Bundle Finance and Performance OPEN 17 September 2024

Agenda attachments
ITEM 00 FPC Open Agenda

0 09:30 - OPENING ITEMS

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

2 Declarations of Interest
ITEM 02 Board Member Register of Interests

3 Minutes of Last Meeting
ITEM 03 2024-07-16 Draft OPEN F and P Minutes

4 Action Log and Matters Arising
ITEM 04 Action Log

4.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:35 - Financial Position for Month 5, 24/25

6 09:55 - Financial Sustainability Programme Position Paper
ITEM 06 Financial Sustainability Programme August 2024

7 10:05 - Value Based Healthcare Report
ITEM 07 Value Based Healthcare August 2024

8 10:15 - Monthly Integrated Quality Performance Report
ITEM 08 MIQPR SBAR FPC July August 24 Final
ITEM 08.1 Annex 1 MIQPR FPC July August 24 Final

9 10:30 - Digital Reporting - Metrics for Digital Systems Infrastructure
ITEM 09 Digital Reporting September 2024 - Cover Paper
ITEM 09.1 Digital Reporting September 2024 - Metrics

10 10:40 - Specialist Operations Key Performance Indicators 2023/24
ITEM 10 Exec Summary for FP Cttee - Specialist Operations Key Performance Indicators Q4 2023-24
ITEM 10.1 Specialist Ops KPI report
ITEM 10.1a KPI Summary

11 10:55 - IMTP Delivery/Assurance - Progress Update
ITEM 11 240917 - Executive Summary - IMTP Delivery & Assurance Report
ITEM 11.1 Appendix 3 IMTP Performance Overview August 2024 report version

11.1 11:15 - COMFORT BREAK

12 11:30 - Cymru High Activity Response Unit Report
ITEM 12 CHARU Data - FPC September 2024

13 11:45 - Environment, Decarbonisation and Sustainability Update August 2024
Item 13.1 Circulated by E mail
ITEM 13 Decarb and Sustainability FPC 17-09-24

14 12:00 - Waste Management Update - September 2024
ITEM 14 Finance and Performance Committee - Waste management update 0924
ITEM 14.1 Utility and Waste update 2023-24

15 12:10 - Estates condition and backlog maintenance update - September 2024
ITEM 15 Finance and Performance Committee - Estate Condition 17.09.2024
ITEM 15.1 EFPMS Data Report
ITEM 15.1a EFPMS Trust Profile Data Report
ITEM 15.1b EFPMS Estates Data Report

16 12:20 - EMS Operational Transformation Programme
ITEM 16 EMS Operational Transformation Programme SBAR 20240828
ITEM 16.1 Closure Evaluation Report EMS Transformation Programme Board 20240828

17 12:30 - Information Governance Report
ITEM 17 Information Governance Reporting September 2024 - Cover Paper
ITEM 17.1 Appendix 1 - IG Toolkit Improvement Plan - Status Report (Aug24)
ITEM 17.2 Appendix 2 - Information Security & Governance Reporting - Metrics (Aug24)

18 12:45 - Risk Management and Board Assurance Framework Report

ITEM 18 Executive Summary Risk Management Report FPC 170924

19 12:55 - Audit Tracker 2.0 - June 2024 (Q1)

ITEM 19 SBAR Audit Tracker to Committees - Q1 Reporting - April-June Reporting - FPC

ITEM 19.1a FPC Tracker- Internal Audit

ITEM 19.1b FPC Tracker - External Audit

19.1 CONSENT ITEMS

20 Committee Priorities and Cycle Monitoring Report

ITEM 20 Finance and Performance Committee Priorities and Cycle Monitoring Report

ITEM 20.1 Monitoring report

ITEM 20.1a COB notes

20.1 13:05 - CLOSING ITEMS

21 Reflections and Summary of Decisions/Actions

22 Any Other Business

23 Date & Time of the Next Meeting: 19 November 2024 at 09:30

Length of Meeting:	03:45	Agenda Status:	[OPEN] FINANCE AND PERFORMANCE COMMITTEE - 17 SEPTEMBER 2024					Deadline for Papers:
Time	**Mins allotted**	**Agendum**	**Title**	**Format**	**Item for**	**Item requested by**	**Paper prepared by**	**Item presented by**
			OPENING ITEMS					
09:30	00:05	1	Chair's Welcome, Apols and Quorum [Peter Curran will be Chairing the meeting]	Verbal	Information	Standing	n/a	Chair
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair
		3	Minutes of the Last Meeting: 16 July 2024	Paper	Approval	Standing	n/a	Chair
		4	Item 4 Action Log & Matters Arising	Paper	Discussion	Standing	n/a	Chair
			FOR APPROVAL, ASSURANCE AND DISCUSSION					
09:35	00:20	5	Financial Position for Month 5, 24/25 [PPT]	Presentation	Assurance	CoB	FinCor	Chris Turley
09:55	00:10	6	Financial Sustainability Programme Position Paper	Paper	Assurance	CoB	People	Chris Turley
10:05	00:10	7	Value Based Healthcare Report	Paper	Assurance	CoB	FinCor	Liam Williams
10:15	00:15	8	Monthly Integrated Quality Performance Report	Paper	Assurance	CoB	SPP	Rachel Marsh
10:30	00:10	9	Digital Reporting - Metrics for Digital Systems Infrastructure	Paper	Assurance	CoB	Digital	Jonny Sammut
10:40	00:15	10	Specialist Operations Key Performance Indicators 2023/24	Paper	Assurance	CoB	Ops	Lee Brooks
10:55	00:20	11	IMTP Delivery/Assurance - Progress Update	Paper	Assurance	CoB	SPP	Rachel Marsh
11:15	00:15		COMFORT BREAK					
11:30	00:15	12	Cymru High Activity Response Unit Report	Presentation	Assurance	Ad Hoc	Ops	Lee Brooks
11:45	00:15	13	Environment, Decarbonisation and Sustainability Update August 2024	Paper	Assurance	CoB	FinCor	Chris Turley
12:00	00:10	14	Waste Management Update - September 2024	Paper	Assurance	CoB	FinCor	Chris Turley
12:10	00:10	15	Estates condition and backlog maintenance update – September 2024	Paper	Assurance	Audit Action	FinCor	Chris Turley
12:20	00:10	16	EMS Operational Transformation Programme	Paper	Assurance	Forward Planner	SPP	Rachel Marsh
12:30	00:15	17	Information Governance Report	Paper	Assurance	CoB	Digital	Jonny Sammut
12:45	00:10	18	Risk Management and Board Assurance Framework Report	Paper	Assurance	CoB	Gov	Julie Boalch
12:55	00:10	19	Audit Tracker 2.0 - June 2024 (Q1)	Paper	Assurance	CoB	Gov	Trish Mills
			CONSENT ITEMS The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.					
13:05	00:00	20	Committee Priorities and Cycle Monitoring Report	Paper	Assurance	CoB	Gov	Trish Mills
			CLOSING ITEMS					
13:05	00:10	21	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair
		22	Any Other Business	Verbal	Discussion	Standing	n/a	Chair
		23	Date & Time of the Next Meeting: 19 November 2024	Verbal	Information	Standing	n/a	Chair
13:15	**03:45**		**CLOSE**					

LEAD PRESENTERS

Name	Position
Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations
Peter Curran (Chairing meeting)	Chair and Non-Executive Director
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Jonny Sammut	Director of Digital Services
Andy Swinburn	Executive Director of Paramedicine
Chris Turley	Executive Director of Finance and Corporate Resources
Liam Williams	Executive Director of Quality and Nursing

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
BROOKS, Lee	**Executive Director of Operations**	Partner employed by Welsh Ambulance Services NHS Trust	Any Other Interest	July 2019		
		Member of the Order of St John	Any Other Interest	01 March 2023		
		Volunteer – St John's Ambulance Cymru	Any Other Interest	06 April 2023		
		Council Member – St John's Ambulance Cymru Gwent Council	Any Other Interest	06 April 2023		
CURRAN, Peter	**Non-Executive Director** * Chair of the Audit Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021		
		Company Director - Action for Children [04764232]	Directorships	01 February 2021		
		Company Director - Action for Children (Wales) Ltd [10011497]	Directorships	05 April 2022		
		Trustee of National Youth Arts Wales [1170643]	Position in Charity or Voluntary Organisation	06 May 2021		
		Company Director - National Youth Arts Wales [10449512]	Directorships	06 May 2021		
		Non-Executive Director for Taff Housing	Position in Charity or Voluntary Organisation	01 May 2022		
		Company Director - Team Police Ltd [12518812]	Directorships	01 January 2022		
		Independent Board Member of the Project Board - National Contemporary Art Gallery for Wales	Any Other Interest	01 January 2024		
		Interim Finance Director for Torfaen Leisure Trust	Directorships	01 September 2023	29 February 2024	
		Interim Independent Member – Kaplan International Colleges UK Ltd [05268303	Directorships	01 March 2024		
		Independent Member - Kaplan Open Learning (inc member of the Audit & Risk Committee)	Directorships	21 March 2024		
DAVIES, Kevin	**Non-Executive Director** * Member of Academic Partnership Committee * Member of Audit Committee * Member of Finance & Performance Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Colonel Commandant Queen Alexandra's Royal Army Nursing Corps	Any other interest	May 2020		
		Charity Trustee - Queen Alexandra's Royal Army Nursing Corps Association	Position in Charity/Voluntary Organisation	28 January 2021		
		Patron Motivation and Learning Trust	Position in Charity or Voluntary Organisation	2014	December 2023	
		Chair ABF The Soldiers Charity (Glamorgan)	Position in Charity/Voluntary Organisation	2015		
		Honorary Colonel 203 (Welsh) Multi-Role Medical Regiment (Commanding Officer's Principal Advisor)	Any Other Interest	01-Apr-24		
		Member Royal College Nursing	Any other interest	1978		
DENNIS, Colin	**Chair of Trust Board and Non-Executive Director** * Chair of Remuneration Committee	Chair - Citizen Housing [Charity] (previously WM Housing Group)	Position in Charity or Voluntary Organisation	01 January 2015		
		Company Director - Citizen Treasury PLC (previously WM Housing Treasury Ltd)	Directorships	29 August 2017		
		Company Director - Citizen Treasury Vehicle Ltd	Directorships	04 September 2017		
		Chair - North Devon Homes	Position in Charity or Voluntary Organisation	01 October 2021		
		Company Director - North Devon Homes	Directorships	01 April 2022		
		Chair - Green Square Accord (Housing Association)	Position in Charity or Voluntary Organisation	26 March 2024		
		Company Director - LowCarbonLiving Homes Ltd [04207671]	Directorships	26 March 2024		
		Company Director - Green Square Estates Ltd [8719365]	Directorships	26 March 2024		
EVANS, Bethan	**Non-Executive Director** * Chair of Quality, Patient Experience & Safety Committee * Member of Charity Committee * Member of Finance & Performance Committee * Member of People & Culture Committee * Member of Remuneration Committee	Managing Director (Employed) at My Choice Healthcare Limited.	Any Other Interest	01 June 2019		
		Non-Executive Board Member at RHA (Social Housing Organisation - Community Benefit Society)	Position in Charity or Voluntary Organisation	01 November 2019		
		Company Director - My Choice Healthcare South Wales Limited	Directorships	11 March 2020		
		Company Director - Moorlands Rehabilitation (Staffordshire) Limited.	Directorships	20 December 2019		
		Company Director - Springfield (Bargoed) Limited.	Directorships	12 March 2020		
		Company Director - Homes of Excellence Limited	Directorships	19 March 2021		
		Company Director - Victoria House Care Property Limited	Directorships	05 March 2020		
		Company Director - My Choice Healthcare (Four) Limited	Directorships	27 April 2022		
		Company Director - Luk Ros Property Limited	Directorships	12 March 2020		
		[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]	*Directorships*	*12 March 2020*		
		Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022		
		[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]	*Directorships*	*27 April 2022*		
		Company Director - Ocean Living Property Limited	Directorships	22 July 2022		
		Company Director - Hawthorn Court Care Limited	Directorships	22 July 2022		
		Company Director - Glyncornel Property Limited	Directorships	01 July 2022		
		Company Director - My Choice Healthcare (Two) Limited	Directorships	01 July 2022		
		Company Director - Carmarthen Care Limited	Directorships	02 January 2024		
		Company Director - Towy Castle Property Limited	Directorships	01 September 2023		
HITCHON, Estelle	**Director of Partnerships and Engagement**	Nil Declaration				

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust
JACKSON, Ceri	**Non-Executive Director & Vice Chair of the Trust Board** * Chair of Charity Committee * Chair of the People and Culture Committee * Member of Audit Committee * Member of Quality, Patient Experience & Safety Committee * Member of Remuneration Committee	Management Consultant primarily working in third sector	Interest in Companies and Securities	01 May 2019		
		Associate Director of SamKat Consulting Ltd in my capacity as self-employed management consultant	Directorships	01 June 2021		
		Charity Trustee - Stroke Association Trustee, Chair Wales Advisory Group.	Position in Charity or Voluntary Organisation	08 October 2020		
		Charitable Company - Stroke Association - Company Director	Directorships	08 October 2020		
KILLENS, Jason	**Chief Executive**	Honorary Professor - Swansea University	Personal or Departmental Sponsorship	2019		
		Member of the Order of St John	Any Other Interest	2009		
LEWIS, Angela	**Director of Workforce and Organisational Development [12 September 2022]**	Nil Declaration				
MARSH, Rachel	**Executive Director of Strategy, Planning and Performance**	Nil Declaration				
MILLS, Patricia (Trish)	**Board Secretary**	Nil Declaration				
PARRY, Hugh	**Trade Union Partner**	Nil Declaration				
ROWAN, Hannah	**Non-Executive Director** * Chair of Academic Partnership Committee * Member of Charity Committee * Member of People & Culture Committee * Member of Remuneration Committee	Director, St Martin's Associates (Business consulting and coaching)	Directorships	04 April 2022		
		Non -Executive Director Qualifications Wales (regulator for all non degree qualifications in Wales)	Any Other Interest	01 April 2021		
		Trustee MAE Cymru (Christian charity which champions gender equality in church of Wales)	Position in Charity or Voluntary Organisation	13 November 2021	November 2023	
		Elected member, The governing body of the church in Wales (Parliament of church in Wales - voting member)	Any Other Interest	01 April 2021		
		Relative (Parent) is a Non-Executive Director for Social Care Wales	Any Other Interest	01 April 2017		
SAMMUT, Jonathan (Jonny)	**Director of Digital Services [appointed 26.09.2023]**	Fellow of the British Computer Society – FBCS	Any Other Interest	04 March 2024		
		Panel Member of the UK CIO Advisory Panel – Digital Health	Any Other Interest	05 July 2023		
		Federation of Informatics Professionals - Leading Practitioner	Any Other Interest	25 April 2024		
SINGH, Anoop Joga (Joga)	**Non-Executive Director** * Chair of the Finance & Performance Committee * Member of the Audit Committee * Member of People & Culture Committee * Member of Remuneration Committee	Geldards LLP	Any Other Interest	03 March 2009		
		Membership of the Law Society	Any Other Interest	01 January 2006		
		Membership of the Employment Lawyers Association	Any Other Interest	01 January 2006		
		Member of the Fairness, Inclusion & Respect Committee for the Institute of Civil Engineers in Wales	Position in Charity or Voluntary Organisation	01 March 2018	31 December 2023	
		Independent Member of the South Wales Police Ethics Committee, 2 – 3 days a year.	Any Other Interest	01 March 2018		
SWINBURN, Andrew (Andy)	**Executive Director of Paramedicine**	Strategic Advisor to College of Paramedics	Any Other Interest	01 January 2020		
TURLEY, Christopher	**Executive Director of Finance and Corporate Resources**	Treasurer of Royal Gwent Hospital League of Friends.	Position in Charity or Voluntary Organisation	01 February 2022		
TURNER, Damon	**Trade Union Partner**	Nil Declaration				
WILLIAMS, Liam	**Executive Director of Quality and Nursing [from 01 August 2022]**	Chair/Director - Thornbury Carnival Community Interest Company Voluntary	Position in Charity or Voluntary Organisation	01 August 2019		
		Member Royal College Nursing	Any Other Interest	01 August 2022		
		Committee member Royal College Nursing, Nurses in Management and Leadership Forum Steering Committee	Position in Charity or Voluntary Organisation	01 August 2022		

UNCONFIRMED MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE (OPEN SESSION) HELD ON 16 JULY 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
Angela Lewis	Director of People and Culture
Osian Lloyd	Head of Internal Audit
Trish Mills	Director of Corporate Governance/Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner (Left meeting during Item 60/24)
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

Apologies

Rachel Marsh	Executive Director of Strategy, Planning and Performance

51/24 PROCEDURAL MATTERS

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

Minutes

The minutes of the open session held on 14 May 2024 were considered by the Committee and confirmed as a correct record.

Action Log

Minute 36/24: Digital report: The Committee asked that the next update provide details with progress on staff ICT training. *The following was taken from the action log update: May Numbers: Low NEPTS uptake due to early deployment in the vehicle cohort impacted the original number that we provided. Looking at the current dashboard, this is showing the % increase in May and June, ending June at 64%. Second Issue: Uptake appears low due to reliance on staff self-certification. No automated system to track training completion, requiring manual confirmation in ESR. Following investigation, the actual training completion is very likely higher, as indicated by few user error incidents. - We are looking at options to track completion better.* Action Closed.

Minute 38/24: Information Governance Toolkit: *To provide enhanced reporting on the toolkit for the next report, and potentially to include a Gantt Chart. The report was on the agenda*. Action Closed.

Minute 48/24: Financial Sustainability Programme Update: *The Committee asked that consideration be given in terms of how the report is presented going forward; with details regarding the extrapolation of the efficiencies and savings differences and to be clear on the level of recurrent savings versus non-recurrent. Chris Turley added this would be part of his financial update.* Action Closed.

This Action Item was transferred from the People and Culture Committee (PCC): Cymru High Activity Response Unit Report. *Cymru High Activity Response Unit Report (continued deployment of CHARU, aiming to illustrate progress, activity and deployment) Deferred from May meeting due to some challenges with data and the HI Team (Action Transferred from PCC: Andy Swinburn agreed to take a paper to the Quest Committee around the continued deployment of Charu, aiming to illustrate progress, activity and deployment) Note: This item has been transferred to the FPC following discussion at the Quest ASM on 28 May 2024.* Item deferred to 17 September FPC meeting; Lee Brooks will provide the update. Action to remain open.

RESOLVED: The

(1) Minutes of the meeting held on 14 May 2024 were confirmed as a correct record; and

(2) The Action log was considered and updated as described above.

52/24 OPERATIONS QUARTERLY UPDATE – QUARTER ONE 2024/25

Lee Brooks updated the Committee on the following points:

1. Manchester Arena Inquiry - Work on the recommendations has continued with the Capability to Prepare, Capability to Respond and Capability of Specialist Assets papers completed. To date, 30 of 68 recommendations have been completed with 20 of those outstanding requiring investment to progress.

2. Operational effectiveness – The Trust has aimed to enhance operational efficiency by addressing key areas such as mobilisation times, time spent on scene, clinician travelling unavailability, and multiple auto-allocations. The focus of the work was to emphasise the need for a system-focused approach and the implementation of a live dashboard for dynamic efficiency management. The plan included identifying stakeholders, discussing strategies, and documenting an action plan, along with the development of new measures specific to the key areas of the job cycle time that required improvement.

3. The Trust went into remediation with the International Academies of Emergency Despatch (IAED) for the Medical Priority Despatch System (MPDS) following Quarter 4. An action plan has been approved and was submitted to the IAED as per its Remediation Policy. The Trust was required to fall within the specified thresholds of compliance to come out of remediation status. So far for Quarter 1, the Trust has reported compliance within the accreditation threshold, which bodes well for the Trust well to come out of remediation following Quarter 1.

4. The Organisational Change Policy (OCP) consultation for Emergency Medical Services Coordination (EMSC) commenced on Friday 10 May 2024 and was due to conclude on 7 June 2024. In consultation with Trade Union Partners, this was extended for two weeks and therefore closed on 21 June 2024. There were a range of questions raised during the formal consultation period and the formal response to those questions was being finalised.

5. While it was noted that the level of investigation of over two hour end of shift overruns has continued to improve, along with the uptake of utilising the options available to reduce the end of shift overruns, work has progressed on several initiatives to further reduce end of shift overruns to support the wellbeing of staff. Despite the continued level of handover delays, the average length of overrun has remained at levels lower than 12-15 months ago.

6. The 2023/24 Financial Savings Plan (FSP) concluded successfully with original savings assumptions mainly achieved and overtime allocation following suit. In 2024/25, Quarter 1, has been overachieved to date and a performance report reviewing the progress will be submitted to the Senior Operations Team (SOT) on

26 July 2024. The report will incorporate the overtime allocation and savings targets for the full financial year.

7. The 111 Clinical Assessment Software (CAS) replacement system was fully implemented on the expected date of 30 April 2024 and the old system has been taken out of service. Early indications show that more calls were being handled without clinical intervention and there has been a reduction in the time a patient waited for a clinical assessment. The average time speaking to a call handler has returned to similar levels as before as has the average time waiting for the 111 calls to be answered. There were expected to be further clinical and operational improvements to the system throughout the financial year which will be scoped and implemented.

Comments:

Following a query on the benefits to staff of teams-based working Lee Brooks commented that the Trust was considering adopting the London Ambulance Service (LAS) teams-based working model (if doable), which could significantly enhance both the welfare of staff and the operational capabilities of the Trust. By fostering better communication, improving resource management, and providing a supportive work environment, such a model can address many of the challenges faced in high pressure, dynamic settings. A visit to the LAS would likely provide valuable insights and practical examples of these benefits in action.

Members queried if there were, from the shift overruns, any cost implications albeit there were factors outside of the Trust's control. Lee Brooks explained that the cost was quantifiable and was being monitored, with the Trust spending less than it has previously. One of the issues was rural crew change overs; the Trust was aiming to promote and utilise the opportunity, particularly for rural crews, to facilitate alternative crew changeovers. Furthermore, Damon Turner added it was important to note that there were other occurrences outside of the financial example, such as staff taking time back as time off in lieu. This created a performance issue later for the Trust, adding to the problem. Additionally, there was the impact on staff morale to consider.

The Committee asked, in terms of the element that was directly attributable to the handover delays, things that were outside of the Trust's control, was that figure used strategically to indicate how it was impacting on the Trust. Lee Brooks added that in the past, the Trust has produced reports on the costs of handover delays and utilised that data in its dialogue and correspondence with commissioners.

In terms of Coroners responses, it was queried if there were any signs of improvement in this area. Lee Brooks explained that the Quality Team has distributed a number of statements for others to finalise, particularly for cases that were less complex and more directly attributable to handover delays. This process was definitely improving and would give the Trust an opportunity to test its potential moving forward. As people gradually filled positions and stability was achieved, it would provide the Trust with a great opportunity to assess the potential for either recovery or maintaining the current standing.

Members recognised that there were pockets of poor culture among EMS staff that required addressing. They questioned whether there was a pattern or trend to these issues or if these pockets were disparate. Lee Brooks explained that the reason this issue was mentioned was due to the number of investigations currently underway. These have increased and were remaining relatively high, which had been anticipated. The Trust was seeing the consequences of the work done to date, where staff feel more comfortable coming forward about their experiences at work. There appears to be an emerging theme around behaviours, which aligned with the ongoing cultural work. There was a correlation between these efforts and the number of issues being reported. Ideally, the Trust had hoped to see a plateau in the number of new issues.

RESOLVED: The update was noted.

53/24 FINANCIAL POSITION FOR MONTH THREE 24/25

Chris Turley gave a presentation on the Month three financial position of the Trust and drew attention to the following areas:

1. The month three reports were submitted to Welsh Government at 12pm, Thursday 11 July 2024;

2. The cumulative year to date (at Month three end of June 2024) revenue financial position reported was an underspend against budget of £0.029m;

3. The Income and Expenditure forecast for 2024/25 was one of breakeven;

4. The Capital plan was being progressed and current planned expenditure of £19.622m was forecast to be fully spent by the end of the financial year, this however did not currently include an additional £0.635m to address backlog maintenance issues, funding for which was confirmed by WG in early July;

5. In line with the financial savings plans that supported the Integrated Medium Term Plan (IMTP), gross savings of £1.967m has been achieved against a year-to-date target of £1.704m;

6. Public Sector Payment Policy was on track with cumulative performance to month three, against a target of 95%, of 97.5% for the number of non-NHS invoices paid within 30 days.

7. In terms of the financial performance by Directorate, most directorates were in line with the budget plan for month three.

8. At Month three, the key assumptions underpinning the year-to-date financial performance, remained broadly in line with that within the 31 March approved IMTP/Trust Board financial plan and budget set.

9. An update was given on the total assessed risks being reported at Month three and given it was only Month three, there was a balanced IMTP and the risks recorded were all categorised as low or (1) medium risk. However these need to be captured and continually monitored. Now included in the risks was a medium risk around the funding of EMT re-banding, the Trust was in the process of finalising a business case to submit to WG / commissioners for this; further updates will be provided in future months.

10. Members were shown a slide which illustrated the current savings schemes for month three and this also now included the split of recurrent and non-recurrent savings

11. Work continued around the Financial Sustainability Programme including the launch of the Siren page with a number of other objectives set for 2024/25. One area of focus is on the plans around increasing commercial activity.

12. Capital funding at Month three has been confirmed as £19.622m of which £5.455m was via discretionary capital funding with £14.167 via All Wales Capital Funding. (it does not doesn't include the Estates backlog funding confirmed in early July). The breakdown of the month three confirmed All Wales Capital funding now included that which is being funded for the fleet replacement programme in 2024/25. It should be noted that the amount provided was circa half (52.6%) of the amount requested via the submitted BJC (£24.388m), therefore further urgent prioritisation works has now taken place and confirmed via the relevant governance groups.

Comments:

The Committee noted it was helpful to see the savings breakdown in terms of recurrent and non-recurrent savings. Recurrent savings were those permanently delivered within a particular budget area, while nonrecurrent savings were one-offs that cannot be saved going forward. It was encouraging that over 50% of the total was recurrent, which helped to minimise risk. However, a key point about the non-recurrent savings was that developing them into recurrent savings was crucial. There was a nuanced category between recurrent and nonrecurrent savings, particularly with vacancies in corporate functions, where savings arose from gaps in employment but were variable and not fully recurrent. The year-to-date overachievement in savings was more in the recurrent savings area, suggesting a good outlook for future financial sustainability. Nonrecurrent savings were where any underachievement was likely to occur, but efforts were ongoing to manage this effectively.

Regarding the additional £0.635 million capital funding allocated to address backlog issues, the key question posed by Members was whether this amount allowed the Trust to perform extra maintenance or if it served more as a budget-relieving benefit. Chris Turley explained that the additional £0.635 million was additional capital funding. Welsh Government had asked NHS organisations in Wales to submit a range of schemes that could be progressed as capital spend this financial year, for estate backlog maintenance.

The Trust submitted a list of needed maintenance projects, and the first three or four of these projects were supported.

Members asked that given the insufficient funding to replace vehicles and the resulting increased maintenance costs, whether the current budget and forecast outturn accounted for the likely implications of these additional maintenance expenses. Chris Turley explained that in terms of the bottom line forecast for this financial year, it did include the increasing costs of fleet vehicle maintenance, some elements of which were likely to be over and above that identified within the 2024/25 financial plan, which in itself identified a reasonable cost pressure for this. The Trust would however also need to consider these costs in next year's budget, as there were offsets this year to manage some of these expenses.

Angela Lewis advised the Committee that regular quarterly updates to the Executive Leadership Team (ELT) were provided on the recruitment control panel process. For the committee's information, 614 roles have been reviewed in this quarterly period. It was important to remember that this recruitment control process was not necessarily about freezing positions but about cost avoidance. This has been achieved through internal processes creating internal opportunities and using fixed-term contracts where appropriate. Additionally, there has been a need to fill some posts quickly, particularly digital roles, balancing the need for efficiency with necessary recruitment.

RESOLVED: That the Finance & Performance Committee noted the Month three update.

54/24 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT INCLUDING ANNUAL REVIEW OF METRICS

Hugh Bennett provided the Committee with an update on the following points:

1. 111 call answering performance has improved over recent weeks, although the call abandonment performance was at 11.9% in June and off target (5%). One of the key issues has been the reduction of call handling staff in post as recruitment was paused during preparation for the new CAS system. Recruitment was now underway and it was anticipated that the full complement of funded staff will be in post by September. It should be noted that the Trust is anticipating a reduction in the commissioned level of call handler FTEs next year compared to last year (-4%).

2. 111 Clinical response: clinical ring back times for patients with the highest priority remained above target at 98.7%. Response times for lower priority calls, although remaining below target, have improved significantly over the past three months, with P2CT and P3CT calls achieving 83.7% and 85.5% respectively in June 2024. This was despite continued high levels of clinician sickness absence, which was at 16.86% in June 2024.

3. Ambulance Response (safety / patient experience): the red 8-minute response performance for June 2024 was 46.6%, remaining below the 65% target; however, the

Trust was reaching more red patients in 8 minutes, but the denominator (demand) has also grown. The Amber 1 median in June was 1 hour 29 minutes and the Amber 1 95th percentile was 7 hours 6 minutes.

4. The one area of particular focus for recruitment was Cymru High Acuity Response Unit (CHARU) with the Trust looking to recruit up to the modelled 153 Full Time Equivalents; and connected to this a focus on CHARU productivity, with on-going analysis work on their contribution.

5. The extreme level of lost hours to handover outside Emergency Departments remained the critical component of long waiting times and patient safety incidents. 22,229 hours were lost during June 2024. Cardiff & Vale's handover lost hours continued to remain low, due to an organisational focus within the Health Board. While some small improvements have been seen in other health boards in recent months, Betsi Cadwaladr University Health Board remained significantly high and above its two year average figure (8,001).

6. Oncology performance in June 2024 was 76%, achieving the 70% target. Renal performance also remained above target at 72%. Advanced discharge & transfer journey performance decreased compared to the previous month to 72% and remained below the 95% target. Overall demand for Non Emergency Patient Transfer Services (NEPTS) continued to increase but remained below pre-pandemic levels. The Trust has a comprehensive Ambulance Care Transformation Programme in place, which included delivering a range of efficiencies and improvements, for example: aligning clinic patient ready times to ambulance availability and addressing oncology performance. The Trust was expecting to re-roster NEPTS transport in 2024/25 which would better align capacity with demand patterns.

7. National Reportable Incidents (NRIs) / Concerns Response: the Trust reported four NRI's to the NHS Executive in June 2024, an increase from the one reported in May 2024; and three serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In June 2024 complaint response times improved to 88%, an improvement on the 50% recorded in May 2024, and achieving the 75% target, however, cases remaining complex. The Trust was 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.

8. In June 2024, 9,737 patients cancelled their ambulance, and the Trust was unable to send an ambulance due to application of the Clinical Safety Plan levels to approximately 488 callers. The Trust believed that 50% of this combined number is unmet demand and was likely to be showing up elsewhere in the system.

9. Trust sickness absence: the Trust's overall sickness percentage was 7.55% in May 2024, a minimal increase on the 7.56% recorded in May 2024. Actions within the IMTP concentrated on staff well-being with an aim to continue to reduce this level supported by the ten-point plan. The 7.58% was above the 2023/24 IMTP ambition of 6% but was a good improvement.

10. Staff training and Personal Appraisal Development Review (PADR) rates did not achieve the 85% target in June 2024, but have been steadily improving (77.53%). Compliance for Statutory and Mandatory training increased to 84.05%.

Overall, most performance metrics were stable, and ambulance care was performing well, meeting key metrics above target. The Trust was doing everything within its power to maintain this performance. However, the high level of demand, particularly for red calls, and the extended handover times were significant challenges that impact on the Trust's ability to deliver the level of patient safety and outcomes aimed for.

Comments:

The Committee recognised that the Trust was doing everything within its power to manage the situation. However, the high level of demand, particularly for red calls, and the handover delays remained significant challenges.

Annual review of Metrics.

Hugh Bennett in providing the update advised the Committee that ELT had reviewed and considered information provided by the Performance team on potential areas of change. The only change was to the falls metric.

The following observations were made:

1. WG or Commissioner Targets: All WG or commissioner targets were included in the MIQPR key metrics, with no additional metrics needing to be added from that perspective.

2. Operational Highlights: The team highlighted some areas of the Trust's business that were not routinely highlighted through the MIQPR, such as volunteer contributions, fleet, capital and estates, mental health, falls, digital, and research. However, the ELT felt that these were too operational and not required at a Board level. Information on these issues was provided through other channels and reports at regular intervals, ensuring the Board and Committees remain aware.

3. Focus on Outcome Measures: There was an ongoing need to improve the focus on outcome measures as opposed to input or process measures. This was difficult to achieve at present due to limited linked data. However, it was agreed that an indicator on the length of lie for falls would be developed as a proxy for outcomes.

4. Duty of Quality Metrics: Potential metrics associated with the Duty of Quality will be developed over the next year in parallel with those being developed nationally.

5. Operational Metrics: While there was a general sense that many MIQPR metrics were operational, it was agreed that a smaller number of metrics related to the Trust's strategic ambition would be highlighted in a visual report provided twice a year.

6. Evolution of Clinical Model: As the clinical model evolves, some metrics currently included in the MIQPR may change over the course of the year. This will require consideration by commissioners and was currently under discussion.

The Committee recognised that the Trust Board would receive an update on the metrics at its next meeting.

RESOLVED: The Committee

(1) Considered the May/June 2024 Integrated Quality and Performance Report and actions being taken and determined it provided sufficient assurance.

(2) Received the annual review of metrics and endorsed them for Board approval.

55/24 DIGITAL REPORTING

Jonny Sammut explained that this was the regular digital report. Before delving into the details of it, he highlighted two changes this cycle:

1. ICT System Score: The Committee will notice that the report now included this year's and the previous financial year's results. This was beneficial as it provided a baseline of performance comparison between the two years.

2. Key Projects: The report now outlined some of the key projects under each of the new strategic pillars, offering a clearer view of progress and priorities in the digital domain.

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

3. Data & Analytics metrics, the average turnaround time for non-trivial data requests saw a record spike in March 2024 due to the pressures of demand and the commencement of the "pause & improve" initiative, whereby the team operated with a "pause" on all new non-essential requests for a period of six weeks, focusing instead on the 111 Clinical Assessment Software (CAS) replacement programme along with a small list of other key priorities and improvements.

4. Records Requests continued to be received at a sustained high level – progressing the trend of Q4 2023/24. Investment has been received which will allow the Health Informatics Team to increase the number of Records Officers from 1.8 Whole Time Equivalents (WTE) to 3.8, and recruitment process has commenced. However, due to long term sickness within the Records team, compliance to the target was at risk, and many broader records management activities are currently on hold.

5. The ICT System Availability Metrics showed that almost all systems exceeded the 99.99% industry standard of availability or 'up-time' in Q4 of 2023/24 and Q1 of

2024/25 so far. This was in all areas except for the Ambulance Care CAD – Cleric, where for a short period on 17 April the South East region was not able to radio NEPTS vehicles due to an issue with call sign visibility in the LifeX system. However, this still resulted in more than 99.9% availability for the month.

6. The Drones initiative has seen the Drone Wales Highway Project commence in Q1 2024/25.

7. *111 Wales Website*: Initial work was underway on defining the scope for a short-term solution for this winter and a long-term strategic solution to develop the 111 Wales website. A cross-Directorate group will now develop a business case.

8. The PowerBI migration initiative was the ongoing effort of transitioning reporting and dashboards from Qlik to PowerBI to help modernise, streamline and secure the Trust's intelligence. This had a deadline of September due to licencing constraints with QlikSense, but this timeline was at risk due to the Data & Analytics team's effort being diverted to (and sustained on) the 111 CAS implementation.

9. The installation of the Mobile Data Vehicle Solution across the existing EMS & Ambulance Care fleet was now complete. There was successful installation of 501 EMS vehicles and 256 Ambulance Care vehicles - a huge milestone for the project, and the result of great collaboration between Digital, Operations and Fleet.

Comments:

The Committee asked whether there were any barriers to the success of the Drone initiative and whether there were any legal requirements. Johnny Sammut advised that there was a legal requirement to retain a visual line of sight of drones. To address this, the Future Flights Programme had been implemented. This programme aimed to provide sufficient evidence that the Trust can operate drones safely beyond the visual line of sight, ensuring compliance with regulatory requirements and enhancing the operational capabilities of the drone initiative.

It was queried in terms of records requests, why it was high and was there a reason for this. Jonny Sammut explained there was no particular trend, it was just a higher hunger for data but not of a trend and was just a sustained pattern of data enquiries.

RESOLVED: The Committee noted the report and the trends in metrics.

56/24 INTEGRATED MEDIUM TERM PLAN (IMTP) DELIVERY/ASSURANCE - PROGRESS UPDATE

Hugh Bennett updated the Committee on the headlines from the report:

The only deliverable significantly off track (Red) continued to be the introduction of Independent Prescribing as a core requirement within the Advanced Paramedic Practitioners (APP) job description. Independent Prescribing was included within the

generic job description for APPs and will subsequently need to be incorporated into the academic education plan for new and existing APPs.

The Trust will continue to deliver core business and tactical change and service improvement through existing forums such as the Senior Leadership Team/Assistant Directors Leadership Team, and Corporate Boards, with assurance through traditional delegation of authority through hierarchy.

The update included a focus on the clinical model transformation and provided an update on the changes to the governance around the IMTP delivery structures. The Committee took assurance from the detail regarding the revised structures, which consolidated the existing programme structures into a broader programme, framed around the revised clinical transformation model. This structure included five constituent elements and aimed to streamline efforts and improve outcomes. The only deliverable significantly off-track was the introduction of the independent prescribing as a core requirement within the Advanced Paramedic Practitioners' job description and the associated challenges around implementation.

Comments:

Kevin Davies commented on the IMTP delivery / assurance report, specifically addressing the red rating for independent prescribing for APPs. He highlighted the exponential rise in prescribing opportunities and capabilities against community demand. Kevin pointed out that the challenge was not solely organisational but also involved external factors, such as the availability of supervisory support and training placements for APPs. He emphasised the importance of understanding the context behind the red rating, suggesting that the underlying reasons were broader than just an organisational challenge.

Trish Mills highlighted the shift in focus of the Strategic Transformation Board towards transformation and noted the alignment with the Quality and Performance Management Framework (QPMF). Furthermore, the integration of Local Directorate Plans into the QPMF was crucial for ensuring that local efforts contributed effectively to broader enabling programs. She added that the Audit, Risk, and Assurance Committee would be reviewing the implementation of the QPMF in-year. And finally, the contributions of Alex Crawford and Heather Holden in developing the revised structure this was acknowledged. They have simplified a complex process whilst ensuring it is accessible / presentable.

RESOLVED: The Committee:

(1) Noted the revised arrangements for IMTP delivery and assurance.

(2) Noted the IMTP 2024-27 Q1 position.

57/24 DIGITAL PLAN REFRESH – 2024-2029

Jonny Sammut provided an overview of the report and drew attention to the following points:

1. The purpose of this update was to present the Refreshed Digital Plan to the Finance & Performance Committee, for endorsement for Board approval.

2. The Digital Plan emphasised using digital tools to improve responsiveness and patient safety, such as employing predictive analytics and digital platforms to streamline patient flow and decision-making. Furthermore, it aimed for better integration across primary, secondary, and tertiary care, leveraging real-time data and telehealth solutions to enhance care coordination, reduce bottlenecks, and improve overall service delivery.

3. Following a comprehensive review of digital demand and global sector benchmarking, the plan was produced using a VMOST (Vision, Mission, Objectives, Strategies, Tactics) framework.

4. There have been two updates and improvements to the plan. Enhanced Narrative on System and Partnership Work: There has been an addition of improved narrative that focused on system and partnership work within the wider health system. This likely meant that the documentation now better explains how the Trust collaborated and integrated with other entities in the health system. A FAQ Guide Development which following a useful trade union session, has been implemented. This guide will supplement the go-live communications package and address key topics, including artificial intelligence (AI). The aim was to provide clear answers and guidance on FAQ's that may arise, particularly in relation to AI and possibly other areas of interest or concern.

5. This plan was designed to be agile and dynamic in nature, with actions for years 2-5 to evolve as it progressed, with the year one projects outlined in the plan document as part of the commencement of this digital journey.

6. A "rich picture" has also been developed, with the aim of bringing to life the digital vision and how this will look and feel for the Trust. This picture was currently in final stages of design and will supplement the plan as it was published.

7. The Equality Impact Assessment was included for review by the Committee.

8. Pending endorsement by the Finance and Performance Committee & Trust Board, the plan will be officially launched in August 2024

Comments:

The Chair commented that Ceri Jackson as the Digital Lead firmly endorsed the plan which the Committee also endorsed.

Following a query in terms of whether the investment was secure and, in the budget, and deliverable, Jonny Sammut confirmed that was the case, and was comfortable it was deliverable with a slight risk on recruitment which was being managed.

RESOLVED: That the Committee endorsed the digital plan for Board approval.

58/24 INFORMATION GOVERNANCE REPORTING

Jonny Sammut drew the Committee's attention to the following areas:

1. Information Governance (IG) Toolkit 23/24: The IG Toolkit for 2023/24 was submitted on time with some areas exceeding the minimum expectations standard (namely: Business Continuity, Breach response & monitoring, and Leadership oversight). However, provisional results show that the Trust did not meet the minimum expectations across a significant number of categories in the Toolkit, including Information Governance training compliance, and so was showing an overall "Standards Not Met" position.

2. IG Training: the Trust was not compliant with its mandatory IG training requirements and missed the 75% target (as it was) in 2023/24. The target has increased to a minimum of 85% across the Trust for 2024/25.

3. Meeting Etiquette: A Task and Finish Group (TFG) has been established by the Information Governance Steering Group (IGSG) to ensure the Trust has articulated its approach to, and expectations for, staff regarding meeting conduct, etiquette, and use of technology to record and support virtual meetings.

Comments:

The Committee Chair asked if there were any sanctions imposed on failing to meet the statutory mandatory target. Jonny Sammut confirmed that the Confidentiality Advisory Group was involved in reviewing approvals. They have taken a stance on ensuring that mandatory training requirements were met. There was a clear deadline set for November 2024 to ensure that all necessary training was completed, and standards were met.

In summary, while reminders and notifications were being sent out, Jonny Sammut emphasised it was crucial to confirm any sanctions for non-compliance, ensure specific targets for Directorates were clear, and consider additional enforcement measures to meet mandatory training standards effectively by the November deadline.

RESOLVED: The Committee received the report.

59/24 ANNUAL EMERGENCY PLANNING AND RESILIENCE REPORTS

Lee Brooks provided an update to the Committee on the following reports:

Business Continuity Annual Report 2023/24

The Business Continuity (BC) Annual Report was provided to Committee for assurance and information on all BC related activity for the previous year as part of Committee's work plan. This report highlights that although the Trust met its obligations under the Civil Contingency Act 2004, there were challenges within this area to ensure cross directorate working is achieved.

The report detailed the new BC structure that will be introduced to allow for more robust senior management overview of the BC planning within the Trust, with the Assistant Directors Leadership Team (ADLT) providing support and direction for BC planning, to reiterate the importance of BC and embed BC across all areas of the Trust.

The introduction of the new structure will not alter the current BC plans in place and therefore the Trust's adherence to the Civil Contingency Act will remain unchanged, but it will build and strengthen the BC planning across all departments of the Trust. Additionally, new BC software was currently in a procurement process following the prioritisation of funding by the Trust. This would also strengthen and support BC reporting and planning for all directorates.

NHS Emergency Planning Annual Report for Welsh Government 2023-24

On an annual basis the Trust was required to provide assurance to Welsh Government that it has plans in place to meet its obligations under the Civil Contingencies Act 2004.

This year's return looked at the activities across 2023 and included activities up to May 2024. The Trust was asked to give assurance against five key areas within the report:

- Mitigation, where possible, for the risks identified within the National Security Risk Register (NSRA).
- Having robust emergency plans in place for major incidents including our response to Chemical Biological Radiological Nuclear (CBRN), terrorist attacks, major power outages, high consequence infectious diseases and cyber-attacks.
- Having appropriate business continuity arrangements in place.
- Regular testing of emergency plans through training and exercising.
- Ensuring staff were appropriately trained in command and control processes and maintain their skills and knowledge.

The Trust has been able to provide good assurance, although capability gaps were found through the Manchester Arena Inquiry work. The Trust has also highlighted those areas that will continue to remain challenging without the additional funding set out through the MAI recommendations being progressed by commissioners.

Comments:

The Committee asked if there was any shared learning that the Trust took advantage of and was there any feedback from WG. Lee Brooks commented that the Trust has the

opportunity to engage in shared learning through various mechanisms. This included participating in platforms such as the UK Ambulance platform and Joint Emergency Services Group (JESC) meetings. These platforms provided a venue for sharing best practices, lessons learned, and improvement strategies with other organisations.
Lee Brooks indicated that WG consolidated feedback and learning into an all-Wales return, which was a broader summary of findings and recommendations from across Wales. The Trust has not received any negative feedback from WG in the past. This suggested that the Trust's performance and compliance has been satisfactory or that any issues have been addressed effectively.

Incident Response Plan (IRP)

Lee Brooks advised the Committee that the IRP set out the framework for the Trust to respond to a range of incidents within Wales, including major, mass casualty incidents and incidents which required a specialist response. The plan was subject to annual review. The key principles of the IRP have not altered in this annual update. The previous V2.0 of the IRP was rewritten in October to consider the recommendations from the Manchester Arena Inquiry and to reflect learning from internal debriefs.

Since the rewrite of the IRP, in April 2024, the Ten Second Triage (TST) and Major Incident Triage Tool (MITT) algorithms went live across the UK and needed to be reflected in a new version of the IRP.

RESOLVED: The Committee

(1) Received the Business Continuity Annual Report 2023/24, the Annual Emergency Planning Report (inc. self-assessment against WG Framework) and endorsed for Board Approval.

(2) Received the Incident Response Plan for assurance.

60/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

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 those that were 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: Risks 223 (the Trust's inability to reach patients in the community causing patient harm and death) and Risk 224 (significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe and effective service), remain static at the highest score of 25.

Key highlights:

A detailed discussion took place at the May Board in relation to Risk 424 (Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated

Medium-Term Plan (IMTP)) which has reduced in score to 12 (3x4) and which was closely linked with Risk 139 Failure to Deliver our Statutory Financial Duties.

Two risks have achieved their target score and have been de-escalated to the Directorate Risk Registers (DRR) for monitoring. These were Risk 543 (Major disruptive incident resulting in a loss of critical IT systems) from 15 (3x5) to 10 (2x5) and Risk 283 (Failure to implement the EMS Operational Transformation Programmes) from 12 (3x4) to 8 (2x4).

Two new risks have been assessed and approved for inclusion on the Corporate Risk Register and Board Assurance Framework (BAF); these were Risks 542 (Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan) at a score of 16 (4x4) and Risk 623 (Failure to comply with Data Protection Legislation) at a score of 15 (3x5).

A summary of these risks was set out in Annex 1 with a detailed description contained within the BAF in Annex 4. The more detailed description contained within the BAF provided 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.

Comments:

Chris Turley commented that the decarbonisation risk was complex with many facets. This complexity made it challenging to capture and detail all aspects effectively in risk assessments. It was a Trust-wide responsibility, as decarbonisation was a broad issue affecting various parts of the Trust. The risk has been assessed and scored at a certain level, reflecting the current understanding and management of the risk. The risk will continue to be monitored to ensure that the management strategies remain effective and that any changes in the risk profile were promptly addressed.

In addressing Risk 542 and its implications regarding non-organisational compliance due to system-wide failures, Trish Mills commented that by splitting the BAF document, similar to the approach taken with Risks 223 and 224, this would distinguish between what can be managed internally and what needs to be monitored externally. This would help in clearly delineating responsibilities and expectations. Trish Mills indicated that the Trust was developing a new strategic BAF. This new framework will better reflect and address the risks, including those related to external factors.

Jonny Sammut updated on Risk 623 and drew several key aspects related to recruitment, data protection, and data sharing agreements.

RESOLVED: The Committee took assurance from the update given the relevant risks and noted the contents of the report.

61/24 COMMITTEE HIGHLIGHT REPORT

The 14 May 2024 highlight report was received.

RESOLVED: The Committee received the 14 May 2024 highlight report

62/24 CYCLE OF BUSINESS MONITORING REPORT AND COMMITTEE PRIORITIES

Trish Mills commented that while it was important to note there were two deferred items, none of these were currently placing any significant risks. Additionally, the priorities were progressing as planned and remained on track.

RESOLVED: The Committee noted the update.

63/24 REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

Trish Mills commented on the succinctness and quality of reports.

Meeting concluded at 11:55

Date of Next Meeting: 17 September 2024.

ACTION LOG - CURRENT
FINANCE AND PERFORMANCE COMMITTEE

Action Number	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
Transferred from PCC		Cymru High Activity Response Unit Report	Cymru High Activity Response Unit Report (continued deployment of CHARU, aiming to illustrate progress, activity and deployment) Deferred from May meeting due to some challenges with data and the HI Team (Action Transfer from PCC: Andy Swinburn agreed to take a paper to the Quest Committee around the continued deployment of Charu, aiming to illustrate progress, activity and deployment) **Note: This item has been transferred to the FPC following discussion at the Quest ASM on 28 May 2024**	Lee Brooks	17 September 2024	Update for 16 July 2024 Item Deferred to 17 September 2024 Update is on the Agenda - proposed for closure	Complete

AGENDA ITEM No	**6**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

Financial Sustainability Programme Position Paper

MEETING	Finance & Performance Committee
DATE	17/09/2024
EXECUTIVE	Angela Lewis, Director of People and Culture Chris Turley, Executive Director of Finance & Corporate Resource
AUTHOR	Gareth Taylor, Project Manager
CONTACT	Email: gareth.taylor3@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper sets out the M4 position of the Financial Sustainability Programme and highlights key areas of progress against key schemes within Achieving Efficiency and Income Generation.

2. Key areas of progress since the last reporting period have centred on the Service Review, delivering on our commercial ambitions, establishing improved alignment with Trust-wide improvement processes, and developing improved comms and engagement approaches.

3. Following feedback, the Trust's overall savings approach has been divided into recurrent and non-recurrent, allowing better understanding of the year-on-year planning required to achieve our set savings targets.

4. With regards to recurrent schemes, as of M4 FY2024/25, there is an overperformance of £233,000 (£1.628m) against the established planned M4 position (YTD) of £1.395m.

5. With regards to non-recurrent schemes, there is an overperformance of £106,000 (£982,000) against the established M4 position (YTD) of £876,000.

Recommended: That the Finance & Performance Committee are asked to note the content of this M4 Position Report.

KEY ISSUES/IMPLICATIONS

As set out above.

REPORT APPROVAL ROUTE

Strategic Transformation Board 19/08/2024 For Noting Finance & Performance Committee 17/09/2024 For Noting	
REPORT APPENDICIES	
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 M4 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, has increased to £6.4m for 2024/25.

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. 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.

3.2. 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.

3.3. As of 31st July 2024, 6 of the 22 actions have been completed, across areas such as digitisation of documents, meeting governance, integrating and centralising systems and processes, and skills training.

3.4. Following publication of the Administrative Report, a further Service Review was initiated. Having been developed over 6 months, it is currently nearing conclusion and publication.

3.5. Summary Reports have been developed and distributed to each business area for comment. These will be collated into an Executive Summary before submission to ADLT and ELT around mid-late September.

3.6. The Service Review is expected to outline current service provision, including resources allocated, value of resource allocation, and to identify opportunities for efficiency and growth through consolidation or amalgamation of resource.

4. Income Generation

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

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

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

4.4. Focus since March 2024 has been on developing a Head of Commercial position, whose responsibilities will include developing a commercial strategy for the Trust.

4.5. As noted in the May FPC paper, this will include developing a substructure, with a clear mission statement of assessing opportunities in enough detail, 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.

4.6. The job description has been written and submitted to the job evaluation panel along with Pro Forma and Technical Document.

4.7. There has been slippage in the recruitment timescales, with further delay anticipated at the job evaluation stage. We are currently operating at 6-8 behind where we planned to be in the recruitment process.

5. Financial Position

5.1. Following feedback, the Trust's overall savings approach has been divided into recurrent and non-recurrent for 2024/25, allowing better understanding of the year-on-year planning required to achieve our set savings targets.

5.2. The Trust was targeting approximately £6.421m ahead of the new year, with approximately £3.646m of non-recurrent schemes and £2.775m in recurrent schemes.

5.3. With regards to recurrent schemes, as of M4 FY2024/25, there is an overperformance of £233,000 (£1.628m) against the established planned M4 position (YTD) of £1.395m.

5.4. With regards to non-recurrent schemes, there is an overperformance of £106,000 (£982,000) against the established M4 position (YTD) of £876,000.

5.5. This signifies a total overperformance of £339,000 (£2.610m) against the planned M4 position (YTD) of £2.271m. This equates to approximately 40.6% of the 2024/25 savings target.

5.6. Forecast Year End position remains a break-even position as of Month 4 and will be reviewed ahead of publishing M5 figures.

5.7. Example YTD overachievements include,

- Interest receivable (£214k) Interest rate falls, expected to move scheme back into breakeven position
- Corporate vacancies (£126k). Breakeven anticipated due expectation of recruitment into posts
- Fuel Spend (£117k) Review due in M5 due to anticipated rise in costs

5.8. Example YTD under achievements include,

- Planned apprenticeship funding (£21k). A Year End underachievement is anticipated due to previously noted income stream changes.
- Non pay local schemes (£67k) Corporate and Operations combined.

Recommended: That the Finance & Performance Committee are asked to note the content of this M4 Position Report.

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

VALUE BASED HEALTHCARE POSITION PAPER

MEETING	Finance & Performance Committee
DATE	17/09/2024
EXECUTIVE	Liam Williams, Executive Director of Quality and Nursing
AUTHOR	Gareth Taylor, Senior Project Manager
CONTACT	Email: gareth.taylor3@wales.nhs.uk

1. EXECUTIVE SUMMARY

1. This paper is to set out the current position of the Value Based Healthcare Working Group as of July 2024.

2. The VBHC Working Group currently provides the vehicle for reporting on value-based change within the organisation, however it is acknowledged that there are ongoing programmes of work across the organisation that could also be considered to deliver 'value-based' outcomes that are not currently reported within this group. Work is ongoing across the Trust to identify potential workstreams, and re-structure the VBHC governance structure accordingly.

3. This paper will consider the current priorities and progress, areas of focus applicable to the NHS Wales Planning Framework, opportunities for alignment with national priorities and/or opportunities to pursue WAST-specific priorities.

Recommendation: The Committee is asked to Note the position and intentions around delivering Value Based Healthcare within WAST.

KEY ISSUES/IMPLICATIONS

As set out above.

REPORT APPROVAL ROUTE

Strategic Transformation Board 19/08/2024 For Noting
Finance & Performance Committee 17/09/2024 For Noting

REPORT APPENDICIES

None

Situation

1. The purpose of this paper is to set out the current position of the Value Based Healthcare Working Group, and the progress of the key workstreams encompassed within its portfolio.

2. The VBHC Working Group has provided the vehicle for reporting on value-based change within the organisation.

3. It was noted in the March 2024 F&P Committee update that recent workshops and discussions resulted in a draft proposal being put forward for consideration, regarding both a change of structure, and a change of key priorities.

4. It was acknowledged that there are ongoing programmes of work across the organisation that could also be considered to deliver 'value-based' outcomes that are not currently reported within this group.

5. A workshop has been arranged for September 2024, which will set out the key objectives and milestones ahead of the new Task & Finish approach.

Background

6. Within the current Value Based Healthcare Working Group portfolio, several work packages report progress updates directly from their individual programmes of work into Strategic Transformation Board. These include,

    - Patient Reported Outcome Measures (PROMS)
    - Patient Reported Experience Measures (PREMS)
    - Patient Level Information and Costing System (PLICS)
    - Evaluation Methodologies
    - Revenue Business Case Proposal Processes
    - Benchmarking

7. In addition to these packages of work, there are several streams of reportable VBHC activity and transformation accountable to the NHS Performance Framework bi-annual report. These include,

    - Demonstrate improvements in the reduction of adverse clinical outcomes (as captured in clinical audit) in chronic conditions.

    - Delivery programme of PROM collection and sharing PROM data nationally to inform value-based decision making and direct clinical care.

- Progress with allocating resources to secondary prevention activities in high volume clinical areas that have a significant influence on patient outcomes and utilisation of resources.

- Reduction in unwarranted variation and activity of limited value, and standardisation of best practice pathways which support delivering improved outcomes.

8. While the core packages of work align with the NHS Performance requirements, there are some workstreams that currently operate outside of the Working Group's remit.

9. The draft proposal outlines the Trust's desire to work towards a model that emphasises value over volume. Work is already underway across several service lines to deliver value, however bringing together all workstreams into one programme that aligns with VBHC principles would support WAST's ability to assess overall outcomes within the patient journey.

Assessment

10. As a Trust WAST are involved in a small part of the patient pathway, so capturing outcomes that matter to our patients is key to identifying successful practices.

11. The core workstreams that we currently deliver on, are attempting to deliver, already contribute to a better understanding of outcomes.

12. The following table sets out a summary of the progress against the current work programme set out in paragraph 9.

Workstream	Current Position	Key Issues / Risks	RAG
PROMS & Data Linkage *Patient recorded outcome measures*	DHCW currently linking the National Data Resource with focus on the Welsh Out of Hospital Cardiac Arrest Registry, however risk of funding being redirected meaning a shift in focus to HB-to-HB data sharing rather than WAST to HB. This will result in less potentially support or funding for WAST projects. Risk being monitored and escalated internally via Digital.	• Funding	
PREMS *Patient recorded experience measures*	Work continuing, hoping to have initial discussion with Information Commissioner in coming months on EMS and 111 data collection and	• 111 IIS delay impacted data	

	subsequent information sharing agreement. Work continuing with NEPTS via SMS and postal surveys, and further projects initiated with FALLS and CW Responders, engaging with patients in-home. New reporting mechanism due to be implemented following new People and Community Experience Framework initiated by NHS Exec and Welsh Gov. From September onwards, expectations for WAST to report on all data collection exercises and outputs.	collection abilities.	
PLICS *Patient level information and costing system*	As noted in the March update, the revised timeline for this project considers progress to be on track, however resourcing within the finance team continues to present prioritisation issues, and a formal project team to manage to live rollout has not yet been established. This is currently being monitored. As per the original plan, the process will continue to prioritise EMS, however NEPTS data has been collated in preparation for Go Live. Timeframe remains Quarter 4 2024/25 for complete delivery of initial PLICS dashboard.	• Resource (both internal and external to finance)	
Revenue Business Case Process	Business Case Process to be implemented during ongoing programmes of change, where appropriate.		
Evaluation Framework & Methodology	As noted in the previous update, project evaluation now embedded within the Project Pathway which is which was approved in March 2024. The principles of the Pathway are now being implemented throughout the CMT Programmed delivery structure, including evaluation and benefits realisation.		

	Alongside this, the WAST LOGIC model template developed with Academic colleagues (Swansea University) is now in place and will form the basis of all workstreams within the CMT Programme including testing on the APP scheduling Test of Change.		
Benchmarking	Conversations are ongoing with regards to how this work aligns with ongoing transformation portfolios, and external partners.		

Next Steps

13. The workshop in September aims to establish the core T&F activities required ahead of the end of the financial year, in line with the identified areas below, however final agreements on structure will take place at executive level.

14. As noted previously, the topics of conversation around potential Task & Finish Group-led priorities have identified areas of enquiry within,

- A WAST evaluation framework and the role of Logic Models in evaluating transformational service change
- Population health analytics and outcomes
- Small Business Research Institute (SBRI) technology initiatives and Connect Support Cymru community welfare service.
- Mental Health and Dementia (MH&D)
- Tissue Viability
- The use of Advanced Practice (APP and ACPs)

15. The draft WAST VBHC proposal has been out for comment, with initial feedback received. Further discussions are due to take place ahead of the September workshop before being finalised at ELT over the coming months.

Recommendation: The Committee is asked to Note the position and intentions around delivering Value Based Healthcare within WAST.

AGENDA ITEM No	8
OPEN	Open
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – July/August 2024

MEETING	Finance and Performance Committee
DATE	17th September 2024
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Melanie O'Connor - Senior Performance Analyst Mark Thomas – Commissioning & Performance Manager Hugh Bennett - Assistant Director, Commissioning & Performance
CONTACT	Melanie.O'Connor@wales.nhs.uk Mark.Thomas12@wales.nhs.uk Hugh.Bennett2@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **July/August 2024.**

2. Data quality issues have been identified and are being addressed within 111, APPs and throughout Quality indicators.

3. The response times to 999 callers remains a key concern with red 8-minute performance at 51.75% in August 2024 and Amber 1 median at 1 hour and 11 minutes, which the Trust knows leads to avoidable patient harm. The Trust continues to work on tactical actions within its control to mitigate this risk including maintaining high levels of EA production (declined in August) and fully rolling out the CHARU service (improving); whilst also undertaking more transformative actions through the Clinical Model Transformation (CMT) Programme. The Trust lost 17,545 hours to handover in August 2024 (lower than August 2023). This level of lost capacity is difficult to compensate for, despite all the actions being taken by the Trust. The 2024/25 budget includes further investment in activities designed to shift demand left and mitigate the impact of handover lost hours, in particular, investing in clinical screening and APPs, which form part of the CMT Programme.

4. Data quality issues have been identified in 111. These are currently being addressed. 111 call handling performance has stabilised post-delivery of the new 111CAS, but the call abandonment rate is higher than the 5% target. This is due to a number of factors, in particular, a lower level of staff in post caused by training capacity having to be diverted to the implementation of the new system, sickness absence. The Trust anticipates that staff in post will be restored to commissioned levels by October 2024.

5. 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 (on target), a key efficiency.

6. 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 8.06% in July 2024 breaking the consistency of being below 8% since March 2024. The IMTP ambition is 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, February, April, and June respectively, for the first time since the pandemic, but were at 33% in Aug-24 (annual leave & sickness absence).

7. The Trust is continuing to deliver its Clinical Model transformation (CMT) programme at pace, aiming to get key aspects of the change programme in place in advance of winter. More detailed progress on the CMT can be found in the last Finance & Performance Committee's IMTP 24-27 Q1 delivery assurance report.

RECOMMENDATION: The Committee is asked to: -

Consider the July / August 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.

REPORT APPROVAL ROUTE
11.09.24 Executive Director Strategy, Planning & Performance

REPORT APPENDICES
Appendix 1 – Top Indicator Dashboard

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

SITUATION

1. The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the "vital few" key metrics. This report is for **July/August 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. The 2024/25 revised metrics have been agreed.

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 improved in August with the 95th percentile at 4 seconds, compared to 9 seconds in July 2024. The 65th percentile and median performance remain consistently good in July 2024.

