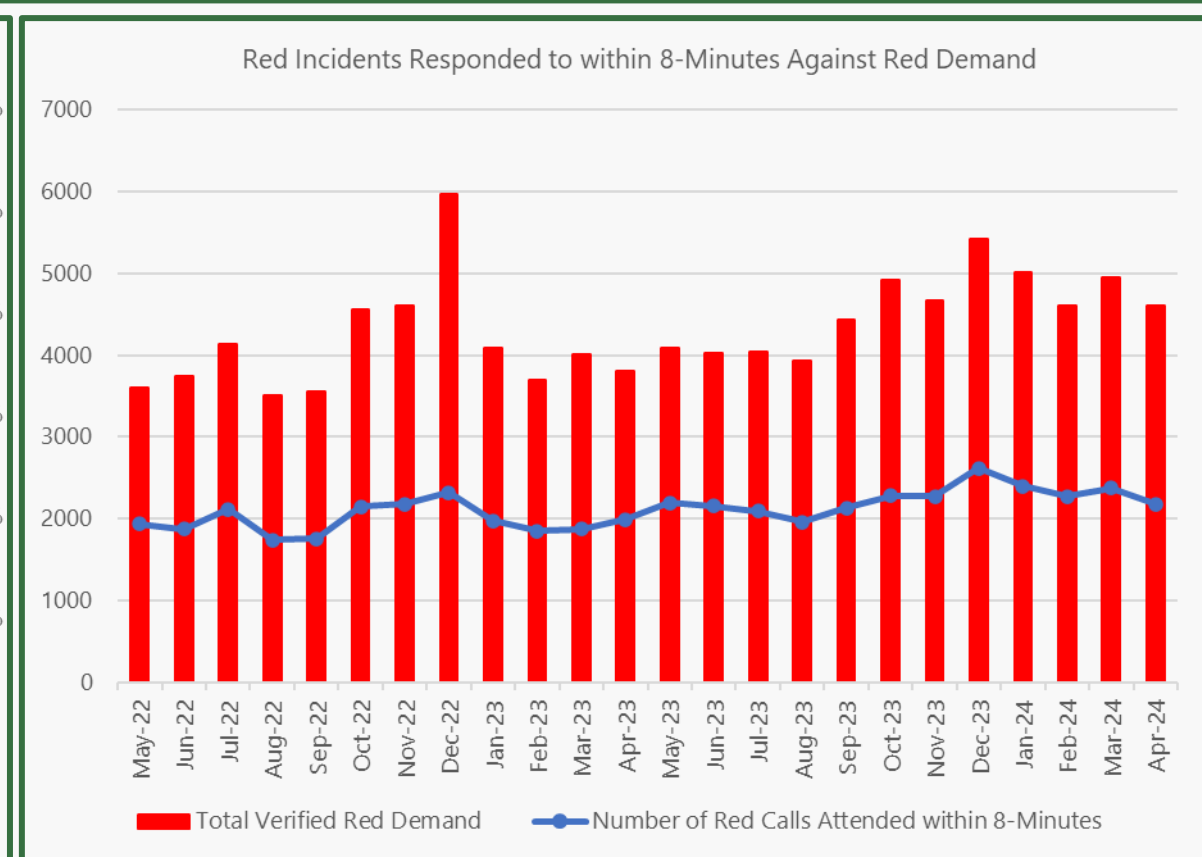
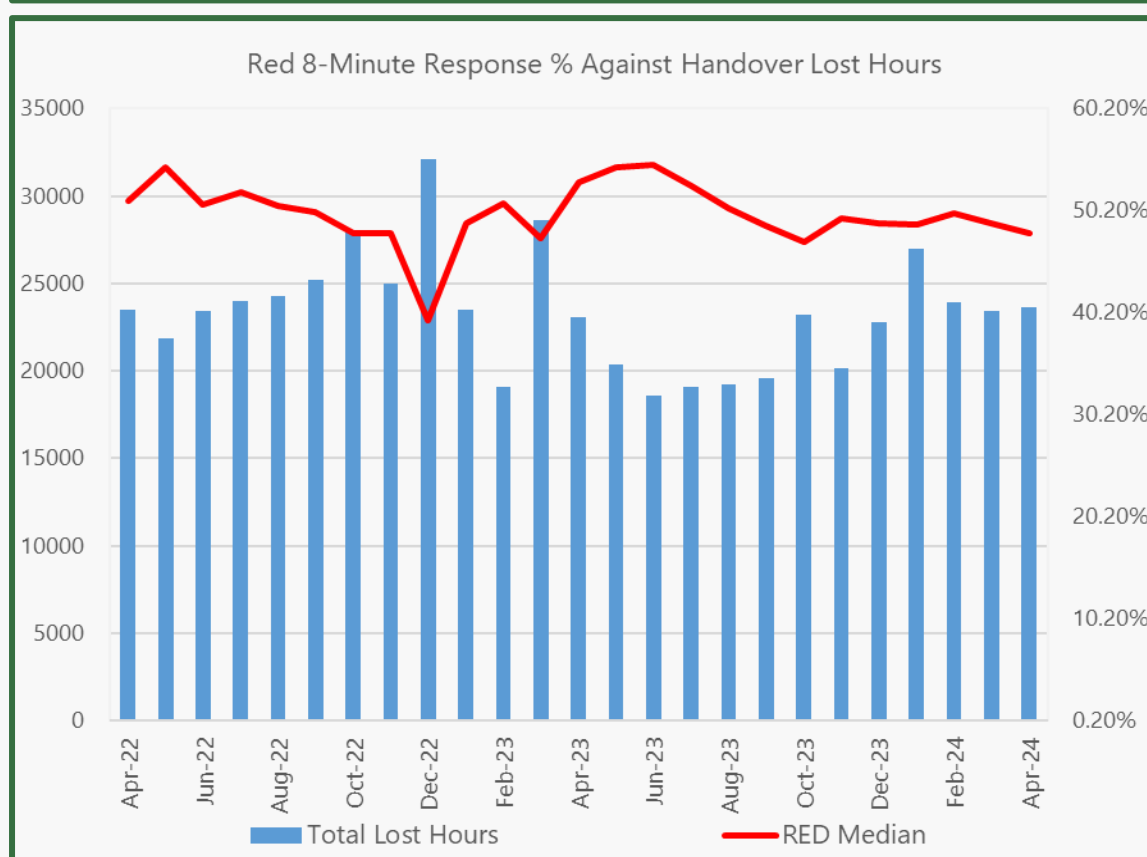
The main improvement actions are:

- To maintain commissioned establishment levels overall. Funding for the +100 now secure.
- Full roll out of the Cymru High Acuity Response Unit (CHARU), now largely complete (127 FTEs v target of 153 FTEs) with the exception of some hard-to-reach areas. Further actions to address;
- Continued focus on production and abstractions (EA production was 96% UHP in April and CHARU production 73% against full roll out);
- The rapid deployment, before winter 2024/25, of an updated clinical model e.g. red screening, Amber Hot, Amber Cold etc.

### Expected Performance Trajectory

Modelling has been completed for Spring 2024. This continues to indicate a level of Red performance below target (most likely scenario 52%) and Amber 1 (one hour and 12 minutes). This modelling includes changes already operationalised and some further improvements but does not include the major change to the clinical model i.e. this will not come on stream in Q1.

\*NB: Data correct at time of abstraction

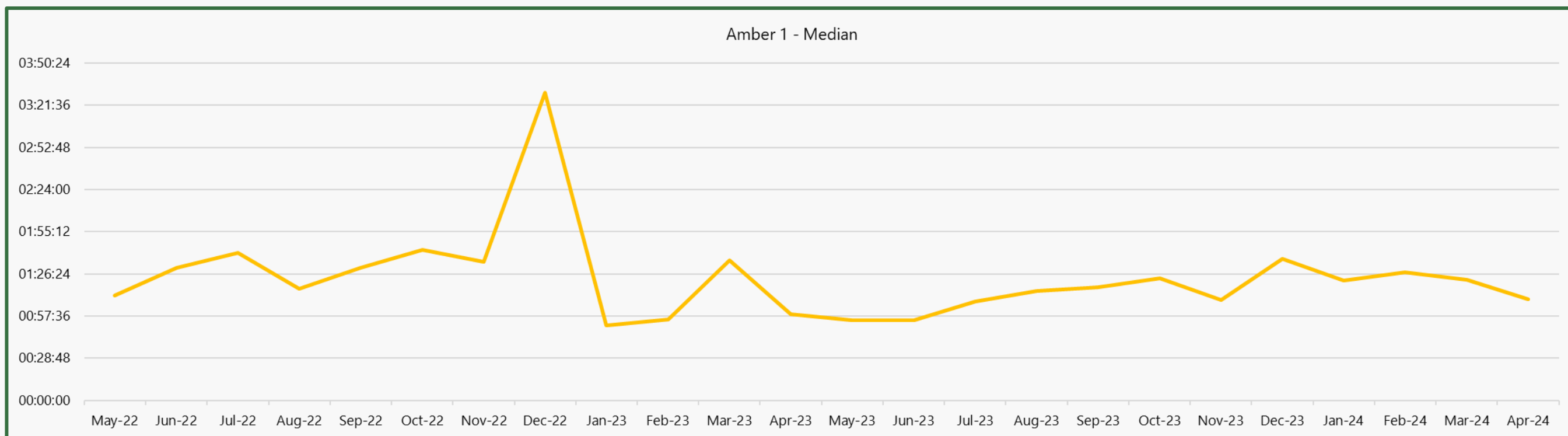
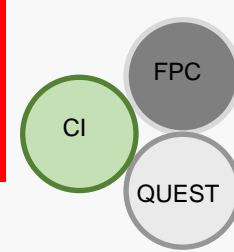
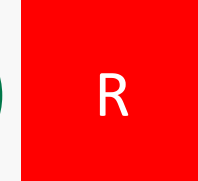


# Our Patients: Quality, Safety & Patient Experience

## Amber Performance Indicators

### Influencing Factors – Demand, Hours Produced and Hours Lost

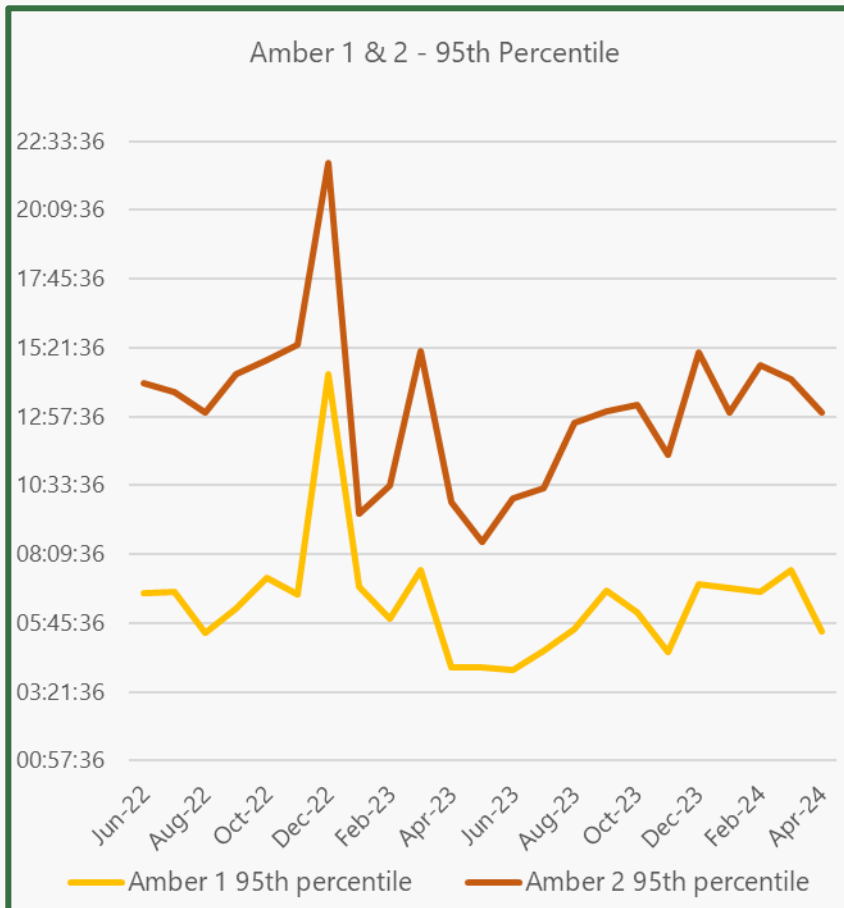
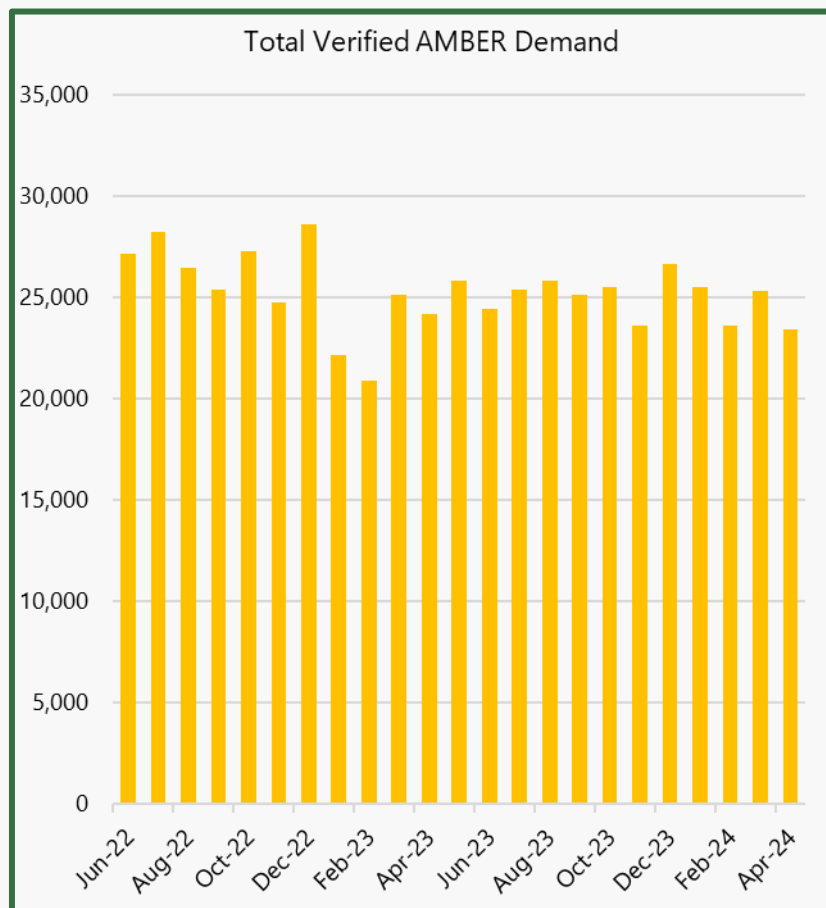
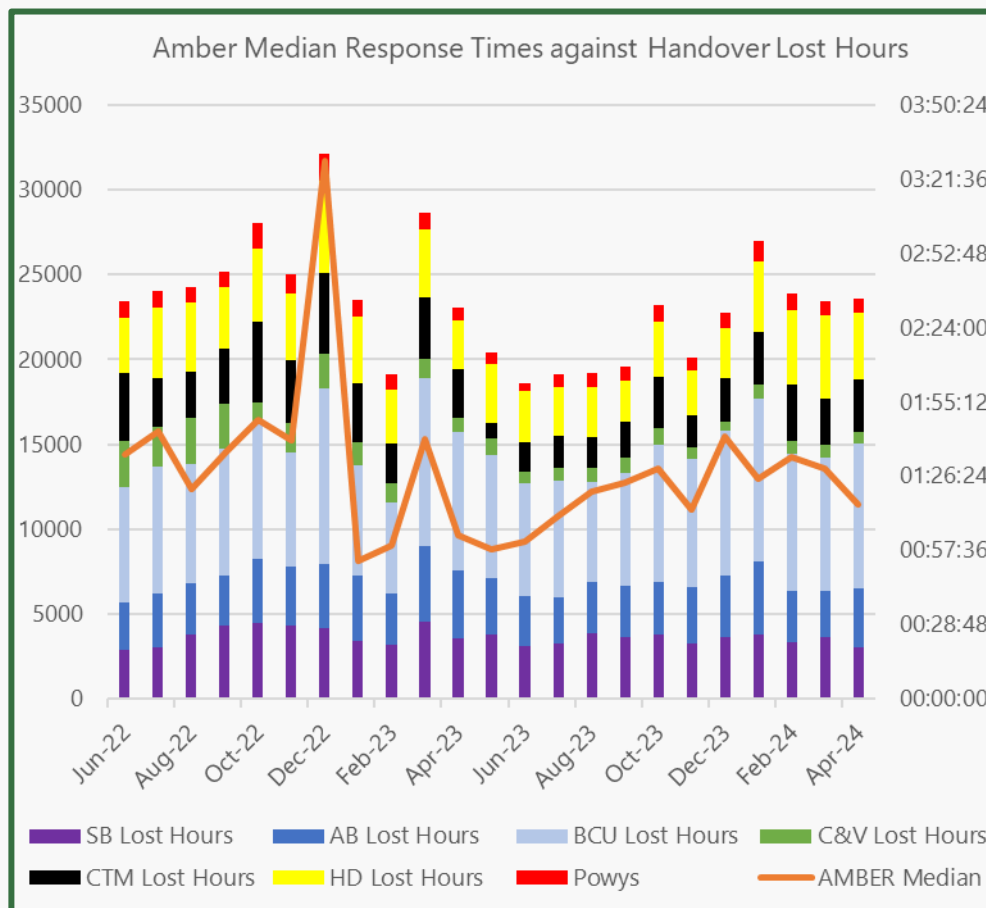
(Responsible Officer: Lee Brooks)



**Analysis**  
 Amber 1 median performance time improved slightly during April 2024 to 1 hour 8 minutes, from the 1 hour 22 minutes recorded in March 2024. Although this figure is lower than the 1 hour 35 minutes recorded for March 2023, it is against a month of higher Amber demand (+187) and an extreme and higher level of hospital handover lost hours, compared to April 2023. The ideal Amber 1 median response time remains at 18 minutes, although this has yet to be achieved.

The Amber 1 95<sup>th</sup> percentile improved slightly during April 2024 to 5 hours and 26 minutes from 7 hours 35 minutes in March 2024.

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 was the Trust's key strategic response to the 2018 Amber Review. This programme has now concluded, having successfully delivered +343 FTE staff uplift, exceeded the 2019 EMS Demand & Capacity Review consult & close benchmark, implemented CHARUs and re-rostered EMS Response (efficiency 72 FTEs). The Trust has also recently seen abstractions return to the 2019 review benchmark of 30%. Despite delivery of the programme, performance and patient safety is some distance from the required levels. The primary cause being extreme handover (+23,000, compared to the 6,000 on which the programme was predicated).

The Trust is currently developing a new clinical model and is also nearing the completing of a new 2023 EMS Demand & Capacity Review.

# Our Patients: Quality, Safety & Patient Experience

## Patient Experience – Influencing Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

Oncology

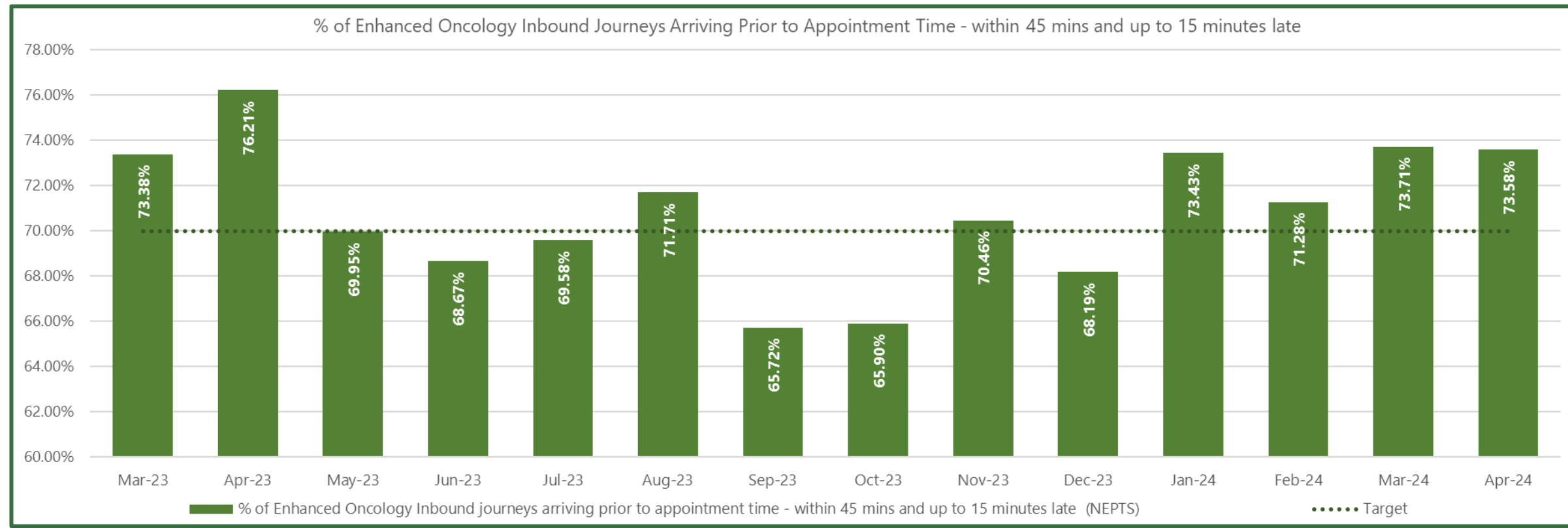
G

Welsh Calls

R

FPC

CI



**Analysis**  
**Ambulance Care (NEPTS element) performance minimal decreased during April 2024.** 73.58% of enhanced oncology journeys arrived within 45 minutes prior and up to 15 minutes late to their appointment time, a minimal decrease from 73.71% in March 2024, still achieving the 70% target. Enhanced Renal journeys, saw a slight decrease, from 75.70% in March 2024 to 74.01% in April 2024 and continues the pattern of the last two years of exceeding the agreed performance standard.

The recent good performance of the enhanced service has been achieved despite continual growth in the sector, mainly driven by renal activity increasing.

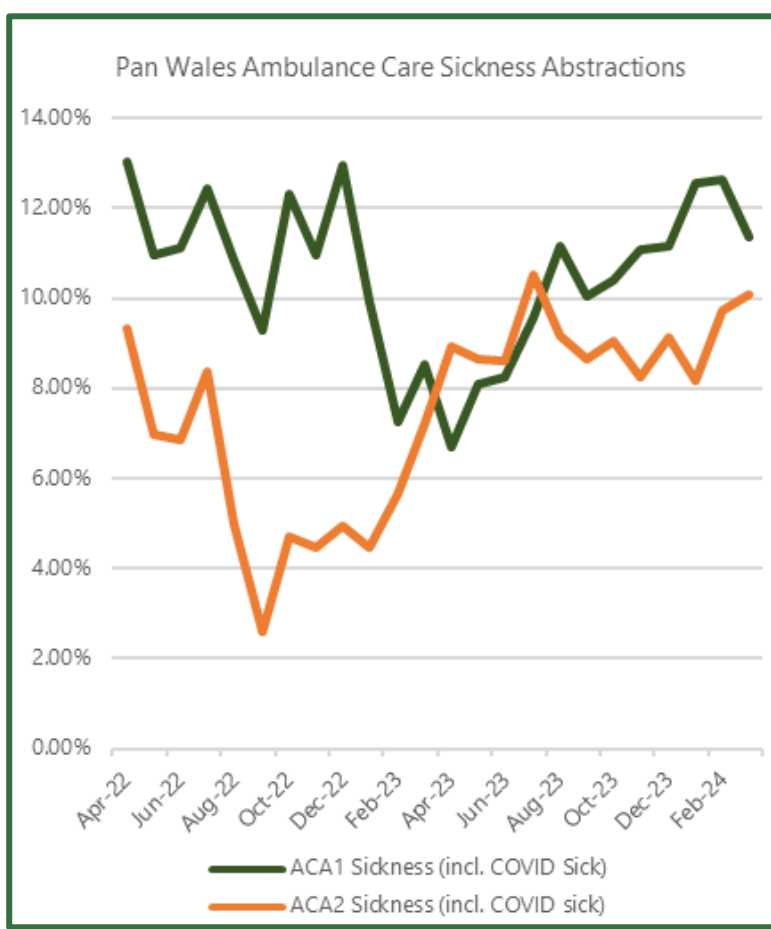
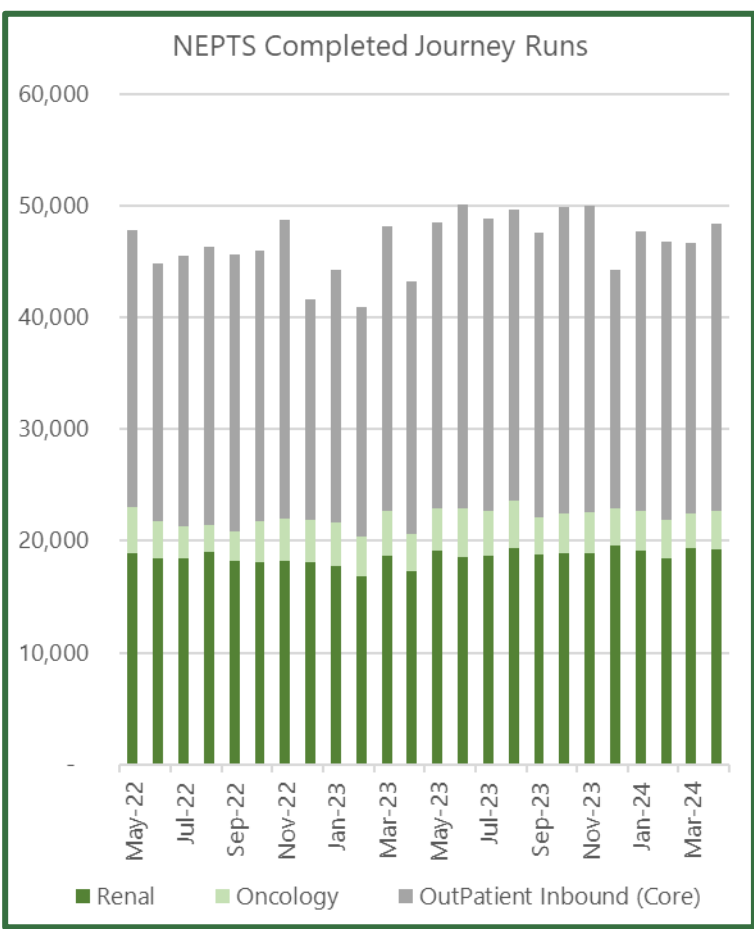
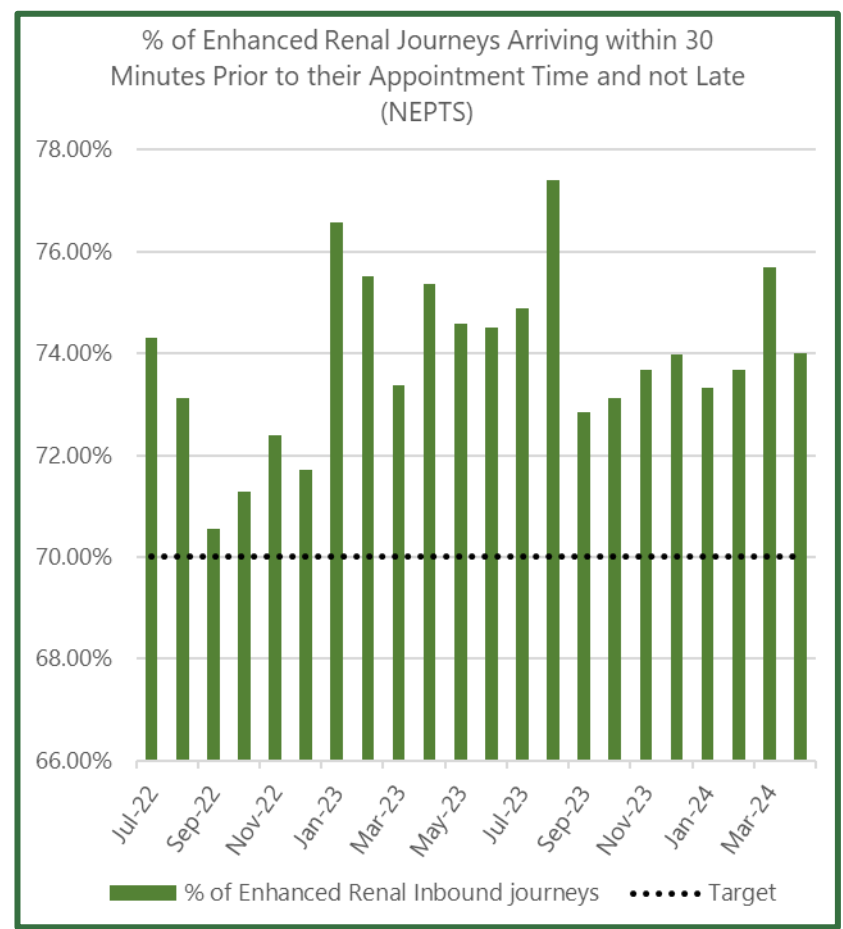
The NEPTS service continues to be completely committed and focused on improving both timeliness and service quality and is currently trialling a focused service matching oncology patients up with dedicated drivers which has returned an initially positive set of outcomes. In addition, investment has been made in Oncology transport within areas of traditional poor performance,

Call volumes answered increased in April 2024 (19,821) compared to March 2024 (16,939). The average speed of call answering improved in April 2024 (00:02:54) for the third consecutive month compared to March 2024 (00:03:01).

ACA1 (NEPTS) sickness decreased slightly in March 2024 to 11.37% compared to 12.65% in February 2024. However, ACA2 (UCS) sickness increased to 10.06% in March 2024 compared to 9.73% in February 2024.

- Remedial Plans and Actions**
- The journey booking team are reviewing both the existing service standards, which are uncontracted historical measures and not fully funded. This has already been discussed with the NEPTS DAG.
  - Opening hours and delivery methodology are also being reviewed to establish a more focused resource profile compared to demand.
  - Sickness is a particular area of focus and enhanced monitoring processes have been implemented.
  - Re-roster of NEPTS transport services.

**Expected Performance Trajectory**  
 To maintain oncology and renal above 70%.



# Our Patients: Quality, Safety & Patient Experience

(Responsible Officer: Andy Swinburn)

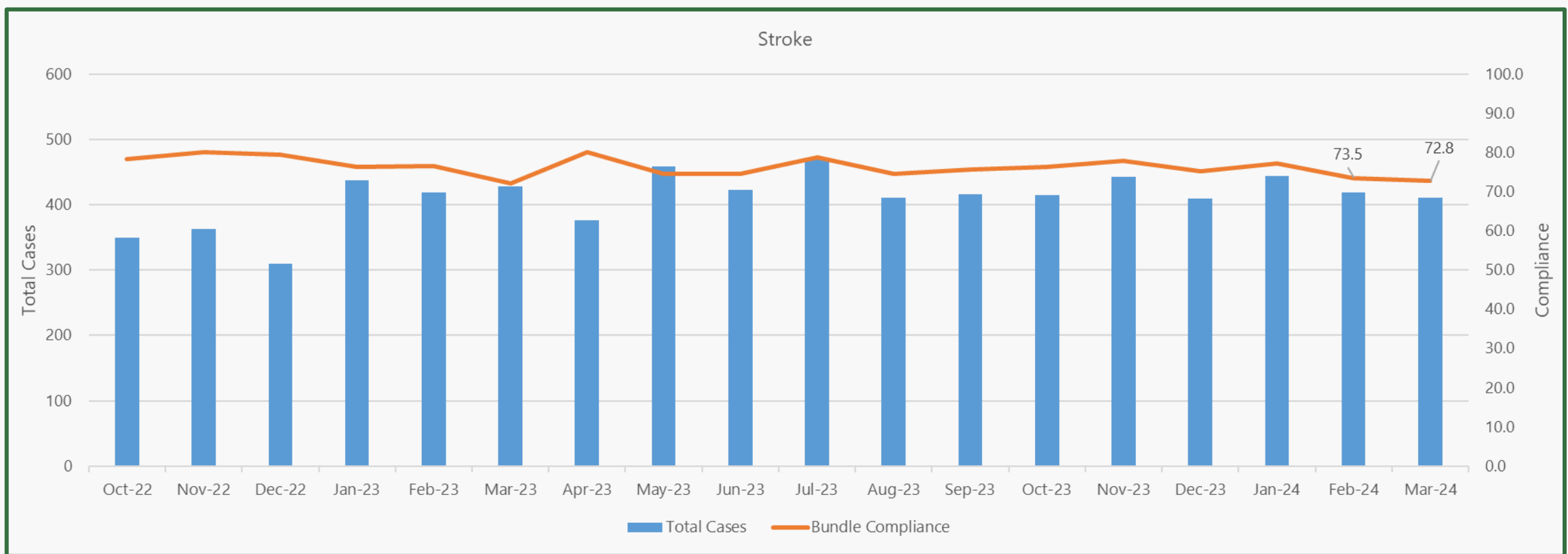
ROSC/Stroke/STEMI  
**A**

Self-Assessment:  
Strength of Internal  
Control: Moderate

QUEST

## Clinical Indicators

### Return of Spontaneous Circulation, Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care



#### Analysis

The percentage of suspected stroke patients receiving an appropriate care bundle in March 2024 was 72.8%, a decrease from the 73.5% recorded in February 2024. This was against a total case number of 411 during the month of March. There is a correlation between documenting FAST and the care bundle, this will inform the improvement plan.

The ROSC rate for March 2024 was 21% an increase from 14.7% in February 2024. This was against a total case number of 253 during the month of March. The highest rate recorded since the implementation of ePCR was seen in August 2023, achieving 23.8%.

Due to the nature of this metric, common cause variation occurs which can result in a marked reduction in performance from small numbers of unsuccessful resuscitations attempts. The factors that influence this may include response times, bystander resuscitation and response type/numbers.

As a result of the recent decline in ROSC at hospital, the Clinical Intelligence & Assurance Team undertook work to understand the reason. This so far has identified an improved clinical picture as information is documented in the narrative and not the specific ePCR fields for CIs reported on using raw data. Draft data was presented at CIAG in April 2024 and a further update and option appraisal will be presented at CIAG in May 2024.

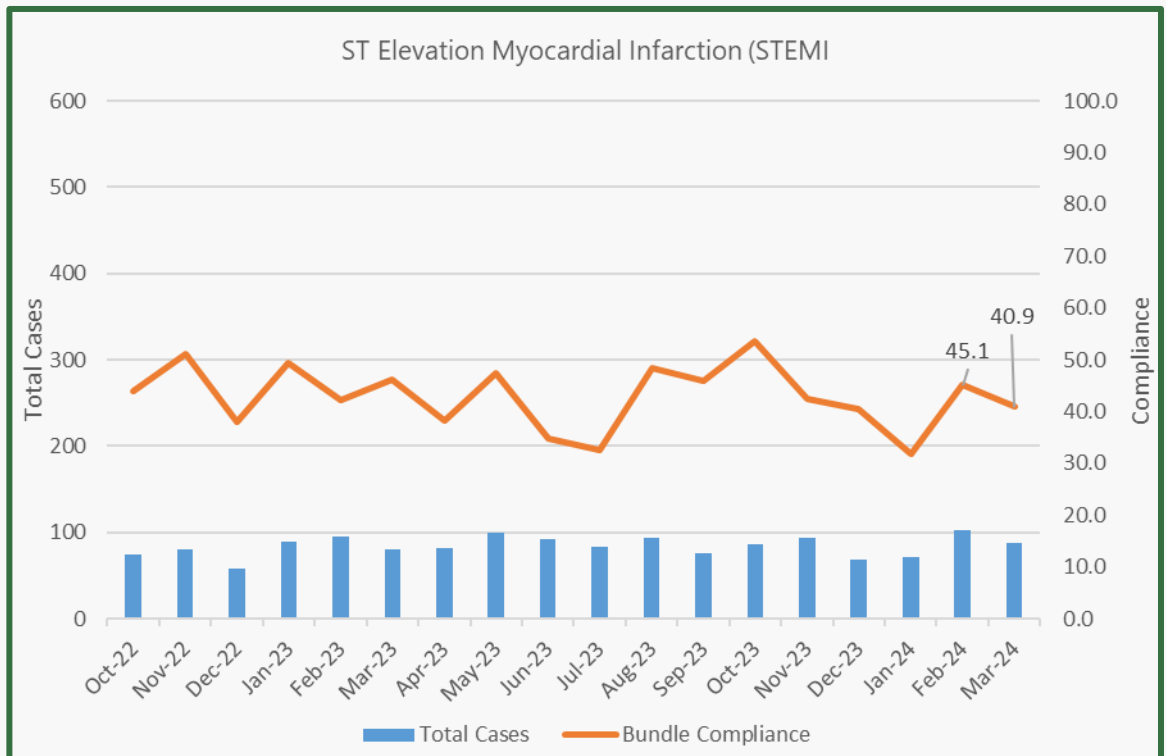
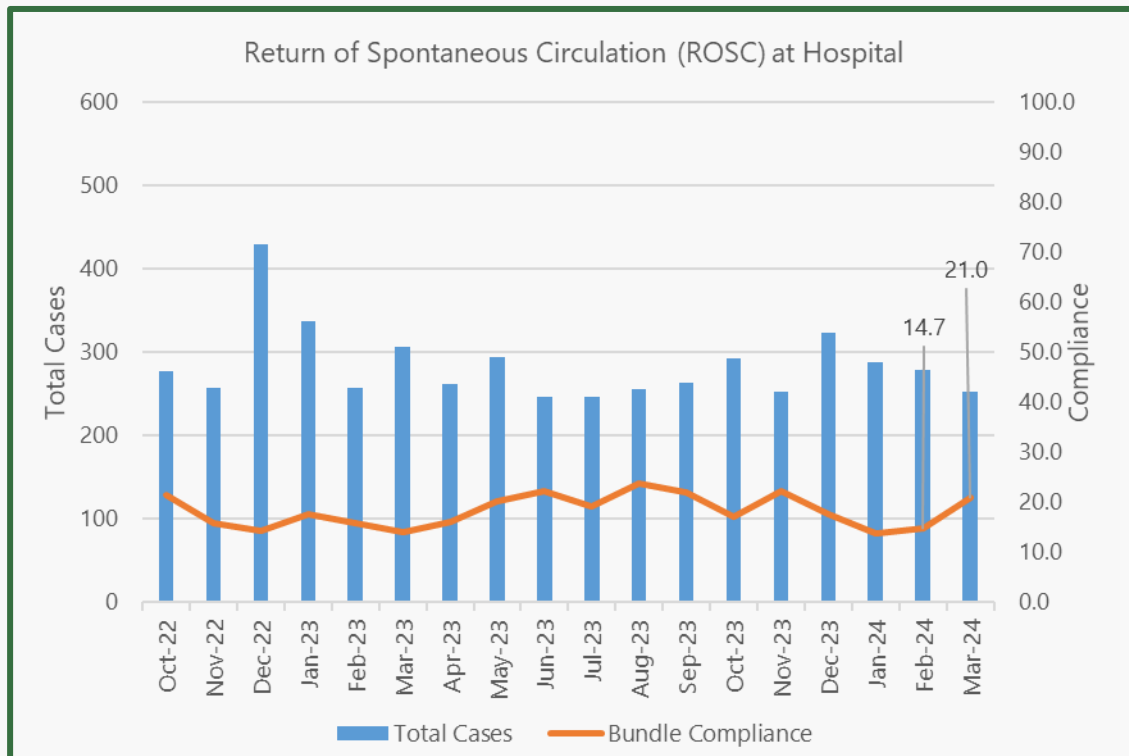
The percentage of suspected STEMI patients receiving an appropriate care bundle in March 2024 was 40.9%, a decrease from 45.1% in February 2024. This was against a total case number of 88 during the month of March. There is a correlation between documenting of analgesia and the care bundle, this will inform the improvement plan.

All Clinical Indicators remain within the normal bundle control limits.

Updates to the User Interface for the ePCR were rolled out in December 2023, including some of those that affect the CIs. We continue to work with the suppliers for the remaining changes.

Following the switch to ePCR, the way data is collected when with the patient has changed. Automated Clinical Indicator reports are generated from data directly inputted onto ePCRs by clinicians. There are theoretical advantages to the new process, however this has not yet been realised with the monthly results. A recovery plan has been implemented to improve compliance to the reports.

As a result of the anticipated low compliance, risk 535 was generated with three key mitigations to work on:  
 Design of the User Interface  
 Clinician interaction with the ePCR  
 Accuracy of the scripting to extract the data from the data warehouse to create the report



# Our Patients: Quality, Safety & Patient Experience

(Responsible Officer: Andy Swinburn)

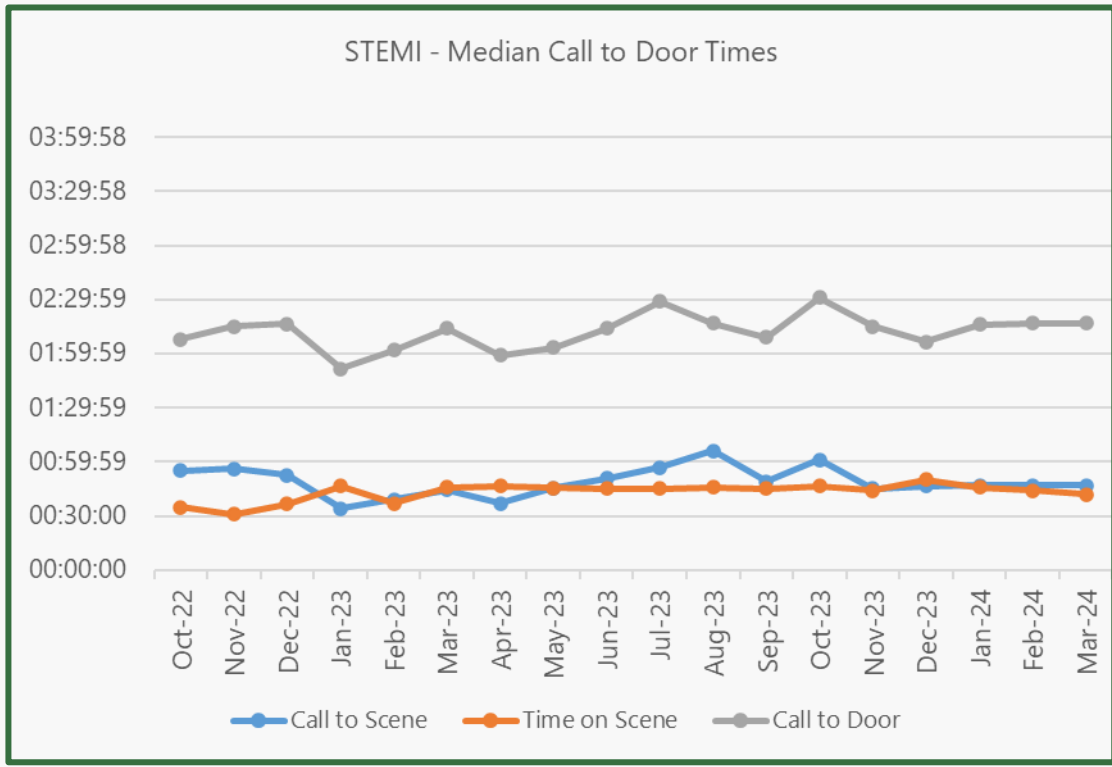
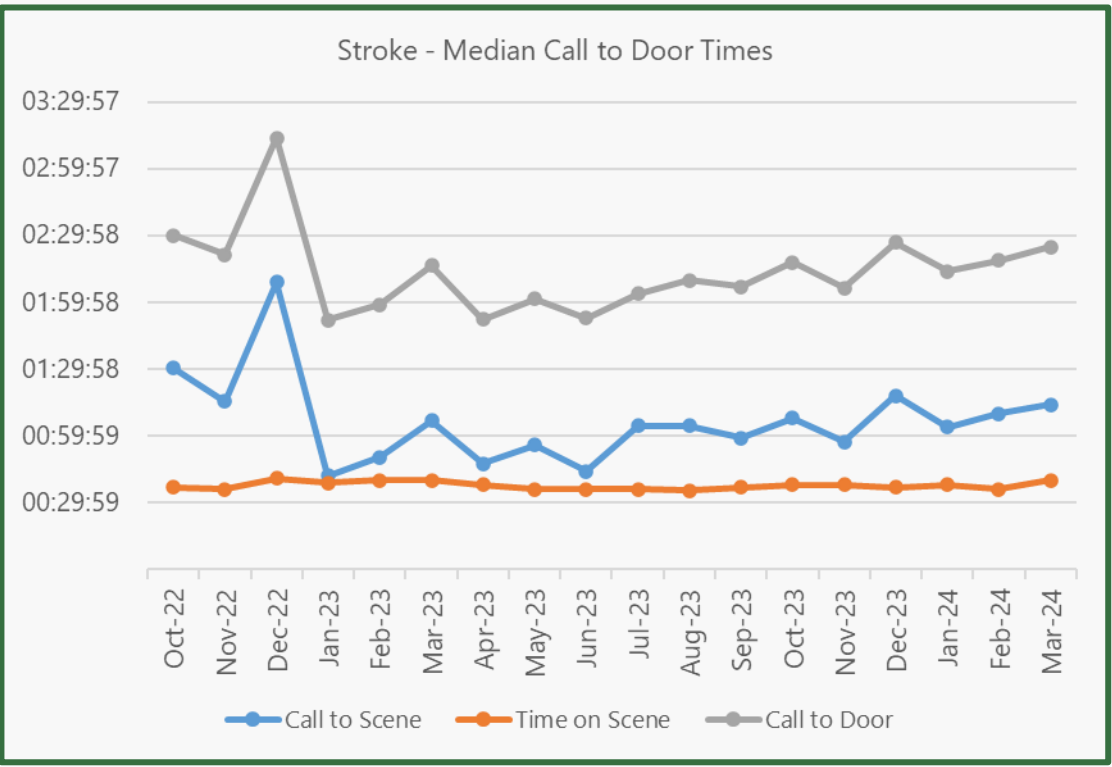
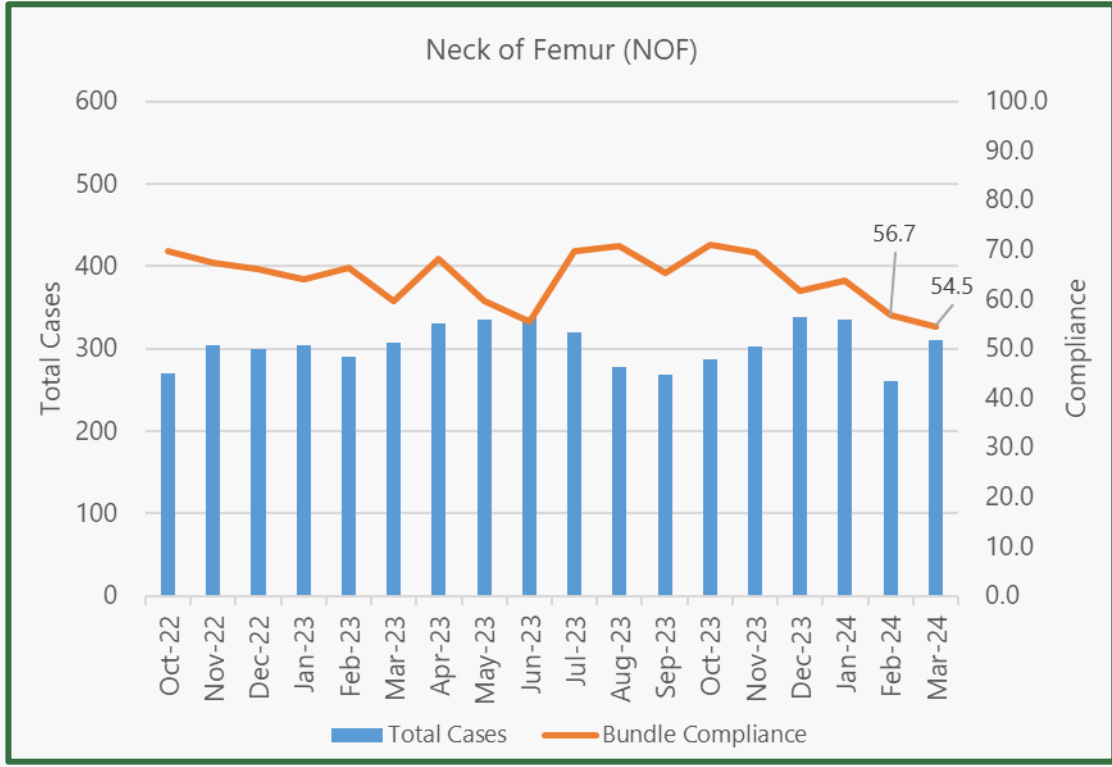
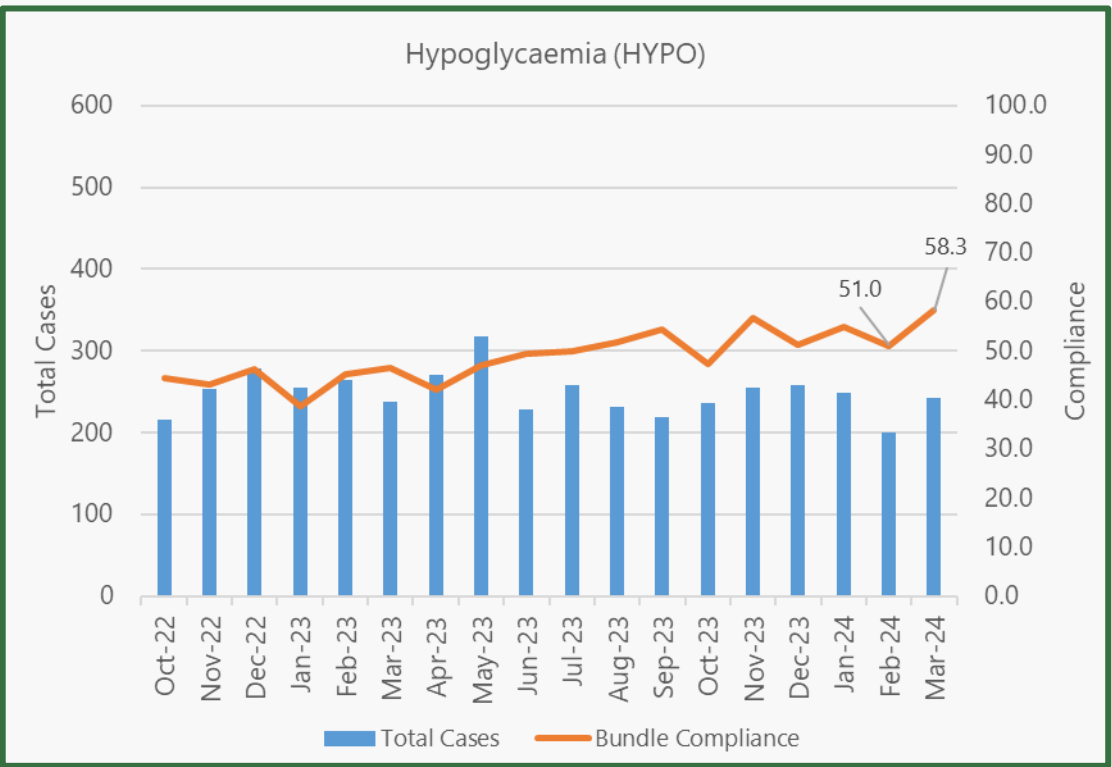
Door to Door  
**A**

Self-Assessment:  
Strength of Internal  
Control: Moderate

QUEST

## Clinical Indicators

### Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (Stroke & STEMI)



#### Analysis

The percentage of hypoglycaemic patients receiving an appropriate care bundle in March 2024 was 58.3%, an increase from 51% in February 2024. This was against a total case number of 242 in March. There is a correlation between documenting BM readings and the care bundle, this will inform the improvement plan.

The percentage of #NOF patients receiving an appropriate care bundle in March 2024 was 54.5%, a decrease from 56.7% in February. There is a correlation between documenting pain score and analgesia and the care bundle which will inform the improvement plan.

Clinical Indicators relating to call to door times for STEMI and Stroke are now reported on as part of the Ambulance Service Indicators reported to EASC. These show the breakdown for:  
 Time the call started to time of arrival at scene  
 Time on scene of the conveying vehicle  
 Time the call started to time of arrival at hospital

#### Remedial Plans and Actions

- A recovery plan has been implemented to improve the CI compliance; actions include:
  - Full deployment at pace of the CI Improvement Plan
  - Focussed communication with WAST clinicians to use the bespoke ePCR boxes for CIs
  - Supporting Senior Paramedics to have conversations about CIs
  - Health Board focussed clinical workshops to promote understanding of CIs and care bundles
  - Invest in resources to utilise Natural language Processing, a form of AI to interrogate clinical narrative
  - Review scripting in a structured way for each CI bundle, monitor and repeat annually
  - Implementation of the clinical supervision policy to embed CIs
  - Plan resources required to provide clinical data at an individual level to all clinicians

The Trust's introduction of the Cymru High Acuity Response Unit model, based on improved clinical leadership and enhanced training, will further improve outcomes for patients and is our main response to improve Return of Spontaneous Circulation (ROSC) rates. Since May 2023 there has been an increase in numbers and availability.

#### Expected Performance Trajectory

The ePCR Compliance Approval Group are exploring options to improve ePCR completion and compliance to CIs with prompts when an ePCR is being closed to enable clinicians to easily return to the required filed for completion. This will be implemented in a stepwise approach.

This, along with continuing improvements in clinical supervision and the support of SPs working with the Clinical Improvement and Clinical Intelligence and Assurance Teams should increase compliance rates.