6. **111 call answering performance has improved over recent weeks,** although the call abandonment performance was at 8.9% in August and off target (5%). One of the key issues has been the temporary reduction in call handling staff in post caused by a redirection of available training capacity towards the delivery of the new 111CAS system. Recruitment is now underway again and it is anticipated that the staff in post to establisment position will be recovered by by October. It should be noted that there is also a reduction in the commissioned level of call handler FTEs in 2024/25 compared to last year (-4%).

7. 111 demand in August 2024 was 1.15% higher than during August 2023, and the longer term trend is up. The Trust is expecting to shortly procure a third party to undertake a collaborative (with commissioners) and independent review of the

Trust's 111 call handler rostering practices, including a review of demand levels and required staffing capacity.

8. **111 Clinical response:** data quality issues have been identified and these are currently being addressed. Clinical ring back times for patients with the highest priority remained above target at 98.7%. Response times for lower priority calls, although remaining below target, have improved significantly over the past three months, with P2CT and P3CT calls achieving 83.7% and 85.5% respectively in June 2024. This is despite continued high levels of clinician sickness absence, which was at 16.86% in June 2024.

9. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for August 2024 was 51.75%, 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 August was 1 hour 11 minutes and the Amber 1 95th percentile was 6 hours 7 minutes. These long response times have a direct impact on outcomes for many patients.

10. Traditionally the factors which affect response times are demand and capacity (recruitment and lost hours). A recruitment gap has been identified and is currently being addressed through a series of corrective actions, but the lost capacity through handover at hospital remains extremely challenging and largely out of the Trust's control to address. 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 evolving its clinical model through the Clinical Model Transformation (CMT) programme, before winter. A series of workshops were undertaken in May 2024, with additional leadership capacity also being put into this area: both designed to move this forward at pace. Areas of focus include: -

    - Data quality issues have been identified with APPs and these are currently being addressed.
    - Further investment into remote clinical capacity (+28.5 FTEs);
    - Further investment in APPs (+32 APPs);
    - Development of the remote integrated care service (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.

11. The one area of particular focus for recruitment is CHARU: with the Trust looking to recruit up to the modelled 153 FTEs; and connected to this a focus on CHARU productivity, with on-going analysis work on their contribution (initial findings positive with a report to Sep-24's Finance & Performance Committee) etc.

12. 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. 17,545 hours were lost during August 2024. Cardiff & Vale's handover lost hours continue to remain low, due to an organisational focus within the health board. While some small improvements have been seen in other health boards in recent months, Betsi Cadwaladr health board remains significantly high and just below its two-year average figure (7,700). WG have re-iterated to health boards the critical importance of improvements in this area.

13. **Ambulance Care (Patient Experience)**: Oncology performance in August 2024 was 76.6%, hitting the 70% target. Renal performance also remains above target at 72.8%. Advanced discharge & transfer journey performance increased compared to the previous month to 78% and remains below the 95% target. Overall demand for NEPTS continues to increase but remains below pre-pandemic levels. The Trust has a comprehensive Health Transport Transformation workstream in place, which includes delivering a range of efficiencies and improvements, for example: re-rostering NEPTS transport in 2024/25 which will better align available capacity with changing demand patterns (on target).

14. **National Reportable Incidents (NRIs) / Concerns Response**: data quality issues have been identified and these are currently being addressed. The Trust reported four NRI's to the NHS Executive in June 2024, an increase from the one reported in May 2024; and three serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In June 2024 complaint response times improved to 88%, a strong improvement on the 50% recorded in May 2024, and achieving the 75% target, however, cases remain complex. Reviews of lower graded concerns are being undertaken to ensure proportionate investigations are undertaken. The Trust has recruited to a new structure for the Putting Things Right (PTR) team, which is a key enabler in the improved performance.

15. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 85.9% in July 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 22.8% in July 2024 compared to 14.4% in June 2024.

16. The Trust is now able to report on call to door times for Stroke and STEMI patients. For July 2024, these highlight call to hospital door times of two hours and 10 minutes for stroke patients and two hours and eight 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.

17. In August 2024, 8,785 patients **cancelled** their ambulance, and the Trust was unable to send an ambulance due to application of the Clinical Safety Plan levels to approximately 264 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)

18. **Hours Produced**: The Trust produced 118,091 Ambulance Response unit hours in August 2024 and delivered an emergency ambulance unit hours production (UHP) of 90%, below the 95% target. The primary causes were vacancies, annual leave, and sickness absence. Whilst EA UHP declined in August 2024 the Trust produced more ambulance units' hours (all resource) than August 2023. As per paragraph 10 above the Trust is taking a series of corrective actions to address these vacancies.

19. **Response Abstractions:** EMS abstraction levels increased to 33.07% in August 2024, remaining just above the 30% benchmark figure. Response sickness abstractions stood at 7.46% (benchmark 5.99%).

20. **Trust sickness absence:** the Trust's overall sickness percentage was 8.06% in July 2024, an increase on the 7.44% recorded in June 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 8.06% is above the 2023/24 IMTP ambition of 6%.

21. **Staff training and PADRs:** PADR rates did not achieve the 85% target in August 2024 but have been remaining consistent (75.96%). Compliance for Statutory and Mandatory training increased to 84.66%, just shy of the 85% target.

22. **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 will undertake another round of a pan-Wales of CEO Roadshows in November 2024.

Finance & Value

23. **Financial Balance**: The reported outturn performance at Month 4 is a surplus of £29k and the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

24. The consult & close rate was 10.0% in August 2024, a reduction from the previous month due to the system changes within the 111 CAS system, which has affected reporting capabilities i.e. the 111 contributions to consult & close is not currently included in the 10.1% above. The IMTP ambition (and Welsh Government target) remains 17% at this point in time. The Trust has a recovery plan in place, with further work continuing during 2024/25.

25. Same Day Emergency Care (SDEC) centres continue only see a low level of ambulance activity and handover levels remain extreme, which make the work on the updated clinical model, before next winter, a tactical imperative.

Summary

26. Data quality issues have been identified and are being addressed within 111, APPs and throughout Quality indicators.
The indicators used at this high-level highlight that 111 has stabilised post the 111CAS implementation with the coming months seeing a focus on recruiting back up to the establishment, which was affected by the implementation of the new system. EMS is stable, but likewise off target with the primary cause being handover lost hours. The Trust has largely exhausted traditional approaches to improving EMS performance and therefore is now focused on evolving the clinical model at pace this side of winter. Ambulance Care performance is stable and above target for its two-headline metrics.

RECOMMENDATION: The Committee is asked to: -

Consider the July / August 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

July / August 2024

Annex 1 – Top Indicator Dashboard

GIG CYMRU NHS WALES

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
University NHS Trust

Annex 1 – Top Indicator Dashboard
Version 1.0
Released: September 2024

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by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2024/25	Jul-24	Aug-24	2 Year Average	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	10.6%	8.9%	11.5%	R
111 Clinical Triage Call Back Time (P1)	90%	N/A	N/A	98.3%	
999 Call Answer Times 95th Percentile	00:06	00:09	00:04	00:22	G
999 Red Response within 8 minutes	65%	48.2%	51.8%	49.2%	R
999 Amber 1 Median	00:18	01:26	01:11	01:22	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	77.0%	76.8%	72.1%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	77.0%	78.0%	82.1%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	22.75%	N/A	18.3%	R
Stroke Patients with Appropriate Care	95%	85.90%	N/A	77.9%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:10	N/A	02:15	A
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	58.89%	N/A	45.7%	R
National Reportable Incidents reports (NRI)		N/A	N/A	5	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	9,881	8,476	9,087	A
Concerns Response within 30 Days	75%	N/A	N/A	41.1%	
Enactment of the Duty of Candour	100%	N/A	N/A	73.3%	
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	90%	90%	90%	A

Top Monthly Indicators	Target 2024/25	Jul-24	Aug-24	2 Year Average	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	8.06%	N/A	8.16%	R
Mental Health Absence Rates	Reduction Trend	2.43%	N/A	2.21%	G
Staff Turnover Rate	Reduction Trend	8.12%	8.10%	9.25%	G
Statutory & Mandatory Training	>85%	84.47%	84.66%	75.64%	R
PADR/Medical Appraisal	>85%	76.76%	75.96%	73.46%	R
Number of Shift Overruns	Reduction Trend	3869	3812	3,669	R
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	2.8%	2.0%	1.5%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100.00%	N/A	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	27.4%	25.3%	28%	A
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.35	2.34	2.35	R
NEPTS on the Day Cancellations	Reduction Trend	21.4%	21.4%	20%	A
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	11.0%	10.1%	13.3%	
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.25%	N/A	11.2%	A
Number of Handover Lost Hours	7,500	19,596	17,540	22,904	R
NHS111					
NHS111 Dental Calls	Increasing Trend	N/A	N/A	6,665	
Consult & Close Volumes by NHS111	Increasing Trend	N/A	N/A	1,012	

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

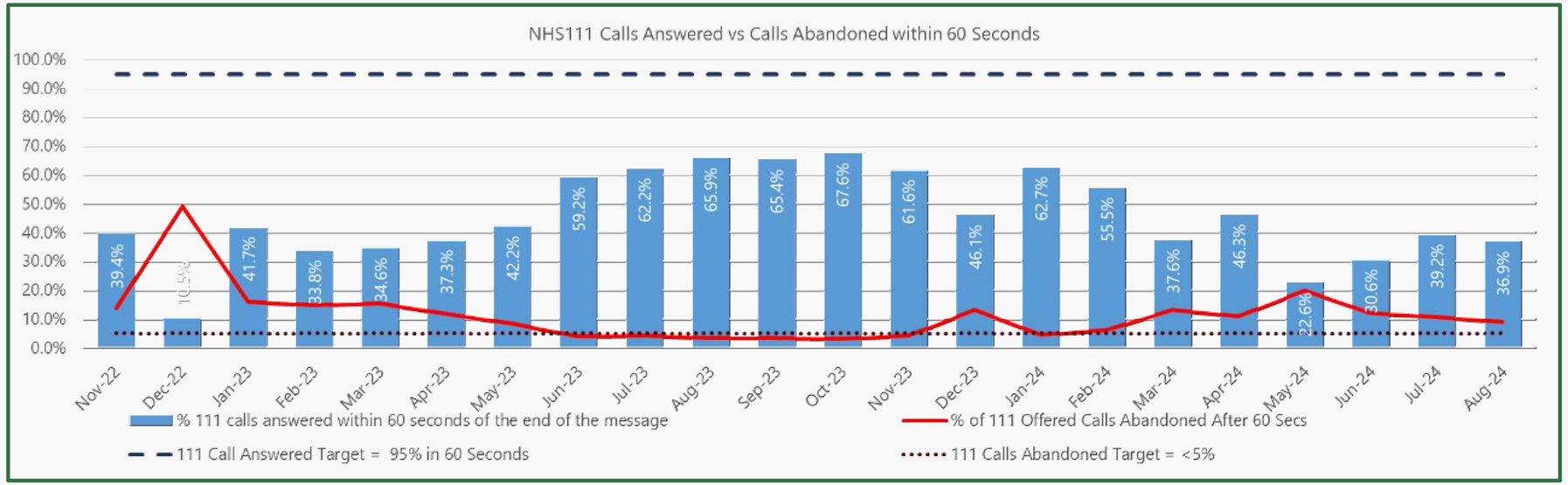
(Responsible Officer: Lee Brooks)

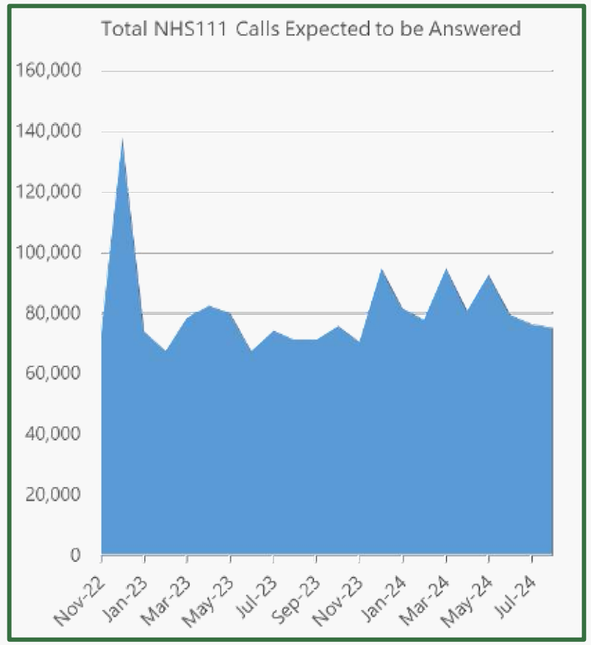
Abandonment Rate **R**

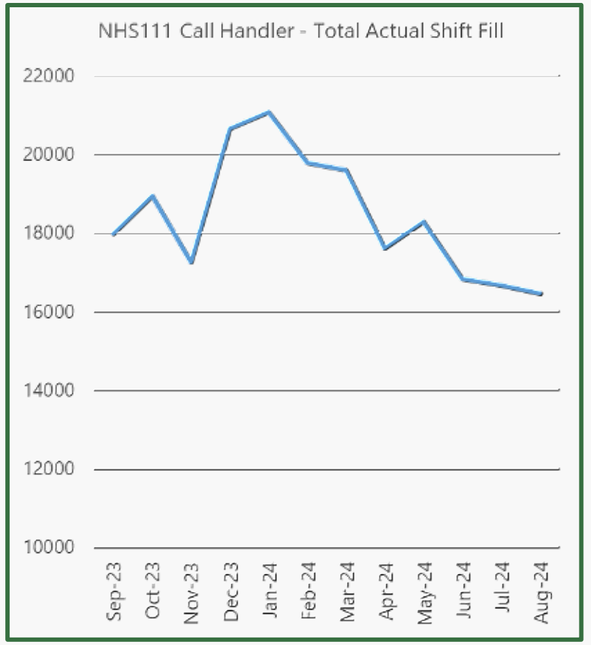
FPC

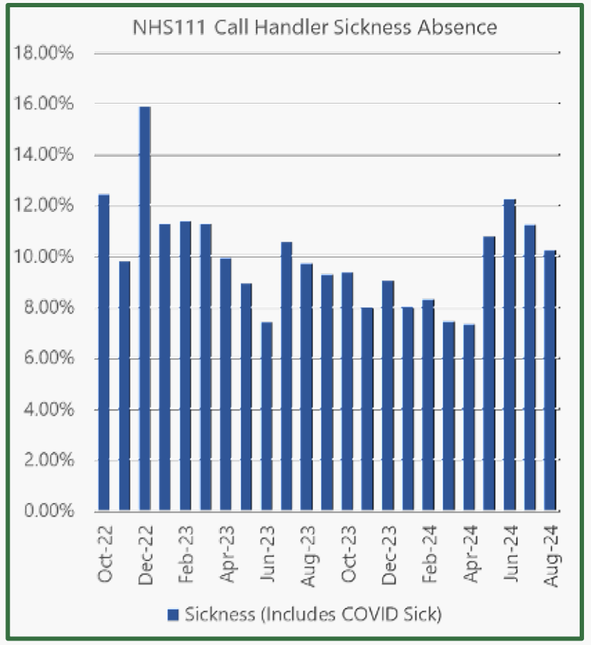
Influencing Factors – Demand and Call Handling Hours Produced

NB: Data quality issues have been identified in 111. These are currently being addressed.









Analysis

The 111-call abandonment rate improved from 10.6% in July 2024 to 8.9% in August 2024, but did not achieve the 5% target for the 7th month in a row. The percentage of 111 calls answered within 60 seconds decreased, from 39.2% in July 2024 to 36.9 % in August 2024, and continues to be below the 95% target.

The drop in performance over the past few months has been due in part to increased call handler sickness levels, staffing numbers below establishment and to the new 111CAS system going live on 30th April 2024. In the run up to implementation, staff were abstracted for training, and in addition recruitment was paused. After go-live, staff are familiarising themselves with the system, which is having some impact on efficiency at this early stage.

Remedial Plans and Actions

Key actions include:

- Recruitment up to commissioned levels, with cohorts starting over the summer and a plan to be at commissioned levels by October, a slip from the previous August deadline;
- Further action is being undertaken to try and improve on the call handling position across the Winter months e.g. possible over-establishment.
- A focus on realising the benefits of the new 111CAS;
- A 111-re-roster pre-work 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

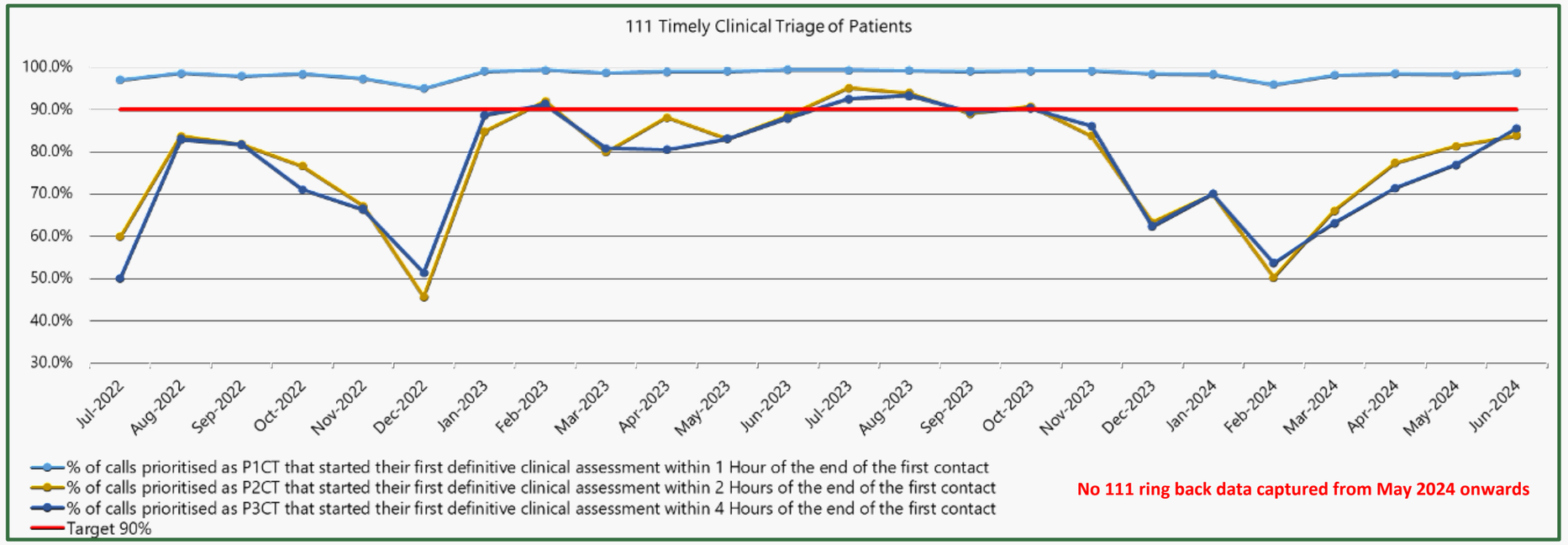
The expectation is that once the new system has bedded in and additional staff have been recruited performance will improve once again; however, there are risks including demand, levels of commissioned call handers being lower than last year and an unknown impact of the new system.

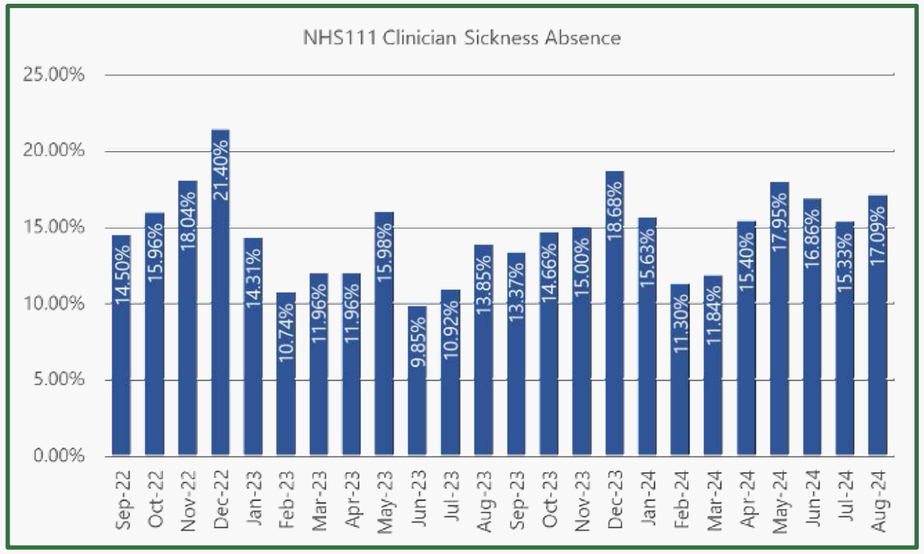
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators
Influencing Factors – Demand and Clinical Hours Produced

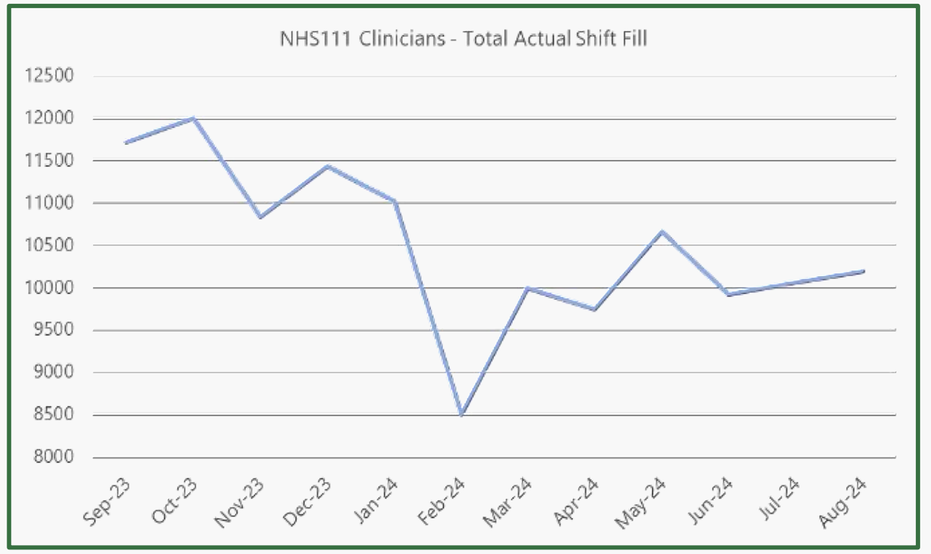
(Responsible Officer: Lee Brooks)

P1CT

FPC







NB: Data quality issues have been identified in 111. These are currently being addressed.

Analysis

The highest priority calls, P1CT, achieved the 90% target, recording 98.7% in June 2024. No further data is available.

Ring back times for lower category calls improved during June 2024, reversing a previous deterioration in performance, this was despite a drop in shift fill levels during June, compared to May 2024.

Numbers of hours produced, after decreasing during June 2024 improved in July 2024, partly due to a drop in sickness levels, however clinician sickness absence was 17.09% in August 2024.

Remedial Plans and Actions

The key actions include:

- A focus on delivering the benefits of the new 111CAS.
- Recruitment up to commissioned levels of clinicians
- A demand and capacity review to determine appropriate levels of capacity to meet increasing demand (this may now be delayed to enable the impact of the work on the digital front end to take effect).

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. Therefore, it is unclear what performance levels will be able to be achieved.

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

(Responsible Officer: Lee Brooks)

G

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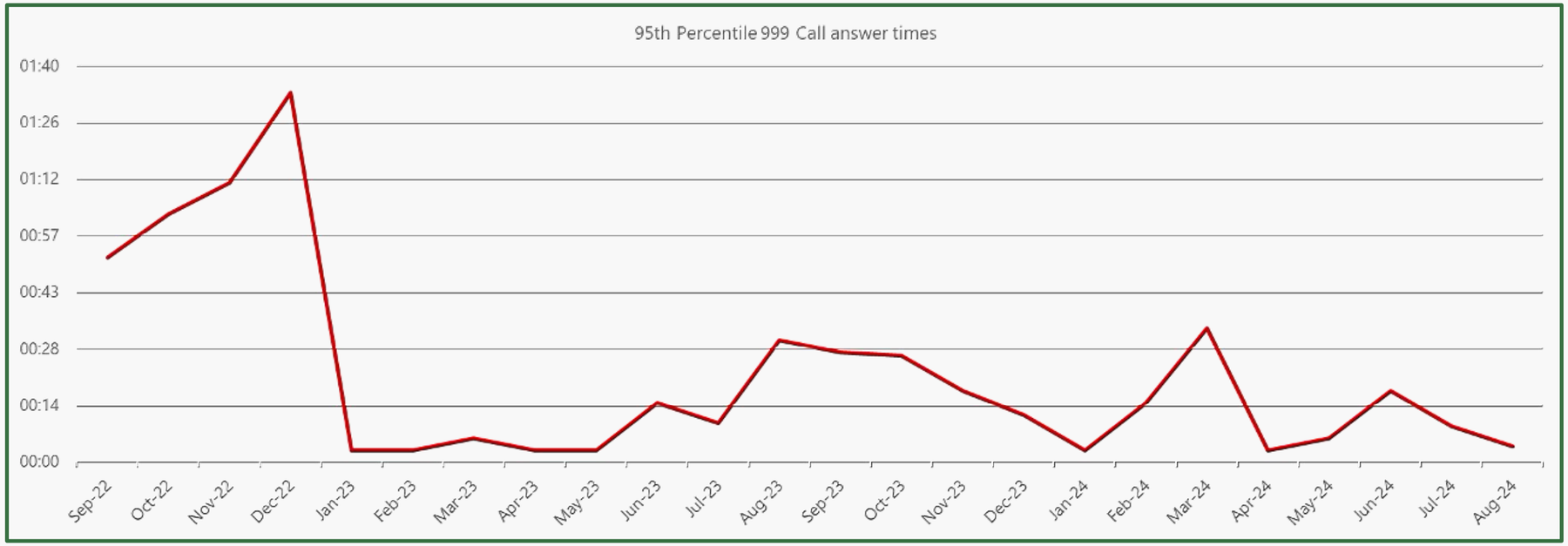
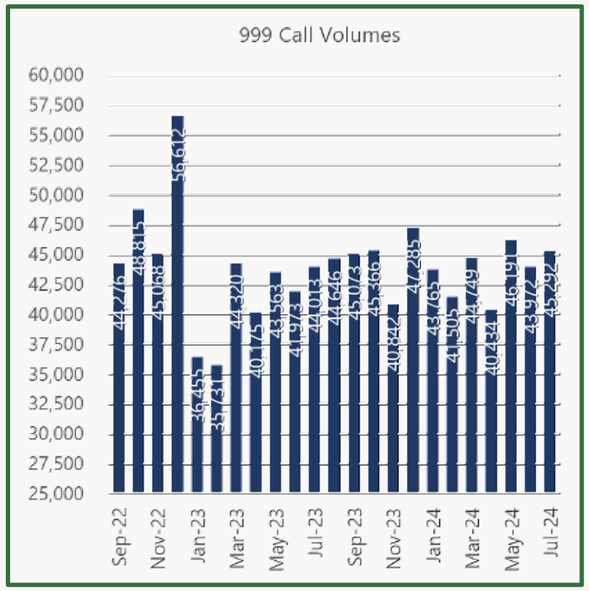
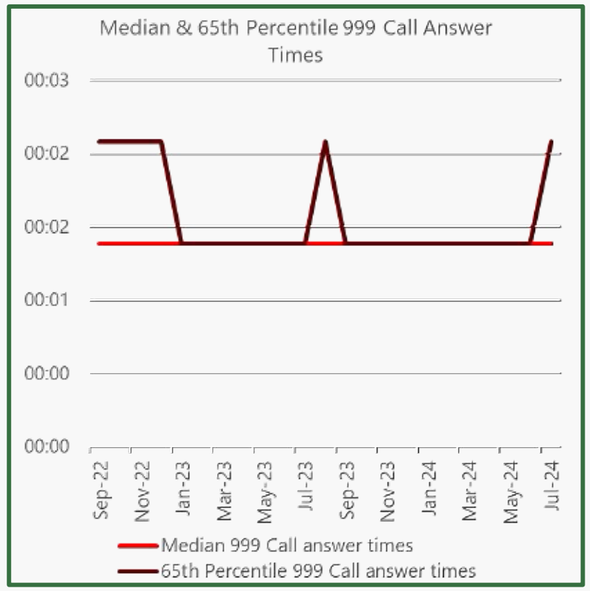
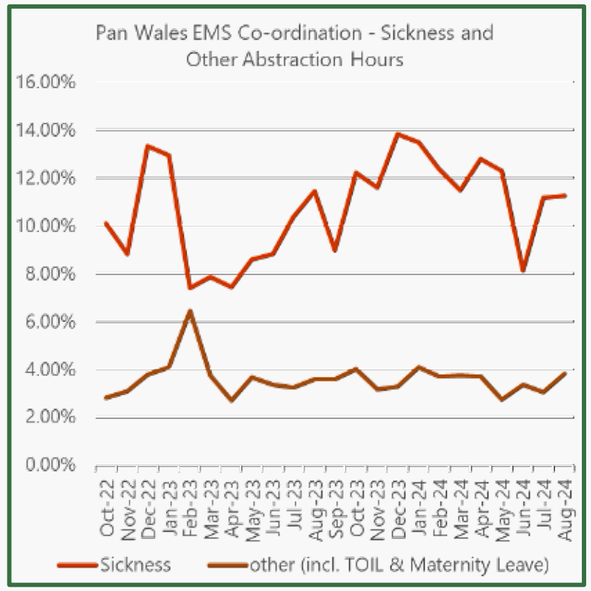
Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance achieved the 6 second target (00:04) in August 2024. The median call answer time for the 999-service remained consistent at 2 seconds in July 2024.

There was an increase in demand in July 2024 to 45,292 from 43,972 in June 2024.

Sickness levels saw minimal movement from 11.20% in July 2024 to 11.26% in August 2024.

Remedial Plans and Actions

- Over establishment has been approved for EMSC by the Executive Director of Operations with call takers currently above establishment (105.5 FTEs v 126.26 WTEs)
- Will continue to overrecruit for the next few months (as approved by the ADO and the EDoOps) into the winter months.
- Further recruitment drives in all three centres are planned for November, January & March with 12 per cohort.

A transformation programme is underway:

- **Roster Review.** A dispatch roster review for Allocators and Dispatchers.
- **Boundary changes.** Realignment of dispatch boundaries to balance workload and pressures for individual dispatch teams.
- **Broader Ways of Working**. This project is looking to create efficiency, effectiveness and improved productivity through a review of processes and procedures as well as providing consistency and reduction in variation across centres.

Expected Performance Trajectory

The median and 65th 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)

8 Min
R

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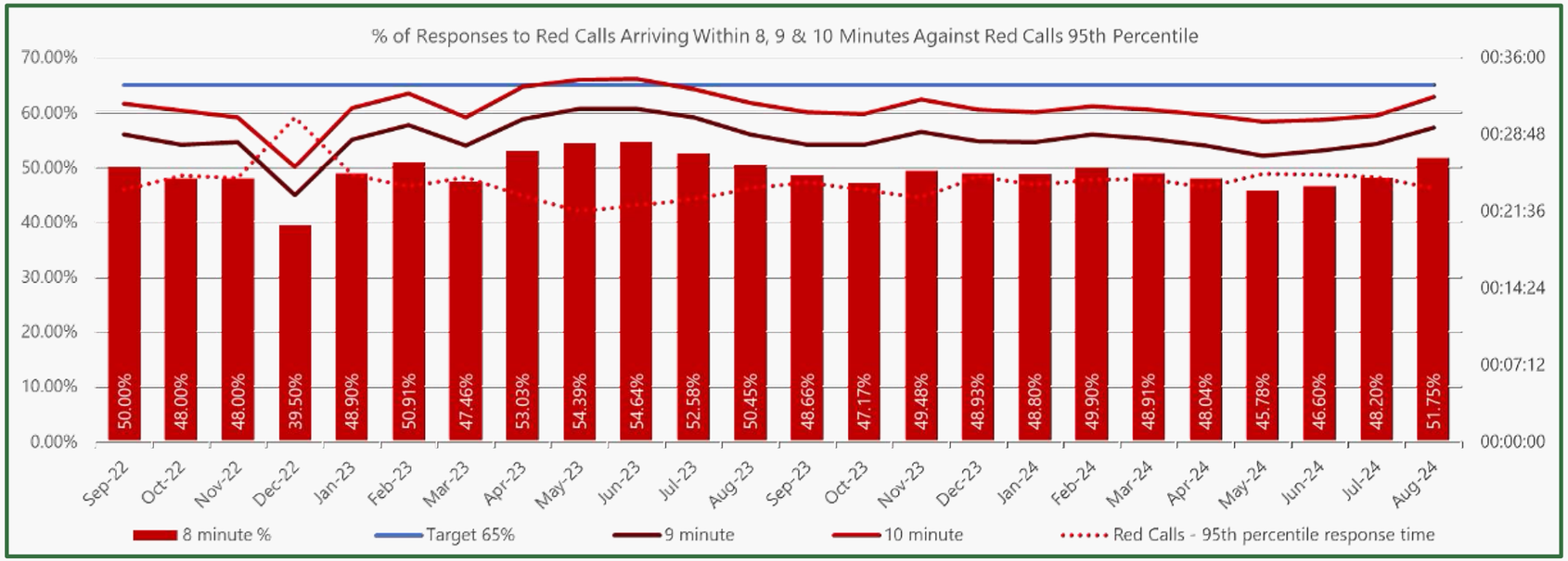

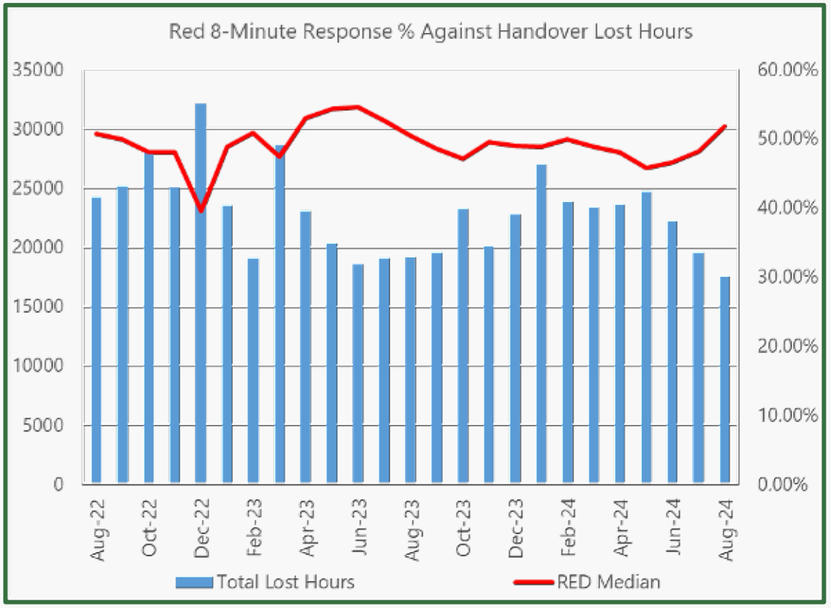

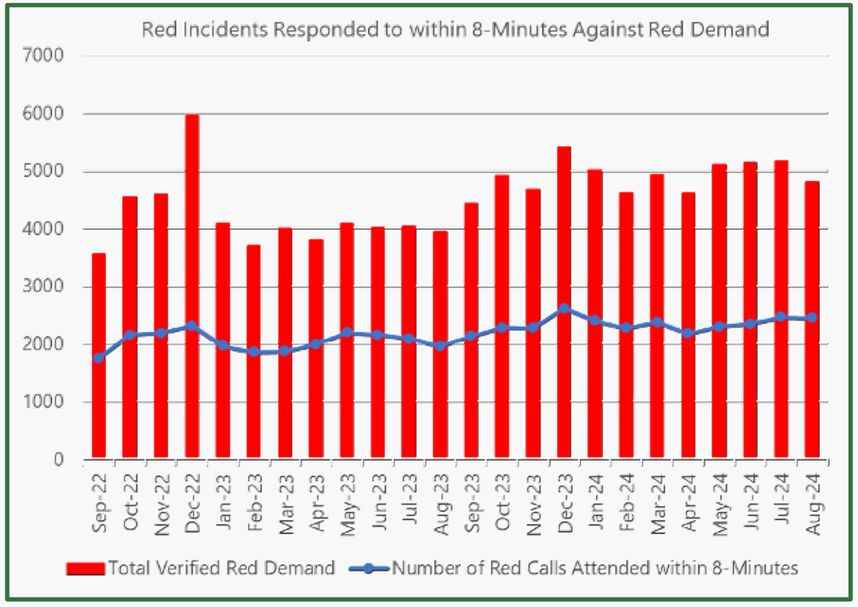

Analysis

Red 8-minute performance continues to remain below the 65% target increasing marginally during August 2024 to 51.75%.

Red 10-minute performance for August 2024 was 63%, which is marginally above the 2-year average (60.9%).

One of the main determinants is **red demand**, which has **increased** over the last few years, with red demand in August 2024 being 21.9% higher than that seen in August 2023. As red demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for August 2024 being 2,449 (25.07% above the figure for August 2023) 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**. There were 17,545 lost hours in August 2024.

Remedial Plans and Actions

The main improvement actions in the Trust's gift are:

- To maintain commissioned establishment/staff in post levels overall.
- To recruit an additional cohort of 21 EMTs in November.
- Full roll out of the Cymru High Acuity Response Unit (CHARU), now largely complete (128 FTEs v target of 153 FTEs) with the exception of some hard-to-reach areas.
- Continued focus on production and abstractions (EA production was 90% UHP in July 2024 and CHARU production 74% against full roll out);
- The rapid deployment, before winter 2024/25 of the first phase of actions towards an updated clinical model e.g. rapid clinical screening, as outlined in our IMTP.

Expected Performance Trajectory

Modelling for Summer 2024 (school holiday period) indicates a level of Red performance below target (most likely scenario 46%) and Amber 1 (over two hours).

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

(Responsible Officer: Lee Brooks)

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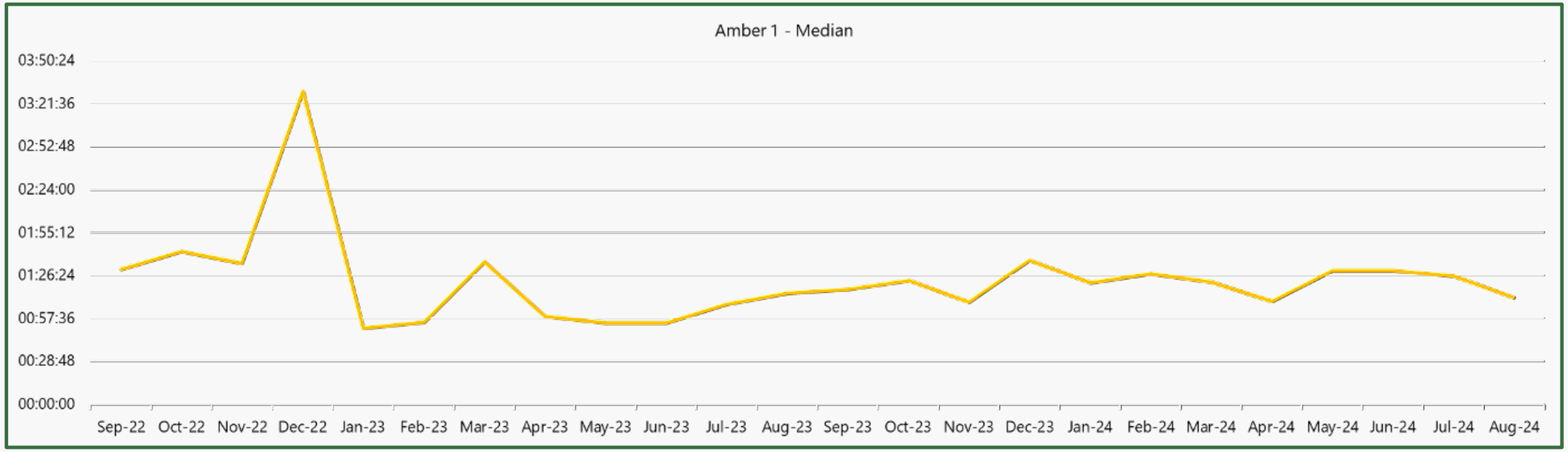
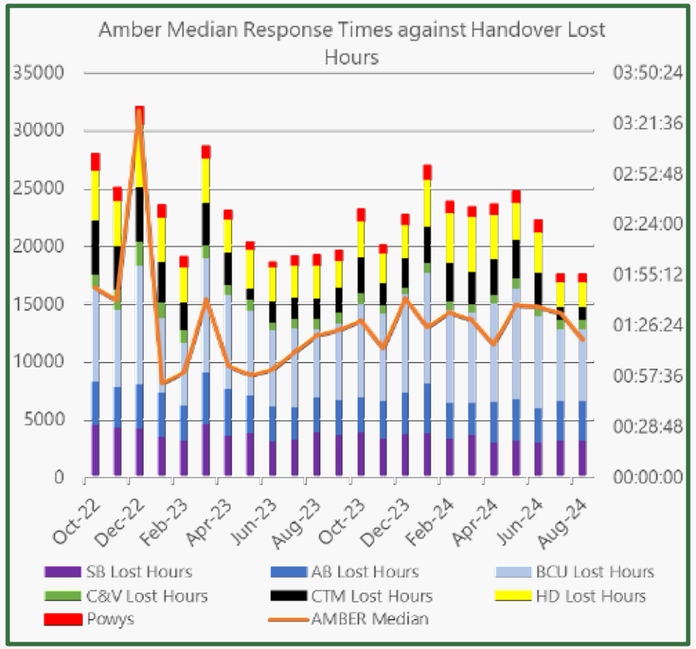
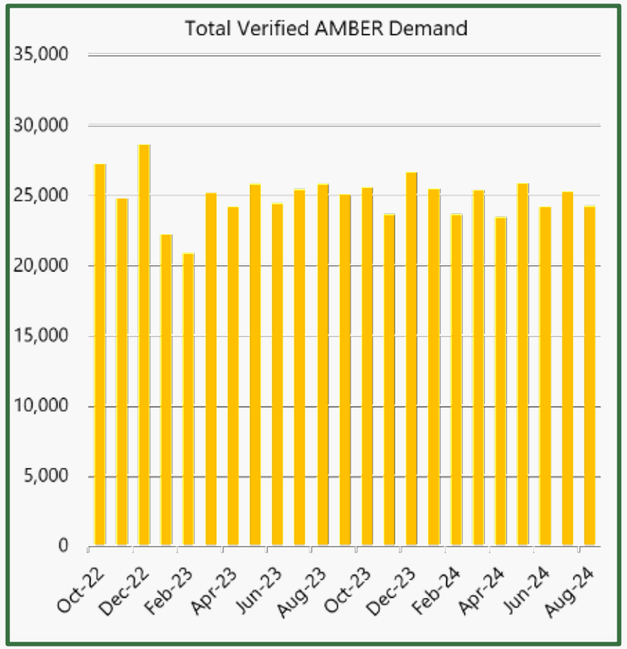
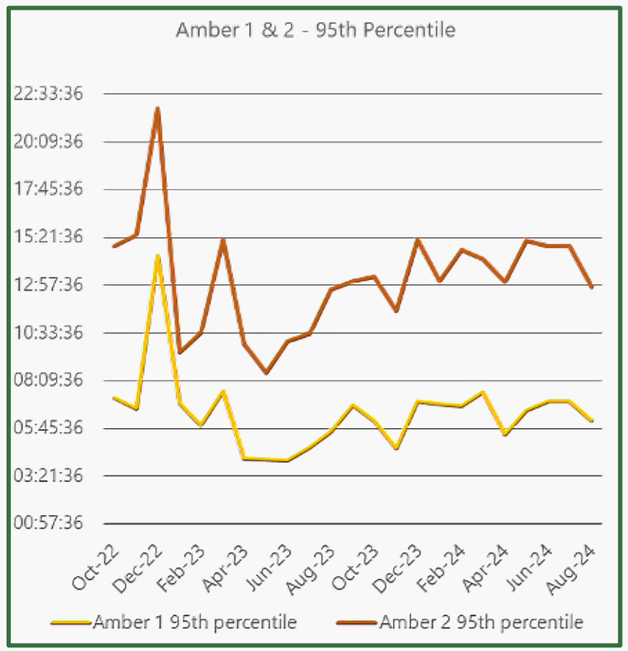
Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

The Amber 1 median performance time improved marginally during August 2024 to 1 hour 11 minutes, during a month when demand decreased (-1,040). Although also improving, there remains an extreme level of hospital handover lost hours. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile increased slightly during August 2024 to 6 hours 07 minutes and remains far too long, but was below the 2-year average figure of 6 hours 32 minutes.

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

The Trust has also recently seen abstractions return to the 2019 review benchmark of 30%; however, they have spiked up a bit in August (sickness/annual leave) and the numbers of hours produced remains relatively good, but lower at EA UHP of 90%.

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 Trust is currently evolving its clinical model and has completed a new 2023 EMS Demand & Capacity Review.

Our Patients: Quality, Safety & Patient Experience

Patient Experience – Influencing Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

D&T	Oncology	Welsh Calls
R	G	G

FPC

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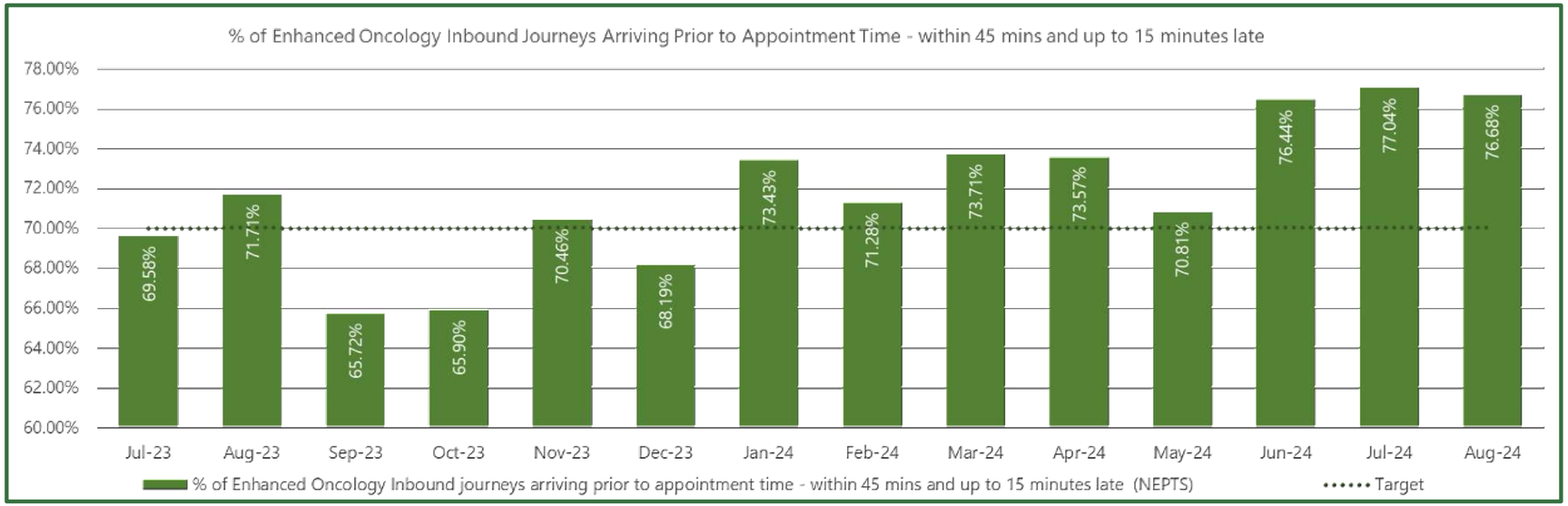
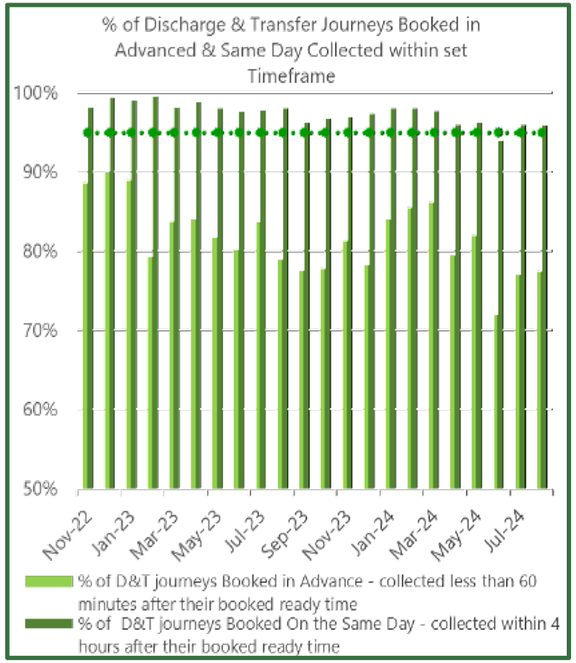
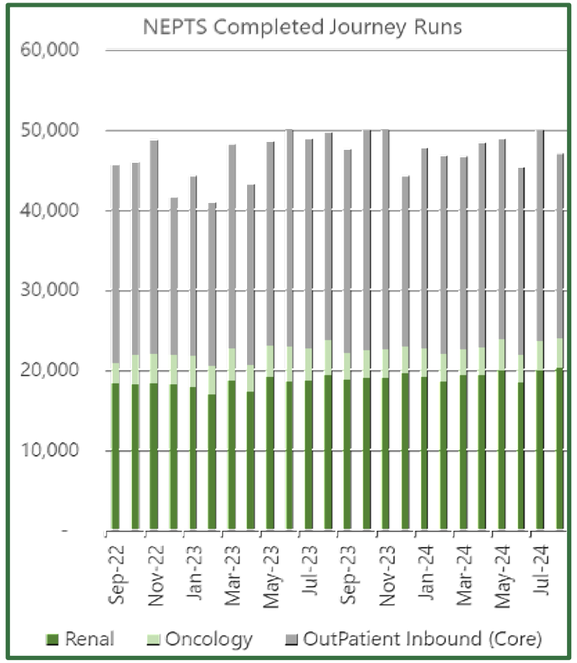
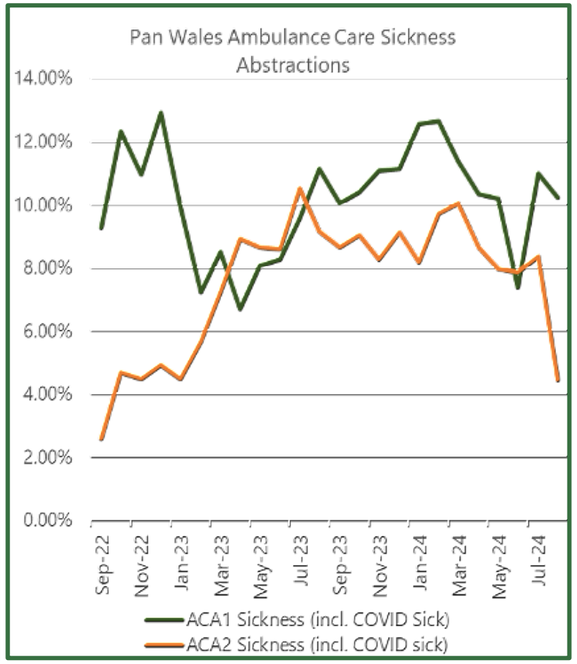








Analysis

Ambulance Care (NEPTS element) performance remained stable during August 2024. 76.6% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time, a minimal decrease from the 77% in June 2024, and achieving the 70% target for the eighth month in a row. Oncology performance continues to be an area of focus for the service, and we continue to invest both time and resources on these journeys.

Discharge and Transfer journeys booked in advance and collected less than 60 minutes after their appointment remains below target (95%) at 78% in August 2024, although this was an improvement from 77% in July.

Enhanced Renal journeys, remained stable at 73%, but continues to exceed the agreed performance standard (70%).

Call volumes answered declined further in August 2024 to 16,222 compared to 17,576 in July 2024; however, the average speed of call answering also declined from 9 minutes 10 seconds in July to 5 minutes 12 seconds in August.

Remedial Plans and Actions

Increased performance on data management and journey recording times is underway, with enhanced focus on weekend performance. Projecting an improvement in performance over next few months, although caution on achieving the 95% figure as this was always an aspirational target that needs engagement and system change from Health Boards which is complex and challenging to achieve.

New rosters keys are just being finalised based on updated demand, which will then be taken into a NEPTS transport roster review.

Enhanced sickness monitoring has been implemented at the ADO/HoS level and all long term and complex cases are being reviewed regularly.

Expected Performance Trajectory

Performance is anticipated to follow recent trends.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

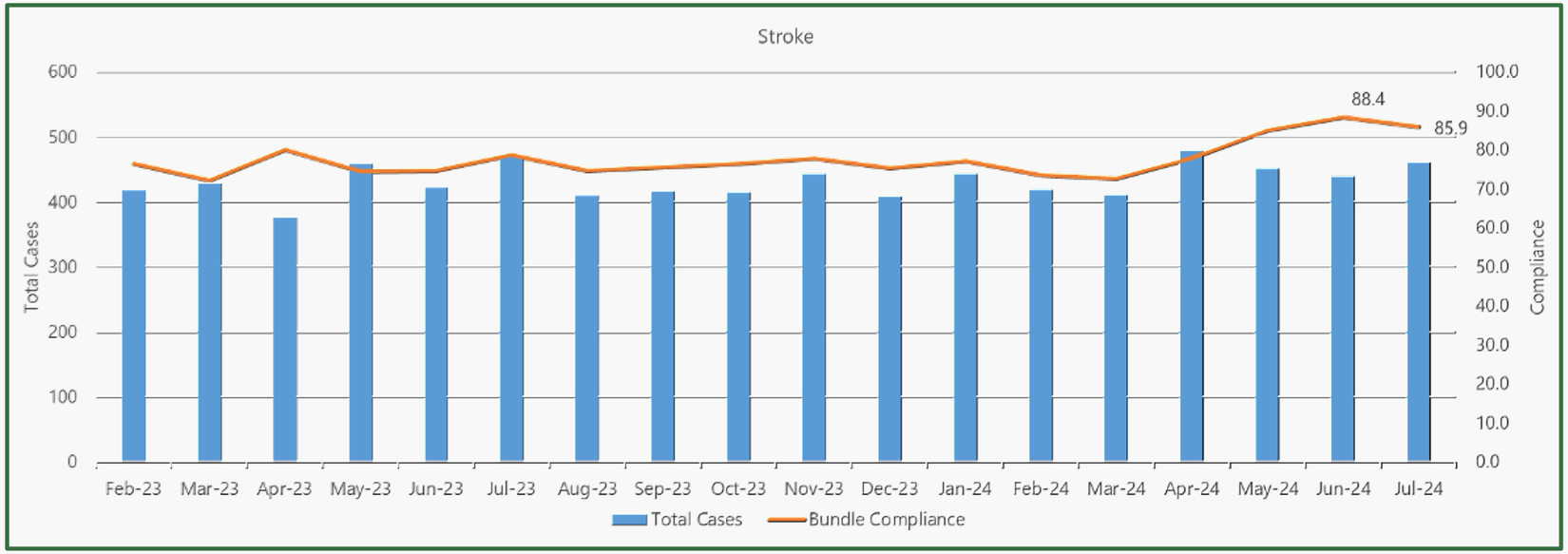
Return of Spontaneous Circulation, Suspected Stroke Patients with Appropriate Care, ST-elevation myocardial infarction (STEMI) with Appropriate Care

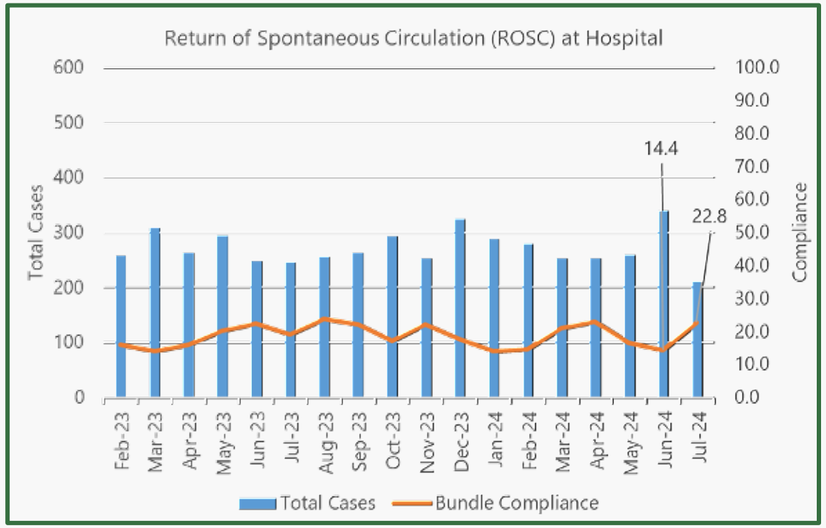
Stroke	ROSC	STEMI
A	R	R

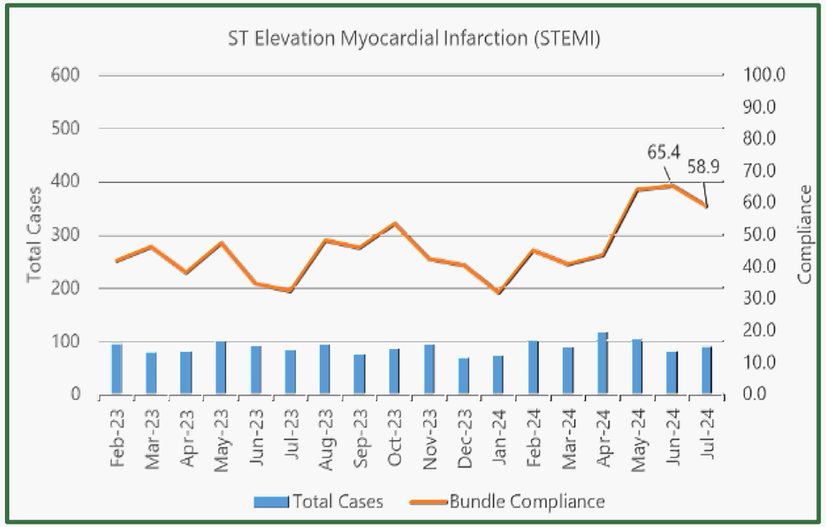
Self-Assessment: Strength of Internal Control: Moderate

QUEST

(Responsible Officer: Andy Swinburn)







Analysis

The percentage of patients documented as receiving appropriate care bundles in **July 2024** was:

- **Stroke – 85.9%, a decrease from 88.4% in June.** There is a correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance, this has informed the recovery plan and is a focus during Senior Paramedic ride outs with clinicians.
- **STEMI (heart attack) – 58.9%, a decrease from 65.4% in June.** There has been a compliance increase to the administration of Aspirin. ePCR User Interface changes are planned for justified exceptions with GTN to improve electronic Patient Clinical Record completion and compliance.
- **Return of Spontaneous Circulation at hospital (from cardiac arrest) – 22.8%, an increase from 14.4% in June**. Issues with the ROSC coding specification were identified, and subsequently updated for the July 2024 figures, which now shows a step change.

N.B. 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.

Following the switch to the electronic Patient Clinical Record , the way data is collected has changed. Automated Clinical Indicator reports are generated from data directly inputted by clinicians. There are advantages to the new process; however, this has not yet been fully realised within the monthly results. As a result of the anticipated low compliance, risk 535 was generated with three key mitigations to work on:

- Design of the electronic Patient Clinical Record User Interface
- Clinician interaction with the electronic Patient Clinical Record
- Accuracy of the scripting to extract the data from the data warehouse to create the reports.

Several electronic Patient Clinical Record User Interface changes were implemented in June 2024 and the impact is being monitored.

Our Patients: Quality, Safety & Patient Experience
Clinical Indicators

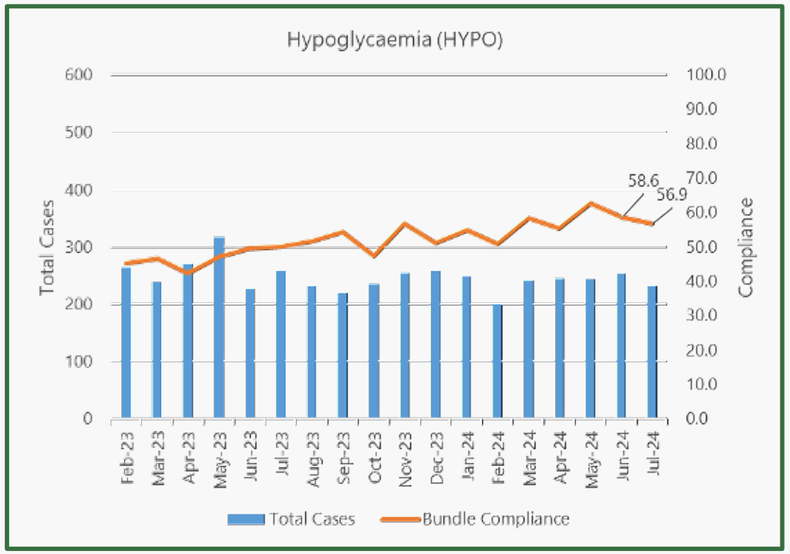
Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (Stroke & STEMI)

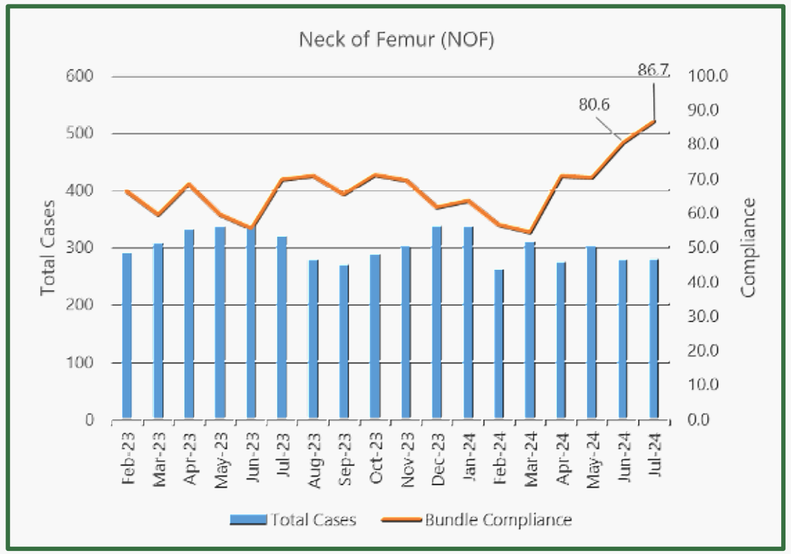
(Responsible Officer: Andy Swinburn)

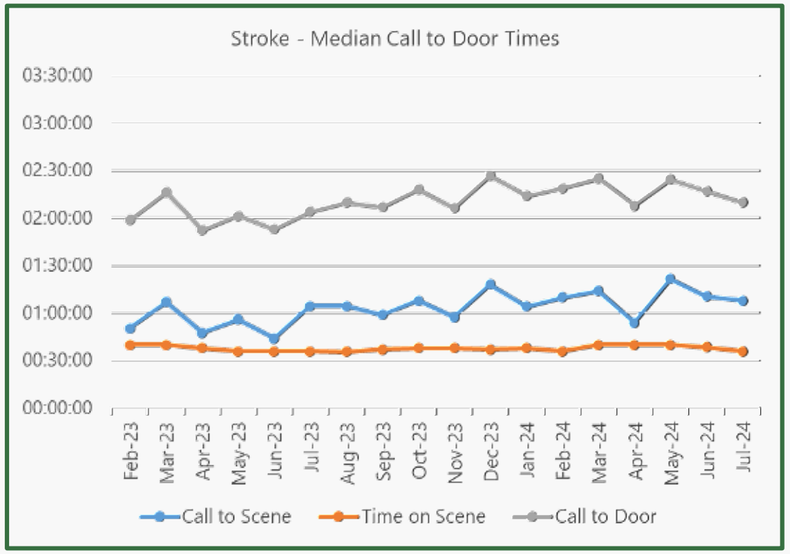
Call to Door
A

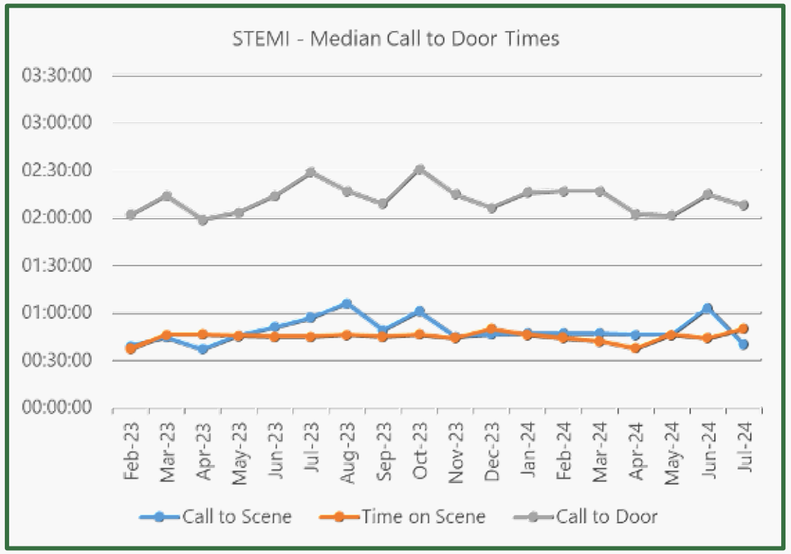
Self-Assessment: Strength of Internal Control: Moderate

QUEST









Analysis

The percentage of patients documented as receiving appropriate care bundles in **July 2024** was:

- **Hypoglycaemia (diabetic patients with low blood glucose) – 56.9%, a decrease from 58.6% in June.** There has been a reduction in documenting post blood glucose checks. This is being picked up within the recovery plan and the review of the scripting used to generate reports.
- **Fractured Neck of Femur (hip fracture) – 86.7%, an increase from 80.6% in June.** The use of a 'nudge tool' for analgesia implemented in June provided a prompt when important information is not documented. Compliance has improved since then, with July compliance to analgesia and the care bundle being the highest since the electronic Patient Clinical Record was implemented.
- **Call to door times for Stroke and STEMI** - the data did not identify any concerns, time on scene is monitored to identify potential improvements.