# Our Patients: Quality, Safety & Patient Experience

## Patient National Reportable Incidents & Patient Concerns Responses Indicators

(Responsible Officer: Liam Williams)

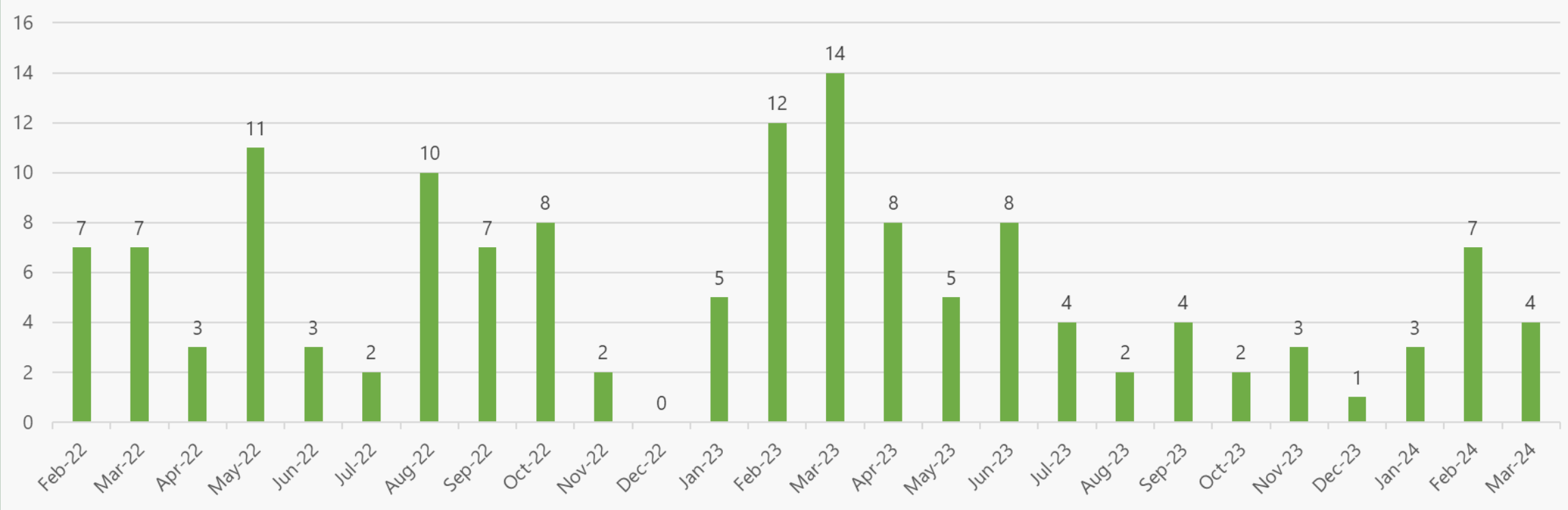
Concerns: **A**

Self-Assessment: Strength of Internal Control: **Moderate**

QUEST

Health & Care Standard  
Health - Safe Care / Timely Care

Number of National Reportable Incidents (NRIs) Reported to the NHS Executive - All Wales



### Analysis

The percentage of responses to concerns in March 2024 is 56% against a 75% target (30-day response) which is an increased position but is expected to reduce ahead of stabilising by quarter 3 due to new staff education and training. Several factors continue to affect the Trust's ability to respond to concerns, including, overall increased demand, a rise in the number of inquests, continuing volumes of Nationally Reportable Incident's (NRIs) and timely response to requests for information from key parties. The number of total concerns has slightly decreased with 109 complaints being received and processed in March 2024. These complaints are frequently complex with our concerns administrators taking lengthy calls from distressed patients or family members for up to one hour per call. Five (5) Serious Case Incident Forums (SCIF) were held during the month and 34 cases were discussed. Following discussion 4 serious patient safety incidents were reported to the NHS Wales Executive and 21 serious cases were referred to Health Boards for investigation under the Joint Investigation Framework. The Trust received 1 referral from a Health Board under the Joint Investigation Framework during the period. Learning from the Joint Investigation Framework process remains limited with Health Boards citing high levels of escalation as causal factors. All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team, who will consider the requirement to enact the Duty of Candour and contact patients and families as appropriate and metrics will be included in the MIQPR from April 2024.

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 and predominately ineffective breathing which is being discussed at national ambulance forums as a consistent theme.

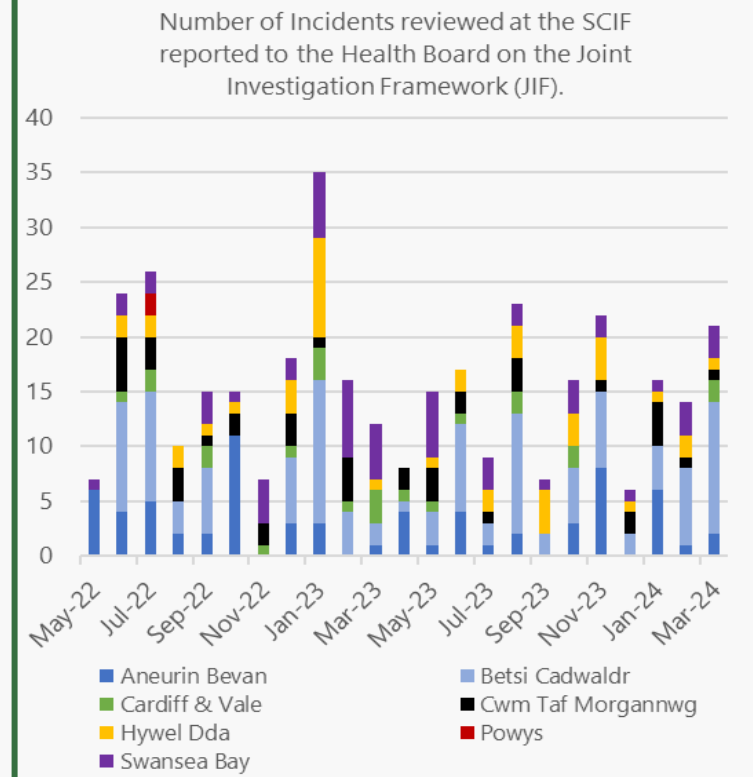
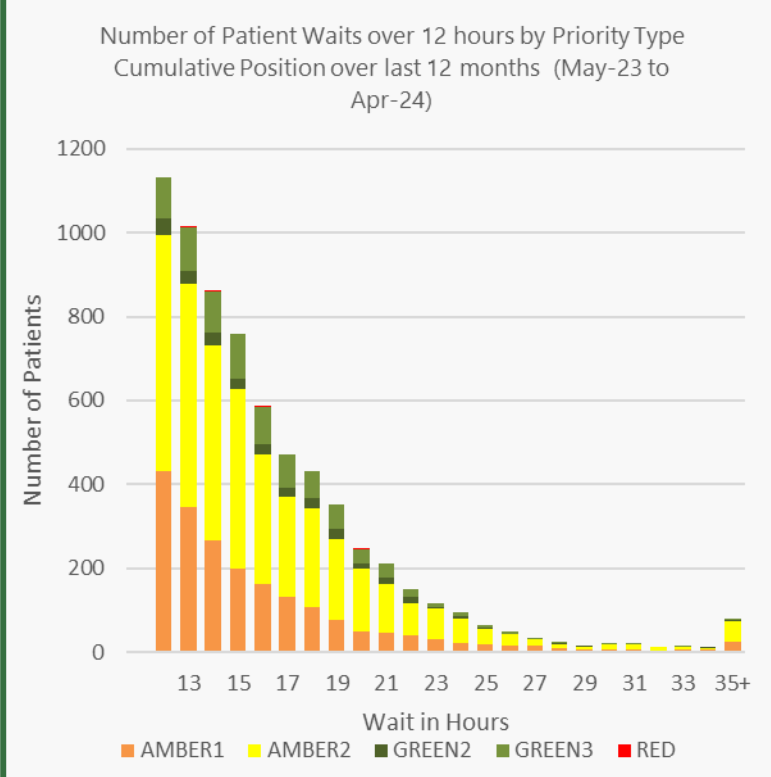
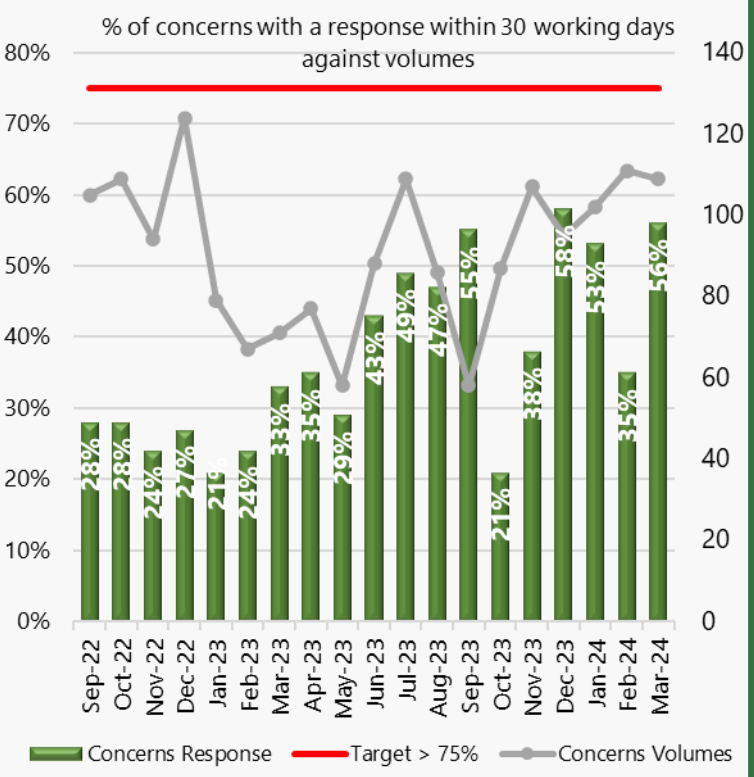
In April 2024, 584 patients waited over 12 hours for an ambulance response and 69 compliments were received from patients and/or their families.

### Remedial Plans and Actions

A range of actions are in place:-  
Good progress is being made in recruitment to posts following the Putting Things Right organisational change process. New staff require induction, education and training which takes existing resource. A recovery plan will be presented at the Clinical Quality Governance Group in April 2024.  
Delayed community response (Risk 223) and handover of care delays at hospitals (Risk 224) are the two highest rated risks on the Trust's Corporate Risk Register (both rated 25) and include detailed mitigations and current actions, both are considered at Board sub-committee level and at Trust Board.  
The key strategic action was EMS Operational Transformation Programme. See slide on Amber for more information.

### 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.



\*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

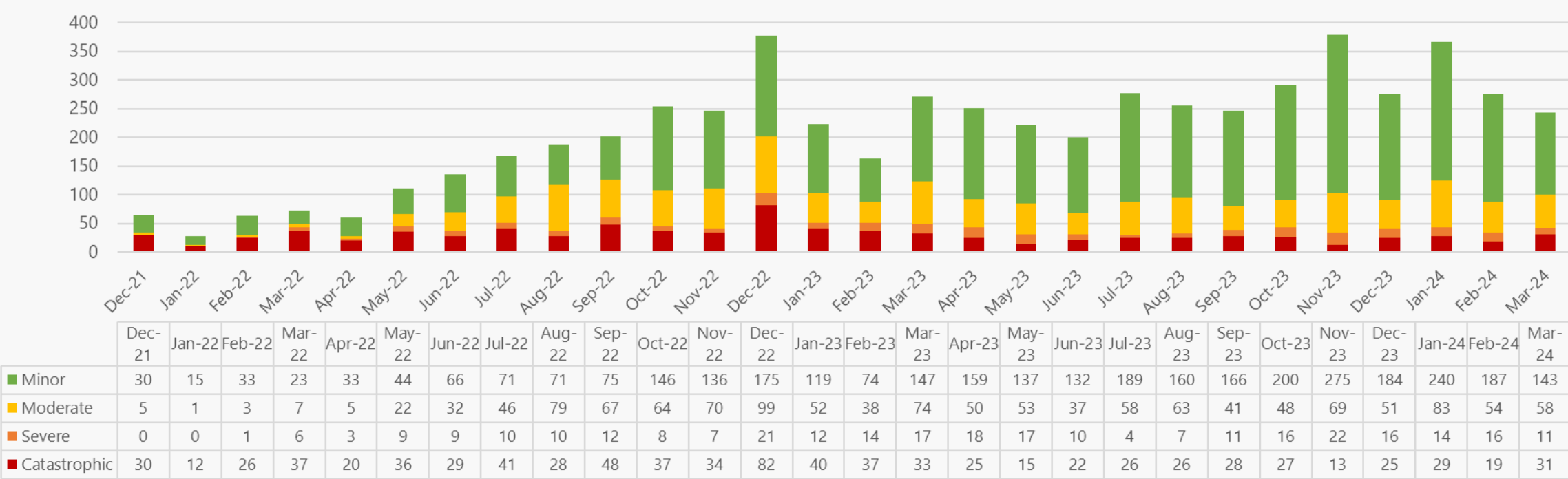
Self-Assessment:  
Strength of  
Internal Control:  
Moderate

PCC

(Responsible Officer: Liam Williams)

Health & Care  
Standard  
Health – Safe Care

Number of incidents Received on Datix system within the reporting month, by Harm grading (Volumes Received)



### Analysis

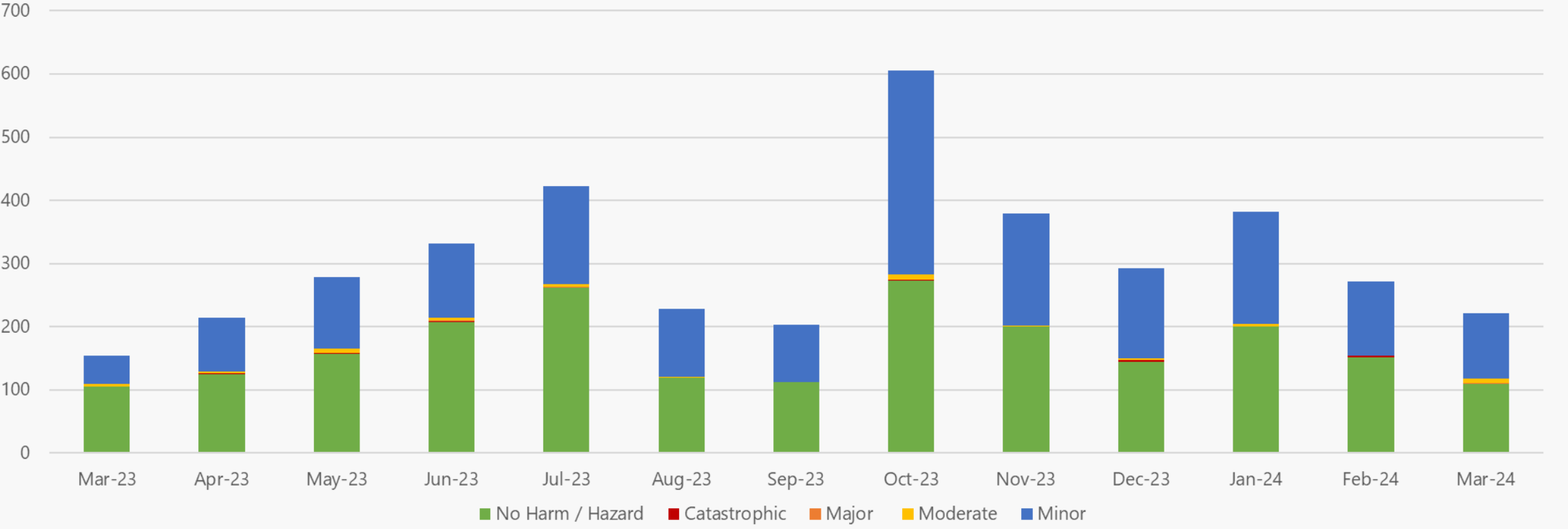
Once cases are investigated and any improvement actions / learning is identified by the Patient Safety or Clinical Team, (or for instances where serious harm has occurred referred to the Serious Case Incident Forum (SCIF) for review) they are closed. All patient safety incidents graded moderate or above 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 – 40
- Minor harm – 143
- Moderate harm -58
- Severe Outcomes - 11
- Catastrophic - 31

(\*NB: Volumes received).

The bottom graph highlights the 222 Incidents that were closed on the Datix system in March 2024. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

Number of Incidents closed on Datix system within the reporting month, by harm grading at point of closure (Volumes Closed)



### Remedial Plans and Actions

Workload for all members of the team continues to be high due to continued system pressures resulting in a backlog of Putting Things Right concerns which are frequently complex. The combination of the implementation of the Duty of Candour, Duty of Quality and the Medical Examiner Service has meant additional activity for the Putting Things Right Team. There is also a backlog of MPDS audits currently. The EMSC team are working hard to conclude these as soon as possible.

The Putting Things Right Team organisational change process is progressing, and final posts will be recruited to by July 2024. This new structure has taken into consideration the Trust's local and national priorities and resources to meet the needs of patients and families. It is envisaged that the new structure will take some time to become established. A recovery plan will be presented to Clinical Quality Governance Group at the April 2024 meeting.

The Trust is represented at national networks including Duty of Candour, Complaints, Ombudsman, Learning, Mortality, Claims, Redress and Datix Cymru development groups as resources allow. Work is progressing in respect of the development of dashboards and the aggregation of data and information to inform patterns, trends and learning opportunities as part of the quality management system.

### Expected Performance Trajectory

The Trust will continue to identify quality and safety improvements through the Putting Things Right processes.

\*NB: Data 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

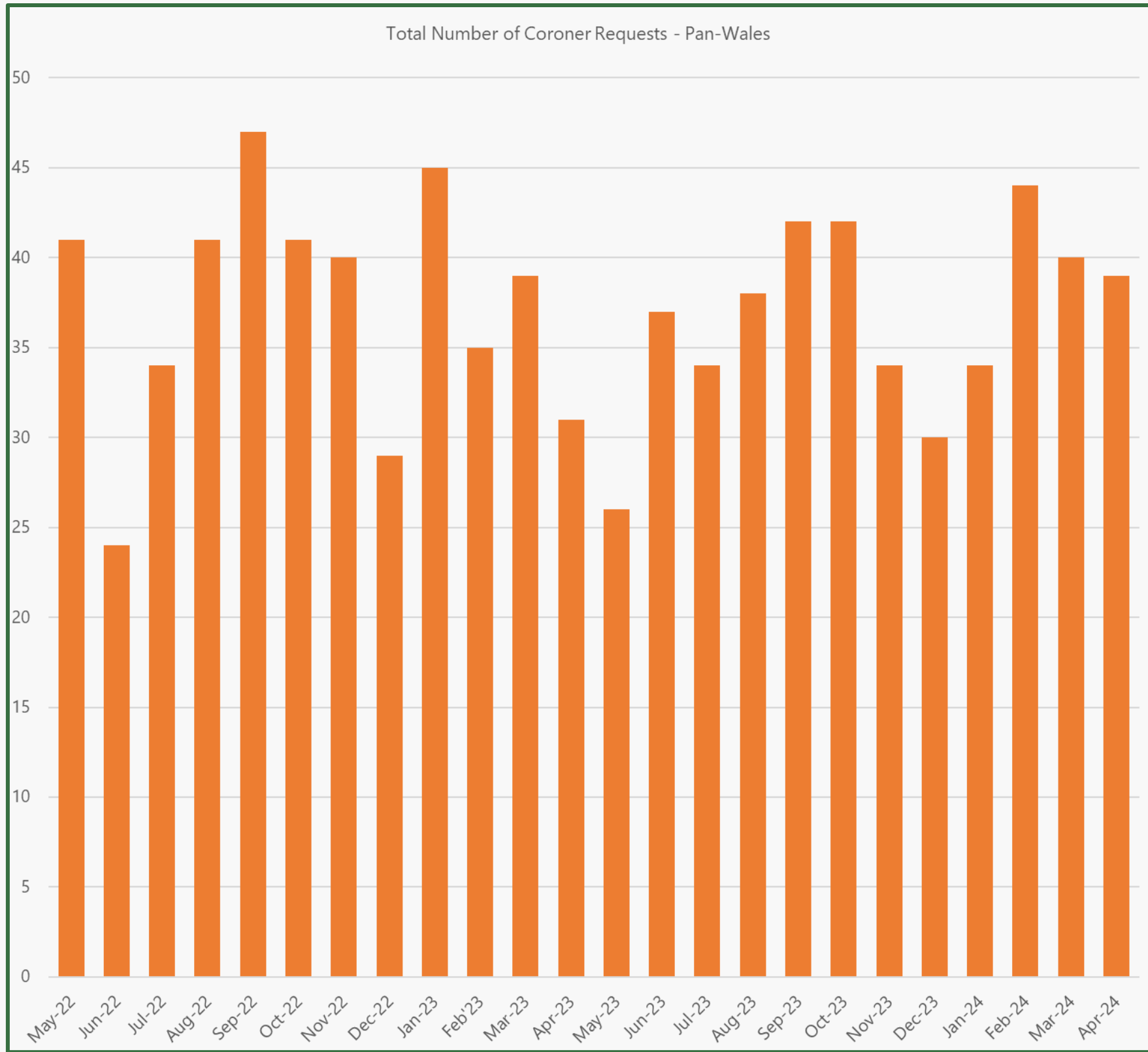
(Responsible Officer: Liam Williams)

**Coroners**  
Self-Assessment:  
Strength of  
Internal Control:  
Moderate

**Mortality**  
Self-Assessment:  
Strength of  
Internal Control:  
Moderate

QUEST

Health & Care  
Standard  
Health – Safe Care



### Analysis

**Coroners:** The complexity of the cases remains high, with multiple statements and actions per approach. This is in addition to the work required to manage cases where the Trust has been given IP status. The number of cases in which the Trust is an IP raised in April 2023 and continues higher, we now consider this to be the new normal. Cases continue to be registered and distributed. Delayed statement requests are escalated to ensure that the Trust does not receive a Schedule 5 summons.

**Ombudsman:** There has been a reduction in initial approaches to the Trust by the PSOW. All PSOW cases are now being managed via Datix Cymru. A deeper dive into the cases has been undertaken and will be reported as part of the next quarter report. The Ombudsman is considering issues surrounding joint investigations and the issues of elderly patients laying on floors waiting for ambulances.

**Mortality Review:** The Trust continues to participate in Health Board led mortality reviews as appropriate, with attendance from the Patient Safety Team and clinical colleagues as available. Data and information is also provided by the Trust as required to the Medical Examiner Service to inform their reviews of deaths in acute care. Feedback from the Medical Examiner Service in respect of themes and trends include timeliness in response to patients in the community, handover of care delays, lack of ceilings of care in place for patients and patients on the end-of-life care pathway being conveyed to acute care. Currently the focus of the Medical Examiner Service is undertaking 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 2024 (moved from April 2024). An increase in referrals for the Trust is expected when this occurs. There is a backlog of the review of referrals currently. Following initial screen cases are currently escalated to the Serious Case Incident Forum and an analysis and mapping exercise of all cases up to 31.03.2024 is currently underway (due to be completed Q2 2024/5).

### Remedial Plans and Actions

**Coroners:** There continues to be additional work due to the ongoing recovery of the Trust solicitor/claims manager, who is unable to travel for long distances. A temporary staff member's contract has been extended to the end of April 2024 to try and minimise the impact of the additional work. The Legal Services Team is not yet fully staffed following OCP, and work continues to ensure that the Team is fully formed as soon as possible.

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

**Mortality Review:** The Trust is in the process of developing the internal mechanisms in order to facilitate mortality reviews aligning to the national approach. This includes consideration of the resources required in the new Putting Things Right (PTR) Team structure with additional roles included in the Patient Safety Team. Recruitment to the new structure is expected to be completed by July 2024. Representation and contribution by the Trust at the All-Wales Mortality Working Group continues. The Patient Safety Team are engaged in the meetings lead by the Once for Wales Datix Cymru Team who are developing the Datix Cymru Mortality Module. The Learning from Deaths Forum, chaired by the Assistant Director of Quality & Nursing is established and is currently meeting on at least a quarterly basis, with oversight and reporting to the Clinical Quality Governance Group. Following the publication of the next iteration of the All-Wales National Mortality Framework which includes the processes in primary care, the Learning from Deaths Forum will oversee the updates to the Trust's Framework.

### Expected Performance Trajectory

**Coroners:** This level of activity seems to be the new normal and will continue to be monitored.

**Ombudsmen:** Learning has been placed in a PTR, for sharing pan Wales.

**Mortality Review:** Whilst the multiple benefits of the Medical Examiner Service are recognised there will undoubtedly be significant resource implications for the Trust, particularly as the process expands to every non-coronial death in NHS Wales by the end of September 2024 and the Health Boards (who are at different levels of maturity regarding mortality reviews) start to develop and embed their processes. Following the recruitment to the new PTR Structure (expected by July 2024) improvements in the timely review of MES referrals is expected which is detailed in the Putting Things Right Recovery Plan (April 2024).

\*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

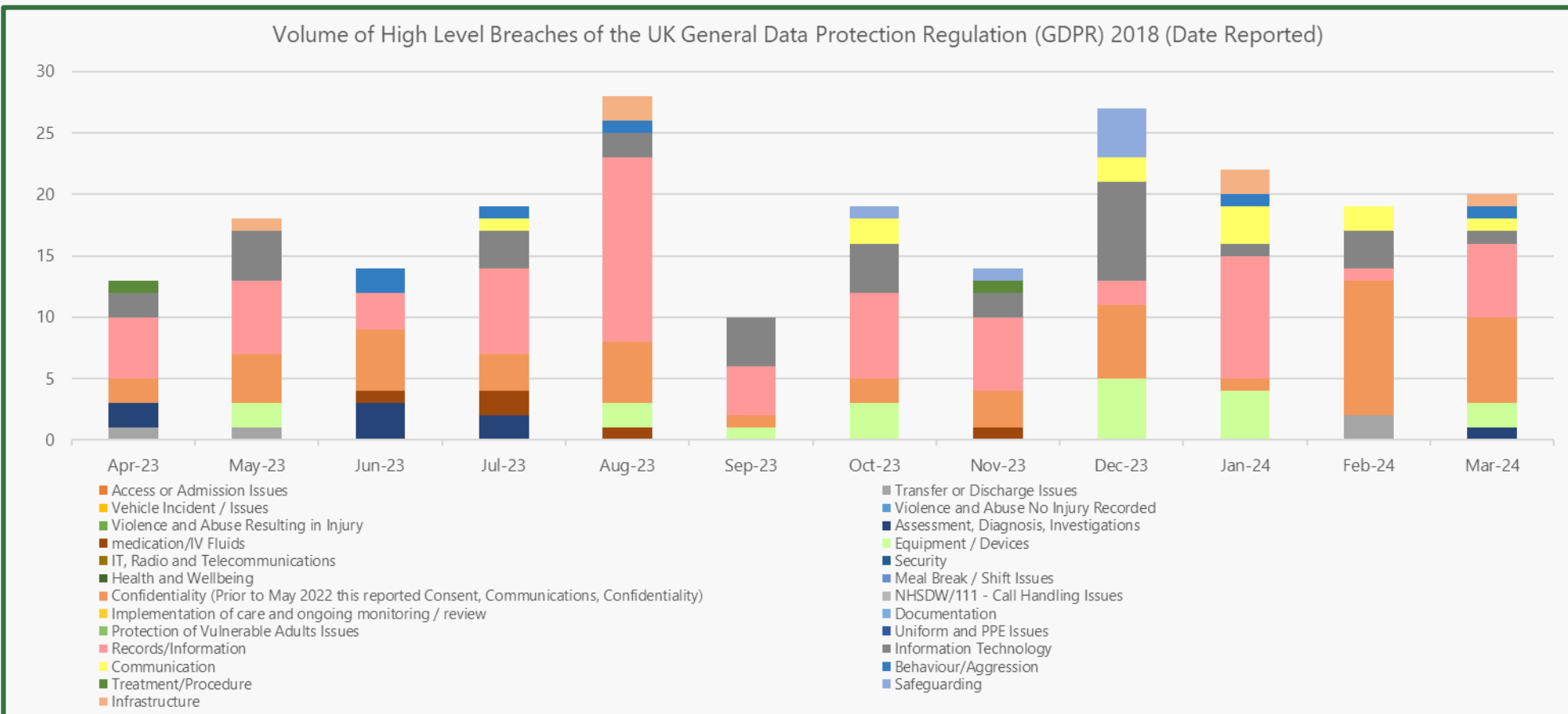
# Our Patients: Quality, Safety & Patient Experience Safeguarding, Data Governance & Public Engagement Indicators

(Responsible Officers: Jonny Sammut & Liam Williams)

Self-Assessment:  
Strength of  
Internal Control:  
Strong

Health & Care  
Standard  
Health – Safe Care

Safeguarding Data source: Doc Works



### Analysis

**Safeguarding:** In March 2024 staff completed a total of 203 Adult at Risk Reports, 92% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 565 referrals were received and processed to the local authority during this reporting period. There have been 251 Child Safeguarding Reports in March 2024, 94% of these were processed within 24 hours.

**Data Governance:** In March 2024, there were 20 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 20 breaches, 7 related to IG/Confidentiality, 6 Records/Information, 2 equipment/devices, 1 Communication, 1 Information Technology, 1 behaviour, 1 Infrastructure, and 1 Assessment Investigation and Diagnosis.

**Public Engagement:** During March, the Patient Experience and Community Involvement Team attended 24 community engagement opportunities, engaging with approximately 652 people. This month engagement has included attendance at an Aneurin Bevan University Health Board led 'Big Conversation' event talking to members of the public about their experiences of grief, bereavement, death and dying. We celebrated International Women's Day at a community event in Newport with a focus on building resilience and confidence in women. We attended an event in support of the UN International Day for the Elimination of Racial Discrimination where we promoted the new WAST Welcome Pack for people whose first language isn't English or Welsh. In addition, we continued to meet and engage with colleagues from Llais and have had introductory meetings with Care & Repair Cymru to explore ways of future partnership working. We have also continued on our co-production journey by attending workshops led by Co-Production Wales, sharing emergent practice and learning from real-life examples. Through the month we also continued to use engagement events as an opportunity to promote Patient Experience Surveys, asking people to provide feedback about their interactions with our services. We acknowledge that response rates to some of these surveys remains low and isn't truly reflective of all patient's experience, though we are working with colleagues to try and increase return rates. Engagement and survey outcomes remain largely consistent and tell us that people find calling 999 a stressful experience, our questioning is repetitive, and people don't understand why they need to repeat the process if they re-dial 999 to check on an ETA. But people continue to tell us that they are generally happy with the clinical care they eventually receive and that our staff are reassuring and professional. 111 callers have told us that they experienced long waits for their calls to be answered and reported long waits for call backs. NEPTS users told us that overall, they continue to be happy with the transport they receive but experience longer than wanted delays when waiting for their transport home following their appointment. We have also seen an increase in people complaining about short notice cancellation of transport, leaving some with no option but to miss their much-needed hospital appointment.

### Remedial Plans and Actions

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

**Data Governance:** During the reporting period, of the 20-information governance related incidents reported on Datix, 0 incidents were reported to the Information Commissioner's Office (ICO). The IG Team continues to review and provide advice on reported incidents.

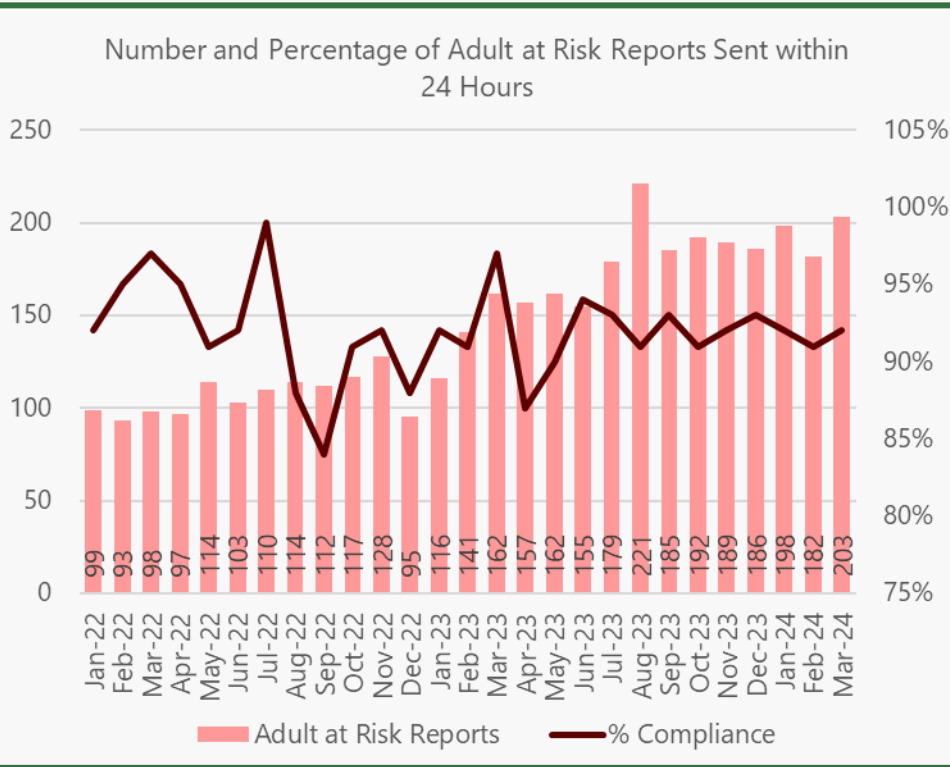
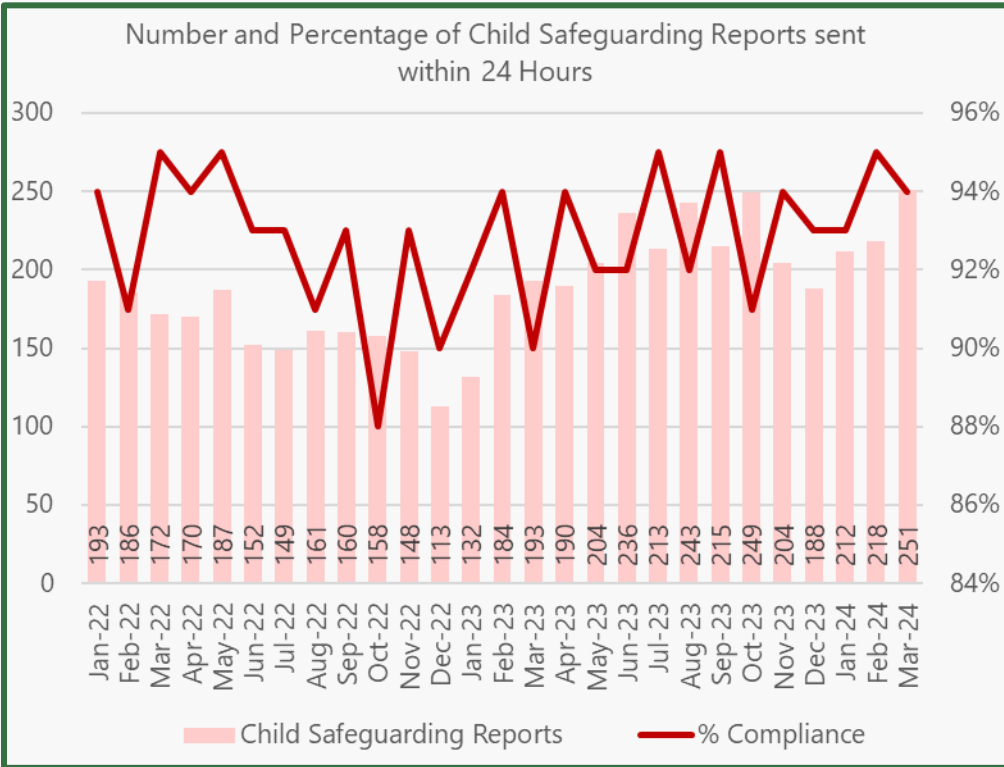
**Public Engagement:** Community involvement and engagement with patients/public forms an integral part of the Trust's ambition to 'invert the triangle' and deliver value-based healthcare evaluated against service users' experiences and health outcomes. The work delivered by the PECEI Team is supporting 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 PECEI Team will continue to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve services they receive. Response rates to some of our PREM's surveys is disappointingly low and we acknowledge that this means we cannot report a truly reflective picture of what it feels like to be a user of some of our services. We are actively working with colleagues across the Trust in a number of different departments to try and agree on solutions that would allow us to directly contact more patients to ask for feedback about their experiences with us. We have escalated our concerns to barriers which are preventing us from directly contacting patients to colleagues at the Welsh Risk Pool who oversee implementation of the Once for Wales Civica & Datix systems. We are seeking their advice on a way forward. WAST's Information Governance Team has also contacted the Information Commissioner's office who are reviewing the situation for us and will provide further guidance.

### Expected Performance Trajectory

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

**Data Governance:** The IG Toolkit submission for FY23/24 was submitted end of March. An Improvement Action Plan will be developed in readiness for the next submission in March 2025.

**Public Engagement:** All feedback received is shared with relevant Teams and Managers and continues to be used to influence ongoing service improvement. Patient experience and community engagement information is now shared weekly at the Senior Quality Team meeting.



\*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

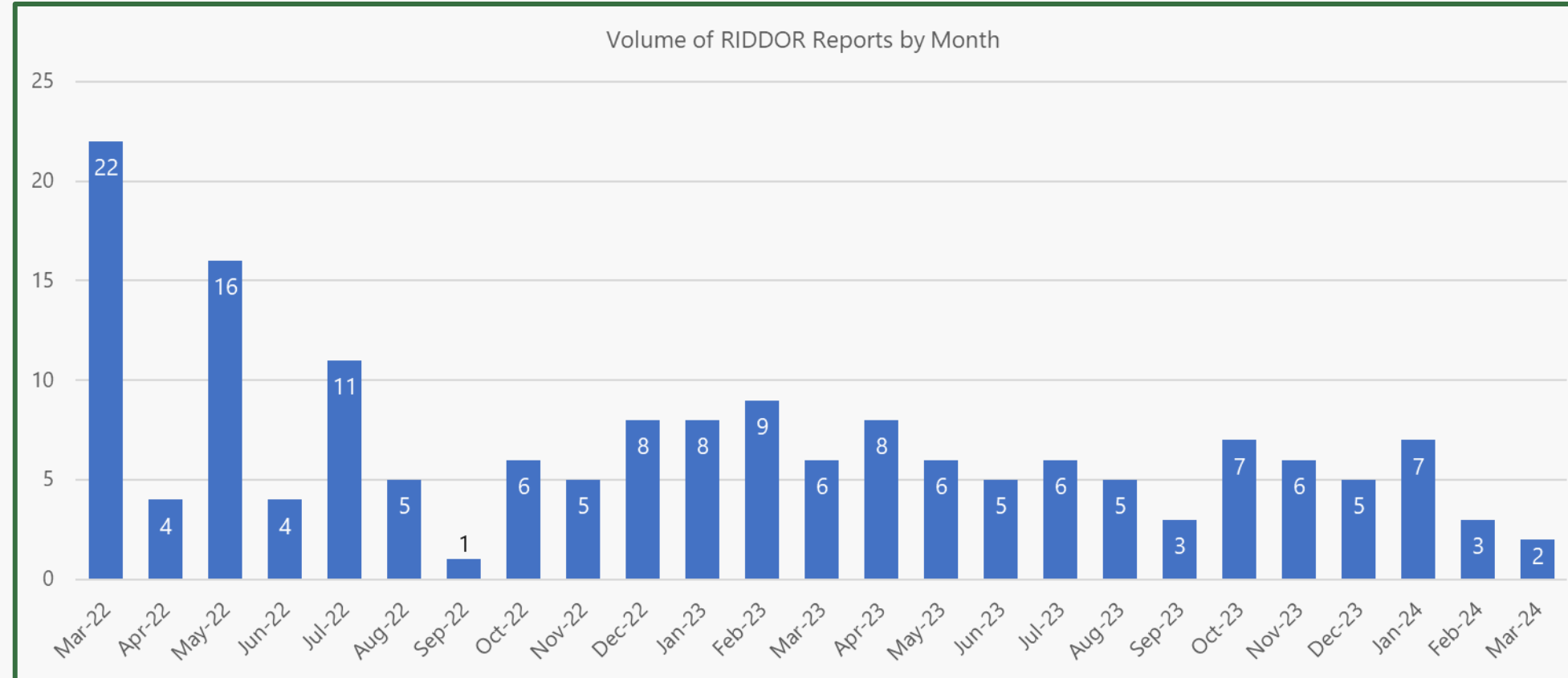
(Responsible Officer: Liam Williams)

Self-Assessment:  
Strength of  
Internal Control:  
Moderate

PCC

Health & Care  
Standard  
Health – Safe Care

Volume of RIDDOR Reports by Month



### Analysis

**RIDDOR:** There were 2 incidents requiring reporting under RIDDOR during March. All were related to staff being absent from work for over 7 days because of their injury that resulted from manual handling activities.

100% of the reports were completed within the reporting required time frames. Health and Safety team will continue to work with Incident Handlers to ensure reports are submitted within the required timescales. Manual handling continues to be the highest category of incidents reported under RIDDOR.

**Violence and Aggression:** A total of 53 incidents have been reported of V&A in March. 6 Physical Assaults on staff were reported during the month with incidents of verbal abuse amounting to 47 for the month.

There were 3 reports for inappropriate sexual behaviour 1 verbal and another behavioural. 14 incidents were reported as Moderate in harm and 23 noted as low harm which continues the higher trend seen since August 2023.

Verbal abuse continues to be the major category of reporting received with aggressive and threatening behaviour toward staff still at high levels. Several Individuals convicted of violence an aggression toward staff from previous incidents have been convicted and sentenced in March.

No fines, prosecutions or notices were issued from the Health and Safety Executive (HSE) during March.

### Remedial Plans and Actions

**RIDDOR:** A new DSE/Manual Handling Advisor has been appointed and they are undertaking an analysis of the manual handling incidents within the Trust to identify areas for continuous improvements.

**Violence and Aggression:** The V&A Team have visited the 111 call centres and completed visit to the EMSC areas to gain a better understanding of the incidents of verbal abuse received and the challenges of reporting the incidents on Datix. The aim is to ensure more consistent reporting and investigation to ensure the physical and mental safety of our staff.

We are assisting EMS – Mental Health to RA The impact of RCRP

### Expected Performance Trajectory

**RIDDOR:** As recommendations from the manual handling review are implemented the number of incidents are projected to fall.

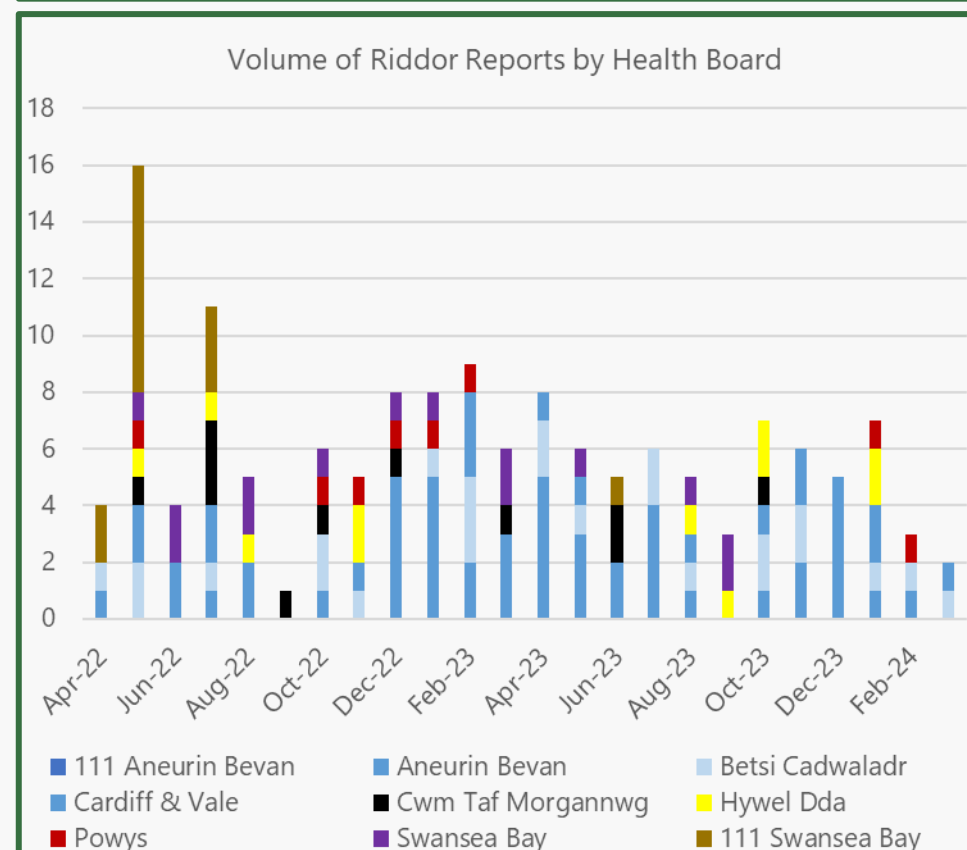
**Violence and Aggression:** The impact of RCRP Police attendance at welfare/mental health calls may result in an increase reporting of V&A incidents as staff try to deal with unstable patients. This is a national concern and has been raised at NAVSEG. All Police forces are implementing a phase approach to not attending calls as previously experienced .. only if there is immediate threat to life.

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

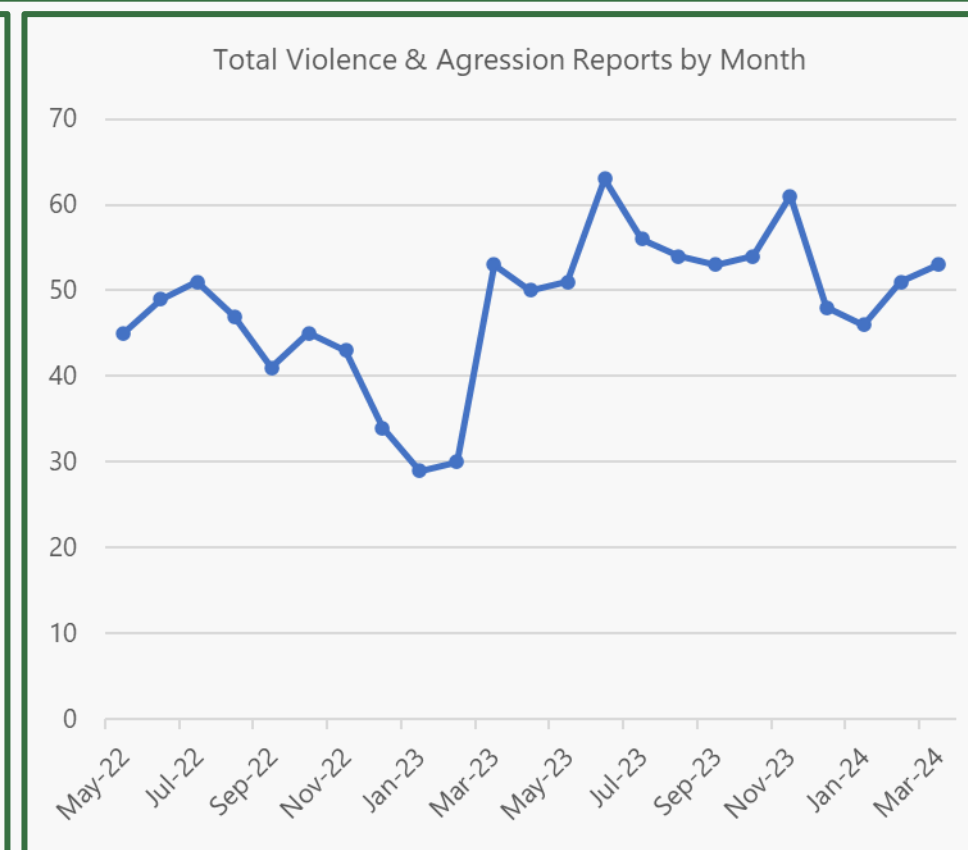
Data source: Datix

Welsh Ambulance Services University NHS Trust

Volume of Riddor Reports by Health Board



Total Violence & Agresion Reports by Month



# Our Patients: Quality, Safety & Patient Experience

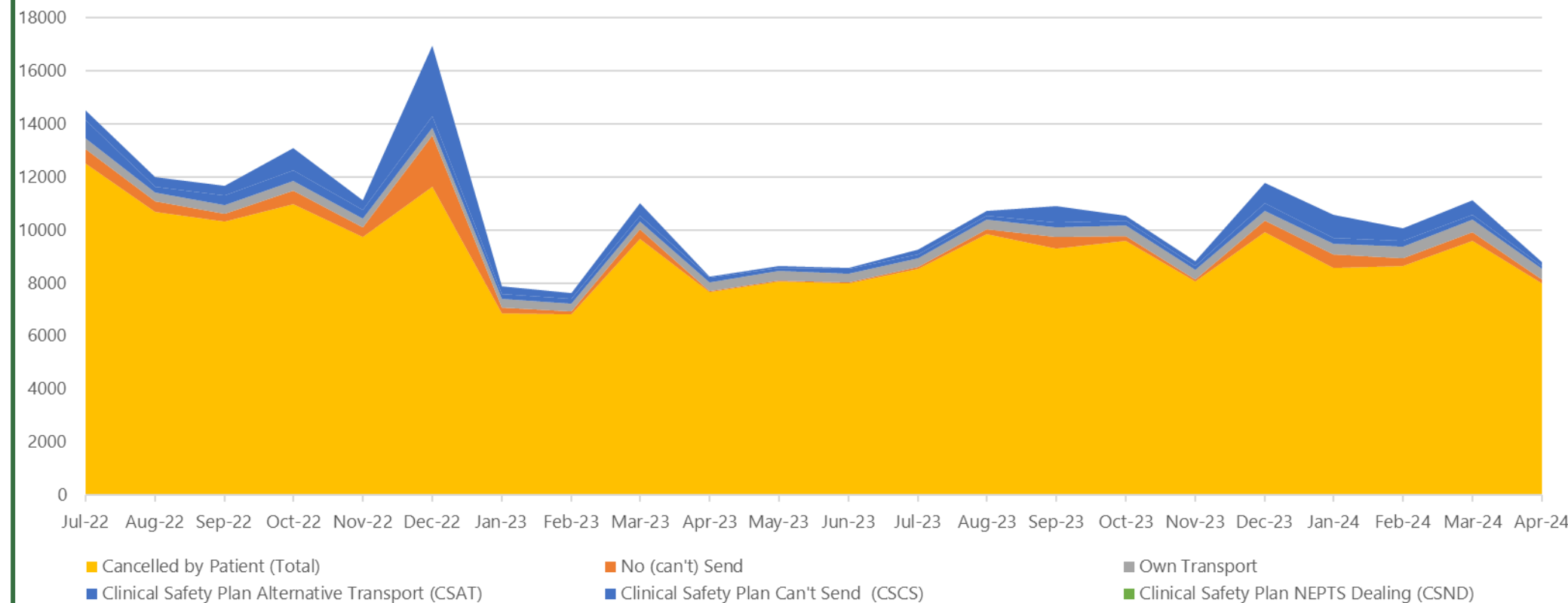
## Potential Patient Harm Indicators

(Responsible Officer: Andy Swinburn)

R

FPC

Numbers of Patients with No Send or Cancelling Ambulance



### Analysis

In April 2024, 104 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 170 were stopped due to CSP 'Can't Send' options. In addition, 7,975 ambulances were cancelled by patients (including patients refusing treatment at scene) a decrease from 9,605 in March 2024.

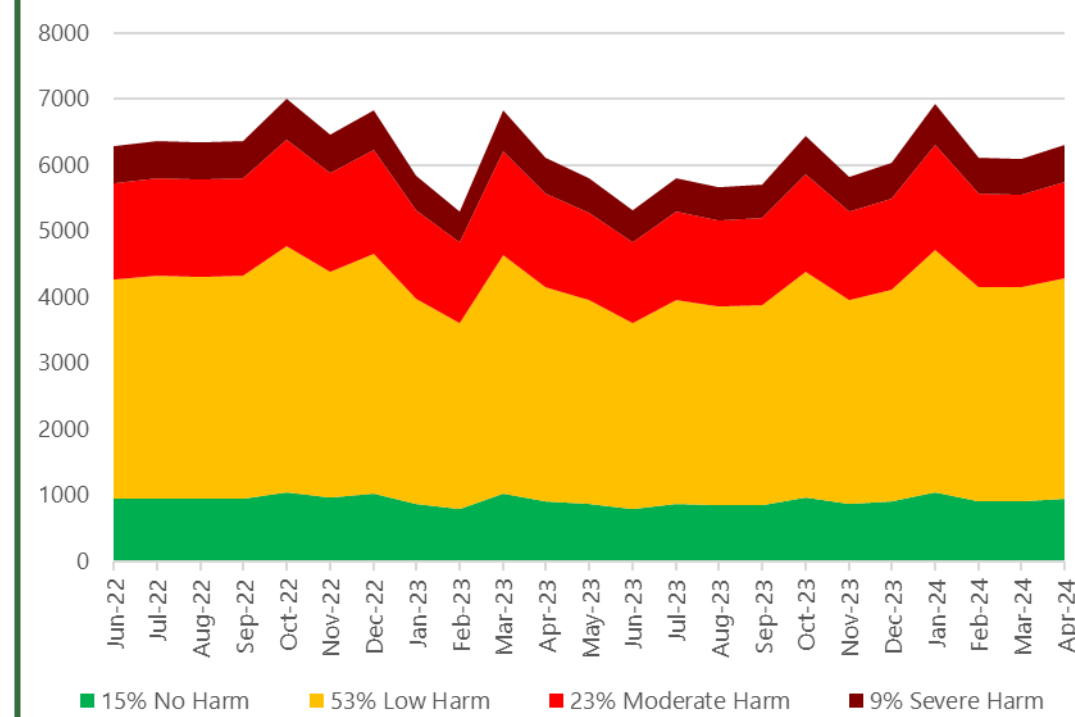
There were 483 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in April 2024. Of these 124 were accepted and released in the Red category, with 7 not being accepted. Further to this, 115 ambulances were released to respond to Amber 1 calls, but 237 were not.

The graph in the bottom left shows that in April 2024 of the 6,304 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% (945 patients) would experience no harm, 53% (3,341 patients) would experience low harm, 23% (1,449 patients) would experience moderate harm and 9% (567 patients) would experience severe harm.

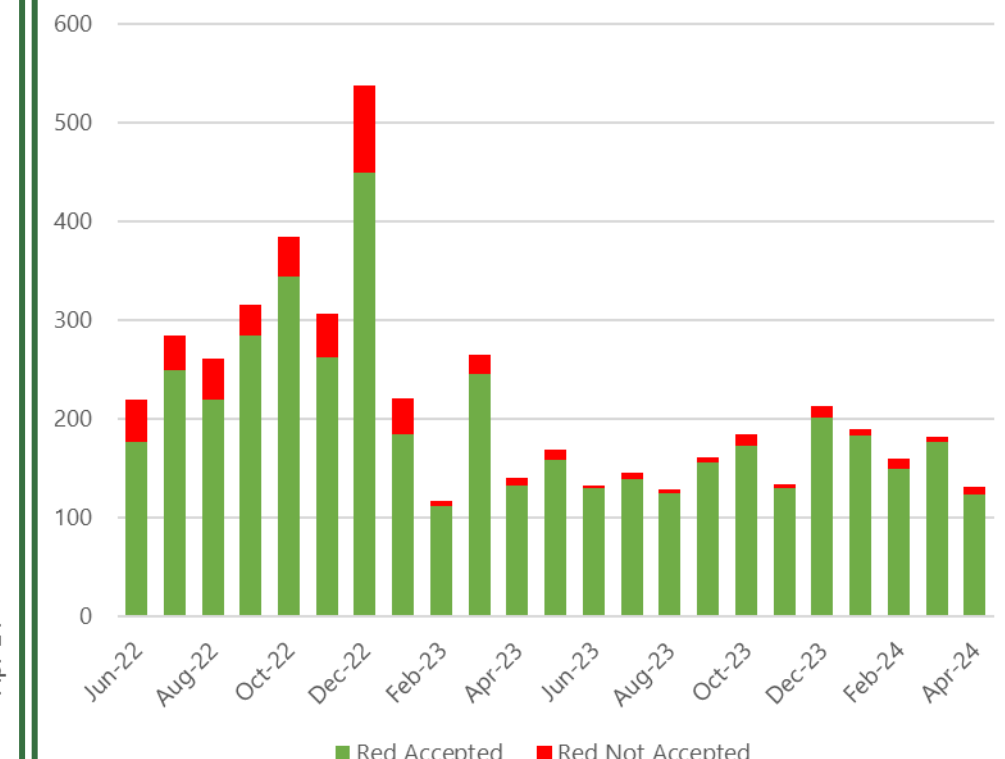
In March 2024 CSP levels for the Trust were:



Modelled Harm Coming to Patients Who Wait Over 60 Minutes for a Hospital Handover



Pan-Wales Immediate Red Release



### 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 been suspended as the Trust moves into the new commissioning arrangements. The NHS Wales Performance Delivery framework 2024/25 has a target of no handovers of more than one hour, this equates to 7,000 hours of handover lost hours.

### 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 Trust's ability to respond to demand. See also slides on Red performance and Amber performance, in particular, remedial actions.

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

# Our Patients: Quality, Safety & Patient Experience

## Patient Experience Surveys

(Responsible Officer: Liam Williams)

Self-Assessment:  
Strength of  
Internal Control:  
Moderate

PCC

Health & Care  
Standard  
Health – Safe Care

### Analysis

Within the NEPTS survey the responses provided did not hit the benchmark in relation to the questions 'How long did you wait for your transport to take you home after your appointment and 'Were you happy with the transport you received', therefore not providing the level of service the patient expected. However, 92% in the 111-survey confirmed they took the advice given by NHS 111 Wales.

It is acknowledged that the small number of respondents for the 999 and 111 surveys does not provide a great enough response to reflect a true patient experience picture, but work is currently underway to develop a process that will increase response rates and make them more meaningful.

### Remedial Plans and Actions

We continue to make available 4 core Patient Experience surveys, covering the Trust's main service delivery areas:

- 999 EMS Response (incorporating CSD)
- Ambulance Care (NEPTS)
- NHS 111 Wales Telephony
- NHS 111 Wales Online

Response rates to the 999 and 111 surveys are low and it's acknowledged that these do not reflect an entirely representative picture based on overall call volumes, but we are working consistently to develop a process that will help increase these response rates. An updated DPIA is nearing completion and will soon be submitted to the ICO for their consideration and advice about a way forward around us of SMS text messages to distribute survey requests to service users. However, we are not completely relying on this approach and have been looking at alternative methods of distribution also. We have met with colleagues at South East Coast Ambulance Service who have successfully placed QR codes in the back of all their EMS vehicles to increase patient feedback and we plan to explore use of the same model here at WAST. We have been working closely with the Trust's Falls Improvement Lead, and in March we launched a targeted survey looking at the experiences of people who are responded to by either a Level 1 or Level 2 falls responder. Patients who are left at home with no further intervention required are left an invitation to share their experience with us by completing a survey. The invitation contains a QR code that can be scanned to access an online survey, contact details for the Peci Team are also included allowing people to request a hard copy survey is sent to them. So far just over 20 people have completed a survey with all respondents rating their experience with the Falls service as 'Very Good'. Capturing service user experience through the use of surveys is a mandatory requirement and a new reporting framework is submitted to the NHS Executive and Welsh Government on a monthly basis outlining how many surveys have been completed.

### Expected Performance Trajectory

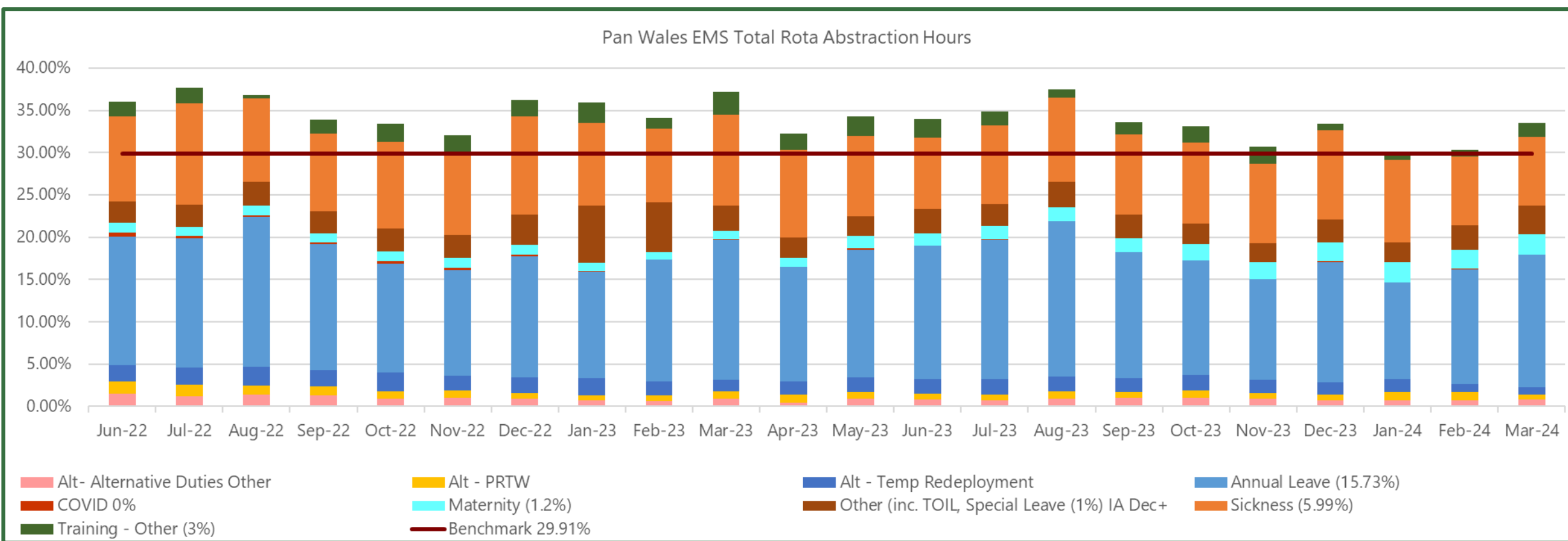
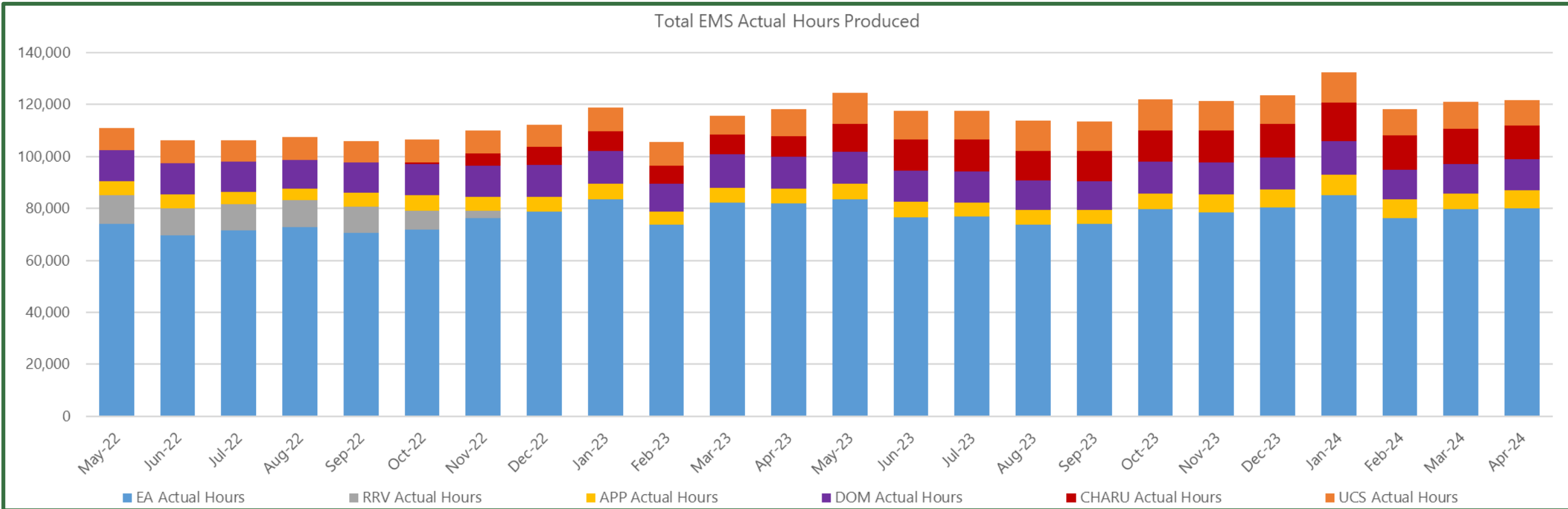
Work to further integrate our systems with Civica to push email/text surveys to patients. Using Other methods of survey delivery such as QR codes in EMS vehicles to compliment this, with an overall aim of increasing visibility of experience surveys and maximising opportunities to capture patient experience data through experience surveys.

March 2024		
<b>NEPTS</b> (132 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	82
Were you happy with the transport you received?	85	85
<b>999</b> (39 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	69
The 999-call taker who answered your call explained what was going to happen next.	85	74
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	65
The length of time I waited for an ambulance to arrive was acceptable.	85	43
<b>111</b> (38 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	55
Did you follow the advice given to you by NHS 111 Wales?	85	92
Would you consider using NHS 111 Wales again?	85	67
<b>WAST Overall - Friends &amp; Family Test</b>	Ranked from very poor to very good.	
How was your overall experience with the service today?		
o Ambulance care	81.58% Good	12.28% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	50.00% Good	27.78% Poor
o EMS (including CSD and Falls Response)	61.70% Good	21.79% Poor
o NHS 111 Wales Online	58.06% Good	29.03% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

# Our People Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions	CI	PCC
A	R		FPC



### Analysis

The total hours produced is a key metric for patient safety. The Trust produced 121,578 hours in April 2024, compared to the 118,141 hours produced during April 2023. The Trust is delivering good levels of production.

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced, as are the total number of staff in post. In March 2024, total EMS abstractions (excluding Induction Training) stood at 33.49%. This was an increase from the 30.33% recorded in February 2024 meaning the Trust remains above 30% (which is the benchmark figure). The highest proportion of abstractions was due to annual leave at 15.62% followed by sickness at 8.17%. This figure for sickness abstractions for March 2024 was a decrease when compared to the same month last year (10.75%).

**Emergency Ambulance Unit Hours Production (UHP) achieved 96% in April 2024** which equated to 80,076 Actual Hours. This is a 2.3% decrease on the Actual Hours produced during April 2023 but is above plan.

CHARU UHP achieved 148% (12,784 Actual Hours) compared to 154% in March 2024 (this is the commissioned level not the modelled level). This equates to 73% UHP of the full roll out requirement against the agrees rosters.

### Remedial Plans and Actions

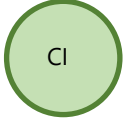
- Continued focus on managing attendance across the Trust and managing abstractions from rosters.
- Full roll out of CHARUs.
- Continued focus on staff in post to establishment, aiming for 95% benchmark.
- Smoothing of staff between urban and rural areas.

### Expected Performance Trajectory

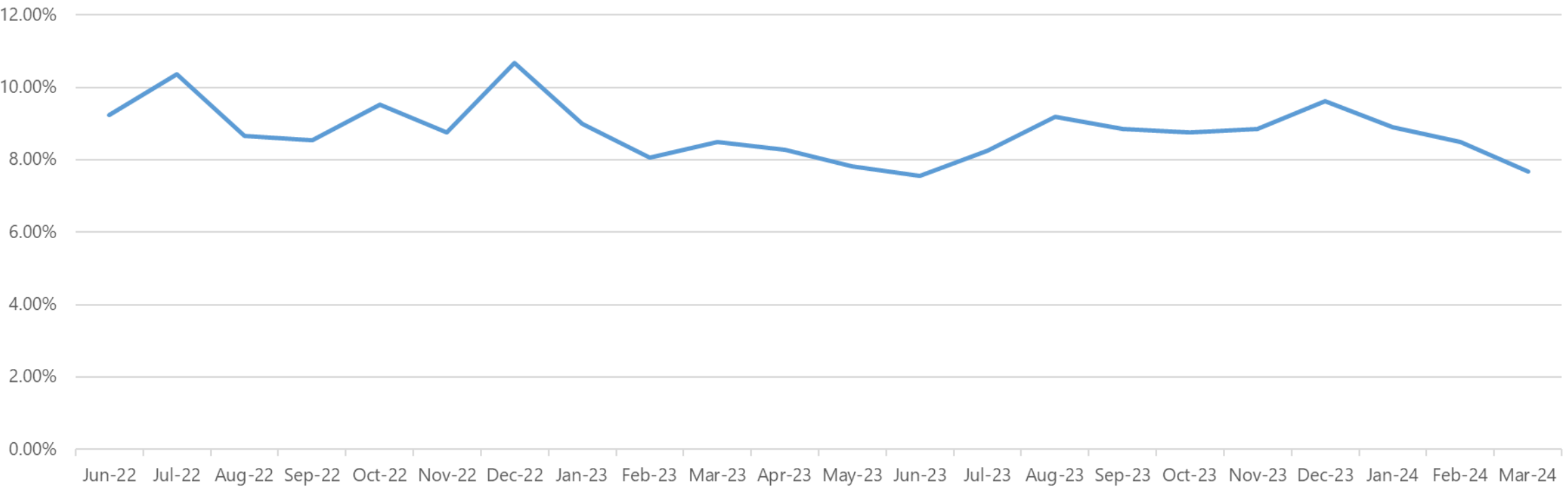
UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to ELT. Production is good. The Trust has an ambition to reduce sickness to 6% and abstractions to 30% by March 2024. This has not quite been achieved, but the direction of travel is good, with the abstractions benchmark being achieved in January and February and sickness absence (whole Trust) below 8% for March 2024 (see next slide).

# Our People Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)



Monthly Sickness Absence (All Directorates)



**Analysis**

There was a decrease in overall sickness absence rates between February 2024 and March 2024, dropping from 8.50% to 7.67%. Long term absence decreased from 6.34% in February to 5.31% in March and short-term absence increased from 2.16% in February to 2.35% in March.

The highest reason for short term absence in February 2024 was Anxiety/ Stress/ Depression, other musculoskeletal problems and cold, cough, flu-influenza. Long term sickness case management continues and indicative figures for April 2024 shows a decrease to 5.47% from 6.23% in March. Indicative figures for short term absence in April 2024 shows an increase to 3.13% from 3.24% in March.

Absence due to Mental Health has had an upwards trajectory since June 23, however, it is now at 2.07%, which is back in line with figures seen during the early part of 2023.

Physiotherapy:

- 8 referrals were received in March 2024. This is 4 less than the previous month.
- Average length of time from referral to first contact: 1.25 days - in February this was 1.09 days.
- 50.75 is the average age of referrals received, with the majority of referrals being for back injuries (37%).
- At the point of referral 50% of employees were off work, 37% were at work on full duties and 13% were on amended duties.
- Health Assured (EAP): -58 Calls in March, -3.3% change from February (60)

**Remedial Plans and Actions**

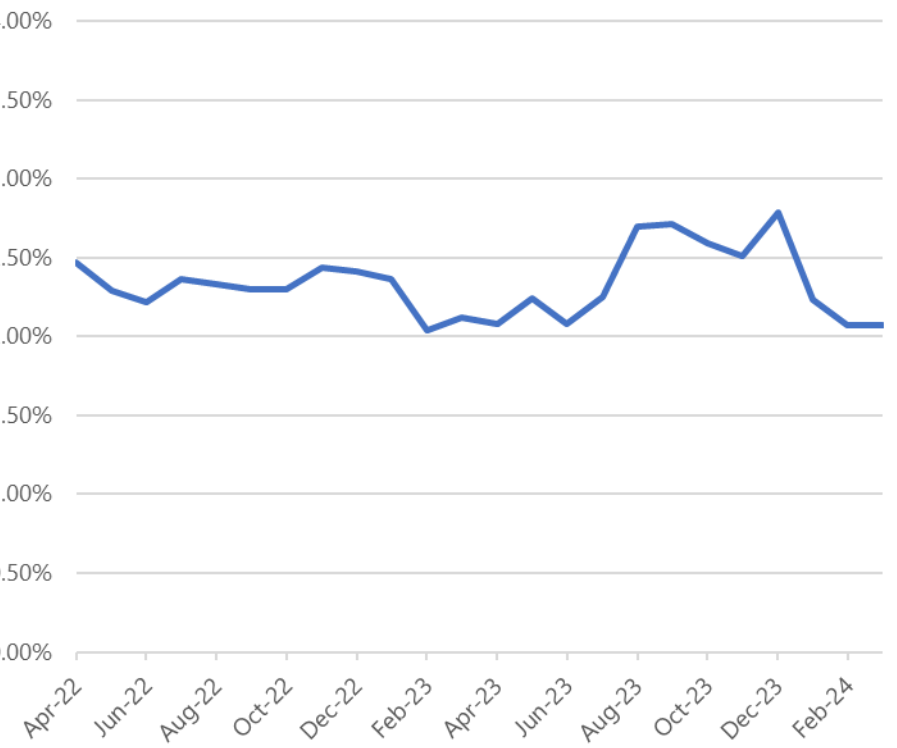
- Monitoring continues with ongoing reviews in both long term and short-term absences with monthly meetings to track sickness and provide support.
- MAAW training and bitesize training sessions continue to be scheduled on a bi-monthly (MAAW) and monthly basis (Bitesize sessions).
- In line with the Improving Attendance Action Plan, the People Services Advisors have undertaken audits on short term absence occurrences within the Operations Directorate.
- Audits for all Directorates, will be undertaken on a monthly basis over the next 6 months and the People Services Team will provide targeted support to line managers on reasonable adjustments and the appropriate use of discretion in areas identified as hot spots.

**Expected Performance Trajectory**

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

**NB:** Sickness data will always be reported one month in arrears. It should be noted that the figures reported in this presentation are official to 31st March 2024. All figures for April 2024 are indicative only (as of 23.04.24).

Absence due to Anxiety, Depression and Other Psychiatric Illnesses FTE%



Average working days lost per FTE (Annual)

19.43 days

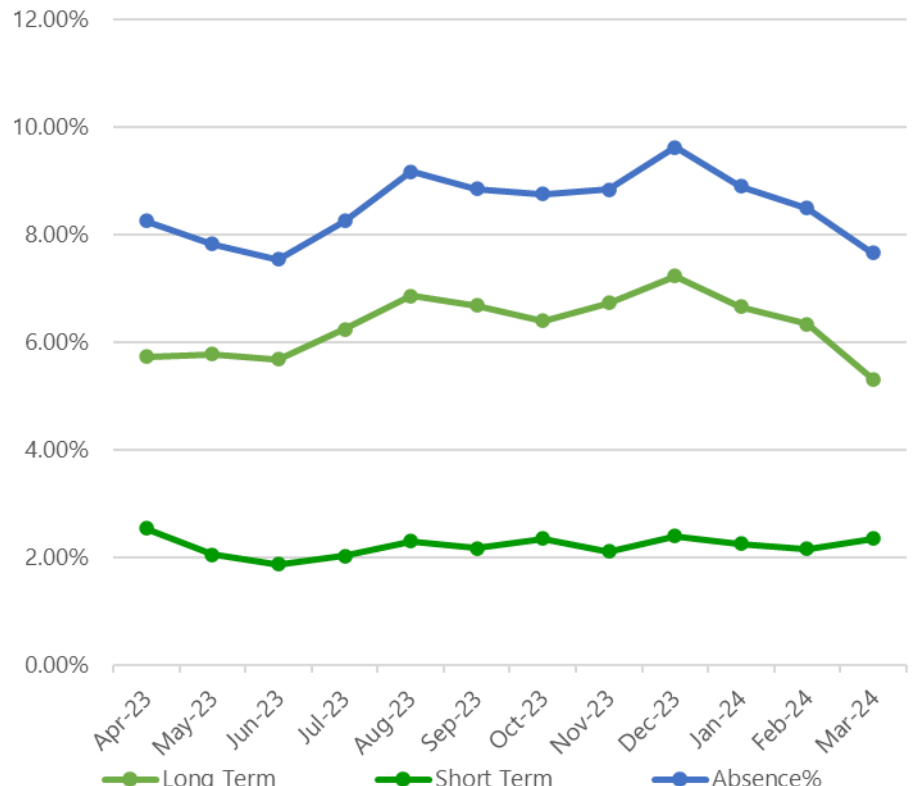
Single month Absence %

7.67%

Long Term	Short Term
5.31%	2.35%
Mental Health	Other MSK
S10 Stress/Anxiety	(excluding Back)
2.07%	0.87%

March 2024

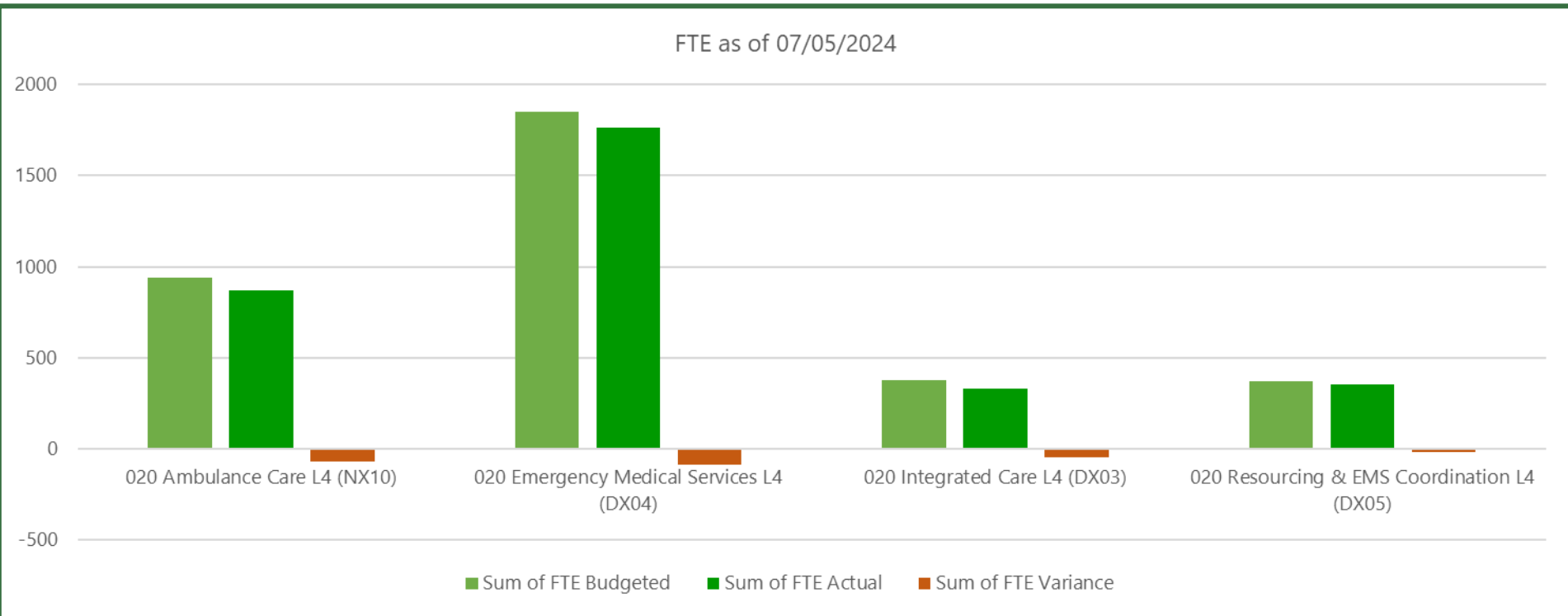
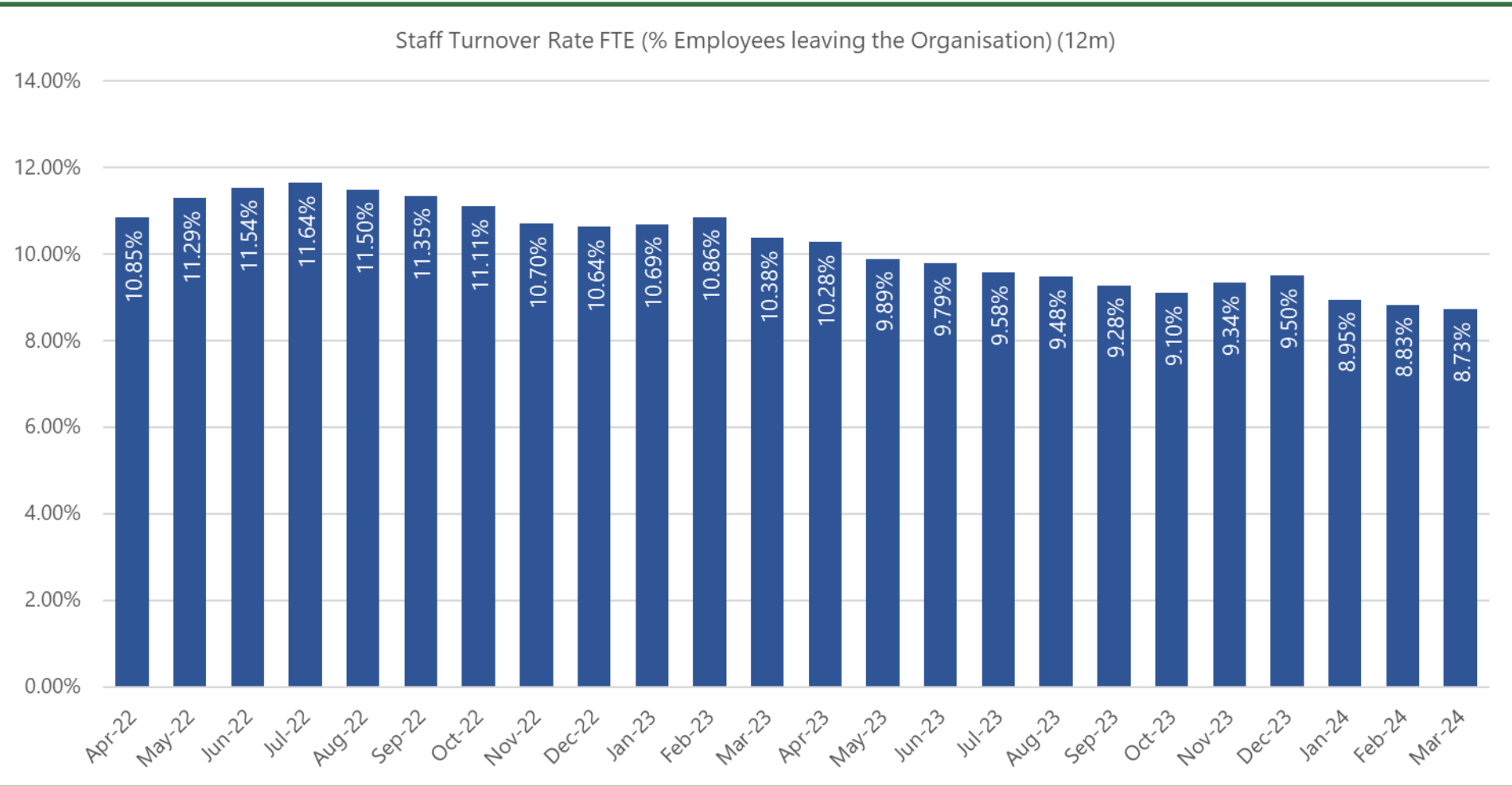
All Sickness Reasons LT/ST%



# Our People Capacity - Turnover

(Responsible Officer: Angela Lewis)

Turnover  
A



### Analysis

Staff turnover rates in March 2024 were 8.73%, which is a slight decrease from the 8.83% recorded in February 2024, and rates have generally been declining since they peaked in July 2022. March saw 35 leavers (29.35 FTE) from WAST compared to 26 in February and 27 in January. (Turnover in months at the end of the quarter are generally higher). This was unbalanced with 16 joiners (14.35 FTE) in March. Of those leaving, the majority were from Ambulance Care (5 people) and Emergency Dispatchers (5 people). 9 leavers were due to retirement, 3 were granted flexible retirement, 5 were dismissals, 1 due to the end of a fixed term contract and 17 were resignations

Shift overrun average times have been steadily increasing again following a two year low recorded in June 2023, however, the average figure for April 2024 was 40 minutes and 49 seconds compared to 41 minutes in March 2024. 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.

### Remedial Plans and Actions

We continue to improve our data collection through Our MI system (Opas G2), so that we can produce accurate and reliable data. We have defined our standard reports, i.e. which reports need to be run regularly, on a daily, weekly or monthly basis, etc. Also, building our own customised reports for which we can report on themes and trends and identify areas that may require additional support. From this information we can complete appropriate analyses and target our Occupational Health and Wellbeing provision (including themes/promotional events) in an appropriate way. Our MI reports can be used to support strategic decision-making regarding the service, also to provide impact analysis and highlight value for money. We are still working closely with the Welsh health boards to standardise our reporting. The Wellbeing team continue to support colleagues and managers who are facing large-scale changes through holding regular meetings and facilitating drop-in sessions for colleagues. We are currently offering support to managers through scheduled events; Occupational Health - Guidance on Management Referrals. We have facilitated two events already; attendance has been good at both. Our provider for our Employee Assistance Programme has now been appointed and a launch will be conducted in May/June. Our self-booking option for Occupational Health referrals has proved extremely popular and has improved the service for everyone whilst streamlining processes for the team, creating capacity to address other projects. We continue to evaluate the service through gathering feedback from our colleagues, we are improving this process by updating our questionnaire and will be circulating this through Opas G2. The clinical team continue to support People Services and managers through sickness absence meetings. Team members from OH/Wellbeing/TRiM continue to promote the service using our Occupational Health & Wellbeing vehicles, also through presenting to new starters within WAST and through attendance at managers' meetings. The team continue to deliver Drop-in sessions across all our Clinical Contact Centres, (CCCs) dates for 2024 have been advertised. These are delivered in person at the CCCs and online via Teams. The REACT (Recognise, Engage, Actively Listen, Check Risk, Talk) training is still proving popular, new dates have been advertised on Siren. The Wellbeing team will be present at each of the CEO roadshows in April, promoting the service and providing advice and guidance to colleagues. We are still in the process of writing the Health and Wellbeing strategy for 2025/29. The team has implemented outcome measures and integrated them into OPAS G2, our MI system, this means that we will be sending questionnaires to colleagues around mental health assessment measures. The Health Surveillance programme is starting with HAVS at the fleet workshops - H&S are beginning a scoping exercise on the equipment used. We continue to plan for the pilot Health Check Programme Health Diagnostics, which is still in process to look at reducing risk of cardiac ill health in our older workforce, by implementing a screening programme. We are continuing MMR audits for frontline staff.

### Expected Performance Trajectory

The People and Culture Strategy will continue with its wellbeing focus. We are currently in the process of writing the WAST Health and Wellbeing strategy for 2025/29. The wellbeing provision is regularly reviewed to ensure that services/interventions offered are relevant, appropriate, and up to date, our focus is on continuous improvement. Our tender process for an EAP has been successful and a provider will be appointed. The contract will be in place for 2 years. The team are currently evaluating the In Work Support programme, (currently funded by Welsh Government), to which the team have been referring colleagues for physiotherapy. We are monitoring turnaround times/general quality of service for our colleagues. The team will be promoting the service and raising awareness of the OH and Wellbeing offer at each of the CEO roadshows in April.

# Our People Culture - Staff Vaccination Indicators

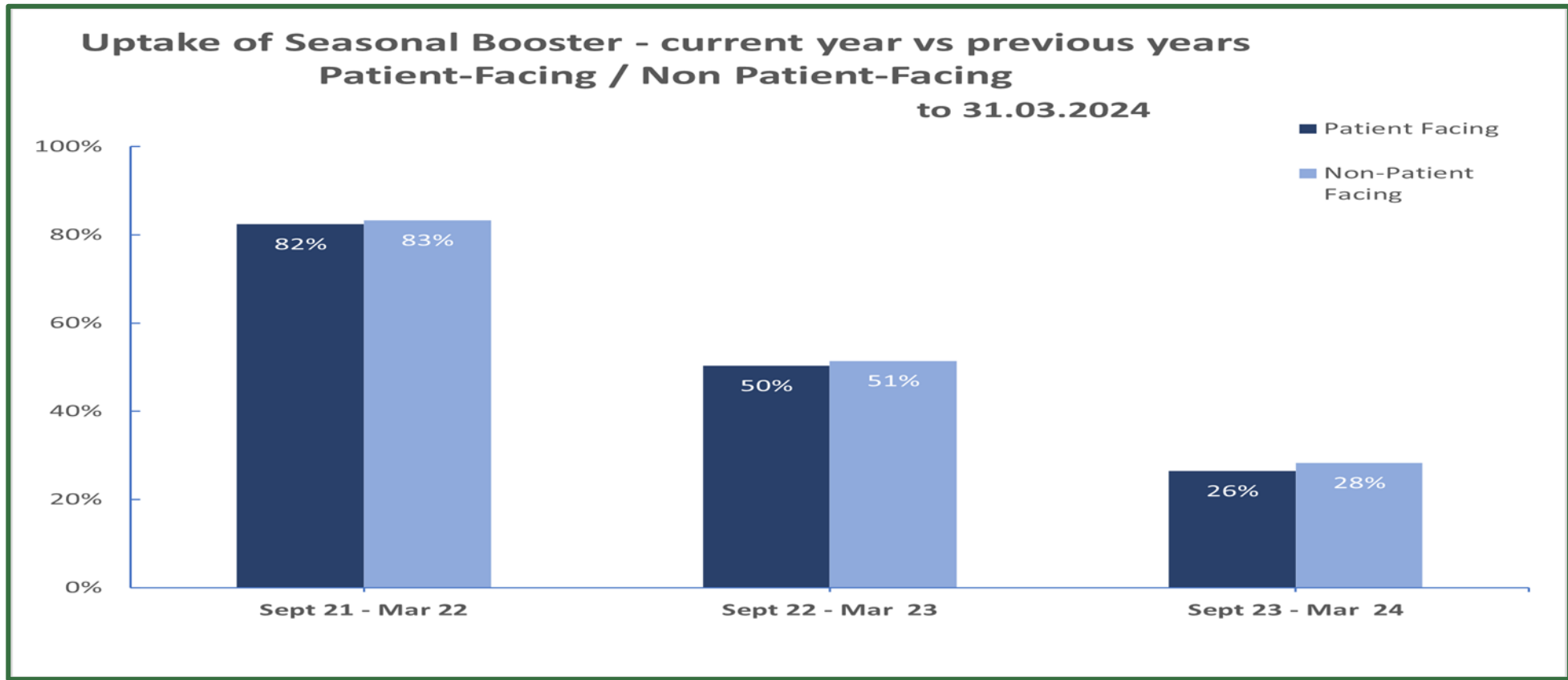
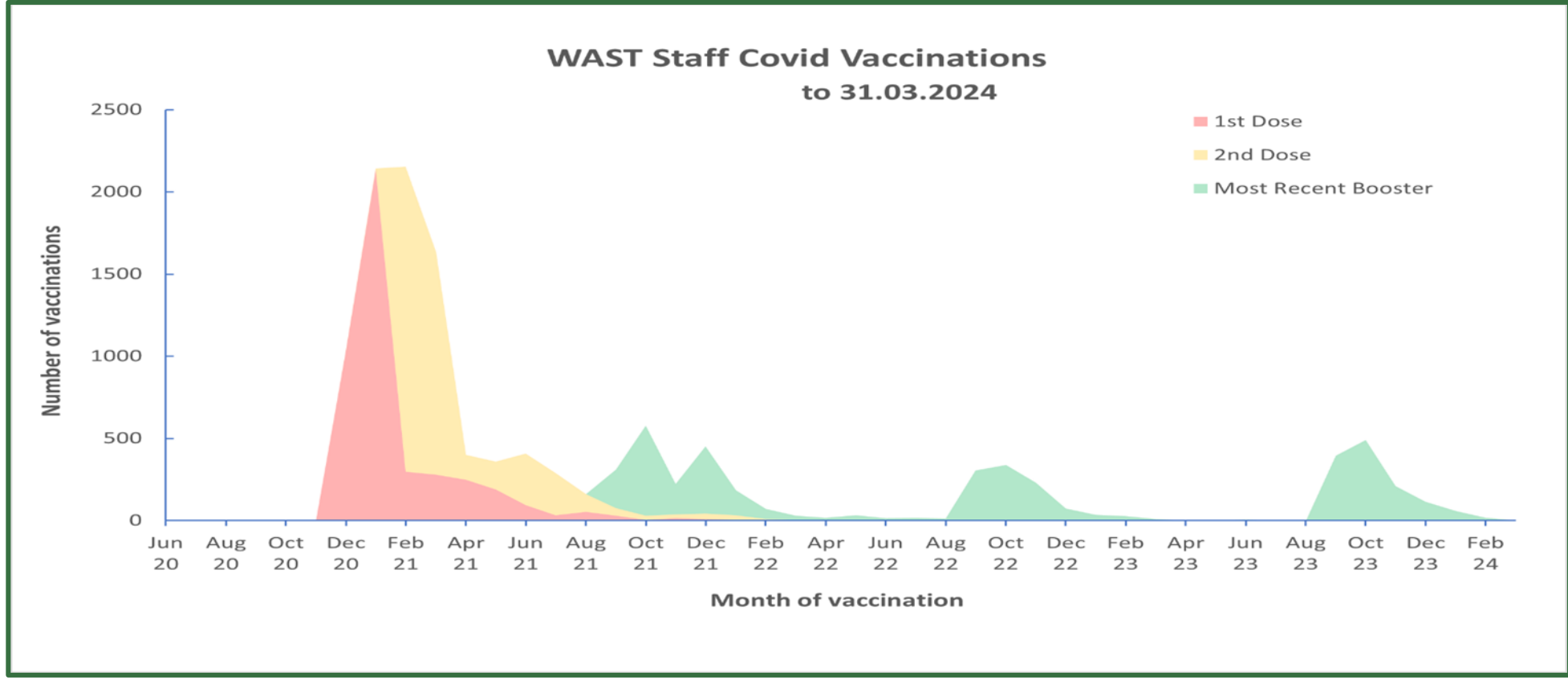
(Responsible Officer: Angela Lewis)

Self-Assessment:  
Strength of Internal  
Control: Moderate

PCC

Health & Care  
Standard  
- Health (PPI)

CI



## Analysis

**Flu:** The target set out by Welsh Government is to improve on last year's flu vaccination uptake. However, this was unfortunately not met during this year's campaign. The Trust's final uptake of staff vaccinated was 36.5% of WAST staff, which is a decrease of 8% from last year's campaign. The number of patient facing staff that are recorded as receiving the vaccine for the 2023-24 campaign has also noticeably decreased by 15.2%, reporting 31.1% at the end of the campaign. This equates to 820 out of 2,639 being recorded as having the flu vaccine during this campaign, in comparison to 1171 out of 2527 during the previous campaign. This is reported alongside a 44.2% engagement rate for the organisation and for those that engaged via Microsoft Form, 36.5% decided to receive the vaccination this year. The remaining 7.7% decided to decline the flu vaccine and opt-out. The Charitable bid for an incentive of vouchers has had a positive effect on the engagement rate of staff completing the form. 11.3% (491 WAST staff) completed the form to state they have had the vaccine elsewhere during this campaign, in comparison to 6.8% (289 WAST staff) in the previous campaign, therefore, a 4.5% increase.

**COVID-19:** As of the end of March 2024, 93% of Patient-Facing staff have received both the first and second COVID-19 vaccination dose. As of the end of March 2024, 93% of Patient-Facing, and 92% of Non-Patient-Facing, staff have received the second COVID-19 vaccination dose. 85% of Patient-Facing, and 84% of Non-Patient-Facing, staff have received at least one of the Covid-19 boosters offered in the last 3 years.

As of the end of March 2024, 26% of Patient-Facing, and 28% of Non-Patient-Facing, staff have received this season's Covid-19 Booster. The season started in September 2023. This is compared to 50%/51%, respectively, for the equivalent time period in 22/23 and 82%/83%, respectively, for the equivalent time period in 21/22.

## Remedial Plans and Actions

**Flu:** The 202/24 WAST Flu campaign ended at the end of February 2024. The end of season report has been shared and discussed at the Clinical Directorate Business meeting and ELT.

**COVID-19:** The four UK CMOs agreed it was appropriate to pause the alert level system, which was suspended on 30<sup>th</sup> March 2023. Routine testing was also paused for all symptomatic health and social care workers, care home residents, prisoners and staff and residents in special schools during the spring of 2023.

## Expected Performance Trajectory

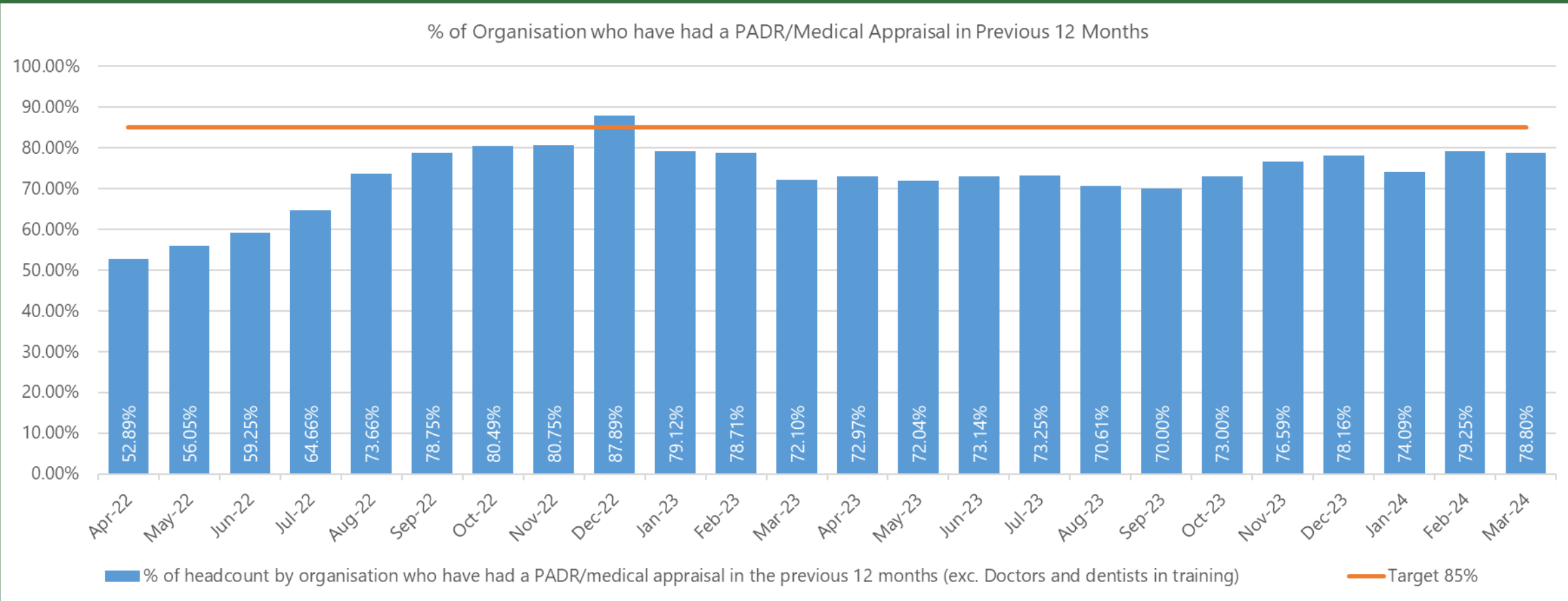
It is evident via the report that lessons have been learnt from this campaign and consequently, there is an extensive list of areas that require continued development for future flu campaigns.

*\*\*NB: COVID Vaccinations for the past 2 years have only reported using the WAST definition of Frontline Patient Facing employees and therefore only includes those employed within Emergency Services, and Patient Transport Services..*  
*\*\*\*NB: Flu data accurate at time of publication and subject to change / COVID-19 vaccination data correct at time of publication and subject to change.*

# Our People Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

PADR	Stat & Mand	CI	PCC
A	A		
Health & Care Standard Health – Staff & Resources		Self-Assessment: Strength of Internal Control: Strong	



### Analysis

PADR rates for March 2024 78.80% decreased slightly when compared to the previous month to 79.25% and remains below the 85% target. Over the reporting period this target has only been achieved once, in December 2022, but the current rates are 9.2% higher than the same month last year.

In March 2024 Statutory & Mandatory Training rates reported a combined compliance of 81.89%; with only Dementia Awareness (93.34%) and Moving & Handling (92.25%), achieving the 85% target. Equality & Diversity (82.69%), Fire Safety (77.26%), Safeguarding Adults (76.96%). Violence Against Women, Domestic Abuse & Sexual Violence (74.99%), Information Governance (73.46%), Paul Ridd (68.58%), Welsh Language Awareness (61.01%) and Fraud Awareness (58.86%), all remain below this target.

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

### Remedial Plans and Actions

At time of reporting, annual Mandatory In-Service update programmes have been accessed by 88% of colleagues across ACA, EMT and Paramedic roles. Those absent from work access this programme on their return to practice providing assurance of their up-to-date knowledge and skills.

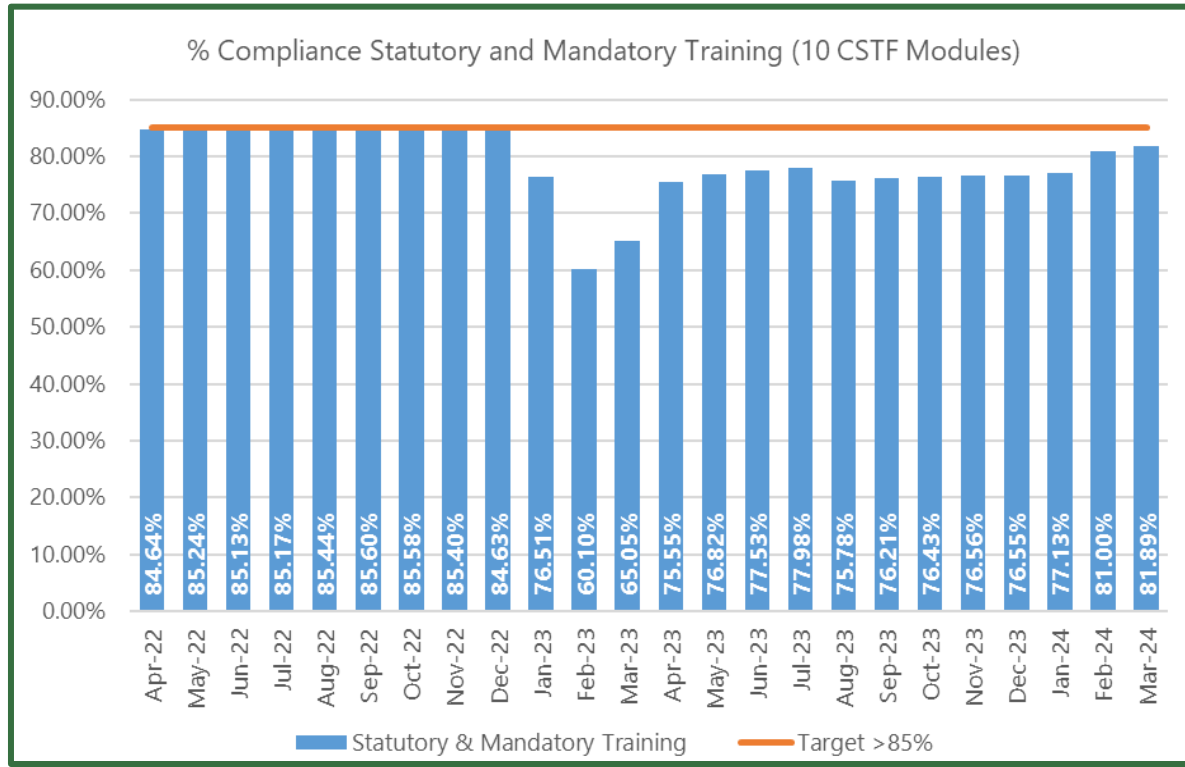
Progress toward 85% target for mandatory competencies introduced in 2023/24, namely Welsh Language Awareness, Fraud Awareness and the Paul Ridd Learning Disability awareness is falling short on the first anniversary of their reporting; this is a disappointing position and targeted focus will be applied to these 3 competencies in the early part of 2024/25.

There has been a continuation of the climb toward achievement of the 85% target across the remainder of the Core Skills Training Framework competencies which is projected to continue to increase as more learning content is moved to the user friendly LMS365 environment enabling easier access to these reportable competencies and the wider suite of Ambulance Service specific learning hosted outside ESR.

### Expected Performance Trajectory

Performance is improving as compliance has risen.

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
<b>Mandatory Courses</b>	
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



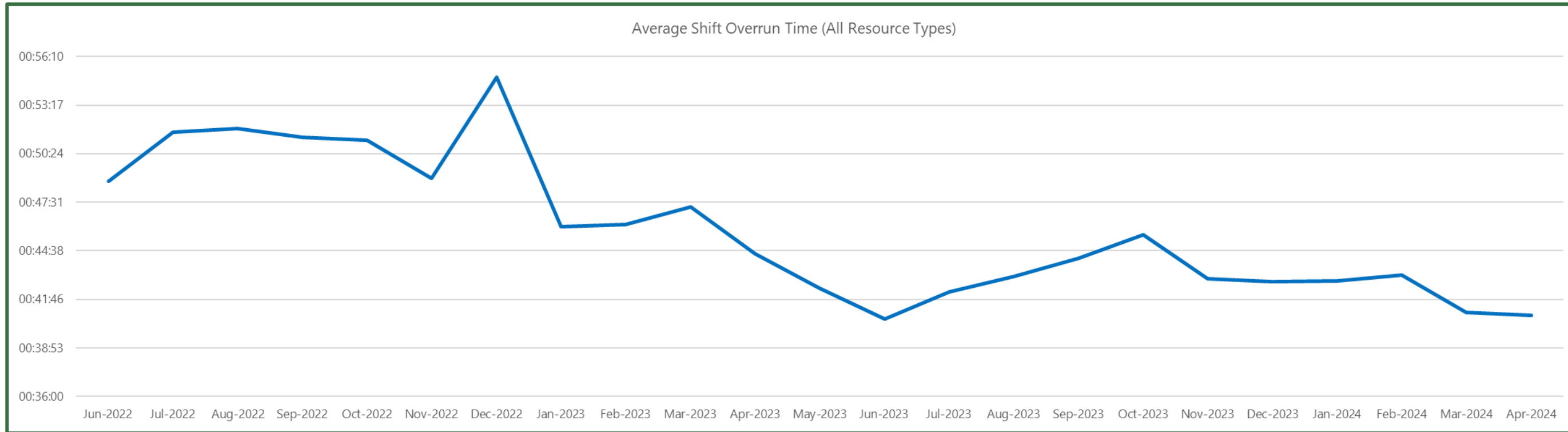
# Our People

## Health and Well-being – Shift OVERRUNS

(Responsible Officer: Angela Lewis)

Overruns  
**R**

CI



### Analysis

The average figure for April 2024 was 40 minutes and 49 seconds compared to 41 minutes in March 2024. The graph indicates a downward trend.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 73.6% of the total. 20% fall within the 61 to 120-minute category, 5.7% in the 121 to 180-minute category, 0.5% in the 181 to 240-minute category and 0.3% in the 241 minutes and over category.

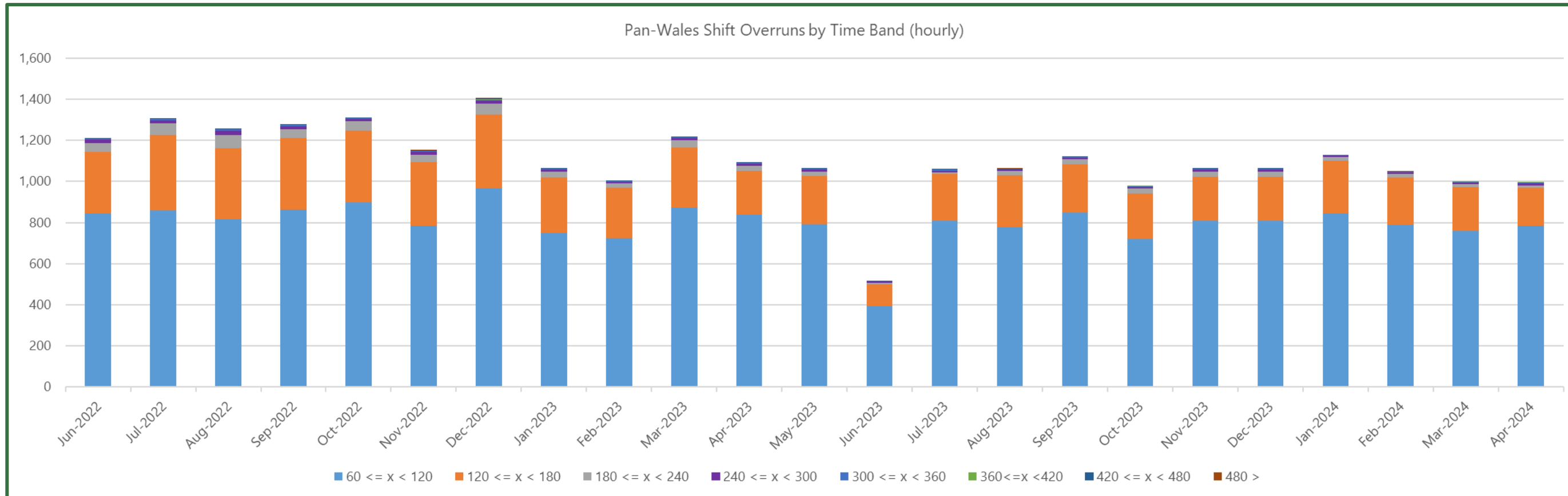
### Remedial Plans and Actions

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

As part of the Trust's winter resilience planning, it is introducing "pods" at some hospital locations to aid staff finishing on time. These are continuing, at this time, into 2024/25.

### Expected Performance Trajectory

Overruns correlate with handover lost hours. As we have moved out of winter both levels had started to drop. We may expect this to stabilise before moving into higher levels again next winter.

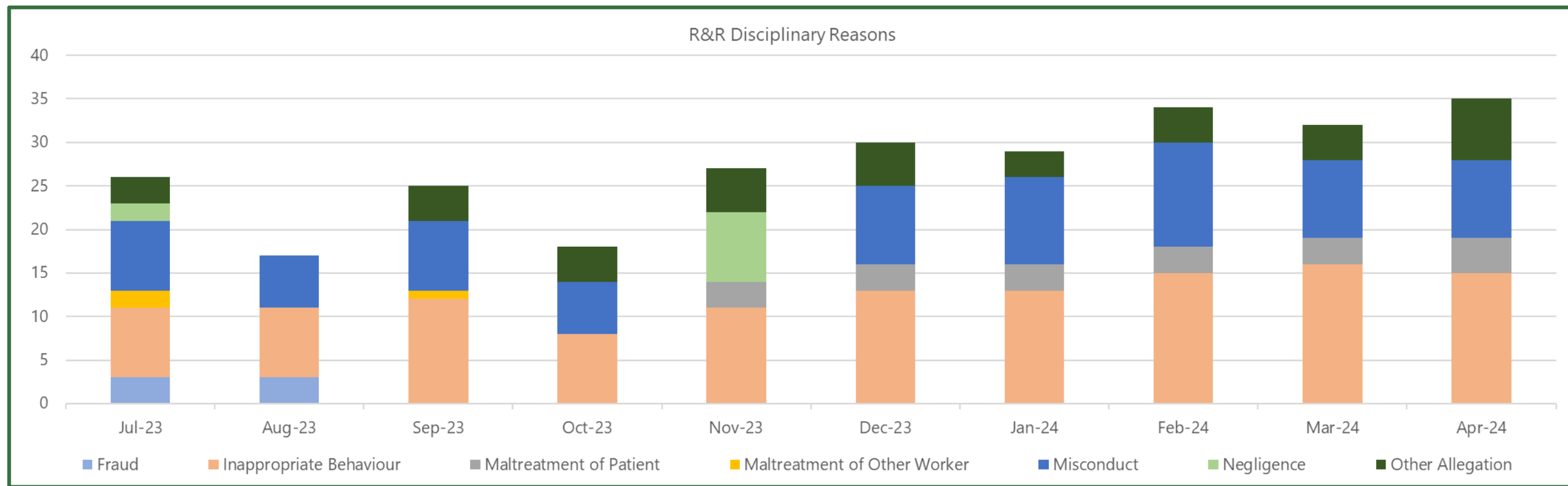


# Our People

## Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment:  
Strength of Internal  
Control: Moderate



**Analysis**  
There were 35 open formal disciplinary cases recorded at the end of April 2024, a slight decrease compared to the month of March 2024 where 32 open cases were recorded. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by misconduct.