Remedial Plans and Actions

A recovery plan has been implemented to improve compliance; actions include:

- Focussed communication with clinicians to use the bespoke electronic Patient Clinical Record fields (in addition to the narrative).
- Providing weekly non-compliant data to support Senior Paramedics conversations with clinicians to improve compliance.
- Health Board focussed workshops to promote understanding of Clinical Indicators, care bundles and electronic Patient Clinical Record completion.
- Reviewing the scripting used for reports for each Clinical Indicator bundle. The revised scripting for Inter Hospital Transfers has positively impacted on data from May 2024.
- Following the success of the 'nudge' tool with analgesia for Fractured Neck of Femur (hip fracture), further 'nudges' will be implemented in a stepwise approach.

Expected Performance Trajectory

The continued support of Health Board Clinical Leads and Senior Paramedics, working closely with the Clinical Improvement, and Clinical Intelligence and Assurance Teams, will contribute to a continued increase in compliance rates.

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

(Responsible Officer: Liam Williams)

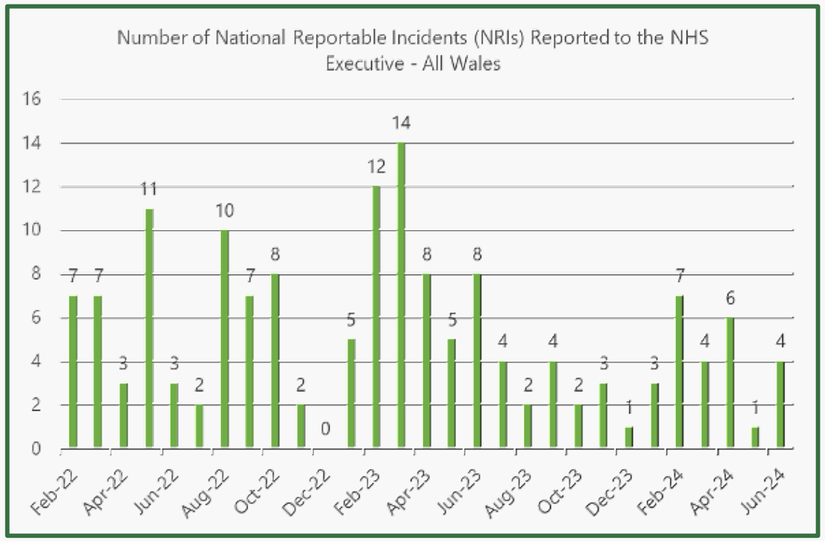
Concerns.

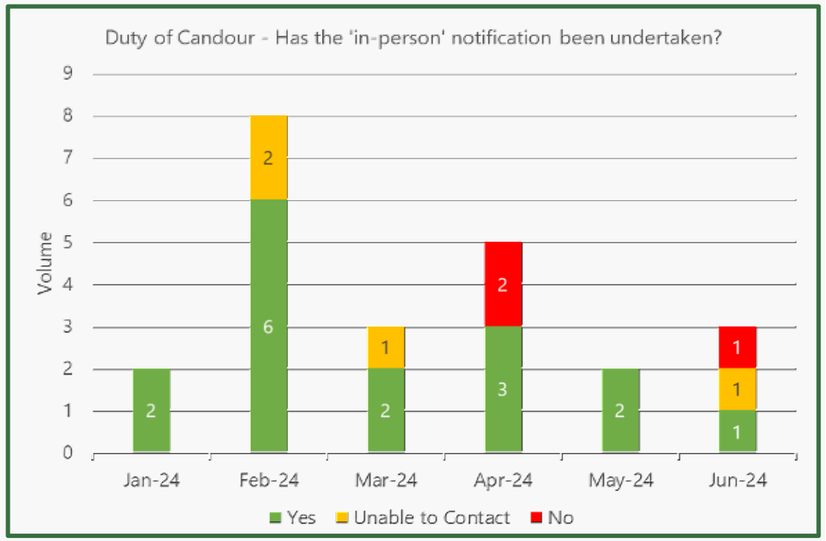
Self-Assessment: Strength of Internal Control: Moderate

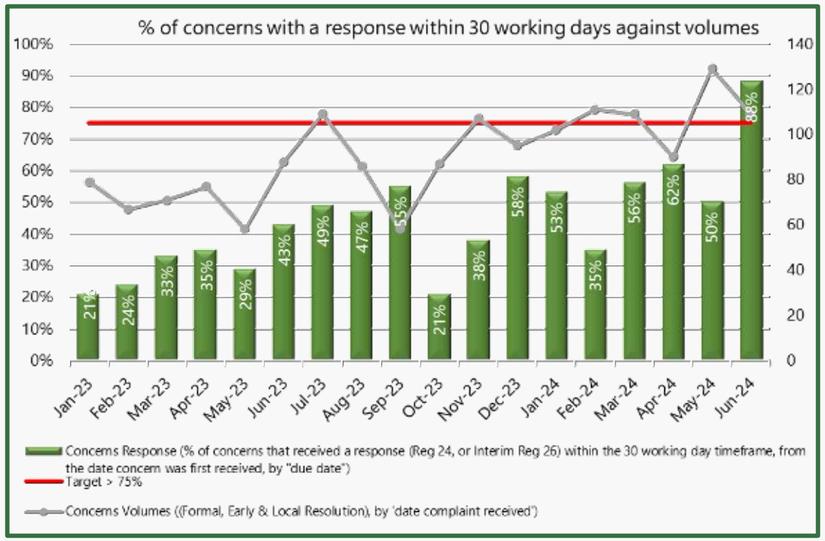
QUEST

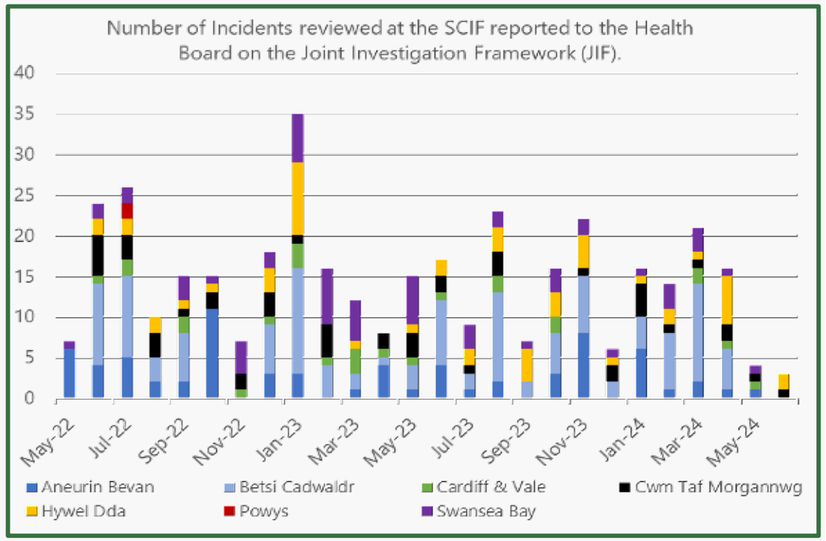
Health & Care Standard
Health - Safe Care / Timely Care

NB: Data quality issues have been identified. These are currently being addressed.









Analysis

The improvement in complaints timescales continues with the Trust exceeding the minimum target of 75% 30 working day compliance for the first time in several years. This is as a direct result of improved resourcing in the PTR team, particularly in leadership positions, following investment in the department. Acknowledgement of formal complaints is also fully compliant with the national timescales. It is anticipated that 30 working day compliance will begin a temporary decrease next month as the team begins to focus on resolving long-standing complaints and the total number of open cases. 4 NRIs were reported to the NHS Wales Executive in the previous month. There has been a notable decrease in cases requiring escalation to the SCIF. A decrease in incidents shared with Health Boards under the Joint Investigation Framework is also apparent. Further monitoring and triangulation will be undertaken to provide assurance on whether this is reflective of reducing system harm or a change in incident-reporting profiles.

Duty of Candour

Duty of Candour Regulations (2023): An “in-person” notification is made when the Trust becomes aware of a notifiable adverse outcome. There are occasions when we have not been able to contact patients or families despite trying several avenues. Where enactment of the Duty has been attempted, but unsuccessful the rationale is documented on the Datix Cymru System.

Remedial Plans and Actions

Recruitment to the full PTR establishment is nearly completed. New staff are expected to be in post by Q3 at the latest. A detailed Putting Things Right Recovery Plan has been presented and accepted by QUEST Committee. This includes SMART actions, expected performance trajectories and key dependencies over the coming financial year.

Expected Performance Trajectory

The PTR Department will, over the coming months, begin to focus on ensuring that recent improvements in the timeliness of complaints responses are sustainable and that we are reducing the longest waiting complaints. There are high staff vacancy and absence levels in the Patient Safety Team and the remaining team members are focused on maintaining statutory and national priorities, including identification, reporting, investigating and closure of NRIs and the enactment of the Duty of Candour.

**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*

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

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

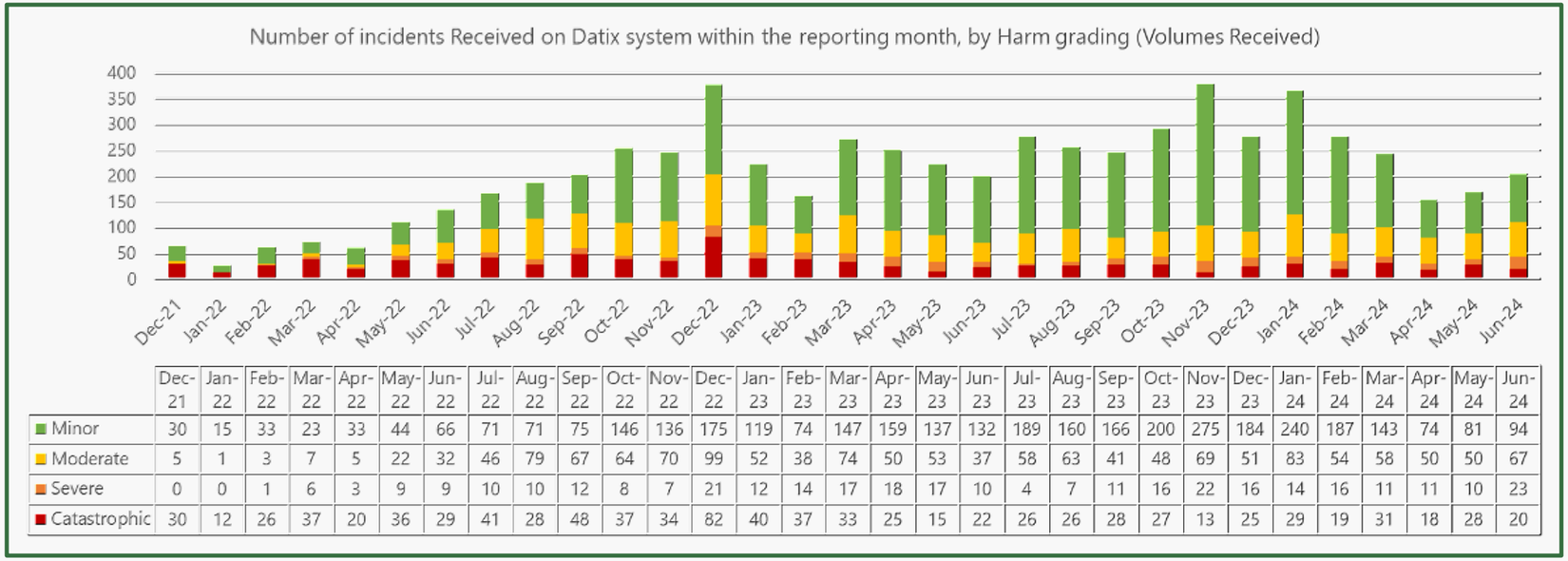
(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

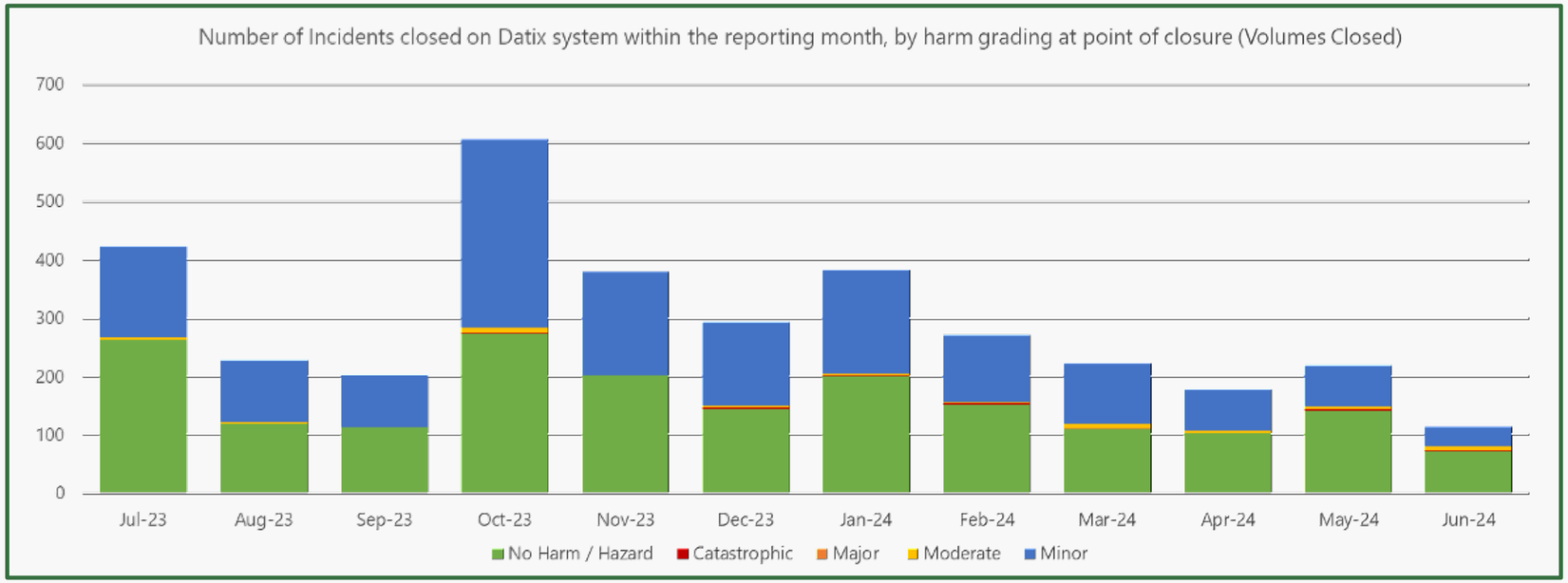
QUEST

Health & Care Standard
Health – Safe Care

NB: Data quality issues have been identified. These are currently being addressed.



	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Minor	30	15	33	23	33	44	66	71	71	75	146	136	175	119	74	147	159	137	132	189	160	166	200	275	184	240	187	143	74	81	94
Moderate	5	1	3	7	5	22	32	46	79	67	64	70	99	52	38	74	50	53	37	58	63	41	48	69	51	83	54	58	50	50	67
Severe	0	0	1	6	3	9	9	10	10	12	8	7	21	12	14	17	18	17	10	4	7	11	16	22	16	14	16	11	11	10	23
Catastrophic	30	12	26	37	20	36	29	41	28	48	37	34	82	40	37	33	25	15	22	26	26	28	27	13	25	29	19	31	18	28	20



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.

An increase in incident reporting during June 2024 is observed across all harm gradings.

All patient safety incidents graded moderate or above will continue to be reviewed by the Patient Safety Team. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident). Incident volumes include those reported internally by WAST staff but also those reported by Health Board colleagues about WAST services or care and transferred onto our Datix database.

The bottom graph highlights the 114 Incidents that were closed on the Datix system in June 2024.

Remedial Plans and Actions

The Putting Things Right teams continue to focus on the priorities outlined in the departmental Recovery Plan to improve the Trust position and performance across a number of quality metrics and Tier 1 targets. 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

As captured in the PTR Recovery Plan, Incident management priorities will initially be focused on reducing the number of overdue NRIs.

**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)

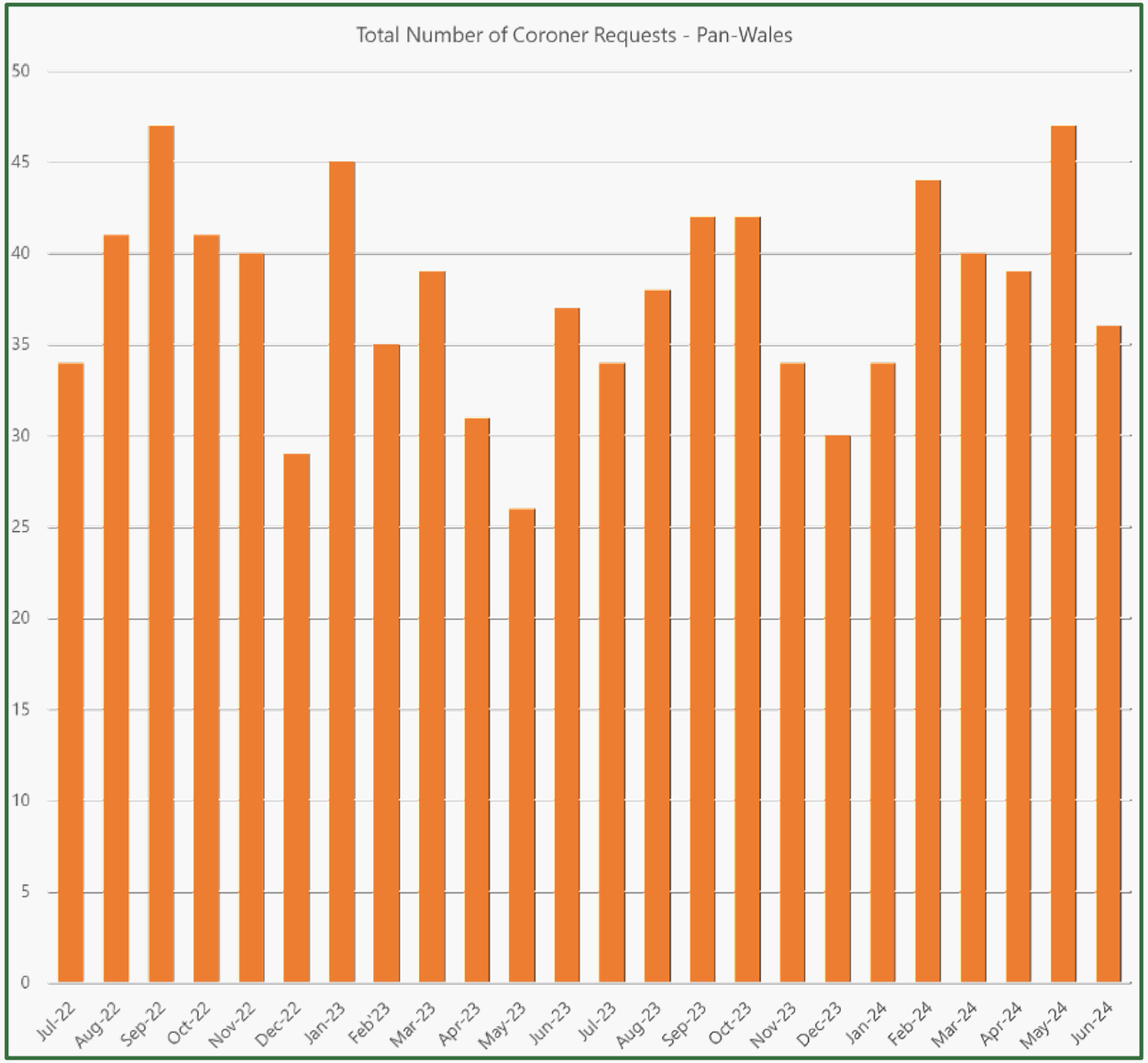
Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care

NB: Data quality issues have been identified. These are currently being addressed.



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

Analysis

Coroners: The complexity of the cases remains high, with multiple statements and actions per approach. Coroners are attempting to clear backlogs, still outstanding since Covid. This has resulted in the need for more prevention of future deaths statements. Some coroners have reduced administrative support (documented in the Chief Coroners Annual Report) , which has resulted in some delayed requests reaching the Trust.

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. Management responsibility for PSOW cases has been transferred to the Patient and Family Relations team to allow an end-to-end understanding of cases that progress through to PSOW consideration.

Mortality Review: The Trust continues to participate in Health Board led mortality reviews as appropriate, with attendance from the Patient Safety Team and clinical colleagues. Data and information is also provided by the Trust as required to the Medical Examiner Service to inform their reviews of deaths in acute care. 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.

Remedial Plans and Actions

Coroners: The Team are requesting extensions were possible and escalating issues earlier to ensure we are reaching deadlines. One specific coroner has advised that if statements are not received within the requested timeframe, a schedule 5 will be issued.

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
- The Patient Safety Team engaging in meetings led by the Once for Wales Datix Cymru Team who are developing the Datix Cymru Mortality Module.
- The establishment of the Learning from Deaths Forum, chaired by the Assistant Director of Quality & Nursing

Expected Performance Trajectory

Coroners: This level of activity seems to be the new normal and will continue to be monitored.

Ombudsmen: The team are pleased with the low conversion rate of complaints to PSOW cases, demonstrating the quality of responses to formal complaints.

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.

Mortality Reviews Data source: Internal Web Application

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

(Responsible Officers: Jonny Sammut & Liam Williams)

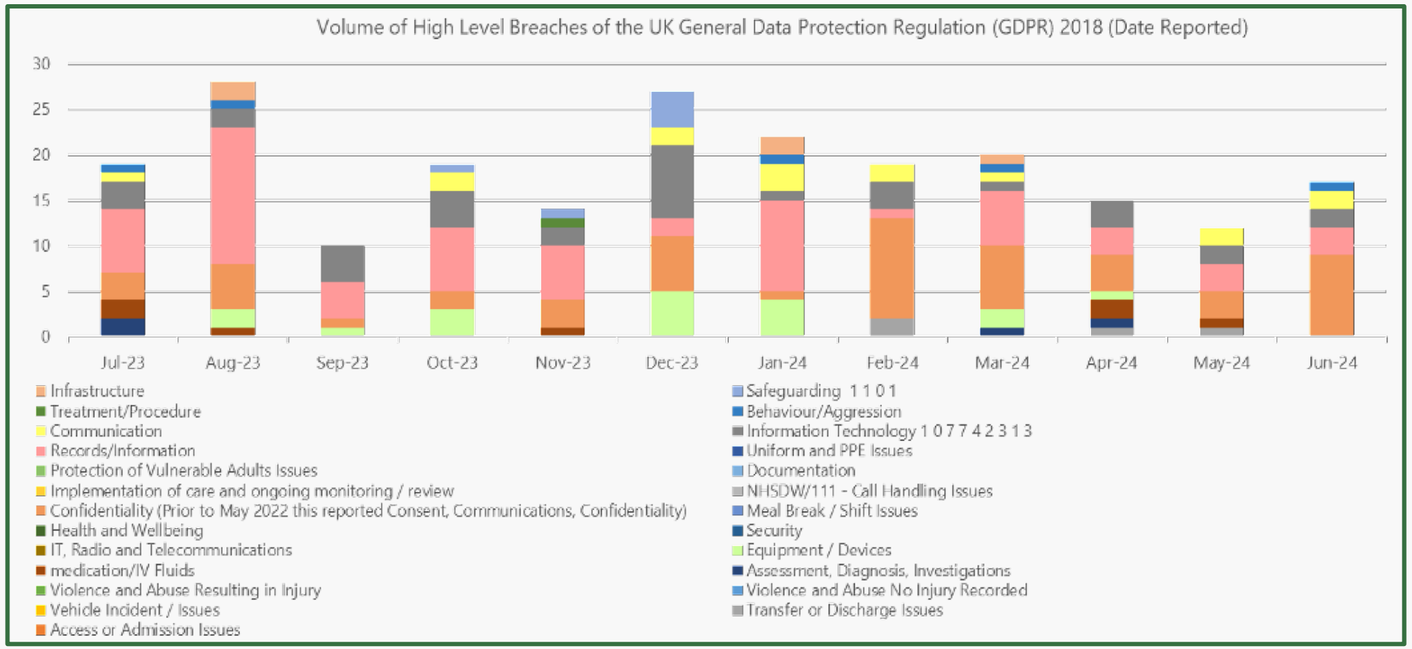
Self-Assessment: Strength of Internal Control: Strong

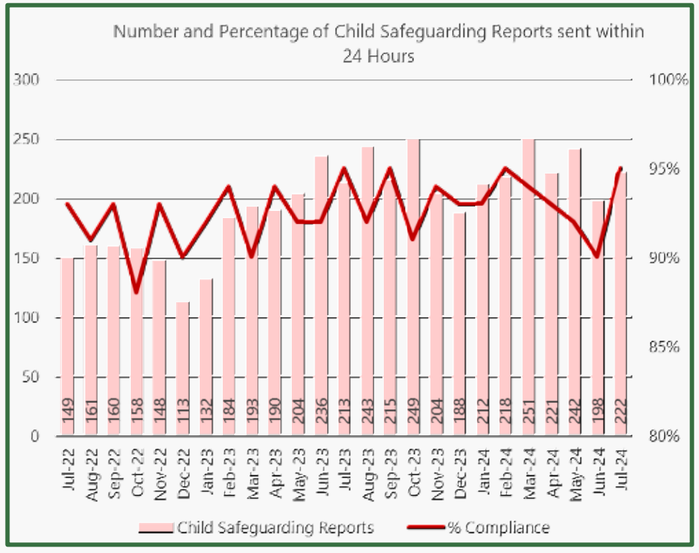
PCC

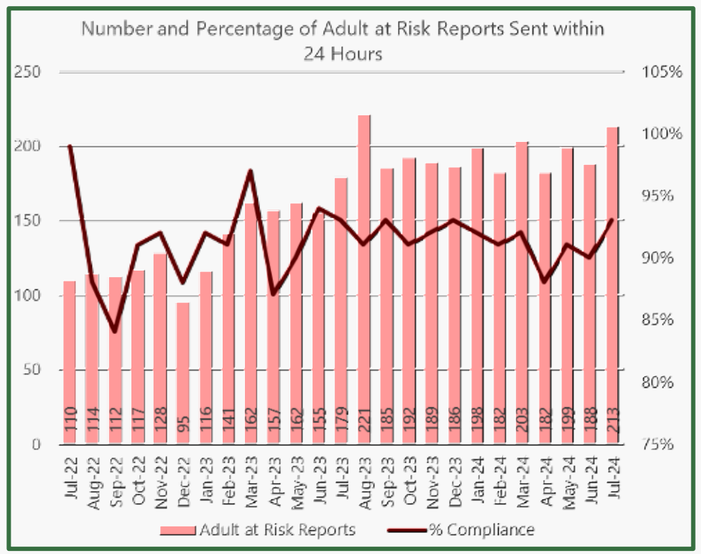
Health & Care Standard
Health – Safe Care

Safeguarding Data source: Doc Works

NB: Data quality issues have been identified. These are currently being addressed.







Analysis

Safeguarding: In July 2024 staff completed a total of 213 Adult at Risk Reports, 93% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 556 reports were received and processed to the Local Authority during this reporting period. There have been 222 Child Safeguarding Reports in July 2024, 95% of these were processed within 24 hours.

Data Governance: In June 2024, there were 17 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 17 breaches, 9 related to IG/Confidentiality, 3 Records/Information, 2 Information Technology, 2 communication, and 1 behaviour/aggression.

Public Engagement: During July, the Patient Experience and Community Involvement Team attended 19 community engagement opportunities. This month engagement included: -

- Attending the Caldicot Castle 999 Emergency Services Open Day,
- The Flying Start Family Fun Day in Barry
- Wrexham Pride.

At all of these events we have been able to talk to members of the public about the experiences and expectations of using the Welsh Ambulance Service.

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. 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.

Data Governance: During the reporting period, of the 17-information governance related incidents reported on Datix, 1 incident was reported to the Information Commissioner's Office (ICO) relating to lost paper records.

Public Engagement: 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. We are actively working with colleagues across the Trust to try and agree on solutions that would allow us to directly contact more patients.

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 Improvement Action Plan continues to be worked on with aims to achieve all actions by November 2024. The Action Plan has been shared with IGSG and will also be taken to ADLT.

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

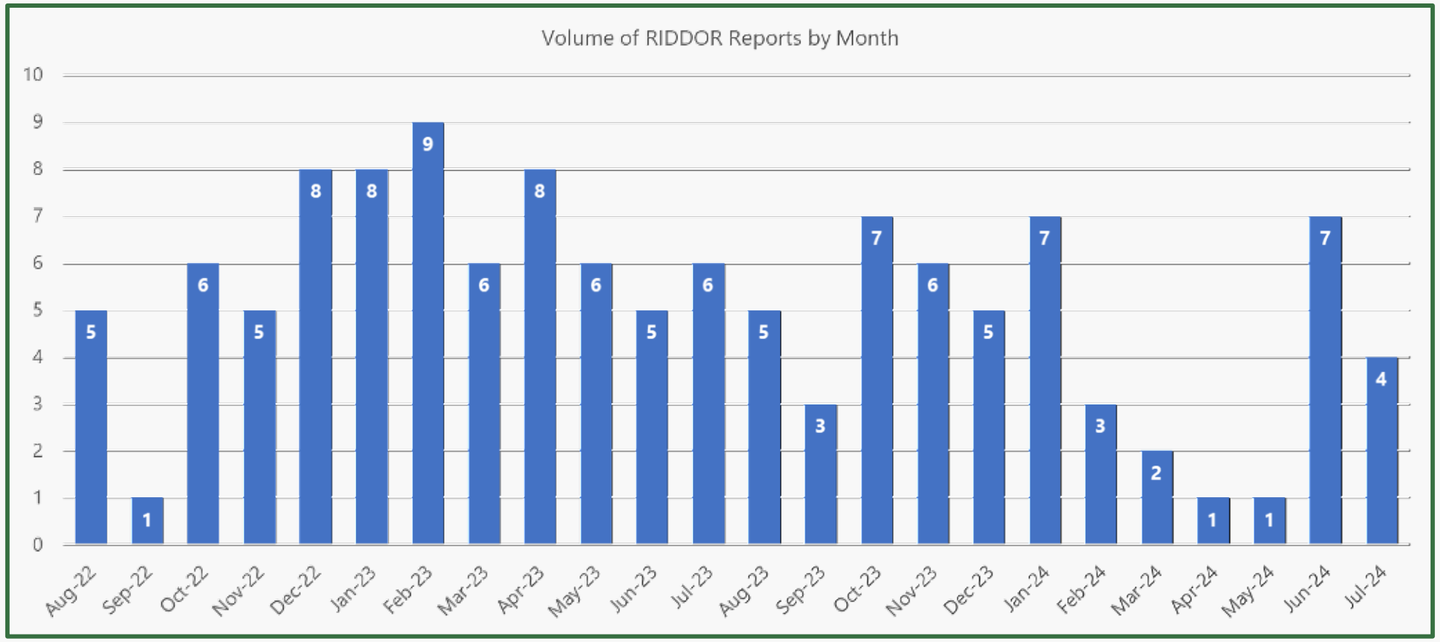
(Responsible Officer: Liam Williams)

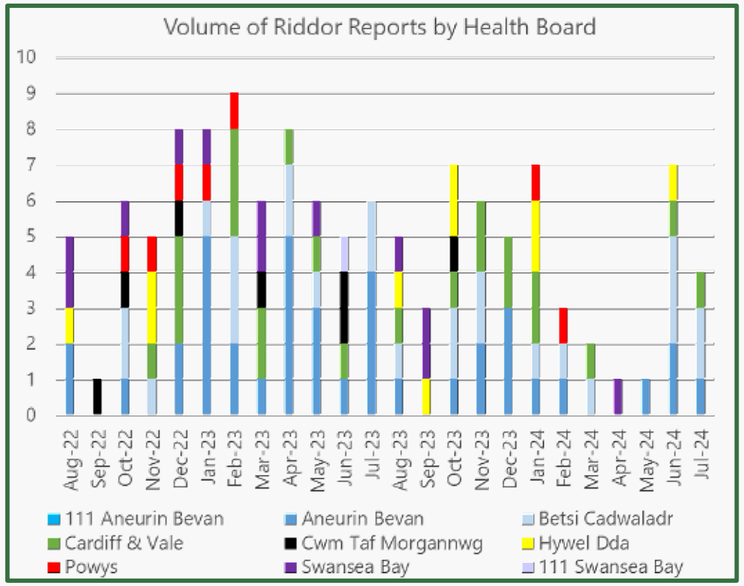
Self-Assessment: Strength of Internal Control: Moderate

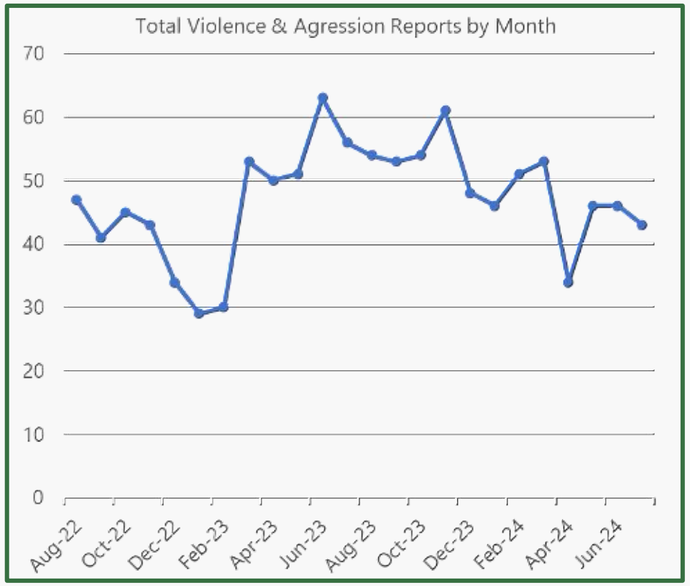
PCC

Health & Care Standard
Health – Safe Care

NB: Data quality issues have been identified. These are currently being addressed.







Analysis

RIDDOR: There were 4 incidents requiring reporting under RIDDOR during July all were as a result of being unable to perform their normal duties for more than 7 days.
One was reported as a result of a manual handling incident that occurred whilst pulling a stretcher with a patient on board.

There were 2 reports resulting from slip and trip incidents 1 on the stairs of a patient's property and the second was as a result of oil left on the floor of an ambulance station garage.
One member of staff received and injury when they struck some stationary machinery in one of our vehicle workshops.

The HSE requirement for more detailed information when reporting RIDDOR's is continuing to have an impact on reporting times due to the time taken to communicate with staff ahead of submission.

Violence and Aggression: A total of 43 incidents have been reported of V&A in July.
2 Physical Assaults on staff were reported during the month with incidents of verbal abuse amounting to 41 for the month.

11 incidents were reported as Moderate in harm and 20 noted as low harm with 2 cases being noted as causing severe harm.

The number of moderate harm incidents have returned to the lower levels previously seen within the Trust. Such variations can have a number of causes which are being investigated by the V&A Team.

Remedial Plans and Actions

RIDDOR: The vacant administrative role within the department has been filled and the new member of staff will be assisting in the collection of the information required for RIDDOR reporting to improve reporting times and data quality.

Violence and Aggression: V&A incident causation is being trended to identify the suitability of recording incidents in response to the volume of low harm and no harm incidents to with the aim of undertaking suitable investigations and providing sufficient support for staff members affected.
The team have been working with the Clinical Support Desk to explore mechanisms to better protect staff by use of Community Behavioural Orders via the Patient Care Plans.

Expected Performance Trajectory

RIDDOR: The number of manual handling injuries sustained whilst moving patients is currently static with an average of 13 being reported each month. The DSE/Manual Handling Advisor is completing their findings into the manual handling injuries within the Trust, and these will be compiled for trending and causation analysis.

Violence and Aggression: Whilst there has been a downward trend in V&A incident numbers the current performance remains steady in terms of numbers. The majority of incidents recorded are verbal in nature arising from our call centres. Work is being undertaken by V&A team and call centre staff is aiming to improve the reporting of incidents.

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

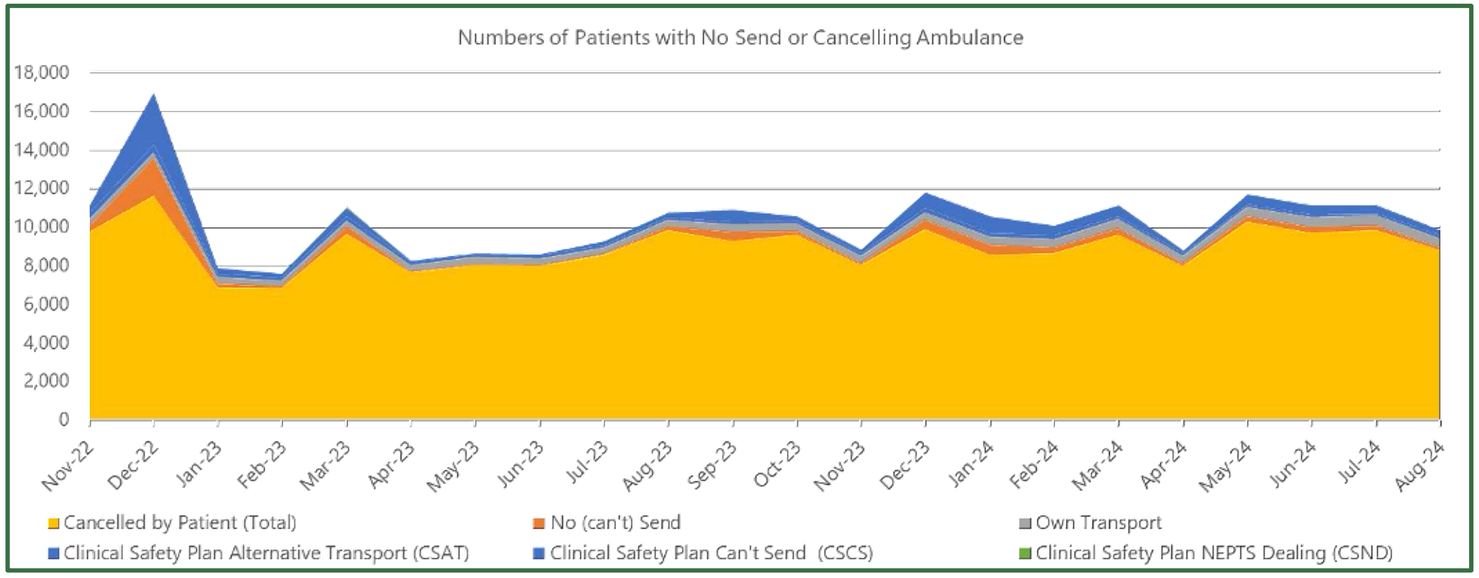
Data source: Datix

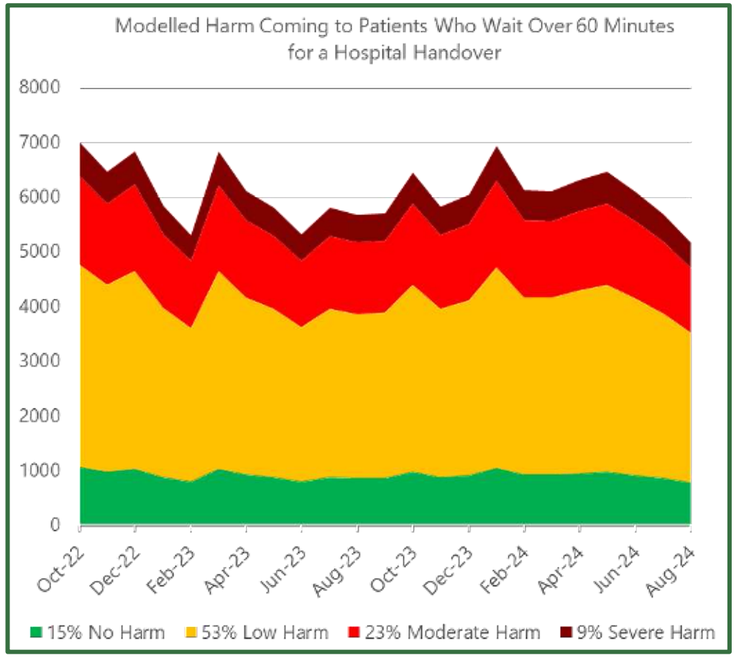
Our Patients: Quality, Safety & Patient Experience
Potential Patient Harm Indicators

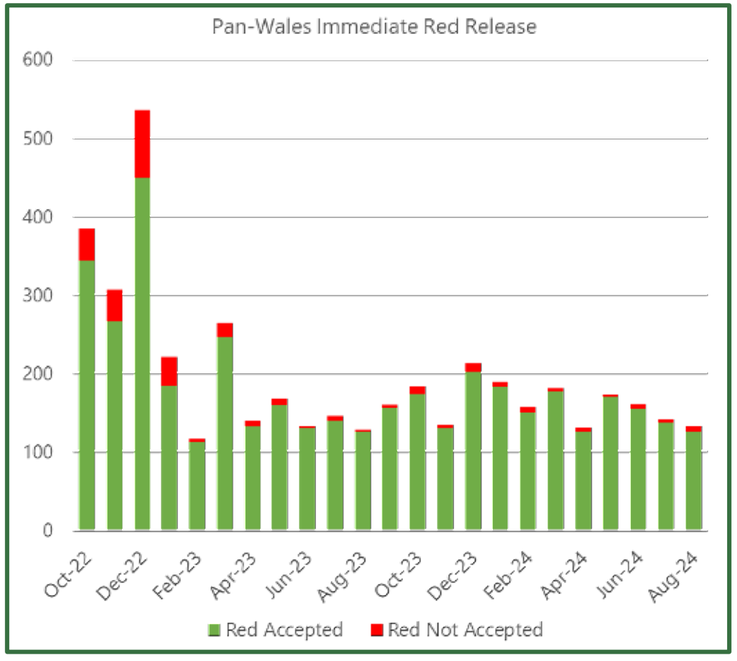
(Responsible Officer: Andy Swinburn)

A

FPC







Analysis

In August 2024, 161 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 264 were stopped due to CSP 'Can't Send' options. In addition, 8,785 ambulances were cancelled by patients (including patients refusing treatment at scene) a decrease from the 9,659 in July 2024.

There were 436 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in August 2024. Of these 125 were accepted and released in the Red category, with 8 not being accepted. Further to this, 112 ambulances were released to respond to Amber 1 calls, but 218 were not.

The graph in the bottom left shows that in August 2024 of the 5,162 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% (774 patients) would experience no harm, 53% (2,735 patients) would experience low harm, 23% (1,187 patients) would experience moderate harm and 9% (464 patients) would experience severe harm.

In August 2024 CSP levels for the Trust were:

Remedial Plans and Actions

Red immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Red Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings had been paused as the Trust moves into the new commissioning arrangements but have now restarted. The NHS Wales Performance Delivery framework 2024/25 has a target of no handovers of more than one hour, this equates to 7,500 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

Duty of Quality – Patient Experience
These are mandatory requirements; Under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, WAST has a duty to secure quality in its services and must exercise its functions with a view to securing improvement in the quality of its services. The Duty of Quality includes the experiences of individuals to whom health services are provided.

July 2024

NEPTS (18 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	66
Were you happy with the transport you received?	85	93
999 (37 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	73
The 999-call taker who answered your call explained what was going to happen next.	85	77
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	70
The length of time I waited for an ambulance to arrive was acceptable.	85	50
111 (13 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	88
Did you follow the advice given to you by NHS 111 Wales?	85	90
Would you consider using NHS 111 Wales again?	85	78
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
o Ambulance care	71.43% Good	0.00% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	77.78% Good	0.00% Poor
o EMS (including CSD)	48.15% Good	44.44% Poor
o NHS 111 Wales Online	58.33% Good	25.00% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

Analysis
Within the NEPTs survey the response provided did not hit the benchmark in relation to the question 'How long did you wait for your transport to take you home after your appointment, while the question 'Were you happy with the transport your received', came out above the 85-benchmark figure (n=93).

All the responses within the 999-section failed to achieve the benchmark, while within 111 two questions saw responses achieve the benchmark 85, these being 'Did you follow the advice given to you by NHS 111 Wales?' (n=90) and 'Do you feel your call to 111 Wales was helpful?' (n=88).

Response rates to the 999 and 111 surveys remain low and it's acknowledged that these do not reflect an entirely representative picture based on overall call volumes.

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

- We are continuing to work on a DPIA to be submitted to the ICO for their consideration about use of SMS text messages to directly distribute survey requests to service users.
- 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 also continue to work closely with the Trust's Falls Improvement Lead to deliver a targeted survey looking at the experiences of people who are responded to by either a Level 1 or Level 2 falls responder.
- Throughout this month we have also continued to engage with the Once for Wales Programme Board who have been reviewing the 'All Wales Patient Experience Question Set' and the updated 'People's Experience Framework'. The Framework and new questions will be presented to Executive Directors of Nursing at their next meeting for final approval.

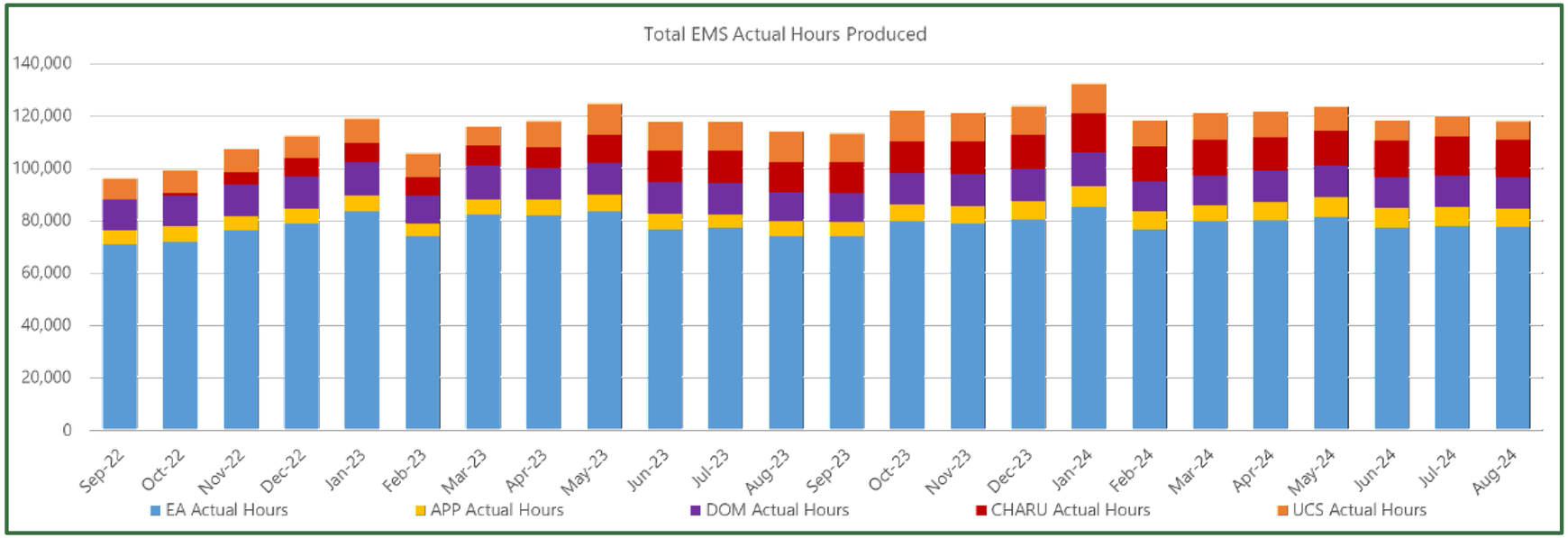
Expected Performance Trajectory
An overall aim of increasing visibility of experience surveys and maximising opportunities to capture patient experience data.

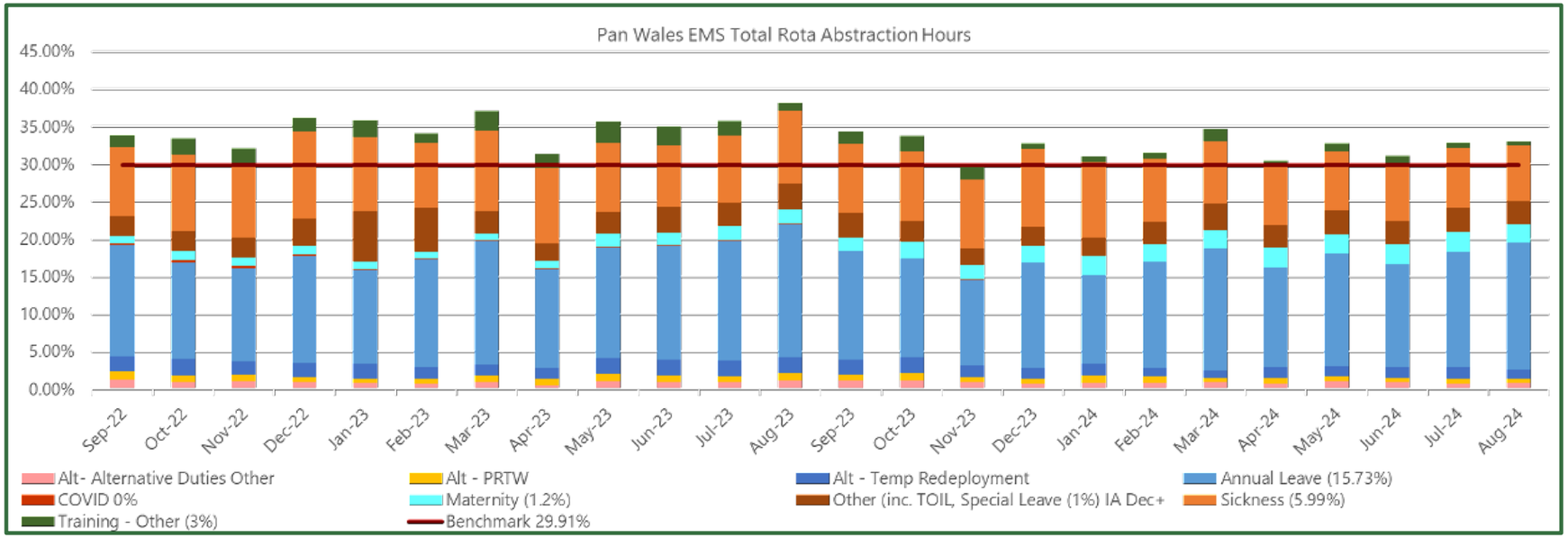
Our People
Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions
A	R

CI PCC FPC





Analysis

The total EMS hours produced is a key metric for patient safety. The Trust produced 118,091 hours during August 2024, an increase compared to 113,830 hours produced during August 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. As well a high number of vacancies, August 2024, saw a total EMS abstractions (excluding Induction Training) of 33.07%. This was an increase on the 32.95% recorded in July 2024. The highest proportion of abstractions was due to annual leave at 17.01% followed by sickness at 7.46%.

Emergency Ambulance Unit Hours Production (UHP) achieved 90% in August 2024 which equated to 77,500 Actual Hours.

In August 2024 CHARU UHP was 80% against the full roll out requirement.

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.
- Focus on recruitment to reduce identified vacancy gap, in particular, EMTs and APPs.

Expected Performance Trajectory

UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to ELT. Production is good.

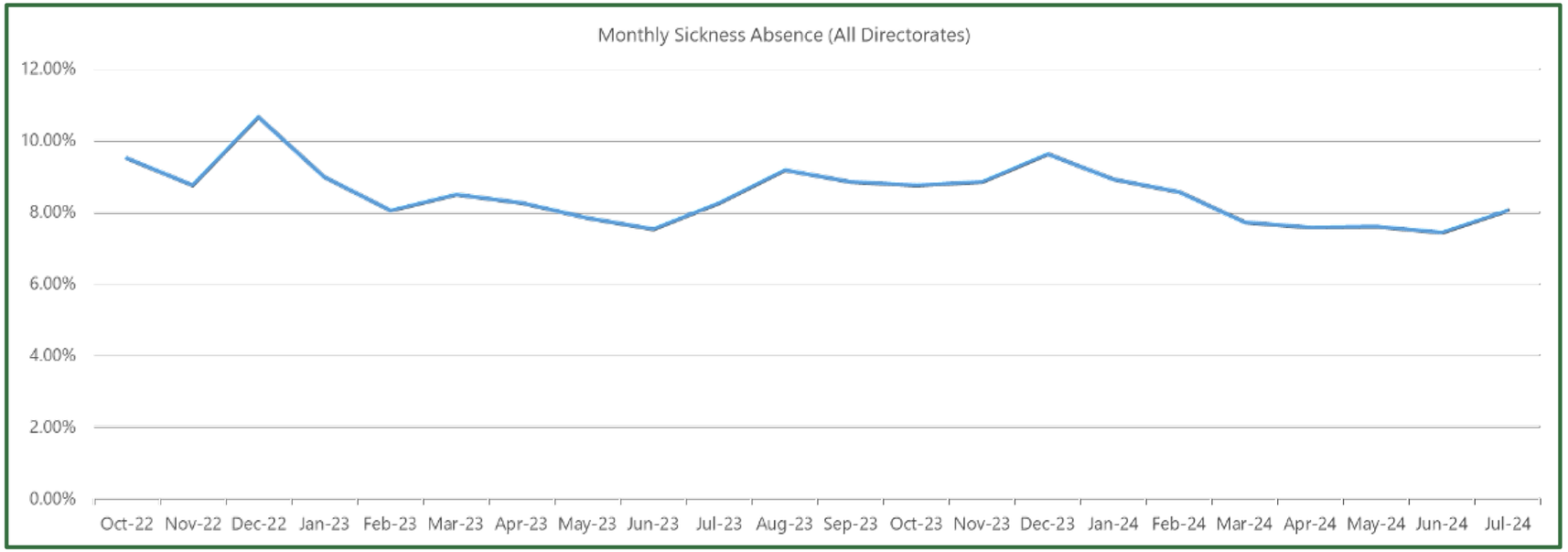
The Trust maintains an ambition to reduce sickness to 6% and abstractions to 30%. This has not yet been achieved for sickness, but the direction of travel is good, while the abstractions benchmark has been achieved a number of times this year.

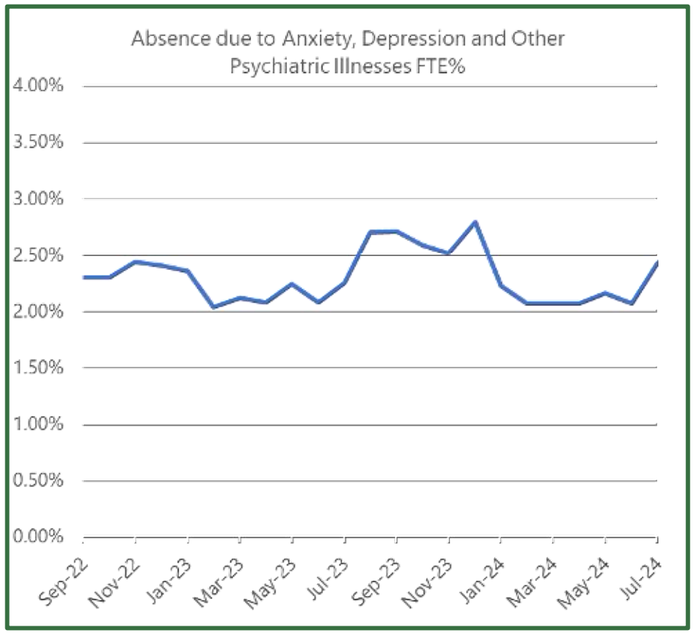
Our People
Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)

Mental Health
G

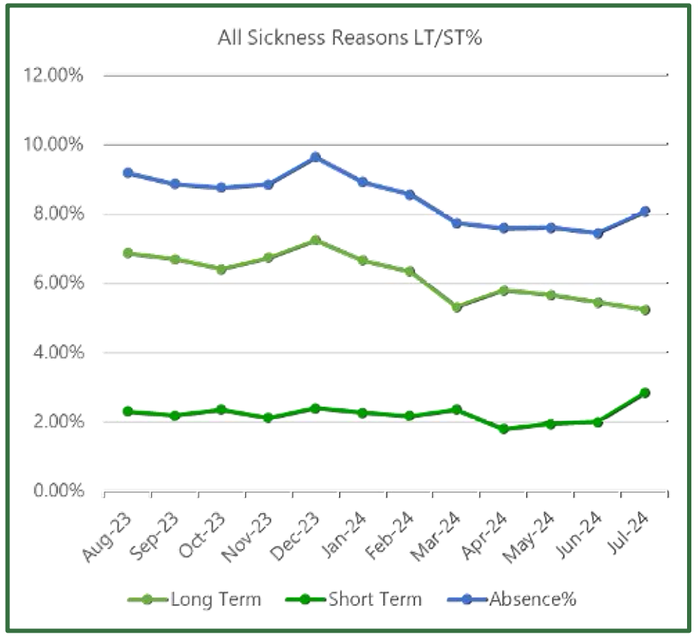
CI





Average working days lost per FTE (Annual)	
19.24 days	
Single month Absence %	
7.75%	
Long Term	**Short Term**
5.23%	2.83%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.43%	0.88%

July 2024



Analysis

There was a slight increase in overall sickness absence rates between June 2024 and July 2024, rising from 7.4% to 8.1%. Long term absence decreased from 5.45% in June 2024 to 5.23% in July 2024, while short-term absence increased slightly to 2.83% in July from June 2024 (1.99%).

The highest reason for absence in July 2024 was Anxiety/ Stress/ Depression, other musculoskeletal problems and injury, fracture.

Absence due to Mental Health increased from 2.07% in June 2024 to 2.43% in July 2024.

Occupational health waiting times have greatly improved, our KPI of 10 working days from receipt of management referral to first offer of appointment is being met, with colleagues currently waiting for 3 to 5 working days. From receipt of Wellbeing referrals to first call (from one of our Wellbeing Practitioners), the waiting time is still 2 days. The team continue to triage all referrals and enquiries to ensure prioritisation of anything that requires urgent attention.

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).
- 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.
- We have recently recruited 2 Occupational Health Advisors to cover maternity leave, we also recruited a Clinical Team Lead.

Expected Performance Trajectory

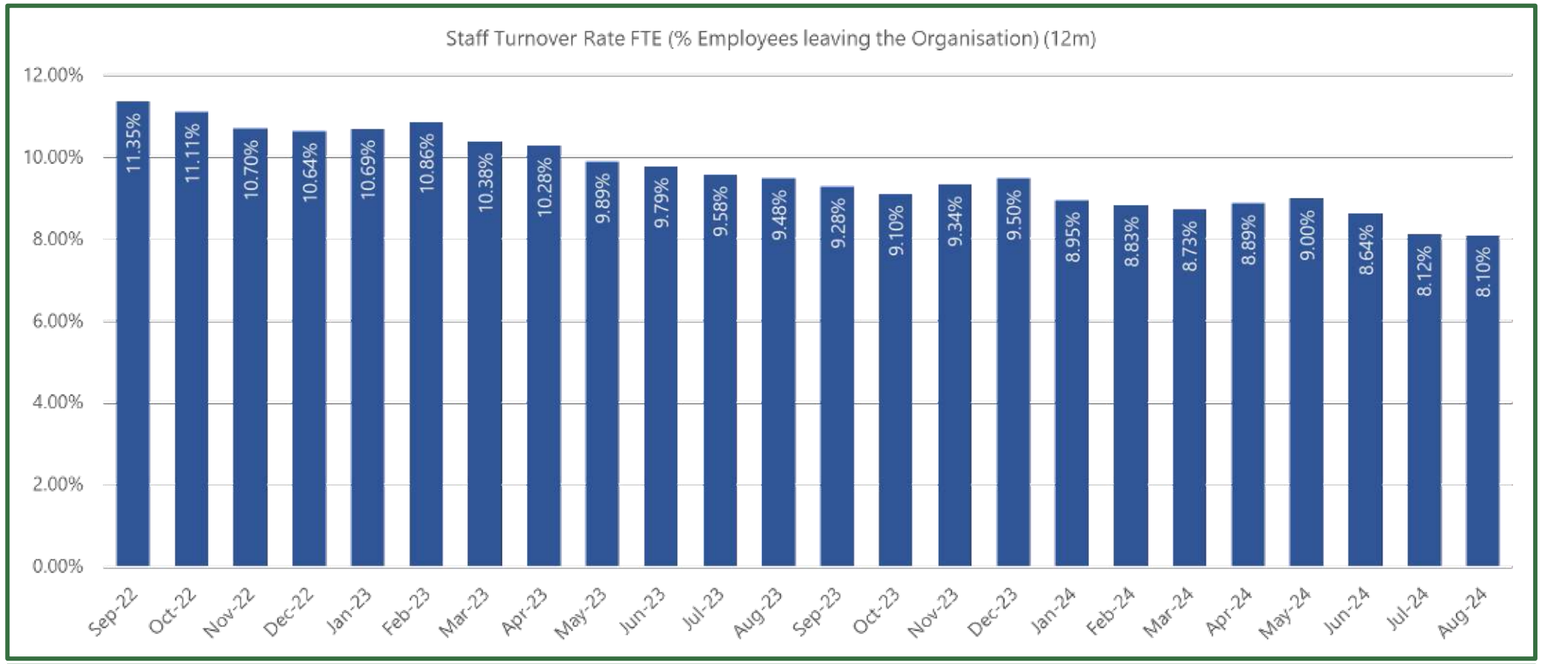
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but that there remain risks to delivery.