There were 12 open formal Respect and Resolution cases submitted by employees, an increase from the number recorded in March. These are a mixture of both Respect and Resolution Grievances and Dignity at work.

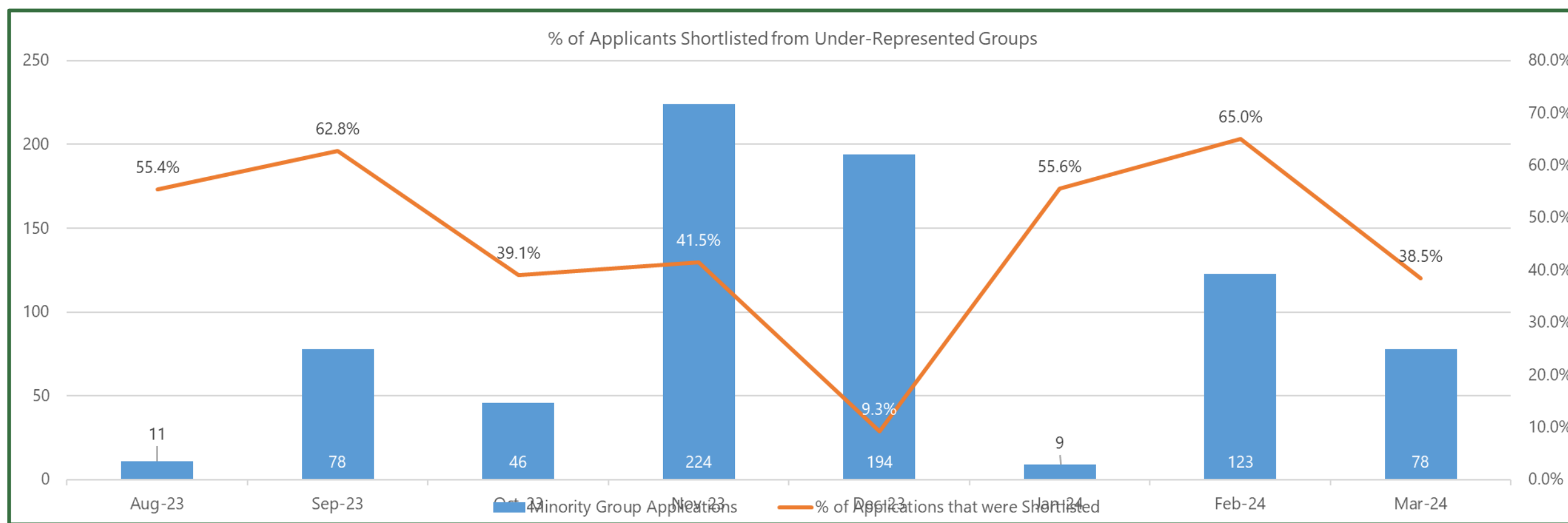
In February, 38.5% of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 65% in February 2024, while the volume of applications also decreased, from 123 to 78.

Of the 78 total applications from under-represented groups in March 2024, 43 were in the category of Ethnicity, 22 within Disability and 13 within Sexual Orientation.

**Remedial Plans and Actions**  
**R&R Formal Disciplinary Cases:** Continue to monitor. The Trust has a substantial programme of work in place, connected to behaviours.

**Applications:** The inclusive recruitment work is ongoing to develop targeted recruitment campaigns and events.

**Expected Performance Trajectory**  
Continue to monitor levels, no trajectory for this measure.

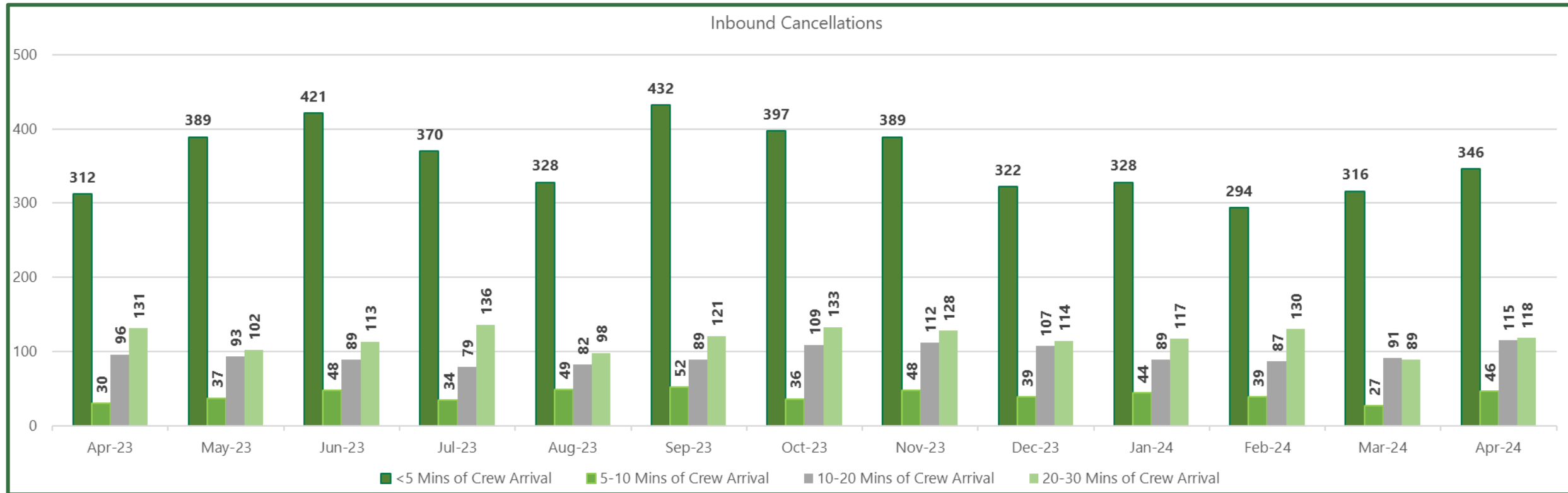


# Finance, Resources and Value

## Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

Cancellations  
**A**



### Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw an increase in April 2024 to 346, compared to 316 in March 2024. The total number of cancellations within 30 minutes increased from 523 in March 2024 to 625 in April 2024.

Cancellations within 5-minutes of arrival appears to have seen an overall increase during the past 12 months. In April 2024 there were 98 cancelled by patient\* entries made within 5-minutes of crew arrival, remaining consistent with the previous month (98). The top reasons for less than 5-minute cancellations included: 35 patient not located, 13 too ill to travel and 6 no appointment. During the past 16 months there has been a minimum of 30 patients not located in the 5-minutes or less each month.

Same day cancellations decreased slightly from 19.8% in March 2024 to 19.1% in April 2024.

### Remedial Plans and Actions

As described last month, work is well advanced with Hywel Dda to develop a direct link between their PAS system and our CAD but has been delayed by an extended focus on the MDCS system from the system team. Once in place this will allow for WAST to be notified once the health board cancels or alters an appointment.

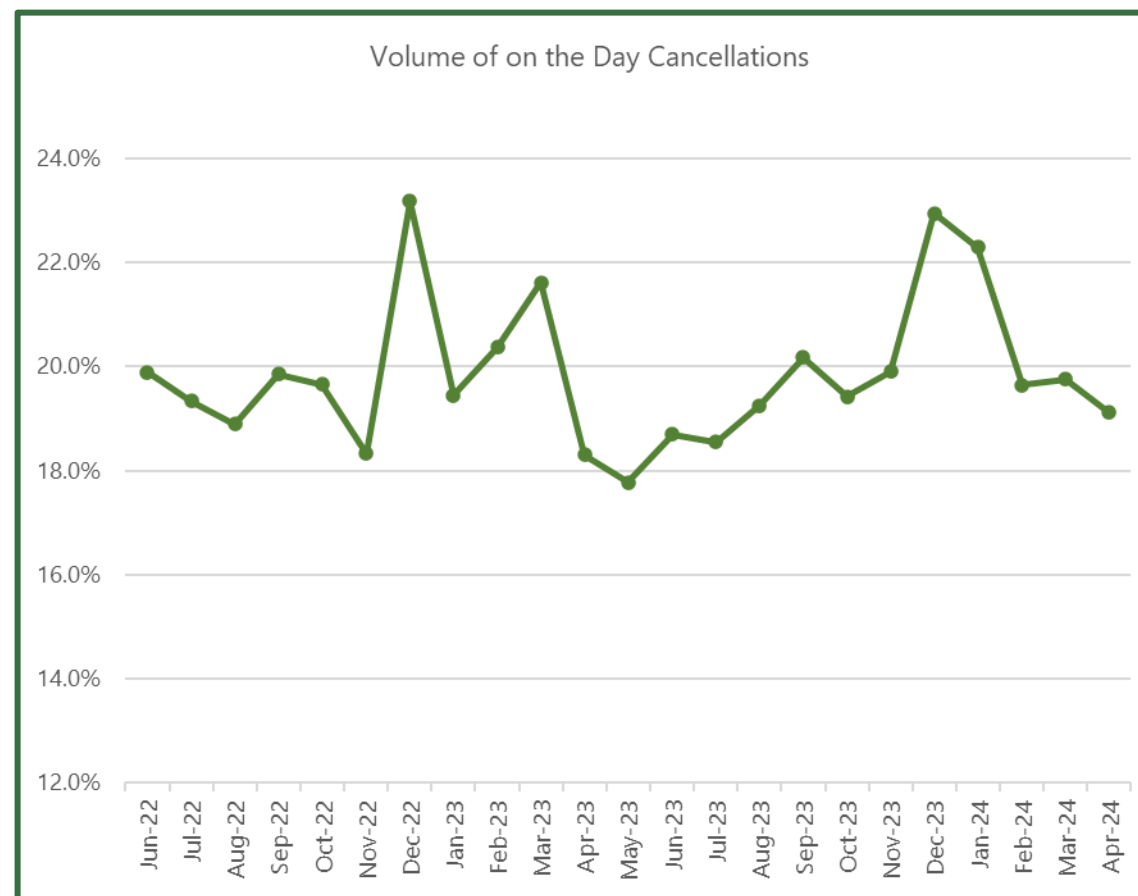
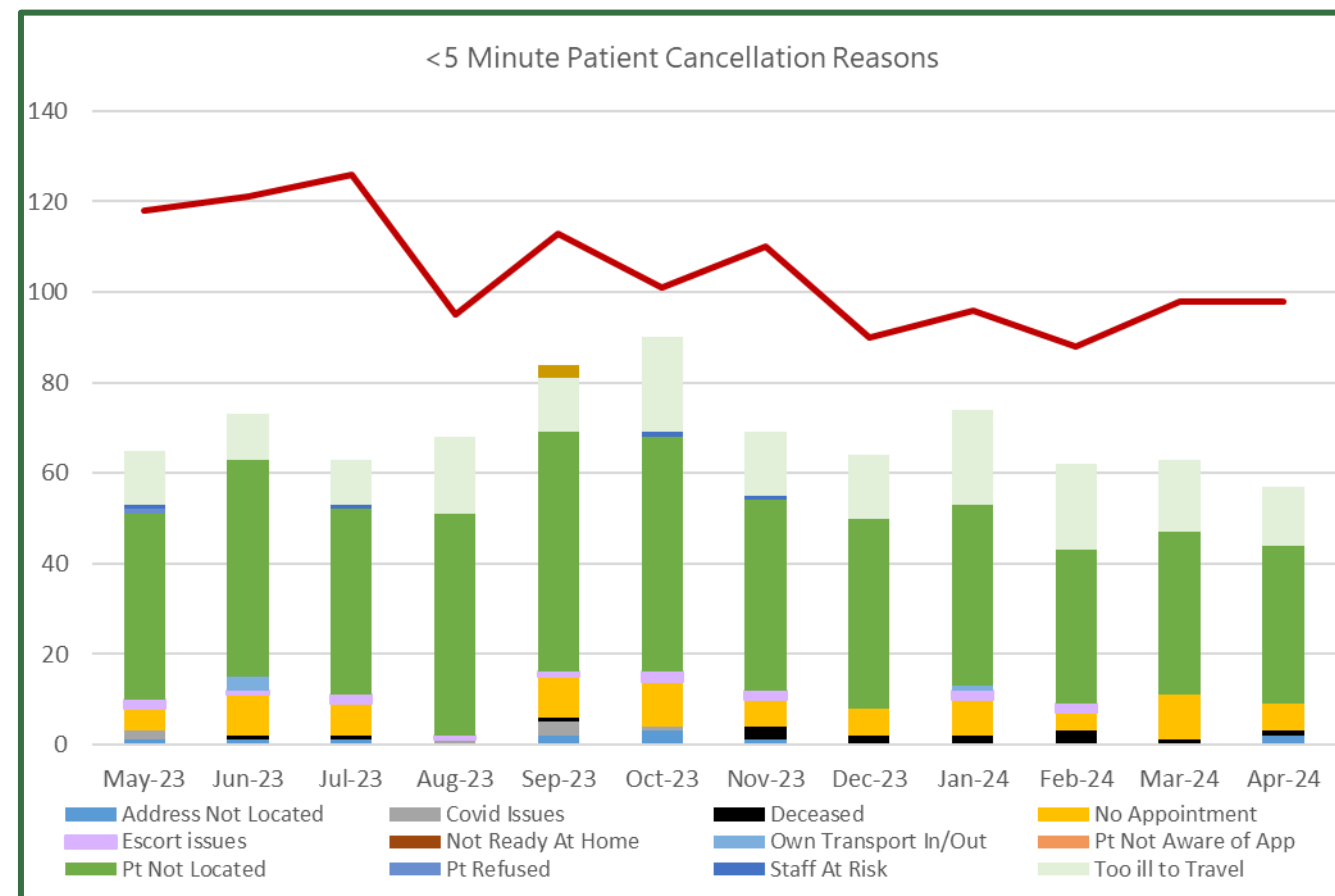
This work is at an advanced stage and should go live in Q1, once evaluated and, if successful we will explore a wider geographical rollout.

### Expected Performance Trajectory

Until this work is completed, we do not anticipate a significant shift in the trajectory as many of the factors affecting this are outside of our direct control.

*Please note that that figures may be lower than overall totals due to some records having no cancellation date.*

*\*Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*



# Finance, Resources and Value

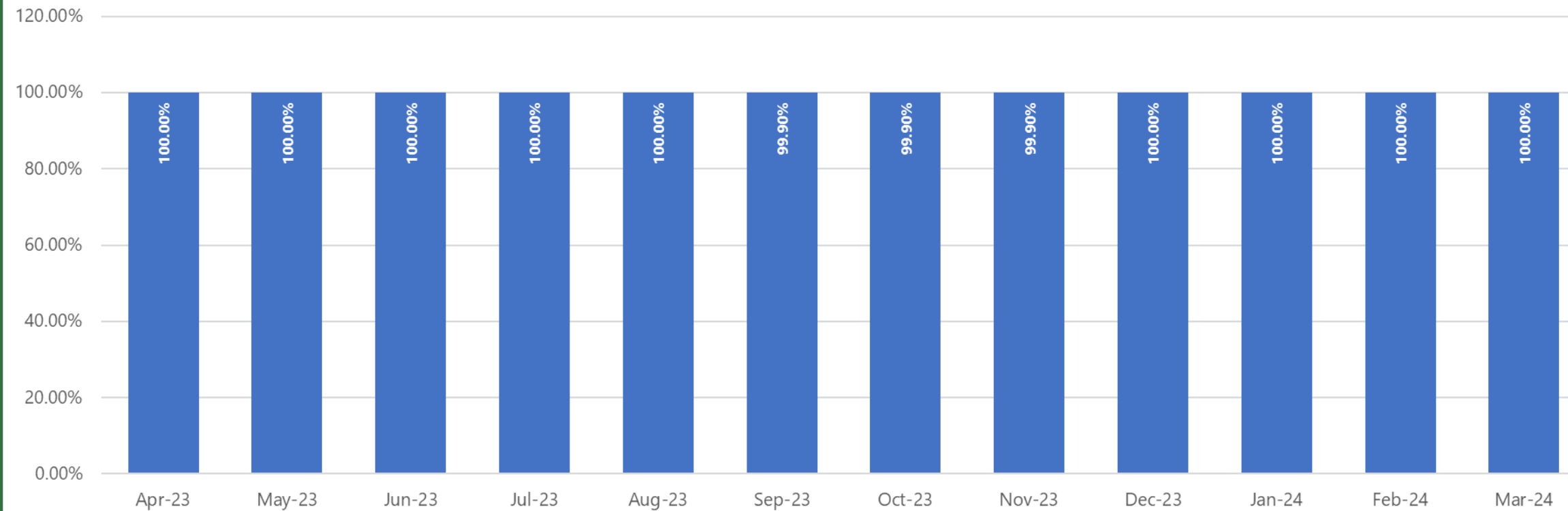
## Value - Finance Indicators

(Responsible Officer: Chris Turley)

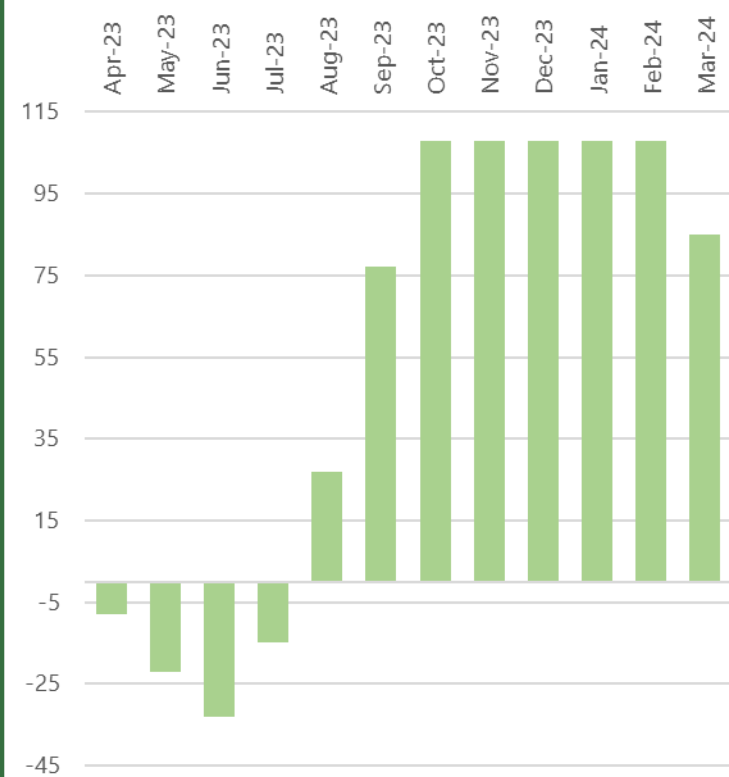
G

FPC

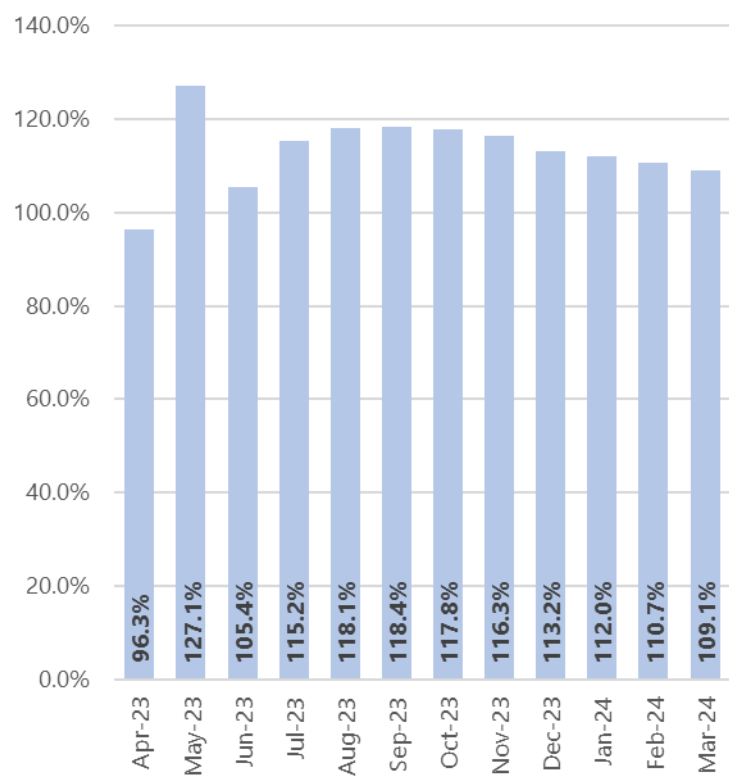
Financial Balance - Annual Expenditure YTD as % of Budget Expenditure YTD



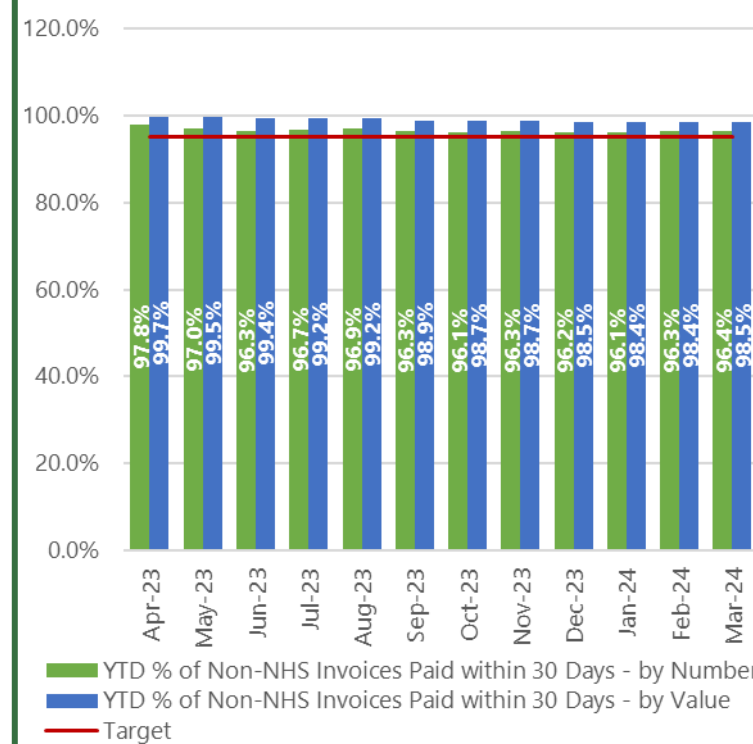
Actual Trust Surplus/(Deficit) YTD - £000



Actual Savings YTD as % of Planned Savings YTD



YTD % of Non NHS Invoices Paid Within 30 Days - By Number & Value



### Analysis

The reported outturn performance at Month 12 is a surplus of £85k.

For Month 12 the Trust is reporting planned savings of £6.000m and actual savings of £6.547m (an achievement rate of 119.1%).

The Trust's cumulative performance against PSPP as at Month 12 is 96.4% against a target of 95%.

At Month 12 the Trust achieved both its External Financing Limit and its Capital Resource Limit.

### Remedial Plans and Actions

There is no remedial plan required given the Trust has reported a breakeven position (subject to audit); however, as the Trust moves into 2024/25 key areas of focus include:-

- Undertaking a review of commercial opportunities for income generation (Report being considered by FSP group).

- A continued focus on the Trust's financial sustainability programme.

- Improved governance for Value Based Health Care, with a particular focus on benchmarking; and

- An improved approach to benefits realisation

### Expected Performance Trajectory

The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2024/25 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver a planned level of savings in the 2024/25 financial year of c£6.4m.

# Finance, Resources and Value

## EMS Utilisation & Average Job/Shift Times

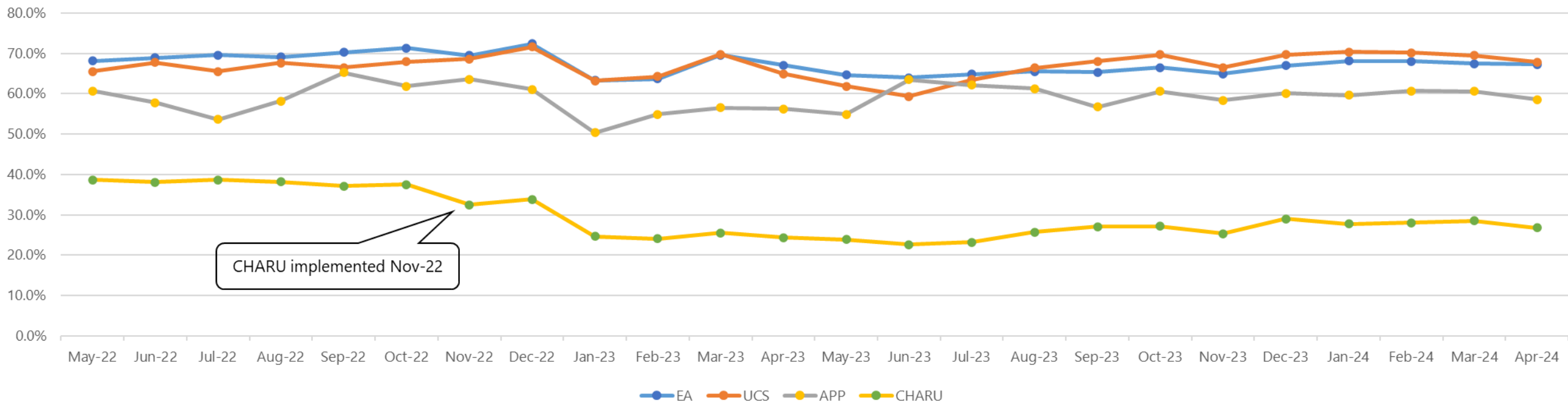
(Responsible Officer: Lee Brooks)

Job Cycle  
**A**

CHARU Utilisation  
**R**

FPC

Pan-Wales Utilisation % By Vehicle Type



### Analysis

**Pan Wales Utilisation metrics in April 2024 were 58% for all vehicles types, decreasing slightly from March 2024 (58.6%).** UCS achieved the highest rate during the month at 67.9% while EA was at 67.3%. Both have seen a generally stable trend over the past two years. The optimal utilisation rate for EAs needs to lower so that they are free to respond to incoming calls.

As demonstrated in the bottom left graph, the average job cycle in April 2024 increased to 2 hours 15 minutes for EAs, to 2 hours and 48 minutes for UCS and CHARU increased to 56 minutes. The average for APPs increased to 1 hour and 31 minutes.

Overall average jobs per shift was 2.25 in April 2024, indicating a slight decrease from March 2024 (2.27). EAs 2.37 jobs per shift, UCS crews 2.15 jobs per shift This is less than half of what would be ideal and a product of handover delays.

APPs attended on average 3.46 jobs per shift, and CHARU's 1.86 jobs per shift. The CHARU data is under review. See below.

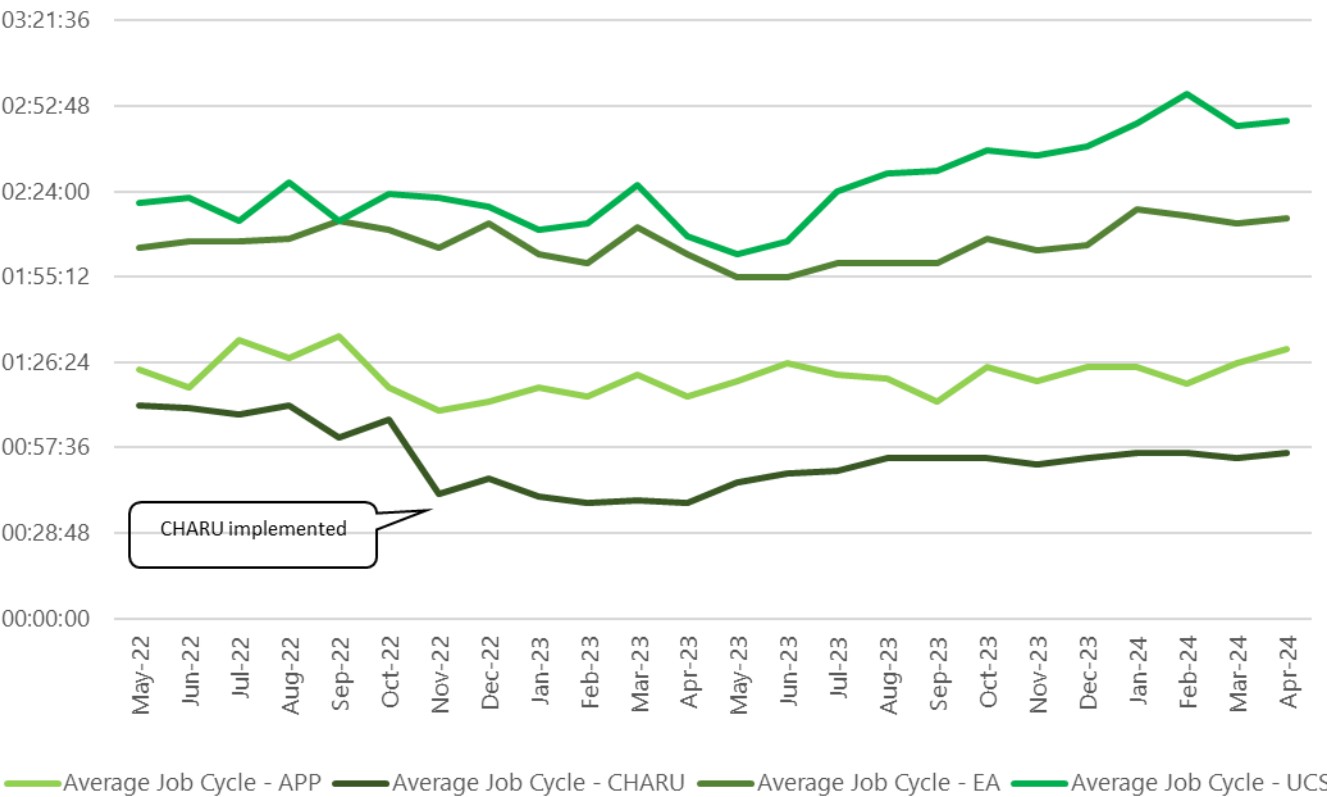
### Remedial Plans and Actions

EA and UCS jobs per shift is fundamentally a product of handover delays. For APPs, the newly created APP Recruitment Task & Finish Group will give a focus on further improvement, in particular, improved information and a re-roster. CHARU is a particular area of focus. Initial analysis indicates that CHARU contribution to Red compares favourably with the previous resource: RRVs. Further analytical work being undertaken.

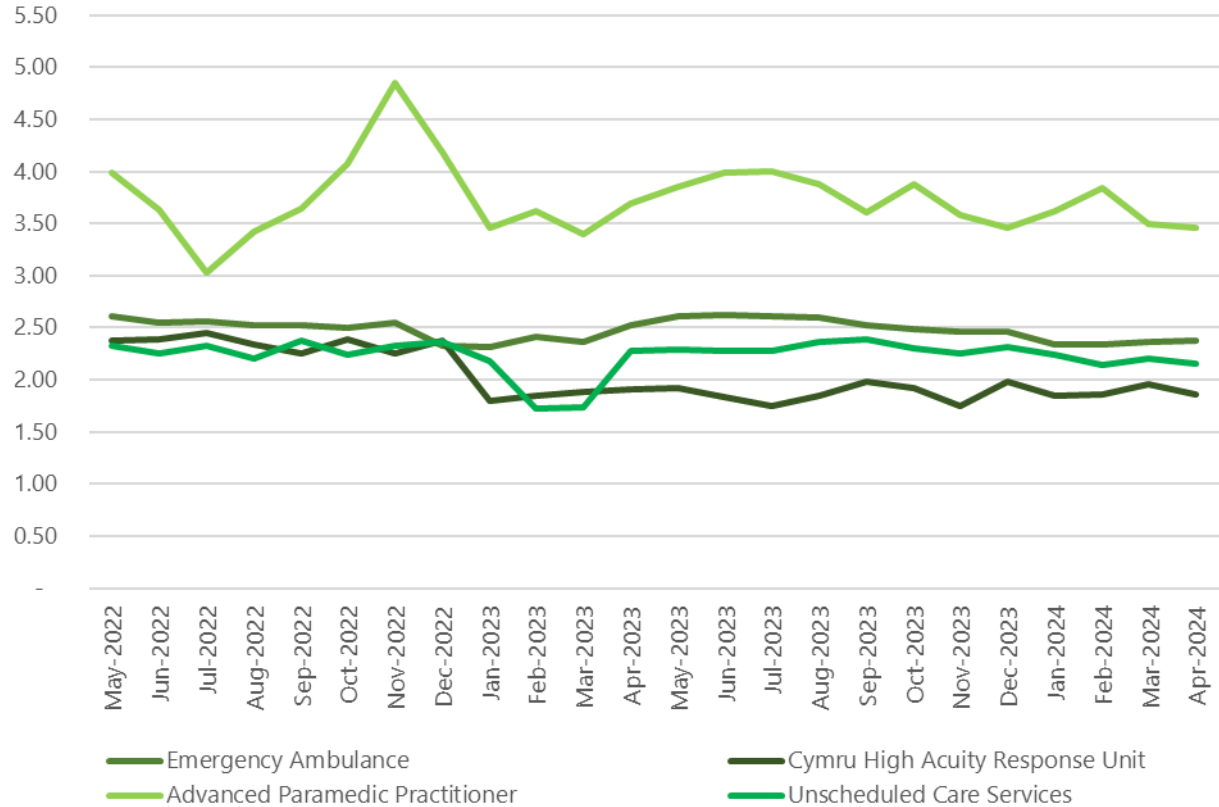
### Expected Performance Trajectory

The Trust ability to reduce the high utilisation rates for EA and UCS is a product of handover, which it does not control. The Trust would expect an increase in APP and CHARU utilisation during 2024/25 linked to the remedial actions identified above.

Average Job Cycle by Vehicle Type (EA, CHARU, APP & UCS)



Average Jobs per Shift by Vehicle Type (EA, CHARU, APP & UCS)

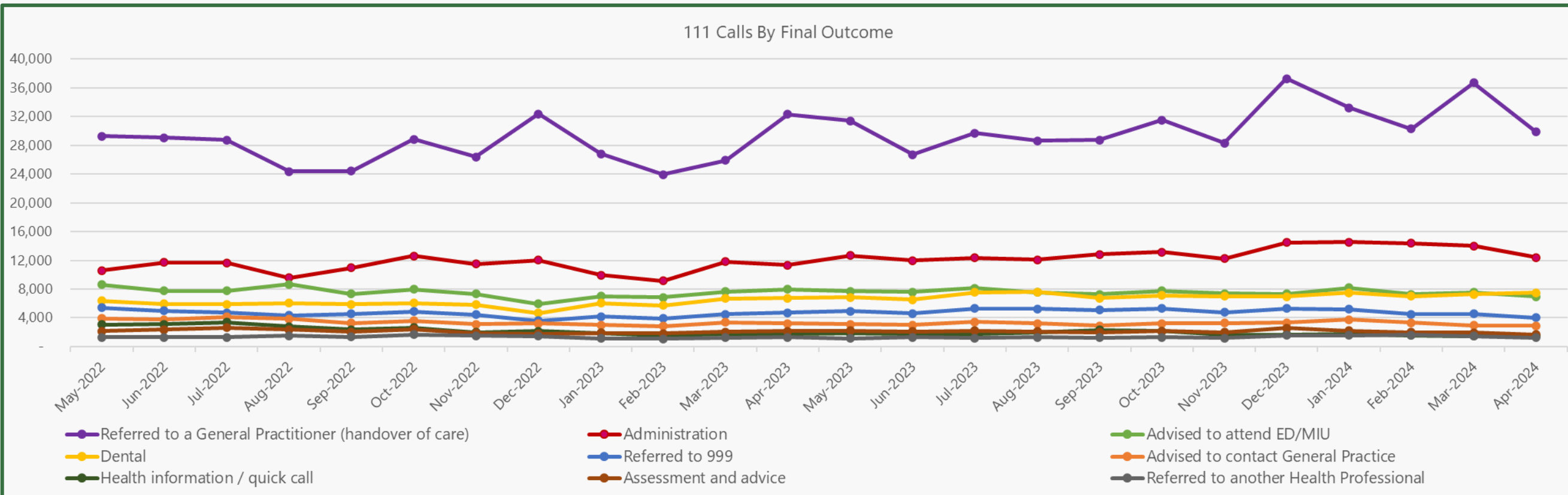


# Partnerships / System Contribution

## NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators

### Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)



**Analysis**  
During April 2024, 67,954 calls were received into the 9 categories displayed in the graph opposite, a decrease compared to the 77,865 received during March 2024.

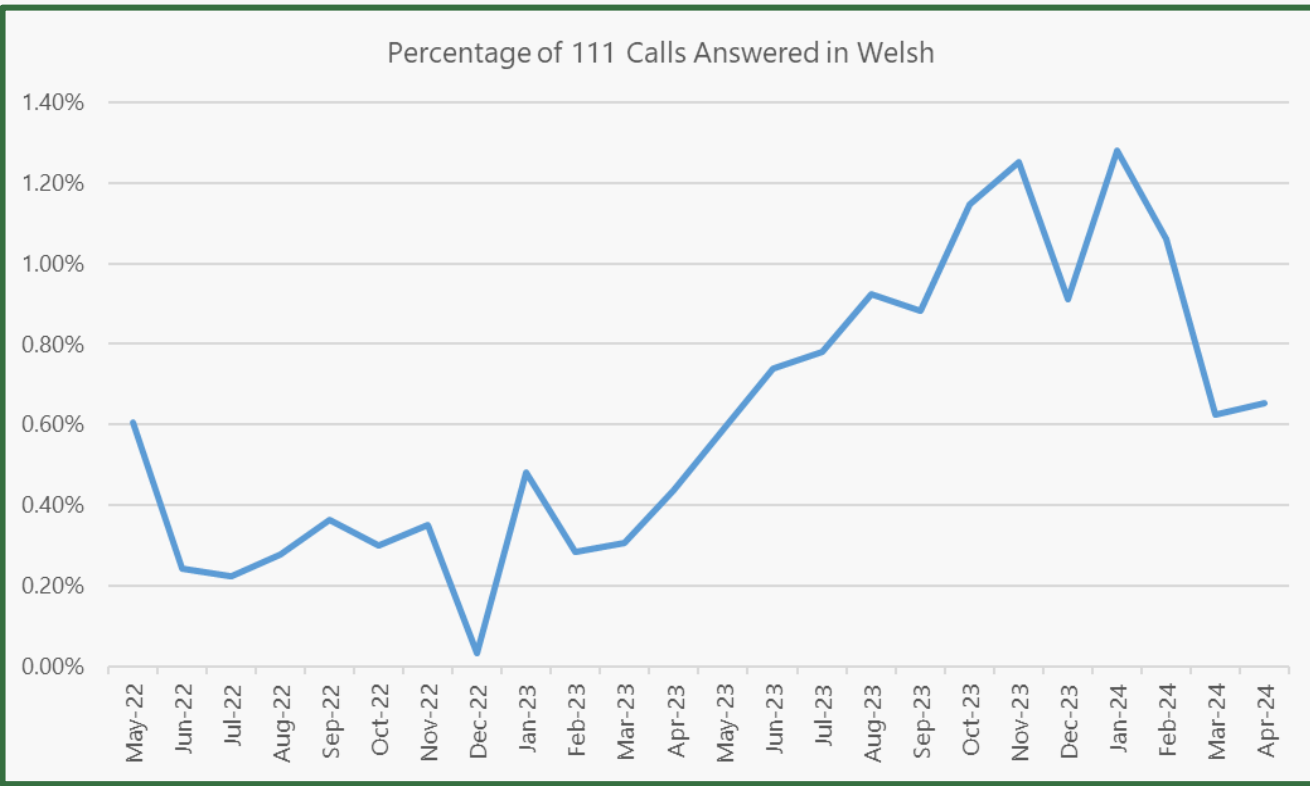
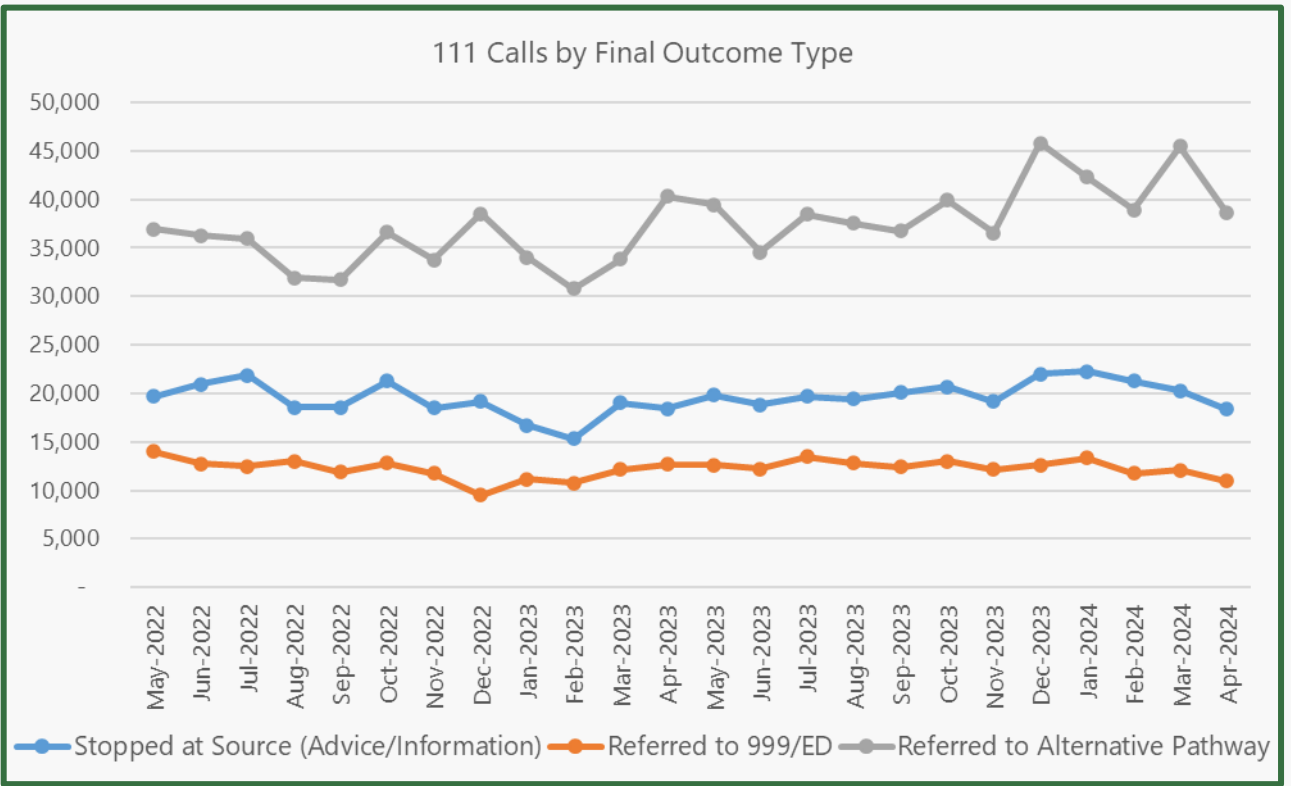
Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 43.93% of all calls during April 2024.

As the bottom left graph highlights, in April 2024, 18,382 calls into 111 were provided with information or advice, with no onward referral, a decrease from the 20,294 in March 2024, and a decrease from the 18,446 during April 2023.

The percentage of 111 calls answered in Welsh increased marginally from 0.63% in March 2024 to 0.65% in April 2024. This equated to only 30.2% of all 111 calls being offered in Welsh being answered, an increase from the 27.2% answered in March 2024.

**Remedial Plans and Actions**  
There is currently a 111 Measures Task and Finish Group. This is a collaborative meeting between WAST its commissioners and DCHW. The focus is the development of a nationally reportable 111 data set. Similar to what is currently in place for Ambulance Service Indicators (ASIs). Part of this work involves looking at the reporting of disposition final outcomes.

**Expected Performance Trajectory**  
No performance trajectory is set at this time, as the Trust develops measures and systems around these metrics. Once these have been developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.

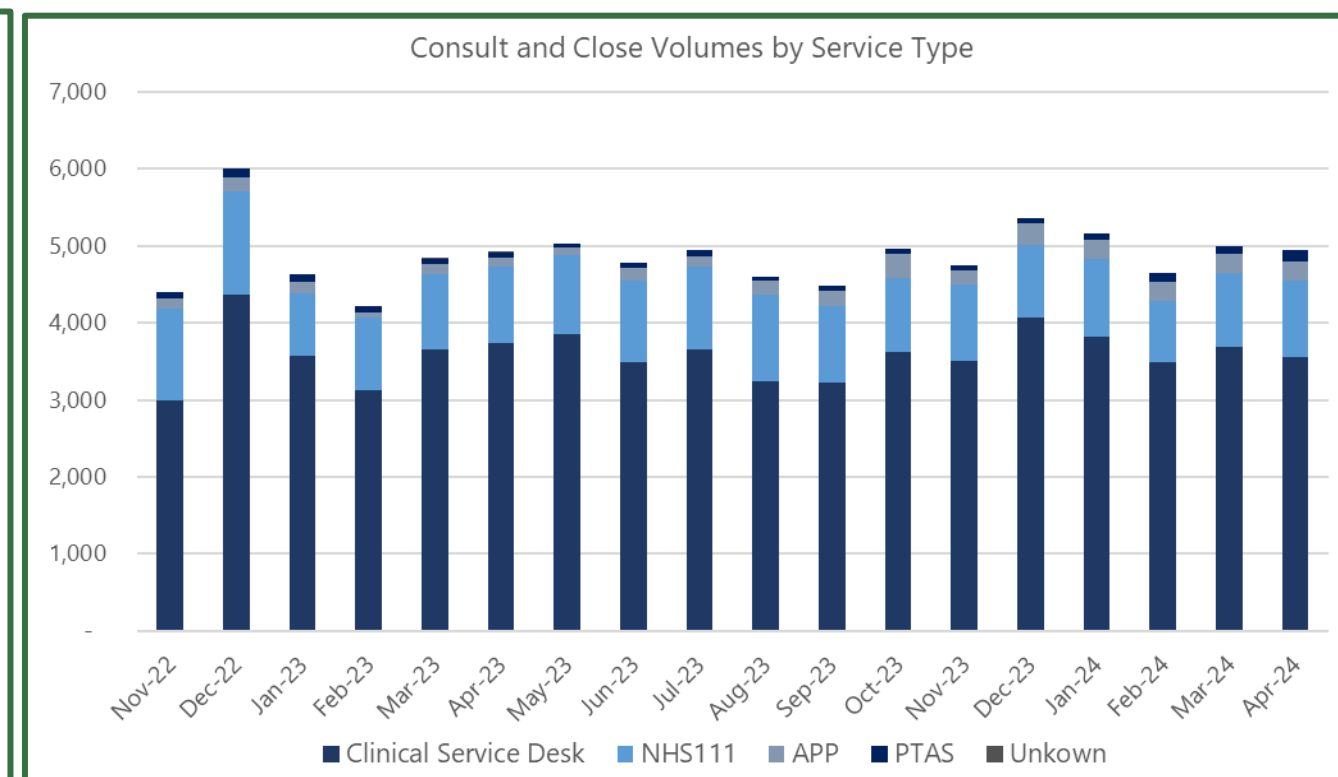
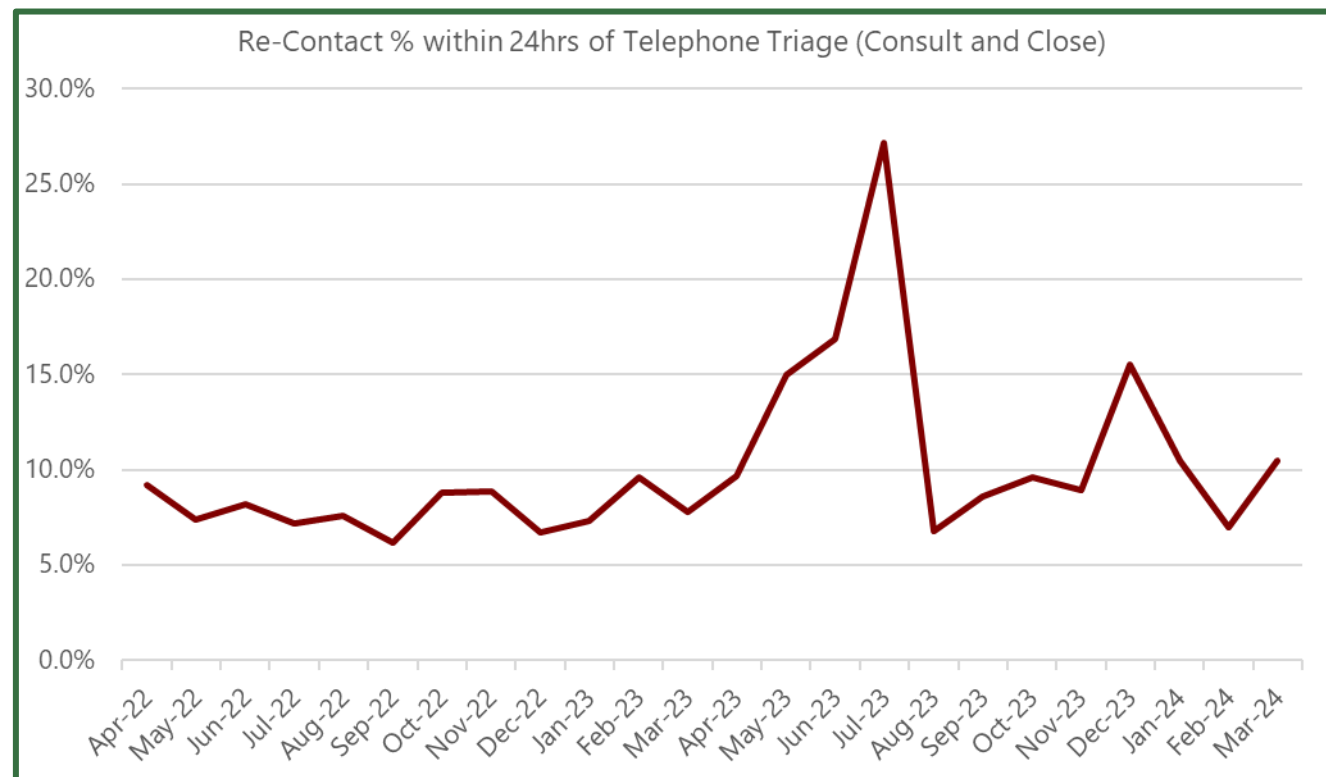
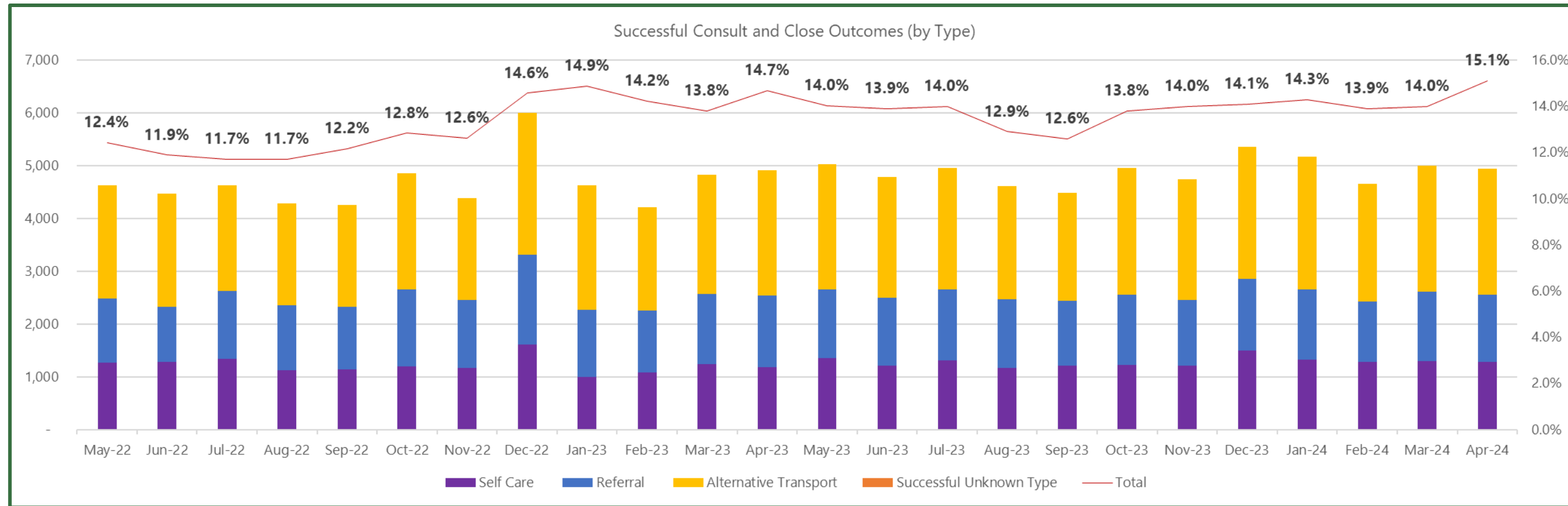


# Partnerships / System Contribution Consult & Close Indicators

(Responsible Officer: Lee Brooks)

C&C  
A

FPC



**Analysis**  
**Consult and Close**, with contributions from Clinical Service Desk (CSD) (10.8%), NHS111 (3%), WAST APP (0.8%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.4%) achieved 15% in April 2024, an increase of 1% compared to March 2024, however remaining short of the new 17% IMTP ambition. In April 2024, the number of 999 calls resulting in a Consult and Close outcome was 4,945, down from 4,992 in March 2024.

Of the calls successfully closed in April 2024, 1,277 patients received an outcome of self-care; 1,274 patients were referred to other services (including to Minor Injury Units and SDEC) and 2,396 were advised to seek alternative transport services to acquire treatment.

Re-contact rates in March 2024 were 10.5%, an increase on the 7% seen in February 2024.

**Remedial Plans and Actions**

- Work underway reviewing processes, has yielded efficiencies in remote clinical support which is recognised by those calling.
- Implementation of 15 recommendations from commissioner review.
- Progressing process with 111 to pass calls electronically from CSD, saving time.
- Recruitment of additional 23 FTEs for 24/25.
- Future Service Model transformation workshops arranged for early May.

**Expected Performance Trajectory**  
 Further improvement is expected linked to CSD staff attendance (reduced absences and less vacancies). The ambition remains 17%.

# Partnerships / System Contribution

## Conveyance to ED Indicators

(Responsible Officer: Andy Swinburn)

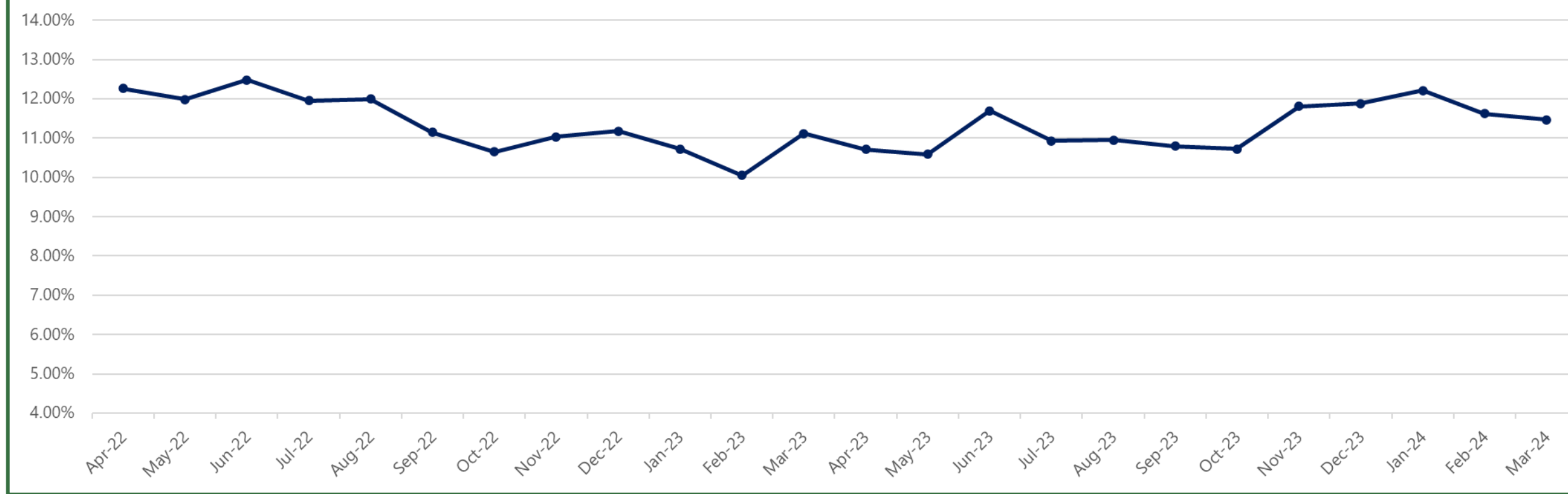
Conveyances

A

FPC

Ministerial Measure

% of Total Conveyances taken to a service other than a Type One Emergency Department



### Analysis

**In March 2024 11.46% of patients (1,646) were conveyed to a service other than a Type One ED, while 35.65% of patients were conveyed to a major ED, as a percentage of verified incidents.**

The combined number of incidents treated at scene or referred to alternate providers increased slightly, from 3,599 in February 2024 to 3,717 in March 2024.

APP conveyance rates increased slightly to 42.6% in March 2024, after experiencing a generally increasing trend since June 23.

Patients conveyed to SDEC's remained consistent at 0.15% in April 2024 and March 2024.

### Remedial Plans and Actions

Continued provision of information to external stakeholder about the effectiveness of SDECs.

Further investment in the APP workforce in 2024/25 (+32 APPs).

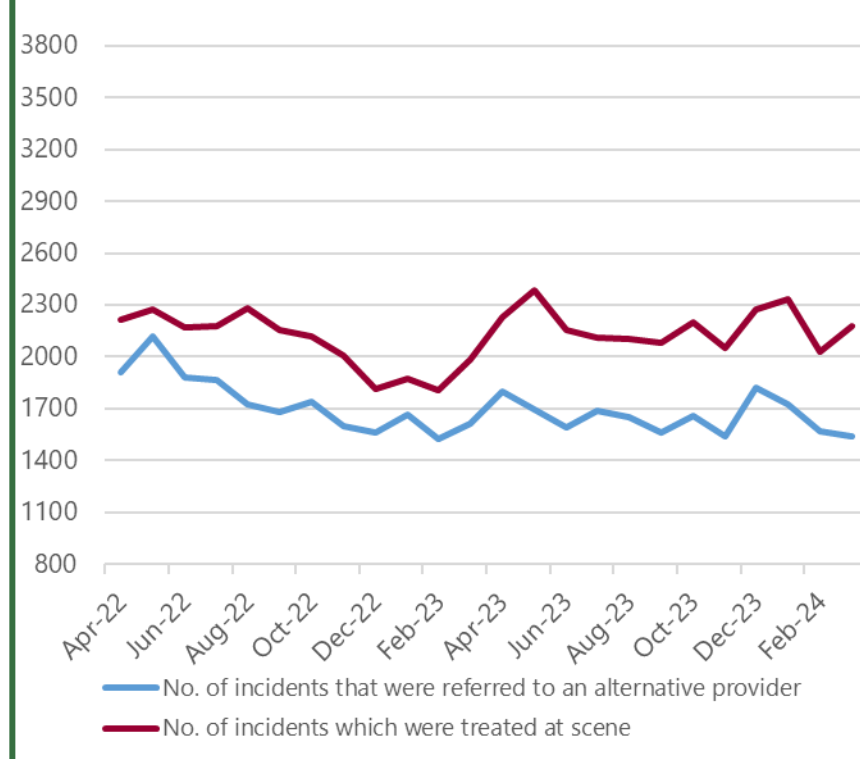
Establishment of APP Recruitment Task & Finish Group, with focus on re-rostering to demand keys, improved placement (training) experience, more certainty for TAPPs about where they will be located.

Review of performance systems for APPs to improve data quality.

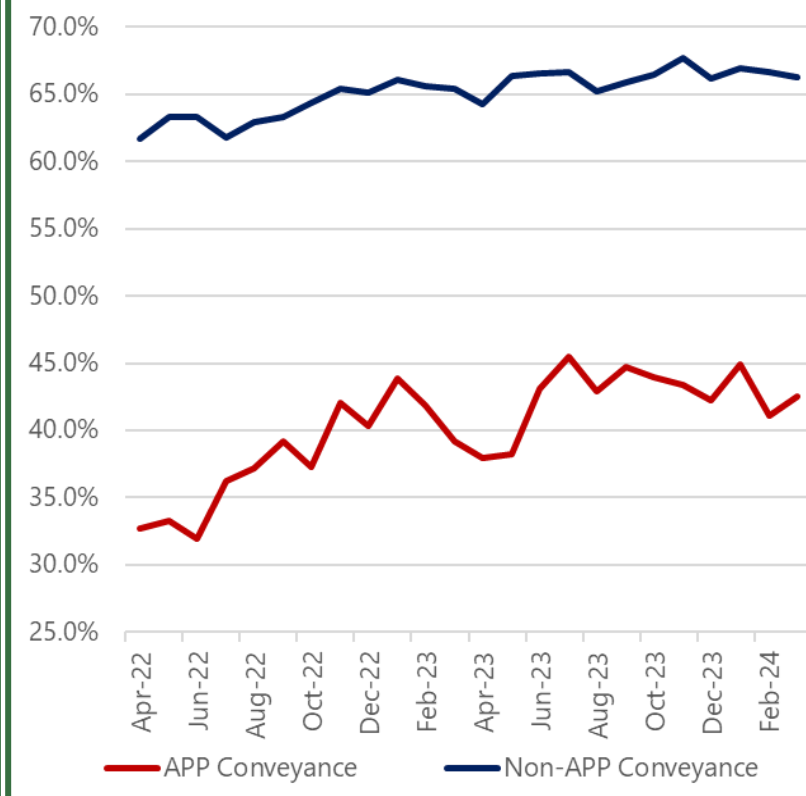
### Expected Performance Trajectory

The 2023 EMS Demand & Capacity Review (strategic) models various future states. The modelled scenarios indicate that the Trust will need to fully invert the triangle with health boards significantly reducing handover e.g. 12,000 hours or 7,000 hours, alongside varying levels of investment. Further in year tactical modelling for winter will be required to determine a performance trajectory for 2024/25. This cannot be undertaken at this point in the year.

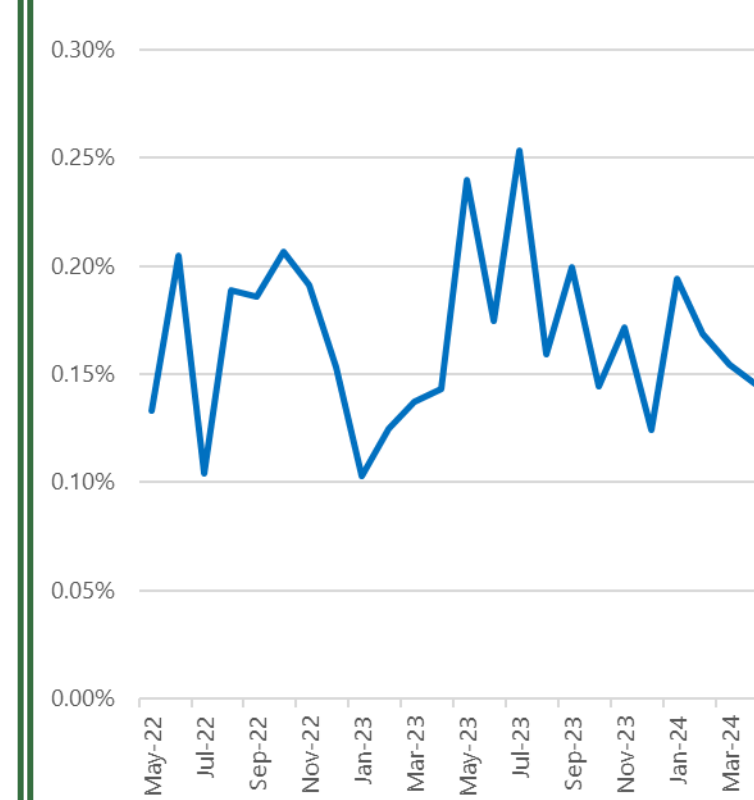
Incidents Treated at Scene VS Incidents Referred to Alternative Providers (Ambulances Stopped)



APP vs Non-APP Conveyance Rates



% Patients Conveyed to SDEC Units Pan-Wales



# Partnerships / System Contribution Handover Indicators

(Responsible Officer: Health Boards)

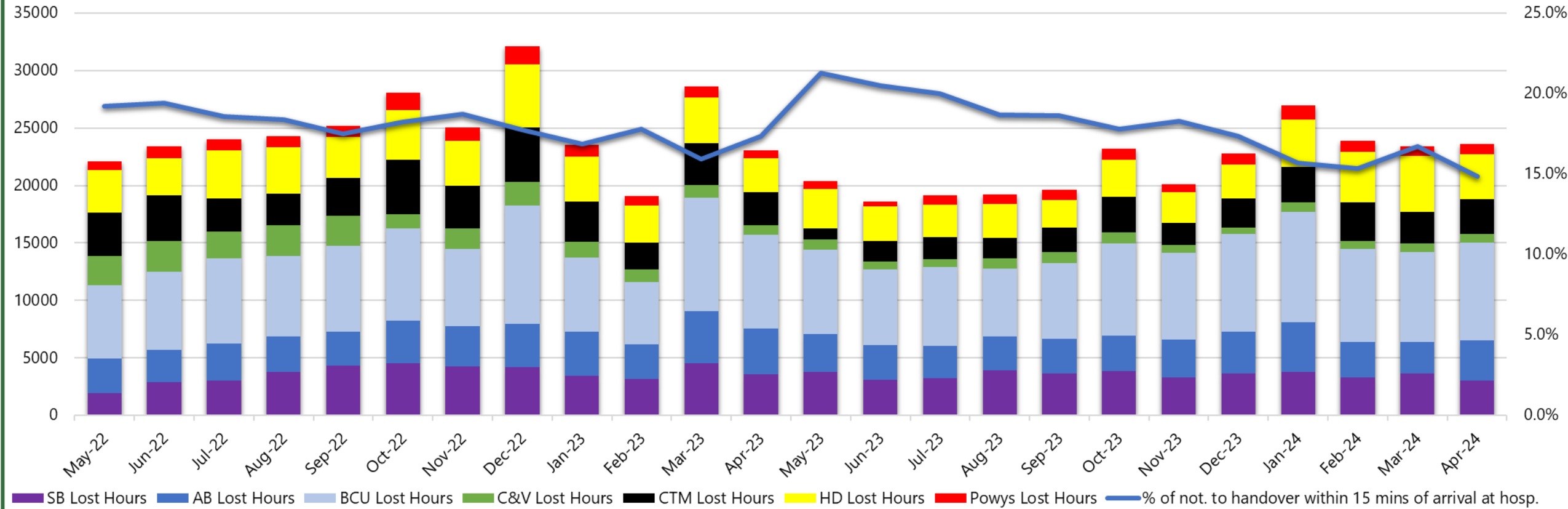
Lost Hours

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Notification to Handover Lost Hours by Health Board



## Analysis

**260,930 hours were lost to Notification to Handover, i.e., hospital handover delays, over the last 12 months (May-23 to Apr-24), compared to 299,336 over the same timeframe the previous year.** There were 23,614 hours lost in April 2024, a slight increase from the 23,403 lost in March 2024 (although over 1 less day). April 2024 levels were 532 hours above where they were during April 2023 (23,082).

The hospitals with the highest levels of handover delays during April 2024 were:

- The Grange University Hospital (ABUHB) at 3,361 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 3,056 lost hours
- Glan Clwyd Hospital (BCUHB) at 3,016 lost hours
- Morriston Hospital (SBUHB) at 2,889 lost hours
- Wrexham Maelor Hospital (BCUHB) at 2,196 lost hours

Notification to handover lost hours averaged 787 hours per day during April 2024 compared to 755 hours a day in March 2024.

In April 2024, the Trust could have responded to approximately 7,3449 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).

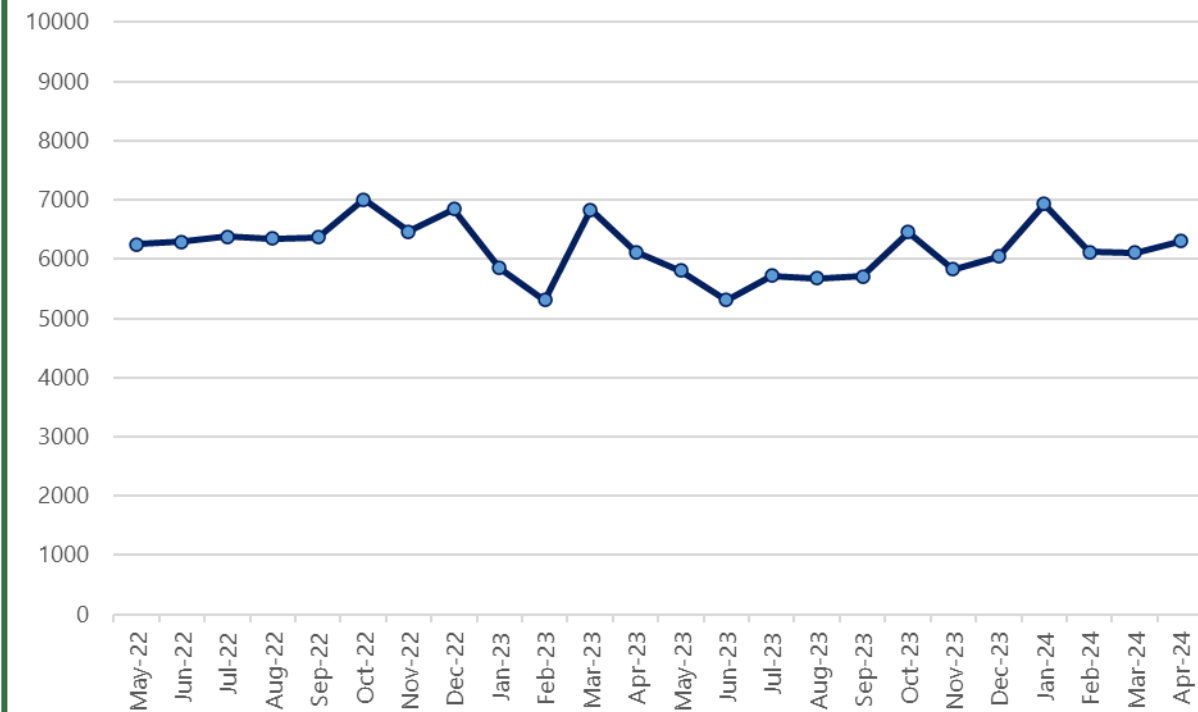
## Expected Performance Trajectory

The Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,000 hours lost to handover delay. There would need to be a 70% reduction in handover levels in 2024/25 for this to be achieved.

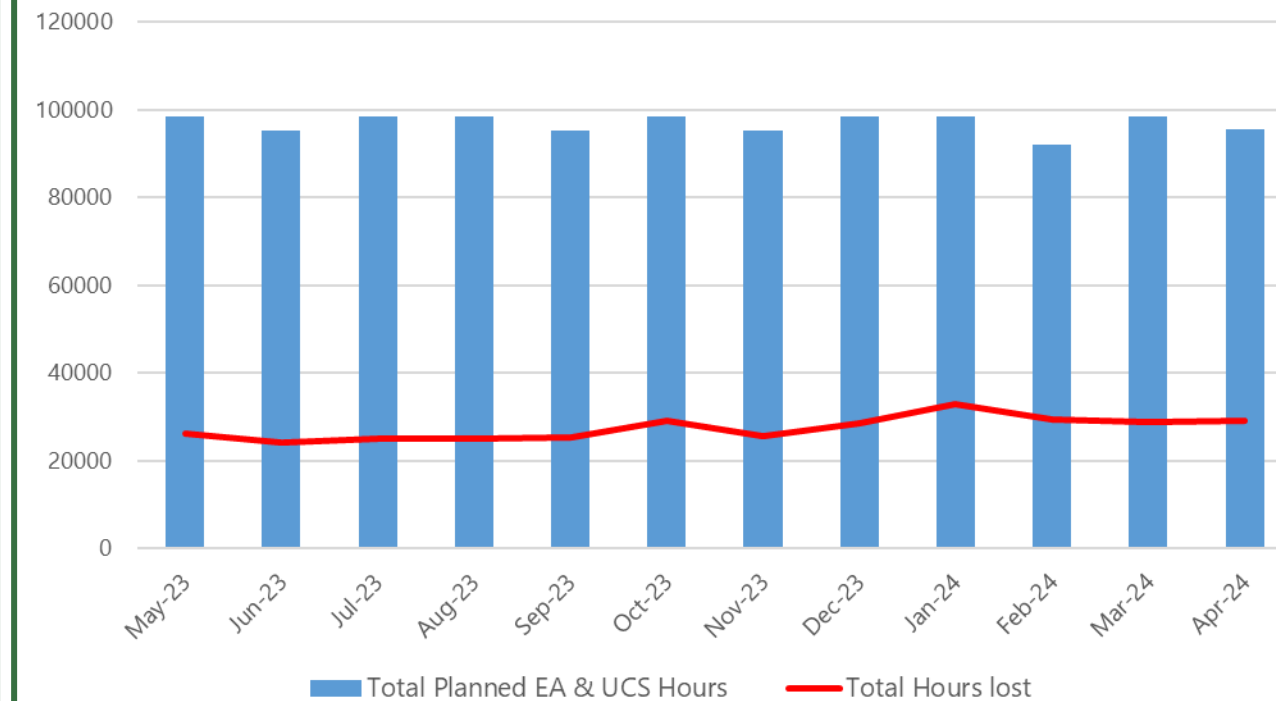
We may expect to see some further handover reduction in 2024/25, but achieving the one-hour Welsh Government target would require a massive improvement.

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

Handover Rates Over 1 Hour (including first 15 minutes)



Total Planned hours VS Total Hours Lost



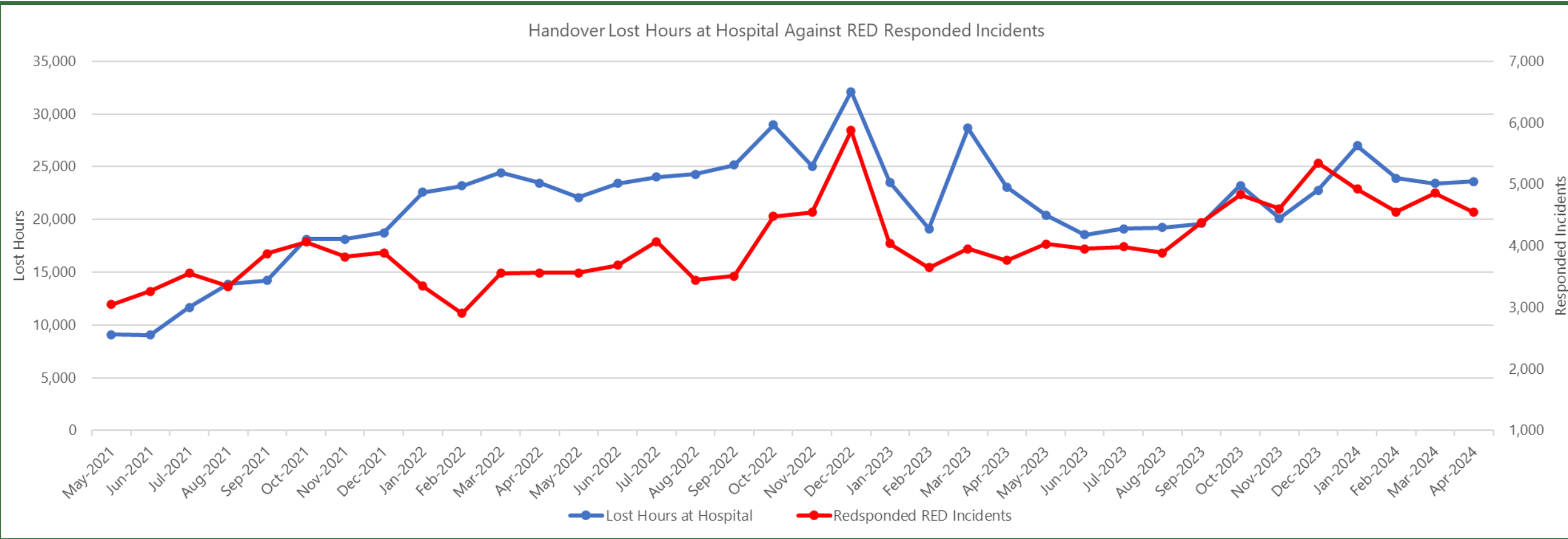
# Partnerships / System Contribution

## Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

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**Analysis**

The top graph highlights that as handover lost hours have increased since March 2021, so too have the number of Red incidents being responded to. This shows that when CSP is in periods of high demand and hospital handover increases, Red responses are protected, even during high pressure within the system.

However, as the bottom graph illustrates, as the response to Red increases, there is an impact on Amber 1 responses, particularly at times of high demand, such as during December 2022. During these periods, the number of Amber 1 incidents attended decreases, notwithstanding that some of these patients within the Amber 1 category will still be seriously ill, although during December 2023 Amber 1 responses also increased slightly when compared to November 2023.

The bottom graph also highlights that as lost hours have increased since mid-2021, so Amber 1 responses have declined, due to the increased system pressures. However, as lost hours reduced during the first half of 2023, so Amber 1 responses increased, from 10,326 in December 2022 to 13,055 in May 2023. Therefore, it was possible to see the reduction of pressure within the system and subsequent performance improvement through the Amber 1 metric.

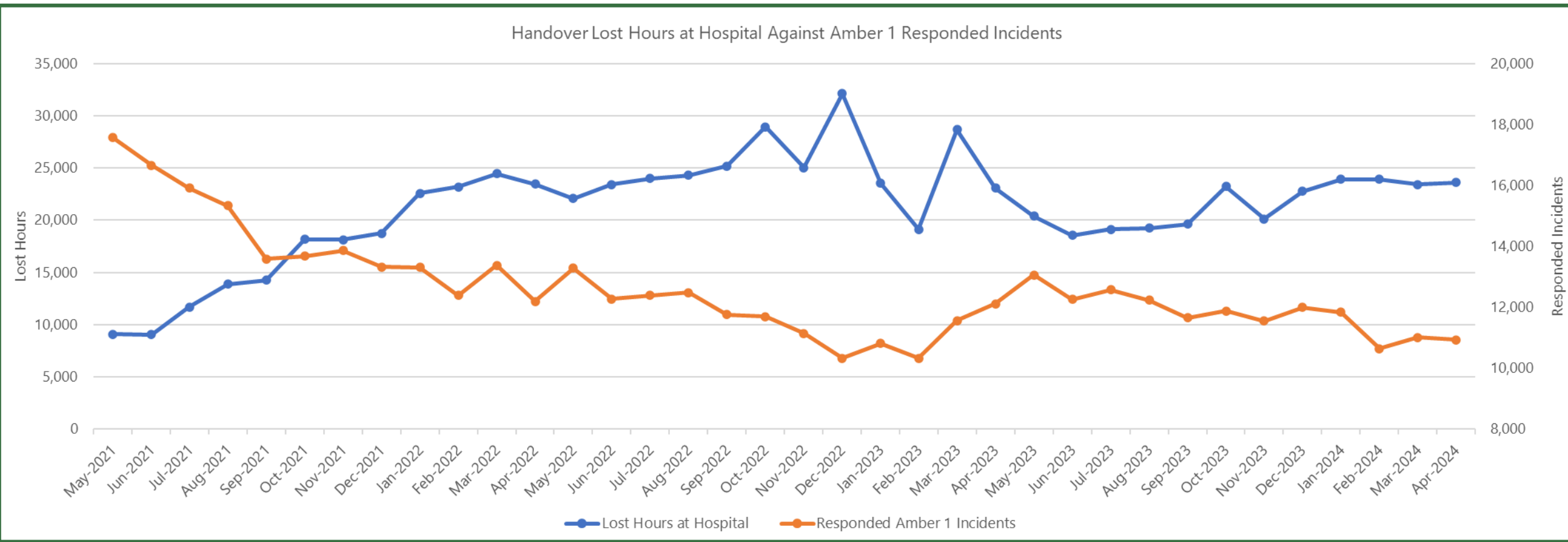
**Remedial Plans and Actions**

Significant time has been spent by all Executives and non-Executives highlighting this patient safety issue to EASC, Health Boards and to Welsh Government/Minister, and this will continue through the year as we seek to influence and put pressure on the system to improve.

**Expected Performance Trajectory**

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

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



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

# Definition of Indicators

Indicator	Definition	Indicator	Definition
<b>111 Abandoned Calls</b>	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	<b>Hours Produced for Emergency Ambulances</b>	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
<b>111 Patients Called back within 1 hours (P1)</b>	(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.	<b>Sickness Absence (all staff)</b>	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
<b>999 Call Answer Times 95<sup>th</sup> Percentile</b>	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.	<b>Frontline COVID-19 Vaccination Rates</b>	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
<b>999 Red Response within 8 Minutes</b>	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	<b>Statutory and Mandatory Training</b>	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).
<b>Red 95<sup>th</sup> Percentile</b>	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).	<b>PADR/Medical Appraisal</b>	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.
<b>999 Amber 1 95<sup>th</sup> Percentile</b>	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).	<b>Ambulance Response FTEs in Post</b>	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
<b>Return of Spontaneous Circulation (ROSC)</b>	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.	<b>Ambulance Care, Integrated Care, Resourcing &amp; EMS Coordination FTEs in Post</b>	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
<b>Stroke Patients with Appropriate Care</b>	Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of care that have a greater effect on patient outcomes if done together in a time-limited way, rather than separately).	<b>Financial Balance – Annual Expenditure YTD as % of budget Expenditure</b>	Annual expenditure (Year to Date) as a proportion of budget expenditure.
<b>Acute Coronary Syndrome Patients with Appropriate Care</b>	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.		
<b>Renal Journeys arriving within 30 minutes of their appointment (NEPTS)</b>	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	<b>111 Consult and Close</b>	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.
<b>Discharge &amp; Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)</b>	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	<b>999 / 111 Hear and Treat</b>	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.
<b>National reportable Incidents (NRI)</b>	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.	<b>% Incidents Conveyed to Major EDs</b>	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).
<b>Concerns Response within 30 Days</b>	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	<b>Number of Handover Lost hours</b>	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.
<b>EMS Abstraction Rate</b>	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.	<b>Immediate Release requests</b>	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

<b>AGENDA ITEM No</b>	<b>18</b>
<b>OPEN or CLOSED</b>	<b>Open</b>
<b>No of ANNEXES ATTACHED</b>	<b>4</b>

<b>RISK MANAGEMENT &amp; BOARD ASSURANCE FRAMEWORK REPORT</b>
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<b>MEETING</b>	Finance & Performance Committee
<b>DATE</b>	14 <sup>th</sup> May 2024
<b>EXECUTIVE</b>	Trish Mills, Director of Governance / Board Secretary
<b>AUTHOR</b>	Julie Boalch, Head of Risk/Deputy Board Secretary
<b>CONTACT</b>	<a href="mailto:Julie.Boalch@wales.nhs.uk">Julie.Boalch@wales.nhs.uk</a>

<b>EXECUTIVE SUMMARY</b>
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1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically the 8 risks that are relevant to Committee's remit for oversight and additionally the Trust's 2 highest scoring risks which are assigned to the Quality, Safety & Patient Experience Committee (QuEST) for oversight.
2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF) in Annex 4.
3. The more detailed description contained within the BAF provides the Committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the frameworks in Annex 2 of the report.
4. Each of the principal risks were presented to the Trust Board on 28<sup>th</sup> March 2024 and are updated as at 7<sup>th</sup> February 2024 These high rated risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3 and the results of this review will be presented to Trust Board on 30 May 2024.
5. Updates are highlighted in blue on the BAF which show changes to the narrative, mitigating actions, controls, and assurances.
6. The focus for the forthcoming round of reviews will predominantly be in relation to the mitigating actions identified and taken to support risks to achieve their target score.
7. The Trust's highest rated **Risks 223** *the Trust's inability to reach patients in the community causing patient harm and death*) and **Risk 224** *(Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for*

*patients, scoring 25, remain unchanged because of sustained and extreme pressure across the Welsh NHS urgent and emergency care system which is negatively impacting on patient flow leading to avoidable patient harm and death. These risks continue to be closely monitored by management, Board Committees, and at the Trust Board meetings as well as internal forums.*

8. As reported to the March 2024 Trust Board, whilst good progress has been made on the actions that the Trust can control, the extreme pressure continues. As a result, the likelihood is that the levels of avoidable harm will continue. That does not mean that the Trust is not continually seeking additional actions to mitigate these risks and the actions are articulated in the avoidable harm paper that the Board receive at each meeting.
9. Several updates have been made to the controls and assurances in relation to Risk 223 and 224 during this period and these are highlighted on the BAF to address gaps in assurance. These two risks have been reviewed closely in conjunction with each other to ensure the synergy between them both and that they reflect the actions from the avoidable harm paper in the same way.
10. Additionally, these risks will be considered further as to how the Trust can approach them by applying the risk appetite methodology as part of the Risk Management Improvement Programme and the most efficient and effective way of managing them internally.
11. Whilst both risks remain static at the highest score of 25, it is anticipated that this will be the case for the foreseeable future as long as the Trust is in a position where it is highly likely to have an incidence of premature death or avoidable harm because of being unable to respond in a way that it would wish to. The score is not based on the volume of cases of catastrophic harm, it is based on any one individual that experiences avoidable harm. The quality dimension of each of these risks will always be a challenging one to reduce whilst patients and the Trust are experiencing delays in the way in which they currently are.
12. These risks will be considered further as to how the Trust can approach them by applying the risk appetite methodology as part of the Risk Management Improvement Programme and the most efficient and effective way of managing them internally given that their score has remained catastrophic over a significant period of time.
13. It is foreshadowed that there will be a number of changes to the CRR and risks under FPCs remit that are currently navigating the Trust's governance processes in readiness for the Trust Board on 30 May 2024 – these include:
  - 13.1. **Risk 542** Decarbonisation Risk will be included on the CRR at a score of 16 (4x4).
  - 13.2. **Risk 458** will be closed from the CRR on the basis that this was specifically in relation to the 100 and the overlap with Risks 424 and 139.

<p>13.3. <b>Risk 283</b> will be de-escalated from the CRR to the Directorate Risk Register as the actions have been completed and the risk mitigated to the target of 8 (2x4) from 12 (3x4).</p> <p>13.4. A new <b>Risk 623</b> will be included on the CRR in relation to Data Protection Legislation scoring 15 (3x5).</p> <p>14. A detailed review, discussion and challenge takes place with the Executive Leadership Team (ELT) and Assistant Director Leadership Team (ADLT) on each of these risks monthly including new risks, changes to scores and those that have achieved target.</p> <p><b>RECOMMENDATION:</b></p> <p>15. <b>Members are asked to consider the contents of the report.</b></p>
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<b>KEY ISSUES/IMPLICATIONS</b>
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16. The key issues are set out in the Executive Summary above.
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<b>REPORT APPROVAL ROUTE</b>
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<p>17. The BAF was considered by:</p> <ul style="list-style-type: none"> <li>• ADLT (05 February 2024)</li> <li>• ELT (07 February 2024)</li> <li>• Trust Board (28 March 2024)</li> </ul>
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<b>REPORT ANNEXES</b>
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| <ul style="list-style-type: none"> <li>• Annex 1 - Summary table describing the Trust’s Corporate Risks.</li> <li>• Annex 2 – Scoring Matrix</li> <li>• Annex 3 – Frequency of Risk review</li> <li>• Annex 4 - Board Assurance Framework</li> </ul> |
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<b>REPORT CHECKLIST</b>
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<b>Confirm that the issues below have been considered and addressed</b>		<b>Confirm that the issues below have been considered and addressed</b>	
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**

<b>CORPORATE RISK REGISTER</b>				
<b>RISK ID</b>	<b>NEW RISK TITLE</b>	<b>NEW SUMMARY DESCRIPTION</b>	<b>EXECUTIVE OWNER</b>	<b>RISK SCORE</b>
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	<p><b>IF</b> significant internal and external system pressures continue</p> <p><b>THEN</b> there is a risk of an inability and/or a delay in ambulances reaching patients in the community</p> <p><b>RESULTING IN</b> patient harm and death</p>	Director of Operations	<p><b>25</b> <b>(5x5)</b></p> 
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	<p><b>IF</b> patients are significantly delayed in ambulances outside A&amp;E departments</p> <p><b>THEN</b> there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised</p> <p><b>RESULTING IN</b> patients potentially coming to harm and a poor patient experience</p>	Director of Quality & Nursing	<p><b>25</b> <b>(5x5)</b></p> 
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	<p><b>IF</b> a major incident or mass casualty incident is declared</p> <p><b>THEN</b> 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</p> <p><b>RESULTING IN</b> catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.</p>	Director of Operations	<p><b>20</b> <b>(4x5)</b></p> 
424 FPC	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's	<p><b>IF</b> resources are not forthcoming within the funding envelope available to WAST (link to risk 139)</p>	Director of Strategy Planning and Performance	<p><b>16</b> <b>(4x4)</b></p> 


## CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
	Integrated Medium-Term Plan (IMTP)	<p><b>THEN</b> there is a risk that there is insufficient capacity to deliver the IMTP</p> <p><b>RESULTING IN</b> 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</p>		
458 FPC	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	<p><b>IF</b> 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</p> <p><b>THEN</b> 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.</p> <p><b>RESULTING IN</b> patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage.</p>	Director of Finance & Corporate Resources	<p><b>16</b> <b>(4x4)</b></p>
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	<p><b>IF</b> 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</p> <p><b>THEN</b> there is a risk of a significant information security incident</p>	Director of Digital Services	<p><b>15</b> <b>(3x5)</b></p>

## CORPORATE RISK REGISTER

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

## CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		<b>RESULTING IN</b> potential patient harm, deterioration in staff wellbeing and reputational damage		
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation	<p><b>IF</b> the Trust does:</p> <ul style="list-style-type: none"> <li>• not achieve financial breakeven and/or</li> <li>• does not meet the planning framework requirements and/or</li> <li>• does not work within the EFL and/or</li> <li>• fails to meet the 95% PSPP target and/or</li> <li>• does not receive an agreement with commissioners on funding (linked to 458)</li> </ul> <p><b>THEN</b> 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)</p> <p><b>RESULTING IN</b> potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage</p>	Director of Finance & Corporate Resources	<p><b>8</b> <b>(2x4)</b></p> 

## Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	Catastrophic
<b>Safety &amp; Well-being - Patients/ Staff/Public</b>	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.	Moderate 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.
<b>Quality/ Complaints/ Assurance/ Patient Outcomes</b>	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.
<b>Workforce/ Organisational Development/ Staffing/ Competence</b>	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.
<b>Statutory Duty, Regulation, Mandatory Requirements</b>	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.
<b>Adverse Publicity or Reputation</b>	Rumours. Low level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public 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.
<b>Business Objectives or Projects</b>	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.
<b>Financial Stability &amp; Impact of Litigation</b>	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.
<b>Service/ Business Interruption</b>	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.
<b>Environment/Estate/ Infrastructure</b>	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.
<b>Health Inequalities/ Equity</b>	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	Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

### Annex 3 - Frequency of Risk Review

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

Annex 4 – Board Assurance Framework

<b>Risk ID</b> 223	<b>The Trust's inability to reach patients in the community causing patient harm and death</b>			<b>Date of Review:</b>	17/01/2024	<b>TREND</b>	25 (5x5)
				<b>Date of Next Review:</b>	14/02/2024		
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		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>	
			<b>Inherent</b>	4	5	20	
			<b>Current</b>	5	5	25	
			<b>Target</b>	2	5	10	
IMTP Deliverable Numbers:							
<b>EXECUTIVE OWNER</b>		Director of Operations	<b>ASSURANCE COMMITTEE</b>		Quality, Safety and Patient Experience Committee		
<b>Risk Commentary Q3 2023/24</b>							
<p>The risk score remains constant at 25 (almost certain &amp; catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death because of the Trust not being able to reach patients in the community. <b>The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust has received 6 reports since April 2023, including 1 report in quarter 3 2023/4. 5 of these reports directly relate to system pressures with the coroners raising concerns about delays in responding to patients in the community and handover of care delays at emergency departments.</b> In November 2023, over 20,126 hours were lost and 22,756 in December 2023. Only Cardiff &amp; Vale University Health Board has demonstrated material improvement and is a positive outlier. The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.</p>							
Improvement actions led by Welsh Government and system partners include: -							
<ul style="list-style-type: none"> <li>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)</li> <li>b) Consideration of additional WAST schemes to support risk mitigation through winter (I)</li> <li>c) NHS Wales reduces emergency department handover lost hours by 25% (E)</li> <li>d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E)</li> <li>e) Alternative capacity equivalent to 1000 beds (E)</li> <li>f) Implement nationwide approach to emergency department 'Fit 2 Sit' (E)</li> <li>g) Implementation of Same Day Emergency Care services in each Health Board (E)</li> <li>h) National Six Goals programme for Urgent and Emergency Car (E)</li> </ul>							
<b>CONTROLS</b>				<b>ASSURANCES</b>			
				<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. Regional Escalation Protocol				1. Daily conference calls to agree RE levels in conjunction with Health Boards			
2. Immediate release protocol				2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)			
3. Resource Escalation Action Plan (REAP)				3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP <b>has undergone an</b> annual review with v4.1 released <b>in November 2023.</b>			
4. 24/7 Operational Delivery Unit (ODU)				4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.			
5. Strategic, Tactical and Operational 24 hour/ 7 day per week system to manage escalation plans				5. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required. On Call cover is reviewed weekly at SLT Performance Meetings.			
6. Limited Alternative Care Pathways in place				6. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.			
7. Consult and Close (previously Hear and Treat)				7. The Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Reported through integrated quality meeting. <b>Whilst Consult and Close is in place, the action to increase compliance is detailed in action 10.</b>			

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death		Date of Review:	17/01/2024		TREND	25 (5x5)
			Date of Next Review:	14/02/2024		→	
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	
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation		8. WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.					
9. Clinical Safety Plan		9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group. <b>In December 2023, Version 2.21 of the Clinical Safety Plan was released. The subsequent reduction in the demand is the assurance which is dynamically monitored via ODU.</b>					
10. Recruitment and deployment of CFRs		10. CFR numbers have grown during 2022/23 which alongside a cleanse of the volunteer database has realised 500 current active volunteers with an ambition to recruit a further 100 by end of Q4. Response data indicates that our CFRs are reaching more patients, especially those with life threatening conditions in 8 minutes compared to this time last year. Numbers of CFR's, percentage of contribution to performance a governance framework is in place. Monitoring through AD 1:1's and volunteer highlight report (IMTP).					
11. ETA scripting		11. The ETA Dashboard is a tactic that was signed off by ELT. The dashboard supports scripting analysed by comparing with real time data. ETA performance is reviewed weekly at SLT weekly performance meeting. The effect of the ETA scripting results in cancellations of ambulances which is monitored through algorithmic review process.					
12. Clinical Contact Centre (CCC) emergency rule		12. Emergency Rule is incorporated into CSP 999 levels.					
13. National Risk Huddle		13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.					
14. Summer/Winter initiatives		14. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24.					
15. CHARU implementation		15. Recruitment of 153 WTE has continued; To lift further, a trial of a rotational model is due to be trialled in Aneurin Bevan Health Board area.					
16. Clinical Model and clinical review of code sets		16. Reported through CPAS and DCR Review reporting through CQGG					
17. Remote clinical support enabling discharge at scene		17. Strategic Transformation Board – IMTP deliverable; Providing support to the Community Welfare Responders (CWR) initiative and supporting CFRs to discharge at scene with current non conveyance rates for CFRs in excess of 40%					
18. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)		18. Formally documented action plan – actions captured are contained within and monitored via the Mitigating avoidable harm paper from PIP.					
19. Information sharing		19. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.					
20. Completed EMS Roster Review		20. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner. Monitor production against the rosters weekly at performance meeting and that provides a level of UHP as a percentage.					
21. Delivered a reduction in the number of multiple <b>vehicle</b> attendances dispatched to red calls		21. This will increase vehicle availability generally across the Trust and is monitored through SLT weekly performance meeting.					
22. Transfer of Care		22. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently, work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief					
23. <b>Virtual Ward – Connect Support Cymru</b>		23. Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD					

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			Inherent	4	5	20	
			Current	5	5	25	
			Target	2	5	10	
		capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers.					
24. ARA – Acute Release Area - GUH		24. Live until 31 <sup>st</sup> March 2024					
25. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents. 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.		25. 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.					
26. 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.		27. 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.					
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>					
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system		1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morrison hospital has increased focus on handover delays with external partners and across the media. Some plans are in train (detailed in actions) following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.					
2. Blockages in system e.g., internal capacity within Health Boards which affect patient flow							
3. Local delivery units mirroring WAST ODU							
4. Handover delays link to risk 224							
5. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 12 months there is a low confidence in attaining this.		The majority of Health Boards have failed to deliver on this ambition; With the exception of Cardiff and Vale University Health Board, the remaining 5 Health Boards with acute Trusts that were required to deliver on this target, have failed to do so.					
6. Handover Improvement Plans agreed between WAST and Health Boards		12. Handover Improvement Plans have been replaced by Integrated Commissioning Action Plans (ICAPS) and are subject to review with EASC; However, it is noted that previous plans did not demonstrate sufficient improvement in reducing handover delays (see above)					
18. Access to Same Day Emergency Care (SDEC) for paramedic referrals		18. This forms part of the handover improvement plans in place with Health Boards; however, assurance is limited given that the uptake is low (less than 1% of total demand). There is an inconsistency in approach from Health Boards on eligibility and availability; The national Once for Wales acceptance criteria has not been uniformly deployed by Health Bards across Wales.					
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST							
<b>Actions to reduce risk score or address gaps in controls and assurances</b>		<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>			
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	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)			

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			Inherent	4	5	20	
			Current	5	5	25	
			Target	2	5	10	
		Operations – National Operations & Support					
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)		ADLT Sub-Group	30.09.22 - Superseded				
3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]		Director of Paramedicine / Director of People & Culture	Extended to March 2024				WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
4. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]			Superseded				
5. 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.
6. New 2023 EMS Demand and Capacity (roster) review		Assistant Director of Planning & Performance	March 2024				ORH modelling underway. Initial findings January 2024, full report to Trust Board and EASC in March
7. Swansea Bay Winter actions		Assistant Director of Operations, EMS	December 2023				Some plans are in train following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.
8. Mental Health response pilot		Assistant Director of Operations, EMS	Not yet Active.				Pilot to commence in Aneurin Bevan Health Board area Nov 2023
9. Connected Support Cymru – is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.		Assistant Director of Quality Governance					Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. Phase 1 delivered through St John Ambulance Cymru, <b>with further funding by the commissioner for a further phase via SJAC.</b> Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers.
10. Maximise the opportunity from Consult and Close – stretch to 17%							Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. <b>Consult and Close compliance remains around 14%. Action plan activities<sup>13</sup> therefore continue with a review of triage processes which may lead</b>

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			Inherent	4	5	20	
			Current	5	5	25	
			Target	2	5	10	
				to shorter triage durations, along with increase in staffing, which together will enable more triages to take place, thus increasing the percentage of consult and close to 17%.			
11. Development of new model of care		Head of Strategy Development	2024/25	Development of the model remains ongoing			
12. Development of the pathway which connects mental health users connecting via the 999 system to 111 Press 2 services		Assistant Director of Operations, Integrated Care	March 2024	Development of the model remains ongoing			
13. Palliative Care Paramedic Unit		Assistant Director of Operations	January 2024	Reducing demand via APPs – 15 <sup>th</sup> January Start.			
14. 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 2023-2024	<ul style="list-style-type: none"> <li>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)</li> <li>WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities.</li> <li>Expected outcomes in 2023/24.</li> </ul>			
15. Winter Ambulance Handover Improvement Plan Meetings		Executive Director of Operations	February 2024 (six weeks duration)	<ul style="list-style-type: none"> <li>Weekly meetings set up with Welsh Government, NHS Executive, CASC and the Health Board COOs. All parties (including WAST) to provide updates on actions being taken to alleviate and improve handover delays. WAST to update on C&amp;C, CWR, red dispatch and local updates from EMS HOS on initiatives.</li> </ul>			

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:	17/01/2024	TREND	25 (5x5)
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			Target	3	2	6	
IMTP Deliverable Numbers:							
EXECUTIVE OWNER		Director of Quality & Nursing		ASSURANCE COMMITTEE		Quality, Safety and Patient Experience Committee	
<b>Risk Commentary Q3 2023/24</b>							
<p>The risk score remains constant at 25 for quarter 3 2023/24 (almost certain &amp; catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. <b>There were 1,888 patient handovers in October 2023 which were over 4 hours.</b> The target was originally to have zero by September 2022. <b>In November 2023 over 20,126 hours were lost and 22,756 were lost in December 2023</b> Cardiff &amp; Vale University Health Board has demonstrated material improvement and is a positive outlier. The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the main focus of patient safety incidents, complaints, coronial enquires and redress / claims. <b>The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust has received 6 reports since April 2023, including 1 report in quarter 3 2023/4. 5 of these reports directly relate to system pressures with the coroners raising concerns about delays in responding to patients in the community and handover of care delays at emergency departments.</b> 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 &amp; Management (May 2023). Themes from system partners following review of incidents remains the consequences of high escalation levels in acute care and crowded emergency departments.</p> <p>Improvement actions led by Welsh Government and system partners include:</p> <ol style="list-style-type: none"> <li>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) <b>by the end of April 2025</b></li> <li>NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) <b>revised to March 2023/24.</b></li> <li>Alternative capacity equivalent to 1,000 beds project (LHB CEOs) – 678 additional beds delivered, a significant achievement, but short of the target of 1,000.</li> <li>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)</li> <li>Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer).</li> </ol>							
<b>CONTROLS</b>				<b>ASSURANCES</b>			
				<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.				1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.			
2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.				2. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work.			
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)				3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.			
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).				4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.			

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			Target	3	2	6
5. Workstreams put in place to meet requirements of <i>Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026</i> . 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 NWS 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. <b>REAP has undergone an annual review with v4.1 released in November 2023.</b>				
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.		8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST				
9. 24/7 operational oversight by ODU with dynamic <b>Clinical Safety Plan</b> 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. <b>In December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.</b>				
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. <b>On Call cover is reviewed weekly at SLT Performance Meetings.</b>				
11. Escalation forums to discuss reducing and mitigating system pressures.		11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.				
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.		12. Monthly Integrated Quality and Performance Report (October 2023 overall 76% - Safeguarding and dementia awareness remains over 91%.				
13. Clinical audit programme in place.		13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.				
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report <i>Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover</i> (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 <i>Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover</i> (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.				
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals. Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time		15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board November 2023) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.				

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lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets.”						
16. Implementation of Duty of Quality, Duty of Candour, and new Quality Standards requirements in April 2023.		16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of December 2023 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candor Implementation Group and is actively engaged in developing resources. From April 2024 the Trust will publish an annual quality report and compliance with Duty of Candour. Operational oversight occurs at the Quality Management Group and Executive oversight is via the Clinical Quality Governance Group.				
17. Clinical Support Desk First in place		17.				
18. Summer/Winter initiatives		18. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24.				
		<b>External Sources of Assurance Management (1<sup>st</sup> Line of Assurance)</b>				
		1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).				
		2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC				
		3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.				
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>				
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures.		1.				
2.		2. Implementation of the revised Joint Investigation process remains in pilot stage with good engagement seen by system partners. Several overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has 38 overdue nationally reportable incident investigations. Shared system learning from the Joint Investigation Framework is currently limited with no new learning identified to date.				
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales.		3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. In October 2023, 23,232 hours were lost with 1,888 +4 hour delayed patient handovers.				
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS.		4. Strengthening of patient safety reports and audit processes as e PCR system embeds.				
5. Variation pan Wales / England as position not implemented across all emergency departments*.		5. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.				
6. 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.		6. HIW approve and sign off WAST elements of recommendations.				
		<b>External Gaps in Assurance</b>				
		1. Lack of escalation and response to AQIs by the wider urgent care system and regulators				
<b>Actions to reduce risk score or address gaps in controls and assurances</b>		<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>		
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).		

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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	<ul style="list-style-type: none"> <li>Q4 2023/24</li> </ul>	<ul style="list-style-type: none"> <li>Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level.</li> <li>Access to ePCR data (NEWS) now available. Work on-going with Health Informatics regarding patient safety and health board dashboards.</li> </ul>																				
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	<ul style="list-style-type: none"> <li>Monthly and as required.</li> </ul>	<ul style="list-style-type: none"> <li>Monthly meetings continue to be held and networking through EDoNS.</li> </ul>																				
4. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	<ul style="list-style-type: none"> <li>Q4 2023/24</li> </ul>	<ul style="list-style-type: none"> <li>WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.</li> </ul>																				
5. Overnight falls service extension	Executive Director of Quality & Nursing	<ul style="list-style-type: none"> <li>31.03.2024</li> </ul>	<ul style="list-style-type: none"> <li>Night Car Scheme extension agreed to 31 March 2024 (2 regional resources)</li> <li>Utilization rates continue to be monitoring. Nighttime falls assistance 64% Utilisation (Apr 2023 -Jun 2023); Nighttime falls assistance 66% Utilisation (July – Oct 2023); Daytime utilisation sustained: July -August 58%. September- October 58% utilisation.</li> <li>Optima modelling has now been completed. The modelling clearly identifies that the level two falls' vehicles are the more effective resource. The modelling has identified an estimated need of 48 (38 day and 10 overnight) falls vehicle level 2 12 hours shifts. The modelling is now being built into the strategic (five year) demand &amp; capacity review.</li> </ul>																				
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	<ul style="list-style-type: none"> <li>Q3 2023/24</li> </ul>	<ul style="list-style-type: none"> <li>Monthly updates to progress against actions following the baseline assessment and readiness returns.</li> <li>RL Datix Dashboards and KPIs under development nationally.</li> <li>Key policies updated and approved.</li> <li>Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly.</li> </ul>																				
7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Executive Director of Quality & Nursing	<ul style="list-style-type: none"> <li>Q3 2023/24</li> </ul>	<ul style="list-style-type: none"> <li>SJAC funded ended on 31 October 2023.</li> <li>Proof of concept using WAST CFR volunteers as CWRs is underway. Grant funding is being used to put in place roles and processes to recruit and train to new volunteer role.</li> <li>This eyes on support to CSD clinicians, by volunteers, is producing positive results, with early data suggesting a 35% consult &amp; close rate for the cohort of patients covered by the pilot.</li> <li>The business case has now been completed and can be made available to key stakeholders. Now awaiting business case approval.</li> <li>The CWR will be modelled as part of the options being considered by the current EMS demand &amp; capacity review.</li> </ul>																				
8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	<ul style="list-style-type: none"> <li>Q4 2023/24</li> </ul>	<ul style="list-style-type: none"> <li>OCP commenced 25.09.2023 and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by <b>May</b> 2024 (taking notice periods into account).</li> </ul>																				
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	<ul style="list-style-type: none"> <li>Q4 2023/24</li> </ul>	<ul style="list-style-type: none"> <li>Positive meeting held in August 2023 as planned with the Chair of the TVN network. Next steps are for the Patient Safety Team to attend a TVN leads meeting to discuss opportunities for collaborative working and data / information sharing. Date to be confirmed and there has been good engagement from Health Board Tissue Viability Nurses. Workshop date confirmed in January 2024.</li> </ul>																				

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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	<ul style="list-style-type: none"> <li>Q4 2023/24</li> </ul>	<ul style="list-style-type: none"> <li>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)</li> <li>WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities.</li> <li>Expected outcomes in 2023/24.</li> </ul>																			
11. Internal Audit to undertake a review of Serious Adverse Incidents & Joint Investigation Framework		Executive Director of Quality & Nursing	<ul style="list-style-type: none"> <li>Q4 2023/24</li> </ul>	<ul style="list-style-type: none"> <li>Internal audit in progress. Delays due to sickness in the internal audit team.</li> </ul>																			
12. Winter Ambulance Handover Improvement Plan Meetings		Executive Director of Operations	<ul style="list-style-type: none"> <li>February 2024 (six-week duration)</li> </ul>	<ul style="list-style-type: none"> <li>Weekly meetings set up with Welsh Government, NHS Executive, CASC and the Health Board COOs. All parties (including WAST) to provide updates on actions being taken to alleviate and improve handover delays. WAST to update on C&amp;C, CWR, red dispatch and local updates from EMS HOS on initiatives.</li> </ul>																			
13. Swansea Bay Winter actions		Assistant Director of Operations, EMS	<ul style="list-style-type: none"> <li>December 2023</li> </ul>	<ul style="list-style-type: none"> <li>Some plans are in train following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.</li> </ul>																			

<b>RISK ID</b> 594	<b>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</b>	<b>Date of Review:</b>	17/01/2024	<b>TREND</b>	20 (4x5)	
		<b>Date of Next Review:</b>	14/02/2024			➔
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	<b>RESULTING IN</b> catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
			<b>Inherent</b>	4	5	20
			<b>Current</b>	4	5	20
			<b>Target</b>	2	5	10
IMTP Deliverable Numbers: TBC						
<b>EXECUTIVE OWNER</b>		Director of Operations	<b>ASSURANCE COMMITTEE</b>		Finance & Performance Committee	
<b>Risk Commentary Q3</b>						
The challenges across the unscheduled care system <b>November 2023, over 20,126 hours were lost and 22,756 in December 2023. Only Cardiff &amp; Vale University Health Board has demonstrated material improvement and is a positive outlier.</b> There is a direct correlation with ambulance availability and high levels of resources unavailable due to protracted waits at hospital E.Ds. Several incidents declared have failed to provide sufficient on the ground assurance that vehicles would be released. Health Boards have declined to incorporate testing of vehicle release into a recent mass casualty exercise. Further, a recent workshop undertaken by the EPRR team as part of the Manchester Arena Inquiry assurance process which has tested our ability to fulfil the PDA in North and South Wales, both in and out of hours, has confirmed that we would only meet the PDA in one of these four mass casualty scenarios.						
<b>CONTROLS</b>			<b>ASSURANCES</b>			
			<b>Internal Management (1st Line of Assurance)</b>			
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. <b>REAP has undergone an annual review with v4.1 released in November 2023.</b>			
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 <b>in December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.</b>			
7. Operational Delivery Unit 24/7 cover			7. Shift reports from ODU & ODU Dashboard received by Exec, SOT, and On-Call Team at start/end of shift and cover review at weekly performance meeting			
8. In hours and out of hours command cover			8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan. Cover review at weekly performance meetings			
9. Notification and Escalation Procedure			9. Published procedure in operation, reviewed 3 yearly by SLT			
10. Continued escalation of risk to partners and stakeholders			10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasised at the face-to-face COO Peer Group meeting on 14 April 2023.			
			<b>External Independent Assurance</b>			
			N/A			
11. <b>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.</b>			11. <b>Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&amp;VHB and ABUHB. This has been sustained form some months across C&amp;V in a phased programme of improvement with no delays more than 2 hours. Programme of improvement underway in ABUHB commencing at 4-hour tolerance with a plan to reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs.</b>			
12. <b>Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration.</b>			12. <b>All Health Boards responded with assurance of plans except BCU.</b>			
13. <b>Multi Agency Exercise to be arranged.</b>			13. <b>This exercise has taken place although Health Boards declined to incorporate vehicle release plans</b>			

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:	17/01/2024	TREND	20 (4x5)	
			Date of Next Review:	14/02/2024			
IF a major incident or mass casualty incident is declared	THEN there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	RESULTING IN catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004		Likelihood	Consequence	Score	
				Inherent	4	5	20
				Current	4	5	20
				Target	2	5	10
14. Meeting with Welsh Government to outline this risk; WG agreed to write to HBs seeking assurance from EPRR leads in HBs on the ability to clear EDs and release vehicles. WG agreed to incorporate testing into the forthcoming mass casualty exercise, and a timeframe for vehicle release was proposed by WAST with 30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.		14. WG have confirmed that they have written to HB EPRR leads. Health Board COOs approved the proposals for vehicle release as outlined.					
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>					
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 11 <sup>th</sup> February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. <b>A further declared major incident at Treforest Industrial Estate in December 2023 following an explosion, failed to release resources from Morriston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted).</b>					
<b>Actions to reduce risk score or address gaps in controls and assurances</b>		<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>			
1. Review of Manchester Arena Inquiry		Assistant Director of Operations	March 2024	This programme of work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios. <b>The financial case associated with MAI is planned to be familiarised with ELT and EASC during Jan and Feb 2024, with the final outline case to ELT in March 2024.</b>			
2. Further correspondence to Welsh Government to seek assurance of testing plans following recent mass casualty exercise where Health Boards declined to incorporate vehicle release plans		Assistant Director of Operations	January 2024	<b>Correspondence with Welsh Government remains ongoing</b>			

Risk ID 424	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)			Date of Review:	17/01/2023	TREND	16
				Date of Next Review:	14/02/2024	➡	(4x4)
IF resources are not forthcoming within the funding envelope available to WAST (link to risk 139)	THEN there is a risk that there is insufficient capacity to deliver the IMTP	RESULTING IN delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing			Likelihood	Consequence	Score
				Inherent	4	4	16
				Current	4	4	16
				Target	1	4	4
IMTP Deliverable Numbers: All							
EXECUTIVE OWNER		Director of Strategy, Planning & Performance		ASSURANCE COMMITTEE		Finance and Performance Committee	
<b>Risk Commentary</b>							
Risk score remains currently at 16 as some outstanding gaps in controls and, linked to risk 458, some continued risk with regards to recurrent funding. There are also currently sickness & vacancies in the Transformation team resulting in gaps to support delivery of key workstreams and delivery of mitigations listed in this BAF, however these are in the recruitment and managing attendance processes. IMTP planning for 2024-2027 underway to refresh our priorities for the next three years, taking into account the external context in which the Trust is working. This risk will therefore remain under review as we put further controls in place but also taking account of the new commissioning landscape, financial context and our strategic developments.							
<b>CONTROLS</b>				<b>ASSURANCES</b>			
				<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
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 Path Framework (PPF)				6. PowerPoint pack detailing Project Path Framework			
7. Regular engagement with key stakeholders				7. Stakeholder Engagement Framework			
8. Financial Sustainability Programme – savings and income work streams				8. FSP programme highlight reports			
				<b>Independent Assurance (3<sup>rd</sup> Line of Assurance)</b>			
				2. Subject to Internal Audit			
<b>GAPS IN CONTROLS</b>				<b>GAPS IN ASSURANCE</b>			
1. Project and programme management (PPM) framework to be reviewed				1. PPM needs to be reviewed and approved through STB			
2.—				2. Benefits have not been fully linked to benefits realisation			
3. Lack of a commercial contractual relationship with Commissioners (link to risk 458)							
<b>Actions to reduce risk score or address gaps in controls and assurances</b>		<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>			
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 PPF		Head of Transformation	Extended from 31.03.23 – To 31.06.23 and then to 30.09.23 in line with milestone for delivery Extend to 31.12.23 in line with timescales for sign off. Extend to 31.01.24 in line with timescales for sign off. Extend to end of Feb in line with next STB.	Currently (January 2023) working through delivery structures for 2023-26 which will inform the PPM review – changed checkpoint date to 31.06.23. Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3. Planning Framework approved by STB on 04.07.2023 which sets out the Project Path framework at a high level. Project Path Framework presented at ISPG on 27.10.23 and is scheduled for approval at STB on 27.11.23. STB reviewed the Project Path Framework and generally good feedback but some alterations to be made and brought back to STB in January 2024 for approval. 22 Further finalisation required; approval deferred to STB meeting 26.02.24.			