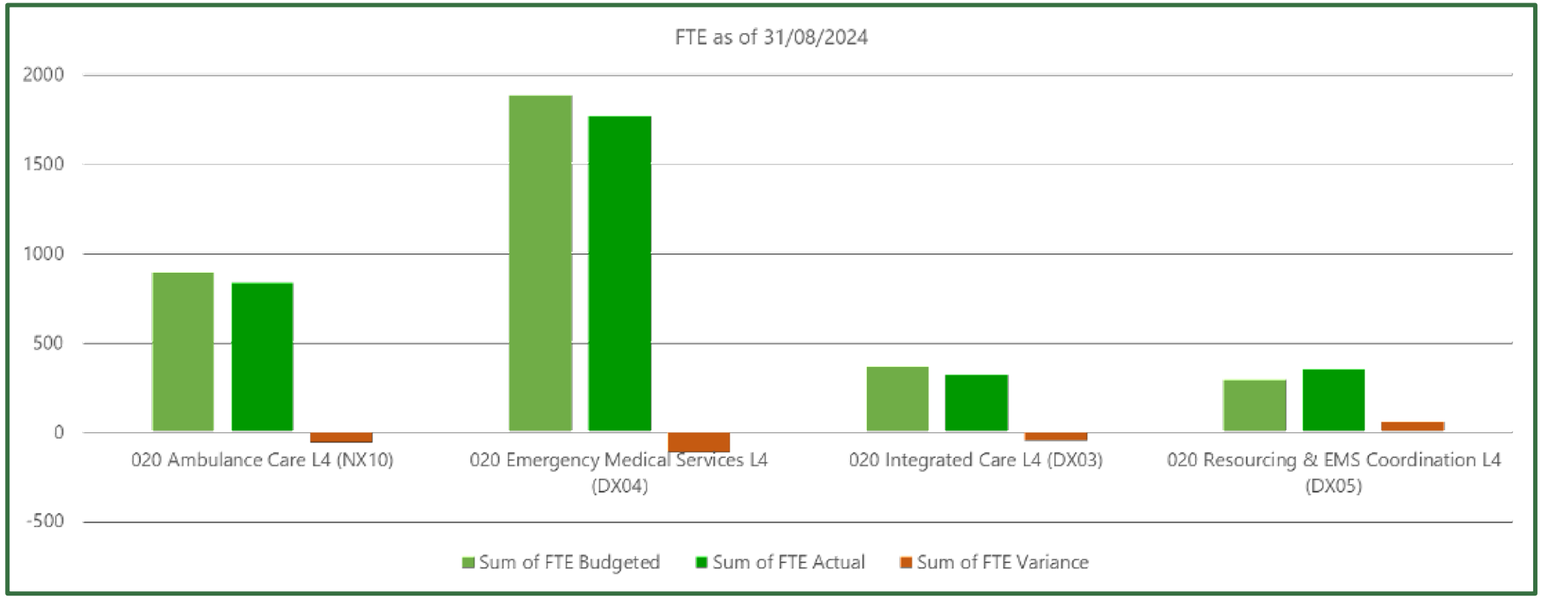
NB: Sickness data will always be reported one month in arrears. It should be noted that the figures reported in this presentation are official to 31st March 2024. All figures for April 2024 are indicative only (as of 23.04.24).

Our People
Capacity - Turnover

(Responsible Officer: Angela Lewis)

G





Analysis

Staff turnover rates in August 2024 were 8.10%, a minimal decrease from the 8.23% recorded in July 2024. August saw 30 leavers (26.88 FTE). Turnover in months at the end of the quarter are generally higher). This was balanced with 41 joiners (20.44 FTE) in August, of those leaving, the group with the greatest number were Emergency Medical Dispatchers (8 people).

WAST are meeting national KPIs. Due to staff sickness and staff changes (new team members to be inducted/trained etc.) our occupational health waiting times have slightly increased. Currently colleagues are waiting around 23 working days. From receipt of Wellbeing referrals to first call (from one of our Wellbeing Practitioners), the waiting time is still 1-2 days.

Remedial Plans and Actions

- We are working to improve our data collection through Our MI system (Opas G2), some ongoing technical issues are being investigated by Civica.
- The team continue to support staff by providing advice and guidance on how to use the MI system. We have facilitated events; Occupational Health - Guidance on Management Referrals, attendance was good, and the team are looking at providing more sessions in the future.
- The self-referral portal on Opas G2 for Occupational Health and Wellbeing continues to prove popular and has streamlined the service.
- We are still working closely with the Welsh health boards to standardise our reporting, however in addition to this we have built our own customised reports, which help us identify themes and trends. The Wellbeing team continue to deliver Drop-in sessions across all our Clinical Contact Centres, (CCCs) dates are advertised on Siren and through our seasonal newsletter. 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.
- Finalised plans for the pilot Health Check Programme, Health Diagnostics, which looks at reducing risk of cardiac ill health in our older workforce.
- Working on reevaluating plans/timelines to attain SEQOHS accreditation, a meeting with SEQOHS has been scheduled with a view to start working on this in September.

Expected Performance Trajectory

The People and Culture Strategy continues with its wellbeing focus. We are currently in the process of writing the WAST Health and Wellbeing strategy for 2025/29.

Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

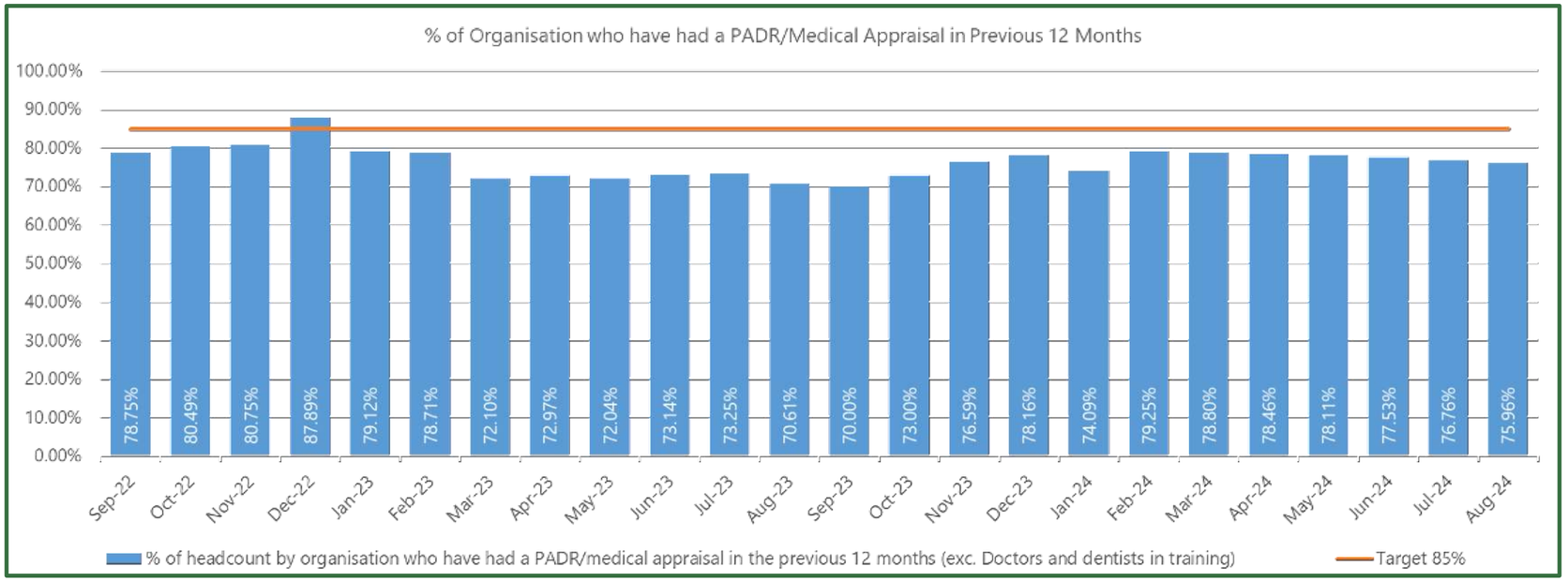
PADR R

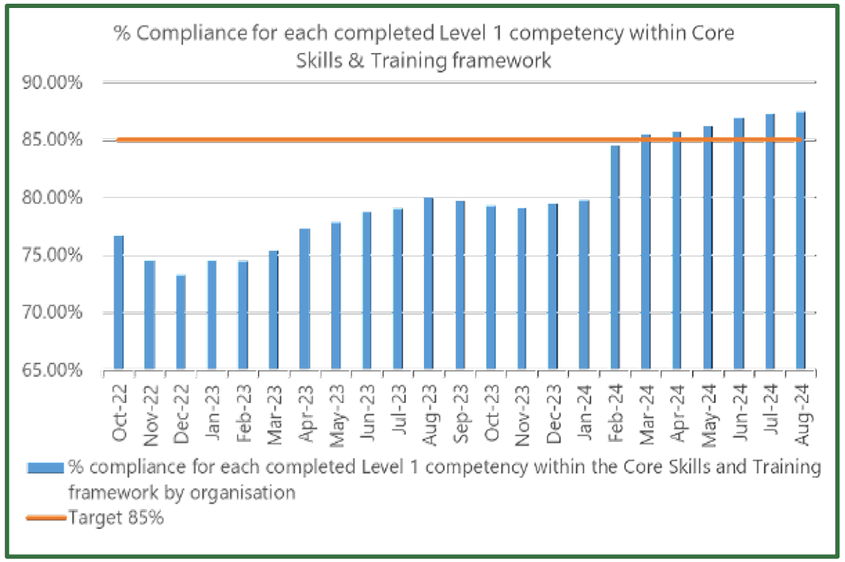
Stat & Mand R

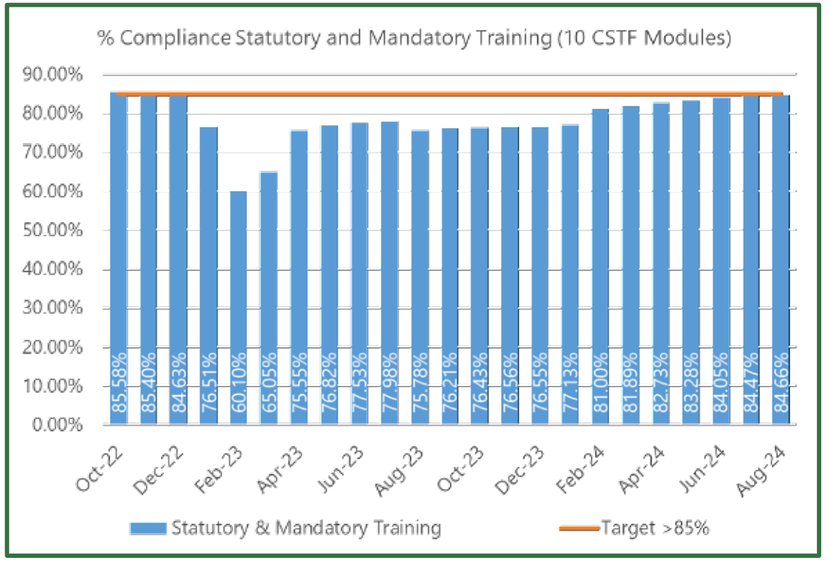
CI PCC

Health & Care Standard Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong







Analysis

PADR rates decreased from 76.76% in July 2024 to 75.96% in August 2024 and remain below the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In August 2024 Statutory & Mandatory Training rates reported a combined compliance of 84.66%; which is the 8th consecutive month to see an improvement. However, only Dementia Awareness (95.18%) and Moving & Handling (93.44%), achieved the 85% target. Equality & Diversity (83.34%), Safeguarding Adults (83.07%). Fire Safety (79.26%), Information Governance (77.09%), Violence Against Women, Domestic Abuse & Sexual Violence (72.82%), Paul Ridd (71.66%), Fraud Awareness (66.73%) and Welsh Language Awareness (65.59%) all remain below this target.

There are currently 18 Statutory and Mandatory courses that NHS employees must complete in their employment. These are listed in the table:

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

Remedial Plans and Actions

Engagement in the PADR process serves as a Key metric for evaluating team cultural health. By increasing engagement with the PADR process, our goal is to enhance employee Development opportunities, support better Communication between managers and employees and develop a culture of accountability and continual improvement.

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.

Expected Performance Trajectory

Performance is improving as compliance has risen.

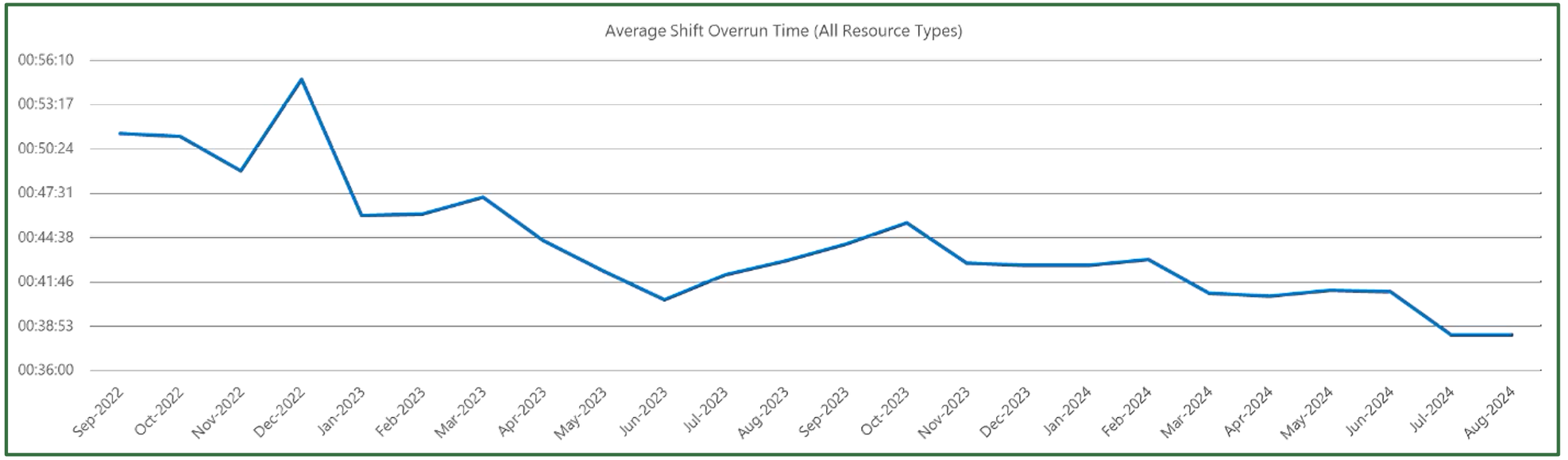
Data source: ESR

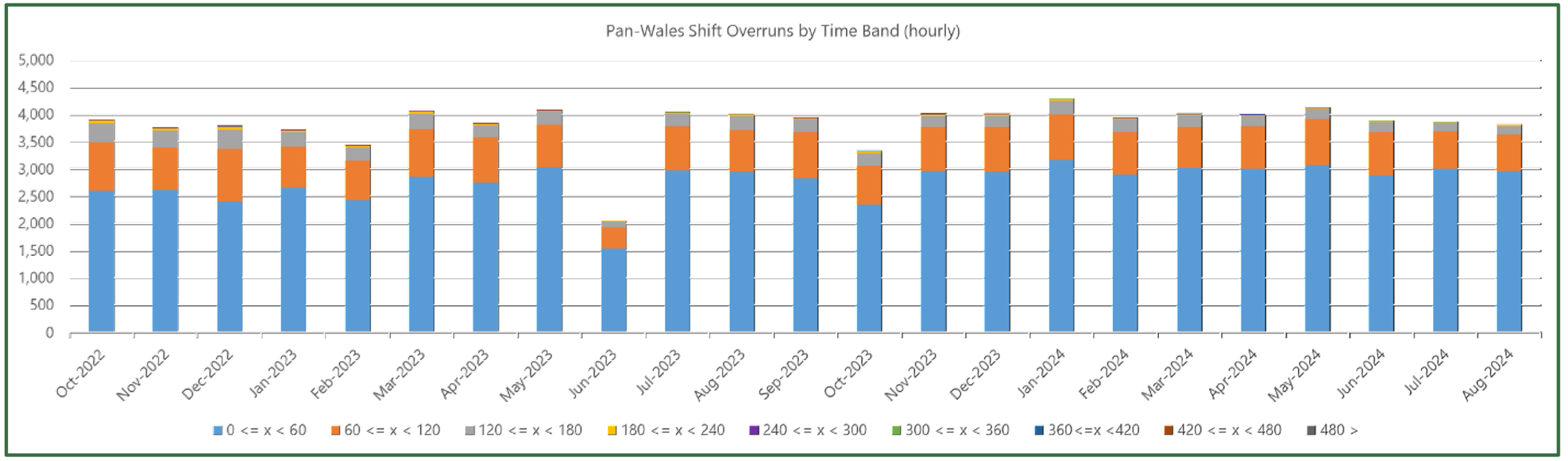
Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

Overruns
R

CI





Analysis

The average overrun figure for August 2024 was 38 minutes and 17 seconds consistent with June 2024. The trend continues to be downward over the past two years.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 73.7% of the total. 19.7% fall within the 61 to 120-minute category, 5.4% 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 introduced "pods" at some hospital locations to aid staff finishing on time. These are continuing, at this time, into 2024/25.

Expected Performance Trajectory

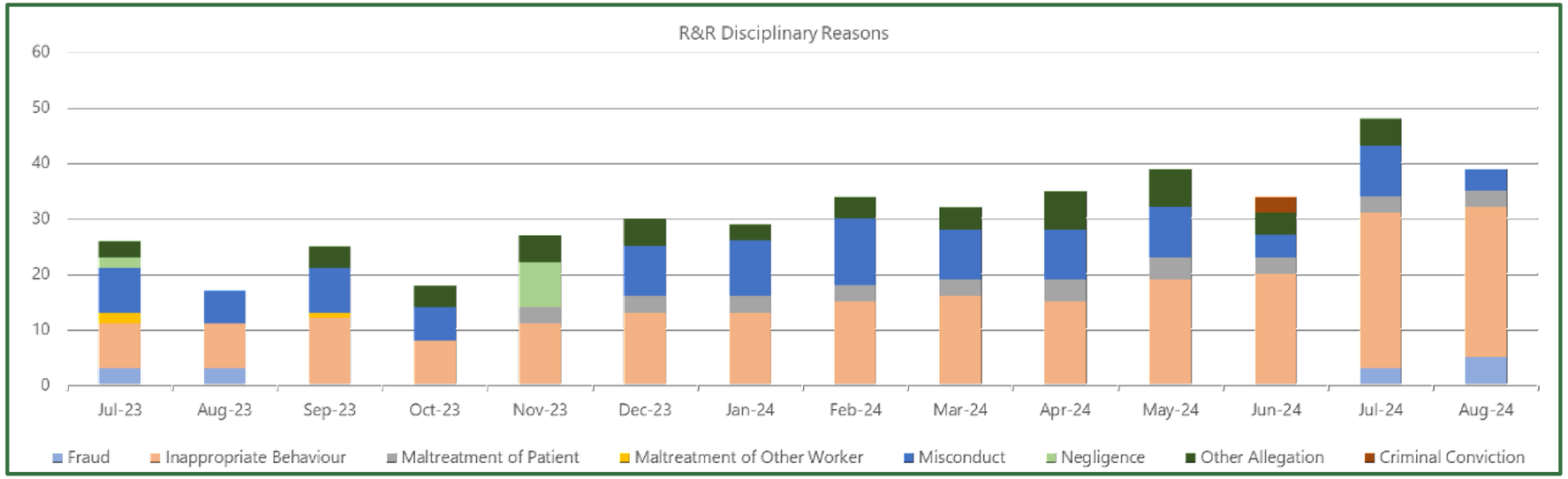
Overruns correlate with handover lost hours. As we have moved out of winter both levels had started to drop. We may expect this to stabilise before moving into higher levels again next winter.

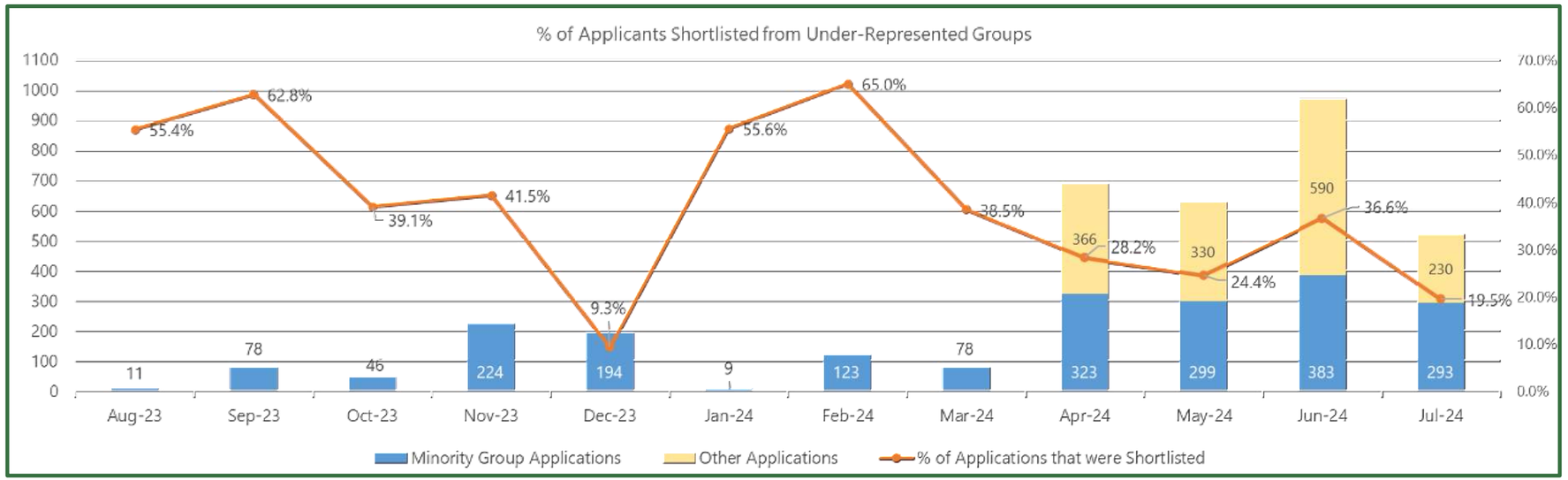
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 39 open formal disciplinary cases recorded at the end of August 2024, a decrease compared to 48 in July 2024 which was the highest number seen over the past 12 months. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by fraud.

There were 17 open formal Respect and Resolution cases submitted by employees in August 2024, two less than in July 2024. These are a mixture of both Respect and Resolution Grievances and Dignity at work.

The bottom graph shows that in July 2024, 523 job applications were processed and 141 interviews were planned.

Of the 523 applications, a total of 293 were from under-represented groups with 208 in the category of Ethnicity, 46 within Disability and 39 within Sexual Orientation.

In June 2024, 19.5% (n=57) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 36.6% in June 2024.

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.

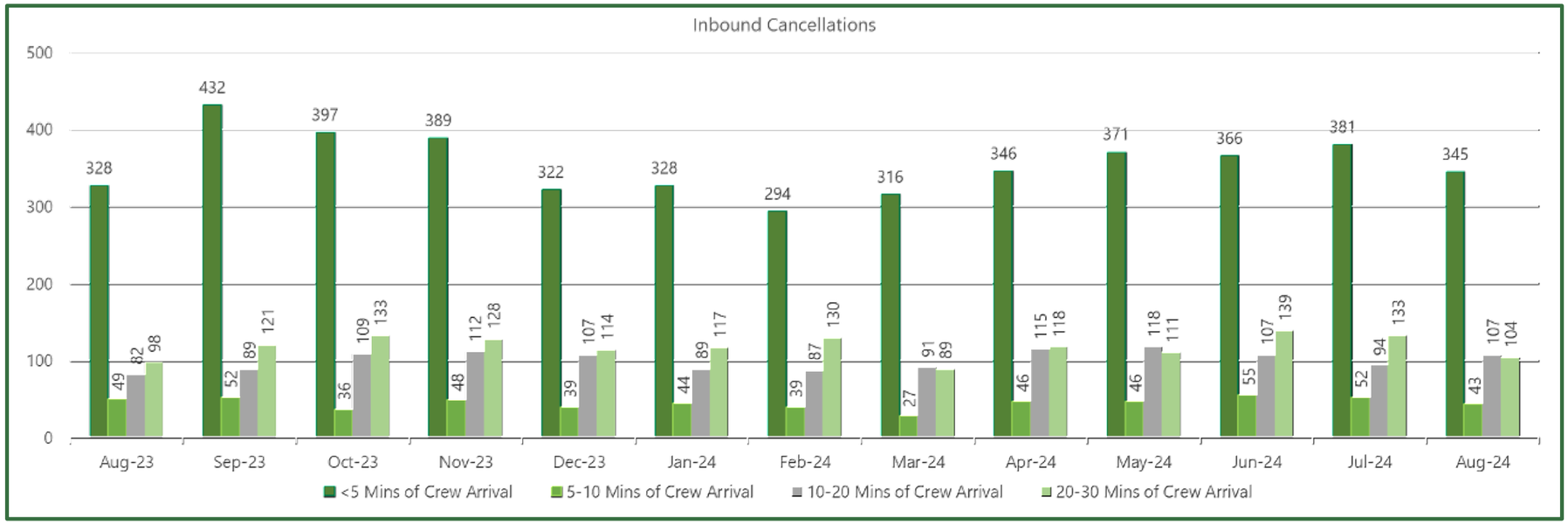
Expected Performance Trajectory

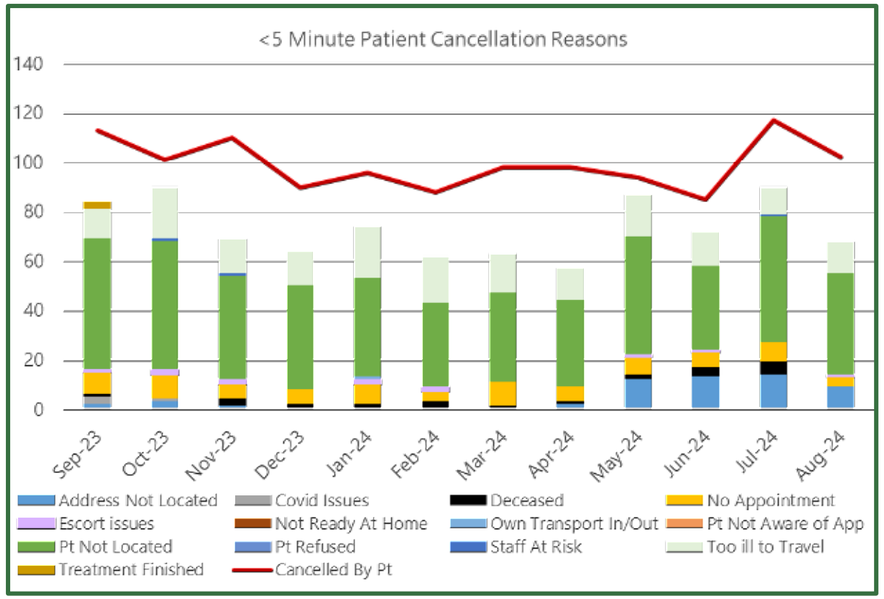
Continue to monitor levels, no trajectory for this measure.

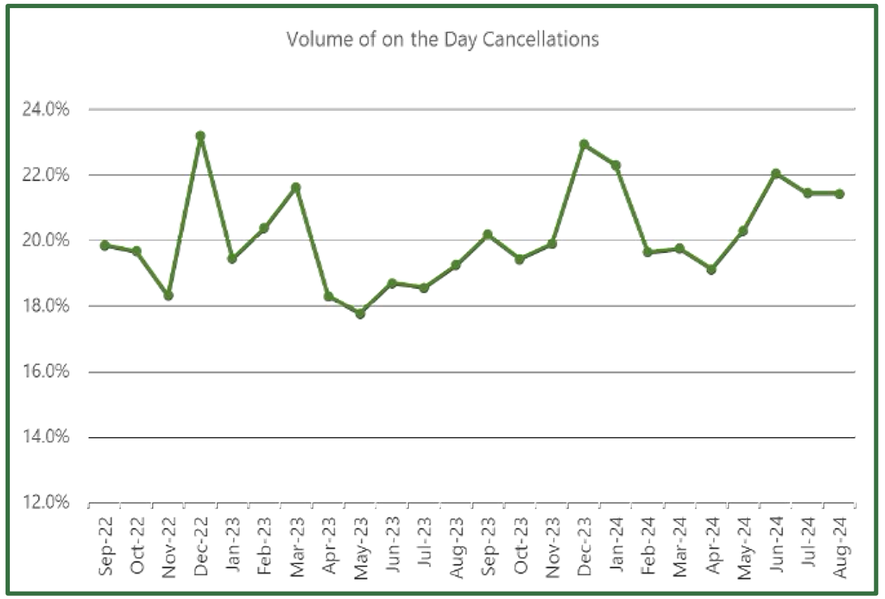
Finance, Resources and Value
Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

Cancellations
A







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw a decrease in August 2024 to 345, compared to 381 in July 2024. The total number of cancellations within 30 minutes decreased from 660 in July 2024 to 599 in August 2024.

In August 2024 there were 102 appointments cancelled by patients, decreasing from 117 in July 2024.

The other top reasons for less than 5-minute cancellations included: 41 patients not located, 13 unwell/too ill to travel and 9 addresses not located.

Same day cancellations remained consistent in both July and August 2024 (21.4%).

Remedial Plans and Actions

Work with Hywel Dda to develop a direct link between their PAS system and our CAD but has been delayed by a clash of organisational priorities but will be picked back up in late Q1. Once in place this will allow for WAST to be notified once the health board cancels or alters an appointment.

Work is also underway to enhance the service's text messaging options to improve notification to patients. This should be complete in Q2.

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.

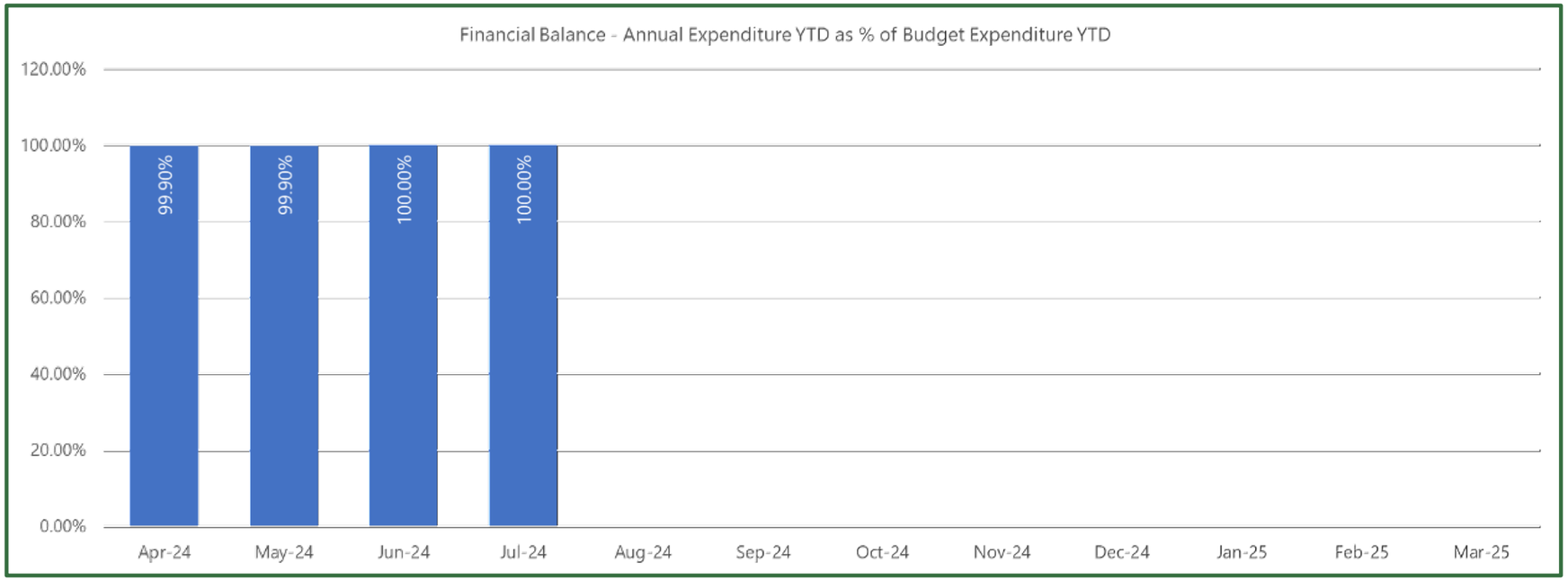
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

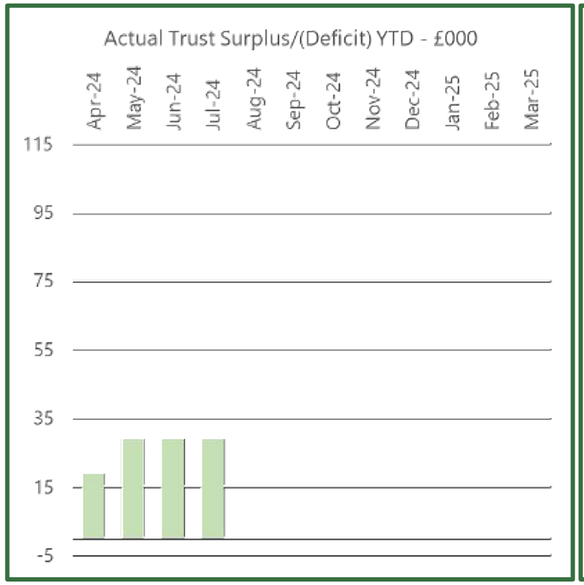
Finance, Resources and Value
Value - Finance Indicators

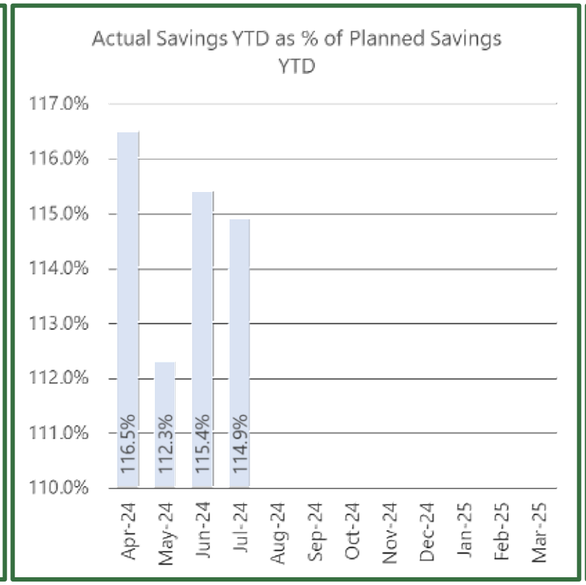
(Responsible Officer: Chris Turley)

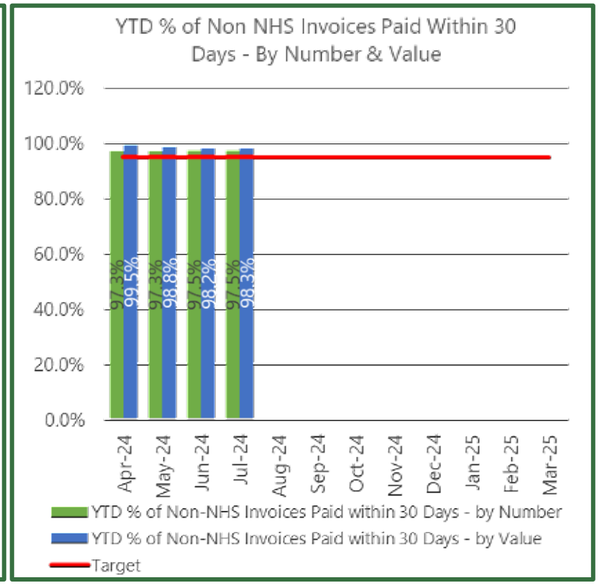
G

FPC









Analysis

The reported outturn performance at Month 4 is a surplus of £29k.

For Month 4 the Trust is reporting planned savings of £2.271m and actual savings of £2.610m (an achievement rate of 114.9%).

The Trust's cumulative performance against PSPP as at Month 4 is 97.6% against a target of 95%.

At Month 4 the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

Remedial Plans and Actions

There is no remedial plan required given the Trust is forecasting to breakeven; 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

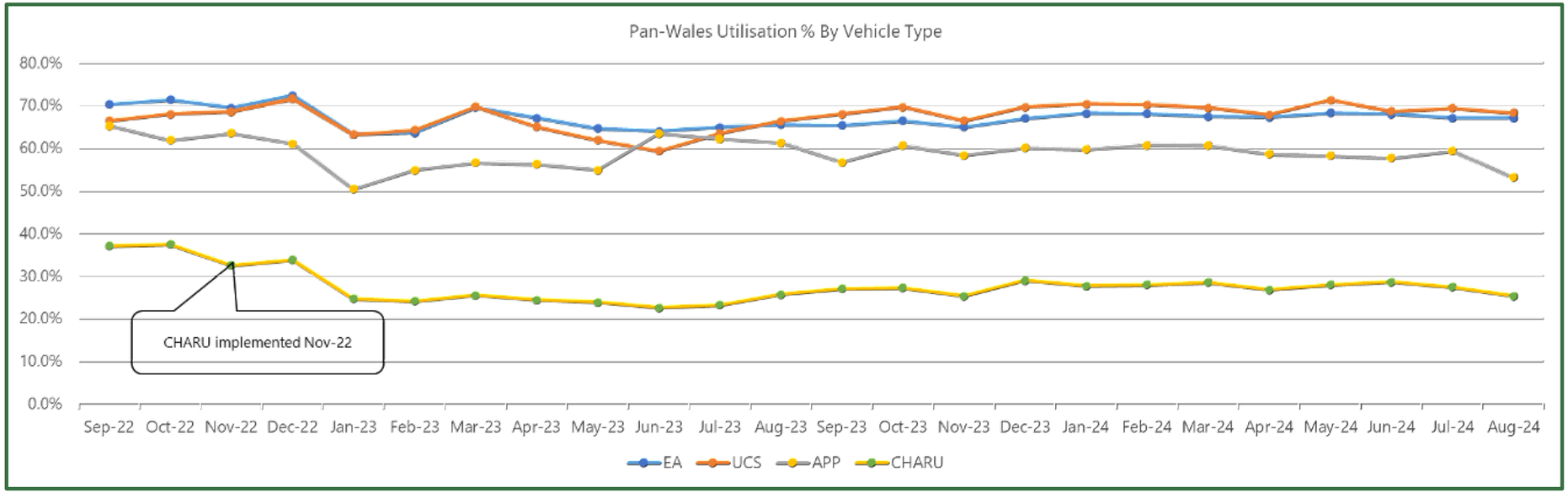
(Responsible Officer: Lee Brooks)

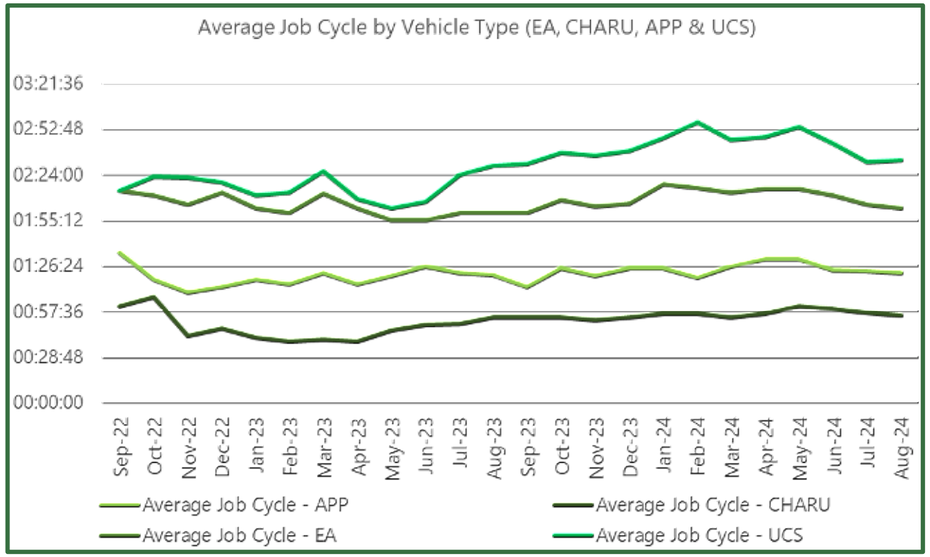
Jobs Per Shift: R

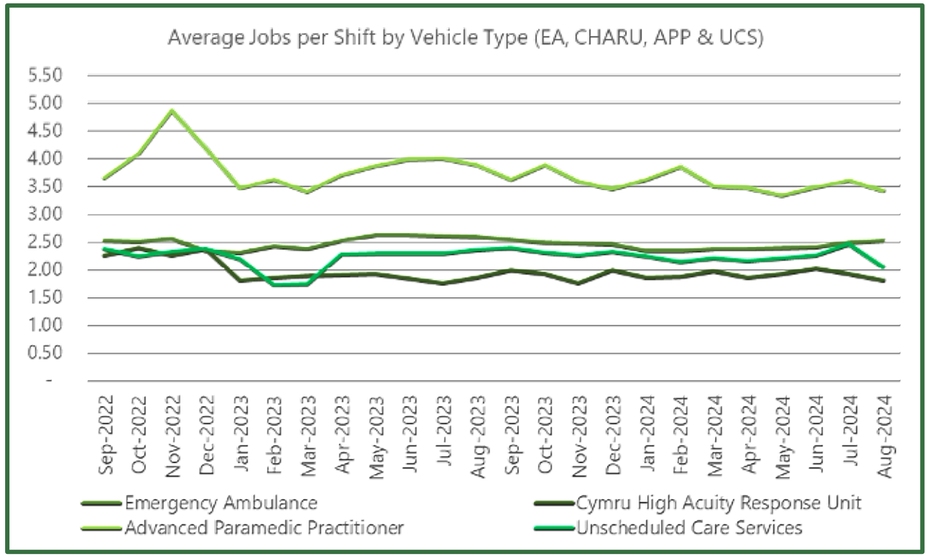
CHARU Utilisation: A

FPC

NB: Data quality issues have been identified in APP utilisation rates. These are currently being addressed.







Analysis

Pan Wales Utilisation metrics in August 2024 were 56.8% for all vehicles types, decreasing slightly from 57.4% in July 2024. UCS was the highest rate during the month at 68.3% while EA was at 67.1%. 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 most categories decreased in August 2024, to 2 hours 3 minutes for EAs, 55 minutes for CHARU and to 1 hour and 22 minutes for APPs. UCS increased by 1 minutes to 2 hours and 33 minutes.

Overall average jobs per shift was 2.34 in August 2024, indicating a slight decrease from July 2024 (2.35). EAs averaged 2.51 jobs per shift and UCS crews 2.03 jobs per shift This is more than what would be ideal and a product of handover delays.
APPs attended on average 3.42 jobs per shift and CHARU's 1.80 jobs per shift. Both sets of data are under review.

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.

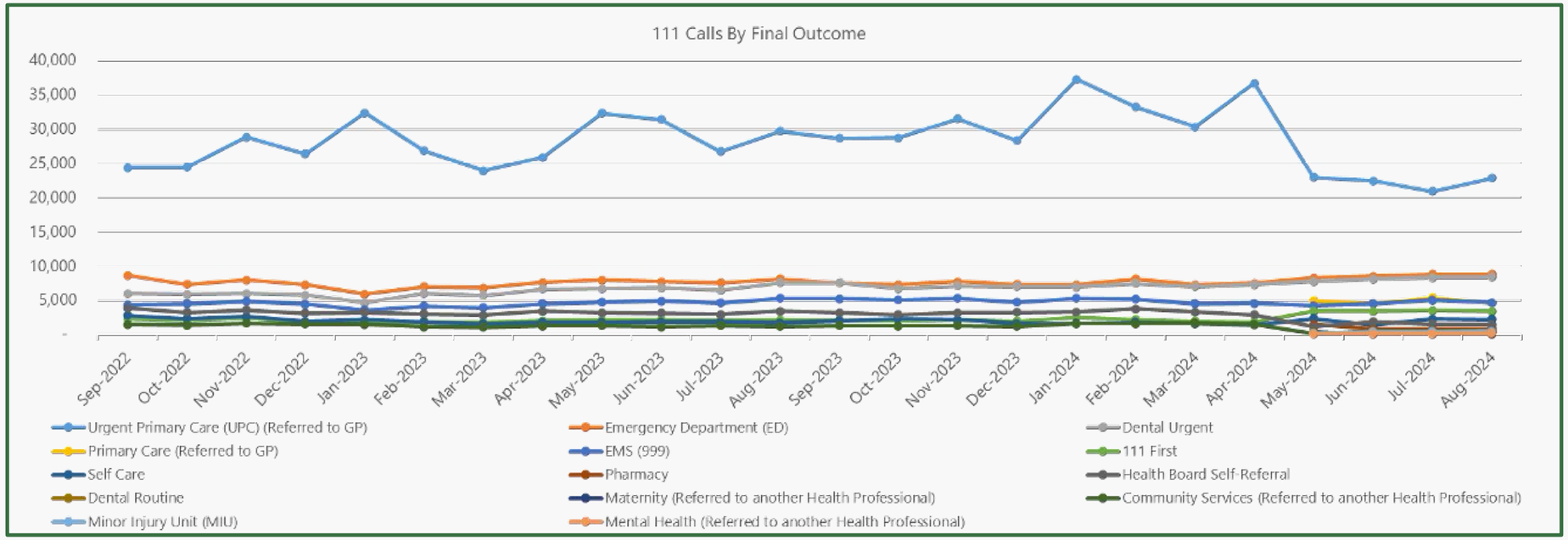
CHARU is a particular area of focus. Initial analysis indicates that CHARU contribution to Red compares favourably with the previous resource: RRVs.

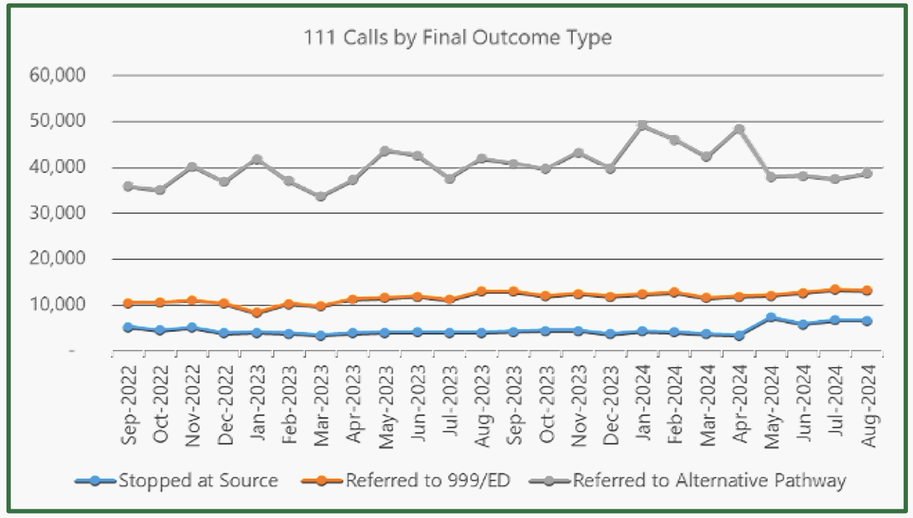
Expected Performance Trajectory

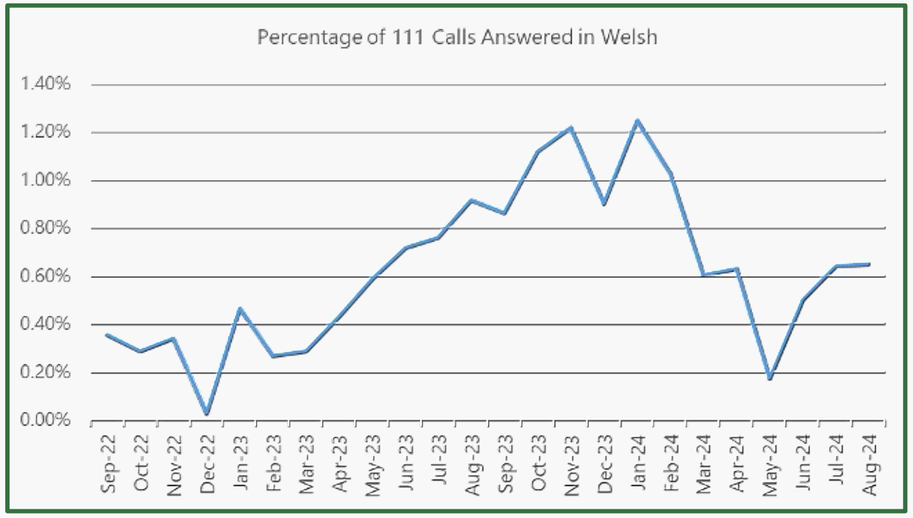
The Trust's ability to reduce the high utilisation rates for EAs and UCS is a product of handover, which it does not control. The Trust would expect an increase in APP and CHARU utilisation during 2024/25 linked to the remedial actions identified above.

Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)







NB: Data quality issues have been identified in 111. These are currently being addressed.

Analysis

During August 2024, 58.745 calls were allocated into the 14 categories displayed in the graph opposite, a slight increase compared to the 57,972 seen during July 2024. However, data quality issues have been identified in 111 which are currently being addressed.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 33.37% of all calls during August 2024, but there has been a material drop since the implementation of new 111CAS.

As the bottom left graph highlights, in August 2024, 6,550 calls were 'Stopped at Source', with no onward referral, a slight decrease from the 6,657 in July 2024. 13,068 calls were referred to 999/ED in August, a decrease from the 12,335 in July.

The percentage of 111 calls answered in Welsh increased from 0.64% in July 2024 to 0.65% in August 2024. This equated to 34.8% of all 111 calls being offered in Welsh being answered.

Remedial Plans and Actions

There is currently a 111 Measures Task and Finish Group. This is a collaborative meeting between WAST its commissioners and DHCW. 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

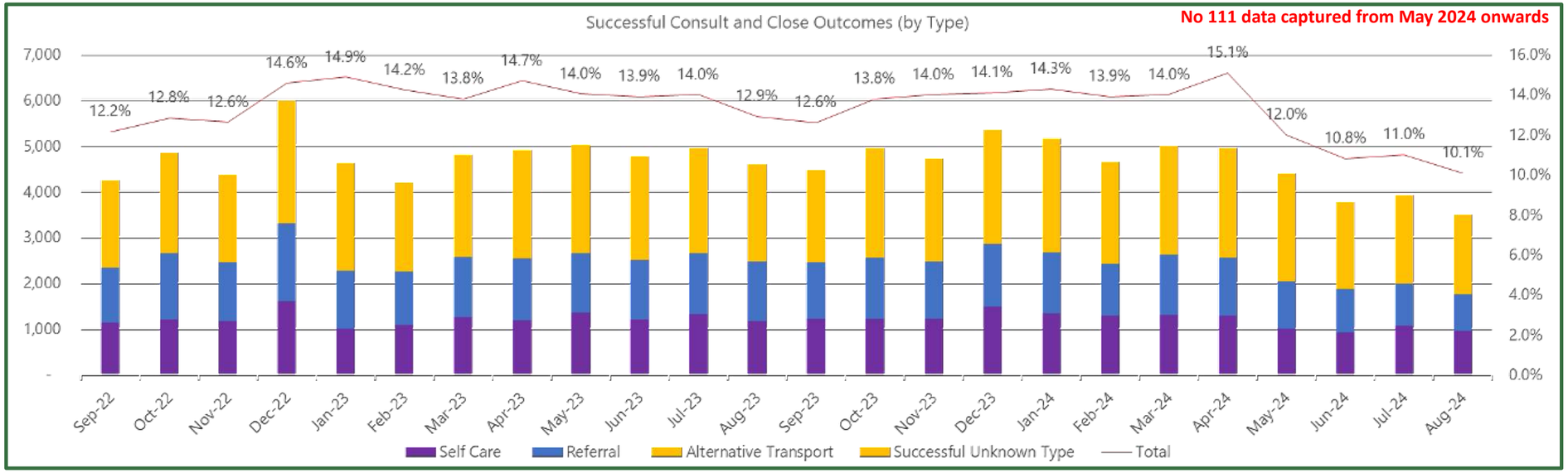
No performance trajectory is set at this time, as the Trust develops its measures and systems around these metrics. Once developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.

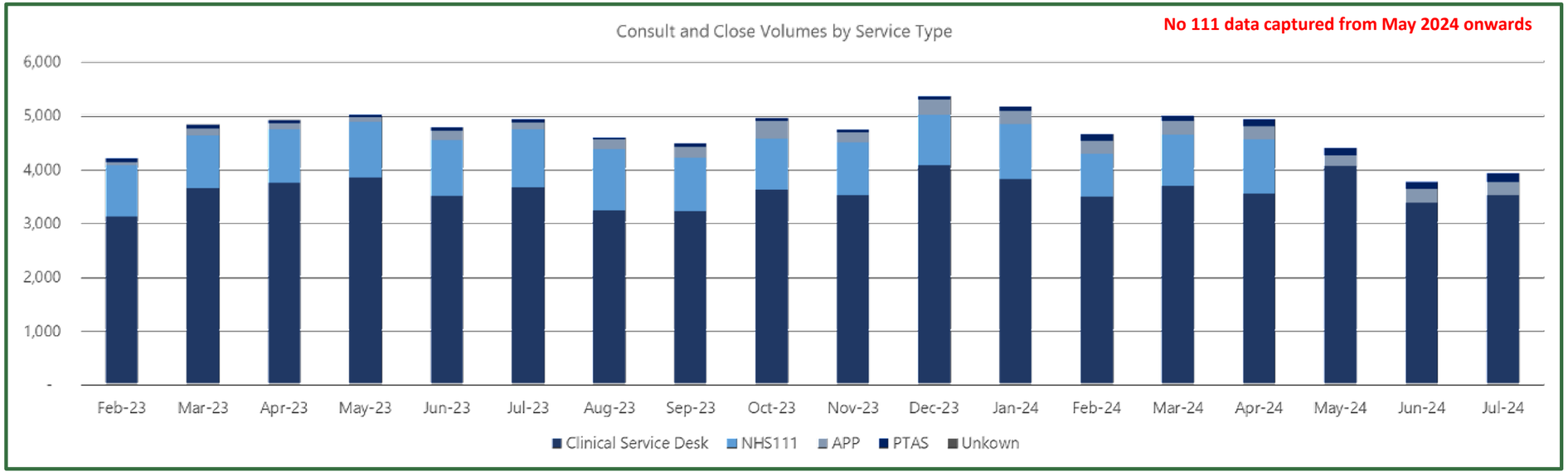
Partnerships / System Contribution
Consult & Close Indicators

(Responsible Officer: Lee Brooks)

C&C Outcomes

FPC





NB: Data quality issues have been identified in 111. These are currently being addressed.

Analysis

Consult and Close, with contributions from Clinical Service Desk (CSD) (9.2%), NHS111 (0%), WAST APP (0.5%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.4%) achieved 10.% in August 2024, remaining short of the 17% IMTP ambition. The number of 999 calls resulting in a Consult and Close outcome was 3,499, a decrease from 3,935 in July 2024.

**There is currently a reporting issue with the 111 contribution, which is incorrectly showing as 0%.*

Of the calls successfully closed in August 2024, 943 patients received an outcome of self-care; 806 patients were referred to other services (including to Minor Injury Units and SDEC) and 1,750 were advised to seek alternative transport services to acquire treatment.

Remedial Plans and Actions

- Work underway with HI to establish a quality assured data warehouse for all new 111CAS data and resolve 111 reporting issue.
- Recruitment of additional 28.5 FTEs into rapid clinical screeding for 24/25.
- Implementation of key aspects of the Clinical Model Transformation Programme before winter are expected to increase remote management

Expected Performance Trajectory

Further improvement is expected linked to CSD staff attendance (reduced abstractions and less vacancies). The ambition remains 17%.

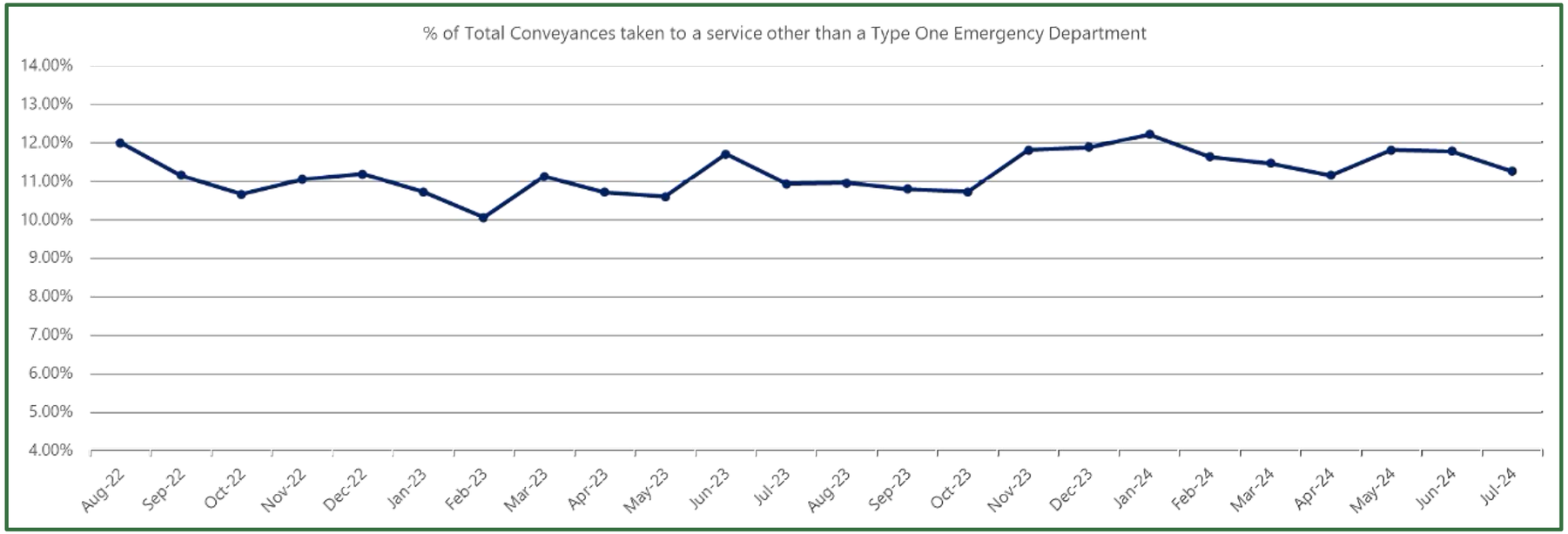
Partnerships / System Contribution
Conveyance to ED Indicators

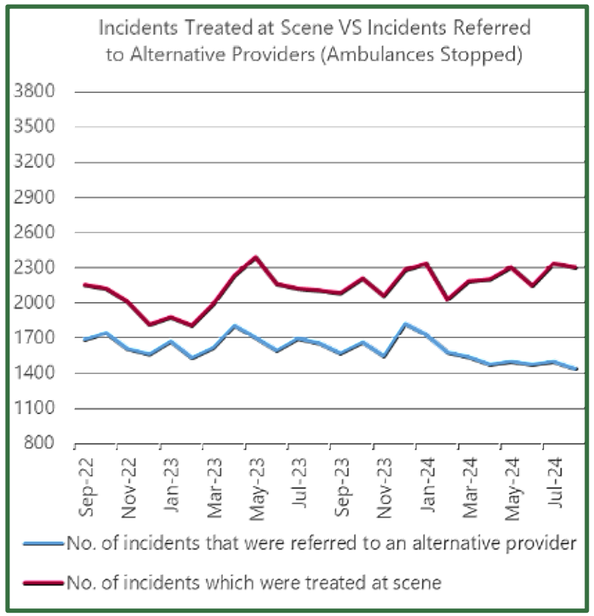
(Responsible Officer: Andy Swinburn)

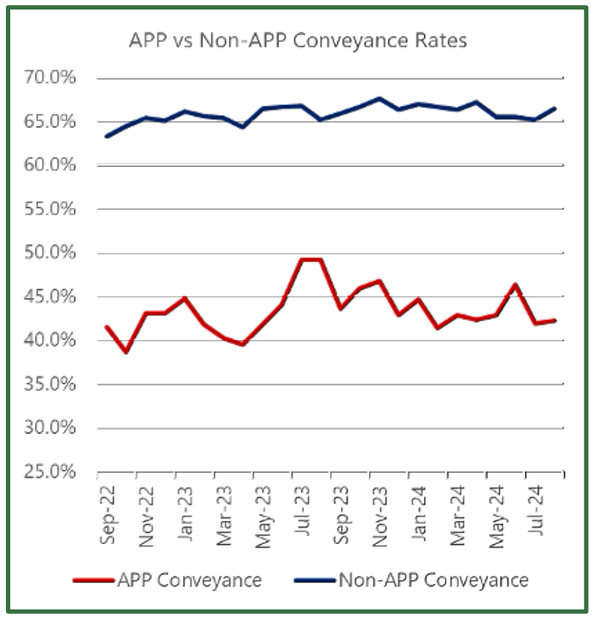
Conveyances
A

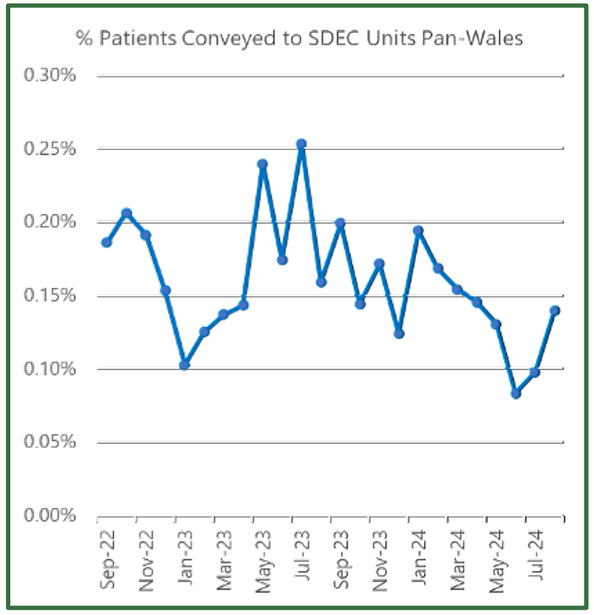
FPC

Ministerial Measure









Analysis

In July 2024 11.25% of patients (1,608) were conveyed to a service other than a Type One ED, while 35.5% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers decreased slightly, from 3,826 in July 2024 to 3,735 in August 2024.