Risk ID 424	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)			Date of Review:	17/01/2023	TREND	16 (4x4)
				Date of Next Review:	14/02/2024	➔	
IF resources are not forthcoming within the funding envelope available to WAST (link to risk 139)		THEN there is a risk that there is insufficient capacity to deliver the IMTP	RESULTING IN delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing		Likelihood	Consequence	Score
				Inherent	4	4	16
				Current	4	4	16
				Target	1	4	4
3. Develop Benefits Realisation plans in line with Quality and Performance Management framework	Assistant Director of Planning/Assistant Director, Commissioning & Performance	Extended from 30.09.22 – to 31.03.23. Further extend to 31.06.23 and then to 30.09.23 in line with milestone for delivery Extend to 31.12.23 as priorities have taken precedence but there is work ongoing in this space. Extend to 29.02.24 as other priorities have taken precedence but there is work ongoing in this space. As above extend to end of Feb.	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. Work continues with the Commissioning and Performance Team to align performance metrics with programme/IMTP deliverables. An evaluation methodology is being trialled with Swansea University to look at benefits realisation of small, agile projects and PDSA cycles. Work continues this but will be rolled out as part of the PPF.				
4. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)	Director of Finance	31.12.22 – checkpoint date 31.06.23 and then to 30.09.23 Extend to 31.12.23. As above extend to end of Feb.	Extend checkpoint date to 31.03.2023 on basis of new financial allocations for 2023 to be worked through with Commissioner. A business case panel process has been developed and trialled as part of the development of the project path framework and is factored into the IMTP planning cycle, to give finance colleagues a timelier view of potential developments into the next 3-year cycle. Extended in line with the roll out of PPF as the business case process is within that framework, however it has been utilised to review the recent CSC Business Case and was found to be helpful and supportive – albeit the model for developing business cases needs to be reviewed further to make the actual output more streamlined				

<b>Risk ID</b> 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		<b>Date of Review:</b>	17/01/2024	<b>TREND</b>	16 (4x4)
			<b>Date of Next Review:</b>	14/02/2024		
<b>IF</b> 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.	<b>THEN</b> 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.	<b>RESULTING IN</b> patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
			<b>Inherent</b>	3	4	12
			<b>Current</b>	4	4	16
			<b>Target</b>	2	4	8
IMTP Deliverable Numbers:						
<b>EXECUTIVE OWNER</b>		Director of Finance and Corporate Resources	<b>ASSURANCE COMMITTEE</b>		Finance and Performance Committee	
<b>Risk Commentary</b>						
Linked to risk 139, though funding has been sourced internally for the EMS staff, and non-recurrently from EASC, the score remains the same as clarity from Commissioners has still not been provided on any recurrent funding ask on this topic which could have a negative recurrent impact on the Trusts financial position. Other key item to note is funding for 111, WAST continues dialogue with commissioners of the service and any financial risk is mitigated by operating on a spend and cost recovery basis with commissioners.						
<b>CONTROLS</b>			<b>ASSURANCES</b>			
			<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. Financial governance and reporting structures in place			1. Risk is reviewed quarterly at FPC, and a report is submitted bimonthly to Trust Board			
2. Financial policies and procedures in place			2.			
3. Setting and agreement of recurrent resources			3.			
4. Budget management meetings			4. Diarised dates for budget management meetings. If an area is in financial deficit, the meeting would be at least once a month. If the area is in balance or surplus, the meeting would be quarterly.			
5. Budget holder training			5. Diarised dates for budget holder training			
6. Annual Financial Plan			6. Submission to Trust Board in March annually			
7. Regular financial reporting to EFG & FPC in place			7. Diarised dates for EFG and FPC with full financial reports			
8. Regular engagement with commissioners of Trust's services			<b>External Management (1<sup>st</sup> Line of Assurance)</b>			
			1. Accountability Officer letter to Welsh Government			
			3 and 8 EASC management meetings. Monthly meetings with EASC and DAG meetings for NEPTS. Meetings are diarised.			
			9. Monthly monitoring returns			
9. Welsh Government reporting monthly			<b>Independent Assurance (3<sup>rd</sup> Line of Assurance)</b>			
			2. Internal Audit reviews of financial policies & procedures as part of their audit plan			
<b>GAPS IN CONTROLS</b>			<b>GAPS IN ASSURANCE</b>			
• 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)			
<b>Actions to reduce risk score or address gaps in controls and assurances</b>			<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>	
1. A formal approach to service change to be developed providing secure recurrent funding with commissioners.			Executive Leadership Team	31.3.24	Update: 23/24 Recurrent funding remains an issue for the 100 WTE £6m funding from commissioners. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis.	
2. Develop a Value Based Healthcare system approach with commissioners. This would mean that funding would flow more seamlessly between organisations and would go some way to mitigating the risk of not receiving recurrent funding.			Deputy Director of Finance	31.3.24	Update: Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.	

<b>Risk ID</b> 260	<b>Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems</b>		<b>Date of Review:</b>	17/01/2023	<b>TREND</b> →	15 (3x5)
			<b>Date of Next Review:</b>	14/02/2024		
<b>IF</b> 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	<b>THEN</b> there is a risk of a significant information security incident	<b>RESULTING IN</b> 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		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
			<b>Inherent</b>	4	5	20
			<b>Current</b>	3	5	15
			<b>Target</b>	2	5	10
IMTP Deliverable Numbers:						
<b>EXECUTIVE OWNER</b>		Director of Digital Services	<b>ASSURANCE COMMITTEE</b>		Finance and Performance Committee	
<b>Risk Commentary</b>						
The latest National Cyber Security Centre (NCSC) assessment indicates that the threat of Cyber-attacks remains unchanged with activities of state actors and criminal gangs still high. Whilst the Trust and wider NHS Wales organisations have in place several layers of technology to protect the Trust and its information systems, there is still a risk that users will be fooled by phishing emails which are becoming ever more sophisticated. To raise user awareness of cyber threats the Trust ICT department run regular phishing exercises as well as short security training packages, reporting the results and uptake through IGSG and into FPC.						
<b>CONTROLS</b>			<b>ASSURANCES</b>			
			<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. Appropriate policy and procedures in place for Information/Cyber Security			1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.			
2. Trust Business Continuity Procedure and Incident Response Plan			2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing			
3. IT Disaster Recovery Plan			3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.			
4. Relevant expertise in Trust with respect to information security			4. Staff undertake relevant training courses e.g., CISSP to increase knowledge and expertise			
5. Data Protection Officer in post			5. In job description of Head of ICT			
6. Cyber and information security training and awareness			6. Training statistics are available on ESR and from Phish threat module			
7. Mandatory Information Governance training which includes GDPR			7. Training statistics reported on by Information Governance department			
8. ICT tests and monitoring on networks & servers			8. Any issues would be identified and flagged and actioned			
9. Information Governance framework			9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.			
10. Internal and NHS Wales governance reporting structures in place			10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.			
11. Checks undertaken on inactive user accounts			11. Software in place to run check on inactive accounts as and when			
12. Business Continuity exercises			12. Annual schedule of testing			
13. Operational ICT controls e.g., penetration testing, firewalls, patching			13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when. 04/08/23 – Exploring procurement of additional penetration tests with the aim of annual testing of all critical systems.			
14. Security alerts			14. Daily alerts are received. Anti-virus alerts received as and when threat discovered			
15. Cyber/Info Security KPI are reported to senior management and committees			15. Monthly KPI reports now being generated routinely and fed into the Digital Leadership Group, ELT, IGSG and FPC			
16. Regular cyber awareness campaigns are conducted			16. Cyber training is provided to staff and regular phishing campaigns are conducted. These are reported as part of the KPI reports			
17 IT recovery Plan does include a cyber response			17. Cyber response incorporated into IT Disaster Recovery Plan			
18. Information Security Policy refreshed and in Trust wide consultation.			<b>External Independent Assurance</b>			
						25

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:	17/01/2023	TREND	15 (3x5)
			Date of Next Review:	14/02/2024		
<b>IF</b> 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	<b>THEN</b> there is a risk of a significant information security incident	<b>RESULTING IN</b> 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		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
			<b>Inherent</b>	4	5	20
			<b>Current</b>	3	5	15
			<b>Target</b>	2	5	10
		NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14)				
<b>GAPS IN CONTROLS</b>		<b>GAPS IN ASSURANCE</b>				
1. Lack of understanding and compliance with policy and procedures by all staff members		1.				
2. No organisational information security management system in place		3. SIRO in place and ISMS evolving in line with refresh of Trust information Security Policy				
3.						
4. 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						
<b>Actions to reduce risk score or address gaps in controls and assurances</b>		<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>		
1. Establish Cyber and Information Security KPIs		Director of Digital Services	31.03.23 complete	KPI format agreed and will be produced from Q1 2023-24 with a retrospective annual report produced for 2022-23.		
2. Discuss how cyber risk is reviewed and frequency of review		Director of Digital Services	28.10.22 Close – now Business as Usual	a. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources. b. The corporate cyber risk assessment will be reviewed monthly at the Digital Leadership Group informed by the threat and intelligence monitoring and national strategic trends.		
3. Suite of business continuity exercises that departments can undertake to test their plans to be provided.		North Resilience Manager	28.10.22 Complete	The Trust has run two exercise Joshua & Joshua 2 to test departments readiness		
4. Exercise template report which shows recommendations to be created		North Resilience Manager	31.12.22 - Complete	Exercise reports being drafted.		
5. Formalise Cyber Incident Response Plan		Head of ICT	30.06.23 – complete	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 – Complete Checkpoint Date 31.03.2024	Additional learning modules purchased, and both will be rolled out from Q1 2023-24. Drive up staff compliance of IG & Cyber training		
<b>7. Cyber Improvement Plan</b>		<b>Senior ICT Security Specialist</b>	<b>Next checkpoint date 31.03.2024</b>	<b>Implementation of Cyber Improvement Plan actions ongoing and reported into IGSG</b>		

<b>Risk ID</b> 543	<b>Major disruptive incident resulting in a loss of critical IT systems</b>			<b>Date of Review:</b>	17/01/2024	<b>TREND</b>	15
				<b>Date of Next Review:</b>	14/02/2024		(3x5)
<b>IF</b> there is an unexpected or uncontrolled event e.g., flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems	<b>THEN</b> there is a risk of a loss of critical IT systems	<b>RESULTING IN</b> 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		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>	
			<b>Inherent</b>	4	5	20	
			<b>Current</b>	3	5	15	
			<b>Target</b>	2	5	10	
IMTP Deliverable Numbers: TBC							
<b>EXECUTIVE OWNER</b>		Director of Digital Services	<b>ASSURANCE COMMITTEE</b>		Finance and Performance Committee		
<b>Risk Commentary</b>							
The risk remains static as work continues to migrate services to the new infrastructure. In addition, controlled cut over of key systems to backup sites was undertaken during this quarter. Maintenance works has been undertaken by estates on power systems supporting key ICT sites which will provide additional assurance for sites in the event of incoming mains disruption. Further desktop exercises are being considered to test both department BCP and ICT recovery plans. Internal audit has completed an audit on ICT system resilience which was rated as reasonable assurance. Work will be undertaken to address the recommendations.							
<b>CONTROLS</b>				<b>ASSURANCES</b>			
				<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. Trust Incident Response Plan and Department Business Continuity Plans				1. Full review of Incident Response plan every 3 years and partial review annually unless there is a major learning point. Annual schedule of testing of BCPs.			
2. IT Disaster Recovery Plan				2. Recent ICT tabletop exercise undertaken			
3. Recovery/contingency plans for critical systems				3. Reports from tabletop exercises			
4. Service management processes in place				4. Documented and approved service management processes in place			
5. Incident Management Policy, Procedure and Process				5. Incident Policy and Procedure put in place in February 2022. This would be required annually and if there is a system change, the review would be earlier			
6. Regular data back ups				6. Daily report on status of backup and fully automated process. Log kept of where restores are undertaken			
7. Resilient and high availability ICT infrastructure in place				7. 04/08/23 – New back-up system ordered with the aim of implementation before the end of Nov23.			
8. Robust security architecture and protocols				8.			
9. Diverse IT network (both data and voice) delivery at key operational sites				9.			
10. Regular routine maintenance and patching				10. 04/08/23 – Ongoing continual update of servers and replacement of out-of-date equipment			
11. Environmental controls				11.			
12. Intelligence gathered from suppliers with respect to future tool sets and enhancements				12. Via email and webinars			
				<b>External Independent Assurance</b>			
				<ul style="list-style-type: none"> <li>2021_16 Internal Audit review of IM&amp;T Control Assessment – baseline exercise</li> <li>2021_19 Internal Audit review of ICT Disaster Recovery – Limited Assurance</li> <li>WAST_2324-14 Internal Audit review of ICT Technical Assurance – Reasonable Assurance</li> <li>NIS Directive internal audit report 2022 – Reasonable Assurance (covering controls 1-12)</li> </ul>			
<b>GAPS IN CONTROLS</b>				<b>GAPS IN ASSURANCE</b>			
Non identified				Undertaking Cyber Essentials assessment			
<b>Actions to reduce risk score or address gaps in controls and assurances</b>			<b>Action Owner</b>	<b>By When/Milestone</b>	<b>Progress Notes:</b>		
1. Suite of business continuity exercises that departments can undertake to test their plans to be provided.			North Resilience Manager	31.12.22 extend to 30.06.23 now complete	Suite of exercise available via BC teams' channel.		
2. Exercise template report which shows recommendations to be created			North Resilience Manager	31.12.22 extend to 30.06.23 now complete	Joshua and Joshua 2 reports produced and circulated.		
3. Cyber Essentials assessment to be completed.			Head of ICT	30.06.23 Extend to 31.03.24 - ongoing.	Evidence submitted to assessor – further works required to meet requirement. Implementation of action plan in response to CRU Cyber assessment recommendations		
4. Implement recommendations of IA Technical resilience audit			Head of ICT	30.06.2024	Implementation of the 4 recommendations from the internal audit technical resilience		

<b>Risk ID</b> 100	<b>Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience</b>		<b>Date of Review:</b>	17/01/2024	<b>TREND</b> ➔	12 (3x4)
			<b>Date of Next Review:</b>	10/04/2024		
<b>IF</b> WAST fails to persuade EASC/Health Boards about WAST ambitions	<b>THEN</b> there is a risk of a delay or failure to receive funding and support	<b>RESULTING IN</b> a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
			<b>Inherent</b>	4	4	16
			<b>Current</b>	3	4	12
			<b>Target</b>	2	4	8
IMTP Deliverable Numbers: 2, 3, 4, 6, 11, 14, 29, 34						
<b>EXECUTIVE OWNER</b>	Director of Strategy, Planning & Performance		<b>ASSURANCE COMMITTEE</b>		Finance and Performance Committee	
<b>Risk Commentary</b>						
<p>The ambition is appropriate levels of patient safety and good working conditions for our staff. Clearly neither of these are currently being achieved in the emergency ambulance care pathway as evidenced by the long waits, shift overruns and volume of concerns and reportable incidents. The Trust is currently commissioned on the assumption of 6,000 hours of handover lost hours, with current levels at <b>23,000 (Dec-23)</b>. EASC has an ambition to achieve 12,000 handover lost hours by the beginning of quarter four 2023/24, which looks very unlikely, but even if it was achieved, it would still be double what the EMS rosters are predicated on. The Trust is not fully funded on these rosters either. The Trust is not fully funded for the CHARU roster lines, with an identified shortfall of -89.5 FTEs. The Trust has made the decision to transfer staff from emergency ambulance roster lines to CHARU roster lines, which is almost complete, but does not add more staff. Similarly, the Trust has made the decision (<b>delivered</b>) to recruit another intake of APPs, an additional 16 FTEs, but this is also being funded through internal movements, with a planned <b>temporary relief gap to fund these internal movements</b>.</p> <p>The 2023 EMS Demand &amp; Capacity Review is live with an estimated completion date of <b>March 2023 EASC</b>. This strategic review will enable the Trust to articulate the type and level of resource that optimises response and conveyance to deliver appropriate levels of patient safety and good working conditions for our staff i.e., the ambition. Health boards are clearly under substantial financial pressures, so whether EASC can then support the ambition as articulated by the review, remains to be seen. The Trust <b>have provided senior external stakeholders with five key areas that it is focused on, as detailed in the Patient Harm Mitigations report to Trust Board (25/01/24) with health boards being asked to do the same</b>.</p> <p>If further funding is not forthcoming, post the 2023 EMS Demand &amp; Capacity Review, the risk may need to be revise its score upwards.</p>						
<b>CONTROLS</b>			<b>ASSURANCES</b>			
			<b>Internal &amp; External Management (1<sup>st</sup> Line of Assurance)</b>			
1. EASC/WAST Forward Plan for EMS and NEPTS in place and monitored at EASC meetings			1. Minutes of meetings and a standard agenda item			
2. EASC and its 2 sub-committees established as a forum to discuss WAST's strategy			2. Minutes of meetings and a standard agenda item			
3. Weekly catch up between CASC/CEO			3. Meetings are diarised every week			
4. Collaboration between EASC and WAST on specific projects e.g. Amber Review, EMS Operational Transformation Programme, Ambulance Care Programme			4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.			
5. Monthly CASC Quality and Delivery Meeting established			5. Formal meeting with agendas, minutes, and action logs available.			
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced			6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholder's fortnightly			
7. Programme structure has been established for 'inverting the triangles' including EASC			7. <b>This is now an established programme of work with the Trust making an offer to the system via the Six Goals Programme in January 2024.</b>			
			<b>External Management (1<sup>st</sup> Line of Assurance)</b>			
			1. Plans go to every bi-monthly meeting			
			2. Meet bi-monthly and agendas, minutes, and action logs available			
<b>GAPS IN CONTROLS</b>			<b>GAPS IN ASSURANCE</b>			
1. EASC meetings focus largely on EMS and cursory note of NEPTS			1. NEPTS is covered in the WAST Provider Report to EASC.			
2. Governance coordination between NCCU and WAST to be improved.			2. Identified need for a governance meeting between NCCU and WAST to manage the overall commissioner/provider interface. Actioned but has lapsed due to capacity and resourcing in NCCU team. <b>The Trust is currently meeting every two weeks connected to the development the IMTP.</b>			
3. WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)			3. Ministerial direction on handover reduction <b>with significant pressure being applied to health boards through the NHS Leadership Board and NHS Executive accountability arrangements.</b>			

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:	17/01/2024		TREND	12 (3x4)
			Date of Next Review:	10/04/2024		➔	
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 & 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. Funding does not flow in a manner to balance demand with capacity (outside of WAST's control)		4. Strategic demand and capacity review being undertaken with output due to be reported to EASC in Mar-24, with initial findings already shared.					
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:			
1. Agree and influence EASC/Health Boards that sufficient funding to be provided to WAST		CEO WAST	02/08/23 Checkpoint Date	30.09.22 Additional £3m provided for +100 FTEs into Response by 23/01/23. 12/01/23 Recurrent funding for the +100 not secure. 02.05.23 Recurrent funding still not secure. 28.07.23 Funding secure for 23/24, but not recurring. 18.01.24 Offer being made to the system in January 2024 via the Six Goals Programme.			
2. Agree and influence EASC/Health Board of the need for significant reduction in hospital handover hours		CEO WAST	02/08/23 Checkpoint Date	30.09.22 4-hour handover backstop agreed and -25% reduction in handover from October 2021 baseline. 12/01/23 There has been a significant worsening picture. 02.05.23 Continued worsening picture with almost 29,000 lost in March 2023. 28.07.23 There has been some reduction, but levels remain extreme. 18.01.24 NHS Leadership Board is increasing accountability and focus of health board handover reduction actions.			
3. Increased understanding of NEPTS by EASC		Executive Director of Strategy Planning and Performance	02/08/23 Checkpoint Date	30.09.22 "Focus on" session in May 2022 EASC and NCCU represented on Ambulance Care Programme Board. 12/01/23 F&P Deep Dive made available to NCCU. 02.05.23 Continued attendance by NCCU at Ambulance Care Transformation Programme. 28.07.23 EASC want WAST to develop a LTS for NEPTS, which will increase the focus on it. 18.01.24 Ambulance Care strategy sessions held as part of the inverting the triangle programme and IMTP development held.			
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface		Assistant Director Commissioning & Performance	02/08/23 Checkpoint Date	30.09.22 Meeting in place and meeting regularly. 12/01/23 Meetings continue. 02.05.23 These have lapsed due to pressures and sickness absence in the NCCU. HB to reboot, subject to ability of NCCU to undertake. 28.07.23 Availability remains a challenge, but there is regular informal dialogue between WAST and NCCU. 18.01.24 This specific meeting remains lapsed, but the Trust is currently meeting every two weeks with the NCCU on the development of the IMTP.			
5. Utilising the engagement framework to engage with the stakeholders		Director of Partnerships & Engagement AD Planning & Transformation	02/08/23 Checkpoint Date	30.09.22 Significant engagement through roster review briefings. 12/01/23 Engagement on roster review largely concluded, with some political interest continuing in a few areas. 02.05.23 Continued interest from various stakeholders as the roster review concludes. 28.07.23 New engagement manager appointed linked to inverting the triangle work. 18.01.24 The Trust is currently still working with PWC on the information that will drive engagement, but as above an offer being made to the system in January 2024.			

<b>Risk ID</b> 283	<b>Failure to implement the EMS Operational Transformation Programme</b>			<b>Date of Review:</b>	17/01/2024	<b>TREND</b> ➔	12 (3x4)
				<b>Date of Next Review:</b>	10/04/2024		
<b>IF</b> there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme	<b>THEN</b> there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters	<b>RESULTING IN</b> potential patient harm, deterioration in staff wellbeing and reputational damage		<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>	
			<b>Inherent</b>	4	4	16	
			<b>Current</b>	3	4	12	
			<b>Target</b>	2	4	8	
IMTP Deliverable Numbers:							
<b>EXECUTIVE OWNER</b>		Director of Strategy Planning & Performance	<b>ASSURANCE COMMITTEE</b>		Finance and Performance Committee		
<b>Risk Commentary</b>							
<p>The EMS Operational Transformation Programme is the Trust's strategic delivery response to the 2019 EMS Demand &amp; Capacity Review. The programme has now largely been delivered e.g., closure of relief gap (recruitment of +300 staff), increase consult &amp; close above the 10.2% benchmark, re-roster EMS, ensure that there was sufficient fleet and estate to support these changes and roll out the new CHARU resource. The main area outstanding is the reconfiguration of EMSC, which was initially delayed by the pandemic and then further delayed by the need to update the data used to ensure the recommended actions were still correct. This update has just been completed, so the focus is now on finishing the EMSC project within this programme. <b>The full role out of the CHARU resource also remains an open action. The programme was subject to internal audit in 2022 and narrowly missed substantial assurance (quoracy to be reflected in PID and PID updated, both of which have been addressed).</b></p> <p>Whilst the programme has largely delivered on its agreed outputs, it has not delivered the required levels of patient safety and staff working conditions for two main reasons: extreme handover (+20,000 lost hours v the 6,000 that the programme was predicated on) and abstractions (34% v the 30% benchmark).</p>							
<b>CONTROLS</b>				<b>ASSURANCES</b>			
				<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1. Implementation Programme Board in place – meetings held every 3 weeks with the DASC and TU reps on the membership. Now every 6 weeks as the programme largely delivered.				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. PID is up to date.			
3. Programme Manager and Programme support office in place (for delivery of the programme).				3. Same as 2 above.			
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.			
				<b>External Management (1<sup>st</sup> Line of Assurance)</b>			
				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.			
<b>GAPS IN CONTROLS</b>				<b>GAPS IN ASSURANCE</b>			
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.			

Risk ID 283	Failure to implement the EMS Operational Transformation Programme			Date of Review:	17/01/2024		TREND	12 (3x4)
				Date of Next Review:	10/04/2024		➔	
IF there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme		THEN there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters	RESULTING IN potential patient harm, deterioration in staff wellbeing and reputational damage		Likelihood	Consequence	Score	
				Inherent	4	4	16	
				Current	3	4	12	
				Target	2	4	8	
2. 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. 18.01.24 The main o/s action here is engaging with the TU partners on the evaluation of the roster review. A draft evaluation has been written up and will be shared with TU partners this quarter.				
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 the gains that the Trust has made. 03.08.23 More capacity unlikely within current financial pressures, but Trust has recently started the next iteration of the strategic EMS Demand & Capacity Review. 18.01.24 Trust currently making an offer to the system via the Six Goals Programme.				
3. Engage with key stakeholders to reduce handover delays		CASC	02.08.23 – Checkpoint Date	30.09.22 Reduction commitments agreed, but trend is still upwards. 12/01/23 Extreme and upward trend. 02.05.23 handover hours remain extreme. 28.07.23 Increasing focus through ICAP meetings, with C&V showing notable progress and early signs of progress in some other health boards. 18.01.24 Significant increase in health board accountability and focus via the NHS Leadership Board.				
4. Reduce abstractions in particular sickness absence		Deputy Director of Workforce & OD	02.08.23 Checkpoint Date	30.09.22 Sickness absence reducing, but abstractions high linked to sickness, but also training abstraction linked to the +100. 12/01/23 Abstractions have reduced, but still very high. Sickness is reducing and on trend to achieving the 10% Mar-23 target. High abstractions linked to internal movements caused by internal recruitment. 02.05.23 the Trust achieved 7.99% in Feb-23, but levels are higher in Operations. Continued focus into 2023/24 to reach 6% by 31/03/23. 28.07.23 Abstractions, which includes sickness now less than 35% with benchmark to 30%. 18.01.24 Abstractions were 31% in November 2023. They did increase in December.				
5. Engage with Assistant Director of Planning and Transformation on process for PID updates		Assistant Director – Commissioning & Performance	02.08.23 Checkpoint Date	30.09.22 HoT recruited and now started. Initial contact made with HoT. PID is up to date. 12/01/23 PID has been further updated but requires sign off by the SRO and STB. 02.05.23 PID has been updated but needs to be signed off by Executive Sponsors. 28.07.23 PID updated and programme aligned to new arrangements required by HoT. 18.01.24 PID up to date.				

<b>Risk ID</b> 139	<b>Failure to deliver our Statutory Financial Duties in accordance with Legislation</b>	<b>Date of Review:</b>		17/01/2024	<b>TREND</b> →	8 (2x4)
		<b>Date of Next Review:</b>		10/04/2024		
<b>IF</b> the Trust does:		<b>THEN</b> there is a risk that	<b>RESULTING IN</b>	<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>
<ul style="list-style-type: none"> <li>not achieve financial breakeven and/or</li> <li>does not meet the planning framework requirements and/or</li> <li>does not work within the EFL and/or</li> <li>fails to meet the 95% PSPP target and/or</li> <li>does not receive an agreement with commissioners on funding (linked to 458)</li> </ul>		the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage	<b>Inherent</b> 3	4	12
				<b>Current</b> 2	4	8
				<b>Target</b> 2	4	8
IMTP Deliverable Numbers:						
<b>EXECUTIVE OWNER</b>		Executive Director of Finance and Corporate Resources	<b>ASSURANCE COMMITTEE</b>	Finance and Performance Committee		
Risk Commentary Q3 2023/24						
The risk has now been further reviewed in conjunction with the level of financial risk detailed in the Trust's financial monitoring returns submitted to WG. The score has improved in year as a result, in part due to WAST being able to resource the remaining cost of the EMS staff increase itself in year, whilst further confirmation and assurance has been received from WG on any pay award funding due. In addition, a recent letter from WG confirmed that the Trust does not need to contribute anything further to the wider NHS Wales deficit reduction plan or will see any further reduction in its income to do so, providing further confidence that for this financial the risk has reduced. It must be noted that even though the risk has reduced for this year, in the current challenging financial climate for all public sector organisations the risk will remain elevated especially as focus turns towards financial planning for the new financial year e.g., recurrent funding will still need to be agreed with Commissioners for the new financial year for the 100 WTE EMS staff.						
<b>CONTROLS</b>			<b>ASSURANCES</b>			
			<b>Internal Management (1<sup>st</sup> Line of Assurance)</b>			
1.	Financial governance and reporting structures in place		1. Risk is reviewed quarterly at FPC, and a report is submitted bi-monthly to Trust Board			
2.	Financial policies and procedures in place					
3.	Budget management meetings		3. Diarised dates for budget management meetings			
4.	Regular financial reporting to ADLT, EFG, ELT, FPC and Trust Board in place		4. Diarised dates for EFG and FPC and monthly reports			
5.	Welsh government reporting					
6.	Monthly review of savings targets		6. ADLT monthly review			
7.	Regular review monitoring and challenge via WAST and CASC quality and delivery meeting with commissioners.					
8.	Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.		8. Diarised dates for ICMB meetings with regular monthly report			
9.	PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications		9. Regular PSPP communications (Trust wide) on Siren			
10.	Forecasting of revenue and capital budgets		a) Monthly monitoring returns to ADLT, EFG, ELT and FPC (b) Reliance on available intelligence to inform future forecasting.			
11.	Business cases and benefits realisation (both revenue and capital)		11. Business cases – scrutiny and approval at senior management team which are submitted to ADLT, ELT, FPC prior to Trust Board for approval as appropriate according to value.			
			<b>External Assurances Management (1<sup>st</sup> Line of Assurance)</b>			
			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			
			<b>Independent Assurances (3<sup>rd</sup> Line of Assurance)</b>			
			1-10 Internal audit reviews covering			
			1-10 External audit reviews			

<b>Risk ID</b> 139	<b>Failure to deliver our Statutory Financial Duties in accordance with Legislation</b>	<b>Date of Review:</b>		17/01/2024	<b>TREND</b>	8 (2x4)	
		<b>Date of Next Review:</b>		10/04/2024	→		
<b>IF</b> the Trust does: <ul style="list-style-type: none"> <li>not achieve financial breakeven and/or</li> <li>does not meet the planning framework requirements and/or</li> <li>does not work within the EFL and/or</li> <li>fails to meet the 95% PSPP target and/or</li> <li>does not receive an agreement with commissioners on funding (linked to 458)</li> </ul>		<b>THEN</b> 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)	<b>RESULTING IN</b> potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage	<b>Likelihood</b>	<b>Consequence</b>	<b>Score</b>	
				<b>Inherent</b>	3	4	12
				<b>Current</b>	2	4	8
				<b>Target</b>	2	4	8
<b>GAPS IN CONTROLS</b>			<b>GAPS IN ASSURANCE</b>				
<ul style="list-style-type: none"> <li>Lack of formalised service contracts between Commissioner and WAST as a commissioned body</li> </ul>			1. None identified.				
<b>Actions to reduce risk score or address gaps in controls and assurances</b>		<b>Action Owner</b>	<b>By When/Milestone</b>		<b>Progress Notes:</b>		
1. Continuing negotiations with Commissioners		Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/24 – Checkpoint Date		In line with the recent WAST financial position and monthly monitoring letter sent to WG, WAST can resource the cost of the EMS staff itself. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis.		
2. Embed a transformative savings plan and ensure organisational buy in		ADLT and Savings subgroup	31/03/24 – Checkpoint Date		The Financial Sustainability workstreams that were launched in May 2023 have now been rebranded as the Financial Sustainability Program (FSP) and the work of the program underpins the need of the organisation to deliver transformative savings via the Achieving Efficiencies and Income Generation subgroups. WAST is currently over delivering against its savings plan.		
3. Embed value-based healthcare working through the organisation		Executive Leadership Team and Value Based Healthcare Group	31/03/24 – Checkpoint Date		Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.		
4. WIIN support for procurement, savings, and efficiencies		WAST Improvement and Innovation Network group	31/03/24 – Checkpoint Date		WIIN ideas are regularly communicated across to the Achieving Efficiencies subgroup of the FSP.		
5. Foundational economy, Decommissioning, and procurement to mitigate social and economic wellbeing of Wales		Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/24 – Checkpoint Date		The organisation utilises the NWSSP Shared Services Procurement framework to ensure contracts tendered provide best value for money while ensuring criteria within the tender docs ask bidders to highlight their ability to serve the aims of FE, Decommissioning, Decarbonisation and social as well as the economic wellbeing of Wales.		

<b>AGENDA ITEM No</b>	<b>19</b>
<b>OPEN or CLOSED</b>	<b>OPEN</b>
<b>No of ANNEXES</b>	<b>1</b>

## AUDIT TRACKER 2.0 – MARCH 2024 (Q4)

<b>MEETING</b>	Finance and Performance Committee
<b>DATE</b>	14 May 2024
<b>EXECUTIVE</b>	Trish Mills, Director of Corporate Governance/Board Secretary
<b>AUTHOR</b>	Trish Mills, Director of Corporate Governance/Board Secretary Alex Payne, Corporate Governance Manager
<b>CONTACT</b>	<a href="mailto:trish.mills@wales.nhs.uk">trish.mills@wales.nhs.uk</a>

### EXECUTIVE SUMMARY

1. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee, in addition to the wider progress in Quarter.
2. There has been excellent engagement with Directorates on the revised Tracker 2.0, for Quarter four, with the result that of the total of 162 internal audit actions on the Tracker, 64 have been closed in quarter. This is a closure figure of 40% of all internal audit actions, and 57% of the total actions due in Quarter.
3. Of those internal audit actions relevant to this Committee, 33 have been closed in Quarter of a total of 95 (35%). This equates to 60%, as a % of those due in Quarter closed in Quarter. Of these actions due in Quarter, 26 action due dates have moved (marked in blue) and 5 actions are on their third revised date.
4. Of those external audit actions relevant to this Committee, 1 has been closed in Quarter of a total of 2 (50%). There is therefore one action where the due date has moved in quarter and there are no actions with a third revised date.
5. The current version of the tracker is now open for Directorate review for actions due in April, May, and June. These updates will then be reported to the Committee at its meeting in August 2024.



**GIG**  
CYMRU  
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WALES

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

## RECOMMENDATION

6. The Committee is requested to:

- (a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. There are none to be received at this meeting (*the ICT Contract Management report was received in March 2024*);
- (b) Monitor management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue).

## KEY ISSUES/IMPLICATIONS

As set out above.

## REPORT APPROVAL ROUTE

Tracker presented to ADLT via email in April 2024.

## REPORT APPENDICIES

Annex 1 – Tracker 2.0 January - March 2024 for Committee Reporting

## REPORT CHECKLIST

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

## SITUATION

7. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee, in addition to the wider progress in Quarter.

## BACKGROUND

8. In September 2023 the Audit Committee approved the Audit Process and Reporting Handbook. The Handbook has been further revised since this date to include Audit Wales content.
9. The Handbook includes roles and responsibilities for the various stakeholders including:
  - The Assistant Directors Leadership Team (ADLT) as the forum to agree closure of actions, taking a check and challenge role on the Tracker.
  - Different reporting for the Audit Committee and Executive Leadership Team (ELT) to that provided to Committees, with the latter focused more on individual audits, progress and impact, and Audit Committee and ELT on the broader audit framework, progress, and exposure. This will start when Tracker 3.0 is developed which will draw the agreed reporting from the tracker via Power BI.
  - The introduction of a point of contact in Directorates for audits. This person(s) steers the audit with the Director and Assistant Directors/Deputies, ensuring internal audits feature on the directorate agenda monthly, they update the Tracker, and escalate issues as appropriate.
10. The Tracker has been updated in Quarter four following its complete revision in Quarter two. Members will receive a copy of the Tracker by email and are invited to filter the excel sheet to their particular Committee to view the relevant audit actions. A copy of the Tracker is also reproduced at Annex 1 filtered to the actions assigned to this Committee for oversight.
11. The team continues to work on the development of the SharePoint solution for Tracker 3.0 with colleagues in Digital Health and Care Wales Centre of Excellence. It is intended that this solution will be ready to implement / use early in the 2024/25 financial year, however further work is required to consider the transition from Tracker 2.0 to Tracker 3.0 – which is a significant task.

## ASSESSMENT

12. The Handbook notes that it is the responsibility of a Board Committee (other than Audit Committee) to:
  - Receive audits in their remit;
  - Monitor management actions to address recommendations; and
  - Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.
13. There has been excellent engagement with Directorates on the revised Tracker 2.0, for Quarter four, with the result that of the total of 162 internal audit actions on the Tracker, 64 have been closed in quarter. This is a closure figure of 40% of all internal audit actions, and 57% of the total actions due in Quarter.
14. Of those internal audit actions relevant to this Committee, 33 have been closed in Quarter of a total of 95 (35%). This equates to 60%, as a % of those due in Quarter closed in Quarter. Of these actions due in Quarter, 26 action due dates have moved (marked in blue) and 5 actions are on their third revised date.
15. Of those external audit actions relevant to this Committee, 1 has been closed in Quarter of a total of 2 (50%). There is therefore one action where the due date has moved in quarter and there are no actions with a third revised date.
16. Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these, and discussions will continue into Quarter one with a view to closing down or revising as many as possible.
17. With respect to the Committee's responsibility to scrutinise the impact of actions, in November the Committee agreed that the most effective way to improve the scrutiny of the impact of actions was by identifying actions within audits as audit reports are reviewed by the Committee, going forward.
18. The current version of the tracker is now open for Directorate review for actions due in April, May, and June. These updates will then be reported to the Committee at its meeting in May 2024. The team will work with Directorate contacts to ensure a smooth transition between Tracker 2.0 and 3.0.

19. There continues to be good engagement with the Directorate points of contact to support the management of the actions in the Tracker. The Corporate Governance Team will work closely with the points of contact as the SharePoint Tracker 3.0 develops.

## **RECOMMENDATION**

20. The Committee is requested to:

- (a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. There are none to be received at this meeting  
*(the ICT Contract Management report was received in March 2024);*
- (a) Monitor management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue).

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

Trust Ref. No.	Year / Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Recomm. No. in Audit	Recommendation	Response No. in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first
420	21/22	FPC	Service Management	Reasonable	Aled Williams	Jonny Sammut	Medium		WAST should develop their Service Management framework and once complete, the Service Catalogue should be published and communicated to all appropriate stakeholders.		Agreement has been reached to employ consultants to undertake a review of current position and to develop ITIL based procedures covering the whole service management disciplines. This work is expected to commence during September 2021. A deliverable of this work will be a refreshed service catalogue which can then be published and communicated.	Mar-22	Not Met	Dec22	Sep-23	Apr-24	Open	Last Updated: 20/03/2024 - The implementation of the new service desk software has been delayed due to contract finalisation and work associated with CAS replacement. Work is now underway with the new system in build and is expected to go-live in Jun-24 with the CMDB and service catalogue available shortly after. suggested revised date on Sep-24  Given a very similar recommendation on service catalogue in the 22/23 Resilience audit suggest this is closed or linked to recommendation 621 (the second one on row 242)  10/10/23 - There is limited capability to support Service Catalogue in Service point and an attempt was made to develop one in Excel see attached draft. Whilst this could be completed and shared with stakeholders it would not be particularly user friendly. We are now close to procuring a replacement for Service Point where there will be a central service catalogue available to digital staff and the users within the system. Aim is to get new system operational by Mar-24.
470	21/22	FPC	Asset Management RAM System	Reasonable	Jill Gill	Chris Turley Jonny Sammut	Medium		The Trust should consider the requirement to use the proposed RFID system to validate assets not included in its current processes (e.g. stretchers, defibrillators, suction units, emergency lifting cushions and oxygen delivery systems) against the RAM Asset Management system and review and update its procedures as appropriate.		The Trust has considered the potential of linking RAM and an RFID system, however this would not be practical as RAM is updated on a quarterly basis and the RFID system is a live system with constant streaming updates. These two products would not align in a manner that would deliver a safe and valued output. The proposed solution will be a quarterly download from the RFID system that will be reconciled into RAM and variances investigated. RFID is currently in development, however due to operational pressures the rollout is unlikely to be completed before December 2022.	Mar-23	Not Met	Mar-24	Sep-25		Open	Last updated 11.03.24 As a result of ongoing issues outlined above, together with the need to divert ICT resources to CAS replacements since November 2024, the RFID tagging system is not yet live. The ICT team are looking to re-engage with the supplier and clinical teams from May 2024 onwards with a view to this system being live by December 2024. Following this, work will commence with the finance team looking to reconcile the two systems. Last updated 25.09.23 This work cannot be taken any further forward until the RFID system is fully implemented and quarterly reports become available to reconcile to RAM, this is as per the management response. The RFID system needs to be implemented at pace by the Trust, work is progressing with Fleet in the North and SE to tag items however currently a separate ICT resource is required in C&W to complete, following the previous update the ICT lead has now left the Trust, in addition ICT currently has circa 10 vacancies and is experiencing difficulties in recruiting to these posts, this is resulting in other schemes having to be prioritised over this scheme to ensure core systems function. The previous completion date of Mar 2023 shows as it is unclear due to the recruitment issues faced by ICT exactly when this action will be completed, Mar 2024 put as estimate by ICT dept.
501	21/22	FPC	Waste Management	Limited	Richard Davies / Nicci Stephens	Chris Turley	High		1. The Waste Process document review should be concluded as scheduled, with consideration given to the Policy guidance set out in WHTM 07-01, and with enhanced detail regarding governance structure and training arrangements. The Trust should ensure the Waste Process document, following review and update, is approved at the relevant Board-level Committee as a formal policy, in accordance with WHTM 07-01 requirements.		1. Agreed as the key priority, recommendation and action for immediate further improvement from this review. From which the response and resolution for many of the other actions will naturally follow. To progress many of these, it has been jointly agreed at Exec level that a task and finish group (TFG) will be immediately created with representatives from the following departments: • Estates and Facilities • IPC • Health and Safety • Operations • ICT • Fleet • Corporate Services • Training • Finance • Medical directorate (for drug management issues) • Clinical equipment and logistics • TU rep The TFG will develop a National Waste policy to cover both domestic waste and clinical waste. The policy will identify the management structure for both sections of waste (which will be different) and therefore a reporting structure, including through to Board Committees (likely to be by exception) and therefore Trust Board itself. It will also identify training needs and all compliance and audit obligations.	Sep-22	Not Met	Sep-23	Nov-23	Mar-24	Closed in Quarter	Proposed closure on the basis that this Policy will be taken to FPC for approval in May 2024. Latest Update 08.03.2024 - Waste Policy being presented at March 27th Policy Group for approval . Ownership of clinical waste management issue resolved. Update 201223. Discussions have now been held at Exec level, including with CEO on any required realignment of Exec level responsibilities, part of which links to changing Exec portfolios from 01/01/24. Following this, all remaining items to conclude the new waste management policy will be progressed at pace in January 2024, with a view for ensuring formal sign off before 31/03/24. Revised date in Q3 to March. Update 180923: Waste management policy is drafted however discussions regarding Director level responsibility for clinical waste are being held. The SOPs that form part of the master list of waste in the policy have been implemented however it is the overarching policy that brings them together with roles, responsibilities and governance structures that is out for consultation. Given the clinical waste ownership discussions, it is proposed that this action be moved to November 2023 for the policy to be presented back to the Policy Group to enable those discussions to be held. The policy will thereafter be approved by the FPC. Last updated 13/07/23 Waste Management Policy out to consultation and due to be approved by FPC in September 2023.
505	21/22	FPC	Waste Management	Limited	Nicci Stephens	Chris Turley	High		5.1 The Trust should review the arrangements in place for the transfer of clinical waste and seek to gain assurance that the current arrangements as detailed are in keeping with the requirements of WHTM-07-01.		5.1 – The WHTM 07-01 was amended from HTM 07-01 in 2013, this predates the separation of HCS from WAST. Under its current form WAST is not able to comply with this particular section of the document as WAST does not have a direct contract with the current clinical waste contractor. NWSSP FS, the documents authors, have been contacted regarding this point. The WHTM is due for review. However, those confirmed under the TFG as clinical waste lead will produce an annual hazardous waste transfer note for Denbigh Stores and Pontypool Ambulance Station for completion by HCS, therefore compliant with current hazardous waste legislation.	Jun-22	Not Met	Sep-23	Jan-24	Mar-24	Closed in Quarter	Last Update 19.03.24 (TM) Finance and Performance Committee agreed, given the passage of time, the way that risks identified are managed and mitigated in a differently, and the fact that the Trust has done everything in its control and influence to close the action it was agreed it should be closed on the tracker. Internal Audit who were in the meeting supported this approach. Minutes of that meeting will serve as evidence. Target date moved in Quarter 3 to align to update in 501 i.e. these will come to FPC with the Waste Management Policy in March 2024. Update 180923: WAST does not have a contract with HCS regarding clinical waste. A hazardous waste transfer note was sent to HCS but they have not signed it, stating it was not required. Natural Resources Wales have also confirmed that we have an exemption for transferring clinical waste to HCS and that the only agreements that need to be in place are between HCS and Stericycle (which they are). The only body to whom WAST could have a contract that satisfied WHTM 07-01 is NWSSP (the authors of that WHTM) and they have declined to do so. Propose that this item is closed when a paper is taken to the Finance and Performance Committee setting out the ways in which the risk regarding the absence of a contract for clinical waste for WAST is mitigated. It is proposed that the timing for this is when the Waste Management Policy is taken to FPC (January 2024) so that director responsibilities for clinical risk are clear. Last Updated: 13/07/23 A paper to be prepared and shared at an appropriate forum detailing the current status and the proposals to manage the risk.

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505(a)	21/22	FPC	Waste Management	Limited	Nicci Stephens	Chris Turley	High		6. WAST should contact the respective Health Boards on an annual basis to obtain a duty of care transfer note covering handover of clinical waste from Ambulances at Health Board sites, in keeping with the requirements as stipulated in WHTM 07-01.		6. The WHTM 07-01 was amended from HTM 07-01 in 2013. HTM 07-01 is the English management of waste in healthcare technical note. On amending the HTM to the WHTM this section should have been replaced. As a commissioned service to the health boards clinical waste sits with the patient and therefore the health board. NWSP F5, the documents authors, have been contacted regarding this point. However, to further add to the assurance of this, it is also now requested that the TFG will propose the production of an annual hazardous waste transfer note for each Health board, therefore compliant with current hazardous waste legislation. This will be included in the national waste management policy.	Sep-22	Not Met	Jan-24	Mar-24		Closed in Quarter	Last Update 19.03.24 (TM) Finance and Performance Committee agreed, given the passage of time, the way that risks identified are managed and mitigated in a differently, and the fact that the Trust has done everything in its control and influence to close the action it was agreed it should be closed on the tracker. Internal Audit who were in the meeting supported this approach. Minutes of that meeting will serve as evidence. Update 08.03.2024 - WTN's have been chased and none been returned, WAST has completed all it can with this action, if healthboards choose not to sign and return there is little more we can do. A national clinical waste group for WAST has been implemented, chaired by an Operations Service Manager, to manage, support and instruct staff in safe segregation and disposal methods of clinical waste, alongside legal compliance. Suggest this action is now closed as the recommendation is fulfilled. Target date moved in Quarter 3 to align to update in 501 i.e. these will come to FPC with the Waste Management Policy in March 2024 Reopened September 23 following 22/23 Follow Up Audit. Update: Only two HBs have not returned the duty of care transfer. CVUHB are awaiting the appointment of their waste manager to sign the document. BCUHB did not sign it based on improvements being required on WAST segregation methods. WAST has held fortnightly meetings with local managers in the HB region, as well as BCUHB management and conducted waste management audits in the area. WAST has identified issues and put in place mitigations and have written to BCUHB indicating as much and seeking their agreement to the duty of care transfer note. It is proposed that this action is closed when the paper which encompasses matter arising 5 and the Waste Management Policy are presented to the FPC in January 2024 Update 02/09/22. WTN have been written and sent.
512	21/22	FPC	Service Reconfiguration	Reasonable	Mark Harris / Deborah Kingsbury	Rachel Marsh	Medium		1.1 We recommend that the service specification is finalised and reissued for the period beginning June 2022, reflecting any amendments to the model that post-implementation service reviews have indicated. This is particularly significant because of the contribution this project may make to an upcoming all-Wales model to cover similar service reconfigurations. Future service change SLAs must be signed before the renew date.		1.1 The timescale is dependent on commissioners agreeing the longer term commissioning agreement. Meetings with commissioners (ABUHB and NCCU leading) have commenced to take forward the recommendations of the GUH Evaluation and this should include the agreement on the next commissioning agreement. However this may need to be backdated.	Sep-22	Not Met	Apr-24			Open	250424: Update from Alex C: Positive progress made with SLA negotiations, final comments and financial response sent to ABUHB. Awaiting response to enable the finalisation of documents and move to formal sign off stages through appropriate governance. Operational changes required to shift to the new level of service underway and delivering agreed against a plan discussed with AB. 4.12.23: Requirement is related to an operational issue around the service specification at The Grange - Planning is assisting with the work and it should be finalised before the review date of April 2024. Updated in quarter 3 to April 2024. Update 101023: After initial exchange as noted on 030523 update, Pending receipt of something formally. Informal conversations indicate that based on activity review and remodelling work ABUHB will be looking to reduce peak capacity Currently 10 crews at 1400 hrs daily to 6 Crews. ABUHB will also be redefining the service purpose in the SLA refresh to take out what is believed to be mission creep example Step Across and Discharge activity. WAST will be undertaking its own modelling to corroborate Health Borad modelling and also to ensure there are no unintended consequences or at least the stakeholders are appraised of the risks if any. ABUHB has also indicated that they will be disinvesting from the Paramedic resource it commissioned under this contract and will be looking to increase the Transfer Practitioner resource (TP) instead. The single system project that is looking to move all ACA2 activity under the GUH inter site transfer service on to Cleric CAD system is being progressed with this assumption in agreement with ABUHB 03.05.23 Initial exchange on SLA undertaken, response from WAST considered by ABUHB who are preparing a report to their Execs, advised by NCCU that they will facilitate a further meeting to discuss, likely to be in June. Acknowledged that SLA will not be able to progress until requirements clear from ABUHB. 25.01.23 NCCU proposing a new SLA for April 23. Regular meetings led by the NCCU continue with supporting work to enable the new specification and SLA following the evaluation of the service. The remaining supporting actions are now being prioritised to enable. One key element is the work being undertaken by the health board to review its future clinical needs for transfers as part of the health boards model. Last updated: 02/11/22 Enabling pieces of work are scheduled to be completed for discussion with NCCU and AB in December, NCCU proposing a new SLA for April 23. Regular meetings led by the NCCU continue with supporting work to enable the new specification and SLA following the evaluation no the service. The remaining supporting actions are now being prioritised to enable. One key element is the work being undertaken by the health board to review its future clinical needs for transfers as part of the health boards model.
502	22/23	FPC	Immediate Release Directions	Reasonable	Caroline Miftari	Liam Williams	High		3.1 Datix incidents should be reviewed and closed in a timely manner and any lessons learned should be shared with the relevant parties.		It remains challenging for the Trust to investigate and subsequently close Datix as refusal to comply with an Immediate Release Direction is a Health Board Decision and so any harm that subsequently occurs, requires the Health Board to lead on a joint investigation, with the same principle being expected by the Trust where harm has not explicitly been identified. A new Joint Investigation Process is being piloted under the leadership of the NHS Wales Delivery Unit, which commenced in November and that will run until March 2023. IRD requests that have been declined and where harm has been identified or is considered to have occurred, will form a part of this Pilot and a decision to recommend changes to the process will follow this pilot. Of note the Duty of Candour, that comes into place on 1 April 2023, further regulates the need for openness and transparency with families across the NHS.	Mar-23	Not Met	Apr-23	Dec-23	Jan-24	Closed in Quarter	Update 4.3.24: Revised procedure for Management of Immediate Release Declines reported via Datix Cymru was approved at the Clinical & Quality Governance Group (CQGG) on 29.2.24. Emergency Medical Services Coordination Standard Operating Procedure to be updated and communication of change to be published to demonstrate improvement. Additional procedure for management of incident management associated with Datix Cymru portal is due for approval on 20th March and will be subsequently published to support line managers in the timely and accurate investigation and closure process. Proposed for closure; accepted and upated to closure proposed 160424.  Update 26.1.24: Quality Management Group Forum now established with themes and trends of adverse incidents discussed as part of quality assurance agenda. Data to information is driving further deep dives and quality improvement initiatives. Ref 502 recommendations include thematic analysis of 6 months data to provide assurance of current monitoring activity.  Target date changed in quarter. 14.12.23 The SOP for the management of all incidents reported over Datix Cymru is currently in final draft on the new Directorate template, feedback from patient safety to be incorporated. The Quality Management Group have received and considered a presentation on open incidents within the incident module on Datix Cymru. As part of the presentation, Immediate Release Declines reported via Datix was also reviewed. A draft SBAR for Immediate Release Declines has been discussed at QMG with a view to looking at an alternative process for the management of immediate release declines that are not considered, adverse incidents, near misses and/or hazards as per the Adverse Incident Policy 2023. Further discussions are planned in December 2023. As the SBAR for an alternative process for reporting Immediate Release Declines has not yet been shared with or approved by SOT, we request a revised date of January 2024 for completion  121023: The SOP developed is a QSPE SOP which relates to the management of records through datix as opposed to the SOP in 504 which is the guidance from EMS Coordination in relation to live management of incidents. The review undertaken by the delivery unit in relation to the joint investigation process did not specifically pick up any additional learning regarding immediate release declines however there is now a 'standing agenda' item in the quarterly PTR report regarding serious incidents linked to declines so that we have a method to capture incidents and identify thematic activity. TBC at next review if this now closes this item. Update: 26.09.23 - Standard Operating Procedure for Datix drafted to step out expectations for managers. Review currently ongoing for how datix is used with proposals to be drafted to more easily identify those IRD records where harm has occurred. Proposed revised date of 31.12.23 to allow datix team to provide analysis and proposals for change. Reason for proposed revised date is due to capacity within team. Senior Quality Governance lead now in place, OCP completed for department but 1.12.23 not complete.

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503	22/23	FPC	Immediate Release Directions	Reasonable	Caroline Miftari	Liam Williams	High		3.2 Noting the capacity issues above, the Trust should review the requirement to investigate all Amber 1 declined directions and consider introducing a streamlined mechanism of reporting. The Trust's SOP should then be updated accordingly to reflect the outcome of this review.		The Trust will agree a process to record all Amber 1 declined IRDs and report occurrence thematically based on UHB and clinical code sets. Where thematic analysis identifies additional areas of concern, these will be taken forward on a 'task and finish' basis by the Trust with the appropriate UHB and clinical representation.	Feb-23	Not Met	Apr-23	Dec-23	Jan-24	Closed in Quarter	Update 4.3.24: Revised process to report only those incidents where patient safety and/or working safety issues have been identified to reduce the number of Amber 1 incident declines that require investigation (EMS Coordination currently review 10% of all Amber 1 level declined requests to provide feedback to the relevant Health Board via the Director of Operations). A thematic analysis is being undertaken by the Quality Management Group covering the 6 months prior to end February 2024. Proposed for closure; accepted and updated to closure proposed 160424.  What will close the action: Thematic analysis is already underway through Quality Management Group. Terms of Reference identifies the purpose of the Quality Management Group in supporting the Quality Management System - this should close the action however approval of the recommendations for improvement ref 502 would meet the recommendation. What will you provide as evidence for the closure: Revised process to address capacity challenges; evidence of thematic analysis from Quality Management Group Is date reasonable: Acceptable to meet the action set out however extension required for end of April 2024 to meet Trust Ref 502 if improved response aligned recommendation is preferable Target date moved in quarter. 14.12.23 A draft SBAR for Immediate Release Decline has been discussed at Quality Management Group with a view to looking at an alternative process for the management of immediate release declines that are not considered, adverse incidents, near misses and/or hazards as per the Adverse Incident Policy 2023. Further discussions planned in December 2023 therefore we request a revised date of January 2024 for completion  Update 121023: Given that the action is to include the process to record all Amber 1 declined IRDs and report thematically, with TFAs being established where areas of concern identified, we will close this when the SOP (the SOP is different to that in item 504) has been approved as that will close off the action. The action was not to embed processes. Propose extending to Dec 23 on that basis. All Amber 1 declined IRDs are now recorded through datix. There may be further tweaks to the process as we continue to develop our quality management system. Update 26.09.23: Linked to Ref 502 review now ongoing for how datix is used which will include recommendations on how thematic analysis can be provided. Quality Management Group now commencing which will allow for review of thematic analysis to support quality improvement planning and subsequent T&F tasking. Proposed revised date of 31.03.24 to allow recommendations to be approved and QMG to embed processes, pre-requisite for Ref 502 to be completed before this action can be recommended for closure. Reason for delay is due to capacity within team. Senior Quality Governance lead now in place, OCP completed for department but 1 vacancy still remains. Last update: 14.04.23 Delayed due to management capacity and impacts of industrial request for extension to end of April 23 - coaching bulletin drafted
522	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Jonny Sammut	Medium		1.1 A report (template) catalogue should be created and maintained. It should list all reports available, their purpose, the data fields they contain, and the parameters that can control the actual report production e.g. period, location etc. This can be supported by the MI on report production; if it has not been produced for over 12 months is it still needed, should it be archived?		A report catalogue is already in development. We will also set up a small selection of report templates to help speed up development, make self-serve easier for consumers, and streamline this report cataloguing effort.	Apr-23	Not Met	Dec-23	Feb-24	Jun-24	Open	Last updated 22/03/24: the report templates are now complete, but work remains to fully populate the catalogue. Request for date to be revised to June 2024. Date revised in Q4 to June24. Update 22/11/23: A specialist 'Reporting Analyst' secondment position was created and successfully recruited into to support this work. Progress has been made since this appointment in Oct-23, with a goal of finalising and publishing Jan-24. Update 28/06/23: Capacity in the analytics team means although progress has been made against this action, it is not yet complete. The report catalogue now exists, but cycles of review for the reports contained within it have not yet commenced.
523	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Jonny Sammut	Medium		1.2 The process of requesting a new or modified report should be formalised. It should include reference to the catalogue at 1.1 so that specialised analyst time is not wasted reproducing existing reports		The recommendation is welcomed, and we will look to expand on the existing request process with a formalised (potentially guided self-serve) check of existing functionality, and an ability to decline requests if the content already exists in other places, or if not aligned with organisational priorities.	May-23	Not Met	Dec-23	Feb-24	Apr-24	Open	Last Updated: The Data & Analytics request process has been revisited and modernised - this is currently being aligned with the wider request process for the Health Informatics function as part of a rapid cycle of improvement currently taking place across the function, before being approved for implementation. Although work is almost complete, evidence will not be able to be provided until launch in April 2024. Date revised in Q4 to April24. Target date moved in quarter. Update 22/11/23: This work is on-track, and the proposed process is waiting review by the data and analytics leadership team. Changed date requested. Update 28/06/23: The new report catalogue has been embedded within HI processes: when new requests for intelligence are received a check is made whether a report already exists which could allow the requestor to self-serve the information before the task is actioned. Due to capacity constraints within the team, the request mechanism is still to be amended to ensure alignment with WAST strategic priorities in 2023-24.
524	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Jonny Sammut	Medium		1.3 Data on report production and usage should be maintained, and feedback from the requestor obtained. This should be used to maintain and limit the reports available to a manageable number of reports with their usage and priority recorded.		We do already obtain some feedback on service and products, but will look to formalise the collection of this and the embedding of findings within the development cycle process, as well as create management KPIs around these metrics to take through Digital governance routes. However, a dependency here is the management of the HI HelpDesk inbox, and work to converge this with the ICT ServiceDesk inbox.	Jun-23	Not Met	Dec-23	Feb-24	Apr-24	Open	Last updated 22/03/24: A review of all reports and dashboards made available by this team is almost complete, but is being finalised as part of a rapid cycle of improvement taking place across the Health Informatics function in March and April. Additionally, all 111 related reports are undergoing a review for utilisation as part of the 111 CAS replacement project. Request for extension to April 2024 when the internal review and 111 review will be complete, and a meta report for report utilisation will be implemented. Date revised in Q4 to April24. Target date moved during quarter. Update 22/11/23: This action is linked to the catalogue work of action 522. We have gathered intel on all available data products and are now grading reports. Expected to be able to complete early 2024 - propose date change to Feb-24. Update 02/10/23: Report usage data is routinely collected and used on an ad-hoc basis, but we don't currently obtain much feedback from requester/users. We are beginning to implement a report review cycle for all reports. Linked to 522.
525	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Jonny Sammut	Low		2.1 There should be a series of Entity Relationship Models available covering all of the tables in the data warehouse.		We will develop an ERD library, including meta-data, starting with EMS CAD. We will plan out a roadmap for this exercise to expand into the other systems supporting EMS, Ambulance Care, 111 and Corporate teams around the organisation, to build up a full WAST ERD library and meta-data source.	Mar-23	Not Met	Mar-24			Closed in Quarter	Last Updated 22/03/24: An Entity Relationship Diagram for EMS CAD is now complete and available for use by the Data Engineering team. Propose Closure accepted. 191223: Update from LS: Role being interviewed for this week. The ability to meet the March date will therefore depend on the notice period and start date of the appointed candidate. Leave as Mar-24 for now and review if required in January. Update 22/11/23: Recruitment is in progress to bring in a principal data engineer to bolster capacity in the team, but also support oversight on this project from March-24. Update 28/06/23: The EMS CAD Data diagram is now complete. Deadline for full ERD library is unrealistic, suggest this is reviewed against other priorities. This work will ultimately be used within Digital and not wider Trust stakeholders. There has been a Principal Data Engineer vacancy since Jun-23 and as part of the savings plan, there is no intention to backfill for this post in the short-term.

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526	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Jonny Sammut	Low		2.2 All tables should have a completed meta-data table describing their contents		We will develop an ERD library, including meta-data, starting with EMS CAD. We will plan out a <b>roadmap</b> for this exercise to expand into the other systems supporting EMS, Ambulance Care, 111 and Corporate teams around the organisation, to build up a full WAST ERD library and meta-data source.	Jul-23	Not Met	Dec 23	Mar-24		Closed in Quarter	Last Updated 22/03/24: An Entity Relationship Diagram for EMS CAD is now complete, as per action 525. This offers a example of what will be created for all other data tables in our warehouse. However, it should be noted that there are over 400 tables, and so this action was to create a <b>roadmap</b> for ERDs for the remaining core data sources. This roadmap has now been developed and will be tracked internally to Digital Directorate. Propose closure accepted. Target date moved in quarter 3. 191223: Update from LS: Update from LS: Role being interviewed for this week. The ability to meet the March date will therefore depend on the notice period and start date of the appointed candidate. Move to Mar-24 for now and review if required in January. Target date moved during quarter 2. Last updated 22/11/23: Recruitment is in progress to bring in a principal data engineer to bolster capacity in the team, but also support oversight on this project from March-24. Update 02/10/23: As per update of item 525. A sequence of design for the ERD library has been agreed within Digital, but timelines for completion are not yet available due vacancies in the team (recruitment is underway). The EMS CAD item is complete, with goal of achieving ePCR diagram by December 2023 (followed by CAS then NEPTS in Spring 2024).
527	22/23	FPC	Data Analysis	Reasonable	Aled Williams	Jonny Sammut	High		3.1 A programme to replace all of the Qlik reports with Power BI equivalents should be scoped and completed. Qlik should then be decommissioned and removed.		<b>A risk-assessment</b> will be conducted to understand the exposure to WAST of Qlik Sense being out of vendor support. This platform is not internet facing (i.e. for internal users only, not on a publicly accessible web url), and not believed to present an information security risk, but pending ICT assessment, we will devise a mitigation plan, or an options appraisal for maturity - <b>due March 23</b> . In the meantime, there is already a programme of work to migrate reports and dashboards to <b>PowerBI</b> . However, this is a lengthy and high-capacity activity, and is not prioritised highly at this current time - due March 24.	Mar 24	Not Met	Oct-24			Open	12042024: BoardSec review - recommended extension to October based on the update given, and that once this programme is completed and evidence received can be closed. Target date moved in Q4 to October 2024. Last updated 22/03/24: Risk assessment complete and on Datix, and monthly meeting in place between Cyber and Data Engineering experts to review the risk and track any vulnerabilities. This is managed through the 'national vulnerability management dashboard' reported through to Closed FPC. Additionally, a migration workstream for moving all dashboards from Qlik to PowerBI is in progress, with completion date of September 2024. Update 02/10/23: Risk assessment completed and in Datix. A 12-month secondment has been created for a PowerBI specialist to start the work of migration from Qlik before decommissioning. March-24 is likely unrealistic, but a roadmap will be developed once the secondment begins (November-23). Previous update 27/06/23: Qlik is considered a low IS risk. Work is already ongoing to move reports into powerBI but due to capacity constraints within the team will take most of 2023-24 to complete
531	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Jonny Sammut	Low		5.1 A defined quality (accuracy) level should be established for all data fields, so that particular focus can be made on those determined as being key, e.g., patient identifiers have to be 100% accurate.		It should be noted that we have only 0.4 WTE capacity in this specialist function and so any activities around data quality management improvements will not be able to be completed quickly. However, we will commit to review our Data Quality Policy, adding in detail regarding the minimum level of acceptable accuracy and error rates for key fields where appropriate.	Aug-23	Not Met	Dec 23	Jun-24		Open	Target date moved during quarter 3 to June24. Last updated 22/11/23: propose that the target date be moved out 12 months to enable review of the policy in 2024-25 and a data quality assurance plan to be created with appropriate resource secured to support the work. <b>The approval of the policy will close this action.</b> Update 02/10/23: Data Quality Policy review not yet started - this is agreed to be part of the 2024-25 policy workplan. (Digital are reviewing 3 other higher priority policies in 2023-24.). Date for approval of the Data Quality Policy aimed at November 2024 QUEST.
532	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Jonny Sammut	Low		5.2 Acceptable error rate(s) should be agreed and processes put in place or improved, so that Trust data reaches the agreed accuracy levels.		It should be noted that we have only 0.4 WTE capacity in this specialist function and so any activities around data quality management improvements will not be able to be completed quickly. However, we will commit to review our Data Quality Policy, adding in detail regarding the minimum level of acceptable accuracy and error rates for key fields where appropriate.	Aug-23	Not Met	Dec 23	Jun-24		Open	Target date moved during quarter 3 to June24. Last updated 22/11/23: propose that the target date be moved out 12 months to enable review of the policy in 2024-25 and a data quality assurance plan to be developed with appropriate resource secured to support the work. <b>The approval of the policy will close this action.</b> Update 02/10/23: Data Quality Policy review not yet started - this is agreed to be part of the 2024-25 policy workplan. (Digital are reviewing 3 other higher priority policies in 2023-24.) Date for approval of the Data Quality Policy aimed at November 2024 QUEST
558	22/23	FPC	IMTP Delivery	Reasonable	Heather Holden	Rachel Marsh	Medium		1.1 The PDDs of the sample programmes should be enhanced to include a Quality Management element to assure the quality of the programme and its deliverables.		This recommendation is accepted. We will define the quality standards to be implemented across all projects and programmes as part of the development of the project and programme management framework and will consider how we define quality measures for project deliverables for the delivery of the next iteration of the IMTP. This will commence with a framework workshop by the end of April to determine the actions required to put this in place.	Apr-23	Not Met	Jun-23	Nov-23	Feb-24	Closed in Quarter	Last Updated 140324 - pathway framework signed off by STB on 26 Feb 24. Published and available on Siren here: <a href="https://nhs.wales365.sharepoint.com/sites/AMB-Intranet-Performance/SitePages/Project-Path-Framework.aspx">https://nhs.wales365.sharepoint.com/sites/AMB-Intranet-Performance/SitePages/Project-Path-Framework.aspx</a> . Closure proposed Target date moved in quarter 3. 4.12.23: It was stated that this would come through the Project Path Framework document which will be updated and brought back to STB on 15th January 2024. This item will be closed when the pathway framework document is approved by the Strategic Transformation Board. Target date moved in quarter 20.09.2023 - Since the audit a review of the approach to IMTP delivery has been undertaken and a more agile approach to IMTP and transformation delivery is being developed recognising the complexity and interrelatedness of the programme structures that are currently running. A Project Path Framework is in development (due October/November 2023) to replace the current outdated Project and Programme Management framework along with a standard suite of templates. A first draft of the framework will be presented internally to the SPP team by the end of September and will then be presented to ISPG for feedback and approval. This will include a revised Programme Definition Document that includes a Quality Management section. Following approval, the current programmes will be transitioned to the new templates and the QM sections will be populated. Last Updated: 17.04.23 Workshop with transformation team on 3rd April, outcomes to be written up and next steps agreed.

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560	22/23	FPC	IMTP Delivery	Reasonable	Kelsey Rees-Dykes	Rachel Marsh	Medium		2.1 The G2C programme board should implement a programme level deliverables plan to assure the management of dependencies in the event of individual project / workstream slippage or other development; and that this is universally implemented across the transformation programmes of the Trust.		Currently programme level plans are included within the overarching reporting via STB. With specific plans developed at project level. We will therefore develop a detailed G2C Programme Action Plan (Milestone timeline aligned to IMTP deliverables) with project Gantt charts feeding into this timeline.	Mar-23	Not Met	Jun-23	Nov-23	Feb-24	Closed in Quarter	Last Updated 140324 - pathway framework signed off by STB on 26 Feb 24; closure proposed. Target date moved in quarter 3 to Feb24. 4.12.23 - Key milestones under each of the projects that sit in G2C to be updated - revised date of February 2024 required. Confirmed that all Project Managers need to ensure there is an overarching deliverable plan for all projects so dates can be seen by SRO in one place. 20.09.2023 - Since the audit a review of the approach to IMTP delivery has been undertaken and a more agile approach to IMTP and transformation delivery is being developed recognising the complexity and interrelatedness of the programme structures that are currently running. This item will be closed when the pathway framework document is approved by the Strategic Transformation Board. A Project Path Framework is in development (due October/November 2023) to replace the current outdated Project and Programme Management framework along with a standard suite of templates. A first draft of the framework will be presented internally to the SPP team by the end of September and will then be presented to ISPG for feedback and approval. RAID (Risk, Action, Issues, Decision) logs are part of the standard suite of documentation. Last updated: 17.04.23 Focus of March planning and transformation was landing the IMTP which required additional attention from the team to meet the challenging outlook for 2023/24. Following a review of the governance and reporting into STB we are now re-setting the programme plans in line with the 2023-26 IMTP so this will form part of that work.
562	22/23	FPC	IMTP Delivery	Reasonable	Heather Holden	Rachel Marsh	Medium		3.1 Programme documentation should incorporate a standard benefit realisation plan that includes the methods to assess the identified benefits, the timing of the benefit realisation work and the criteria that will be applied to measure success.		We would consider there to be a benefits plan in place for EMS Operational Transformation. For other programmes, this has been something that we have intended to do for some time, as we awaited the appointment of a new Head of Transformation. We recognise the need to clearly articulate and plan programme benefits and will review all programmes to determine whether current benefits plans meet the requirement of a benefits realisation plan and will identify dates to hold benefits planning workshops to finalise benefits realisation plans for each programme where this is required.	Apr-23	Not Met	Jun-23	Oct-23	Feb-24	Closed in Quarter	Last Updated 140324 - pathway framework signed off by STB on 26 Feb 24; closure proposed. Target date moved in quarter 3 to Feb24. 4.12.23: Project Path Framework includes Benefits Realisation Plan headings for use across the Trust. To be signed off on 15th January 2024 at STB. REQUEST REVISED DATE OF Feb-24 20.09.23 - A Benefits Realisation Plan template has been developed and will be rolled out across the existing programmes. Due October 2023. Will propose closure once action complete Last Update: 17.04.23 Workshop with transformation team on 3rd April, outcomes to be written up and next steps agreed.
566	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		1.1 The Trust should engage with Welsh Government to update the content within the SLA to recognise that HART capabilities and include reference, where appropriate to National Standards		The Trust accepts this recommendation, recognising that the SLA is provided to WAST by Welsh Government who procure the services from WAST. We will therefore seek to agree the content of the SLA	Mar-22	Not Met	Mar-23	Sep-23	Mar-24	Closed in Quarter	250424: Action status changed to closure proposed following receipt of evidence. Email from Clare Langshaw to Judith Bryce confirming conversations with NHS Executive and the revision of the SLA and that new arrangements supersede the SLA. Funding letter will be prepared in place of the SLA; to be progressed.  Update 22.03.2024 Will provide evidence of information shared with NHS Executive. Email sent to Clare Langshaw to send over on return from leave on Tuesday 26th March.  Update 15.03.2024 Recommend to CLOSE - information has been updated and subject to agreement period with Welsh Government but for the purpose of the recommendation the content has been updated.  Update 11.03.2024 The NHS Executive want the SLA in a different format, requests for information were made to WAST on 19th February and information had been submitted by Clare Langshaw. No further correspondence received. No revised funding arrangement been proposed for HART at this time.  Update 09.02.2024 - Meeting has been held with WG, HART/SORT SLA will now be hosted by the new NHS Executive that will be recognised from 1st April. CL has been advised that the SLA will need to be rewritten to meet with the NHS Exec expectations. Second meeting to discuss SLA planned for February 2024.  Update 22.11.2023 Confirmed March 2024 is a reasonable date for SLA Target. Update 27.09.2023 new SLA in draft and agreement with Welsh Government that the new SLA will come into 2024/2025 financial year. Last Updated: 26.06.2023 - Agreement obtained that Welsh Government will review the SLA and the process has commenced. EPRR Team has commenced the review of SLA. Proposed completion date changed from Sep23 to Mar24 as an extensive amount of work needs to be undertaken.
567	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		2.1 The Trust should undertake a self-assessment against the NARU key lines of enquiry review document. This could support any future "critical friend" review undertaken		The Trust accepts this recommendation and is committed to undertaking a self-assessment against the NARU review document	May-23	Not Met	Mar-23	Mar-24	Jun-24	Open	160424: (AP) Self-assessment is yet to be taken to SOT. Cannot be closed in quarter. Revised date of June 2024 applied in Q4 and can be closed off once the self-assessment has gone to SOT and received evidence. Update 22.03.2024 Copy of self assessment sent to Alex Payne as evidence requested for closure. The Self Assessment is scheduled to go through SOT meeting on 9th April. Once meeting takes place, we will send over minutes of discussions for evidence of closure. Update 11.03.2024 Self assessment been completed, majority of areas compliant with. Next steps will be ongoing annual review to be carried out. Recommend closure. Update 24.01.2024 - Date set to undertake an internal review as mentioned on 22.11.2023. Date confirmed as: 19th February 2024. Update 22.11.2023 We are looking to undertake an internal review carried out by the Specialist Operations Locality Manager against the same criteria that the English Trusts are reviewed against to ensure interoperability is maintained. Update 27.09.2023 NARU still unable to support due to capacity limitations. HART uplift currently rolled out in England which is NARU's current focus. To ensure this action is undertaken an internal review will now take place in line with this action. Last Updated: 26.06.2023 NARU has been approached, but they are not able to support this at the moment due to staff shortages. Although they are supportive of the Trust in this. Proposed completion date changed from Mar23 to Mar24.

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570	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		5.1 The Trust should consider undertaking a periodic review of the CAD codes assigned to prompt specialist response, or establishing a link between the group and HART for its input into ongoing reviews.		The Trust accepts this recommendation and will undertake a review of CAD codes to ensure they are applicable to HART capabilities and also maximise the use of HART deployments. Any changes will be subject to CPAS approval and we will engage with CPAS to reflect this work on their work programme.	Jun-23	Not Met	May-23	Oct-23	Apr-24	Closed in Quarter	290424: Receipt of CAD Codes at DCR (as a sub-group of CPAS) and the Directorate SLT (with the supporting evidence) satisfies closure of this action. Updated to closure proposed. Update 15.03.2024 Clinical sign off has been completed (6th March 2024) and the implementation process i.e training and tech changes to the live DCR will now follow (actioned through SLT), but for the purpose of this recommendation the review has been done and subject to normal procedure through the normal Trust process. Recommendation to CLOSE.  Update 11.03.2024 - Updating of codes to be provided by ICT, no implementation dates planned at this time.  Update 25.01.2024 - meetings took place in September. The HART code sets are going for consideration at the DCR review on 6th March and there they will agree governance route for approval. Further updates to follow.  Target date moved in Quarter 3 Update 22.11.2023 Suggest revised date to change to April 24 to account for the expected winter pressures in the coming months and EMSC capacity to support. Update 27.09.2023 - Specialist ops LM has approached EMSC for support, EMSC unable to support at this time due to thier capacity, unable to move this action forward without EMSC support. Last Updated: 26.06.2023 - EPRR Team linking with EMSC colleagues to progress this audit recommendation.
595	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		6.1 HART management should undertake periodic comparison of data extracted from the CAD system to compare against activity reported on PROCLUS to support ongoing efforts to improve data recording on that system		The Trust accepts this recommendation and will undertake a comparison of CAD data to Proclus, with a view to improving the accuracy and system of reporting on Proclus in the future.	May-23	Not Met	May-23	Oct-23	Apr-24	Closed in Quarter	Update 25.01.2024 - Change of process has been implmented, HART activity is now reported through launchpad not CAD, this ensures activity is reported the same on Proclus as it is within the Trust. Implementation of review of HART activity will be through OM meetings. This action is recommended to be CLOSED.  Target date moved in Quarter 3 Update 22.11.2023 Suggest revised date to change to April 24 to account for the expected winter pressures in the coming months and EMSC capacity to support. Update 27.09.2023 - Specialist ops LM has approached EMSC for support, EMSC unable to support at this time due to thier capacity, unable to move this action forward without EMSC support. Last Updated: 26.06.2023 - EPRR Team linking with EMSC colleagues to progress this audit recommendation.
622	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Jonny Sammut	Medium	1.1	WAST should schedule a physical stocktake to ensure the asset register is 100% accurate.	1.1	With the majority of corporate staff remote working since Covid it has been difficult to conduct a physical audit. Also given the range of equipment provided to staff for home working (laptop, dock and monitors) we will have to develop a new way of undertaking a physical audit.	Apr-24	Not Yet Due				Open	20/03/2024 - This recommendation is now linked with the implementation of the new service desk software has been delayed due to contract finalisation and work associated with CAS replacement. Work is now underway with the new system in build and is expected to go-live in Jun-24 and a review of assets will be conducted as part of this implementation. In parallel work is ongoing to undertake a physical audit of WAST sites when resources are available. However we still considering option for physical stocktake of remote workers where it does not involve a visit staff home address
623	22/23	FPC	IM&T Infrastructure	Reasonable	Robert Walker	Jonny Sammut	Low	2.1	The contract management SOP should be appropriately reviewed and authorised and communicated to relevant staff.	2.1	The Contract Management SOP has been approved at ICT SMT and will now be presented to Digital Leadership Group for approval, following which it will be communicated to staff across the Trust	Sep-23	Not Met	Dec-23	Jan-24		Closed in Quarter	31012024: Update from DoDS - Link to Siren Notice now Contract Management SOP published; can be closed in Q4 reporting - subject to Board Secretary being satisfied (AP). Link: <a href="https://nhs.wales365.sharepoint.com/:u:/r/sites/AMB-Intranet-News/SitePages/Contract-management-SOP---Digital-notice.aspx?csf=1&amp;web=1&amp;e=NLI9D">https://nhs.wales365.sharepoint.com/:u:/r/sites/AMB-Intranet-News/SitePages/Contract-management-SOP---Digital-notice.aspx?csf=1&amp;web=1&amp;e=NLI9D</a> .  Update from DoDS 08.01.24: We have signed off the SOP via SLT and Digital Leadership Group, the communications is currently under draft and will be issued in the next two weeks. CGM has asked that a copy of the notice/comms be provided when available, at which point the action can be updated as 'closure proposed'. It has missed the Q3 reporting period however, so will have to be captured in Q4. Revised date applied in line with this update to Jan-24. Last updated 06/12/23: approved by DLG comms to go out Trust-wide on Siren in Dec-23. Board Secretary reviewed DLG action/decisions log.
624	22/23	FPC	IM&T Infrastructure	Reasonable	Wyn Morris	Jonny Sammut	Medium	3.1	The process for clearing all PRGT/system alerts should be formalised and documented. It would typically include •A shared mailbox, all alerts go to one place •Prioritisation guidelines for all calls. •Scheduled review times for technicians and managers. •Process for storing cleared alerts for periodic analysis to assist with trend /cause identification If there are too many alerts for this to be considered reasonable then the parameters for their production could be reconsidered so that a lower number of what could be considered higher priority alerts is generated.	3.1	Agreed, will look to formalise the process and provide some ownership to the defined process	Dec-23	Not Met	Jun-24			Open	Linked with implementation of House on the Hill ITSM software. Date moved in Q4 to June24.  20/03/2024 - This recommendation is now linked with the implementation of the new service desk software has been delayed due to contract finalisation and work associated with CAS replacement. Work is now underway with the new system in build and is expected to go-live in Jun-24 and automation of PRGT alerts is a key part of this implementation.  Target date moved in quarter 3 Last Updated 06/12/23: Technical solution still to be designed but likely solution superceded by implementation of new Service Desk platform which will address this need in core requirements. Timeline June 2024. 18/12/23: Contract for new service desk software signed 15/12/23, Draft implementation plan produced with full implementation expected to take 6 months, individual modules are yet to be prioritised
625	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Jonny Sammut	High	4.1	Switches should be identified within the asset register.	4.1	This work was underway prior to the audit but the member of staff is on long term sick. As our switches are configured not to respond to general network sweeps it is a manual task to collate and add this information to the CMDB.	Mar-24	Not Met	Sep-24			Open	Linked with implementation of House on the Hill ITSM software. Date moved in Q4 to Sept24.  20/03/2024 - Work completed and list produced and waiting on the implementation of the new service desk software which has been delayed due to contract finalisation and work associated with CAS replacement. Work is now underway with the new system in build and is expected to go-live in Jun-24.
626	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Jonny Sammut	High	4.2	A process for patching of unpatched switches or other network components should be established.	4.2	We will look to develop a risk based patching procedure for network switches and devices	Mar-24	Met	Apr-24			Open	Target date changed in Q4 to April 2024 based on advice from Board Secretary.  20/03/2024 - Process for assessing and patching switches now in place. Risk assessment carried out on existing estate and replacements switches purchased for priority devices. Propose closure now process is in place.

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627	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Jonny Sammut	High	4.3	A mechanism to deal with/isolate equipment that cannot be brought up to the required security specification should be defined.	4.3	This will be included in the above patching procedure	Mar-24	Met	Apr-24			Open	Target date changed in Q4 to April 2024 based on advice from Board Secretary.  20/03/2024 - Risk assessment carried out on existing estate and replacements switches purchased for priority device not able to be brought up to minimum . Propose closure now process is in place.
628	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Jonny Sammut	Low	5.1	Consideration should be given to how long the switch to the disaster recovery site will take and if automation is a practical option.	5.1	There are differing requirements for fail over of Trust systems in DR terms with some also only supporting a manual failover process to the DR site. The Trust infrastructure is being refreshed during 2023-2024 and we will look to areas where it can improve failover where practicable or required	Dec-23	Not Met				Closed in Quarter	Propose closure as systems are all migrated to the new infrastructure and automated DR in place where practicable.  20/03/2024 - In the new infrastructure the primary and backup sites are the same and can cater for all local system running on the solution. Should the DR site need to be invoked all system have been categorised into 6 recovery profiles which prioritise the order of recovery for these systems . A decision has been made not to automate the lowest priority systems to ensure orderly recovery.  Target date moved in quarter 3. 22/11/23: CAD will always have aspects that need manual intervention with MIS. Trust infrastructure refresh in the process of migrating (Dec-23) which will improve capability for failover. Next to agree failover requirements, during annual review Business Impact Analysis (BIA). CONSIDER REVISED DATE TO JUN-24 DEP ON 111 project solution.
629	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Jonny Sammut	Medium	6.1	A review should be undertaken to ensure that the assessment of the criticality of the services is still valid.  The backup site capacity should then be reviewed to ensure all the required services can be hosted and what systems have priority and their restoration order.	6.1	The Trust server, storage and backup infrastructure is being refreshed during 2023-2024 and we will look to align capacity and to improve failover where practicable and affordable	Mar-24	Met				Closed in Quarter	Propose closure as all systems assessed as part of migration activity and systems appropriately classified to RPO/RTO profiles.  20/03/2024 - In the new infrastructure the primary and backup sites are the same and can cater for all local system running on the solution. All systems have one of four agreed RPO profiles which ensure the recovery site is up to date. Should the DR site need to be invoked all system have been categorised into 6 recovery profiles which prioritise the order of recovery for these systems.
643	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	1.1	Guidance should be developed to clearly outline: - Roles and Responsibilities (including assessments, approvals, monitoring and reporting arrangements). - Documentation to be used within the savings process to ensure that key elements are included, e.g. impact, risks, success measures, timescales, etc. - Escalation process to be followed (when, to whom and actions to be taken) where savings are not	1.1	Guidance on roles and responsibilities, documentation and escalation to be developed and shared by Financial Sustainability Programme.	Jul-23	Not Met	Dec-23	Feb-24		Closed in Quarter	11042024: Updated status to closure proposed, as evidence of receipt of the FSP Delivery Framework taken to STB in January received. Paper, agenda and minutes from the meeting of STB received and reviewed by Corporate Governance (AP).  Update 22-03-24: Financial Sustainability Programme Delivery Framework presented to STB January 2024 for noting and comment. Document is Live Document and will continue to be updated to reflect 2024/25 objectives. Document outlines roles, responsibilities, and reporting arrangements, as well as scheme updates via workstreams. Scheme Scoping Document developed to capture risks, quality, clinical, and financial risks and included in Appendix. Governance and Escalation clearly defined in Framework. Proposed for closure.  December 2023 Update: Target date moved in quarter. Update 12.12.23 - Draft Financial Sustainability Programme Delivery Strategy document developed which covers off guidance on roles and responsibilities, documentation and escalation - to be shared with relevant stakeholders over the coming months. Action to be closed off when document presented to STB on 15.1.24.
645	22/23	FPC	Savings & Efficiencies	Reasonable	Jason Collins	Chris Turley	Medium	2.1	A formal programme of financial training should be provided to budget holders to allow them to effectively carry out their role.	2.1	Key objective for WAST FM Team (and wider Finance teams) for 23/24 will be to undertake a series of Finance Training to Board Members, Budget Holders and other non-financial staff. This will be delivered by several methods such as face to face training, TEAMS sessions and induction.	Dec-23	Not Met	24-Mar	Jun-24		Open	Target date moved in quarter three and four (to June24). Update 12.12.23 - this has commenced with formal training to board members / TU partners taken place in April 23 and training sessions held with Operational Managers in November 23. Training to budget managers will now be captured in Quarter 4 to include any potential updates to finance system rollouts being undertaken by NHS Wales. In the interim all budget managers have assigned Senior Finance Business Partners who support and informally train on all finance related matters. UPDATE 21.03.24 ... formal training to budget holders is slightly delayed due to the national rollout of the Qlicksense finance tool to all organisation which will incorporate BI dashboards and WAST Finance Team will deliver the formal training alongside training for this new package. Informal support continues as all Budget Holders / Managers are assigned a Senior Finance Business Partner as first line of contact
646	22/23	FPC	Savings & Efficiencies	Reasonable	Jason Collins	Chris Turley	Medium	2.2	Training records should be maintained to confirm attendance, which should be monitored to identify non-attendance so this can be followed up.	2.1	Schedule of Training and who has attended to be recorded.	Dec-23	Not Met	24-Mar	Jun-24		Open	Target date moved in quarter three and four (to June24). Update 12.12.23 - As per audit ref 645, formal training has commenced and a log of attendees has commenced and this will be further updated during quarter 4 roll out of formal training to budget managers. UPDATE 21.03.24 ... as per audit ref 645 ... list has commenced but will be added to when formal training is rolled out to align with new finance system
647	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	3.1 (a)	Savings and efficiency plans should be enhanced using SMART criteria to define success and provide realistic timescales.	3.1 (a)	Will be evidenced by project management principles being applied to every individual savings schemes as it is identified and its ongoing monitoring.	Mar-24	Met				Closed in Quarter	Update 22-03-24 Continuation of sentences already populated. Example project management techniques applied to schemes such as Administrative and Corporate Services Review and Services Review (PIDs attached). Documents provided as evidence in email to Alex Payne. Recommended closure. Proposed closure accepted.  Financial Sustainability Programme provides a central vehicle for generating, scoping, and monitoring areas of improvement required to achieve financial sustainability by establishing workstreams against realistic targets. Each scheme presented is assessed and scoped from inception to delivery individually. The FSP maintains a forum for scoping and planning. Formal approval for improvement opportunities, in particular those that may have staff impacts, are approved via STB and ELT.
648	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	3.1 (b)	Noting the expected future financial challenges, there should be prioritisation and recording of recurring funding against one-off savings to assist with financial sustainability.	3.1 (b)	Impact of Non-recurring schemes in 23/24 will be addressed by FSP and as part of WAST Financial Plan for future financial years.	Mar-24	Met				Closed in Quarter	Update from Finance: The 2024/25 Financial Savings Plan identified is a balance of recurrent and non-recurrent opportunities and target areas. The organisation tries to emphasise the delivery of more recurrent savings where possible and in such endeavour is pursuing service review & admin efficiencies currently. - Recommend to close as this is a BAU issue and all savings plans throughout all NHS organisations will always have an element of recurrent and non-recurrent saving schemes. Financial Tracking in place with attached RAG Rating. Forward planning encompass' a 'plan on a page' for each scheme. Performance reported and assured via F&P and STB - Recommend to close as process is in place. Proposed closure accepted.

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649	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	3.1 (c)	A log should be implemented to enhance the current process recording changes to the savings programme, during the financial year, from that originally approved.	3.1 (c)	Schedule of 23/24 agreed plans and any additions will be controlled through FSP.	Mar-24	Met				Closed in Quarter	Update from Finance: Financial Tracking in place with attached RAG Rating. Forward planning encompass' a 'plan on a page' for each scheme. Performance reported and assured via F&P and STB. Financial Performance monitored monthly and reported to Welsh Government with full reconciliation of savings schemes applied to financial monitoring.- Recommend to close as process is in place. Proposed closure accepted.
623	23/24	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	1.2	The Trust should advise NWSSP-SES that the "designated person" will be re-allocated to an appropriate Board member in accordance with WHEN 07-02.	1.2	Designated named persons will be updated to appropriate board members.	Dec-23	Not Met				Closed in Quarter	Update 08/03/24 NWSSP -SES were informed of changes to designated persons on the 23/01/24 in line with their timelines to update their NHS Wales list. The action can now be closed. Update 181223: Designated person will be updated by end of December.
626	23/24	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	3.1	Management should review and confirm the accuracy of published backlog maintenance data with consultation with NWSSP: Specialist Estates Services.	3.1	Agreed, however guidance will need to be sought from NWSSP to ensure accuracy of backlog maintenance for the unique ambulance service estate within NHS Wales. Action will be closed once such guidance is sought.	Mar-24	Not Met	Apr-24			Open	Date changed in Q4 to April 2024.
627	23/24	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	4.1	The Trust should review the risk categorisation within the EFPMS and engage with NWSSP: SES to ensure consistency in approach when applying risk categories to the estate backlog maintenance figures.	4.1	Agreed, however again guidance will need to be sought from NWSSP to ensure risk categorisation within EFPMS is appropriate for the unique ambulance service estate within NHS Wales. Action will be closed once guidance is sought.	Mar-24	Not Met	Apr-24			Open	Date changed in Q4 to April 2024.
628	23/24	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	5.1	The Trust should engage with NWSSP: SES to ensure that the survey approach is appropriate noting the need for a consistent all-Wales assessment of the estate.	5.1	Agreed, noting that the service followed the six-facet approach to ascertain the condition of the estate, engagement is therefore required with NWSSP to further highlight the unique ambulance estate within NHS Wales. Action will be closed once this is done.	Mar-24	Not Met	Apr-24			Open	Date changed in Q4 to April 2024.
630	23/24	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	6.1	Management should report progress e.g., annually, against backlog maintenance and estate investment targets to an appropriate forum (e.g., Finance and Performance Committee), including funding variances and forecast variances to targets.	6.1	Agreed, backlog maintenance will be reported through the Finance & Performance Committee annually in line with the EFPMS submission.	Jun-24	Not Yet Due				Open	
631	23/24	FPC	Estates Condition	Limited	Richard Davies Joanne Williams Edward Roberts	Chris Turley	High	7.1	The Estates Strategy should be updated to provide a funded target solution separately to eliminate "high and significant" and overall backlog maintenance profiled by year.	7.1	Agreed, a refreshed Strategic Outline Programme is required upon receiving guidance from NWSSP as detailed within recommendation 4.	Sep-24	Not Yet Due				Open	
632	23/24	FPC	Estates Condition	Limited	Richard Davies Susan Woodham Edward Roberts	Chris Turley	Medium	7.2	Revisions to the Estates Strategy should include performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	7.2	Agreed, noting that this would form part of managing facilities and through pre planned maintenance contracts to ultimately reduce high and significant backlog maintenance.	Sep-24	Not Yet Due				Open	
634	23/24	FPC	Estates Condition	Limited	Richard Davies	Chris Turley	Medium	8.1	Statutory, "high", and "significant" risk backlog maintenance items that remain unaddressed by investment proposals should be appropriately profiled at the corporate risk register and reported to management for acceptance and approval / implementation of mitigating actions.	8.1	As noted at MA 4, additional advice will be taken in respect of "high" and "significant" risk classifications, which may largely remove this issue. Further consideration of any residual reporting through the Corporate Risk Register will then be considered.	Mar-24	Not Met	Apr-24			Open	Date changed in Q4 to April 2024.
635	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	1.1	Noting that roles and responsibilities will have changed since the national NHS 111 Wales service has been implemented, roles and responsibilities should be clearly detailed within the National Collaboration Agreement and signed by both parties (Commissioner and Trust). Opportunities should be provided for partners to reflect on their roles and functions regularly so that the Agreement can be amended to reflect any changes.	1.1	A new Joint Commissioning Committee will come into effect from 01/04/24. The Trust wants to wait and see what develops in this space rather than commit time to a document that could cease on the 31/03/24.	Apr-24	Not Yet Due				Open	
636	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	1.2	A copy of the previous signed version of the National Collaboration Agreement should be retained in a central location and monitored to ensure roles and responsibilities are fulfilled.	1.2	The previously signed version will apply until the new version is agreed, so the Trust will seek to obtain and retain a copy until recommendation 1.1 is enacted.	Dec-23	Met				Closed in Quarter	Last Update 140324 (TM) Board Secretary confirms that a copy of the original agreement has not been able to be located. In any event, new commissioning arrangements begin on 1 April 2024.
637	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	1.3	The Trust should ensure that it has finalised versions of the terms of reference for forums and groups where it participates within the NHS 111 Wales governance structure.	1.3	The responsibility for up-to-date terms of references rests with 111 commissioners, but the Trust will collaborate with commissioners and seek to ensure all relevant terms of reference are updated. The Trust will feedback to commissioners on the National Urgent Primary Care (Out of Hours) Forum and the Joint Operational &	Jan-24	Not Met				Closed in Quarter	Last Update 140324 Board Secretary confirms that new commissioning arrangement start on 1 April 2024 with the Joint Commissioning Committee and revised governance structures. This action is therefore no longer relevant.
638	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	Hugh Bennett	Rachel Marsh	N/A	2.1	Management should ensure that all operational policies and procedures that relate to NHS 111 Wales service delivery, are updated as soon as possible.	2.1	The Clinical Safety Plan and the Fire Evacuation Procedure are currently being reviewed and the other documents are old versions. The reviews will be completed and the old versions of policies removed and replaced.	Feb-24	Not Yet Due	Jun-24			Open	170424: New date added in Q4 of June 2024.
639	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	Hugh Bennett	Rachel Marsh	N/A	2.2	Once approved, policies and procedures should be circulated to all staff.	2.2	Updated policies to be placed on Siren and accompanied by Siren communications and more direct staff briefings, where appropriate e.g. fire evacuation procedure.	Feb-24	Not Yet Due	Jun-24			Open	170424: New date added in Q4 of June 2024.
640	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	3.1	Develop a mechanism to enable post-implementation learning of benefits, lessons learnt and impact to service delivery to be completely captured.	3.1	Proceed with the planned "time out" for Executives who interface with the commissioning arrangements, 111 Senior Leadership Team and other Assistant Directors/Heads of Service who support the commissioning arrangements.	Feb-24	Not Yet Due	Jun-24			Open	170424: New date added in Q4 of June 2024.
641	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	Chris Turley	Rachel Marsh	N/A	4.1	Key outcomes from meetings that Trust employees attend on commissioning arrangements should be appropriately recorded and reported to ensure that there is appropriate oversight of key discussions held.	4.1	Action notes/minutes for the Finance Group are the responsibility of 111 commissioners. The Trust will discuss with 111 commissioners and seek a formal record of each meeting.	Dec-23	Met				Closed in Quarter	Last Update 140324 Board Secretary confirms that new commissioning arrangement start on 1 April 2024 with the Joint Commissioning Committee and revised governance structures. This action is therefore no longer relevant.

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642	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	4.2	Progress with delivering the commissioning framework should be reported within the Trust.	4.2	The Trust does report progress on the commissioning framework i.e. commissioning intentions, but recognises that internal reporting is more intermittent. Re-establish regular reporting of the commissioning intentions (every quarter) to the Trust's Strategic Transformation Programme Board.	Jan-24	Not Met	Jun-24			Open	170424: New date added in Q4 of June 2024.
643	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	4.3	The Trust should obtain written confirmation of the escalation process to be followed within the current governance structure.	4.3	A letter will be collaboratively drafted and agreed between the 111 Board Chair and Trust CEO to formalise the informal escalation arrangements that do currently exist.	Jan-24	Not Met	Jun-24			Open	170424: New date added in Q4 of June 2024.
644	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	5.1	The Trust's Corporate Risk Register should be amended to capture risks relating to the NHS 111 Wales commissioned arrangement or service delivery.	5.1	The Trust's Corporate Risk Register commissioning risks to be updated to reflect that 111 is now also a commissioned service.	Jan-24	Not Met	Jun-24			Open	170424: New date added in Q4 of June 2024.
645	22/23	FPC	111 Commissioning Final Advisory Report	Not Rated	Rachel Marsh	Rachel Marsh	N/A	5.2	The Gateway to Care Programme Board's risk register should be reviewed and updated to ensure that the risks documented remain current and there are appropriate mitigating controls in place.	5.2	Gateway to Care Programme Board's risk register to be reviewed and updated.	Jan-24	Not Met	Jun-24			Open	170424: New date added in Q4 of June 2024.
646	23/24	FPC	Strategy Development	Reasonable	Alex Crawford	Rachel Marsh	Medium	1.1	A refresh of the Long-Term Strategy shall be considered, clearly outlining the aspects of the long-term strategy that require updating, and specifying the new developments to be included.	1.1	Aligned to the continued development of the future clinical service model taking place in Q1 to Q2, a clear recommendation shall be presented to ELT and respective groups outlining the specific requirements (if required) to refresh the Long-Term Strategy document.	Dec-24	Not Yet Due				Open	
647	23/24	FPC	Strategy Development	Reasonable	Alex Crawford	Rachel Marsh	Medium	2.1(a)	The Trust should complete the work to revise engagement framework delivery plan and monitor its implementation.	2.1(a)	Continue work with the Consultation Institute and internal leads to revise and finalise the Engagement Delivery Plan. The revised plan will provide further detail of the key phases of engagement, purpose and approach of the engagement activities with re-profiled timescales for delivery.	Jun-24	Not Yet Due				Open	
648	23/24	FPC	Strategy Development	Reasonable	Alex Crawford	Rachel Marsh	Medium	2.1(b)	The Trust should complete the work to revise engagement framework delivery plan and monitor its implementation.	2.1(b)	Commence implementation of the Engagement Delivery Plan (as per the approach set out and agreed timescales in the revised and approved plan).	Jun-24	Not Yet Due				Open	
649	23/24	FPC	Strategy Development	Reasonable	Alex Crawford	Rachel Marsh	Medium	2.1 (c)	The Trust should complete the work to revise engagement framework delivery plan and monitor its implementation.	2.1 (c)	Build in clear periods of 'pause and reflect' following each phase of engagement to monitor progress and delivery reporting into TSAG / ELT.	Jun-24	Not Yet Due				Open	
650	23/24	FPC	Strategy Development	Reasonable	Alex Crawford	Rachel Marsh	Medium	3.1	The benefits realisation plan should be completed to facilitate monitoring of progress against the achievement of the ambitions set out in the Long-Term Strategy – Delivering Excellence: Vision 2030.	3.1	Draft Benefits Realisation Framework underway. To be finalised and approved in Q1/Q2 FY2024/25, in order to facilitate consistent and standardised approach to developing and monitoring of all Trust ambitions, including the Long-Term Strategy – Delivering Excellence: Vision 2030	Sep-24	Not Yet Due				Open	
651	23/24	FPC	Strategy Development	Reasonable	Alex Crawford	Rachel Marsh	Medium	3.2(a)	The Trust should also consider opportunities to enhance reporting to demonstrate that strategic delivery programmes are having the intended impact in terms of outcome achievement.	3.2(a)	Undertake a review of the internal programme delivery structures to determine the optimal delivery and monitoring structure.	Jun-24	Not Yet Due				Open	
652	23/24	FPC	Strategy Development	Reasonable	Alex Crawford	Rachel Marsh	Medium	3.2(b)	The Trust should also consider opportunities to enhance reporting to demonstrate that strategic delivery programmes are having the intended impact in terms of outcome achievement.	3.2(b)	Implement changes to the programme structures (identified following the initial review).	Sep-24	Not Yet Due				Open	
653	23/24	FPC	Strategy Development	Reasonable	Alex Crawford	Rachel Marsh	Medium	3.1 (c)	The Trust should also consider opportunities to enhance reporting to demonstrate that strategic delivery programmes are having the intended impact in terms of outcome achievement.	3.1 (c)	Aligned to the Benefits Realisation Plan, respective benefits and outcomes to be mapped and regularly monitored as part of the refreshed programme arrangements	Sep-24	Not Yet Due				Open	
659	23/24	FPC	Vehicle Replacement Programme	Reasonable	Dave Holmes / Andrea Davies	Chris Turley	Medium	1.1	Project controls should be reviewed for appropriate compliance with Prince2 principles including: •effective representation of the Supplier, Customer, and Executive roles within the project management structure; •delegated financial tolerances to project managers for stage / annual delivery; •End-stage reports to review project controls, benefits realised, and lessons learnt, etc.	1.1	Agreed to be reviewed, noting that the agreed and stated approach is to a pragmatic approach and the application of an overarching Prince2 methodology. The FSDG Terms of Reference and the Project Initiation Document for future projects will be reviewed with particular consideration being given to project controls including allocation of roles and responsibilities and delegated tolerances to provide clarity, with the outcome of the review being documented and any agreed changes implemented. End stage / project reporting will be reviewed and developed in line with project timescales. Further narrative will be developed in the Project Initiation Document for future projects to provide clarity on such reporting. This will all be reviewed through the FSDG, at which point this action will be considered closed.	Jun-24	Not Yet Due				Open	27/03/2024: Update from Estates: Project controls will be reviewed including the FSDG Terms of Reference and the Project Initiation Document and Business Case templates. It is proposed that the outcome and recommendations of this review will be reported to the May 2024 FSDG meeting for approval, following which, will then be implemented for future business cases and projects. In readiness for this, the Project Initiation Document and Business Case Templates will be reviewed in April 2024 to identify sections which need reviewing and updating.