APP conveyance rate was 42.2% in August 2024 and continues to experience a generally increasing trend since March 2023; however, data quality issues around accurately capturing APPs on shift is likely to be contributing to discrepancies in this figure.

Patients conveyed to SDEC's remained low at 0.14%.

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 an APP Recruitment Task & Finish Group, with focus on re-rostering to demand keys, improved placement (training) experience and 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 evolve its clinical model with health boards also significantly reducing handover e.g. 12,000 hours or 7,500 hours, alongside varying levels of investment. Further in year tactical modelling for spring and summer has been completed.

NB: Data quality issues have been identified in APP Data. These are currently being addressed.

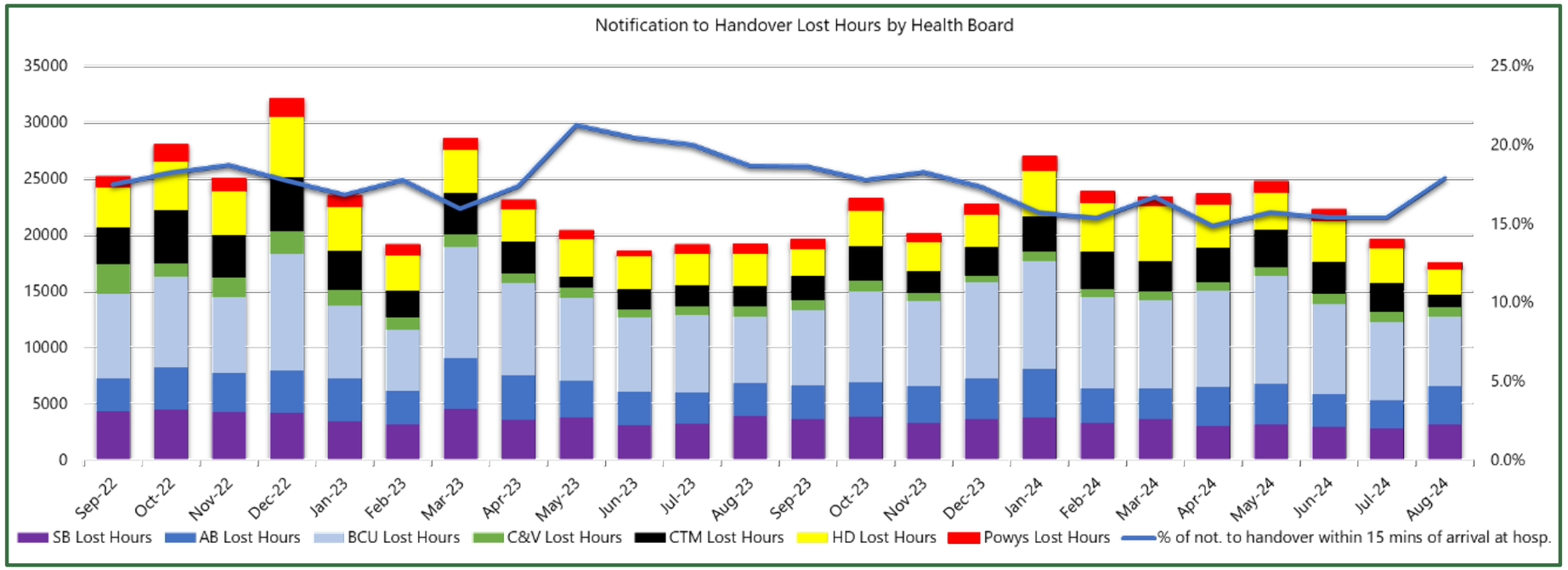
Partnerships / System Contribution Handover Indicators

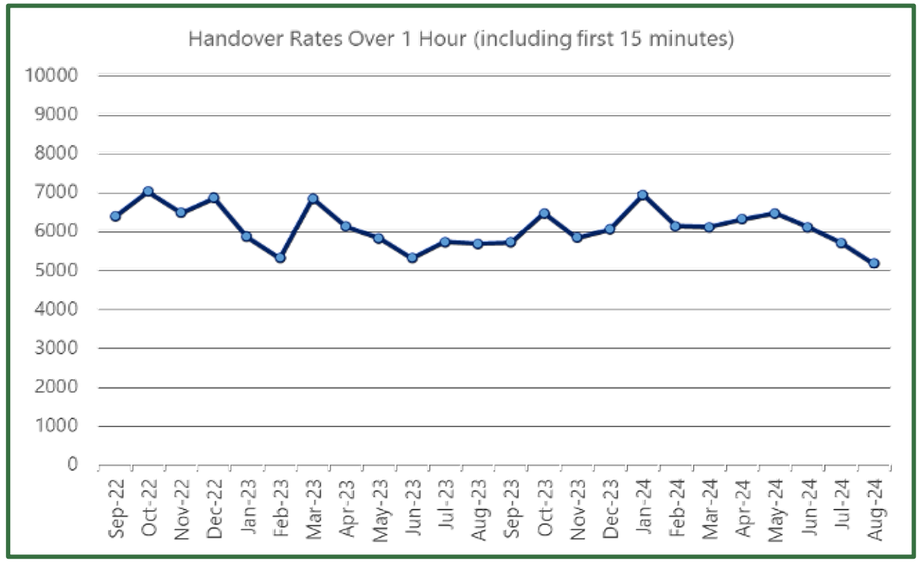
(Responsible Officer: Health Boards)

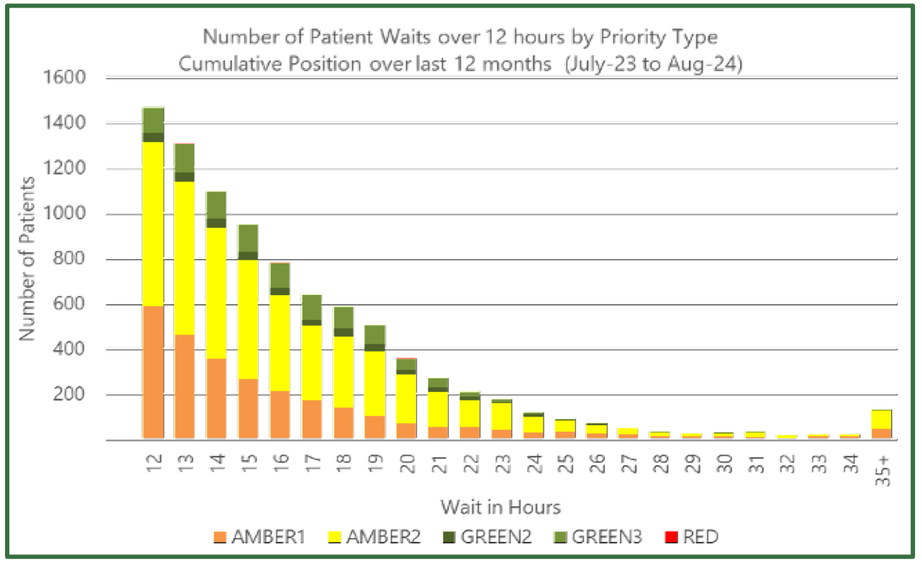
Lost Hours R

CI

QUEST







Analysis

267,820 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Sept-23 to Aug-24), compared to 283,018 over the same timeframe the previous year. There were 17,545 hours lost in August 2024. The August 2024 figure is 8.7% lower than the figure recorded in August 2023.

The hospitals with the highest levels of handover delays during August 2024 were:

- Grange University Hospital (ABUHB) at 3,279 lost hours
- Morriston Hospital (SBUHB) at 3,093 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 2,574 lost hours
- Maelor General Hospital (BCUHB) at 1,818 lost hours

Notification to handover lost hours averaged 566 hours per day during August 2024 compared to 632 hours a day in July 2024.

In August 2024, the Trust could have responded to approximately 5,535 more patients if handovers were reduced, which highlights the impact the numbers are still having on service.

In August 2024, 648 patients waited over 12 hours for an ambulance response. In July 2024 46 compliments were received from patients and/or their families.

Remedial Plans and Actions

Significant time has been spent by all Executives and non-Executives highlighting this patient safety issue to Commissioners, HBs and Welsh Government/Ministers, and this will continue through the year as we seek to influence and put pressure on the system to improve.

Expected Performance Trajectory

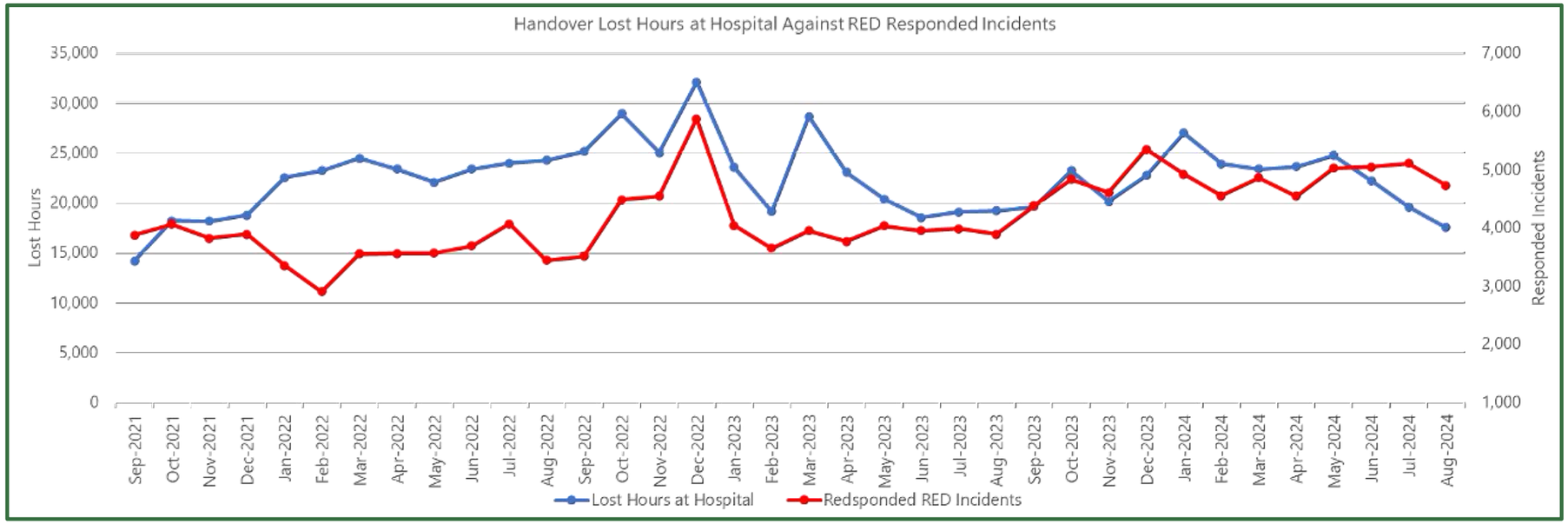
The Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,500 hours lost to handover delays per month. There would need to be a 60% reduction in current handover levels for this to be achieved.

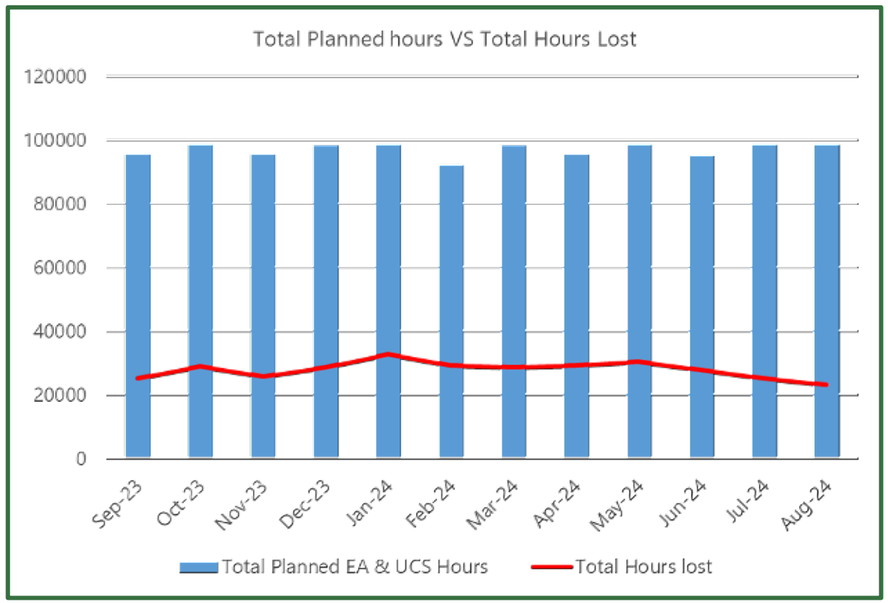
Partnerships / System Contribution

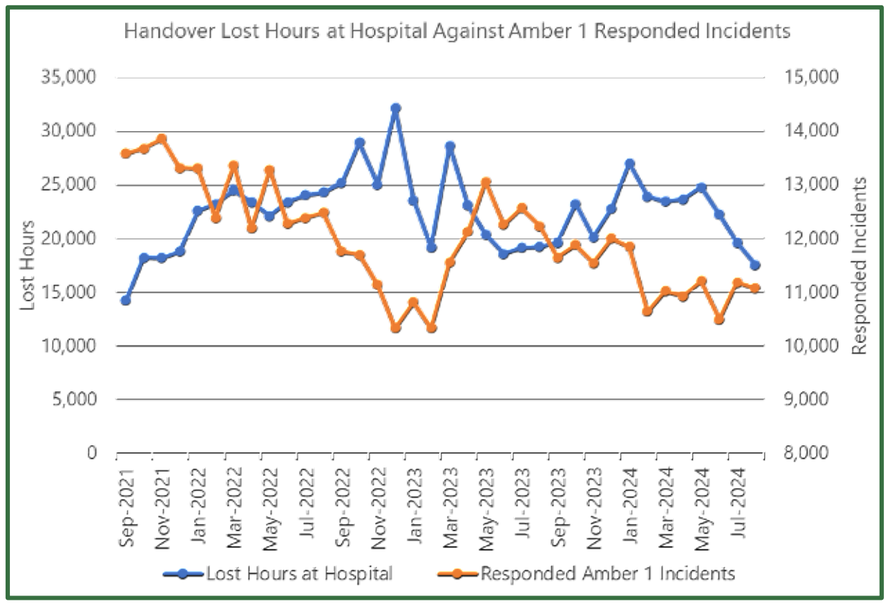
Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI QUEST







Analysis

The top graph highlights that as handover lost hours have increased since September 2021, so too have the number of Red incidents being responded to. This shows that when CSP is in periods of high demand and hospital handover increases, Red responses are protected, even during high pressure within the system.

However, as the bottom graph illustrates, as the response to Red increases, there is an impact on Amber 1 responses, particularly at times of high demand, such as during December 2022. During these periods, the number of Amber 1 incidents attended decreases, notwithstanding that some of these patients within the Amber 1 category will still be seriously ill.

The bottom graph also highlights the correlation between lost hours and Amber 1 performance. As lost hours increase, so Amber 1 performance declines.

Remedial Plans and Actions

Significant time has been spent by all Executives and non-Executives highlighting this patient safety issue to Commissioners, Health Boards and Welsh Government/Ministers, and this will continue through the year as we seek to influence and put pressure on the system to improve.

Expected Performance Trajectory

The Welsh Government target is that no patient handovers of more than one hour, which equates to 7,500 lost hours a month. Welsh Government want to see a 30% reduction by December 2024 as a move towards this target. The Trust is currently experiencing lost hours in excess of 17,500 hours, with handover in August 2024 8.7% lower than August 2023. Unless there is a material change in direction, the Trust is likely to see higher handover lost hours this winter than last.

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

Definition of Indicators

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

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

DIGITAL REPORTING - METRICS FOR DIGITAL SYSTEMS INFRASTRUCTURE

MEETING	Finance & Performance Committee
DATE	17th September 2024
EXECUTIVE	Jonny Sammut, Director of Digital Services
AUTHOR	Leanne Smith, Assistant Director of Digital
CONTACT	leanne.smith4@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report brings to the committee Digital Key Performance Indicators (KPIs) relating to Data & Analytics, ICT Systems, Digital services, projects & programmes, and progress against the recently refreshed Digital Plan (see **Appendix 1** for the KPI report).

2. The data in this report offers a full 12 months of historic data, and in-year trends from 1st April to 31st July 2024, unless otherwise indicated. August 2024 data is not included here due to the timing for submission of committee papers.

3. Key points of note from this report include:

   a. For the **Data & Analytics** metrics, the average turnaround time for non-trivial data requests has stayed consistent around 30 days for the past few months. This is due to the complexity of asks, and although the number of requests *completed* each month is also steady, the number of *received* requests has been higher for 7 out of the last 10 months, and so the backlog / queue continues to grow. If this trend continues, we will expect to see elongated turnaround times, and / or need to decline non-essential incoming requests.

   b. **Records Requests** continue to be received at a sustained high level – maintaining the trend of Q4 2023/24. Investment has been received which will allow the Health Informatics team to increase the number of Records Officers from 1.8 WTEs to 3.8, and recruitment process has commenced. Due to long term sickness within the Records team, compliance to the target is at risk, and many broader records management activities have

been on hold. Focus now shifts to reviewing the Records Management Policy to support the annual IG Toolkit submission and overall, Trust IG compliance.

c. The ICT **System Availability Metrics** show good performance across all critical systems for 2024/25 so far, except with a small dip in availability in July for 111 CAS due to an issue with the network solution PSBA (Public Services Broadband Aggregation), and again in August due to a new module installation which put strain on the server and temporarily prevented access. However, even with these issues 'up-time' was still above the UK industry standard of 99.9% for the period.

4. Service Provision:

a. The **ICT Service Desk** metrics show a gap in contribution from the Robotics Process Automation – this is due to a configuration change within the Service Desk platform (ServicePoint) which passes appropriate tasks to the robot. The impact can be seen in the significant increase in routine tasks such as password resets that instead had to be managed manually. A new IT service management system (known as House on the Hill) is currently in test and a swap from the current platform to the new tool is planned for Q3.

5. Digital's contribution to WAST's strategy and IMTP is monitored against the 5 pillars of the refreshed Digital Plan (namely: Everyday Essentials; Cyber, Security & Safety; Digital Pioneers; Transformation; and Data, Information and Insight), and those projects which were assigned to Tranche 1 (or year 1 of the IMTP). Most of these initiatives are still being scoped or are pending recruitment following the recent additional investment in Digital; however, some key points of note include:

a. A discovery project to help QSPE colleagues scope the process of, and requirements for, an **automated** audit tool is underway. In parallel, other RPA asks are being collated for prioritisation, and JDs are in development to enable us to recruit in-house automation specialists.

b. Efforts around **Data Sharing**, **IG Strategy** and **IG Improvement** are all ongoing, and following a successful (third) round of recruitment, two new Data Protection Compliance Managers are expected to join the Trust in November. As such, not all IG related efforts planned will be able to be completed in-year, and so some of the Data Sharing activities (such as development of an Information Sharing Policy, full review of the data sharing log, and full review of all existing data flows) will be postponed to Tranche 2.

c. The **PowerBI migration** initiative is the ongoing effort of transitioning our reporting and dashboards from Qlik to PowerBI to help modernise, streamline and secure our intelligence. This is on track to complete in September (as per set deadline for QlikSense licensing) despite challenges earlier in the year with Data & Analytics team's efforts being diverted to 111 CAS reporting. Communications and some user-guidance is planned to be published in the coming weeks, ahead of the decommissioning of the Qlik platform.

d. The installation of the MDVS solution across the existing **EMS & Ambulance Care fleet** is complete, except for a few remaining incoming vehicles. The Trust anticipate taking delivery of the remaining new NEPTS fleet, with arrangements already in place to install the new MDVS system once the vehicles are able to be made available to the project team.

Recommendation: The Committee are asked to NOTE the contents of the accompanying report and the trends in metrics presented.

KEY ISSUES/IMPLICATIONS
6. The Clinical Model Transformation programme will require significant input from various Digital teams – including those supporting on changes to CAD or other systems, DOS updates, and data, reporting and analytics for the proposed category, coding and process changes. These requirements were not known at the time of writing of the Digital Plan and so further adjustment to priorities and timelines ahead of Winter 24/25 is expected.

REPORT APPROVAL ROUTE
Digital Leadership Group – 4th September 2025

REPORT APPENDICES
Main report – 'Digital Reporting September 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.

Records Requests

Not including Police requests or ePCR processing

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

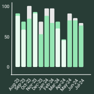
tbc

Metric to be developed

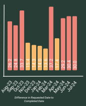
Warehouse availability

Metric to be developed

Information Requests Received vs Completed

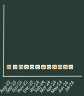


Turnaround for non-trivial tasks (avg days)



Difference in Requested Date to Completed Date

Total Data Load Failures



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

Digital: ICT Systems

System availability metrics

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

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

EMSC CAD C3 — System Availability %
2024/25: A M J J A S O N D J F M
2023/24: A M J J A S O N D J F M

999 EMS Telephony — System Availability %
24/25: A M J J A S O N D J F M
23/24: A M J J A S O N D J F M

NEPTS CAD Cleric — System Availability %
24/25: A M J J A S O N D J F M
23/24: A M J J A S O N D J F M
17/4/24 - LifeX system affecting SE NEPTS not able to radio vehicles as no call signs visible.

CSD ECNS Lowcode — System Availability %
24/25: A M J J A S O N D J F M
23/24: A M J J A S O N D J F M

ePCR Terrapace — System Availability %
24/25: A M J J A S O N D J F M
23/24: A M J J A S O N D J F M
Dec23: Users unable to login to Terrapace app due to database issue (supplier fix)

111 CAS — System Availability %
24/25: A M J J A S O N D J F M
23/24: A M J J A S O N D J F M
Jul24: PSBA issue caused connection to drop.
Aug 24: New Aqua 8 install caused server to run @ 100% preventing access

111 Telephony — System Availability %
24/25: A M J J A S O N D J F M
23/24: A M J J A S O N D J F M

Digital: Service Provision

Quality, efficiency, and stakeholder feedback: JULY 24

ICT Service Desk

0 Service Desk hours saved in March through use of RPA

July saw a significant increase in password resets compared to usual volumes, and a return to the more generic hardware / software requests in June and July compared to Cleric and MDVS specific asks in April and May.

Top 5 Jun + Jul Service Desk Requests

- Password Reset 528
- Hardware - laptop 99
- Distribution Group Change 73
- iPad functionality 42
- New starter 35

94% Incidents resolved within target

97% Requests resolved within target

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

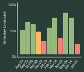
Records

RPA for PCR requests saved people hours in Jun + Jul **24**

Assumes 10 minutes per request

See Information Governance reporting for other Records Services metrics

HI Help Desk



Same day turnaround of 'quick' tasks **22%**

If non-quick tasks = 3 days on average to complete, then 90 requests = 2000 people hours, which would require >13 FTE analysts to complete each month.

Note: May saw over 85% turnaround same day, and 77% in June. Sustained levels of demand but during peak annual leave periods saw a drop in same day turnaround of quick tasks in July, however, it should be noted that a similar proportion and volume of all received tasks were completed in month as previous months.

111 Website

53% average engagement rate

Down from 59% in previous months despite stable visitor numbers

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

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

Digital Contribution 24/25

Everyday Essentials	Simplified Sign-on	pending recruitment
	Design Principles	not yet started
	Automation / RPA	IPC Audit Tool discovery
Cyber, Safety & Security	Cyber Awareness	not yet started
	Data Sharing	postpone to tranche 2
	Records Mngmnt	diesel data vault in progress
	IG Improvement	dependent on new starters
Digital Pioneers	Drones	Drone Wales Highway project
	NEPTS cancellations	not yet started
	111 Visual IVR	scoping
	Digital Innovation Lab	to be defined
Transformation	111 website	Business Case tbd
	e-Timesheets	pending recruitment
Data, Information & Insight	Data Warehouse	cloud exploration underway
	NDR Programme	1st = OHCA; 2nd = ePCR
	Data Literacy	1st = DOS guidance; 2nd = tbc
	Insight Catalogue	Review Cycle now established
	PowerBI migration	
	Data Quality Strat	recruitment; internal audit
	IG Strategy	dependent on new starters

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

RAG and progress based on LDP
Last updated 04/09/2024 by DLG

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

Specialist Operations Key Performance Indicators 2023/24

MEETING	Finance and Performance Committee
DATE	17/09/2024
EXECUTIVE	Lee Brooks, Executive Director of Operations
AUTHOR	Clare Langshaw, Head of EPRR & Spec Ops
CONTACT	Clare.langshaw@wales.nhs.uk

EXECUTIVE SUMMARY

1. Under the HART/SORT Service Level Agreement with Welsh Government, a report on the activities undertaken by WAST Hazardous Area Response Team (HART) and Special Operations Response Team (SORT) is submitted every quarter, and at the end of the financial year an annual report is submitted that provides an overview of the activities across the year.

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

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

4. The internal audit of HART recommended that the HART/SORT annual KPI is shared with the board on an annual basis. This report aims to achieve that requirement.

RECOMMENDED: That Committee RECEIVE and CONFIRM assurance upon receipt of the annual HART/SORT KPI reports.

KEY ISSUES/IMPLICATIONS
1. The activity over the previous 12 months, undertaken by WAST HART highlights that deployment of the unit has returned to pre-pandemic levels and is now being sustained at the expected levels. 2. SORT training and the numbers of SORT staff was low at the start of the annual reports period but has now been improved.

REPORT APPENDICES
Appendix 1 - WAST HART KPI Report Summary Q4 2023/24

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

1. **SITUATION**

1.1. The Trust maintains a Hazardous Area Response Team (HART) and a Special Operations Response team (SORT) capability which is funded through a Service Level Agreement (SLA) commissioned by the Welsh Government.

1.2. WAST receives an annual revenue budget of £2.923m (2023/24) and the SLA requires WAST to report on a quarterly basis on HART/SORT activity based on a number of metrics agreed with our commissioner.

2. **BACKGROUND**

2.1. The KPI report is based on reporting data collated from various sources including staffing, deployment, incident type, vehicle usage and resources.

2.2. Each set of quarterly data is not meant to be a comparison with the previous quarter or any other quarter and simply demonstrates the activity of the HART team during that period of time which is used to demonstrate how the funding is being spent.

2.3. The quarterly reports are submitted through the Senior Operations Team (SOT) with assurance through Senior Leadership Team (SLT) prior to submission to Welsh Government.

2.4. Following the HART internal audit in November 2022, it was recommended that the HART/SORT annual report was presented to the F&P committee for their awareness and noting

3. **ASSESSMENT**

3.1. Over the previous 12 months a number of areas have been monitored and reported upon through the quarterly reports.

3.2. The number of HART operatives has remained at good levels with recruitment having taken place to fill any vacancies as needed. A number of short-term secondments have been facilitated and this has included supporting the national NARU training unit.

3.3. Since the closure of Q4, when we had 131 SORT operatives, recruitment has uplifted the number to the current 138 at the end of Q1 2024/2025. Recognised lower numbers in Q1 across Southeast have improved as part of focussed recruitment resulting in an increase from 37 operatives to 49 with a target of 50 per region.

3.4. HART activity is an area that the quarterly reports focus upon. Q1 showed that the activity HART was below historic levels, however Q3 and Q4 have seen a sustained level of activity that reflects the levels seen before the pandemic.

3.5. The training hours delivered by external and internal trainers has remined consistent and reflects the dedicated training hours the HART operatives require to maintain their core competencies. The Trusts' recognition of the importance of the training hours has supported this to be achieved.

3.6. HART has maintained a clinical element to the unit and continues to support EMS within a radius of the HART base. The number of clinical incidents the unit has responded to has remained consistent with Q4 seeing an increase in the number of calls attended.

3.7. Annual summary information is submitted for assurance to Committee, confirming there is nothing to raise by exception and to demonstrate that the Trust has complied with Welsh Government reporting requirements.

RECOMMENDED: That Committee RECEIVE and CONFIRM assurance upon receipt of the annual HART/SORT KPI reports.

Welsh Ambulance Services NHS Trust — **Q4 Jan - March 2024**

WAST Specialist Operations KPI report

Date team went live: **July 1st 2012**

Personnel in post - please quote WTE	**Target**	**Achieved**	**Notes**
Total number of operatives & Operational Managers currently appointed to HART (out of 42)	42	42	
No. paramedic operatives	42	42	
No. technician operatives	0	0	
No. paramedic Operational Manager - HART	7	7	
No. female operatives		8	
No. female Operational Manager - HART		2	
Admin Support	2	1	
Locality Manager Specialist Operations	1	1	
HART Training Manager	1	1	

Turnover - please quote WTE		
No. current operative vacancies	0	
No. current Operational Manager - HART vacancies	0	
No. of persons who have left in the previous quarter	3	
No. of persons who have joined in the previous quarter	3	

Absence -Jan - March inc		
No. of time HART staffing has dropped below 4	0	
No. hours absence due to work related ill health/injury	408	
No. hours absence due to other ill health/injury	1115.01	
No. hours unauthorised absence	3	
No. hours authorised absence (special leave / compassionate / study etc)	13	
No. WTEs who have been on maternity/paternity leave during quarter	0	
No. WTEs who have been on secondment during quarter	3	

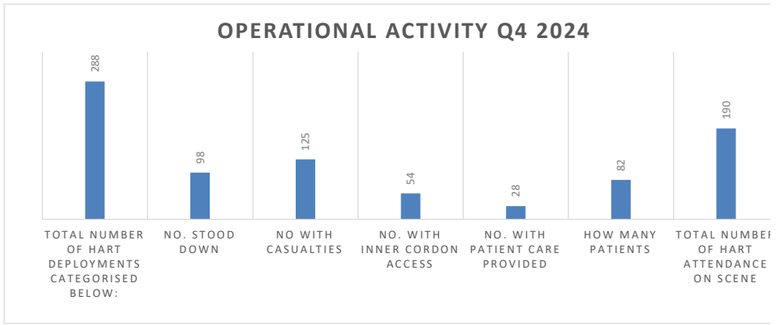
Operational Activity Jan - March inclusive		
Total number of HART deployments categorised below:	288	*Deployment = a job allocated and team member(s) mobilised. Any calls that indicated potential need for HART capabilities - inc. bariatric calls.*
No. stood down	98	
No with casualties	125	
No. with Inner Cordon access	54	
No. with Patient care provided	28	
How many patients	82	
Total number of HART attendance on scene	190	
Number of reported Clinical Support Incidents [CSI]	142	

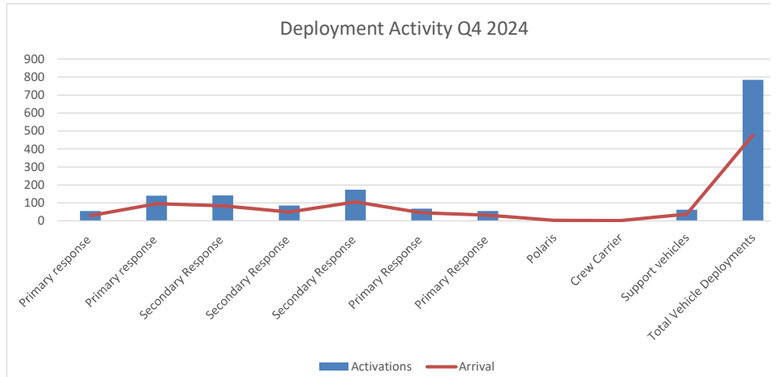
Deployment Activity by Vehicle Jan - March inclusive	**Activations**	**Arrival**	**Call Sign**
Primary response	54	29	WH51
Primary response	140	95	WH52
Secondary Response	141	84	WH14
Secondary Response	85	49	WH11
Secondary Response	174	105	WH12
Primary Response	68	44	WH61
Primary Response	54	31	WH71
Polaris	6	3	WH41
Crew Carrier	1	1	WH31
Support vehicles	62	38	WS02/03/WH81/ws13/ws12
Total Vehicle Deployments	**785**	**479**	

Training Jan - March inclusive		
No. of ongoing training hours delivered (not national courses)	2862.75	
No. of training hours delivered - national courses	450	
No. of ongoing training hours cancelled (not national courses)	115.5	
No. of local multi-agency exercises attended	6	TATA Steel Teir 1 Site x 6
No. of national multi-agency exercises attended	0	

Accidents/Untoward Incidents - Jan - March inc		
No. of SAIs reported & investigated	0	
No. of **RIDDOR** [Reporting of Injuries, Diseases and Dangerous Occurences Regulations] reports	1	Rich Brown - Fractured Leg whilst Training SRT

Special Operations Response Team (SORT)	**Target**	**Achieved**	**Notes**
No. of SORT Supervisors in post	3	3	
SORT Staff in North	50	47	
SORT Staff in C&W	50	47	
SORT Staff in SE	50	37	





Date Range: 01/01/24 to 31/03/24
Vehicle Selection: WH11, WH12, WH14, WH31, WH41, WH51, WH52, WH61, WH71, WH81, WS03, WS05, WS12, WS13
Region is based on the control where the call was entered into the Computer Aided Despatch System.

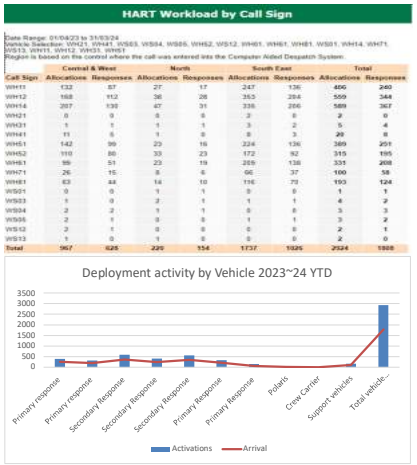
	Central & West		North		South East		Total	
Call Sign	Allocations	Responses	Allocations	Responses	Allocations	Responses	Allocations	Responses
WH11	30	18	12	10	43	21	85	49
WH12	54	37	15	11	105	57	174	105
WH14	53	31	12	10	76	43	141	84
WH31	1	1	0	0	0	0	1	1
WH41	3	2	1	0	2	1	6	3
WH51	25	15	6	5	23	9	54	29
WH52	52	38	18	15	70	42	140	95
WH61	24	14	6	6	38	24	68	44
WH71	15	10	5	4	34	17	54	31
WH81	16	11	3	3	38	21	57	35
WS03	1	0	1	1	0	0	2	1
WS05	1	1	0	0	0	0	1	1
WS12	1	1	0	0	0	0	1	1
WS13	0	0	1	0	0	0	1	0
Total	276	179	80	65	429	235	785	479

Skillset total by region		
CBRNe	*SFR*	*AIT*
47	25	34
47	32	34
37	32	32

All Wales Totals	
EPISHUTTLE	82
AIT Total	100
CBRNe Total	131
SFR Total	89

Training Compliance	
EPISHUTTLE	62%
AIT	77%
CBRNe	100%
SFR	68%

Welsh Ambulance Services NHS Trust	April 2023 to March 2024	Full Year	
WAST HART KPI report			
Date team went live:	**July 1st 2012**		
Personnel in post - please quote WTE	**Target**		**Notes**
Total number of operatives & team leaders currently appointed to HART (out of 42)	41		
No. paramedic operatives	39		
No. technician operatives	2		
No. paramedic team leaders	7		
No. USAR trained paramedics	39		
No. female operatives	6		
No. female team leaders	2		
Admin Support	1		
Manager	1		
HART Trainer	1		
Other (please state in Notes column)	1		Stores person
Turnover - please quote WTE			
No. current operative vacancies	0		
No. current team leader vacancies	0		
No. personnel who have left HART since appointments for this team began	20		
No. of personnel who have left in 2023-2024 reporting period	2		
Absence in reporting period			
No. shifts where < 4 on duty	0		
No. hours absence due to HART work related ill health/injury	538.29		
No. hours absence due to other ill health/injury	5724.49		
No. hours unauthorised absence	26.5		
No. hours authorised absence (special leave / compassionate / study etc)	115.8		
No. WTEs who have been on maternity/paternity leave during past 12 months	0		
No. WTEs who have been on secondment during past 12 months	3		
Operational Activity 2023 -24 reporting period			
Total number of HART deployments categorised below:	1112		Deployment = a job allocated and team member(s) mobilised. Any calls that indicated potential need for HART capabilities - inc. bariatric calls.
No. stood down	363		
No with casualties	697		
No. with Inner Cordon access	231		
No. with Patient care provided	344		
How many patients	479		
Total number of HART attendance on scene	750		
Deployment Activity by Vehicle 2023 -24 reporting period	**Activations**	**Arrival**	**Call Sign**
Primary response	389	251	WH51
Primary response	309	195	WH52
Secondary Response	589	367	WH14
Secondary Response	406	240	WH11
Secondary Response	559	344	WH12
Primary Response	331	208	WH61
Primary Response	147	58	WH71
Polaris	20	8	WH41
Crew Carrier	5	4	WH31
Support vehicles	169	108	WS02/03/WH81
Total vehicle deployments	2924	1783	**61.0%**
Training 2020 -21 reporting period			
No. of ongoing training hours delivered (not national courses)	10168.75		39.25 hours per week for 6 staff times 13 weeks
No. of training hours delivered - national courses	1163		
No. of ongoing training hours cancelled (not national courses)	115.5		
No. of local multi-agency exercises attended	10		
No. of national multi-agency exercises attended	0		
Accidents/Untoward Incidents - 2020 -21 reporting period			
No. of untoward incidents reported	0		
No. of SUIs investigated	0		
No. of RIDDOR incidents	1		



Special Operations Response Team (SORT)	**Target**	**Achieved**	**Notes**
No. of SORT Supervisors in post	3	3	
SORT Staff in CW	50	47	Remained static since last recruitment Awaiting the SORT enhancement uplift alinged to Opt 12
SORT Staff in North	50	47	
SORT Staff in SE	50	37	

Skillset of total		
CBRNe	*SFR*	*AIT*
47	32	34
47	25	34
37	32	32

All Wales Totals					Training Compliance	
EPISHUTTLE	82				EPISHUTTLE	62%
AIT Total	100				*AIT*	77%
CBRNe Total	131				*CBRNe*	100%
SFR Total	89				*SFR*	68%

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

Integrated Medium Term Plan (IMTP) Delivery/Assurance Progress Update

MEETING	Finance & Performance Committee
DATE	17th September 2024
EXECUTIVE	Rachel Marsh - Executive Director of Strategy, Planning and Performance
AUTHOR	Alexander Crawford - Assistant Director of Planning and Transformation Heather Holden – Head of Transformation
CONTACT	Heather.holden@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of this paper is to provide Finance & Performance Committee with an update on IMTP delivery and assurance following approval of revised arrangements for 2024-27. The revised arrangements were presented to Strategic Transformation Board (STB) on 8th July, with approval to transition the existing IMTP Delivery Programmes into the revised structure, distinguishing between the Strategic Transformation portfolio, delivered through a Trust-wide Clinical Model Transformation (CMT) programme, and the wider Directorate-led IMTP portfolio.

2. This paper provides a progress update on the CMT programme and the Directorate-led IMTP portfolio, including the Ministerial (now Cabinet Secretary) Priorities set by Welsh Government. It also sets out the performance and outcomes metrics that should determine 'what good looks like' in delivering the IMTP over the next three years in Appendix 3.

RECOMMENDED:
That the Finance & Performance Committee:

1. **Notes the CMT programme delivery and assurance arrangements and progress update;**
2. **Notes the Directorate-led IMTP delivery and assurance arrangements and progress update and advises whether this gives sufficient assurance to the Committee and onwards to the Board;**
3. **Notes the reporting against performance and outcomes measures linked to IMTP delivery and advises whether the Committee is assured by the way this is presented in the paper; and**

4. **Notes the update against the Cabinet Secretary's priorities set out in the 2024-27 planning framework.**

KEY ISSUES/IMPLICATIONS

The WAST IMTP for 2024-27 was approved by Trust Board on 28 March 2024 and submitted to Welsh Government the same day. Welsh Government approved the IMTP subject to accountability conditions on 9 August 2024. The accountability conditions set out the following:

- Continue with the development of the clinical model, liaising with wider services including health boards, to provide the evidence base and impact expected;
- Continue to derisk the financial assumptions in the plan to secure the organisation's position; and
- Ensure delivery is maintained against the commitments within the plan, including ensuring the availability of the detail behind the plan is available if needed.

This report will set out in detail how the Clinical Model Transformation programme has been established to deliver our commitment to refreshing the current clinical model and how the wider IMTP is being delivered through a directorate led approach. Our plan set out a break even position with a savings target in excess of £6m. The Trust continues to focus on delivery against its savings target and remains cognisant of its role in supporting efficiency across the NHS in Wales and continues to work with Health Boards at a local level on joint plans to deliver improvements in care for patients and efficiencies.

Clinical Model Transformation (CMT) Programme

The CMT programme has been formally initiated and the first CMT Board convened on 29th July to consider updates against the Phase 1 priorities, and next steps to embed a robust programme delivery and assurance structure. The Terms of Reference for the CMT Board were developed and approved by STB on 19th August, and all former IMTP Programme Board meetings have been stood down. These will be replaced by CMT Workstream Boards from w/c 9th September, with a strong focus on key intervention points in the patient journey, with objectives aligned to our overall strategic vision for integrated care.

The overall status of the programme is **YELLOW** (cautionary) indicating that the programme is on track, but that challenges are anticipated in some areas due to the scale and complexity of planned changes.

Directorate-led IMTP Portfolio

A new IMTP Delivery and Assurance framework has been developed and approved by STB. The revised approach to IMTP delivery and assurance will see a transition of existing IMTP Delivery Programmes into a single, cross-organisational Clinical Model Transformation (CMT) Programme. The transition will be supported by a strengthened, consistent approach to the cyclical development of Directorate Local Delivery Plans (LDPs), with Directorate-led projects and initiatives being managed through existing business meetings.

The Planning Team has been working with Directorates to ensure there is clarity over where delivery is within the CMT or directorate level plans, enabling assurance through directorate plans to the CEO and STB and enabling a structured approach to planning through the Integrated Planning and Development Group (ISPD).

With the focus on transition to the new delivery structures and priority placed on the actions within the CMT that will support operational delivery this winter, but also some due to external factors, there are a number of deliverables at directorate level which are **AMBER** (in progress, off track). However, there are a number of key pieces of work progressing well, including (but not limited to) the approval of the Trust's new Digital Plan (i.e. **COMPLETE**) and progress, on track (**GREEN**), of our Health and Wellbeing Plan, Quality Plan, maturity of our requirements under the Duties of Quality & Candour, integrated governance structures and risk management transformation.

REPORT APPROVAL ROUTE
Strategic Transformation Board 19th August 2024

REPORT APPENDICES
Appendix 1 - IMTP Delivery Assurance Report **Appendix 2 - Assurance against the Cabinet Secretary's priorities 2024/25** **Appendix 3 – IMTP Performance Overview**

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

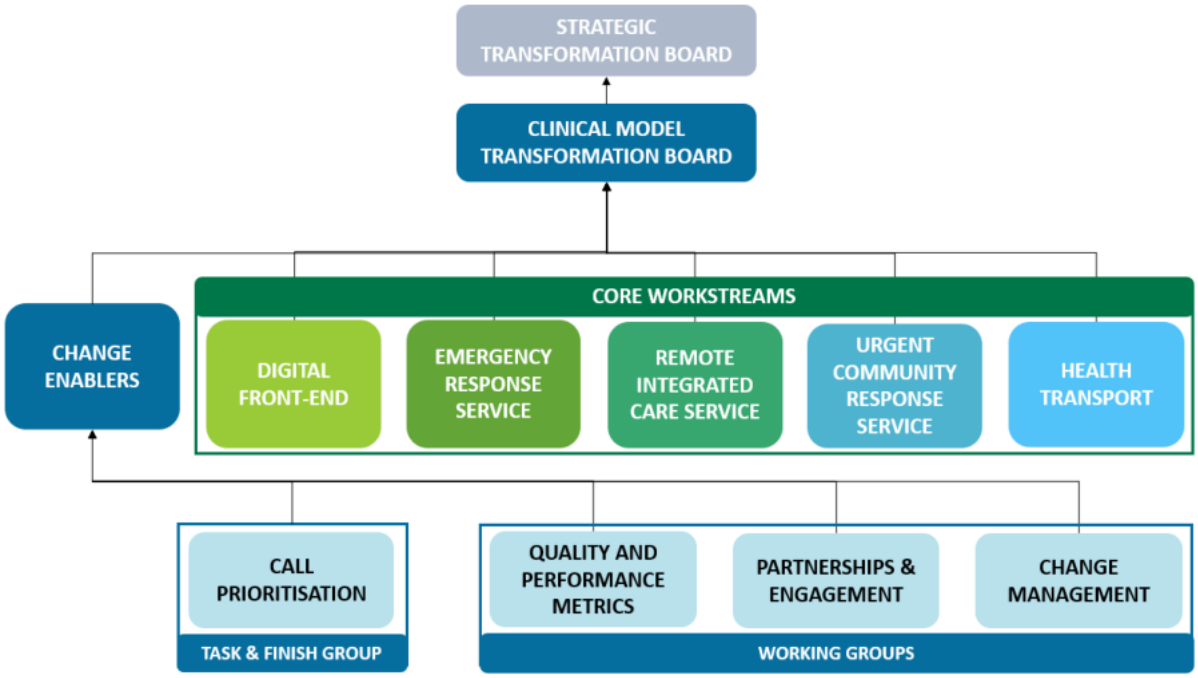
Appendix 1 - IMTP Delivery Assurance Report

Situation

The purpose of this paper is to provide Finance & Performance Committee with an update on IMTP delivery and assurance following approval of revised arrangements for 2024-27. This SBAR sets out the Clinical Model Transformation Programme progress, directorate led IMTP delivery and our assessment against ministerial priorities. The SBAR also includes a performance overview setting out the key indicators of 'what good looks like' as described in the IMTP this year.

Background

Clinical Model Transformation (CMT) Programme Delivery & Assurance Approach



1. The CMT programme is structured around five core workstreams reporting into an overarching CMT Board (formerly Transformation Steering & Assurance Group), providing a forum for holistic oversight, prioritisation, and vision setting.

2. Underpinning the programme are several enabling groups with a focus on internal and external change readiness, performance and evaluation, and on collaborative working to develop revised call flows, enhancing categorisation based on clinical need.

3. The CMT Board will meet 6-weekly, aligned to STB, with informal CMT Executive Programme catch-ups at fortnightly intervals between Boards.

4. A CMT Board cycle-of-business is in development to ensure the timely flow of information through the CMT structure.

5. The Audit Wales Structured Assessment for 2023 published in February 2024 included a recommendation to "provide better clarity on whether the actions delivered have achieved the intended impact." Whilst we have an MIQPR which sets out what has been done and is being done around the performance metrics reported to Committee and Board, we have been cognisant of the need to link the delivery of the IMTP set out above to existing but also emerging metrics which were set out in the plan. The IMTP set out a number of 'what good looks like' statements in each area of the plan and this will form the basis for how we link delivery to impact going forward, without duplicating the reporting already set out in the MIQPR. We have included this below. There are still gaps where data is currently unavailable or needs to be developed. Furthermore the 'what good looks like' statements and metrics align to the service lines and strategic objectives set out in the IMTP and not the programme workstreams in the Clinical Model Transformation Programme. However we ask the Committee through this paper to confirm that the approach taken provides greater assurance that we now have line of sight between IMTP delivery and outcomes.

CMT Programme Management Progress Update and Next Steps

6. The CMT programme has been formally initiated and the first CMT Board convened on 29th July to consider updates against the Phase 1 priorities, and next steps to embed a robust programme delivery and assurance structure. Fortnightly CMT Executive catch-ups have also commenced, providing a touchpoint for issue escalation and executive steering.

7. The Terms of Reference for the CMT Board were developed and approved by STB on 19th August. The group performs a dual function, bringing together Executive Sponsors and Senior Responsible Owners (SRO) from across the CMT workstreams and working groups into a single forum to deliver executive steering from those accountable for delivery, and operational, clinical, and wider specialist leadership from those responsible for delivery.

8. CMT Workstream Boards have been formally initiated from w/c 9th September, operating as the main assurance route for projects and sub-groups with responsibility for change delivery.

9. A detailed CMT programme transition plan has been developed with the Transformation Support Office (TSO) and is being overseen by the Head of Transformation. The transition plan ensures that the Project Path Framework is applied across the CMT programme, delivering a consistent approach to project governance. **Note:** documentation is being developed in increments, prioritising development of project controls and initiation documentation during Q2.

10. Workstream plans are being developed across the five core workstreams, including identification of key milestones to enable effective progress monitoring. These will be consolidated into a single CMT programme plan for presentation to the CMT Board on 27th September.

11. A CMT Programme Vision session will be facilitated at the next CMT Board to consider the development of our CMT 'brand' and the vision statement for our future model including a meaningful name for the programme and model.

CMT Workstream and Enabling Working Group Updates

CORE CLINICAL MODEL TRANFORMATION (CMT) WORKSTREAMS	
DIGITAL FRONT-END	**↓ Yellow**
Yellow (cautionary status): Rapid decision is required on short-term funding to enable plan to progress, and funding discussions are progressing internally. A formal project group has been established and a plan developed for Phase 1, proposing several rapid enhancements to the front-end digital offer including simple Chatbot integration for common health advice topics, improvements to the websites interface, system checker and general content. A short-term funding paper was presented to STB on 16/09, including recurrently funded posts to support short and long-term website development. The paper is currently under review with the Executive Director of Finance and Corporate Resources due to a shortfall in funding.	
RAPID CLINICAL SCREENING	**↑ Green**
On Track: Planning assumptions around recruitment, training, and onboarding of the Clinical Navigators are now back on track for go-live w/c 13/11, following delays in the Job Evaluation Panel process. Clinical Navigator recruitment is now progressing and has generated a good volume of applicants and interest to date. Shortlisting for the Clinical Navigator role is planned for 02/09 with clinical assessment scheduled for 09/09 – 10/09, and interviews scheduled for 11/09 – 12/09, and 17/09 – 18/09.	
URGENT COMMUNITY RESPONSE SERVICE	**↔ Yellow**
Yellow (cautionary status) overall: Advanced Clinical Practice Delivery Group (ACPDG) is currently reporting as **AMBER** due to long-standing challenges to the implementation of Independent Prescribing and clinical supervision arrangements for APPs, however an appraisal relating to APP Clinical Supervision has been considered by Senior Operations Team (SOT) and Senior Leadership Team (SLT), with agreement to create a Senior APP position from existing Band 8a paramedic prescribers. The paper was not formally approved by SLT due to several issues requiring further consideration, however there was support for the creation of the Senior APP role, proposed changes to the job description for independent prescribers, and the proposed professional accountability and line management arrangements, marking a positive step forward in resolving the complexities around APP Clinical Supervision. Development of a Mental Health Response Vehicle (MHRV) model is currently reporting as **YELLOW.** A three-phase approach to roll-out of the MHRV model has been agreed in principle and Phase 1 (pre-Winter) recruitment is underway, however the key delivery risk relates to recruitment timelines and	

potential slippage of EMT recruitment and 2FTE Mental Health Practitioners recruitment. A formal project group has been established to take this work forward, including planning and identification of funding for Phases 2 and 3.

The APP scheduling project is progressing well and has now completed three PDSA Test of Change cycles; learning continues to inform iterative development of APP scheduling to support optimisation of APP tasking.

Outcomes: Turning the dial

In the IMTP we set out what good would look like for 999 callers over the next 3 years. These workstreams within the Clinical Model Transformation more or less cover what is currently the traditional 999 response, and the IMTP set out that the following metrics would determine the positive impacts of our plan:

- 65% red target
- Reducing unmet demand by half
- Doubling the number of patients safely managed at home or in the community
- An increase in ROSC rates

At this stage, the timing of implementation of the actions within this plan together with external factors mean that these areas haven't yet seen the anticipated improvements across these four metrics.

Further actions are being delivered at directorate level on IMTP deliverables to:

- **Fully roll out CHARU** across Wales – this is now at 75% recruited as at the end of July
- Implement the **new structures in EMSC** – an OCP document was issued in July, and a project team stood up to implement

The detail can be seen in Appendix 3.

REMOTE INTEGRATED CARE SERVICE	**↔ Yellow**

Yellow (cautionary status) overall: Internal funding has now been identified to enable testing of the technology enabled care solution, Luscii, however the Connecting Support Cymru project is off-track overall due to external delays in the Business Case decision. A 1-month phased testing plan has been agreed for Luscii utilising internal Clinical Support Desk (CSD) resource as a short-term measure, and a 'Remote Monitoring Clinician' role has been appointed through the EOI process (commencing in post from 21/08).

The Integrated Clinical Model Development group has made significant progress, surpassing early expectations on the pace of operational alignment between 111 and the CSD. This is an ambitious and complex project with c. 10x Task & Finish Groups focusing on operational readiness including process and policy alignment, digital infrastructure, audit, performance monitoring at a team and individual level, and clinical supervision and mentorship.

An Integrated Care Navigator (ICN) post has been agreed by the Operations Senior Leadership Team (SLT), for a 1-month trail commencing in October. The ICN is designed to improve patient care coordination, streamline operations, and enhance health outcomes by acting as a liaison between various departments including the CSD Duty Operations Managers (DOMs), and 111 services.

An Integrated Care Planning Desk trial is planned for Winter and will explore remote clinical monitoring of complex patients that would benefit from observations through technology enabled care to appropriately manage their care needs. The trial is currently being planned for go-live in November and will provide an opportunity for evaluation to inform the potential longer-term establishment of an Integrated Care Planning Desk function.

The Call Handler Development Group has completed a trial of Clinical Prioritisation Streaming System (CPSS) – 111 call handling system)) use for the management of Green calls originating in 999. The trial was completed in July, with positive outcomes as to the appropriateness of CPSS for low-acuity calls, and a further trial is planned for early-September to strengthen evidence to inform longer-term evaluation.

Outcomes: Turning the dial

In the IMTP we set out what good would look like for 111 callers over the next 3 years. The RICS workstream within the Clinical Model Transformation more or less cover what is currently the traditional 111 response (noting that the CSD element of Integrated Care is covered above), and the IMTP set out that the following metrics would determine the positive impacts of our plan:

- 111 Call Abandonment Rate
- Improved patient satisfaction
- Increase in calls closed with no follow up required
- Increased proportion of next steps booked for the patient

At this stage, the timing of implementation of the actions within the transformation programme has focussed on the Clinical Support Desk element of Integrated Care. However, there are actions within the IMTP focussed on 111 website improvement, pathways and skill mix which should start to turn some of the dials. Call abandonment rate remains challenging as delivery of the IMTP action to implement a new CAD system settled in Q1. However, patient satisfaction with the service has improved and more calls are being 'stopped at source' than the same period last year. We are continuing to develop metrics on direct booking and we are working on data linkage to follow patient journeys to monitor the outcome of 111 or 999 calls closed not resulting in attendance in other parts of the system.

Further actions are being delivered at directorate level on IMTP deliverables to:

- Implement a **new clinical leadership team** for remote clinical assessment - in process of recruiting clinical navigators and locality manager

The detail can be seen in Appendix 3.

HEALTH TRANSPORT	**↔ Green**

On Track: New 'MTPS' Transfer Protocols went live in the EMS CAD on 31/07 with positive feedback from Emergency Medical Dispatchers.

Following the NEPTS Collaborative Planning Event in April, a Vision Setting event was held by Joint Commissioning Committee (JCC) on 10/07 to support the strategic development of Ambulance Care.

A specification was approved for a further short piece of ORH modelling to support Transfer and Discharge service development. A new phone number to support single point of access for interfacility hospital transfers is now live. The change has been communicated to Health Boards and usage will be monitored.

Outcomes: Turning the dial

In the IMTP we set out what good would look like for users of Ambulance Care services. Whilst the programme for Health Transport continues to develop and whilst commissioners and WAST work to develop a new vision for non-emergency transport and Ambulance Care services, operational improvements and some of the IMTP delivery actions are contributing to the following metrics:

- Timeliness
- Fewer on the day cancellations
- Inter-site transfers provided within the time required
- Increased patient satisfaction

Ambulance Care continues to perform well on timeliness, including in Oncology journeys where improvement has been seen. However actions to improve on the day cancellations are not yet driving the improvement required. Having implemented MTPS through the Transfer and Discharge project we should now be able to improve understanding on the nature and urgency of transfer demand and the resources required to complete them in a timely manner and enable reporting of metrics to support 'what good looks like'.
Patient satisfaction is mixed, and IMTP actions around process efficiency and roster alignment are anticipated to improve satisfaction around waiting times for transport. However, it should be noted the survey response was small.
The detail can be seen in Appendix 3.

CHANGE ENABLING WORKING GROUPS	
CALL CATEGORISATION	**↔ Green**

On Track: Significant progress collaboratively developing revised call flows, and enhanced categorisation based on clinical need. Workshops convened on 02/08 and 22/08 and arranged for 23/09.

A four-phase approach has been proposed for safe introduction of revised call categorisation, prioritising those changes necessary to enable the introduction of a Rapid Clinical Screening function in mid-November. Phase 1 will be reviewed by the DCR group on 04/09.
Engagement with commissioners and external partners is ongoing with indicative support for the proposal, but formal approval and governance routes will need to be confirmed. An SBAR has been developed for consideration by the fortnightly CMT Executive Programme catch-up (02/09) and will inform a subsequent paper to the Joint Commissioning Committee (17/09) and Trust Board (26/09).

QUALITY & PERFORMANCE METRICS	**↓ Yellow**

Yellow (cautionary) status: Significant HI work related to revised call categorisations will need to be carefully managed.

Structured interviews are in progress with CMT Workstream SROs to scope HI requirements and a project plan will subsequently be developed informed by Workstream plans.

Initial metrics mapping is underway aligned with revised call flows from the Call Categorisation Task & Finish group and is being reviewed with Ops Transformation leads.

A Programme Benefits Workshop has been arranged (17/08) to review Logic Models for Rapid Clinical Screening, RICS, and UCRS and to agree outcome/benefit measures.

CHANGE MANAGEMENT	**↔ Green**

On Track: The Change Management approach was presented to CMT Board with support to initiate the working group. Terms of Reference have been finalised and the first meeting is scheduled for 09/09.

A dedicated Siren page has been established for our Clinical Model Transformation and a series of videos developed showcasing the work being undertaken during Phase 1, and the longer-term vision for our clinical model.

Additionally, recognising the scale of change to implement a Remote Integrated Care Service (RICS), bespoke internal RICS communications have been agreed, including a fortnightly 'Roundup' and special edition video featuring the Clinical Navigator role to encourage internal applications, and to increase awareness and engagement with remote clinicians across Integrated Care.

PARTNERSHIPS & ENGAGEMENT	**↔ Green**

On Track: Two half-day development sessions have been convened (12/08 and 20/08) to focus on the development of the external engagement plan (stakeholders and patients). The updated Engagement plan will be presented to CMT Board on 16/09.

The groups Terms of Reference are in development and arrangements are being embedded including development of the RAID log.

A paper is in development for submission to the JCC (17/09) outlining plans for the Clinical Model Transformation, particularly priority call categorisation work.

Directorate-led IMTP Delivery & Assurance Approach

12. IMTP deliverables outside the scope of the Clinical Model Transformation programme will be managed through Directorate Plans (Local Delivery Plans, (LDPs)), noting that some actions may still require cross-directorate working.

13. Existing Directorate Business Meetings will be utilised, and assurance will be provided to the Strategic Transformation Board and onward to the Committee and Board.

14. This process will be facilitated by the Integrated Strategic Planning & Development Group (ISPD), formerly Integrated Strategic Planning Group (ISPG), with summary updates from Directorates to the group. This will also support with the cycle of strategic planning. Updates by exception will

subsequently be incorporated into quarterly AAA reports to STB, providing status updates on the IMTP deliverables and escalating any key risks/issues or achievements.

15. The current update in this paper is an interim quarter 2 position, with the end of quarter position being available to Committee and the Board in November.

Our People

IMTP Objective	IMTP Actions / Deliverables Q2	Progress / RAG
Capability	• No specific milestones in Q2 • Ongoing work: People Development plan, People Management Essentials and PADR check ins	• Ongoing
Capacity	• Delivery of Strategic Workforce Plan (Q1 milestone) • Ongoing work: Health & Wellbeing Plan, Retention work plan, eTimesheets	• Plan was presented at People & Culture Committee where it was endorsed on 30.08.2024 and will be presented to the Board on 26.09.2024
		• Ongoing work progressing towards Q4 deadlines, albeit there may be some delay on eTimesheets due to the complex nature of the work and the need for project team capacity to undertake the work. • Paper going to ELT in Q3 to progress project team/working group approach to eTimesheets
Culture	• No specific milestones in Q2 • Ongoing work: Allyship and Bystander training, Employee offer, Culture Champions & Change Network, impact of culture toolkit	• Ongoing work progressing towards Q3 & Q4 deadlines
Strengthen Welsh Language compliance	• Welsh language standards baseline established • Recruitment strategy developed to attract and evaluate candidates based on their Welsh language proficiency	• Developed and approved by PCC on 30/08/24. • Ongoing – will form part of the Workforce Strategy

Outcomes: Turning the dial

In the IMTP we set out what good would look like for Our People, by monitoring the following metrics:

- Sickness absence below 6%
- Turnover rates falling
- Engagement rates (measured for example by NHS Staff Survey completion)
- Regular check ins with managers
- More colleagues join WAST internal staff networks

Sickness absence is coming down, but remains above 6% and fluctuates with seasonality. Staff turnover rates are falling and at the lowest rate since 2021. Disappointingly the staff survey completion rate was only

23.2% but this was indicative of a low rate across NHS Wales and measures are in place through our People & Culture plan to address engagement further.
Metrics for regular check ins with staff have not yet been established, however PADR rates have been used as a proxy in this report. These rates are improving but still remain below the target set for the organisation.

The detail can be seen in Appendix 3.

Our Digital Roadmap

Objective	IMTP Action/Deliverable	Progress / RAG
Develop & agree digital plan	Q2 Refresh plan against five cornerstones below: • Everyday essentials • Security, Safety & Cyber • Digital Pioneers • Transformation • Data, Information & Insight	**Complete**. Plan signed off at July Trust Board.

Outcomes: Turning the dial

The digital plan is key to turning the dial on the following metrics:

- No successful cyber breaches
- Reduced numbers of helpdesk calls and better rate of first call resolution
- Increase in the number of scaled up technology projects
- Increased confidence in using data
- Increased levels of patient and staff satisfaction with digital solutions

Whilst some of this data is available there is further work now that the digital plan has been approved to ensuring the data is available across all metrics to show the impact of the plan. We intend to bring these metrics through in future reports.

Our Infrastructure

IMTP Objective	IMTP Actions / Deliverables Q2	Progress / RAG
Developing and implementing our plans for Environmental Sustainability and Adaptation*	• No Q2 milestones • Delivery of EFAB funded schemes through year	Reported through Decarbonisation Programme Board, CMG and F&P (as summaries)
The right buildings in the right place, enabling our staff to provide the best and safest care across Wales	• Prioritised estates capital schemes delivered through year and across IMTP years	Reported through Capital Management Board to ELT, timelines impacted by AWC prioritisation process.
The right fleet in the right place, enabling our staff to provide the best and safest care across Wales	• Prioritised fleet capital schemes delivered through year and across IMTP years	Reported through Capital Management Board to ELT. Fleet SOP development underway

* Adaptation sits with SP&P on behalf of ADLT

Partnerships & Engagement

IMTP Objective	IMTP Actions / Deliverables Q2	Progress / RAG
Meet the requirements of the Wellbeing of Future Generations Act	• No specific Q2 milestone – delivery of wellbeing objectives published by end Q4	• Group to be convened to develop wellbeing objectives by end of Q2
University Trust Status in collaboration with WG, embracing a 'democratised culture' of learning, research and innovation	• Academic Partnership priorities updated and published	• Paper going to next APC at start of October
Well-placed to influence system thinking/strategy development	• Structured engagement commenced with stakeholders & public	• Partnerships & Engagement workstream established for Clinical Model Transformation Programme, and a framework for relationship management with Health Boards and key stakeholders being developed by Assistant Director of Planning & Transformation • RPB engagement continues with WAST on 6 out of 7 RPBs with a seat around table at GASP in Gwent

The Engagement Framework and CMT Engagement plan ar key to turning the dial on the following metrics:

- Improved reputation scores
- Stakeholder support for our strategic plans
- Increasing number of research projects
- Increased levels of alternative (to core commissioning) funding streams

Whilst some of this data is available there is further work to ensuring the data is available across all metrics to show the impact of the plan. We intend to bring these metrics through in future reports.

Quality Driven and Clinically Led

IMTP Objective	IMTP Actions / Deliverables Q2	Progress / RAG
High quality, immediate or timely on scene assessment, care and conveyance where needed.	• Employ 16 APPs completing masters	• Of 18 MSc students applied 11 have passed interviews to be recruited. • An additional 11 external/self-funded APPs so 22 in total have been recruited for the year. • The Consultant Paramedic Advanced Practice and her team are reaching out those who didn't apply to see if they still want to continue with this career path. The Trust have agreed to only fund them for one further year

		and after that funding will stop if they do not apply in the next year.
Systems that meet the requirements of the Duty of Quality and Duty of Candour A culture of quality improvement with robust quality management systems	• Establish a Quality Improvement Hub	• Life QI purchased and implemented within small number of teams including (EMSC, Quality Directorate and Remote Care). • Projects are being tracked and supported. • Meetings held with Transformation team to identify opportunities to utilise software for transformation tracking of PDSA test of change data.
High quality Putting Things Right, Safeguarding and Health & Safety systems	• Implement bespoke training materials	• Framework in development. • Working across the Trust to understand current processes. To undertake training - date to be arranged.
Meaningful engagement and co-production with communities	• CIVICA enhancement	• Report completed Surveys in CIVICA to Welsh Government • Launched the SMS Text Service • Some ongoing IG issues and awaiting agreed DPIA

We are currently refreshing both the Clinical Plan and the Quality Plan for the Trust. We will seek to turn the dial on the following metrics:

- Duty of Candour compliance
- Increased number of patient outcomes reported
- Increased evidence of meaningful public and patient engagement
- Increased opportunities for out people to progress their clinical practice and career

Whilst some of this data is available there is further work to ensuring the data is available across all metrics to show the impact of the plan. We intend to bring these metrics through in future reports.

Well Governed

IMTP Objective	IMTP Actions / Deliverables Q2	Progress / RAG
A risk management framework as a key enabler of our long-term strategy and decision making	• No milestones for Q2 – implementation of Strategic BAF by end of Q3	• Ongoing – Strategic BAF template in hand – meeting with peers, developing paper on handling plan for Sept ARAC.
An integrated governance Framework	• Governance structures mapped out	• Ongoing – presentation of the map at ADLT on 30/09 planned

Value & Sustainability

IMTP Objective	IMTP Actions / Deliverables Q2	Progress / RAG
Developing and implementing our plans for Environmental	• Establish a cross-organisational Adaptation Planning group (Q1 Milestone)	• Delayed. Awaiting national toolkit from WG to progress, but discussed at ADLT on 02.09.2024. Agreed attendance

Sustainability and Adaptation		at national Adaptation Planning event in October before convening Adaptation Planning Group internally within WAST. Reset Milestone to Q3.
Sustainable savings & efficiencies	• Service Review across the Trust completed with recommendations by Q2	• Business area summaries have been produced for each service line, with a report due at ELT on 02.10.2024
Generate income alongside our core commissioned functions	• Develop commercial strategy based on outcome of market analysis exercise in Q2	• Timescale affected by recruitment of a commercial lead for the Trust – to be re-profiled • However, a small group is being stood up to provide executive oversight of commercial strategy

RECOMMENDED:

That the Finance & Performance Committee:

1. **Notes the CMT programme delivery and assurance arrangements and progress update;**
2. **Notes the Directorate-led IMTP delivery and assurance arrangements and progress update and advises whether this gives sufficient assurance to the Committee and onwards to the Board;**
3. **Notes the reporting against performance and outcomes measures linked to IMTP delivery and advises whether the Committee is assured by the way this is presented in the paper; and**
4. **Notes the update against the Cabinet Secretary's priorities set out in the 2024-27 planning framework.**

Appendix 2

Assurance against the Cabinet Secretary's priorities 2024/25

5. 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 and cancer, but also 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 where they align to the national 6 goals priorities. Therefore we will aim to reduce the burden and duplication of reporting through our assurance mechanisms into STB and the Committee.

6. The following table sets out the key areas for WAST against the priorities, and the milestones to be achieved in quarter 2 (interim position).

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Progress
Primary and Community Care, with a focus on improving access and shifting resources into primary and community care	111 Skill Mix	• Group established to consider and develop scope for 111 MDT skill mix	• Scoping paper to commissioners	• As an interim position, the paper is not yet with commissioners.
	111 Pathways	• Dental access improved in 4x health boards by end of Q4 • Strengthened links into primary care / Out of Hours in. Urgent Primary Care Centre access by end of Q4 • Medicines management pathways in place by end of Q4		• Modelling being undertaken for 3 remaining Health Boards to take on dental access pathways • Currently piloting in BCU and C&V direct booking into Urgent Primary Care Centres
	999 Pathways: Falls & Frailty	• Level 1 falls - Assessment of the demand & capacity modelling undertaken • Level 2 falls - Undertake evaluation of our existing services	• Presentation of L1 options and benefits • Present evaluation and options for sustainability of L2 services going forward	• Contract for level 1 extended, pending a re-tender • Discussion taken place with 6 Goals Clinical Professional Advisory Group and the deliverables will be reframed as part of wider CMT work

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Progress
	999 Pathways: Digitised pathways	• Evaluate the effectiveness of the new digital solutions to make referrals to existing pathways and usage	• Develop further opportunity for digital notifications with Welsh portal	• A new digital transformation and innovation programme has been set up to manage and prioritise digital workstreams that fall outside the clinical transformation programme – this is progressing
	999 Pathways: Connected Support Cymru (CSC)	• Recruitment of key roles to support CSC delivery (dependent on outcome of business case) • Commenced recruitment of internal volunteers • Testing 'ambulance in a box' in Care Homes in AB & BCU, evaluate and conclude forward plan	• Engaging with key stakeholders and evaluating overall project data to determine resource requirements moving forward • Commencement of recruitment and on-boarding on external partner organisations and ongoing recruitment and onboarding of internal volunteers • Developing technology enabled care community pathways up until end of Nov; testing in Care Homes in AB & BCU and in patients homes • Evaluate and conclude forward plan	• Six Goals clinical review of CSC business case was not as positive as hoped and view from Six Goals Board that technology enables care needs a consistent national focus • Aneurin Bevan Health Board has decided not to progress with the testing in Care Homes due to competing priorities with Six Goals programme delivery • 10x Care homes live in BCU with technology in situ to support testing. Engagement to date with care homes has been positive • Recruitment and On-boarding: • 55 Active CWRs within the community (30 active teams). • 30 CWRs trained pending activation (e.g. awaiting mentorship/equipment). • 30 CWRs onboarded and awaiting training course • A mixed method approach to evaluation is ongoing with quality improvement PDSA cycles for tests of change; observational studies to determine patient, system and population/health economy impact; and Modelling to determine

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Progress
				scalability and sustainability of the solution • Difficulty progressing recruitment of partnership organisations due to management capacity (which is unfunded) so currently on hold
Urgent and Emergency Care, with a focus on delivery of the 6 goals programme	Goal 2: New 111 System	• Full implementation of new CAS system 30th April • Decommission old system	• Realise benefits in line with business case	• CAS system implemented on time - complete
	Goal 2: 111 website & symptom checkers	• Scoping exercise to review requirements of a 111 website – and develop options appraisal accordingly	• Development of business case • Review and develop requirements to improve symptom checkers, with potential requirement for procurement.	• External review of the NHS 111 Wales website is complete, and the full report submitted to WAST Executives with SBAR to discuss the options presented. • Update of short term proposal agreed internally, with some additional work needing to be completed around financial and other resources.
	Goal 2: 111 re-roster	• No Q1 milestone	• Agreement with commissioners to proceed	• Review of rostering practices. Agreement from commissioners to commence Review of rostering practices. Procurement process ongoing
	Goal 3: • Develop the remote clinical assessment speciality • Develop a fully remote working clinician offer (operations/training/digital) • Develop Pre-Dispatch Outcome Risk Stratification	• Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report	• Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report	• These are key deliverables in the Clinical Model Transformation Programme. See assurance report in appendix 1

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Progress
	Tools linking CAD & ePCR data • Roll out of new integrated (111/clinical support desk) care model • Connected support Cymru • Extend use of video/ phone consultation • Urgent On-Scene Community Response			
	SDEC Pathways	• Re-establish ICAPs with Health Boards (subject to JCC commissioning arrangements) • Complete data quality assurance of end destination in CAD to ensure SDEC direct referrals fully captured	• Implementation of SDEC criteria across WAST	• This is now under goal 4. WAST is now part of the Goal 4 delivery group and will develop its own 6 goals delivery plan reflecting actions to improve referrals into SDEC from clinicians on scene. Actions around SDEC activity largely sit with Health Boards within their 6 goals delivery and a framework has been developed by the 6 goals team setting out referral from remote and on scene clinicians into SDEC. WAST will continue to engage and respond to requests to work collaboratively to improve uptake of direct referrals to SDEC.
	Goal 4: CHARU	• Complete CHARU recruitment by end Q2 • Improve utilisation rate to modelled benchmark by end Q2 • (work ongoing during Q1)		• 75% actual to establishment as at the end of July. Steering Group established to oversee recruitment and utilisation
	Goal 4: Rural variation	• Complete CHARU recruitment by end Q2 • Continue process of targeted recruitment and process of smoothing i.e. aligning SIP to establishment by end Q2 • Build rurality results from 2023 EMS Demand & Capacity Review by end Q2 • Agree Implementation Plan with commissioners by end Q2		• Recruitment in rural areas remains challenging. • We are focussing EMT recruitment in rural areas where there are gaps.

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Progress
				• Completed D&C review and shared with commissioners. • Formal implementation plan for D&C not yet in place but we have incorporated findings into our current ongoing IMTP delivery plans.
	Goal 4: Sickness reduction in EMS and EMSC	• Ongoing continuation of managing attendance and implementation of the health and wellbeing plan throughout year		• Work on managing attendance continues and engagement is ongoing to develop the next iteration of the Trust's Health & Wellbeing Plan
	Goals 5 & 6: Transfer and Discharge model	• Engagement on modelled options for transfer services with health boards commenced • Implementation of new MTPS protocols within the Computer Aided Dispatch (CAD) system designed to allocate transfer resources more effectively	• Development of reporting against new protocols within the CAD post MTPS implementation • Agree outline service model for further engagement with Health Boards. • Develop business case/principles for All Wales service. • Develop business case for 24/7 Major Trauma Desk following outcome of Gateway 5 review.	• Further modelling being finalised to strip out specific services which may skew the data and focus on clinical demand anticipated to be completed Mid September • A review of the model needs to now be considered in the context of the Clinical Model transformation as part of the Health Transport and Emergency Response workstreams • MTPS implemented, single telephone point of access implemented. • MTPS dashboards developed for key data, further development of dashboard to further enhance ongoing.
Planned Care and Cancer, with a focus on reducing the longest waits	Roster review of NEPTS Ambulance Care Assistants	• Continue with NEPTS Demand & Capacity work, in particular, undertake NEPTS transport roster review by end Q3		• Contract let with third party providers, may need to review timescales in Q3 but we are committed to delivering this efficiency
	Enhanced hub for oncology patients	• Establish expected outcomes & principles to develop enhanced oncology service	• Develop action plan to deliver the required change	• Continued working group to establish role of the hub to support the three oncology centres. Creation of draft SOP/Core working practice between

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Progress
				liaisons and Hub. Consultation with Oncology Centres to identify of improvements.
	Quality assurance of external providers	• No specific milestone in Q1	• Welsh Ambulance Quality Standard award implemented	• Ongoing
Mental Health, including CAMHS, with a focus on delivery of the national programme	Develop and implement a referral pathway for 111 Press 2 teams	• Completion of 111 CAS system implementation to aid improvement in 111 press 2	• New CAS system will provide resolution to Press 2 pathway	• CAS implementation complete • Review with health boards effectiveness of press two and where there is opportunity to improve
	Mental Health Response Vehicles	• Collating and presenting evidence from pilot within AB, discussing outcomes and options for further pilots	• Undertake further pilot (pending agreement) • Continuing to engage with national evidence across UK	• See assurance report in appendix 1 – this forms part of the Clinical Transformation Programme
	Right Care Right Person	• Engaging with Police Services in Wales, NHS partners, Local Authorities and third sector providers on changes affecting response to people in crisis	• Assess impact to WAST • Possible update to 2023 EMS Demand & Capacity Review results.	• Modelling can be undertaken but requires further clarity on the likely level of activity
	Mental Health Practitioners in CSD	• 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)	• Share plan with commissioners for further discussion	• See assurance report in appendix 1 – this forms part of the Clinical Transformation Programme

Recommendation: That the Finance & Performance Committee:

- **Notes the update against the quarter 2 milestones in the action plans to meet the Cabinet Secretary's priorities set out in the 2024-27 planning framework and our approved IMTP.**

Welsh Ambulance Services University NHS Trust

IMTP Performance Update

August 2024

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

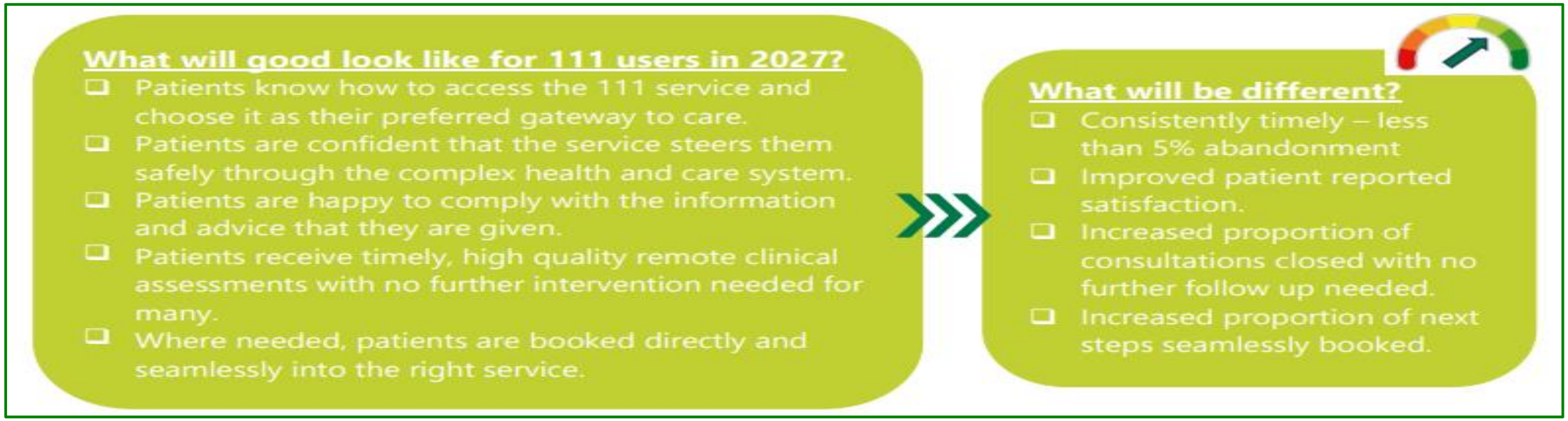
Version 1.0
Released: August 2024

by Commissioning & Performance Team

4.2 Emergency Medical Services (EMS) – 999

Performance Overview	RAG Rating
During quarter 1 2024/25, 46.8% of **Red calls were responded to within 8-minutes**, which was below the 65% target. This was also a reduction from the 54.1% achieved during quarter 1 2023/24. The ability to achieve the 65% target is still being negatively impacted by the high number of lost hours being recorded outside Emergency Departments as well as a sustained increase in Red demand over the past 2-years. The actual number of Red incidents being attended within 8-minutes has increased by 8.9% (n=191) in June 2024 compared to June 2023, but Red demand increased by 27.8% over the same period.	
Unmet EMS demand is defined by the Trust as **patient cancellations and clinical safety plan (CSP) "can't sends** reducing to the levels seen in the 2019 EMS Demand & Capacity Review. In the first four months of 2024/25 there were 39,994 cancellations and "can't sends" compared to 32,400 in the same period last year i.e. they have increased, not gone down. The 2023 EMS Demand & Capacity Review modelled the current levels returning to pre-pandemic levels, which equates to a 50% reduction. Achieving this reduction is dependent on the Trust's transformation of the clinical response model and a reduction in handover lost hours to 7,500 hours.	
During quarter 1 2024/25 12.6% of patients were managed via **Consult and Close** with a further 17.1% of patients responded to being managed via See and Treat, with no requirement for a conveyance of any kind. Over the same period 69.8% of patients required a conveyance of some type. This compares to 14.2% for Consult and Close and 17.0% See & Treat during quarter 1 2023/24. During that quarter, 69.9% of patients were conveyed. This highlights a similar level of performance when comparing quarter 1 year on year, with little change in the overall picture. The Trust's clinical model transformation is the strategic response to these metrics.	
ROSC rates for quarter 1 2024/25 were 17.9%, which was a slight reduction from the 19.5% achieved during quarter 1 2023/24. They also remain below the ROSC rate ambition of 25-30%. The main factors that directly influence this metric are response times, bystander resuscitation and response type/numbers. The Trust has a Clinical Indicator Improvement Plan in place, which has been submitted to commissioners.	

4.1 NHS 111 Wales



Performance Overview	RAG Rating
The **111-call abandonment rate** for quarter 1 2024/25 was 14.2%, higher than the 5% target. The target was achieved in 8 of the 12 months during 2023/24 with figures in recent months being affected by the rapid transition onto the new 111 CAD system, which resulted in training capacity having to be diverted to train existing staff and away from training new recruits. This has led to a reduction in call handlers in post, which has impacted performance. Recovery plan in place, with recovery planned in time for winter.	
During July 2024, **111 patient survey data**, showed that 88% of people 'found the 111-service useful', 90% said 'they complied with the advice provided' and 78% said 'they would consider using the service again'. This data was based on just 13 responses during the month, with proactive work ongoing to increase the number of people who take part in completing the survey.	
The number of **111 calls 'stopped at source'** in quarter 1 2024/25 was 16,292, or 9.2% of the total calls for that period. This was an improvement on the 11,812 closed with no further follow up in quarter 1 2023/24, which equated to 7.1% of the total calls into the service. The expectation is that the new 111CAS will further improve performance as it beds in.	
This ambition is largely dependent on WG's future vision for the 111 service. WG are due to issue a quality statement this year, which will help the Trust understand what WG's policy vision is for 111, but the Trust expects it to be supportive of direct booking by 111 into other parts of the health care system in Wales. The Trust is currently part of **a Six Goals Programme pilot of Direct Booking Urgent Primary Care Centres**. The trial commenced in Feb 24 in BCU and C&V. Trial ongoing.	TBC

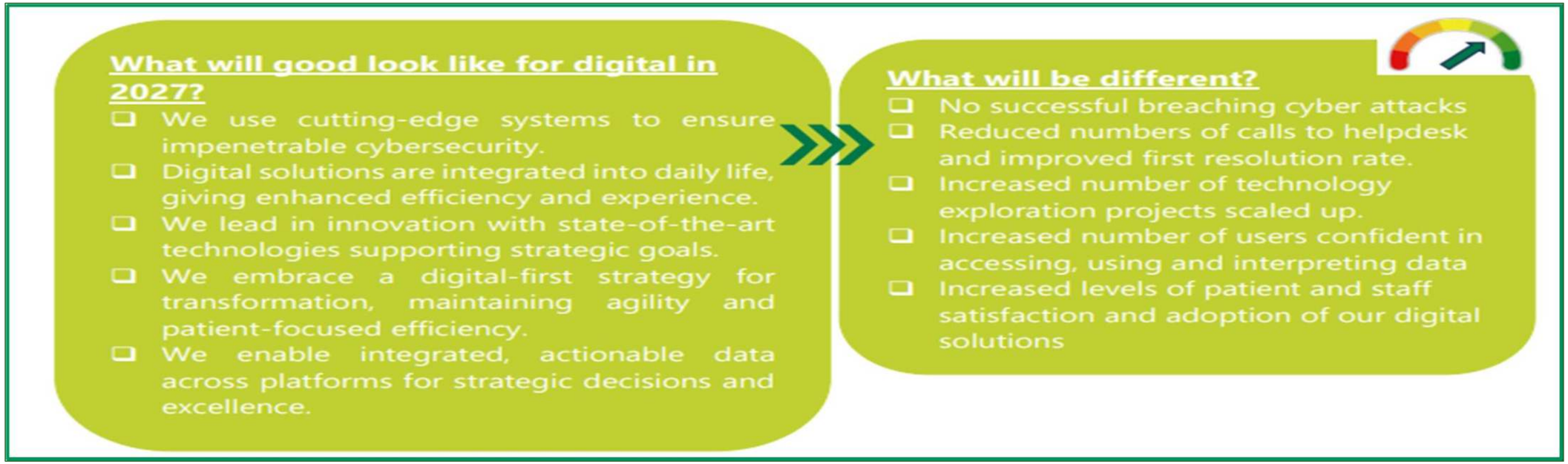
4.3 Ambulance Care

Performance Overview	RAG Rating
Targets on timeliness continue to perform well within Ambulance Care, with Oncology journeys for quarter 1 2024/25 seeing 73.5% of journeys arrive on time and Renal journeys 72.5%. Both achieved the 70% target. Discharge and transfer journeys booked in advance, at 78% for the quarter, did not achieve the 95% target.	
The volume of **on the day cancellations** has increased slightly over the past year, recording a figure of 20.5% in quarter 1 2024/25, compared to 18.3% over the same period last year. This trend will need to reverse over the next year to realise the planned efficiency improvements.	
In July 2 the service introduced the **Medical Transfer Protocol Suite (MTPS)**, which consists of 3 new Medical Priority Dispatch System (MPDS) protocols to process inter-facility transfers from HCPs. The 3 additional protocols will provide more granularity to the assessment and coding of transfers for step up of care, routine inter facility transfers and mental health transfers. **The new protocols will improve understanding on the nature and urgency of transfer demand and the resources required to complete them in a timely manner.**	TBC
In terms of **patient satisfaction rates**, in July 2024, 93% of patients were 'happy with the transport they received'. However, this figure fell to 66% when asked 'how long did you wait for your transport to take you home after your appointment'. As with other patient surveys undertaken, this was based on just 18 responses over the course of the month and work is being carried out to improve this.	

5. Our People

Performance Overview	RAG Rating
Sickness absence, across all directorates, was 7.54% for quarter 1 2024/25, failing to achieve the 6% target. However, sickness has seen a declining, and therefore, improving trend, over the past two years, with the sickness rate for quarter 1 2023/24 being 7.88% and in quarter 1 2022/23 it was 9.78%.	
Staff turnover rates have been steadily declining since July 2022, when they peaked at 11.6%. The rate for July 2024, at 8.1%, was the lowest figure recorded since June 2021.	
NHS Staff Survey completion rate for 2023 was 23.2% (1,006 completions); this ranked 6th out of the 13 NHS Wales organisations (All Wales total = 20.7%). For 2024, our main focus is on increasing participation rates, enabled by a robust communications and engagement plan.	
PADR rates for quarter 1 2024/25 were at 78.1%, which continued to be below the 85% target, but was an improvement on the 72.7% recorded in quarter 1 2023/24. All directorates are being actively encouraged to ensure that PADR compliance and staff engagement is viewed as a priority, and this is reflected in the improving picture.	
Women's Health Network – 96 members, Black Asian and Ethnically Diverse Network – 6 members, WAST Voices – 83 members, Nothing Without Us (Staff Disability Network) – 17, Working Carers Network – 15 and **Culture Champions 120**.	

7. Our Digital Roadmap



Performance Overview	RAG Rating
Data against these metrics is in development for future reporting	TBC

8. Partnerships and the Wider System

Performance Overview	RAG Rating
Data against these metrics is in development for future reporting	TBC

9. Quality Driven and Clinically Led

Performance Overview	RAG Rating
Data against these metrics is in development for future reporting	TBC

Welsh Ambulance Services University NHS Trust

CHARU

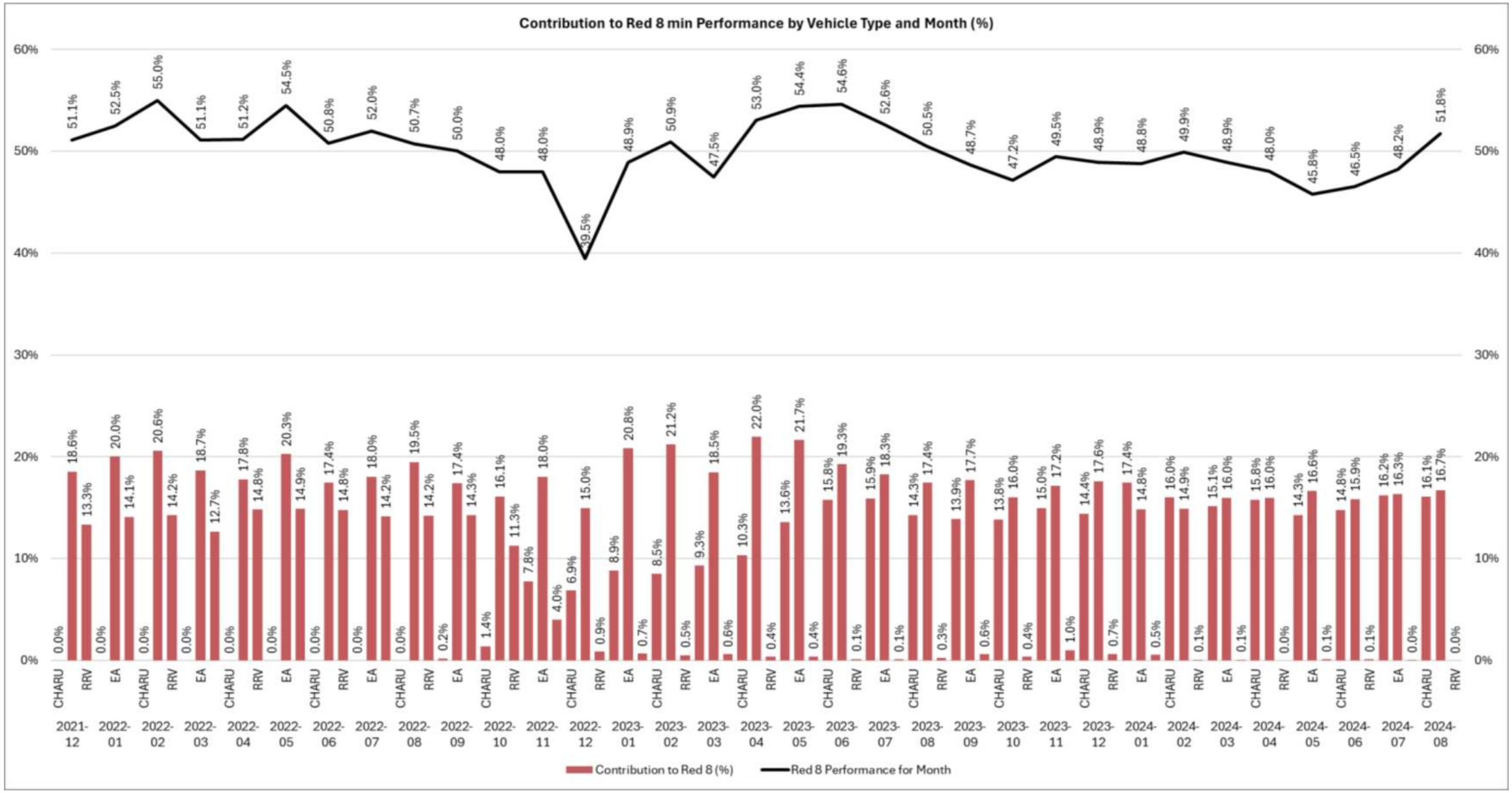
Cymru High Acuity Response Unit

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

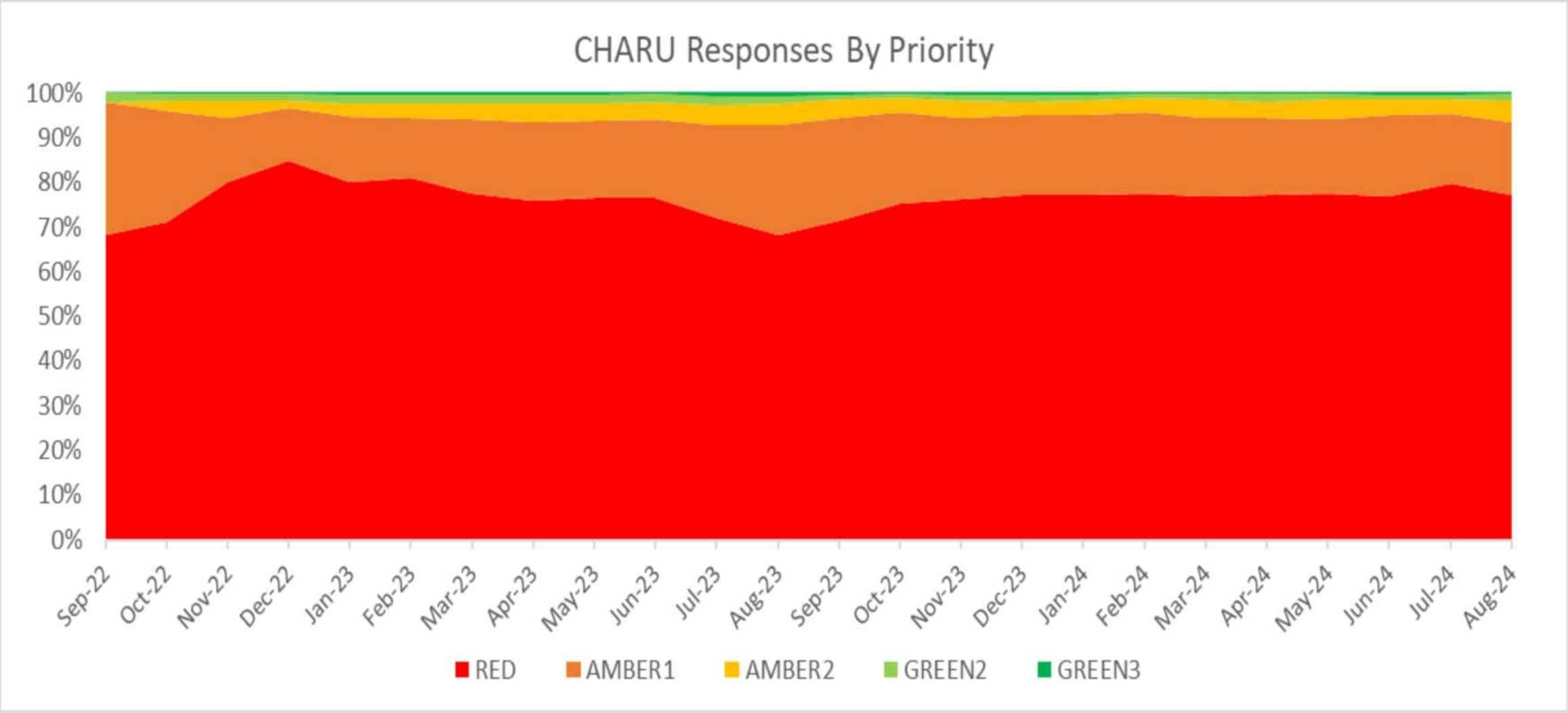
F&P CHARU Analysis
Version 2.0
Released: 09 Sep-24

By: Operations Directorate
Email: Lee.brooks1@wales.nhs.uk

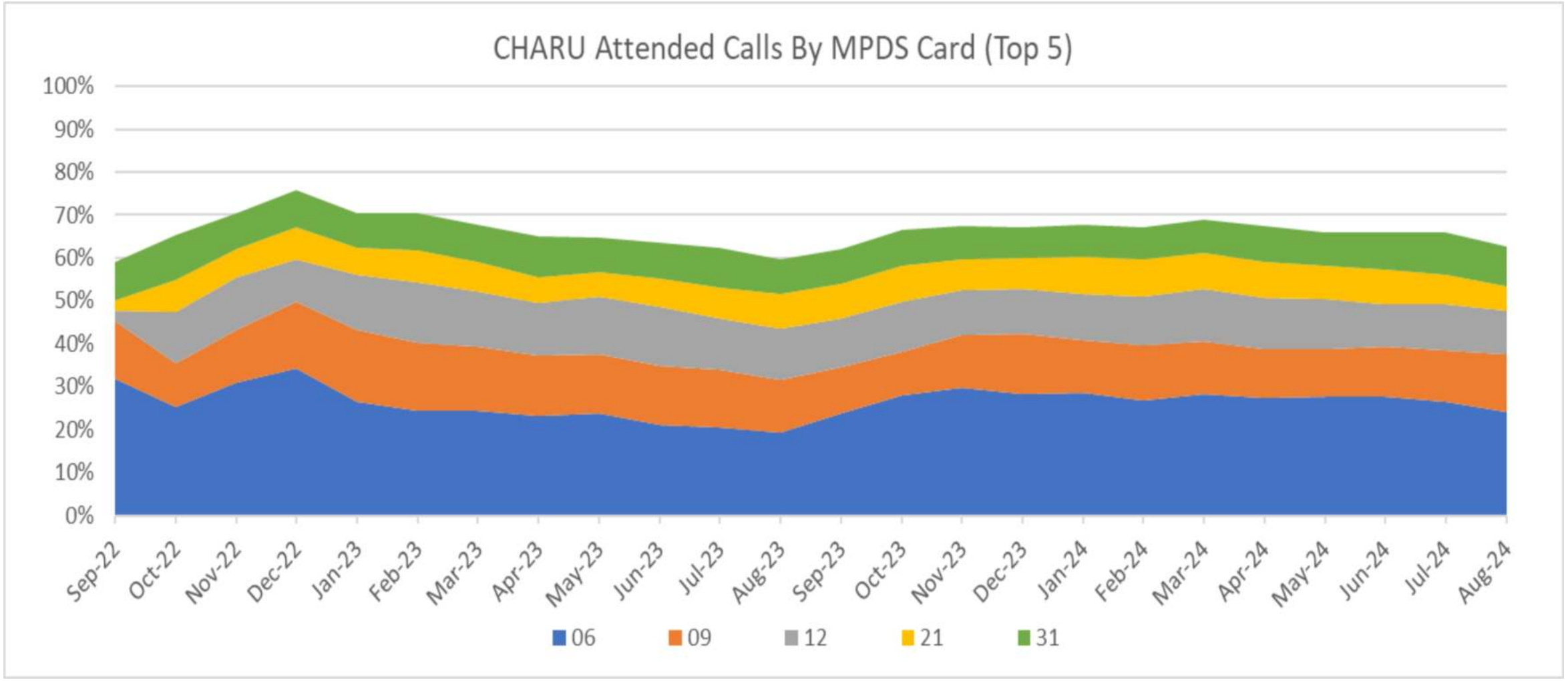
Contribution to Red 8



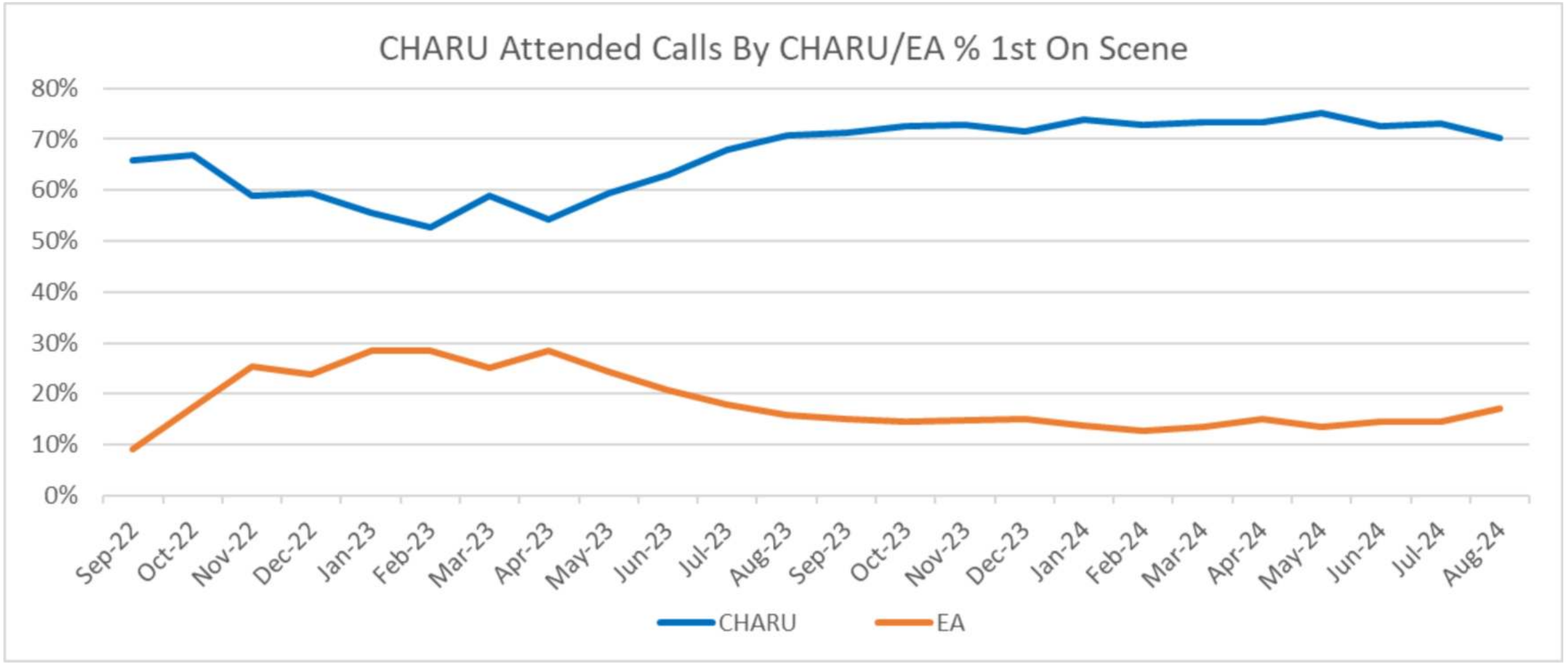
Response by Priority



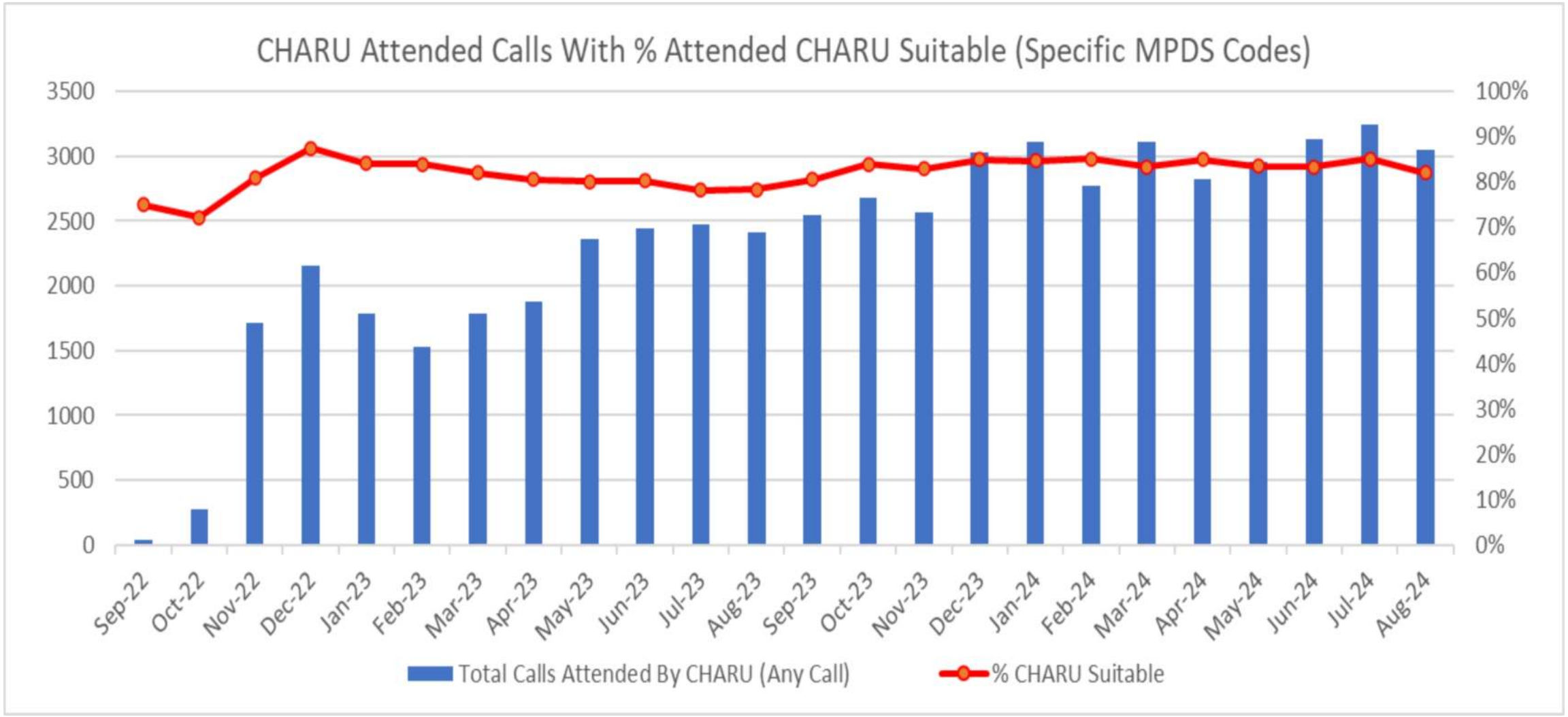
Top 5 MPDS Chief Complaint



Incident Arrival Order



CHARU Dispatch



Utilisation

Month	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Nay
Sep-22	47.4%	46.4%	40.3%	43.4%	35.7%	32.1%	46.8%
Oct-22	43.4%	48.3%	40.2%	41.4%	37.9%	28.4%	41.8%
Nov-22	40.0%	37.9%	42.7%	40.4%	34.9%	26.8%	39.2%
Dec-22	44.3%	38.6%	45.2%	38.9%	37.0%	29.4%	37.5%
Jan-23	36.2%	31.7%	31.8%	32.7%	27.5%	19.1%	30.0%
Feb-23	35.9%	31.9%	34.1%	33.6%	27.3%	17.3%	31.4%
Mar-23	37.9%	30.3%	37.3%	35.2%	29.5%	22.2%	29.6%
Apr-23	37.1%	30.5%	36.6%	34.5%	26.9%	15.5%	31.1%
May-23	32.1%	33.5%	34.6%	27.1%	28.0%	18.1%	29.3%
Jun-23	34.1%	30.2%	33.7%	33.4%	24.3%	21.0%	27.8%
Jul-23	35.4%	28.6%	30.5%	28.3%	26.3%	27.1%	27.1%
Aug-23	34.4%	30.7%	38.1%	32.3%	27.9%	25.4%	33.0%
Sep-23	38.2%	33.1%	35.4%	32.4%	28.4%	26.9%	33.6%
Oct-23	38.7%	32.3%	36.5%	33.3%	31.2%	25.9%	36.5%
Nov-23	41.0%	32.7%	35.4%	32.6%	28.9%	20.2%	32.1%
Dec-23	43.0%	35.9%	37.7%	33.3%	31.7%	30.6%	37.5%
Jan-24	37.6%	33.9%	35.7%	32.0%	31.9%	20.2%	37.7%
Feb-24	37.9%	33.1%	38.9%	32.1%	32.4%	27.0%	37.4%
Mar-24	39.0%	32.7%	34.2%	32.8%	30.6%	28.7%	37.6%
Apr-24	35.8%	34.2%	36.4%	34.3%	29.0%	23.4%	36.5%
May-24	40.3%	35.4%	33.2%	37.4%	30.2%	20.8%	34.1%
Jun-24	37.3%	37.4%	37.7%	35.4%	30.3%	24.8%	34.8%
Jul-24	36.5%	35.1%	35.3%	35.5%	30.6%	25.7%	36.4%
Aug-24	35.2%	33.2%	32.1%	28.9%	28.6%	27.8%	35.0%

Caveats

Period: Sep 2022 - Aug 2024

Only incudes shifts of 10 hours or greater

Only includes job cycle times of 10 minutes or greater

Shift date is the same date as the vehicle arrival on scene date

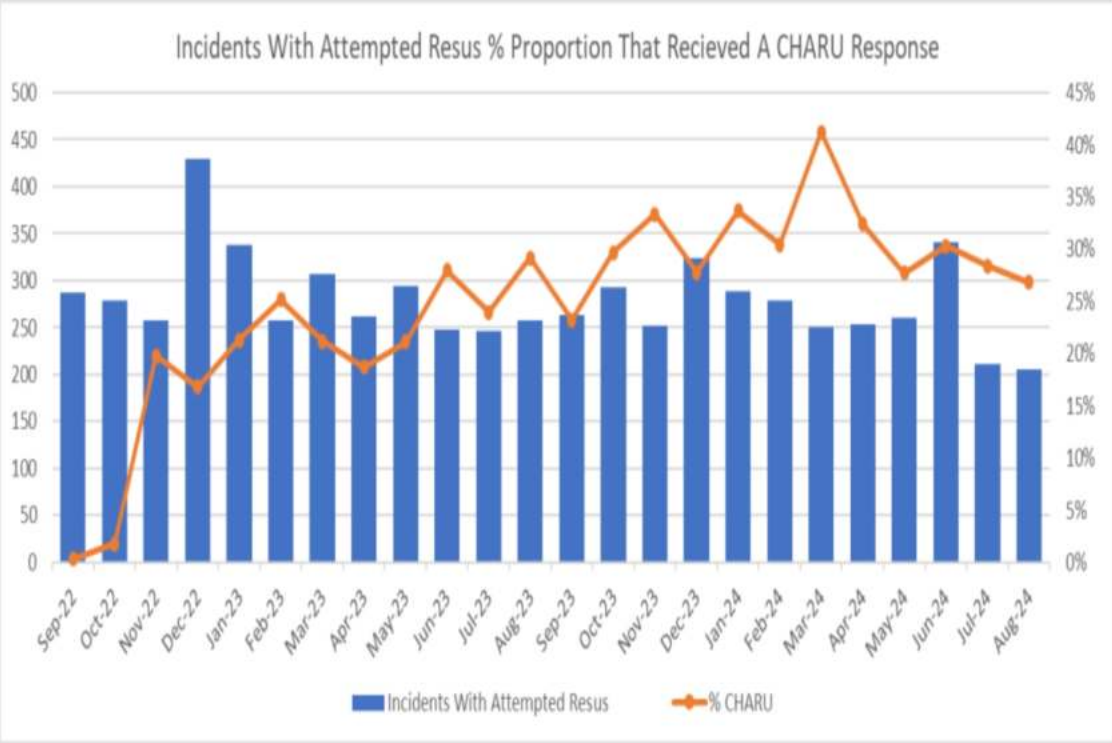
Vehicle arrival at scene time is greater than the shift start time

Vehicle clear time is less than the shift end time

Includes all jobs that CHARU callsigns have responded too irrespective whether they changed vehicle type during their shift.

There are instances where a CHARU callsign has responded to 5 calls in a shift, and they identified as vehicle type CHARU for 2 calls, RRV for 2 calls and then APP for 1 call. All calls have been included so to show their full utilisation.

Resus & ROSC


Incidents With Attempted Resus % Proportion That Recieved A CHARU Response
500
450
400
350
300
250
200
150
100
50
0
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
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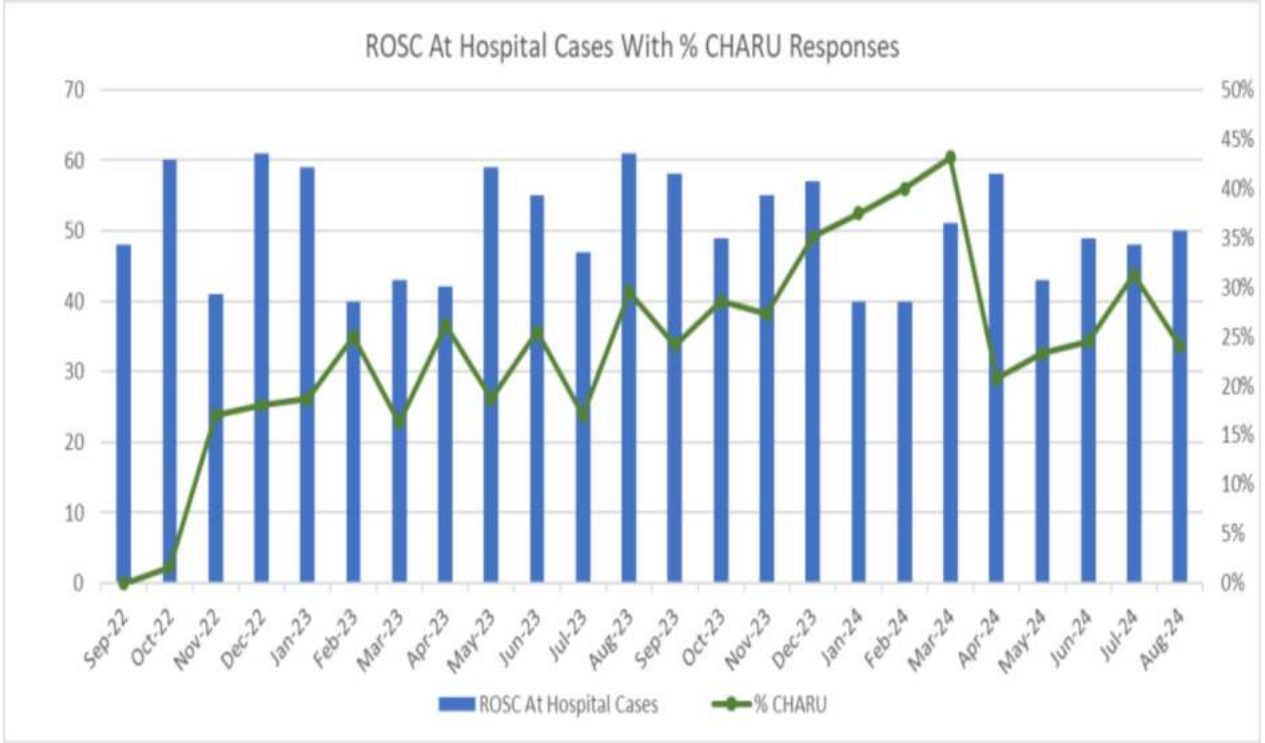
May-24
Jun-24
Jul-24
Aug-24
Incidents With Attempted Resus
% CHARU


ROSC At Hospital Cases With % CHARU Responses
70
60
50
40
30
20
10
0
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
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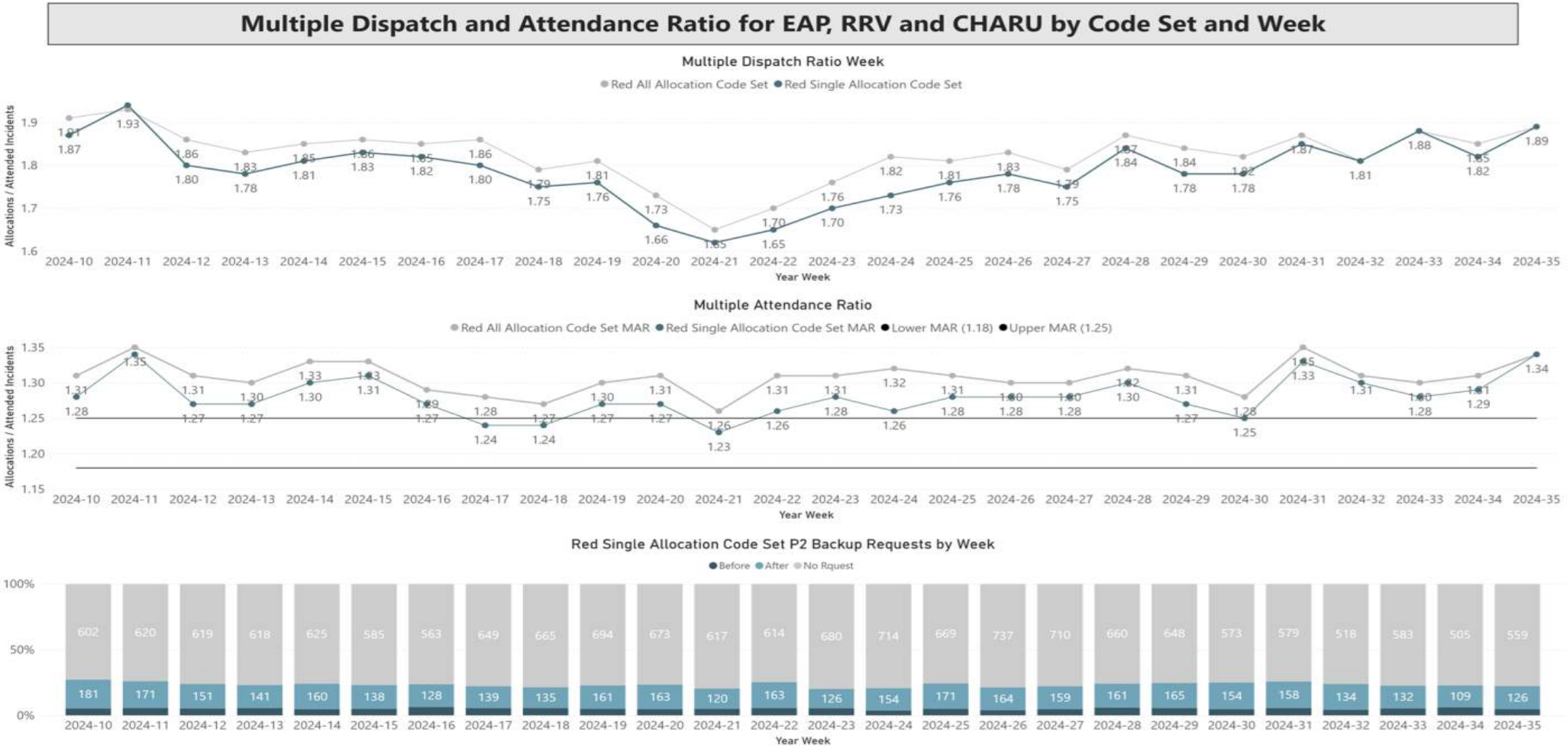
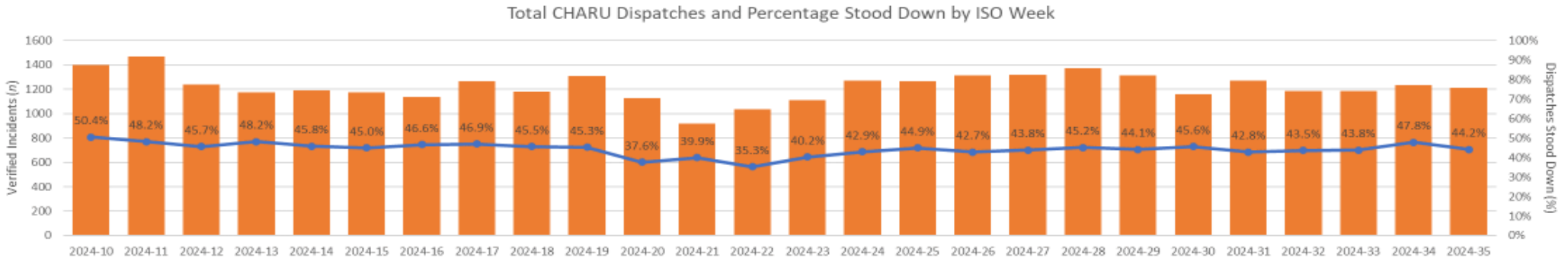
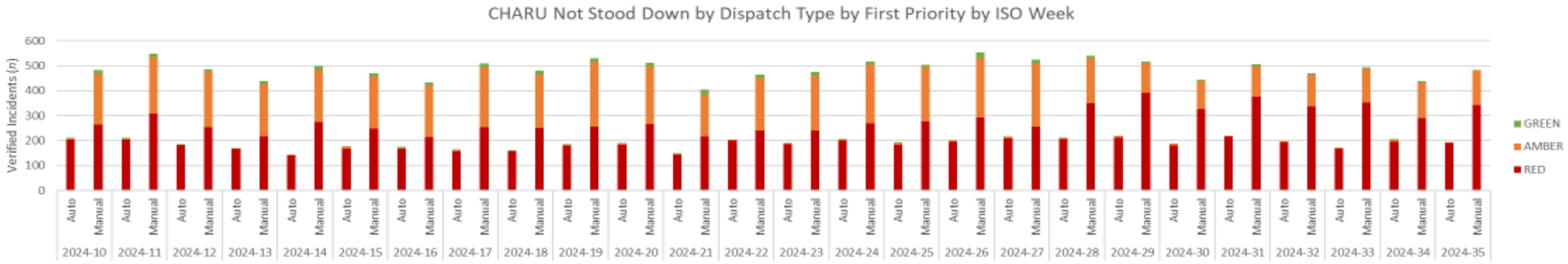
Jul-24
Aug-24
ROSC At Hospital Cases
% CHARU

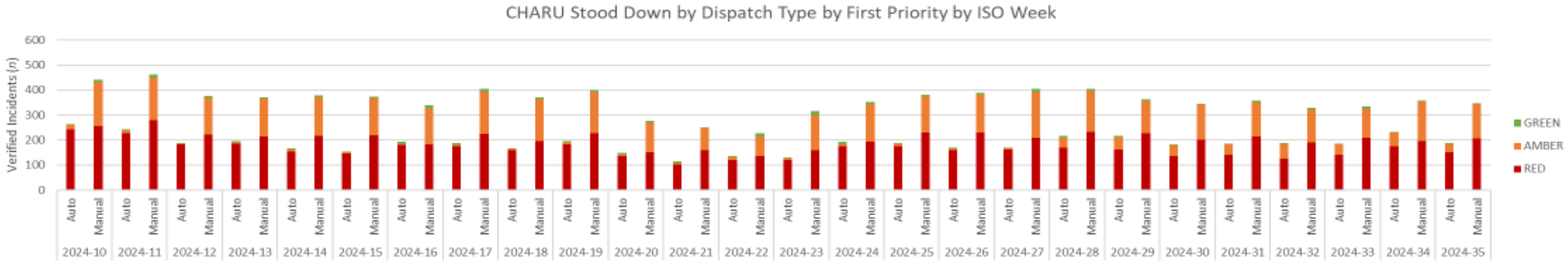
Dispatch Focus



Dispatch Focus – Stand down







Thank you for listening

For any questions and/or support, please contact:

Lee.brooks1@wales.nhs.uk

AGENDA ITEM No	**13**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Environment, Decarbonisation and Sustainability Update August 2024

MEETING	Finance and Performance Committee
DATE	17th September 2024
EXECUTIVE	Chris Turley, Executive Director of Finance and Corporate Resources
AUTHOR	Jo Williams, Head of Capital Development Nicci Stephens, Environment & Sustainability Manager
CONTACT	Joanne.williams10@wales.nhs.uk

EXECUTIVE SUMMARY

To provide an update on:

- Decarbonisation Programme Board and other wider governance
- WAST Decarbonisation Action Plan update and NWSSP Decarbonisation Co-ordination Reporting (DCR)
- Internal Audit – Decarbonisation
- Welsh Government reporting, Sustainability Report and carbon emissions reporting
- Capital Investment – EFAB Funding
- Single Response Vehicle specification design
- ISO14001 recertification.

RECOMMENDATION:
Finance and Performance Committee is asked to note and take assurance from this update.

REPORT APPROVAL ROUTE

Capital Management Board – 23rd August 2024
Executive Leadership Team – 11th September 2024
Finance and Performance Committee – 17th September 2024

REPORT APPENDICES
Appendix 1 - Public sector carbon report - Circulated by E mail.

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

Finance and Performance Committee

Environment, Decarbonisation & Sustainability Update

August 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

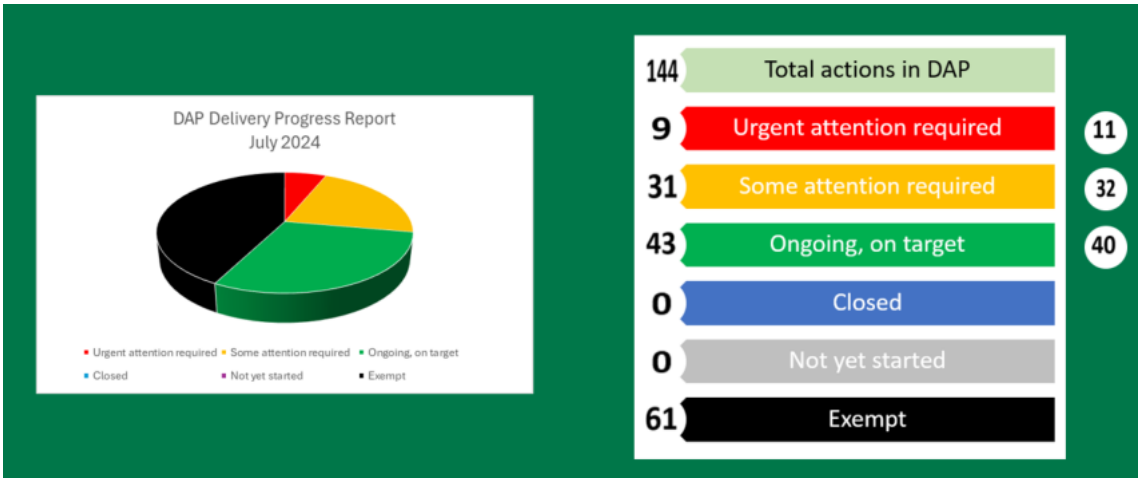
5. The Programme Board met again on 22nd July 2024 and considered a range of updates, including a review of the Decarbonisation Action Plan, highlight reports from the Transport Project Board and EFAB schemes, and an update on delivering the 2024/25 Vehicle Replacement Programme.