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660	23/24	FPC	Vehicle Replacement Programme	Reasonable	Edward Roberts / Andrea Davies	Chris Turley	Low	2.1	The benefit of additional purchases should be contrasted to the associated costs of retention at business cases.	2.1	Agreed. Benefits realisation monitoring will continue as part of project review. Further data and analysis relating to vehicle replacement versus retention will continue to be developed and included as part of this monitoring. Consideration will be given to the relevance of including information on benefits realisation (performance versus targets) in future business cases where appropriate. It should be noted that the agreed vehicle life cycles are identified in the SOP and then drawn down into the annual business cases, and this determines the optimal numbers. In addition, the prioritisation process which had to be undertaken for 2023/24 due to restricted funding took into account the cost of retention versus replacement for the various vehicle types in deciding what vehicles to progress.	Jun-24	Not Yet Due				Open	27/03/2024: Update from Estates: A review of benefits realisation monitoring is to be undertaken in April 2024. It is proposed that the outcome and recommendations of this review will be reported to the May 2024 FSDG meeting for approval, following which, will then be implemented for future business cases and projects.
661	23/24	FPC	Vehicle Replacement Programme	Reasonable	Andrea Davies	Chris Turley	Low	3.1	The process of agreement of specification by relevant parties should be specified at the Project Initiation Document e.g. as involving parties such as the Vehicle Working Group and the Project Board, and user sign-off of requirements / minimum performance specifications.	3.1	Agreed. The process of specification agreement will be further developed and documented, and narrative included in the Project Initiation Document for future projects. A visual process map will also be included.	Jun-24	Not Yet Due				Open	27/03/2024: Update from Estates: Documentation will be developed on the process of specification agreement including a process map. Narrative in the Project Initiation Document will be developed accordingly. In readiness for this, the Project Initiation Document and Business Case Templates will be reviewed in April 2024 to identify sections which need reviewing and updating
662	23/24	FPC	Vehicle Replacement Programme	Reasonable	Andrea Davies	Chris Turley	Low	3.2	Inspections by technical staff should be formally documented and advised to the Senior Supplier, User, and commissioning leads as part of the quality acceptance process.	3.2	Agreed. The inspection and quality acceptance process will be developed and documented and ratified by the FSDG.	Jun-24	Not Yet Due				Open	27/03/2024: Update from Estates: Documentation will be developed on the quality acceptance process and will be submitted to the May 2024 FSDG meeting for approval.
663	23/24	FPC	Vehicle Replacement Programme	Reasonable	David Holmes / Andrea Davies	Chris Turley	Medium	4.1	The various aspects of the procurement strategy include: (a)enhanced narrative within the business case; & (b)evaluation and approval by appropriate parties to confirm that it remains optimal (as detailed within the business case for approval) e.g. to affirm that it best aligns	4.1	Agreed. The current narrative describing the procurement strategy will be further detailed within future business cases to better facilitate evaluation of the procurement strategy.	Dec-24	Not Yet Due				Open	27/03/2024: Update from Estates: Narrative on describing the procurement strategy will be developed for inclusion in future business cases. It is proposed that this will be submitted to the June 2024 FSDG meeting for review and approval. In the meantime, the business case template will be reviewed in April 2024 to highlight areas which will need updating.
664	23/24	FPC	Vehicle Replacement Programme	Reasonable	Andrea Davies	Chris Turley	Medium	4.2	Allocated duties for dialogue and negotiation on the costs and price of the specification should be delineated between procurement and project officers at the Project Initiation Document.	4.2	Agreed. Narrative on roles and responsibilities relating to procurement dialogue and negotiation will be developed and included in the Project Initiation Document for future projects.	Jun-24	Not Yet Due				Open	Update from Estates: Narrative on the roles and responsibilities relating to procurement negotiation will be developed and included in future Project Initiation Documents. It is proposed that this will be submitted to the May 2024 FSDG meeting for approval. In the meantime, in April 2024 the Project Initiation Document will be reviewed to highlight areas which need updating.
665	23/24	FPC	Vehicle Replacement Programme	Reasonable	Trish Mills	Chris Turley	High	5.1	Contracts should be discretely authorised in accordance with Standing Orders.	5.1	Agreed. Noting that the current approach is across the Trust and not specific to fleet procurement, the Trust's Standing Orders and Standing Financial Instructions have been reviewed with regards to contract award approvals and delegated authority. As a result, a proposal to add an additional mechanism to ensure discrete Trust Board contract approval together with an amendment to the narrative relating to delegated authority for purchase order approvals will be presented to the March 2024 Audit Committee and Trust Board meetings for consideration and approval and for subsequent implementation. Such proposals will mitigate this recommendation.	Apr-24	Not Yet Due				Open	27/03/2024: Update by Estates: The suggested amendments will now be presented at the Audit Committee meeting on 30th April 2024 and the action will be closed once approved at that meeting, noting that the amended Standing Orders and Standing Financial Instructions will be adhered to as appropriate in the future. Can be closed once the revised SO are received for approval.
666	23/24	FPC	Vehicle Replacement Programme	Reasonable	Edward Roberts / David Holmes	Chris Turley	Medium	5.2	Pre-tender Estimates and variance commentary should be utilised to inform tender evaluations.	5.2	Agreed - Pre-tender estimates and variance commentary will be utilised for future tender evaluations.	Future BIC compilation.	Met				Closed in Quarter	Last Update 140324 (TM) Propose as closed as this is business as usual and will only arise at the next fleet replacement BIC going to FPC/Board. Propose that a note is placed in the FPC cycle of business to prompt a reminder for EDOF to ensure pre-tender estimates and variance commentary is in the BIC for the tender evaluation.
667	23/24	FPC	Vehicle Replacement Programme	Reasonable	David Holmes	Chris Turley	Medium	6.1	Business Justification Cases should show investment to date (planned and approved) against plans of the Strategic Outline Programme, including variance commentary (for both vehicle numbers and values).	6.1	Agreed. A review of the existing data and narrative contained in previous business cases relating to SOP proposals will be further undertaken and consideration will be given to providing further information in future business cases as appropriate.	Future BIC compilation.	Met				Closed in Quarter	Last Update 140324 (TM) Propose as closed as this is business as usual and will only arise at the next fleet replacement BIC going to FPC/Board. Propose that a note is placed in the FPC cycle of business to prompt a reminder for EDOF to ensure pre-tender estimates and variance commentary is in the BIC for the tender evaluation.
675	23/24	FPC	Decarbonisation	Limited	Lucinda Wassall / Joanne Williams	Chris Turley	Medium	1.1	The named membership in the terms of reference should be reviewed again to ensure reasonable and appropriate representation at the Decarbonisation Programme Board.	1.1	Noted. The membership will be further reviewed to ensure that quorum levels outlined within the Terms of Reference are achieved. All teams will be asked to reconfirm their representatives. It is however noted that the attendance is actually good in comparison to other project and programme board meetings, with it never necessarily being expected that all those invited to attend will do so at all meetings, and no issues have arisen in terms of the ability of the PB to discharge its duties due to any attendance issues. This action will be considered closed once the team is assured that meetings have been, and continue to be, quorate and the updated attendance list has been ratified at the Programme Board.	Apr-24	Not Yet Due				Open	26.03.24 - This will be considered by the Decarbonisation Programme Board at the end of April and closed at this point.
676	23/24	FPC	Decarbonisation	Limited	Joanne Williams	Chris Turley	High	2.1	Challenges and risks to the achievement of the objectives within the Trust's Decarbonisation Action Plan, along with any mitigating factors, should continue to be monitored with regular updates provided via the established governance routes through to Trust Board.	2.1	The DAP and Risk Register will continue to feature as standard agenda items on every Decarbonisation Programme Board. Regular reporting will continue to Capital Management Board, Finance and Performance Committee and Trust Board as per the agreements set out. This action is considered closed, as it forms part of BAU practice	N/A	Met				Closed in Quarter	140324 (TM ) Closed as per action narrative.
677	23/24	FPC	Decarbonisation	Limited	actioned since fieldwork	Chris Turley	Medium	3.1	The 'Date Closed / Next Update Due' should be completed for each risk.	3.1	The date closed and next update due will be completed for each risk. This action has now been completed, and this is considered closed. The risk register will be reviewed on a regular basis, and any relevant new risks added as appropriate	N/A	Met				Closed in Quarter	26.03.24 - evidence provided to Alex Payne to close this action by Jo Williams on 26.03.24. 140324 (TM ) Closed as per action narrative.

Trust Ref. No.	Year/Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No. in Audit	Recommendation	Response No. in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first
678	23/24	FPC	Decarbonisation	Limited	Lucinda Wassall	Chris Turley	Medium	3.2	Noting the recent requirement to include medical gases within the Trust's carbon emissions, the associated risk should be reflected appropriately	3.2	Risk 8 on the current risk register outlines the risk of not being able to compare current emissions to baseline. The item will be updated to reflect the risk of WG further changing the scope of reporting, but will not specifically reference medical gases as this is just one specific example of the risk materialising.	Apr-24	Not Yet Due				Open	26.03.24 - Risk register to be updated for Decarbonisation Programme Board in April and closed at this point
679	23/24	FPC	Decarbonisation	Limited	Joanne Williams / Richard Davies	Chris Turley	Medium	3.3	The development of risk 542: Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan should be finalised to ensure the Trust's Corporate Risk Register is appropriately reflective of prevalent risks.	3.3	Risk 542 will be finalised for inclusion within the Corporate Risk Register	Apr-24	Not Yet Due				Open	26.03.24 - CRR has been updated and will go to ADLT on 8th April, ELT on 24th April and Trust Board on 30th May.
680	23/24	FPC	Decarbonisation	Limited	Edward Roberts Joanne Williams	Chris Turley	High	4.1	The Trust should develop a long-term financial model for the financial support required to support the decarbonisation programme to provide assurance to the Board regarding achievement of the Welsh Government targets. A clear timeline should be determined for undertaking this exercise, with progress monitored at a relevant forum.	4.1	The value of such an overarching exercise at this stage, compared to that previously undertaken and the resource required to do so needs to be considered, and as opposed to the way the Trust has looked to approach this to date. It also needs to be noted that part of the ongoing process to do so is also linked to any initial response from WG to that previously provided and the now confirmed upcoming and updated overall NHS Wales capital prioritisation work that will be progressed through 2024. Again it is not considered good value of resource to further progress anything here until this has now been completed and reported back to us. In the meantime a number of other significant areas of progress continue in relation to this, including the detailed costings undertaken to ensure significant (and greater than could have been expected) funding in relation to EFAB schemes through 2023/24 and 2024/25, along with the detailed decarbonisation impacts being front and centre of all new proposed and planned developments. The cost implications of this and the impact this may have affordability of schemes, either locally through the Trust's discretionary capital funding or nationally via AWCP needs to however also not be underestimated and a balance will always need to be struck in this regard with other competing factors such as operational requirements, staff welfare and safety, etc. Recent Fleet BJs have also included cost estimates to support, where possible and currently commercially and practically available, the electrification of the Trust's fleet, and the required supporting infrastructure. Examples of where other aspects of this can be further enhanced include the estate retrofit guide, which will be used as a framework to assess the impact and potential cost of estate requirements on a priority basis. This is also linked to any planned further refreshes in the overall Estates Strategy (SOP), high level information will also be used (where available) to determine broad fleet replacement costs including infrastructure. This will similarly be a key part of any	Mar-25	Not Yet Due				Open	26.03.24 - Not yet due.
688	23/24	FPC	ICT Contract Management	Reasonable	Robert Walker	Jonny Sammut	Low	1.1	To embed the SOP into the organisation by raising awareness and providing training / workshops to relevant staff within Digital Services to provide a consistent approach to the contract management process.	1.1	An official notice was published on the Trust intranet on the 31st Jan 2024 to raise awareness and the SOP has been made available to access on the Trust intranet. A training / workshop schedule will be devised and delivered across Digital Services.	Jun-24	Not Yet Due				Open	
689	23/24	FPC	ICT Contract Management	Reasonable	Robert Walker	Jonny Sammut	Medium	2.1	The contract register should be developed to include all ICT related contracts and main suppliers.	2.1	Whilst a single register which captures all Digital/ICT related commercial spend across the organisation would be constructive it would however be disproportionate to the time and effort required to maintain and the level of material value that information would provide over and above existing purchasing information which can be generated from the Oracle financial system.  Where the requirement entails a recurring spend and an ongoing deliver of Digital/ICT services to the organisation over a set period (such as the supply of a software system) the register will be developed to provide 'a single source of truth' of the associated Digital/ICT commercial expenditure.	Oct-24	Not Yet Due				Open	
690	23/24	FPC	ICT Contract Management	Reasonable	Robert Walker	Jonny Sammut	Medium	3.1	Contract and supplier performance meetings should be subject to formal recording, wither using minutes or action notes.	3.1	Where a contract / supplier performance meeting is held the respective action notes are to be recorded formally.	Mar-25	Not Yet Due				Open	
691	23/24	FPC	ICT Contract Management	Reasonable	Robert Walker	Jonny Sammut	Medium	3.2	ICT contract management process should be applied to all ICT related contracts, with the ICT Contract Manager feeding into any management meetings within other areas.	3.2	The Contract Management [SOP] process is to be applied to all contracts listed in the contracts register.	Mar-25	Not Yet Due				Open	
692	23/24	FPC	ICT Contract Management	Reasonable	Robert Walker	Jonny Sammut	Medium	n/a	This action supplements 3.1 and 3.2.	n/a	Each contract listed in the contract register is to be classified as requiring either a Low, Medium or High level of contract management to be applied. Supplier / Contract meetings are only required to be held for those contracts classified with a Medium or High level of contract management to be applied.	Jun-24	Not Yet Due				Open	
693	23/24	FPC	ICT Contract Management	Reasonable	Robert Walker	Jonny Sammut	Medium	4.1	Action notes related to contact assessment should be recorded from the ICT SMT meetings.	4.1	The ICT SMT Decision Log will be utilised to record actions to be taken.	Mar-24	Met				Closed in Quarter	Propose closure as process now in place and will be a reported monthly at ICT SMT. Propose closure accepted.  20/03/2023 - Contract renewals discussed at ICT SMT 08/03/2024, some renewal activity agreed and recorded. Will be a rolling update every month at ICT SMT
694	23/24	FPC	ICT Contract Management	Reasonable	Robert Walker	Jonny Sammut	Medium	4.2	Details of end of term review and assessment should be captured on the contracts register.	4.2	The contracts register will be updated to capture associated commercial notes / actions taken with a contract as part of the end of term review.	Jun-24	Not Yet Due				Open	

Task Ref No.	Adult Wales or NIW Report	Year	Classification Assigned to	Responsible Officer	Director	Priority Level	Recomm. No. in AaB	Recommendation	Response # in AaB	Management Response	Agreed Deadline in Report	Status	1st revised date	2nd revised date	3rd revised date	Where a management action has not met the agreed or revised date, Director must include here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. Please add most recent update first	Current Phase
120	HW	20/21	FPC	EMSCCC Patient Safety Review	Lee Brooks	Lee Brooks		21.1 Complete the North Wales EMS CCC estate strategy and identify opportunities for improvement		See note in column 7		Not Met	Apr-24			<p>22/03/2024 CLOSURE PROPOSED - Bryn Tirion move is underway, financial allocations and comms in place and on the pathway to delivery. Links below show a dedicated Siren Page regarding the move and all comms sent out on Siren to colleagues to inform of progress with the project and plans.</p> <p><a href="https://nhswales365.sharepoint.com/sites/AMB-Intranet-Operations/SitePages/Bryn-Tirion-Relocation-Project.aspx?Mode=Edit">https://nhswales365.sharepoint.com/sites/AMB-Intranet-Operations/SitePages/Bryn-Tirion-Relocation-Project.aspx?Mode=Edit</a></p> <p><a href="https://nhswales365.sharepoint.com/sites/AMB-Intranet-Finance/SitePages/Bryn-Tirion-Relocation-Project.aspx?csf=1&amp;web=1&amp;enu=87Qd">https://nhswales365.sharepoint.com/sites/AMB-Intranet-Finance/SitePages/Bryn-Tirion-Relocation-Project.aspx?csf=1&amp;web=1&amp;enu=87Qd</a>.</p> <p>PROPOSED CHECK POINT OF APRIL 2024 Note - the entire EMSCCC review actions have not been transferred to the tracker, only the two identified in the 3/8/23 EMT paper. QUEST updated 10 August 2023</p> <p>Update 030823: The Bryntirion site for EMSC in the North has been allocated some discretionary capital fund for this financial year (23/24) to support some progress in this area. It should be noted that WAST have completed and rolled out the estate's strategy in IPH with a view to progress plans with DPP for Llanganner now to progress with the redevelopment of the ground floor. This is at design stage currently but funding has been allocated from this year's discretionary capital budget to support this)</p> <p>The project will likely span two years. In terms of the North Wales Estate (Bryntirion) initial work has started across departments to ensure that all elements of the work are mapped out and options are considered. The existing site requires remedial work which is considered poor investment given the site is not WAST owned. There is a technological development (Ainwave replacement) required that enables a full move out of Bryntirion; early indication from the Ambulance Radio Programme (ARP) is that the roll-out of this technology is likely to be Q1 2024. A capital budget (discretionary) has been identified and allocated.</p>	Closed in Quarter
121	HW	21/22	FPC	EMSCCC Patient Safety Review	Lee Brooks	Lee Brooks		12.1 Continue with the work of the CAD Phase 3 project to realign workloads within the EMSCCC for more efficient operation		See note in column 7		Not Met	Jan-24	Apr-24		<p>22.03.2024 Propose to move revised date to April 2024. Date moved in Q4 to April 2024.</p> <p>Note - the entire EMSCCC review actions have not been transferred to the tracker, only the two identified in the 3/8/23 EMT paper. QUEST updated 10 August 2023</p> <p>Update 030823: The EMS Configuration Programme recommended in Q1 2023 following being paused due to Industrial Action and Operational Pressures. Roster Review of call takers is complete. The realignment of boundaries aspects of this work, which provides the necessary re-alignment of workloads has commenced and engagement with staff had taken place prior to the pause. This work has re-commenced and is currently waiting on a refresh of the data to finalise discussions with staff and TU partners.</p> <p>The realignment of desks is currently being paused due to awaiting data. It is anticipated that this will be available in Q2 2023 and that this aspect of the project will be completed end of Q3, subject to management capacity. In addition, we continue to pursue the changes identified above that require a £750k investment however funding support for this is contingent on external investment which in the current economic climate is difficult to secure.</p>	Open

<b>AGENDA ITEM No</b>	<b>20</b>
<b>OPEN or CLOSED</b>	<b>Open</b>
<b>No of ANNEXES</b>	<b>2</b>

## COMMITTEE CYCLE OF BUSINESS 2024-25 & MONITORING REPORT

<b>MEETING</b>	Finance and Performance Committee
<b>DATE</b>	14 May 2024
<b>EXECUTIVE</b>	Trish Mills, Director of Corporate Governance/Board Secretary
<b>AUTHOR</b>	Trish Mills, Director of Corporate Governance/Board Secretary
<b>CONTACT</b>	<a href="mailto:Trish.mills@wales.nhs.uk">Trish.mills@wales.nhs.uk</a>

### EXECUTIVE SUMMARY

1. Updating of the cycle of business for this committee is the final step in the 2023/24 effectiveness reviews that were conducted in Q4. Amendments to the Committee's terms of reference agreed in Q4 have been incorporated into this updated cycle of business.
2. The cycle has been developed with direct correlation to the duties in the terms of reference (red text). This will allow members to review the appropriateness of the proposed reports and their frequency.
3. The cycle for the Committee is a maturing document which will grow organically over the next 12 months. There are some areas of the cycle where reporting remains to be developed.

### RECOMMENDATION:

4. The Committee is asked to:
  - (a) Review and approve the 2024/25 cycle of business at Annex 1; and
  - (b) Note the cycle of business monitoring document at Annex 2.

<b>KEY ISSUES/IMPLICATIONS</b>
As above
<b>REPORT APPROVAL ROUTE</b>
N/A

<b>REPORT APPENDICIES</b>
Annex 1 – Cycle of business 2024/25 Annex 2 – Cycle of business monitoring report

<b>REPORT CHECKLIST</b>			
<b>Confirm that the issues below have been considered and addressed</b>		<b>Confirm that the issues below have been considered and addressed</b>	
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

## **CYCLE OF BUSINESS 2024/25**

### **SITUATION**

5. The purpose of this paper is to provide the Committee with the updated cycle of business as the final step in the 2023/24 effectiveness review process.

### **BACKGROUND**

6. The Committee carried out its annual effectiveness review on 19 March 2024. This included a review of its terms of reference, amendments to which were approved by the Committee at that meeting.
7. The final step in the effectiveness review process is the development a cycle of business for the Committee.

### **ASSESSMENT**

Cycle of Business:

8. A cycle of business provides order and structure and sets a Committee work plan for the year. This, together with the Board Assurance Framework and forward planner drives agenda setting. It also:
  - 8.1. allows papers to be planned in advance, giving Directors and report writers the opportunity to plan necessary pre-committee forums and align cycles of business;
  - 8.2. schedules compliance related reports according to legislative or regulatory timeframes;
  - 8.3. provides focus for reporting and an opportunity to see where there may be duplication, gaps, and interrelationships;
  - 8.4. generates commitment to review matters that may sometimes be vulnerable to postponement;
  - 8.5. allows for easy tracking of the Committee's adherence to the cycle which is a marker of an effective Committee;
  - 8.6. provides for a collective awareness and agreement of the areas where it applies its focus on an annual basis; and
  - 8.7. removes the ad hoc elements of agenda setting.

9. Whilst it is inevitable that other items will arise from time to time, the cycle allows them to be prioritised - perhaps coming later on the agenda.
10. The cycle of business at **Annex 1** has been designed to do all the above. It includes further detail on the pre-committee forums, lead presenters, purpose of reports and any relevant and/or helpful commentary. It also includes each of the duties for the Committee in the terms of reference (in red text) so members can see and demonstrate that the reporting expected for each area will in fact provide appropriate assurance, generate discussion, and allow for the right balance of challenge and support.
11. The cycle for the Committee is a maturing document which will grow organically over the next 12 months. The areas which remain to be developed either in terms of reporting or cycling include:
  - 11.1. Cyber reporting;
  - 11.2. Commissioning reporting;
  - 11.3. Annual sustainability report.

Work will continue with the relevant directors on these areas over the coming months.

Continued monitoring of the cycle of business:

12. A monitoring report will be provided to each meeting under the consent section in the agenda, and where issues of escalation are required i.e. where cycle needs to be adjusted or reporting is overdue, these will be drawn out in a short paper by the Director of Corporate Governance/Board Secretary.
13. The monitoring report appears at **Annex 2** and is completed for Q1.

## **RECOMMENDATION**

14. The Committee is asked to:
  - (a) Review and approve the 2024/25 cycle of business at Annex 1; and
  - (b) Note the cycle of business monitoring document at Annex 2.

PAPER	PRE-C'EE FORUM	FREQUENCY	MAY	JUL	SEP	NOV	JAN	MAR	LEAD	PURPOSE	COMMENT/COMPLIANCE
<b>FINANCE AND PERFORMANCE COMMITTEE - CYCLE OF BUSINESS 2024/25</b>											
<b>TERMS OF REFERENCE NOTED IN RED TEXT</b>											
<b>FINANCE</b>											
3.1 Oversee and contribute to the medium and long term financial strategy, in relation to both revenue and capital											
Annual revenue budget	ELT	Annually							EDOF	Endorsement	SFI 4.2.2 - Boards must approve balanced revenue and capital plans before the start of the year
Annual capital budget	Capital M'ment Board	Annually							EDOF	Endorsement	Private session
3.2 Monitor the Trust's in-year and forecast revenue financial position against budget and review and make appropriate recommendations for corrective action to address imbalances											
3.4 Monitor progress against the Trust's capital programme, scrutinise, approve or recommend for approval (where appropriate) business cases for capital investment. This will include those then submitted to Welsh Government for approval via Trust Board											
3.5 Receive assurance that a business case post implementation review is in place and is effective; review post implementation reviews on specific business cases and capital investment schemes from time to time											
3.6 Receive, review and ensure mitigation of financial risks of delivery of plans											
3.8 Review performance against the relevant Welsh Government financial requirements											
3.3 Review progress against the Trust's annual operating framework and make recommendations to the Board in relation to development of the annual financial plan and budget setting and long term financial strategy and financial sustainability programmes, efficiency review implementation and required savings targets											
Financial report	ELT	Each meeting							EDOF	Assurance	Financial sustainability report may be included in this report or separately throughout the year; year end report May
Year end M12 report (same time as M1 in new year)	ELT	May meeting							EDOF	Assurance	
Business cases over £500K	TBC	As required							EDOF	Endorsement	To include pre-tender estimate and variance commentary where applicable (in reference to VRP internal audit recommendations).
IMTP financial plan	STB/ELT	Annually							EDOF	Endorsement	
3.5 Ensure delivery of core aims in relation to delivering value and development of value based health care in an out of hospital setting											
Value Based Healthcare Report	TBC	Every other meeting							EDOF	Assurance	See Note 2
3.7 Monitor progress against a range of key developments and capital schemes, either in development through the business case process or in implementation											
3.5 Assurance that a business case post implementation review is in place and is effective; review post implementation reviews on specific business cases and capital investment schemes from time to time											
3.9 Receive assurance on delivery of core aims in relation to delivering value and development of value based health care in an out of hospital setting;											
Assurance paper on PIR process	TBC	One off and then cyclical							EDSPP	Assurance	To demonstrate the PIR process is embedded in planning cycle and business planning, with cyclical reviews.
Post Implementation Reviews	TBC	As required							EDSPP	Assurance	
Monitoring of key projects as requested from time to time	TBC	As required							EDSPP	Assurance	
Financial Sustainability Report	TBC	Each meeting							DPC	Assurance	Agreed at 18.09.23 FPC to include quarterly updates on the Financial Sustainability Programme (FSP) for future meetings.
<b>PLANNING</b>											
3.18 Hold a central overview of all service or directorate specific long term plans that align to the long term strategy. These plans will be reviewed for alignment by the relevant Committee first and their implementation will be guided by the IMTP or relevant local directorate plans;											
3.15 Oversee and contribute to the development of the Trust's long term strategy 'Delivering Excellence: Our Vision for 2030' and make recommendations to the Board for its approval/amendment											
Refreshes of 2030 Delivering Excellence	ELT	Ad Hoc							EDSPP	Endorsement	
Service or Directorate Specific Plans: New & Refreshes	ELT	Ad Hoc							EDSPP	Endorsement	Long term service or directorate specific plans from time to time See Note 9
3.16 Oversee and contribute to the development of the Trust's Integrated Medium Term Plan (IMTP) and ensure alignment of that plan with Delivering Excellence: Our Vision for 2030											
IMTP for following year	STB/ELT/Board	Annually							EDSPP	Endorsement	NB: IMTP will also go to Board Committees such as PCC and Quest for areas within their remit prior to FPC
3.17 Monitor the effectiveness of commissioning arrangements with the Local Health Boards via the appropriate commissioning forums;											
3.10 Review performance against targets and standards set by Commissioners and/or Welsh Government for the Trust and, where appropriate, against national ambulance quality indicators											
Report on commissioning	TBC	TBC							EDSPP	Assurance	Scope of this element to be developed - see Note 3
3.20 Review and consider matters relating to demand and capacity including proposals for reviews in this area and recommendations arising from such reviews											
Demand and capacity reviews	ELT	Ad Hoc							EDSPP	Endorsement	See Note 6
<b>PERFORMANCE</b>											
3.13 Endorse and monitor progress against Trust wide key performance indicators and ensure the development of robust intelligent targets											
3.14 Monitor and review plans to recover areas of underperformance, reviewing where appropriate associated KPIs as part of any deep dives, and providing assurance to the Board and escalating as required - See Note 4											
Monthly Integrated Quality Performance report	ELT	Each meeting							EDSPP	Assurance	
MIQPR review of metrics	ELT/Board Committees	Annually							EDSPP	Endorsement	KPIs relevant to PCC and Quest reviewed by those Committee in Q4 prior to presentation to FPC
Annual HART KPI report	TBC	Annually							EDO	Assurance	HART Internal Audit Nov 22 recommended annual reporting of HART KPIs which was accepted. See July FPC on HART KPIs
3.11 Monitor and review progress against the Trust's Integrated Medium Term Plan and obtain assurance on the efficient management and delivery of corporate projects and those associated within the agreed strategic transformation programme and its associated work streams											
3.16 Obtain assurance on the efficient management and delivery of corporate projects and those associated within the agreed strategic transformation programme and its associated work streams											
IMTP progress updates	STB/ELT/Board	Each Meeting							EDSPP	Assurance	IMTP outturn position in May
3.12 Review the effectiveness of the Trust's Quality and Performance Management Framework and receive assurance on the value of outcomes produced by the framework, noting that in 2024/25 the Audit Committee will receive assurance on the implementation of the framework.											
QPMF update report	QPMF Steering Group	Bi-annually							EDSPP	Assurance	Assurance on the value of outcomes produced by the framework and effectiveness. TBC reporting as implementation going to AC in 24/25
<b>ESTATES AND FLEET</b>											
3.20 Oversee, contribute to, and receive assurance on monitor the implementation of, the Estate Plan.											
3.21 Oversee, contribute to, and monitor receive assurance on the implementation of, the Fleet Plan.											
3.22 Review proposals for acquisition, disposal, and change of use of land/buildings.											
Estates and fleet strategy refreshes	TBC	Periodically as required							EDOF	Approval	Estates and Fleet strategies refreshed Mar 21. Potential fleet re-write 24/25 and estates 25/26
Fleet replacement programme	Capital M'ment Board	Annual BJC see notes							EDOF	Approval/Endorsement	2018/19 ten year fleet strategic outline proposal (SOP) with annual business justification cases calls down on that SOP (private session)
Fire safety annual report	ELT/Board	Annually							EDOF	Assurance	Timing of annual report TBC (annual compliance report was presented in Jan 24). By exception reporting outside cycle.
Fire safety exception report	TBC	Periodically as required							EDOF	Assurance	By exception outside of annual report
<b>ENVIRONMENTAL AND SUSTAINABILITY</b>											
3.23 Oversee, contribute to, and receive assurance on the implementation of the Environmental Strategy											
3.24 Receive assurance on compliance with environmental regulations and national targets											
Decarbonisation Update	Decarb Programme Board	Every other meeting							EDOF		Progress also against WG action plan and Trust Plan; metrics in development. Annually to include update on waste management. See Note 7
Waste Management Update	Decarb Programme Board	Annually							EDOF	Assurance	Annual update aligned with Internal Audit recommendations. First report in September 2023.
Sustainability Report	Decarb Programme Board	Annually							EDOF	Assurance/Endorse	Annual update - as per Manual for Accounts. See Note 7. Also approved by Board and audited(?)
<b>DIGITAL SYSTEMS AND STRATEGY</b>											
3.25 Oversee, contribute to, and receive assurance on the implementation of, the Digital Plan.											
3.26 Review projects and monitor implementation and delivery of benefits of major digital and information/reporting projects											
Digital Plan - new and refreshed	STB	Periodically as required							DD	Review and Endorse	Implementation through IMTP; strategy/plan refreshes as required - See Note 1
Metrics for digital systems infrastructure	TBC	Three times a year							DD	Assurance	Digital reporting first presented to Sept 23 meeting and will be presented at each meeting - see note 1.
Review/Monitor of major projects	TBC	Ad Hoc							Relevant Director	Assurance	Including WG PARs and gateway reviews
<b>BUSINESS CONTINUITY AND CYBER</b>											
3.27 Oversight and scrutiny of the Major Incident Plan and Business Continuity Plan and receive assurance that such plans are effective											
WG Annual Emergency Planning Report	ELT/Board	Annually							EDO	Assurance	Report provides for compliance with Civil Contingencies Act 2004; exercises carried out; learning from incidents/exercises/debriefs.
Incident Response Plan Report	ELT	Annually							EDO	Assurance	Externally reported - See Note 5
Business Continuity Annual Report	ELT	Annually							EDO	Assurance	See Note 5
3.28 Oversight and scrutiny of cyber resilience including assurance on awareness and training of WAST staff and volunteers; maintenance of upgrades/updates of systems, and replacement of legacy/high-risk systems											
3.29 Oversight and scrutiny of cyber security including assurance of regular monitoring of risks and threats, business continuity planning and engagement with national cyber centres and stakeholders											

Cyber Resilience and Cyber Security Reporting	TBC	TBC						DD	Assurance	Reporting developing in 23/24 - start off at 3 times a year reporting; intention to bring to every meeting if possible.
<b>INFORMATION GOVERNANCE AND INFORMATION SECURITY</b>										
3.30 Receive assurance the information governance and information security arrangements are appropriately designed and operating effectively to ensure the reliability, integrity, safety, and security of information to support the delivery of high quality, safe healthcare across the organisation.										
3.31 Review progress of measures to improve information security and adherence to Caldicott principles against the Information Governance Toolkit, Network and Information Systems (NIS) Directive (2018), Data Protection Act (2018), and receive assurance on compliance with relevant standards, legislation and regulations.										
3.32 Receive assurance on, and review effectiveness of the Trust's information security protocols.										
3.33 Review performance of the Trust in relation to statutory and mandatory information requests and reporting requirements including but not limited to freedom of information requests, data breaches, police requests and subject access requests.										
Information Governance Toolkit	IGSC	Annually						DD	Assurance	
Information Governance Report	IGSC	Each meeting						DD	Assurance	
<b>POLICIES</b>										
3.34 Approval of policies within the remit of the Committee										
Report from policy group	Policy Group	Annually						BS	Assurance	
Policies for review and approval	Policy Group	Ad Hoc						BS	Approval	
<b>CORPORATE RISKS AND AUDIT</b>										
3.35 The Committee will monitor the principal risks relevant to its remit and consider the controls and mitigations of high-level related risks and provide assurance to the Board that such risks are being effectively controlled and managed.										
3.36 The Committee will receive and gain assurance from internal and external audits in their remit. It will also monitor management actions to address recommendations via the audit tracker and where appropriate scrutinise the impact of actions in response to audit recommendations.										
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	
<b>STANDARD ITEMS</b>										
Quarterly operations update	TBC	Each meeting						EDQN	Information/Discussion	Only received in quarter, not at every FPC meeting (if it would otherwise be a duplicate from previous meeting)
<b>GOVERNANCE</b>										
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	
<b>SUB-GROUPS</b>										
Where applicable	N/A	Ad Hoc						N/A	N/A	No sub-committees - but may set up task and finish groups from time to time
<b>PROMPTS</b>										
External Reports	N/A	Ad Hoc						TBC	TBC	

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  
 Reporting developing

<b>1 Digital</b>	<p>IA raised need to be explicit and define intended timescales for delivery of digital strategy phases. Digital strategic outline case September 2022; focus on baseline and business usual in November 2022; SOP and resourcing September 2022 (in IMTP); digital governance</p> <p>Digital reporting presented to Sept 23 meeting and will be presented bi-monthly. Includes data and analytics status, ICT systems status, service provision and quality, summary of IMTP contributions, spotlight item, and people</p> <p>FPC = reporting on technology &amp; process related metrics i.e. where Digital Directorate is responsible</p> <p>oE.g. Provision of training, provision of exercises / campaigns, infrastructure, physical barriers etc.</p> <p>oThis would include near misses related to software, suppliers, network, technology.</p>
<b>2 Value Based Healthcare</b>	<p>VBH is part of the financial sustainability programme and deliverables for IMTP 23-26 set out. Includes PLICS, PROMS and PREMS. Could be part of IMTP reporting generally, but propose a bi-annual update.</p>
<b>3 Commissioning</b>	<p>Review of commissioning standards is the commissioning intentions met as part of IMTP. AQLs published monthly to EASC. Key AQLs included in the 28 KPIs.</p>
<b>4 MIQPR</b>	<p>FPC is primary Committee for review of performance across all four quadrants of the MIQPR.</p> <p>The Committee will commission deep dives or refer such deep dives to other Committees</p>
<b>5 Emergency Preparedness</b>	<p>The Trust is classed as a category one responder under the Civil Contingencies Act (2004) and as a result there is a legislative obligation for us to address 6 key responsibilities, which are</p> <ul style="list-style-type: none"> <li>- Assess local risks and use this to inform emergency planning</li> <li>- Put in place emergency plans</li> <li>- Put in place Business Continuity Management arrangements</li> <li>- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency</li> <li>- Share information with other local responders to enhance co-ordination</li> <li>- Co-operate with other local responders to enhance co-ordination and efficiency</li> </ul> <p>CCA Part one devolved to Wales.</p> <p>WAST is a category 1 responder under the Civil Contingencies Act (2004) and Regulations (2005). Category 1 responders are required to maintain plans for preventing emergencies; reducing, controlling or mitigating the effects of emergencies in both the response and recovery phases, and has a duty to ensure business continuity plans are in place. Trust is working towards ISO22301 accreditation.</p> <p>Internal Audit on Major Incidents - September 2022 AC - raised F&amp;P review of incident response plan when reviewed next.</p> <p>Incident Response Plan Report: WG report accompanied by assurance that Incident Response Plan (IRP) in place and approved by ELT. SBAR includes detail of staff training in place, compliance levels, and resourcing for assurance; list of plans that underpin IRP are in date and regularly reviewed. IRP provides guidance and support to commanders on a range of incidents. Moved from July to November as that is the date of review</p> <p>Business Continuity Annual Report: SBAR to include compliance with CCA 2004 if not included in WG annual report and compliance under policy; list of plans that underpin BCP are in date and regularly reviewed; staff training in place, compliance levels and resourcing for assurance if not included in IRP report show compliance needed and planned learning from incidents/funerals/deaths</p> <p>May 2023 paper to FPC foreshadowed the development of a demand and capacity framework (as per EASC commissioning intentions) however there are current capacity issues</p>
<b>6 Demand and Capacity</b>	
<b>7 Decarbonisation</b>	<p>WAST Decarbonisation Action Plan (DAP) supports delivery of the national NHS Wales Decarbonisation Strategic Delivery Plan. IMTP sets out DAP details. Every second year IMTP must include copy of DAP and update - next 24-27.</p> <p>Decarbonisation reporting to WG as follows, however the reporting to FPC will draw from these reports and may or may not append them:</p> <p>(a) WG Public Sector Carbon Report (annual <u>quantitative</u> report). Demonstrates progress against plans and targets through annual quantitative reporting. Deadline is first Monday of September. This is the Trust carbon emissions for the previous financial year - set guidance for completion and timelines for reporting. Reliant upon data from NWSSP. No requirement for this report to be 'approved' by FPC. Can be signed off by internal governance at discretion of WAST.</p> <p>(b) 2 x <u>Qualitative</u> reports. Narrative update - no data. The qualitative reporting submitted by NHS organisations provides the National Programme Board with assurance on the progress underway at organisational level. Usually compiled by Jo Williams who takes the report through FPC. Looks like there may be a move for an annual qualitative report for 23/24 aligned to IMTP timetables.</p> <p>(c) 4 x Decarbonisation Coordination Reporting (DCR). This is reporting on our decarbonisation action plan (DAP) this is a new requirement where we will need to report updates to our DAP via NWSSP who collate and send to WG as a whole of NHS update. This report is being agreed by the Decarbonisation project Board. There are discussions relating to the need of any further governance routes - this is new.</p> <p>(d) Sustainability Report contained in the Performance Report if the data is available. Amalgamation of quantitative and qualitative reports. Otherwise it is a separate report with a reference to the report being on the publication section of the website. This developed from the data provided in the Quantitative Report above.</p>
<b>8 Fire safety reporting</b>	<p>Updated in January 2024 following compliance report to Committee. Report will be annual report from 24/25 (timing TBC) with exception reporting outside of that where appropriate.</p>
<b>9 Service or Directorate Plans</b>	<p>Committee with related remit to gain assurance on alignment of specific plans to Delivering Excellence. FPC to maintain overall view of aligned strategies. Suggest this is by way of an organogram showing the various plans aligned to the long term strategy and their revision dates</p>
<b>10 Information Governance</b>	<p>Information Governance (IG) is a framework for managing information processes and procedures in accordance with the law and associated standards. It describes the approach within which accountability, standards, policies and procedures are developed, implemented and maintained to ensure that all types of information used in the Trust are sourced, stored and used appropriately, legally, and securely.</p> <p>The Information Governance Steering Group oversees the Information Governance and Security strategy, policies, systems, processes and practices across the Trust and provides assurance that the organisation is compliant, and managing any risk to compliance. The strategic management of Information Governance forms part of the Digital Directorate under the leadership of the Director of Digital Services who holds the position of Senior Information Risk Owner (SIRO). Includes FOI (targeted percentage); Subject Access Request and Access to Health Records Requests (targeted percentage); Police Requests (no regulatory target); Data security and protection incidents: must notify ICO of personal data breaches within 72 hours. WG notified of significant impact on continuity of essential services under the Network and Information Systems Regulations (NIS Regs). H&amp;C Standards x 3 related to IG and identified metrics against these (see annual report).</p> <p>The Welsh IG Toolkit for NHS is an assessment tool that allows organisations to measure their performance against agreed national information governance and data security standards and legislation. All organisation that have access to NHS patient data and systems must use the toolkit to demonstrate compliance with DPA 2018; expected data security standards for health and social care for processing personal data; and readiness to access secure health and digital methods of information sharing such as NHS Email, Welsh healthcare records and systems and local information sharing solutions and agreements. The Trust is required to demonstrate whether it complies with each of the 225 evidence items with each item weighted and a level of compliance generated (foundation stage; satisfactory stage; competent stage). IGSG monitors the toolkit improvement plan. Information Commissioner's Office (ICO) monitors compliance with key legislation (DPA 2018, UK GDPR and FOIAAct).</p>



PAPER	PRE-C'EE FORUM	FREQUENCY	MAY	JUL	SEP	NOV	JAN	MAR	LEAD	PURPOSE	COMMENT/COMPLIANCE
<b>FINANCE AND PERFORMANCE COMMITTEE - CYCLE OF BUSINESS 2024/25</b>											
<b>TERMS OF REFERENCE NOTED IN RED TEXT</b>											
<b>FINANCE</b>											
Annual revenue budget	ELT	Annually							EDOF	Endorsement	
Annual capital budget (Closed session)	Capital M' ment Board	Annually							EDOF	Endorsement	May 24: Received in Q1 24/25.
Financial report	ELT	Each meeting							EDOF	Assurance	
Year end M12 report (same time as M1 in new year)	ELT	May meeting							EDOF	Assurance	
Business cases over £500K	TBC	As required							EDOF	Endorsement	
IMTP financial plan	STB/ELT	Annually							EDOF	Endorsement	
Value Based Healthcare Report (Note 2)	TBC	Every other meeting							EDOF	Assurance	
Assurance paper on PIR process	TBC	One off and then cyclical							EDSPP	Assurance	
Post Implementation Reviews	TBC	As required							Relevant Director	Assurance	
Monitoring of key projects as requested from time to time	TBC	As required							Relevant Director	Assurance	
Financial Sustainability Report	TBC	Each meeting							DPC	Assurance	
<b>PLANNING</b>											
Refreshes of 2030 Delivering Excellence	ELT	Ad Hoc							EDSPP	Endorsement	
Service or Directorate Specific Plans: New & Refreshes (Note 2)	ELT	Ad Hoc							EDSPP	Endorsement	
IMTP for following year	STB/ELT/Board	Annually							EDSPP	Endorsement	
Report on commissioning (Note 3)	TBC	TBC							EDSPP	Assurance	May 24: EMS/NEPTS Commissioning intentions update.
Demand and capacity reviews (Note 6)	ELT	Ad Hoc							EDSPP	Endorsement	
<b>PERFORMANCE</b>											
Monthly Integrated Quality Performance report	ELT	Each meeting							EDSPP	Assurance	
MIQPR review of metrics	ELT/Board Committees	Annually							EDSPP	Endorsement	
Annual HART KPI report	TBC	Annually							EDO	Assurance	
IMTP progress updates	STB/ELT/Board	Each Meeting							EDSPP	Assurance	
QPMF update report	QPMF Steering Group	Bi-annually							EDSPP	Assurance	
<b>ESTATES AND FLEET</b>											
Estates and fleet strategy refreshes	TBC	Periodically as required							EDOF	Approval	
Fleet replacement programme	Capital M' ment Board	Annual BJC see notes							EDOF	Approval/Endorsement	
Fire safety annual report	ELT/Board	Annually							EDOF	Assurance	
Fire safety exception report	TBC	Periodically as required							EDOF	Assurance	
<b>ENVIRONMENTAL AND SUSTAINABILITY</b>											
Decarbonisation Update (Note 7)	Decarb Programme Board	Every other meeting							EDOF		
Waste Management Update (Note 7)	Decarb Programme Board	Annually							EDOF	Assurance	
Sustainability Report	Decarb Programme Board	Annually							EDOF	Assurance/Endorse	
<b>DIGITAL SYSTEMS AND STRATEGY</b>											
Digital Plan - new and refreshed (Note 1)	STB	Periodically as required							DD	Review and Endorse	
Metrics for digital systems infrastructure (Note 1)	TBC	Three times a year							DD	Assurance	
Review/Monitor of major projects	TBC	Ad Hoc							Relevant Director	Assurance	
<b>BUSINESS CONTINUITY AND CYBER</b>											
WV Annual Emergency Planning Report	ELT/Board	Annually							EDO	Assurance	
Incident Response Plan Report (Note 5)	ELT	Annually							EDO	Assurance	
Business Continuity Annual Report (Note 5)	ELT	Annually							EDO	Assurance	
Cyber Resilience and Cyber Security Reporting	TBC	TBC							DD	Assurance	May 24: Cyber risk deep dive deferred to July (taken in closed).
<b>INFORMATION GOVERNANCE AND INFORMATION SECURITY</b>											
Information Governance Toolkit	IGSC	Annually							DD	Assurance	May 24: Verbal update for May; full report to be received in July.
Information Governance Report	IGSC	Each meeting							DD	Assurance	
<b>POLICIES</b>											
Report from policy group	Policy Group	Annually							BS	Assurance	
Policies for review and approval	Policy Group	Ad Hoc							BS	Approval	
<b>CORPORATE RISKS AND AUDIT</b>											
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	
<b>STANDARD ITEMS</b>											
Quarterly operations update	TBC	Each meeting							EDQN	Information/Discussion	
<b>GOVERNANCE</b>											
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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	
<b>SUB-GROUPS</b>											
Where applicable	N/A	Ad Hoc							N/A	N/A	No sub-committees - but may set up task and finish groups from time to time
<b>PROMPTS</b>											
External Reports	N/A	Ad Hoc							TBC	TBC	

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

**Key: Pre-agenda setting**  
  Cycled for each meeting  
  Ad hoc item - prompt for agenda setting  
  Reporting developing



## 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.

<b>Trust Board Meeting Date</b>	28 March 2024
<b>Committee Meeting Date</b>	19 March 2024
<b>Chair</b>	Joga Singh

### KEY ESCALATION AND DISCUSSION POINTS

#### ALERT

(Alert the Board to areas of attention)

1. No alerts for the Board from this meeting.

#### ADVISE

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

2. The **Integrated Medium Term Plan (IMTP) and Financial Plan for 2024-27** were presented, with the Committee noting it had received a report on progress and direction of travel in January, and at the Board Development session in February. **The IMTP was endorsed by the Committee**, noting some amendments will be made before it is presented for approval to the Board at the March meeting.

The Committee noted the IMTP was accompanied by a balanced financial plan that requires a £6.4 million savings target, so was not without risk and significant work to deliver it. The Committee was assured there was confidence the 3.67% revenue uplift would be passed through from Commissioners, and that they would support the plan.

The IMTP demonstrated an ambition over three years that was more aligned to the long-term strategy 'Delivering Excellence'. The plan also moves the Trust towards a new clinical response model that integrates 111 and 999 remote clinical teams, expands face to face care and see and treat options, with the intention of reducing conveyance to Emergency Departments. The stretching aspirations were noted as were some concerns about the Trust's resources and the reliance on external factors to deliver, which the Committee will monitor throughout 2024/25.

Members praised the plan for being clear, coherent, and ambitious, and reflecting the strategic direction of the trust. However, management were urged to continue to push the boundaries on patient engagement for the IMTP in 2025.



3. The Initial **2024/25 Revenue Budget** was received and **endorsed by the Committee**. It will be received by the Board at its March meeting. The budget is consistent with the IMTP financial plan, but there may be some changes as the plan is finalised and endorsed. Through Q1 the Executive Director of Finance and Corporate Resources and the Chief Executive Officer will meet with Directors to confirm and sign off their directorate budgets.
4. A verbal update was received on progress with the **Strategic Demand and Capacity Review**. The timeframe for this to be presented at the Emergency Ambulance Services Committee (EASC) had changed given their transition to new Joint Commissioning Committee and a full update will be provided to this Committee later in the year. The Committee were reassured that work was ongoing on the review in the meantime.
5. This was the first meeting for Peter Curran and members welcomed him to the Committee.  
**Reflections** on the meeting included:
  - Welcomed scrutiny, challenge, and support on the financial position.
  - Internal Auditors and Audit Wales were present at the meeting which was appreciated.
  - The quality of papers was good which allows members to scrutinise and question, and responses from management were clear.
  - From a financial perspective the papers were clear and transparent, and the answers were well made, so members were assured that the outturn for this year and next year's budget have been fully thought out.
  - Good to see a pragmatic approach to closing down audit actions when nothing further can be advanced by the Trust.
  - KPIs for digital will be moved up the agenda following the MIQPR item for future meetings.
  - The focus on our people was welcomed as being considered alongside the financial and performance aspects.
  - Members were thanked for their flexibility as some attendees needed to leave meetings for other unavoidable commitments.

## ASSURE

(Detail here assurance items the Committee receives)

6. The Committee received a presentation on the **financial position for Month 11 2023/24** due to the date of this meeting coming close to end of month. The Board will have a detailed paper on the financial position before it for its March meeting. The cumulative year to date revenue position is an underspend against budget of £0.108m, with the year-end forecast being one of break even, based on the assumptions presented. The capital plan is being progressed and current planned expenditure of £22.6m is forecast to be fully spent by the end of the financial year. The trust is still waiting for confirmation from the Welsh Government on the funding for the fleet replacement business case, which has been submitted for £24 million. The high capital spend planned for March was due to the new 111 CAS replacement, the fleet build slots, the timing of receipt of some defibrillators and some updated times following the tender process for some of the EFAB schemes. It was also noted that the trust is still waiting for confirmation from the Welsh Government on the funding for the 2024/25 fleet



replacement business case, which has been submitted for £24 million.

7. An update was provided on the **Financial Sustainability Programme (FSP)** with significant progress made. In line with the savings plan that supports the IMTP, gross savings of £6.08m have been achieved against a year-to-date target of £5.462m. Whilst the challenge of finding cumulative costs year on year was recognised, the real achievements in terms of a collective response from across the organisation to drive efficiency was celebrated. The income generation workstream is looking at market options and viability for income generation with a presentation this week at the Executive Leadership Team away day with the outcomes reported to the next meeting. The work on income generation and commercialisation is critical to take the financial sustainability programme to the next level and the support of Trade Union Colleagues with this work was also recognised. It was agreed that this would be a priority area for the Committee in 2024/25.
8. The update against progress on the **IMTP 2023-26** was received as at an interim Q3/4 position with exception reporting were applicable. Progress was discussed and areas marked as 'red' will be drawn out in the report to the Trust Board. Many of the enabling actions are reported through the main IMTP delivery programmes and will be managed within directorates. Despite many ongoing challenges this was a positive report with areas marked red related to lack of resources the cause of our inability to address them.
9. The **Digital KPIs** relating to data and analytics, ICT systems, service provision and the IMPT for the period 1 January to 31 March 2024 were reviewed by exception. The Committee noted:
  - The Mobile Date Vehicle Solutions project has been tested and will be deployed across all vehicle types in Q2 2024.
  - 999 telephony platform upgrade aims to go live mid-April 2024 following testing.
  - National Data Resource programme support is at risk as longer term funding has not yet been confirmed as expected in 2024/25.
  - NADEX Integration – single sign and digital experience of staff is currently at risk as work on hold due to CAS replacement programme taking priority.
  - Digital literacy skills – development of accredited and non-accredited education programmes is underway with the expansion of Learning Launchpad content.
  - The Data Linkage project is progressing with focus on the Out-of-Hospital Cardiac Arrest dataset which will be consumed via the National Data Resource (NDR) analytics platform and shared with the NHS Wales Executive / Cardiac Network and national registry.
  - Staffing and resourcing continue to be under pressure, particularly in the areas of Information Governance, Records Services, analytics, web development and ICT engineering which presents a risk to existing and planned projects.
10. The **Monthly Integrated Quality and Performance Report (MIQPR) for January/February 2024** was presented. This report will also be presented to the Trust Board in March. Members discussed the performance which is within the gift of the Trust to influence such as PADR, and statutory and mandatory training and were reassured that whilst performance is not where we would want it to be, given the pressured time of the year the reporting covered and abstractions due to CAS replacement work and training, it was somewhat anticipated. The point was made that the establishment for 111 is not sufficient currently to meet the out of hours demand which impacts on call abandonment rates.



Management will continue to make the case for a demand and capacity review in this area.

11. The **Value Based Healthcare Report** was received and detailed the activities of the Value Based Healthcare Working Group (VBHC) and the key workstreams within its portfolio. This Working Group is the vehicle for reporting on value-based change within the Trust. The workstreams within its the VBHC portfolio are Patient Recorded Outcomes Measures (PROMS), Patient Data Linkage, Patient Recorded Experience Measures (PREMS), Patient Level Information and Costing System (PLCIS), Revenue Business Case Process, Evaluation Framework & Methodology, and Benchmarking. All workstreams are progressing well. Work is ongoing to identify potential workstreams and priorities which could fall within the remit of 'value-based' activity, and a revised view of the associated governance structures may be taken if considered necessary.
12. Upcoming **changes to waste legislation** in Wales requires the Trust to robustly recycle waste into additional segregated waste streams. New contractual arrangements and internal communications to staff are in place to meet these requirements. These changes include civil action for non-compliance.
13. The Committee held its **annual effectiveness review** and approved its annual report for review by the Audit Committee in April and the Board in May. It also approved revisions to its Terms of Reference.
14. The following **internal audits** were discussed with all, other than ICT Contract Management, having been received by the Audit Committee on 1 March:
  - **Decarbonisation** - limited assurance. The Committee noted that this review is being conducted across all NHS Wales Health Bodies and that all have been given a limited assurance rated, therefore WAST is not an outlier. The significant work the Trust has been undertaking to address the requirements of the Decarbonisation Strategic Delivery Plan were recognised. However, the overall rating reflects the complexity and range of risks associated with this area which, along with the financial shortfalls, impacts on the Trust's ability to deliver on the wider decarbonisation agenda.
  - **Vehicle Replacement Programme** - reasonable assurance with key matters arising including compliance with Standing Orders for Trust Board approval of contracts (included in alert section of the Audit Committee AAA); enhance reporting and review of the procurement strategy to ensure best value; ensure procurement and contractual arrangements obtain best value from strategic partnering; detail variances to programme at business cases; demonstrate optimal vehicle procurement numbers; and to better align the project management and business case processes with best practice.
  - **Strategy Development** - reasonable assurance with key matters arising including delays to the Engagement Framework Delivery Plan; and opportunities to improve how the Trust measures and reports progress.
  - **ICT Contract Management** – reasonable assurance with key matters arising related to the contract register, evidence of contract performance monitoring, and evidence of contract end of term review and assessment process.



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

16. In **closed session** members received an update on the CAS replacement programme with the Committee receiving assurance that the programme is on track for go live on 30<sup>th</sup> April 2024. The level of commitment demonstrated by the team working on this was recognised by the members and they were thanked for their intense focus. Cyber KPIs were also presented with results of recent phishing exercises discussed and initiatives to address the outcomes of that.

## RISKS

**Risks Discussed:** There are no material changes to the eight principal risks within the remit of this Committee and all scores remain static as at 7 February 2024. The Committee were assured of the comprehensive review of each risk and received further assurance from the Chair of the Audit Committee on the wide discussion which took place on 1 March 2024.

**Risk 594** (the Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death) remains at 20 (4x5) despite Chief Operating Officers agreeing a framework for the release of ambulances in the event of a major incident.

**Risks 424** (prioritisation or availability of resources to deliver the Trust's IMTP) and **Risk 458** (a confirmed funding commitment from EASC and/or WG is required in relation to funding for recurrent costs of commissioning) remain static at 16 (4x4); however, scores will be reviewed in the next review in line with mitigating actions.

**Risks 260** (a significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems) and **543** (major disruptive incident resulting in a loss of critical IT systems) remain at a score of 15 (3x5). It is foreshadowed that there may be a reduction in the risk score on 543 given achievement of mitigating actions.

### COMMITTEE AGENDA FOR MEETING

Operations Update	IMTP 2023-26 Delivery and Assurance	IMTP 2024-27 Final Version with Financial Plan
Initial 2024/25 Revenue Budget	Financial Position for Month 11	Financial Sustainability Programme
MIQPR	Strategic Demand and Capacity Review	Value Based Healthcare
Annual Committee Effectiveness Review	Fire safety compliance January 2024	Waste Management Update
Risk Management and BAF	Decarbonisation Internal Audit	Vehicle Replacement Programme Internal Audit
Strategy Development Internal Audit	ICT Contract Management Internal Audit	Digital Reporting



COMMITTEE ATTENDANCE						
Name	15 May 2023	17 July 2023	18 Sep 2023	13 Nov 2023	15 Jan 2024	19 Mar 2024
Joga Singh						
Kevin Davies	Until 11.30am	Chair				
Bethan Evans						
Ceri Jackson						
Martin Turner		Left at 11.30	Left at 12.00			
Peter Curran						
Chris Turley		Navin Kalia				
Rachel Marsh		Hugh Bennett			Left 11-12	Hugh Bennett <sup>1</sup>
Lee Brooks	Sonia Thompson	Judith Bryce <sup>2</sup>	Judith Bryce		Jon Edwards	
Liam Williams	Wendy Herbert			J Turnbull-Ross		Left 11.30 <sup>3</sup>
Angie Lewis	Liz Rogers					Left 11.30
Jonny Sammut						
Leanne Smith			Aled Williams			
Hugh Parry						From 10.00am
Damon Turner						
Trish Mills				Julie Boalch		

	Attended
	Deputy attended
	Apologies received
	No longer member

<sup>1</sup> Rachel Marsh in attendance for IMTP 24-27 item

<sup>2</sup> Lee Brooks in attendance for EPRR item

<sup>3</sup> Returned for closed session