6. A detailed risk register is reviewed at each Programme Board meeting and is regularly updated. This risk register development is also linked to work on the Corporate Risk Register and Risk 542 has now been formally adopted at CRR level and included in the Board Assurance Framework.

WAST Decarbonisation Action Plan update and DCR Reporting.

7. Finance & Performance Committee has 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.

8. The dashboard below outlines the position as reported to the Decarbonisation Programme Board in July 2024. It should be noted that the milestones for Decarbonisation Co-ordination Reporting (DCR) have changed to twice yearly and therefore the deadline for the next DCR report is 4th October for Q1 and 2 progress reporting.



9. 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 all Wales capital (AWC) vehicle replacement funding. The next Decarbonisation Programme Board in October 2024 will consider further barriers to delivering current red and amber actions.

Internal Audit – Decarbonisation

10. Following the Internal Audit report, which was formally considered at Audit Committee on 1st March 2024, work has been ongoing to close 3 of the recommendations with a fourth not due until March 2025. The report outlined a limited assurance supported by 3 reasonable and 2 limited objective assurance ratings.

11. 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.

Welsh Government reporting, Sustainability Report and carbon emissions reporting

12. The deadline for the latest **Qualitative Report** was 14th April 2024 and feedback was received in June 2024 confirming WG's assessment of the WAST reporting status as Amber which aligned to the self-assessment provided.

13. In providing feedback, WG commended the Trust on its completion of the estate survey for EV charging infrastructure, successful bids for and delivery of schemes within EFAB funding, and the submission of the Vehicle Replacement Business Justification Case. Areas for action were highlighted within WAST influence of NWSSP Procurement processes, and alternative fuel vehicles as a 'stepping stone' to EV e.g. hybrid. It is acknowledged that the Trust is progressing with both of these aspects, as well as some specific estate interventions highlighted such as LED lights and low carbon heating.

14. 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. The carbon emissions reported data for 2023/24 is now attached as **Appendix 1.** No new reporting factors have been included for the 2023/24 period; **however**, a robust carbon calculation factor has been introduced for Entonox, removing the need to use an alternative, much higher carbon factor used for this medical gas calculations in 2022/23. Other reportable avenues have also decreased levels on the previous year, such as heating gas, business miles, waste & supply chain emissions. Some have increased such as Electricity and Fleet fuel, but these are broadly in line with expectations.

15. Overall **reported** emissions for 2023/24 have therefore decreased from 773,379 tCO^2e to 33,097 tCO^2e. However, some of the factors reported above need to be taken into consideration in reviewing these figures and the significant medical gas reporting variation noted.

16. Whilst not required as a separate addendum to the Trust's Annual Report, as in previous years (with the more regular and detailed DAP and DCR reporting having somewhat succeeded it), a Sustainability Report for 2023/24 has continued to be drafted for internal reporting purposes and sets out in detail further narrative in support of a number of aspects. Some headlines from this for noting are as follows:

a. Electricity use/emissions- Electricity emissions have increased by 15% on last years. This is not unexpected due to increased numbers of electrically fed heating systems, and plug in EV vehicles, increase electricity use across the Trust. This has been offset by 193k kWh of renewable energy generated by PV arrays on Trust premises.
b. Heating emissions – As stated above, due to increase low carbon heating retrofits and closure of inefficient estate, especially Blackweir Station, heating emissions have **reduced by 23%.**
c. Water – Water use and therefore emissions have seen an increase on last year's figures. Two major leaks at Newtown and Cardiff have contributed to this situation, however more work is required to understand why the rest of this increase has happened.
d. Fleet – There is an increase in fleet emissions, due to an increase in diesel use (1%).

Capital Investment – EFAB Funding

17. Delivery is ongoing against a range of WG Estates Facilities Advisory Board (EFAB) schemes for 2024/25. 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.

18. Schemes range across decarbonisation and infrastructure and an update by scheme is provided below:
    a. Newtown – the specification for the scheme is now out to tender, with a closing date of mid-September given the time of year it is being published. An open day will be held at the site in late August for prospective contractors.
    b. Tredegar – the specification for the scheme is now out to tender with a closing date towards the end of September.
    c. HART, Brynmenyn – the specification for the scheme is now out to tender with a closing date towards the end of September.
    d. Pontardawe - the specification for the scheme is now out to tender with a closing date towards the end of September.
    e. Fire alarms – work will commence to engage on a site by site basis to confirm arrangements for installation works to begin
    f. Medical gases - work will commence to engage on a site by site basis to confirm arrangements for installation works to begin

    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.

Single Response Vehicle specification design

19. It has now been agreed that the Single Responder Vehicles (SRVs) will be one common vehicle across all solo response EMS service lines including CHARU and APP. The decision has also been taken to move from a car to a van, to accommodate the more generic nature of the vehicle, and to ensure that all the required kit can be accommodated. In line with the DAP commitment to move to hybrid or full EV, the next 20 vehicles to be replaced will be hybrid as standard. In addition to this, however, the Trust has taken the decision to pilot 10 full EVs, and this is currently being designed for roll-out and evaluation when the vehicles are available in early 2025.

20. In support of this, and to anticipate any future impacts, further work is being done to consider the required range and operational practices, the charging processes and infrastructure, and the proposed locations of the vehicles. It is anticipated that this will require a change in operational processes and the way in which vehicles are used, given the reliance on a period of time required to charge the vehicles, and a significant amount of engagement will be required within Operational teams to ensure the successful roll out. However, work is also required to scope out EV options and ensure that there is an ability for the infrastructure (WAST or external) to support the implementation.

ISO14001

21. Following a rigorous process, the annual reaccreditation for ISO14001 has been successful and it has been confirmed that the Trust has retained its status. WAST continues to be the only UK ambulance Trust with this status.

22. Audits were completed at seven sites in the North Region, plus system audits completed at Ty Elwy, St Asaph.

23. Under the accreditation conditions all stations must provide a volunteer to act as environmental coordinator for their site, to meet with the auditor, participate in internal and external audits, and provide environmental support. Operational staff have supported this requirement for the past nine years and did so again in 2024, assuring compliance.

24. The Trust has no outstanding nonconformities, however three minor non-conformities were found during the audit

    - **Waste -** Incorrect waste segregation methods found at one site. This was resolved on the day**.**
    - **Fire safety** - Incorrect placing of firefighting equipment at another site, this was resolved on the day.

- **COSHH** – Some minor lack of COSHH procedure and processes. Currently there is no COSHH policy or procedure document for sites to follow, COSHH risk assessments found were out of date and therefore out of compliance. This is an open action for the Health and Safety Team and will be resolved well before the 2025 visit.

25. An action plan was developed with timescales and actions owners and submitted to BSI.

RECOMMENDATION:
Finance and Performance Committee is asked to note and take assurance from this update.

AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Waste Management Update – September 2024

MEETING	Finance and Performance Committee
DATE	17th September 2024
EXECUTIVE	Chris Turley - Executive Director of Finance and Corporate Resources
AUTHOR	Nicola Stephens – Environment and Sustainability Manager
CONTACT	Nicola.stephens@wales.nhs.uk

EXECUTIVE SUMMARY

To provide an update on:

- Utility and Waste Management annual report 2023/24
- Waste legislation changes – first quarter review
- Waste Management Policy.
- HCS SLA on the collection of clinical waste.

RECOMMENDATION

Finance & Performance Committee is asked to:

- **NOTE the Utility and Waste Management annual report 2023/24**
- **NOTE Waste legislation changes – first quarter review and**
- **NOTE that an amended SLA with NWSSP HCS is in the process of being finalised.**

REPORT APPROVAL ROUTE

Executive Leadership Team – 11th September 2024
Finance and Performance Committee – 17th September 2024

REPORT APPENDICES
Appendix 1: Waste Management Annual Report 2023/24

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

FINANCE & PERFORMACE COMMITTEE

Waste Management Update

September 2024

SITUATION

1. This paper presents Finance and Performance Committee with the annual Utility and Waste Management Report 2023/24 for review.

2. It also includes an update on the 1st quarter review of the Trust compliance to the April 2024 changes in waste management legislation, along with an update on the waste internal audit recommendations to update the Waste Management Policy, plus an amended service level agreement (SLA) with Health Courier Service (HCS) regarding collection of clinical waste across the Trust.

3. It was one of the recommendations from a recent (limited assurance) internal audit review that an annual update such as this is presented to F&PC.

BACKGROUND

4. The Trust is required to follow waste management legislation, which includes the requirement to recycle domestic type waste into a separate waste stream.

5. Changes to waste legislation in Wales (April 2024) require the Trust to robustly recycle into four segregated waste streams, a move from two previously. These changes include civil action for non-compliance.

6. The Trusts contracted waste management company, Biffa, found the changes to segregation challenging, with support in some areas slow to comply, impacting on the Trusts ability to adhere to legislation.

7. Following an internal audit on waste, and its recommendations, a Waste Management Policy has been rewritten and approved. Plus, negotiations are ongoing to amend the current clinical waste SLA with NWSSP, for collection of clinical waste across the Trust and provide robust legislative compliance and training.

ASSESSMENT

Utility and Waste Management annual report 2023/24

8. To provide robust utility usage, carbon calculation and financial cost assessment of the Trust's estate portfolio, known as Operation Carbon Footprint (OCF) a Utility and Waste Management report is to be presented to this committee annually. This is attached at ***Appendix 1***

9. This report details individual buildings OCF, both in totality and per $m^{2,}$ this enables comparison to other buildings and identifies areas of concern, enabling the Estates Team to investigate and resolve any issues.

10. As with 2022/23 calculations, VPH holds the highest OCF within the Trust estate. Representing 13% of the portfolio's total operational emissions and 17% of the portfolio's total operational financial cost.

11. The report also details domestic waste emission and cost. With AFSRC Wrexham as the Trusts highest producer of waste in 2023/24, producing 8% of the Trusts total domestic waste weights.

12. As with previous years, Newtown Ambulance Station topped the recycling leaderboard, recycling 82% of their waste, a huge achievement. With Beacon House second highest recycling 72% of their waste.

13. 2023/24 did show a bit of a concerning trend of limited recycling at a number of sites, many under 50%. As waste segregation during this period was a simple two bin approach of general waste and dry mixed recycling, the 2024/25 system of four bin segregation will clearly be challenging.

Waste legislation – First Quarter Review

14. The new waste regulations (as a provision under the Environment (Wales) Act 2016) came into force on 4th April 2024.

15. To comply with new legislation the external waste contract, with Biffa, was amended to provide the required additional waste streams.

16. Challenges with providing a glass waste stream across Wales, has resulted with no provision available. This issue has been mitigated by asking staff to take home glass waste for disposal.

17. To ensure limited external space at some sites is not compromised, changes to waste bin sizes and frequency of collections has been included to this contractual amendment.

18. To support increased segregation, additional internal waste bins were purchased and delivered throughout the Trust. The utilisation of previously used internal waste bins, to supplement the newly purchased bins, was achieved by providing new bilingual signage.

19. Biffa's ability to complete additional external bin role out, and changes to their current waste bin signage, has been challenging due to the demand of Welsh customers, resulting in a small delay at some WAST sites, which were without their correct bins & in accurately signed bins, until late June.

20. Due to the increase in work levels, diarised waste collections were also missed at some sites, with waste being left for, in some cases, weeks, without collection.

21. Contractual concerns were raised, by WAST, with weekly meetings being held with the regional business manager, in order to assess the need for additional support and the need for cross charging Biffa, if required, for others to provide waste collection support. NWSSP FS have also been updated, in order to assess NHS Wales issues with compliance.

22. The end of June saw abatement to most issues, with only a hand full of sites still affected. Contractual meetings are ongoing and will continue throughout the remainder of the contract.

23. Due to these issues, a national picture of compliance with the new legislation has not yet been possible. Sites will continue to be audited and compliance dashboards produced as we go through the rest of the year.

Waste Management Policy

24. An internal audit of Trust waste management processes took place in April 2022. The audit found limited assurance of compliance to some waste management requirements and compliance with Welsh Health Technical Memorandum (WHTM) 07-01 health care waste. Ten recommendations were made, all of which have now been able closed off on the audit tracker, including the provision of an annual waste report to committee such as this one.

25. One of the recommendations was 501 – Writing of a new Waste Policy. To comply with WHTM (07-01) an updated, formal Waste Policy was required, this was written and presented to Policy Group, and, as committee members will recall, was approved by committee on 14th May 2024. This will be set for review by May 2027.

HCS SLA on the collection of clinical waste

26. Another of the internal audit recommendations was 505(b)- Clinical waste transfer. Current clinical waste transfer arrangements form part of a service level agreement (SLA) with the Heath Courier Service (HCA) run by NWSSP. The previous SLA did not specifically define clinical waste arrangements and was therefore technically non-compliant.

27. An amended SLA has been presented to the Trust by NWSSP, to provide complaint clinical waste collections, including pre acceptance audits as required under the movement of dangerous goods act, training and additional extra waste collections for batteries.

28. Whilst much of that defined is the current service provided in practice, there has been some volume increases in recent years and the new proposed service provision does include some enhancements as highlighted above. As such, there is a cost increase attached to these amendments, therefore negotiations are ongoing, to secure an agreement that is acceptable to both parties.

29. It should be noted that if agreement cannot be met, the cost of procuring an external clinical waste contactor will be in excess of the costs highlighted by NWSSP, so it is expected that the revised agreement and associated cost impact, which will be able to be covered within the Trust's existing budget, will be finalised and signed off imminently.

RECOMMENDATION

Finance & Performance Committee is asked to:

- **NOTE the Utility and Waste Management annual report 2023/24**
- **NOTE Waste legislation changes – first quarter review and**
- **NOTE that an amended SLA with NWSSP HCS is in the process of being finalised.**

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

Welsh Ambulance Services University NHS Trust (WAST)

Utility & Waste Update.

2023-24

Version 1.1 16.08.2024

CONTENTS

1.0 INTRODUCTION

This document will provide the reader with a brief overview of the WAST estate portfolios operational Carbon Footprint (OCF) for 2023-24 alongside the financial costs of supply. Included within these calculations will also be the usage, OCF and cost in relation to the building floor area (m^2). This information will hopefully provide a more robust data set.

Energy, water, and waste contributes to the Trust carbon footprint, alongside a significant financial spend. The calculation of individual sites OCF will identify those sites with not only the highest OCF, but also provides important information to the Estates and Facilities Team, in relation to unusual trends and anomalies requiring further investigation.

1.1 OCF – WAST ESTATE PORTFOLIO

Following the 2022-23 trend, the largest OCF within the trust estate portfolio one again belongs to Vantage Point House (VPH), nearly double that of the 2nd largest emitter. This is primarily due to the significantly high electricity use at the site. *(Fig 1)*. However, using a floor area calculation, Corwen Station has the highest emission value per m^2, closely followed by 2nd highest emitter, Barry Make Ready. *(Fig 2)*.

VPH has significant finance requirements in relation to utilities and waste management, more than double that of the 2nd highest costing site. *(Fig 3)*. Notwithstanding, Central and West Control (Llangynnor), cost per m^2 represents an unusually high value. (Fig 4).

It should be noted that the majority of buildings with a higher m^2 value, both of carbon and cost, are leasehold properties (as indicated in purple text). At these sites WAST does not have a direct utility contract, and landlords therefore recharge the Trust for utilities.

No	PREMISES	Total $KgCO^2e$
1	Vantage Point House Regional Administrative and Control Centre	**236727.83**
2	Ty Elwy Administrative Building and 111 Control	**122632.35**
3	Ambulance and Fire Service Resource Centre - Wrexham	**119897.11**
4	Cardiff Area Ambulance Centre	**103675.18**
5	North Control Centre	**100731.23**
6	HART Emergency Response Centre	**68896.68**
7	Central & West Control Centre	**59641.81**
8	NHS Direct Thanet House Control Centre	**52762.83**
9	Beacon House (Administration & GUH Transfer Service Building)	**43828.61**
10	SE Workshops Merthyr	**36747.54**

Figure 1:WAST estates portfolio; Operational carbon footprint Top 10.

No	PREMISES	Total $KgCO^2e$ per m^2
1	Corwen Ambulance Station	**167.39**
2	Barry Make Ready	**141.83**
3	Central & West Control Centre	**124.77**
4	Bronllys Ambulance Station	**102.93**
5	Newport Ambulance Station	**96.71**
6	North Control Centre	**93.97**
7	Llandrindod Wells Ambulance Station	**88.61**
8	Pwllheli Ambulance Station	**79.80**
9	Tredegar Ambulance Station	**79.05**
10	NHS Direct Snowdon House Control Centre	**75.82**

Figure 2 :WAST estates portfolio; Operational carbon footprint per m^2: Top 10.

No	PREMISES	Total £
1	Vantage Point House Regional Administrative and Control Centre	**£298,836**
2	Ty Elwy Administrative Building and 111 Control	**£130,786**
3	Ambulance and Fire Service Resource Centre - Wrexham	**£96,874**
4	Central & West Control Centre	**£72,042**
5	North Control Centre	**£70,872**
6	Cardiff Area Ambulance Centre	**£69,602**
7	HART Emergency Response Centre	**£67,893**
8	SE Workshops Merthyr	**£67,593**
9	Beacon House (Administration & GUH Transfer Service Building	**£53,103**
10	NHS Direct Thanet House Control Centre	**£46,822**

Figure 3 : WAST estates portfolio; overall cost: Top 10.

No	PREMISES	£ m^3
1	Central & West Control Centre	**£150.71**
2	Bronllys Ambulance Station	**£139.77**
3	Barry Make Ready	**£134.81**
4	Holywell SDP	**£132.57**
5	Corwen Ambulance Station	**£115.25**
6	Monmouth Ambulance Station - Modular Building	**£94.85**
7	Newport Ambulance Station	**£85.96**
8	Vantage Point House Regional Administrative and Control Centre	**£82.19**
9	Matrix House Workforce Education and Development Centre	**£78.74**
10	North Control Centre	**£66.11**

Figure 4 Figure 3: WAST estates portfolio; overall per m^2 cost: Top 10.

2.0 ELECTRICITY

As per previous years VPH is the largest electricity user within the estate portfolio, utilising approximately 21% of the trust's electricity use, at a cost of over £290k. *(Fig 5, 6,7)* However, it should be noted that VPH, alongside other sites (as indicated in blue) are single utility sites, where energy is used for building and water heating, alongside traditional electricity requirements. The building designation is also a key factor to a higher-than-average use, with significant numbers of staff using electrical technology on a 24/7 basis. This being said, the estates team are reviewing this usage for accuracy.

The top ten energy consumers, alongside emissions per floor area is concentrated mostly at buildings with a single energy supply. Significant increase in cost at co-located sites such as Central & West Control (Dyfed Powys Police) and Bronllys Station (Powys Healthboard) are currently under review with the landlords. (*Fig 8,9,10)*

No	PREMISES	kWh
1	Vantage Point House Regional Administrative and Control Centre	861268.00
2	Ty Elwy Administrative Building and 111 Control	384429.70
3	North Control Centre	223821.00
4	Central & West Control Centre	187818.08
5	Ambulance and Fire Service Resource Centre - Wrexham	182281.15
6	Beacon House (Administration & GUH Transfer Service Building	156433.80
7	HART Emergency Response Centre	155638.00
8	SE Workshops Merthyr	130738.30
9	Cardiff Area Ambulance Centre	128293.00
10	NHS Direct Thanet House Control Centre	122047.30

Figure 5 : Electricity usage in kWh 2023-24 Top 10 users

No	PREMISES	*KgCO²e*
1	Vantage Point House Regional Administrative and Control Centre	236727.61
2	Ty Elwy Administrative Building &111 Control	105664.12
3	North Control Centre	61519.31
4	Central & West Control Centre	51623.56
5	Ambulance and Fire Service Resource Centre - Wrexham	50101.69
6	Beacon House (Administration & GUH Transfer Service Building	42997.30
7	HART Emergency Response Centre	42778.57
8	SE Workshops Merthyr	35934.65
9	Cardiff Area Ambulance Centre	35262.54
10	NHS Direct Thanet House Control Centre	33545.85

Figure 6 : Electricity emissions in kgCO2e 2023-24, Top 10

No	PREMISES	£
1	Vantage Point House Regional Administrative and Control Centre	£293,130
2	Ty Elwy Administrative Building & 111 Control	£122,792
3	Central & West Control Centre	£67,615
4	Ambulance and Fire Service Resource Centre - Wrexham	£66,699
5	SE Workshops Merthyr	£65,954
6	North Control Centre	£59,375
7	HART Emergency Response Centre	£54,759
8	Beacon House (Administration & GUH Transfer Service Building	£50,226
9	Cardiff Area Ambulance Centre	£44,909
10	NHS Direct Thanet House Control Centre	£37,733

Figure 7: Electricity spend. 2023-24, Top 10

No	PREMISES	kWh per m^2
1	Central & West Control Centre	392.92
2	Bronllys Ambulance Station	374.49
3	Barry Make Ready	238.00
4	Vantage Point House Regional Administrative and Control Centre	236.87
5	Matrix House Workforce Education and Development Centre	216.01
6	North Control Centre	208.79
7	Monmouth Ambulance Station - Modular Building	192.66
8	Llandovery Ambulance Station	172.05
9	Aberaeron Ambulance Station	167.19
10	Newport Ambulance Station	164.77

Figure 8: Electricity usage in kWh, per m^2 2023-24, Top 10

No	PREMISES	Kg CO^2e per m2
1	Central & West Control Centre	**108.00**
2	Bronllys Ambulance Station	**102.93**
3	Barry Make Ready	**65.42**
4	Vantage Point House Regional Administrative and Control Centre	**65.11**
5	Matrix House Workforce Education and Development Centre	**59.37**
6	North Control Centre	**57.39**
7	Monmouth Ambulance Station - Modular Building	**52.96**
8	Llandovery Ambulance Station	**47.29**
9	Aberaeron Ambulance Station	**45.95**
10	Newport Ambulance Station	**45.29**

Figure 9 :Electricity emissions in kgCO2e per m^2. 2023-24, Top 10

No	PREMISES	£ m^3
1	Central & West Control Centre	£141.45
2	Bronllys Ambulance Station	£134.82
3	Holywell SDP	£132.57
4	Barry Make Ready	£92.60
5	Monmouth Ambulance Station - Modular Building	£80.91
6	Vantage Point House Regional Administrative and Control Centre	£80.62
7	Matrix House Workforce Education and Development Centre	£77.13
8	Newport Ambulance Station	£61.05
9	North Control Centre	£55.39
10	Aberaeron Ambulance Station	£51.81

Figure 10: Electricity spend in £ per m^2. 2023-24, Top 10

3.0 HEATING

Due to the disposal of Blackweir Station, and the Trust's move to retrofit sites with low carbon heating systems, WAST has significantly reduced its natural gas use, and therefore emissions. The largest natural gas user within the estate portfolio, utilising approximately 11% of the trust's total is Cardiff Station, closely followed by AFSRC Wrexham at 10% and Bryn Tiron North Control at 6%. *(Fig 11).*

The top ten gas consumers, calculated via emissions per floor area, holds a more challenging explanation, with a mixture of both freehold and leasehold site, varying sizes, and designations. An exercise should be completed to identify heating use in relation to age of heating plant and building envelope condition to produce a schedule of future priority works. (*Fig 14,15,16).*

No	PREMISES	kWh
1	Cardiff Area Ambulance Centre	313252
2	Ambulance and Fire Service Resource Centre - Wrexham	306016
3	North Control Centre	183973
4	Corwen Ambulance Station	131255
5	HART Emergency Response Centre	113945
6	Tredegar Ambulance Station	106726
7	NHS Direct Thanet House Control Centre	81566
8	NHS Direct Snowdon House Control Centre	77363
9	Barry Make Ready	75290
10	Ty Elwy Administrative Building	74244

Figure 11: Natural Gas / LPG usage in kWh 2023-24 Top 10 users

No	PREMISES	Total $KgCO^2e$
1	Cardiff Area Ambulance Centre	66766
2	Ambulance and Fire Service Resource Centre - Wrexham	65224
3	North Control Centre	39212
4	Corwen Ambulance Station	27975
5	HART Emergency Response Centre	24286
6	Tredegar Ambulance Station	22747
7	NHS Direct Thanet House Control Centre	17385
8	NHS Direct Snowdon House Control Centre	16489
9	Barry Make Ready	16047
10	Ty Elwy Administrative Building	15824

Figure 12: Natural Gas / LPG kg CO^2e 2023-24 Top 10 users.

No	PREMISES	£
1	Ambulance and Fire Service Resource Centre - Wrexham	£22,973
2	Cardiff Area Ambulance Centre	£21,721
3	Corwen Ambulance Station	£17,554
4	North Control Centre	£9,701
5	HART Emergency Response Centre	£9,391
6	Barry Make Ready	£8,594
7	Blackweir Ambulance Station	£8,317
8	Tredegar Ambulance Station	£6,791
9	Ty Elwy Administrative Building	£5,403
10	NHS Direct Thanet House Control Centre	£5,368

Figure 13 :Natural Gas / LPG usage in £ 2023-24 Top 10 users

No	PREMISES	kWh per m^2
1	Corwen Ambulance Station	737.39
2	Llandrindod Wells Ambulance Station	374.39
3	Barry Make Ready	358.52
4	Pwllheli Ambulance Station	269.83
5	Cowbridge Ambulance Station	259.17
6	Tredegar Ambulance Station	255.94
7	Newport Ambulance Station	219.05
8	Welshpool Ambulance Station	185.26
9	NHS Direct Snowdon House Control Centre	185.08
10	Ambulance and Fire Service Resource Centre - Wrexham	180.33

Figure 14: Natural Gas / LPG usage in kWh per m^2 2022-23 Top 10 users

No	PREMISES	$KgCO^2e$ per m^2
1	Corwen Ambulance Station	157.16
2	Llandrindod Wells Ambulance Station	79.80
3	Barry Make Ready	76.41
4	Pwllheli Ambulance Station	57.51
5	Cowbridge Ambulance Station	55.24
6	Tredegar Ambulance Station	54.55
7	Newport Ambulance Station	46.69
8	Welshpool Ambulance Station	39.49
9	NHS Direct Snowdon House Control Centre	39.45
10	Ambulance and Fire Service Resource Centre - Wrexham	38.43

Figure 15: Natural Gas / LPG usage in $kgCO^2e$ per m^2 2023-24 Top 10 users

No	PREMISES	£ per m^2
1	Corwen Ambulance Station	£98.62
2	Barry Make Ready	£40.92
3	Llanfyllin Ambulance Station (LPG)	£30.99
4	Llandrindod Wells Ambulance Station	£26.21
5	Cowbridge Ambulance Station	£19.23
6	Pwllheli Ambulance Station	£18.31
7	Tredegar Ambulance Station	£16.29
8	Newport Ambulance Station	£15.32
9	Ambulance and Fire Service Resource Centre - Wrexham	£13.54
10	Welshpool Ambulance Station	£12.26

Figure 16: Natural Gas / LPG usage in £ per m^2 2023-24 Top 10 users

4.0 WATER

Water is one of three emission fields to have increased since 2021-22. During the first wave of the COVID pandemic 2020-21 the use of water increased significantly, for obvious reasons. 2023-24 however, has also seen an increase of water use compared to the previous year. Following the Welsh Governments NHS Wales Decarbonisation Strategic Delivery Plan, the use of water requires efficient monitoring and a concerted effort to protect this finite resource. This, however, must not produce an infection control risk. The installation of washing machines at stations during the pandemic helped to support staff in reducing the need for unform to be taken home for cleaning, however, most equipment installed were domestic type systems, not commercial, that will no doubt require replacement or removal in the near future.

The highest users of water within the portfolio are Cardiff and Newtown Ambulance Stations. During 2023-24 both sites developed large water leaks, which have obviously contributed to such a high level of identified usage. The use at high footfall buildings such as VPH and Central &West Control Centre is understandable, alongside MRD's and larger ambulance stations. VPH has the highest financial cost, with unit costs defined by the site landlord. (*Fig 17,18,19).*

The top ten consumers, calculated via emissions per floor area, are primarily ambulance stations, with the assumption water is being used for vehicle washing. An exercise should be completed to identify vehicle washing equipment with reduced water requirements. Producing a whole of Wales specification. (*Fig 20,21,22).*

No	PREMISES	m^3
1	Cardiff Area Ambulance Centre	2092
2	Newtown Ambulance Station	2025
3	Central & West Control Centre	1604
4	Vantage Point House Regional Administrative and Control Centre	1220
5	Flintshire Make Ready Centre	1035
6	HART Emergency Response Centre	1034
7	Neath Ambulance Station	932
8	NHS Direct Thanet House Control Centre	813
9	Bryncethin Ambulance Station	785
10	Ambulance and Fire Service Resource Centre - Wrexham	774

Figure 17: Water usage in m^3 2023-24 Top 10 users

No	PREMISES	Kg CO^2e
1	Cardiff Area Ambulance Centre	0.37
2	Newtown Ambulance Station	0.36
3	Central & West Control Centre	0.28
4	Vantage Point House Regional Administrative and Control Centre	0.22
5	Flintshire Make Ready Centre	0.18
6	HART Emergency Response Centre	0.18
7	Neath Ambulance Station	0.16
8	NHS Direct Thanet House Control Centre	0.14
9	Bryncethin Ambulance Station	0.14
10	Ambulance and Fire Service Resource Centre - Wrexham	0.14

Figure 18 : Water usage in kgCO^2e 2023-24 Top 10 users

No	PREMISES	£
1	Vantage Point House Regional Administrative and Control Centre	£5,706
2	Newtown Ambulance Station	£3,911
3	Flintshire Make Ready Centre	£2,150
4	North Control Centre	£1,796
5	HART Emergency Response Centre	£1,677
6	Central & West Control Centre	£1,532
7	Gelli Ambulance Station	£1,389
8	NHS Direct Snowdon House Control Centre	£1,369
9	NHS Direct Thanet House Control Centre	£1,323
10	Swansea Ambulance Station	£1,322

Figure 19 Water costs in £ 2023-24 Top 10 users

No	PREMISES	m^3 per m^2
1	Monmouth Ambulance Station - Modular Building	5.72
2	Newtown Ambulance Station	3.99
3	Central & West Control Centre	3.36
4	Bronllys Ambulance Station	2.67
5	Hensol Ambulance Station	2.07
6	Newport Ambulance Station	1.73
7	Machynlleth Ambulance Station	1.71
8	Llandrindod Wells Ambulance Station	1.63
9	Neath Ambulance Station	1.53
10	Flintshire Make Ready Centre	1.46

Figure 20: Water in m^3 per m^2 2023-24 Top 10 users

No	PREMISES	KgCO²e per m²
1	Monmouth Ambulance Station - Modular Building	0.0010
2	Newtown Ambulance Station	0.0007
3	Central & West Control Centre	0.0006
4	Bronllys Ambulance Station	0.0005
5	Hensol Ambulance Station	0.0004
6	Newport Ambulance Station	0.0003
7	Machynlleth Ambulance Station	0.0003
8	Neath Ambulance Station	0.0003
9	Bryncethin Ambulance Station	0.0003
10	Flintshire Make Ready Centre	0.0003

Figure 21: Water use in kg CO^2e per m^2. 2023-24 Top 10 users

No	PREMISES	£ per m³
1	Monmouth Ambulance Station - Modular Building	£9.60
2	Newtown Ambulance Station	£7.70
3	Bronllys Ambulance Station	£4.95
4	Hensol Ambulance Station	£3.56
5	NHS Direct Snowdon House Control Centre	£3.28
6	Central & West Control Centre	£3.21
7	Machynlleth Ambulance Station	£3.17
8	Flintshire Make Ready Centre	£3.03
9	Llandrindod Wells Ambulance Station	£3.02
10	Newport Ambulance Station	£2.96

Figure 22: Water usage in £ per m^2. 2023-24 Top 10 users

5.0 WASTE – (General & Recycling)

Waste management, related to municipal domestic waste, is managed by the Environment and Sustainability Manager supported by the incumbent contractor Biffa. Unlike utilities, higher weights within particular waste streams, such as mixed recycling, and primarily cardboard/paper are a positive. However, the use of the waste hierarchy is key to reducing waste weights over all and meeting WG targets of zero waste to landfill by 2050. *(Fig 23)* Preventing the existence of waste should be a priority for the trust, alongside NWSSP procurement. Packaging waste presents a particular challenge, and is presumably the reason, alongside high foot fall, that the top 10 highest

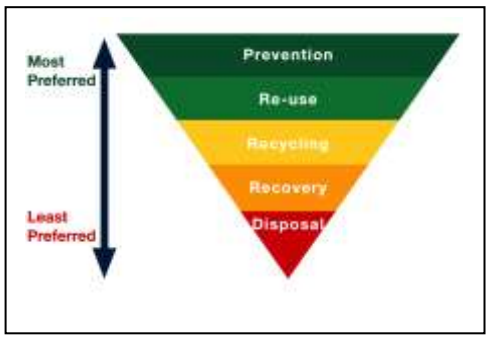


Figure 23: Waste Hierarchy

producers of waste are MRD, control rooms and larger locality offices/stations. *(Fig 24)*. AFSRC waste weights are significantly higher than any other site, however the site is shared with North Wales Fire and Rescue Service, plus the building houses not only an ambulance Station but also an MRD and Fleet Workshop.

The calculation of carbon emissions for waste requires different calculation factor dependent on the waste, and its means of disposal. Within the following tables emissions have been calculated for general waste collections presuming all of this waste goes to landfill, however there will be a percentage sent to energy recovery plants to generate electricity. The use of landfill waste in this manner is a step forward but does not negate the need for a more proactive approach to waste in general.

The top ten emission producers differ slightly to those sites with high volumes of waste. This is due to the volume of general waste collected in weight, and therefore producing higher emissions. Reducing general waste volumes and increasing recycling will reduce this figures.

A recycling leaderboard has been produced and shared with service managers to show those sites with impressive levels of recycling, and those with concerning recycling averages. Newtown Ambulance Station tops the leaderboard for the 3rd year running by recycling over 80% of their waste. Tenby Station has improved on their 2022-23 recycling percentage, from 24% to 49% in 2023-24. However, Newport Ambulance Care Hub requires some more support to increase their 23% recycling figure. *(Table 1)*. The cost to dispose of general waste is also significantly more expensive than recycling waste. *(Fig 25&26)*.

Waste volumes, emissions, and costs per m^2 are interesting. The majority of sites on the top ten list are some of, if not, the smallest buildings within the estate portfolio. The challenge would now be to understand how similar volumes of waste are being generated by smaller sites as larger ones. A full audit of the Trust estate is required, detailing types of waste sent for disposal & lessons to be learned. *(Fig 27,28&29)*.

No	PREMISES	Tonne
1	Ambulance and Fire Service Resource Centre - Wrexham	15.34
2	NHS Direct Thanet House Control Centre	6.09
3	Cardiff Area Ambulance Centre	5.84
4	Flintshire Make Ready Centre	5.75
5	Bryncethin Ambulance Station	5.52
6	Beacon House (Administration & GUH Transfer Service Building	5.42
7	Blackweir Ambulance Station	5.41
8	HART Emergency Response Centre	5.25
9	Swansea Ambulance Station	4.69
10	Blackwood Ambulance Station & Fleet Workshop	4.53

Figure 24 : Domestic waste per tonne 2023-24

No	PREMISES	KgCO²e
1	Ambulance and Fire Service Resource Centre - Wrexham	4571
2	Bryncethin Ambulance Station	1937
3	NHS Direct Thanet House Control Centre	1832
4	HART Emergency Response Centre	1832
5	Cardiff Area Ambulance Centre	1646
6	Swansea Ambulance Station	1507
7	Neath Ambulance Station	1341
8	Flintshire Make Ready Centre	1224
9	Blackwood Ambulance Station & Fleet Workshop	1200
10	Ty Elwy Administrative Building	1144

Figure 25: Domestic waste per kg CO^2e produced 2023-24

No	PREMISES	£
1	Ambulance and Fire Service Resource Centre - Wrexham	£6,034
2	NHS Direct Thanet House Control Centre	£2,399
3	Cardiff Area Ambulance Centre	£2,304
4	Flintshire Make Ready Centre	£2,237
5	Bryncethin Ambulance Station	£2,170
6	Beacon House (Administration & GUH Transfer Service Building	£2,148
7	Blackweir Ambulance Station	£2,144
8	HART Emergency Response Centre	£2,066
9	Swansea Ambulance Station	£1,847
10	Blackwood Ambulance Station & Fleet Workshop	£1,786

Figure 26: Domestic waste cost in £. 2023-24

No	PREMISES	Tonne per m^2
1	Llandovery Ambulance Station	0.02
2	Tywyn Ambulance Station	0.02
3	Bangor Ambulance Station	0.02
4	Newport Ambulance Station	0.02
5	Amlwch Ambulance Station	0.02
6	Ystradgynlais Ambulance Station	0.01
7	Monmouth Ambulance Station - Modular Building	0.01
8	Bryncethin Ambulance Station	0.01
9	Hensol Ambulance Station	0.01
10	Hawthorn Ambulance Station	0.01

Figure 27: Domestic waste per tonne / m^2- 2023-24

No	PREMISES	$KgCO^2e$ per m^2
1	Llandovery Ambulance Station	**8.14**
2	Tywyn Ambulance Station	**6.27**
3	Bangor Ambulance Station	**6.22**
4	Amlwch Ambulance Station	**5.09**
5	Newport Ambulance Station	**4.74**
6	Ystradgynlais Ambulance Station	**4.38**
7	Bryncethin Ambulance Station	**3.53**
8	Bala Ambulance Station	**2.98**
9	Porthcawl Ambulance Station	**2.98**
10	Ambulance and Fire Service Resource Centre - Wrexham	**2.69**

Figure 28: Domestic waste kg CO^2e per m^2 2022-23

No	PREMISES	£ per m^2
1	Llandovery Ambulance Station	**£9.81**
2	Tywyn Ambulance Station	**£7.90**
3	Bangor Ambulance Station	**£7.38**
4	Newport Ambulance Station	**£6.63**
5	Amlwch Ambulance Station	**£6.21**
6	Ystradgynlais Ambulance Station	**£4.47**
7	Monmouth Ambulance Station - Modular Building	**£4.34**
8	Bryncethin Ambulance Station	**£3.95**
9	Hensol Ambulance Station	**£3.72**
10	Hawthorn Ambulance Station	**£3.61**

Figure 29: Domestic waste £ per m2 2022-23

Table 1: Recycling leaderboard 2023-24

Site Name	Recycling	Site Name	Recycling
NEWTOWN AMBULANCE STATION	82%	LLANRWST AMBULANCE STATION	39%
BEACON HOUSE	72%	TYWYN AMBULANCE STATION	39%
PONTYPOOL AMBULANCE STATION	65%	PORTHMADOG AMBULANCE STATION	39%
MONMOUTH AMBULANCE STATION	60%	PWLLHELI AMBULANCE STATION	39%
FLINTSHIRE MRD	60%	PORT TALBOT AMBULANCE STATION	38%
BARMOUTH AMBULANCE STATION	58%	LLANDEILO AMBULANCE STATION	38%
HOLYHEAD AMBULANCE STATION	58%	TREDEGAR AMBULANCE STATION	38%
LLANGEFNI AMBULANCE STATION	57%	ABERCONWY AMBULANCE STATION	37%
BASSALEG AMBULANCE STATION	57%	SWANSEA AMBULANCE STATION	37%
MATRIX ONE	56%	ABERDARE AMBULANCE STATION	37%
CAERPHILLY AMBULANCE STATION	55%	TUMBLE AMBULANCE STATION	37%
CWMBRAN AMBULANCE STATION	54%	AMLWCH AMBULANCE STATION	37%
FISHGUARD AMBULANCE STATION	53%	MERTHYR FLEET WORKSHOPS (	36%
CARMARTHEN AMBULANCE STATION	53%	Unit 34 BENNETT STREET	36%
GLYNNEATH AMBULANCE STATION	51%	LLANDOVERY AMBULANCE STATION	36%
COLWYN BAY AMBULANCE STATION	50%	CARDIFF EAST AMBULANCE STATION	36%
TENBY AMBULANCE STATION	49%	CARDIGAN AMBULANCE STATION	35%
LLANDUDNO AMBULANCE STATION	49%	BANGOR AMBULANCE STATION	35%
BLACKWOOD AMBULANCE STATION	49%	BANGOR FLEET WORKSHOP	35%
HAWTHORN AMBULANCE STATION	48%	HAVERFORDWEST AMBULANCE STATIO	35%
PORTARDAWE AMBULANCE STATION	48%	LAMPETER AMBULANCE STATION	34%
TRUST HEADQUARTERS	47%	LLANELLI AMBULANCE STATION	33%
DENBIGH AMBULANCE STATION	47%	AMMANFORD AMBULANCE STATION	33%
RHYL AMBULANCE STATION	47%	NEATH AMBULANCE STATION	32%
NEWPORT AMBULANCE STATION	46%	HART FACILITY	31%
HENSOL AMBULANCE STATION	46%	MERTHYR AMBULANCE STATION	31%
BRECON AMBULANCE STATION	45%	BRYNCETHIN AMBULANCE STATION	31%
MERTON HOUSE	45%	PARKWALL AMBULANCE STATION	30%
PEMBROKE DOCK AMBULANCE STATION	43%	BARGOED AMBULANCE STATION	29%
WELSHPOOL AMBULANCE STATION	43%	GORSEINON AMBULANCE STATION	28%
CAERNARFON AMBULANCE STATION	42%	ABERYSTWYTH AMBULANCE STATION	26%
FERNDALE AMBULANCE STATION	42%	ABERGAVENNY AMBULANCE STATION	25%
AMBULANCE/FIRE SERV RES CENTRE	42%	CRICKHOWELL AMBULANCE STATION	24%
THANET HOUSE	41%	YSTRADGYNLAIS AMBULANCE STATIO	24%
COWBRIDGE AMBULANCE STATION	40%	PORTHCAWL AMBULANCE STATION	23%
BALA AMBULANCE STATION	40%	GELLI AMBULANCE STATION	23%
BLAENAU FFESTINIOG AMBULANCE	39%	NEWPORT CARE HUB - PHOENIX HOUSE	23%
		BLACKWEIR AMBULANCE STATION	19%

5.1 OCF – CHANGES TO WASTE LEGISLATION

Changes to waste regulations (as a provision under the Environment (Wales) Act 2016) will come into force on 1st April 2024.

This regulation requires:

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

Due to the regulation changes current waste management systems will have to be amended, with the Trust open to civil sanctions for non-compliance. This will also require additional funding for initial infrastructure and additional waste collections.

The trust will have to move from the two-bin approach of dry mixed recycling and general waste to a five + bin approach:

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

Additionally, further waste streams will be introduced after this initial change.

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

AGENDA ITEM No	**15**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

Estates condition and backlog maintenance update – September 2024

MEETING	Finance and Performance Committee
DATE	17th September 2024
EXECUTIVE	Chris Turley - Executive Director of Finance and Corporate Resources
AUTHOR	Susan Woodham – Head of Estates and Facilities. Shaun Rose – Estate Manager Nicola Stephens – Environment and Sustainability Manager
CONTACT	Susan.woodham@wales.nhs.uk

EXECUTIVE SUMMARY

To provide an update on:

- Estates and Facilities Performance Management System (EFPMS) annual reporting for 2023/24
- Backlog maintenance values
- Backlog maintenance reduction plan.

RECOMMENDATION

Finance & Performance Committee is asked to:

- **NOTE the EFPMS Return for 2023/24, and**
- **NOTE the plan for further reducing backlog maintenance.**

REPORT APPROVAL ROUTE

Executive Leadership Team – 11th September 2024
Finance and Performance Committee – 17th September 2024

REPORT APPENDICES
Appendix 1: EFPMS return 2023/24

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

FINANCE & PERFORMACE COMMITTEE

Backlog Maintenance Update

September 2024

SITUATION

1. This paper presents Finance and Performance Committee with the annual Estates and Facilities Performance Management System (EFPMS) report for 2023/24, along with an update on outstanding Backlog Maintenance.

2. This is provided, at least in part, in response to one of the recommendations in a recent internal audit review.

BACKGROUND

3. The Trust is required to complete and return to NWSSP an annual review of the Trust' estate, its quality, compliance to statutory legislation and utilisation, called EFPMS.

4. This report also provides data on backlog maintenance costs for the Trust's estate portfolio, segregated by risk.

5. As the result of the internal audit (November 2023) a recommendation was made to report such estate information and backlog maintenance costs, and in particular for those deemed to be for high and significant risk areas, to this committee on an annual basis.

ASSESSMENT

Internal Audit: Estate Condition

6. In November 2023, an Estate Condition Internal Audit was undertaken by NWSSP. The resultant classification was limited assurance as this was an all Wales audit of backlog maintenance across all NHS Wales, with a classification of medium priority and nine recommendations.

7. Five of these recommendations have now been completed, with two addressing the need to update the Estates Strategic Outline Plan (SOP), this update is currently scheduled for the end of this financial year, although following recent

discussions with Welsh Government colleagues this timing will be at least in part determined by when an ongoing review of capital prioritisation across the NHS in Wales can be completed, as this could clearly significantly impact on this..

8. The remaining two recommendations are related to communicating levels of backlog maintenance within the Trusts estate to this committee. This paper will deliver the required information as needed, and therefore provide closure to these recommendations.

The NHS Wales Estates and Facilities Performance Management System (EFPMS)

9. The NHS Wales Estates and Facilities Performance Management System (EFPMS) encourages a disciplined approach to data collection, dissemination and review and supports strategic decision making at both a local and national level.

10. The EFPMS data captures various estate data including, estate spend, both revenue and capital, floor area, space utilisation, energy use, renewable energy systems and levels of backlog maintenance cost.

11. It is essential that the physical condition of the NHS estate is accurately assessed and maintained to ensure it is fit for purpose. The NHS utilises a risk-based methodology for establishing and managing backlog maintenance, with condition rankings based on those given in 'Estatecode' (NHS Estates, 2002).

12. Physical condition surveys are completed every 5 years, and updated annually after completion of essential works, or disposal. These surveys determine building condition, including compliance with fire safety requirements and statutory safety legislation, and present those findings in condition ranking, A-DX, and produce risk rankings of Low, Moderate, Significant and High.

13. It is important to note that a building will always have some level of backlog maintenance cost assigned if over 12 months old for new builds and even earlier for refurbishments. This is associated with statutory requirements and general wear and tear.

14. The 2023/24 EFPMS report data has been collected (appendix A). From inception 2002/03 until 2023/24, the EFPMS report was requested from WAST in three regional totals.

15. For 2024/25 the report template has been amended, where buildings over 1,000m^2 will be reported individually, and the remainder of sites as one. We are

working closely with NWSSP SES to adapt the reports to provide meaningful constructive data.

16. The ongoing key investment focus has been to reduce the High and Significant backlog figures. These figures identify the major risk to the Trust, and it is encouraging that high has reduced by 13% and significant reduced by 20%. Even despite inflation running at 4% and the actual reportable floor area increasing by 14% on 2022/23 report. *See Table 1.*

Table 1: Backlog Maintenance Figures 2022-23 & 2023-24: EFPMS Returns

Cost to eradicate	2023/24	2022/23	Difference
High Risk Backlog	£246,810	£283,153	-£36,343
Significant Risk Backlog	£2,919,040	£3,669,780	-£750,740
Moderate Risk Backlog	£3,853,246	£2,514,340	£1,338,906
Low Risk Backlog	£2,737,305	£820,728	£1,916,577

17. This has been achieved by targeting the high and significant risks within the Estates strategy and capital investment. Rationalisation of the estate such as the relocation of the vehicle workshops to Merthyr, and the disposal of Cefn Coed and Blackweir have further assisted in reducing the high and significant risks and improving the functional suitability of our buildings.

18. Various Estates Facilities Advisory Board (EFAB) funded works have also helped improve the estate and target the funding appropriately. The funding being addressed for 2024/25 for example, will result in a further reduction in high and significant risk, particularly with the North Control (Bryntirion) relocation and various Fire Safety EFAB projects

19. The cost to bring all the estate up to "condition B" has slightly reduced, even despite inflation and the additional floor space. The percentage of the occupied floor area in physical condition A&B, plus Health & Safety compliance has increased, another reassuring indicator that our focus is showing dividends.

20. An external review by Arup has re-confirmed that there is **no RAAC** (Reinforced Autoclaved Aerated Concrete) identified within the Trust estate.

Backlog Reduction Plan

21. As stated above, the EFAB funding for 2024/25 will address improvements to fire safety and gas storage facilities as well as improvements to some sites along with the introduction of renewable technology to reduce carbon emissions.

22. The Trust has also been successful in receiving further all Wales capital funding in year of £635k to address backlog maintenance issues at Ty Elwy, Merthyr Tydfil ambulance station and further minor backlog maintenance issues across the estate.

23. The Estates team have also focused revenue expenditure, where available, to improve working environments such as new kitchen facilities, decoration, flooring replacement, improved infrastructure (cabling and connectivity). In 2023/24 up to 50 sites benefited from varying levels of investment. Plans are well advanced to progress similar works for the remainder of the estate this financial year, where resources are available to do so, where further works such as garage door replacements has also been highlighted at several sites.

24. The estate is also due it's quinquennial condition surveys in 2025, this coupled with the new way of reporting the EFPMS submission for next year will provide the estates team an opportunity to plan for future years of investment, as there has been substantial improvement to the estate over the last 5 years.

25. Backlog maintenance has reduced over the past 5 years as a result of the disposal of several high risk backlog sites, such as Blackweir, HM Stanley and Cefn Coed, and the substantial capital investment at VPH, Ty Elwy and Cwmbwrla and the acquisition of new estate and investment in Cardiff, Aberaeron and Merthyr. There has also been an increase in the leased estate at Matrix One, Beacons House and Bennett Street Bridgend, plus additional estate since COVID at Phoenix Business Park Newport, Botanic Gardens, Brecon Police station, Abercarn Fire station and NRW facility in Llandarcy.

RECOMMENDATION

Finance & Performance Committee is asked to:

- **NOTE** the EFPMS Return for 2023/24, and
- **NOTE** the plan for further reducing backlog maintenance.

Trust Data Report

Name	WELSH AMBULANCE SERVICES NHS TRUST
ODS Code	RT4
Type	AMBULANCE

Trust Profile	Unit	Value
Occupied beds	No.	
Available beds	No.	
Number of sites - General Acute Hospital	No.	
Number of sites - Multi-service Hospital	No.	
Number of sites - Short Term Non-Acute Hospital	No.	
Number of sites - Long Stay Hospital	No.	
Number of sites - Specialist Hospital	No.	
Number of sites - Community Hospital	No.	
Number of sites - Treatment Centres	No.	
Number of sites - Non-Hospital (Patient)	No.	
Number of sites - Support Facilities	No.	
Total Number of sites	No.	118
Estates Development Strategy	Yes/No	Yes
Occupied Beds per Available Beds	%	
Total In-patient Days	Bed Days	
Notes		
Finance	**Unit**	**Value**
Total Capital Investment	£	2041164
Capital investment for changing/improving existing buildings	£	703839
Reduction of backlog maintenance	£	??????
Total Hard FM (Estates) Costs	£	6,719,227
Total soft FM (Hotel Services) Costs	£	0
Investment to reduce Backlog Maintenance	£	
Income from Leases	£	194125
Cost of Leases	£	2042333
Total Estates and Facilities Management Costs (Cost of Occupancy) per Occupied Floor Area	£/m²	

Income from Leases per Leased Out Floor Area	£/m²		
Cost of Leases per Leased In Floor Area	£/m²		
Cost of Leases per Income from Leases	%		
Total Capital Investment per Occupied Floor Area	£/m²		
Estates Services Cost per Total Estates and Facilities Cost	%		
Notes			
Staff	**Unit**	**Value**	
Total number of staff employed	WTE	4306	
Total number of staff employed in relation to the hard FM (estates) function.	WTE	7	
Total number of staff employed in relation to the soft FM (hotel services) function.	WTE	0	
Estates WTE Staff per Total Trust WTE Staff	%		
FM Services WTE Staff per Total WTE Staff	%		
Estates WTE Staff per FM Services WTE Staff	%		
Total Estates and FM Services Staff per Total WTE Staff	%		
Estates WTE Staff per Total Estates and FM Services WTE Staff	%		
Notes			
Transport Services	**Unit**	**Value**	
Sustainable travel plan	Yes/No	No	
Patient transport mileage	Miles	11080951	Mark Pawlett-Awaiting response
Visitor transport mileage	Miles	0	
Staff transport mileage	Miles	29,207.00	15,229.96
Vehicle fuel cost	£	6504212.26	
Fleet electric vehicles	No.	85	92
Do you use a single system to capture all your fleet data	Yes/No		

Does your organisation have operational vehicle trackers installed to support improve route / vehicle optimisations, monitor driver behavoir	Yes/No	
Do you Do have a car sharing scheme in place	Yes/No	
Do you have a pool car / vehicle scheme in place	Yes/No	
Do you offer any incentives for staff to use public transport	Yes/No	

Areas	Unit	CENTRAL & WEST REGION RT4X2	NORTH REGION RT4X1	SOUTH EAST REGION RT4R3		CENTRAL & WEST REGION 22-23	NORTH REGION 22-23	SOUTH EAST REGION 22-23	
Gross internal site floor area	m²	18564	13775	23279	Data from Site list 3I repo	17489	12908	17796	
Occupied floor area	m²	18564	13775	23199	55538	17489	12908	17469	47866
NHS estate Occupied Floor Area	%	100	100	100		100	100	98	
Site footprint	m²	14191	7980	16490		17031	11183	16261	
Site land area	Hectare	4.9	5.04	9.85		4.3	5.04	8.32	
Patient occupied floor area	m²	0	0	0		0	0	0	
Non-patient occupied floor area	m²	18564	13775	23199		17489	12908	17469	
Unoccupied floor area	m²	0	0	80		0	0	327	
Main circulation area	m²	0	0	0		0	0	0	
Leased in floor area	m²	14706	4435	11975		10640	4123	10212	
Leased out floor area	m²	0	0	100		0	0	60	
Temporary buildings and portacabins	m²	0	37.4	0		0	18.69	262	
Essential Building	%	100	100	100		100	100	100	
Essential Land	%	100	100	100		100	100	100	
Budlings on Site	No.	52	32	34		49	33	29	
Site Building Footprint per (Land Area*10,000)	%	29.0	15.8	16.7		39.6	22.2	19.5	
Occupied Floor Area per Gross Internal Floor Area	%	100	100	99		100	100	98	
Patient Occupied Area per Occupied Floor Area	%	0	0	0		0	0	0	
Leased In Floor Area per Occupied Floor Area	%	79.2	32.2	51.6		60.8	31.9	58.5	
Main Circulation Area per Occupied Floor Area	%								
Unoccupied Floor Area per Gross Internal Floor Area	%	0	0	2		0	0	2	
Non-Patient Occupied Area per Occupied Floor Area	%								
Notes									
Function and Space	**Unit**	**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**		**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**	
Not functionally suitable	%	30	35	32	Property details EFPMS R	58.2	61.5	61.1	
Un-utilised space	%	1	1	1		1	1	1	
Available beds	No.	0	0	0		0	0	0	
Percentage of single bedrooms for patients	%	0	0	0		0	0	0	
Percentage of Single bedrooms for patients that include en-suite facilities	%	0	0	0		0	0	0	
Occupied beds	No.	0	0	0		0	0	0	
Occupied Beds per Available Beds	%	0	0	0		0	0	0	
Floor Area per Available Bed	m²/Bed	0	0	0		0	0	0	
Notes									
Age and Asset Profile	**Unit**	**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**		**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**	

Age Profile - 2020 to present	%	0.48	0	13.29		1.96	0	2.7	
Age Profile - 2015 to 2019	%	0.39	22.39	0		3.92	2.86	2.7	
Age Profile - 2005 to 2014	%	19.49	5.14	1.85		1.96	5.71	10.81	
Age Profile - 1995 to 2004	%	42.51	39.83	18.44		9.8	37.14	8.11	
Age Profile - 1985 to 1994	%	12.31	3.6	43.03		19.61	14.29	29.73	
Age Profile - 1975 to 1984	%	5.79	8.96	7.81		13.73	8.57	8.11	
Age Profile - 1965 to 1974	%	4.24	10.13	8.33		15.69	11.43	18.92	
Age Profile - 1955 to 1964	%	7.81	1.2	3.55		17.65	5.71	13.51	
Age Profile - 1948 to 1954	%	4.27	7.03	3.7		7.84	8.57	5.41	
Age Profile - pre 1948	%	2.71	1.72	0		7.84	5.72	0	
Age Profile - Total (must equal 100%)	%	100	100	100		100	100	100	
Notes									
Quality of Buildings	**Unit**	**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**		**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**	
Cost to eradicate High Risk Backlog	£	19576	227234	0	246810	41168	221876	20109	283153
Cost to eradicate Significant Risk Backlog	£	1227070	323239	1368731	2919040	1645282	511613	1512885	3669780
Cost to eradicate Moderate Risk Backlog	£	1847413	706852	1298981		1084955	411109	1018276	
Cost to eradicate Low Risk Backlog	£	1239997	675604	821704		378258	216890	225580	
Risk Adjusted Backlog Cost	£	1501007	733001	1548832	3782840	1984915	880972	1783923	4649810
Cost to achieve Physical Condition B	£	1903910	835324	1644446	4383680	2130855	832482	1689111	4652448
Percentage of total occupied floor area in physical condition C plus D	%	21	40	19		50	44	38	
Percentage of total occupied floor area not in Statutory Health and Safety compliance	%	4.5	6	8		6	6	8	
Percentage of total occupied floor area not in Statutory Fire Safety compliance	%	4.5	6	8		6	6	8	
Methodology used to review costs to eradicate backlog	Select	Formal 6 facet survey, reviewed 2024	Formal 6 facet survey, reviewed 2024	Formal 6 facet survey, reviewed 2024		Formal 6 facet survey, reviewed 2023	Formal 6 facet survey, reviewed 2023	Formal 6 facet survey, reviewed 2023	
Formal survey year	Select	2020	2020	2020		2021	2021	2021	
Review Year	Select	2024	2024	2024		2026	2026	2026	
Methodology used to review costs to eradicate backlog - Reason	Notes								
Does this site include properties which are within the Reinforced Autoclaved Aerated Concrete (RAAC)	Yes/No	No	No	No		No	No	No	
If yes, is this recorded in the health board risk log and accompanied by a management plan which reflects the Standing Committee on Structural Safety Alert (SCOSS) requirements (May 2019)	Yes/No								
When was condition of the planks and the management plan last reviewed	Date								
Cost to manage RAAC	£	0	0	0		0	0	0	
Total Backlog Cost	£	4334056	1932929	3489416	9756401	3149663	1361488	2776850	7288001
Total Backlog Cost per Occupied Floor Area	£/m²	£ 233.47	£ 140.32	£ 150.41		£ 180.09	£ 105.48	£ 158.96	
Total Risk Adjusted Backlog Cost per Occupied Floor Area	£/m²	£ 80.86	£ 53.21	£ 66.76		£ 113.50	£ 68.25	£ 102.12	

Percentage Risk Adjusted Backlog to Total Backlog	%	34.63%	37.92%	44.39%	63.02%	64.71%	64.24%
Physical Backlog per Occupied Floor Area	£/m²						
Physical Backlog per Occupied Floor Area in C+D	£/m²						
Statutory Health & Safety Backlog per Occupied Floor Area	£/m²						
Fire Safety Backlog per Occupied Floor Area	£/m²						
Total Backlog Maintenance Costs per Occupied Floor Area	£/m²						
Notes							
Estate Maintenance	**Unit**	**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**	**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**
Building and Engineering maintenance costs	£	502,406	553706	1077240	255828	226084	258472
Grounds and Gardens maintenance costs	£	32980	31660	26986	21831	27560	18388
Total Building & Engineering Maintenance Cost per Occupied Floor Area	£/m²	29	42	48	16	20	16
Total Grounds & Gardens Maintenance Cost per Land Area	£/Hectare	6,731	6,281.75	2,739.70	5,077	5,468.25	2,210.10
Notes							
Energy - Utility	**Unit**	**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**	**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**
Electricity (Green Tariff)	kWh	911374.93	911374.93	911374.93	634420.10	818012.05	665667.10
Electricity (Non Green Tariff)	kWh	432063.70	432063.70	432063.70	623573.37	40665.93	1099842.18
Gas	kWh	950292.50	950292.50	950292.50	777142.28	804815.02	1208035.01
Oil	kWh	2388	0	0	0	0	0
Total Energy Cost	£	£533,654.77	£530,758.77	£530,758.77	£458,901.89	£416,729.38	£947,994.27
Electricity (Green Tariff)	£	£308,284.94	£308,284.94	£308,284.94	£237,663.35	£312,526.68	£329,686.32
Electricity (Non Green Tariff)	£	£148,926.93	£148,926.93	£148,926.93	£126,753.17	£9,417.28	£429,112.82
Gas	£	£73,546.90	£73,546.90	£73,546.90	£94,485.37	£94,785.42	£189,195.13
Oil	£	£2,896.00	£0.00	£0.00	£0.00	£0.00	£0.00
Total Electrical Energy Consumed per Occupied Floor Area	kWh/m²						
Total Fossil & Renewable Non-Fossil Energy Consumed per Occupied Floor Area	kWh/m²						
CO2 Emission	Tonnes						
CO2 Emission per Occupied Floor Area	kg/m²						
Carbon Emissions	Tonnes						
Carbon Emissions per Occupied Floor Area	kg/m²						
Total Energy Cost per Occupied Floor Area	£/m²						
Total Electrical Energy Cost per Occupied Floor Area	£/m²						
Total Fossil & Renewable Non-Fossil Energy Cost per Occupied Floor Area	£/m²						
All Energy Costs per Occupied Floor Area	£/m²						
Average Cost per Unit of Energy Consumed	Pence/kWh						

Notes		Please note from 2023-24 WAST will no longer be able to record or report in regioanl values, chnages to NHS contracts will see a whole of Wales approach				Please note from 2023-24 WAST will no longer be able to record or report in regioanl values, chnages to NHS contracts will see a			
		CENTRAL & WEST REGION	**NORTH REGION**	**SOUTH EAST REGION**		**CENTRAL & WEST REGION**	**NORTH REGION**	**SOUTH EAST REGION**	
Renewable Energy	**Unit**	**RT4X2**	**RT4X1**	**RT4R3**		**RT4X2**	**RT4X1**	**RT4R3**	
Renewable energy (Electricity)	kWh	64491.33	64491.33	64491.33	193473.99	10926.75	58040.00	35457.79	104424.54
Renewable energy (non-fossil fuel)	kWh	0	0	0		0	0	0	
Renewable energy (Electricity) Cost	£	0	0	0		0	0	0	
Renewable energy (non-fossil fuel) Cost	£	0	0	0		0	0	0	
Total Renewable Energy Consumed per Occupied Floor Area	kWh/m²								
Percentage Renewable Energy to Total Energy Consumed	%								
Total Renewable Electrical Energy Cost per Occupied Floor Area	£/m²								
Total Renewable (non-fossil fuel) Cost per Occupied Floor Area	£/m²								
Total Renewable Energy Cost per Occupied Floor Area	£/m²								
Notes									
		CENTRAL & WEST REGION	**NORTH REGION**	**SOUTH EAST REGION**		**CENTRAL & WEST REGION**	**NORTH REGION**	**SOUTH EAST REGION**	
Environmental	**Unit**	**RT4X2**	**RT4X1**	**RT4R3**		**RT4X2**	**RT4X1**	**RT4R3**	
Maximum electrical demand	kW								
Available electrical capacity	kVA								
Number of primary heating gas boilers older than 10 years (100kW and above)	No.	0	0	0		0	0	0	
Number of primary heating gas boilers older than 10 years (less than 100kW)	No.	5	1	1		5	4	3	
Heat pumps installed on site	No.	3	3	3		3	2	2	
Oil-led heating sources	No.	0	0	0		0	0	0	
LED lighting coverage	%	85	71	84		80	47	78	
Notes									
		CENTRAL & WEST REGION	**NORTH REGION**	**SOUTH EAST REGION**		**CENTRAL & WEST REGION**	**NORTH REGION**	**SOUTH EAST REGION**	
Water Services	**Unit**	**RT4X2**	**RT4X1**	**RT4R3**		**RT4X2**	**RT4X1**	**RT4R3**	
Water volume	m³	8012.67	8012.67	8012.67		5547.89	5547.89	5547.89	
Water Cost	£	£15,267.78	£15,267.78	£15,267.78		£11,029.73	£11,029.73	£11,029.73	
Water Volume (Borehole)	m³	0	0	0		0	0	0	
Sewage Volume	m³	5534.00	5534.00	5534.00		4271.97	4271.97	4271.97	
Sewage Cost	£	£15,244.50	£15,244.50	£15,244.50		£10,927.61	£10,927.61	£10,927.61	
Water and sewage cost for non metered premises	£	£1,663.16	£1,663.16	£1,663.16		£1,667.23	£1,667.23	£1,667.23	
Surface water highways and drainage charges	£	0	0	0		0	0	0	
Water Cost per Total Water Volume	£/m³								
Water Cost per Occupied Floor Area	£/m²								

Water Vol per Occupied Floor Area	m³/m²							
Total Water Vol per Occupied Bed	Ltrs/Bed/Day							
Notes		Water is longer recorded in regions , WAST is a whole of wales orgainsation and no longer records data in regions therefore whole of wales cost has been split into 3rds			Water is longer recorded in regions , WAST is a whole of wales orgainsation and no longer records data in regions therefore			
Waste	**Unit**	**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**		**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**
High Temperature Disposal Waste Weight	Tonnes	0	0	0		0	0	0
High Temperature Disposal Waste Cost	£	0	0	0		0	0	0
Non Burn Treatment (Alternative Treatment Plant) Disposal Waste Weight	Tonnes	22.81	22.81	22.81		46.92	10.79	22.77
Non Burn Treatment (Alternative Treatment Plant) Disposal Waste Cost	£	£12,795.58	£12,795.58	£12,795.58		£17,408.10	£8,570.02	£14,007.19
Non-infectious Offensive Waste weight	Tonnes	0	0	0		0	0	0
Non-infectious Offensive Waste cost	£	0	0	0		0	0	0
Landfill Disposal Waste Weight	Tonnes	0.70	0.70	0.70		0.64	0.64	0.64
Landfill Disposal Waste Cost	£	£272.48	£272.48	£272.48		£216.76	£216.76	£216.76
Waste recovery weight	Tonnes	34.17	34.17	34.17		31.92	31.92	31.92
Waste recovery cost	£	£13,351.64	£13,351.64	£13,351.64		£10,755.86	£10,755.86	£10,755.86
Recycling weight	Tonnes	27.23	27.23	27.23		24.58	24.58	24.58
Recycling cost	£	£10,951.96	£10,951.96	£10,951.96		£8,739.77	£8,739.77	£8,739.77
Total Waste Weight	Tonnes	84.91	84.91	84.91		104.06	67.94	79.92
Total Waste Cost	£	£37,371.66	£37,371.66	£37,371.66	£112,114.98	£37,120.48	£28,282.41	£33,719.57 £99,122.46
Food Waste Collection weight	Tones	0	0	0		0	0	0
Food Waste Collection cost	£	0	0	0		0	0	0
High Temperature Waste Cost per Tonne	£/Tonne							
High Temperature Waste Cost per Occupied Floor Area	£/m²							
Total Waste Cost per Occupied Floor Area	£/m²							
Total Waste Volume (high temperature, non burn, landfill & WEEE) per Occupied Floor Area	kg/m²							
Notes		Municiple Waste contract in place is not regional and therefore regional figures cannot be given . Total figures presented as a 3rd for each region - WAST is a whole of Wales organisation and does not report regionally in any other reporting avenue, this includes to WG			Municiple Waste contract in place is not regional and therefore regional figures cannot be given . Total figures presented as a 3rd for each region - WAST is a whole of			
Car Parking	**Unit**	**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**		**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**
Total parking spaces available	No.	478	416	581		479	422	555
Total disabled parking spaces	No.	8	6	8		8	6	6
Total parking spaces available for patients/visitors	No.	0	0	0		0	0	0
Total parking spaces available for staff	No.	470	410	573		471	416	549
Fleet Electric Vehicle Charging Points	No.	20	20	30		22	20	25
Visitor/Patient Electric Vehicle Charging Points	No.	0	0	0		0	0	0

Notes				
Cleanliness	**Unit**	**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**
Cleaning services costs	£	456810	320787	517772
Audit score against National Specification of Cleanliness for the NHS	%	0	0	0
Cleaning hours	Hrs	0	0	0
Number of cleaning staff	WTE	3.01	0	1.27
Total Cost of Cleaning per Occupied Floor Area	£/m²	25	23	22
Total Cost of Cleaning per WTE	£/WTE	0	0	0
Number of Cleaning Hours per WTE	Hrs/WTE	0	0	0
Notes				
Laundry and Linen	**Unit**	**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**
Total Laundry and Linen cost	£	11198	12360	21840
Pieces per annum	No.			
Cost of Laundry and Linen Services per Occupied Floor Area	£/m²	0.60	0.90	0.94
Cost of Laundry and Linen Services per Item	£/item			
Notes				
Security Services	**Unit**	**CENTRAL & WEST REGION RT4X2**	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**
Security incidents reported	No.	187	120	248
Total Security services costs	£	0	0	0
Security staff	WTE	0	0	0
Security incidents requiring police attendance	No.	59	38	79
Assaults on staff	No.	4	2	6
Cost of Security Services per Occupied Floor Area	£/m²			
Cost of Security Services per WTE	£/WTE	0	0	0
Cost of Security Services per Incident	£/Incident			
Security Incidents per 1,000m² of Occupied Floor Area	No./1,000m²	0.01007326	0.008711434	0.010690116
Security Incidents Requiring Police Attendance per Total Security Incidents	%	31.6	31.7	31.9
Assaults on staff per total Security Incidents	%	2.1	1.7	2.4
Notes				

CENTRAL & WEST REGION RT4X2	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**
454071	289201	455689
0	0	0
0	0	0
3.45	0	1.27
26	22	26
0	0	0
0	0	0
CENTRAL & WEST REGION RT4X2	**NORTH REGION RT4X1**	**SOUTH EAST REGION RT4R3**
11488	10940	29178
0.66	0.85	1.67

Data from ambreen Security Incidents Apr23 - March 2024

AGENDA ITEM No	**16**
OPEN	**Open**
No of ANNEXES ATTACHED	**1**

EMS Operational Transformation Programme

MEETING	Finance & Performance Committee
DATE	17/09/24
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Hugh Bennett - Assistant Director, Commissioning & Performance
CONTACT	Hugh.Bennett2@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of this report is to assure Committee that the EMS Operational Transformation Programme has been delivered, closed and evaluated.

2. The EMS Operational Transformation Programme emerged out of the 2019 EMS Demand & Capacity Review. The EMS Operational Transformation Programme was, at the time, the largest transformation programme the Trust has undertaken. Both have now been superseded by the 2023 EMS Demand & Capacity Review and the Clinical Model Transformation Programme.

3. Essentially, the EMS Operational Transformation Programme has achieved its planned deliverables, however, the programme has not delivered the planned benefits to the 999 emergency ambulance care pathway.

4. The key reason for not delivering the expected benefits (Red 65% 8 minute performance and Amber 1 median 30 minutes) is the extreme level of handover lost hours. The programme was predicated on Dec-18 handover lost hour levels of 6,000 hours, as collaboratively agreed with commissioners, compared to the 32,000 hours in Dec-22 when the bulk of the new rosters had been put in place along with the agreed front line staff uplift.

5. The programme involved a series of interlinked projects, in particular, front-line recruitment to EMS, replacing Rapid Response Vehicles with Cymru High Acuity Response Units (CHARUs), re-rostering every CHARU, EA and UCS roster across Wales, related estate and fleet adjustments to support the

recruitment and re-rostering; and a series of efficiencies, in particular the consult & close rate.

6. With funding support from the then Emergency Ambulance Services Committee (EASC), the programme delivered: -

    i. A front-line EMS full time equivalent (FTE) staff uplift of 343 FTEs;
    ii. An efficiency gain of 72 FTEs from re-rostering;
    iii. The new CHARU;
    iv. Exceeding the modelled consult & close benchmark of 10.2% (in Apr-24 the Trust achieved 15.1%).

7. The programme was complex anyway, but its delivery was further complicated by it taking place during a pandemic. The programme required a high degree of collaboration with TU partners, between different directorates and with commissioners, during a period of very high system pressure and is further evidence of the Trust's ability to deliver on its plans.

8. The total elapsed time, from initiation to closure, for the programme was 1,615 days. The full closure and evaluation report is contained in Appendix 1. A particular focus of the closure and evaluation process was capturing lessons learnt.

9. The main programme cost was £16.5m revenue with estates capital works on top.

10. The one area that was not delivered as intended by the programme was the reconfiguration of EMSC. This was delayed due to a prolonged period at maximum escalation during the pandemic. The main programme has now been closed, with the EMSC reconfiguration being a standalone project reporting into Strategic Transformation Board (STB). The EMSC reconfiguration is currently in the delivery phase e.g. dispatch boundary changes and single allocator model.

RECOMMENDATION: The Committee is asked to: -

- **Note the successful delivery of the EMS Operational Transformation Programme.**
- **Note that whilst the programme achieved its deliverables it has not delivered the intended benefits to patient safety. The primary cause is the extreme levels of handover lost hours.**

REPORT APPROVAL ROUTE
09/09/24 – WAST Executive Director of Strategy, Planning & Performance

REPORT APPENDICES
Appendix 1 – EMS Operational Transformation Programme Closure & Evaluation 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)	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 assure committee that the EMS Operational Transformation Programme has been delivered, closed and evaluated.

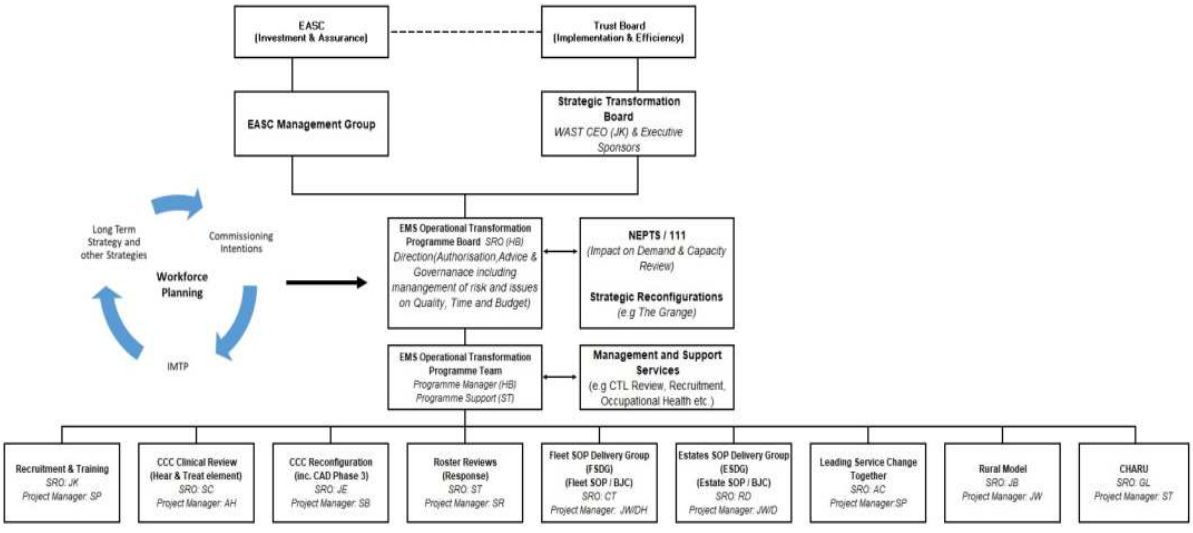
BACKGROUND

2. The EMS Operational Transformation Programme emerged out of the 2019 EMS Demand & Capacity Review. The EMS Operational Transformation Programme was, at the time, the largest transformation programme the Trust has undertaken. Both have now been superseded by the 2023 EMS Demand & Capacity Review and the Clinical Model Transformation Programme

ASSESSMENT

3. The EMS Operational Transformation Programme was the Trust's main delivery mechanism for recommendations arising from the 2019 EMS Demand & Capacity Review, which in turn was an action arising from the 2018 Amber Review.

<u>EMS Transformation Programme Governance Map</u>

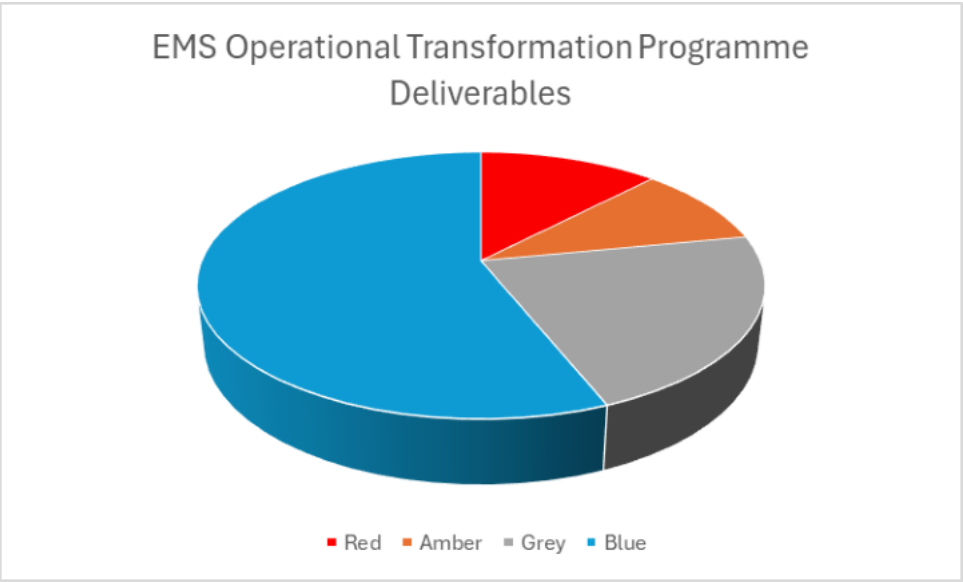


4. The EMS Operational Transformation Programme was the Trust's largest transformation programme at the time. The following facts and figures give some idea of its scale and its political sensitivity

   - Recruitment of +343 FTEs.
   - 1,615 elapsed days start to finish.

- 1,800 directly affected staff.
- 5 months of negotiation with TU partners on the Core Principles as part of the roster review project
- 25 Core Principles (and 15 iterations of them).
- 29 stakeholder briefings by the CEO & Director of Engagement & Partnerships.
- 146 rosters and 86 affected stations.
- 12 R&Rs (one partially upheld, on upheld).
- 11 estate changes to accommodate the related uplift in FTEs to close the relief gap.
- Creation of a large spreadsheet, designed to work out the estate and fleet requirements; and
- 60 working groups.

5. The Programme commenced on 01 Dec-19 and was closed on 03 May-24, totalling 1,615 days. The overall programme set out to achieve 13 objectives, including closing the relief gap, implementing CHARU and undertaking a pan Wales EMS roster review. There were 13 main programme objectives which sub-divided into 41 sub-objectives. Of these, the programme delivered 23 (blue), partially delivered 4 (amber), removed from the programme 9 (grey) e.g. EMSC reconfiguration and failed to deliver 5 (red):-



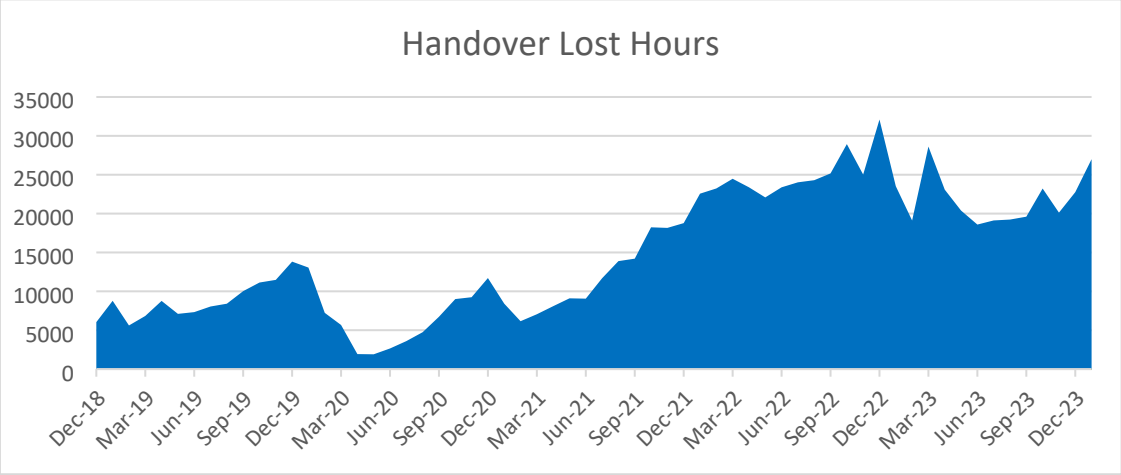
6. The five red non-deliverables were: -

No.	Objective	Delivery Work-stream	Desired Outcome	Achieved?
1.	Recruit and train FTE requirement and ambition of Demand and Capacity programme 2019 by March 2025	Recruitment and Training	Sufficient FTEs to keep pace with demand as modelled by ORH (subject to further modelling).	The FTEs were sufficient to close the relief gap, but not cope with the level of handover lost hours which increased from 6,000 hours to 34,000 hours at peak.
6b.	Achieve 17% hear and treat rate by DEC -22 – by increasing the establishment with plus 36 Paramedics and plus 5 MHP's	CCC Clinical Programme Board (linked to +36 FTEs uplift)	Improved patient safety through a timely telephone "response" Increase in ambulances not dispatched as a result of achieving revised benchmark of 17%, freeing up ambulances to respond to higher acuity calls thereby improving patient safety.	Remains an IMTP ambition. Now forms part of Clinical Model Transformation Programme (Trust did achieve 15.1% in April 2024).
6e.	Physician Triage Assessment and Streaming (PTAS)	CCC Clinical Programme Board	Improved patient safety through a timely telephone "response" provided by health boards. Would be a separate measure in the AQIs and not part of hear & treat measure.	Health board dependent with support from JCC
9b	Deliver a 6% sickness abstraction from EMS Response rosters by Mar-24.	Managing Attendance Programme	A contribution to delivering the UHP benchmarks of 95% for RRV, EA and UCS.	Clear downward trend, but 6% not yet achieved. Separate programme of work
12	Cymru High Acuity Response Unit (CHARU)	CHARU Task & Finish Group	Improved clinical outcomes (ROSC)	ROSC rate has seen improvement. Further improvement via

			CHARU parameters delivered in each health board (20 urban and 30 minute rural) 65% of Red incidents responded to in 8 minutes in each health board. These three outcomes will not be delivered unless the CHARU roster keys are fully funded. Decision (Jan-23) to move Paramedics across from EA lines to CHARU lines to fully deliver CHARU roster keys, with reduced EA UHP.	Clinical Indicator Plan submitted to commissioners. See separate report to F&P Committee (17 Sep-24) on impact of CHARUs. Trust is reaching more red incidents, but denominator (red demand) is much higher. Now being taken forward by CMT Programme.

7. The full closure and evaluation report (Appendix 1) was reviewed at May-24's Strategic Transformation Board (STB). Whilst the programme has not delivered the intended benefit of improved patient safety, as defined by Red 8 minutes 65% and Amber 1 median 30 minutes, the view of STB was that the levels of performance and patient safety would have been further from the required levels, if it had not been for the delivery of the programme.

8. As per the summary, the primary cause of non-delivery of the intended benefits is the extreme levels of handover lost hours. The programme was predicated on 6,000 hours of handover lost hours, compared to the 32,000 hours witnessed in Dec-22, 34,000 hours if handover hours to English hospitals are added in:-



9. Lessons Learnt reports were completed for each project in the programme. These can then be used in future projects, for example, the EMS roster review lessons learnt report is currently being used in the NEPTS re-roster project.

Summary

10. The programme was complex anyway, but its delivery was further complicated by it taking place during a pandemic. The programme required a high degree of collaboration with TU partners, between different directorates and with commissioners, during a period of very high system pressure and is further evidence of the Trust's ability to deliver on its plans.

11. Whilst the programme was essentially delivered the non-delivery of the required patient safety benefits, caused by the extreme levels of hospital handover lost hours, points to a more radical approach being required by the Trust to mitigate the impact of the levels of lost hours. This is now being taken forward by the Clinical Model Transformation Programme.

RECOMMENDATION: The Committee is asked to: -

- **Note the successful delivery of the EMS Operational Transformation Programme.**
- **Note that whilst the programme achieved its deliverables it has not delivered the intended benefits to patient safety. The primary cause is the extreme levels of handover lost hours.**

2024

EMS Operational Transformation Programme Board Closure Report (May 2024 STB)

Hugh Bennett- Assistant Director, Commissioning & Performance & Senior Responsible Owner for the Programme

EMS Operational Transformation Programme: Project Closure & Evaluation Report

Contents

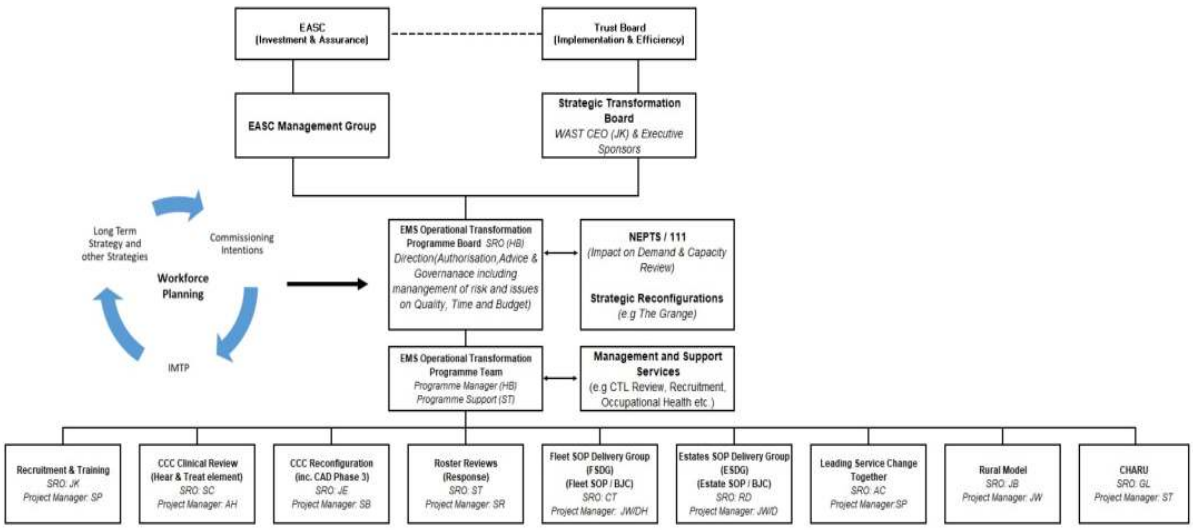
Document Purpose

1.1 The purpose of this closure report is to review how the programme performed against the Programme Initiation Document used to authorise it. It also allows the passing on of any lessons learnt that can be usefully applied to other programmes; and the handover of details of unfinished work, ongoing risks, or potential product modifications.

Some Facts & Figures

2.1 The EMS Operational Transformation Programme was the Trust's main delivery mechanism for recommendations arising from the 2019 EMS Demand & Capacity Review, which in turn was an action arising from the 2018 Amber Review.

EMS Transformation Programme Governance Map



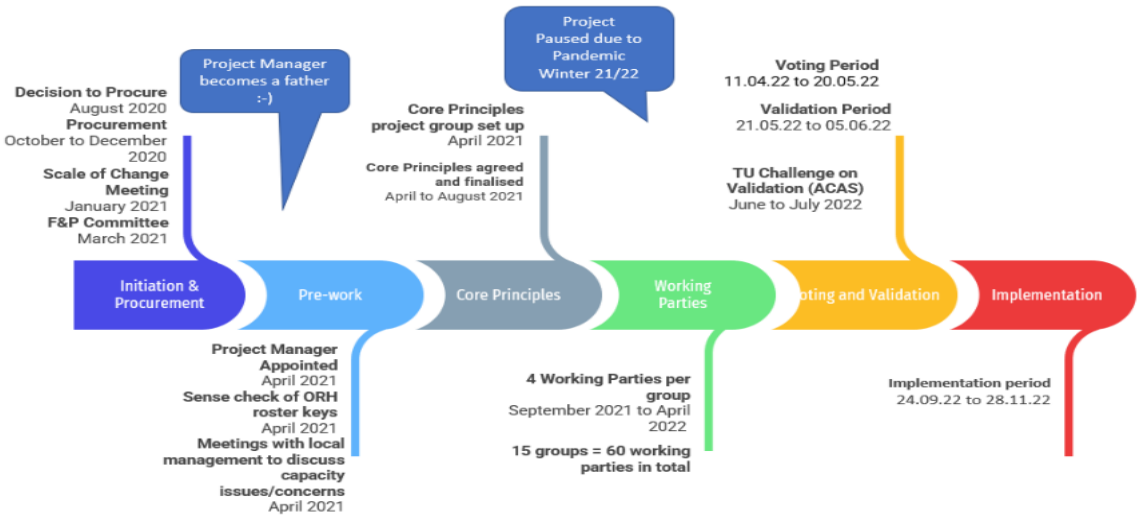
2.2 The EMS Operational Transformation Programme was the Trust's largest transformation programme at the time. The following facts and figures give some idea of its scale and its political sensitivity: -

- Recruitment of +343 FTEs.
- 1,615 elapsed days start to finish.
- 1,800 directly affected staff.
- 5 months of negotiation with TU partners on the Core Principles as part of the roster review project

- 25 Core Principles (and 15 iterations of them).
- 29 stakeholder briefings by the CEO & Director of Engagement & Partnerships.
- 146 rosters and 86 affected stations.
- 12 R&Rs (one partially upheld, on upheld).
- 11 estate changes to accommodate the related uplift in FTEs to close the relief gap.
- Detailed station level fleet calculations; and
- 60 working groups for staff to design their rosters.

2.3 The roster review project was the critical path through which the other parts of the programme (recruitment, fleet, estate) connected. The following image illustrates the roster review project timeline.

EMS Roster Review Timeline



Note: the bulk of the rosters were implemented between 24.09.22 and 28.11.22, but the final ones post Christmas 2022.

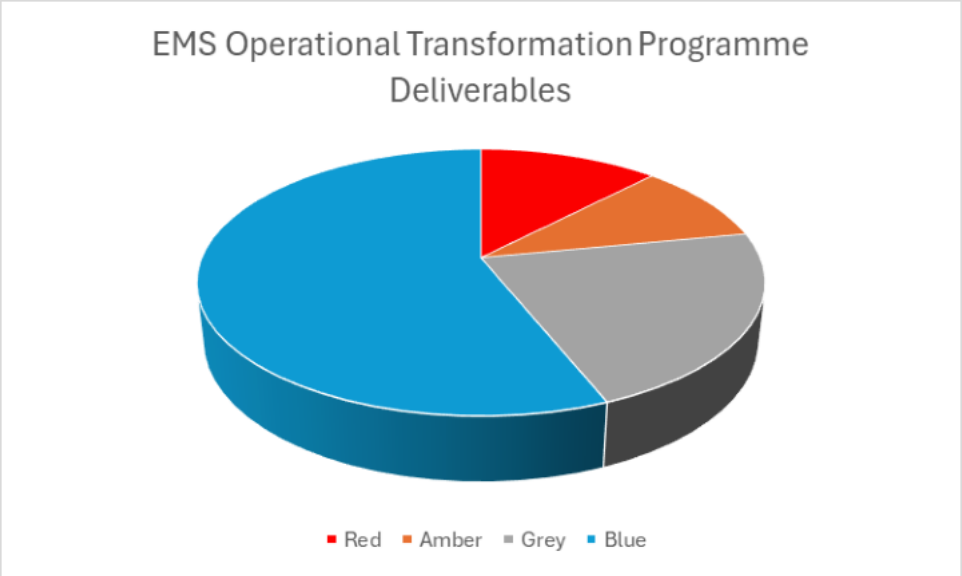
Executive Summary

3.1 The purpose of the programme was to "deliver improved 999 patient safety and experience, as defined by a range of performance parameters, through a combination of investment, efficiencies and effectiveness (shift left), during the timeframe Apr-20 to Mar-25."

3.2 There is a tension at the heart of this closure report. The programme has delivered the majority of the outputs in terms of investment, efficiency and effectiveness, but these have not resulted in the desired improvements in outcomes for patients. This has created frustrations, with one member of staff commenting that *"we have run flat out only to go backwards at a slower rate" (like swimming against a tide).* The primary reason for this was the changing context in which the Trust was operating, with handover levels very significantly increasing over the course of the programme. The programme was predicated on 6,000 hours of handover lost hours, when the rosters went live in Dec-22 the Trust lost 34,000 hours to hospital handover.

3.3 The programme commenced in 2019 with a view to be completed by March 2025; however, the programme is being closed now due to a number of the objectives being achieved prior to this date and the programme being superseded by the clinical model transformation programme and the 2023 EMS Demand & Capacity Review. One project within the programme is still in delivery phase, the EMSC reconfiguration project. This has now become a stand-alone project, reporting directly to Strategic Transformation Board (STB).

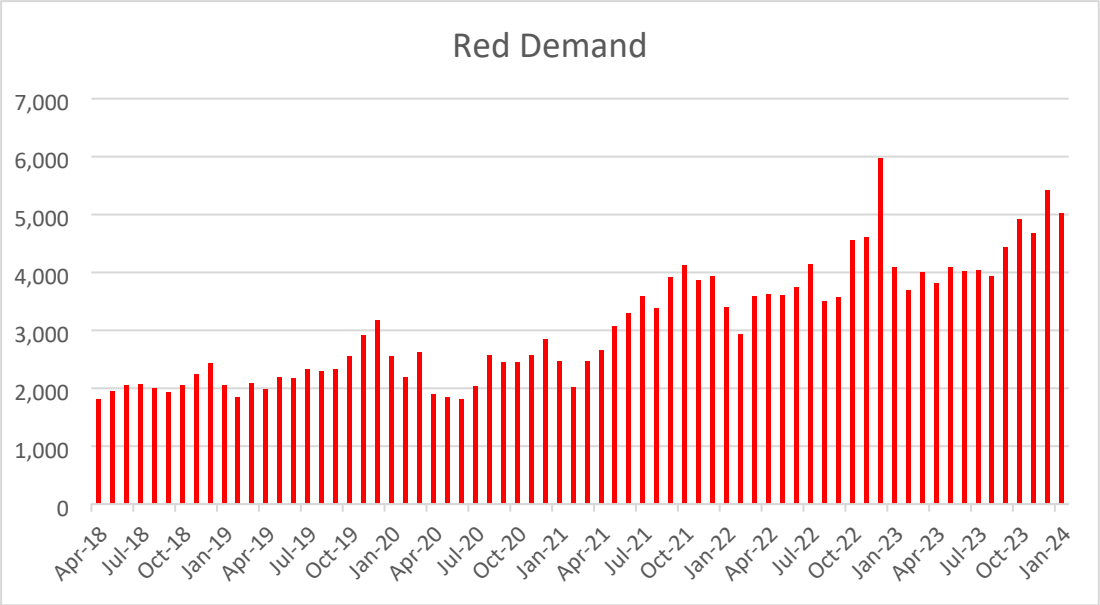
3.4 The programme commenced on 01 Dec-19 and was closed on 03 May-24, totalling 1,615 days. The overall programme set out to achieve 13 objectives, including closing the relief gap, CHARU and roster review. For full list of objectives see (appendix 1). Of the 13 objectives which sub-divides into 41 sub-objectives the programme achieved: -



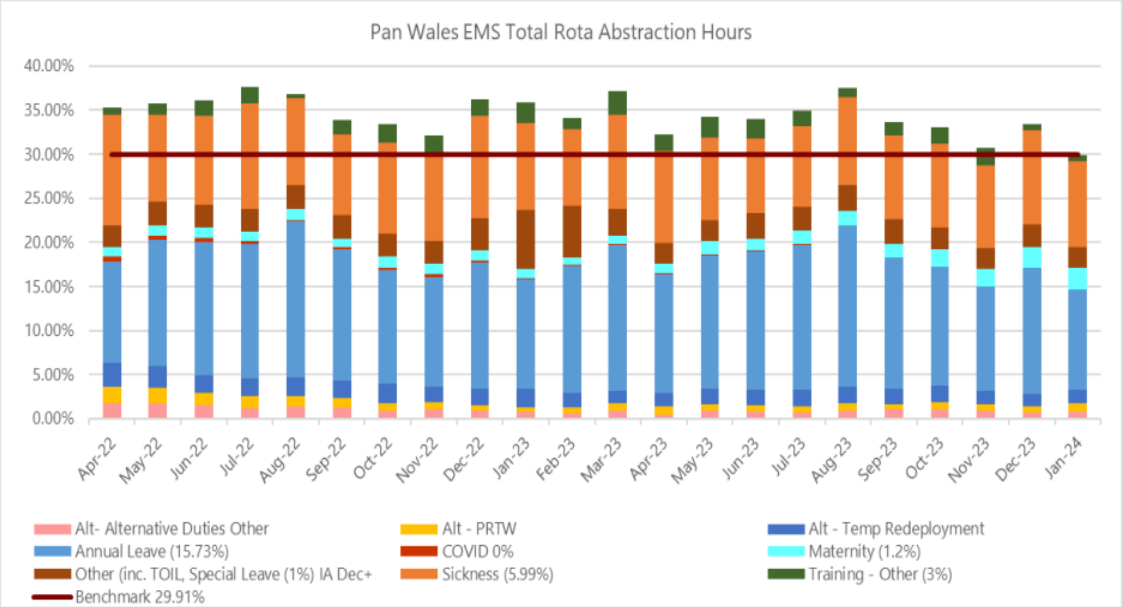
3.5 There were three main benefits that the programme set out to achieve by December 2024 which were tracked using a benefits map and score card. The three main benefits were:

Pan-Wales Benefit	Dec-21 Position	Dec-24 Position
Red A8 Performance	67.3%	74.2%
Amber 1 Median	34.55 (mm:ss)	17.42 (mm:ss)
ROSC	13.18 (2019/20)	average or >* actual ROSC rate in England of 24.8%. It must be noted that this has not been modelled in Wales.

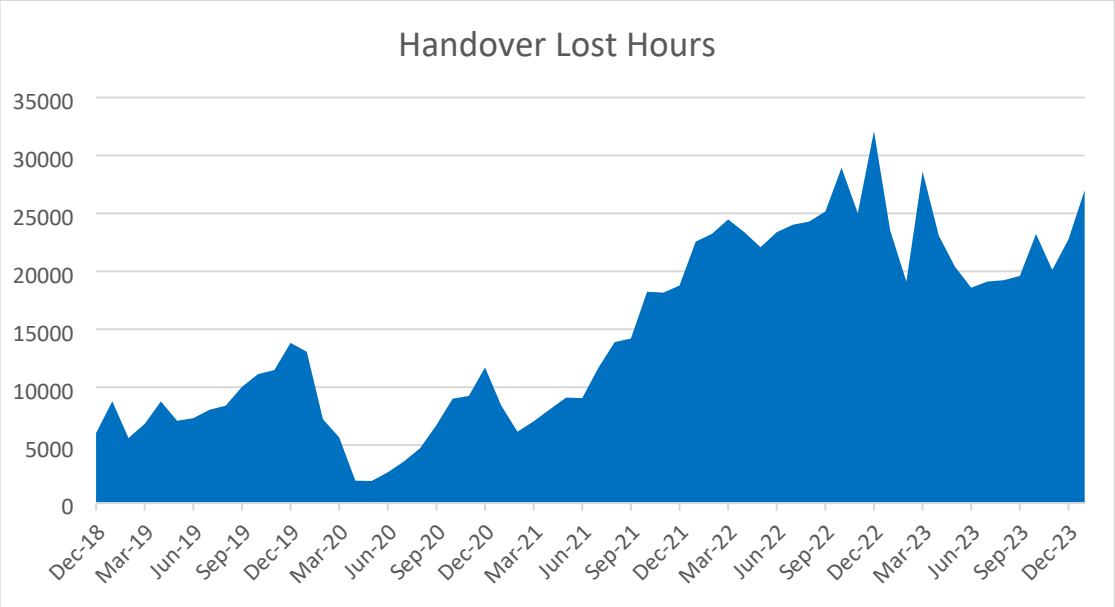
3.6 Whilst the programme has largely delivered its agreed outputs e.g. close relief gap, re-roster, CHARU etc., it has not delivered the modelled levels of performance improvement and associated patient safety. The three primary reasons for this are red demand, abstractions and, in particular, the extreme levels of handover: -



3.7 The programme was predicated on a demand forecast of 2.3% per annum. Red demand doubled during the programme. The 2023 EMS Demand & Capacity Review has forecast a need for a further 52 FTEs, an uplift of 34% on the current modelled FTE requirement.



3.8 The programme was predicated on an abstraction rate of 30%, which became undeliverable as a result of CoVID-19, but had recovered by Jan-24.



3.9 The programme was predicated on 6,000 of handover, not the 32,000 hours seen in Dec-22 (another 2,000 if losses to English hospitals are added in).

3.10 The programme completed the roster review during a pandemic, within the context of extreme levels of handover, within a backdrop of looming industrial action, whilst levering in +343 FTEs additional FTEs and withdrew and introduced a new ambulance resource i.e. CHARU. This is another example of the Trust delivering a difficult programme in complex circumstances and gives further weight to the Trust's reputation with its stakeholders for delivery.

Programme Management & Cost

4.1 The overall programme was led by the Assistant Director of Commissioning & Performance with key representation from Strategy, Planning & Performance, People & Culture, Operations, Finance & Resources and the Medical Directorate, along with other key stakeholders including commissioners, trade unions and Quality, Safety and Patient Experience. The Executive Sponsors were the Executive Director Strategy, Planning & Performance and Executive Director of Operations.

4.2 The programme was subject to an internal audit during its delivery phase. It received a "reasonable assurance", missing a substantial assurance rating because the PID was not fully up to date and the PID had not defined quoracy. These felt like minor technicalities within the scale and complexity of the programme.

Cost

4.3 The main programme's cost were: -

- £16.104m revenue costs of recruiting the +343 FTEs (direct costs of the establishment uplift only).
- £408,000 for the roster review.
- Estates capital works.

Quality

5.1 The programme was expected to deliver five main quality benefits, Amber 1 90th percentile, Amber 2 90th, a reduction in patient waits (12 hours and over), a reduction in national reported incidents and a reduction in in concerns volumes. These quality metrics have not been achieved, with handover lost hours being the main cause.

Follow on Actions & Recommendations

6.1 The main follow-on actions from the programme are: -

i. Undertake a new five-year 2023 strategic EMS demand & capacity review (completed).

ii. ORH have identified a modelled a large uplift of FTEs (traditional conveyance model) to offset handover lost hours of 25,000, which is considered prohibitively expensive, therefore it is a strategic necessity to change the model of delivery.

iii. ORH are not recommending any tweaks to the Dec-21++ keys delivered, but more resource, much less if the clinical model is transformed and handovers reduce to more reasonable levels of 12,000 and 7,000 hours respectively.

iv. Close the programme and connect the 2023 review to the Clinical Model Transformation programme.

v. Continue to focus on reducing abstractions to benchmark 30% as part of BAU performance management.

vi. Continue to recruit to the full 153 FTE CHARU requirement through the now stand-alone CHARU Benefits Realisation Group (currently 75%).

vii. Continue to focus on the effectiveness of CHARUs, again through the CHARU Benefits Realisation Group (see presentation to Sep-24 F&P Committee).

viii. Complete the EMSC Re-configuration project (in deliver phase).

ix. Onward reporting of the programme's closure as directed by STB.

Review of Benefits

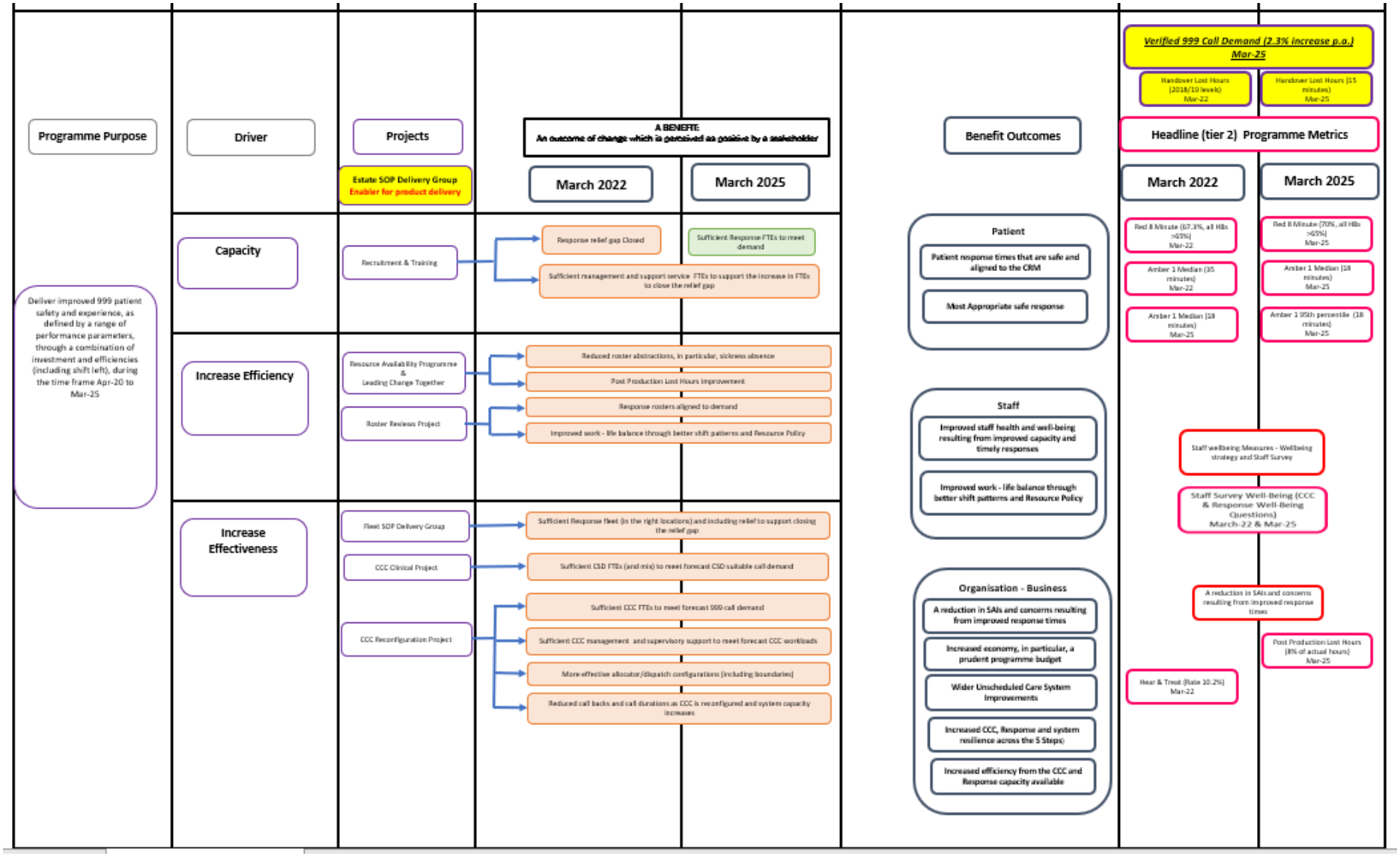
7.1 The programme's purpose was to:

"Deliver improved 999 patient safety and experience as defined by a range of performance parameters, through a combination of investment, efficiencies and effectiveness (shift left), during the timeframe Apr-20 to Mar-25."

7.2 The main overall programmes benefits realisation was to achieve:

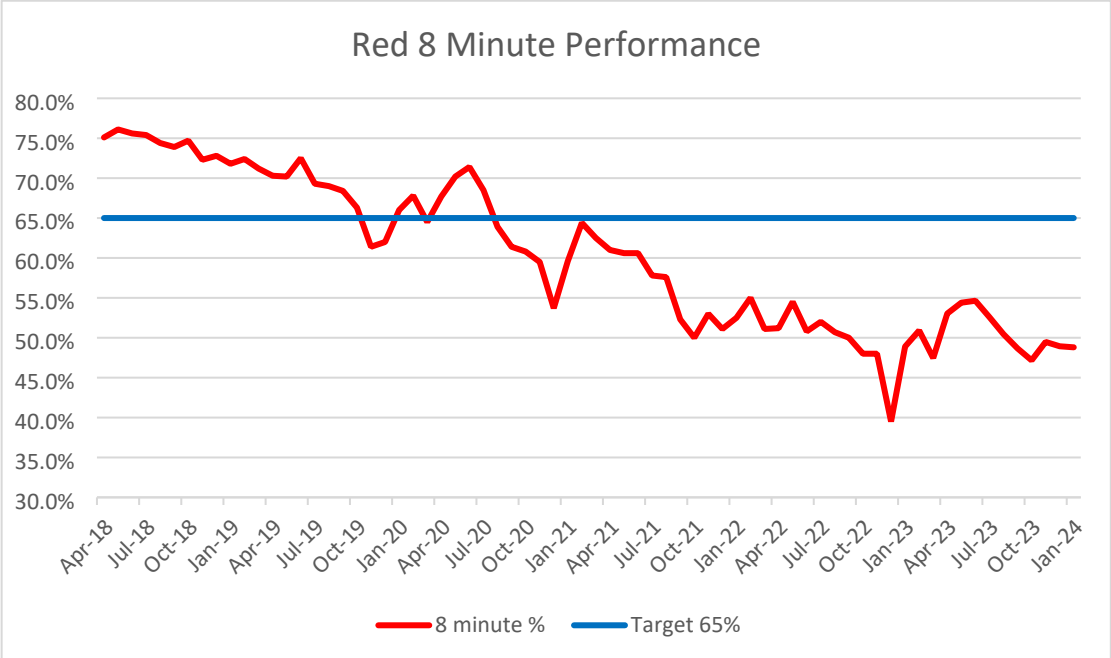
Pan-Wales Benefit	**Dec-21 Position**	**Dec-24 Position**
Red A8 Performance	67.3%	74.2%
Amber 1 Median	34.55 (mm:ss)	17.42 (mm:ss)
ROSC	13.18 (2019/20)	average or >* Actual ROSC rate in England of 24.8%. It must be noted that this has not been modelled in Wales.

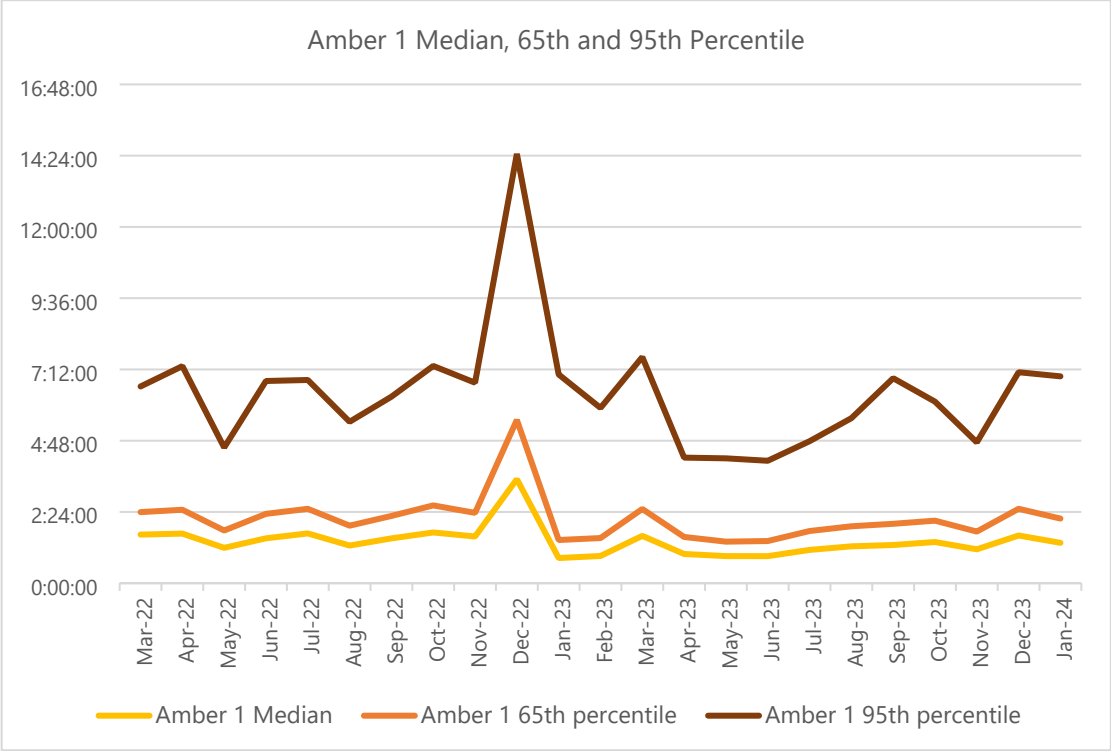
7.3 The programmes benefits were measured by benefits score card (produced throughout the programme) and against the benefits map produced: -

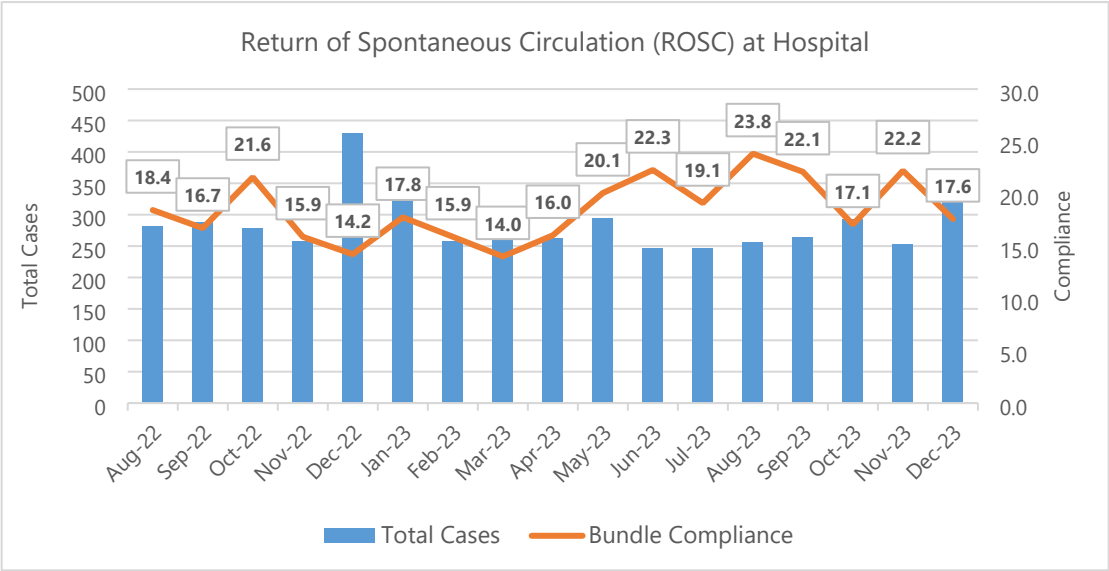

Programme Purpose
Deliver improved 999 patient safety and experience, as defined by a range of performance parameters, through a combination of investment and efficiencies (including shift left), during the time frame Apr-20 to Mar-25
Driver
Capacity
Increase Efficiency
Increase Effectiveness
Projects
Estate SOP Delivery Group
Enabler for product delivery
Recruitment & Training
Resource Availability Programme & Leading Change Together
Roster Reviews Project
Fleet SOP Delivery Group
CCC Clinical Project
CCC Reconfiguration Project
A BENEFIT:
An outcome of change which is perceived as positive by a stakeholder
March 2022
March 2025
Response relief gap Closed
Sufficient Response FTEs to meet demand
Sufficient management and support service FTEs to support the increase in FTEs to close the relief gap
Reduced roster abstractions, in particular, sickness absence
Post Production Lost Hours improvement
Response rosters aligned to demand
Improved work - life balance through better shift patterns and Resource Policy
Sufficient Response fleet (in the right locations) and including relief to support closing the relief gap
Sufficient CSD FTEs (and mix) to meet forecast CSD suitable call demand
Sufficient CCC FTEs to meet forecast 999 call demand
Sufficient CCC management and supervisory support to meet forecast CCC workloads
More effective allocator/dispatch configurations (including boundaries)
Reduced call backs and call durations as CCC is reconfigured and system capacity increases
Benefit Outcomes
Patient
Patient response times that are safe and aligned to the CRM
Most Appropriate safe response
Staff
Improved staff health and well-being resulting from improved capacity and timely responses
Improved work - life balance through better shift patterns and Resource Policy
Organisation - Business
A reduction in SAIs and concerns resulting from improved response times
Increased economy, in particular, a prudent programme budget
Wider Unscheduled Care System Improvements
Increased CCC, Response and system resilience across the 5 Steps)
Increased efficiency from the CCC and Response capacity available
Verified 999 Call Demand (2.3% increase p.a.) Mar-25
Handover Lost Hours (2018/19 levels) Mar-22
Handover Lost Hours (15 minutes) Mar-25
Headline (tier 2) Programme Metrics
March 2022
March 2025
Red 8 Minute (67.3%, all Hills >65%) Mar-22
Amber 1 Median (35 minutes) Mar-22
Amber 1 Median (18 minutes) Mar-25
Red 8 Minute (70%, all Hills >65%) Mar-25
Amber 1 Median (18 minutes) Mar-25
Amber 1 95th percentile (18 minutes) Mar-25
Staff wellbeing Measures - Wellbeing strategy and Staff Survey
Staff Survey Well-Being (CCC & Response Well-Being Questions) March-22 & Mar-25
A reduction in SAIs and concerns resulting from improved response times
Post Production Lost Hours (8% of actual hours) Mar-25
Hear & Treat (Rate 10.2%) Mar-22

7.4 Due to the high levels of abstraction, Red demand and handover delays these benefits were not delivered.

7.5 As of the end of March 2024 the position of the benefits were:

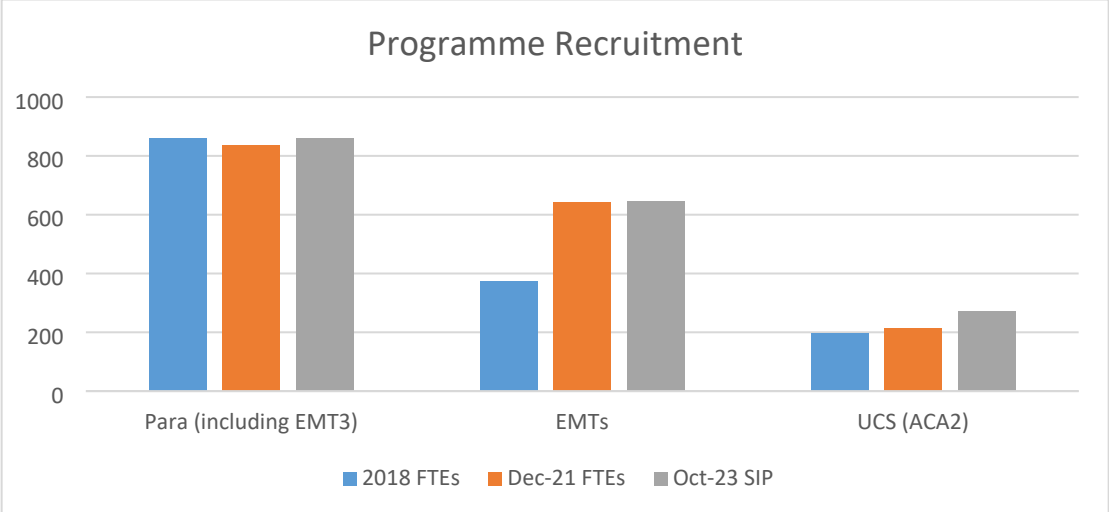


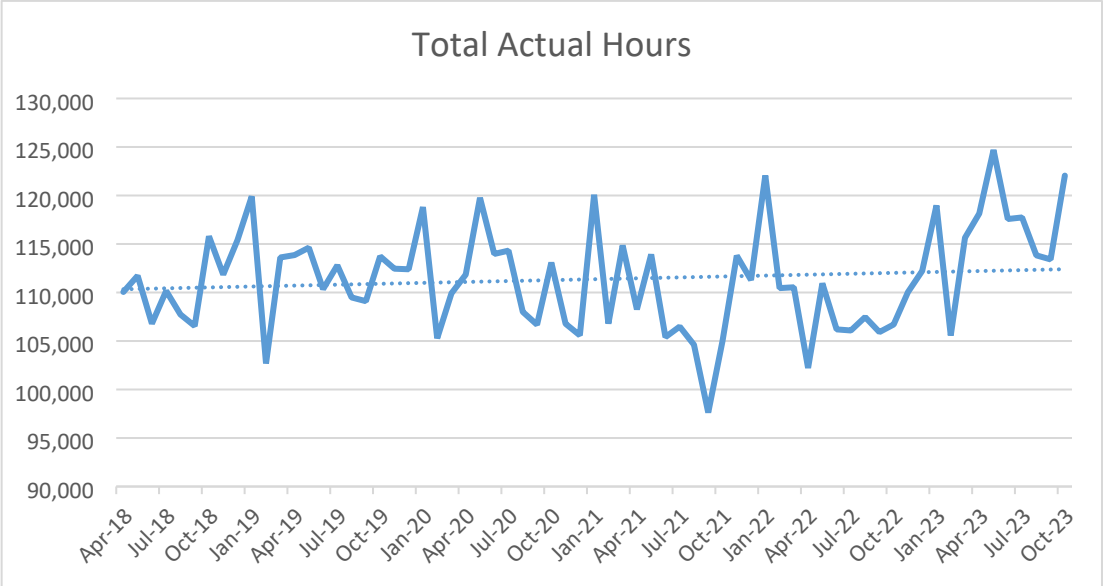




7.6 There has been some improvement in the ROSC rate, but it is not yet sustained.

7.7 Whilst the outcomes have not been delivered capacity has been improved: -





Residual Benefits Expected (post programme)

What benefits have yet to be realised and when will they be?

8.1 Delivery of the benefits i.e. patient safety in the 999-emergency ambulance pathway, will transfer into the new clinical model programme, with the exception of: the delivery of the EMSC reconfiguration project that is now be a stand-alone project reporting directly to STB; and CHARU benefits realisation, which will stay with the CHARU Task & Finish project, which will now focus on CHARU benefits realisation.

How will they continue to be tracked?

8.2 The primary method of onward benefits tracking will be the MIQPR, but this will be supported by more specific dashboards linked to the clinical model transformation programme, e.g. measuring our strategy dashboard.

- Patient Safety

8.3 The origin of the programme was the Amber Review, commissioned by Welsh Government in 2018. The Amber Review was concerned with the long waits in the Amber category and the resultant patient harm.

8.4 During the EMS roster review there was some staff concerns that the review was a cost cutting exercise. There is no information trail to support this view. The PID very clearly sets out a focus on patient safety (and staff well-being) and no "benefit" was ever set around any efficiency saving (there was an efficiency gain of 72FTEs).

8.5 Clearly the programme has not delivered the outcomes intended, as detailed on the above pages, but it should be noted that as part of the decision-making process on the go live of the rosters, OMDA Optima undertook the following modelling for the Chair and CEO: -

Scenarios (1 Jan 2022 - 24 Apr 2022)	RED Performance (% < 8 min)	AMBER1 Median (min)	AMBER1 95th (min)	AMBER2 Median (min)	AMBER2 95th (min)	Abandoned Demand * (%)
Historical	50%	1h 36m	8h 50m	2h 22m	15h 40m	-
"Partial funding" scenario:						
1A) Current rota	40%	2h 05m	13h 12m	3h 36m	15h 02m	2.0%
1B) Dec21++ rota	41%**	71m	9h 52m	2h 37m	11h 47m	0.5%
Difference between rotas	*+1%*	*-54m*	*-3h 20m*	*-59m*	*-3h 15m*	*-1.5%*
"Full funding" scenario (95% UHP):						
2A) Current rota	50%	54m	8h 51m	2h 40m	11h 22m	0.3%
2B) Dec21++ rota	53%**	34m	7h 46m	1h 43m	9h 47m	0.1%
Difference between rotas	*+3%*	*-20m*	*-1h 05m*	*-57m*	*-1h 35m*	*-0.2%*

* = the abandoned demand only applies to simulations. This is on top of any suppressed demand that is already excluded from historical responded data due to high Clinical Safety Plan (**CSP**) levels. In simulations, once an incident has been queued for 12 hours, there is 0.1% chance per minute that the incident gets abandoned (never responded to). Higher abandonment values indicate overwhelming resource utilisation.
** = the RED performance may be understated or overstated. This is highly dependent on the future CHARU dispatch rules, which are not fully understood yet. In these scenarios, CHARUs have been modelled as standard RRVs but with the restriction that they can only respond to RED and AMBER1 incidents.

Colour coding:	Acceptable	Poor	Very Poor	Disastrous

8.6 The results clearly indicate improved performance in both the partially funded and fully funded scenarios.

8.7 OMDA Optima also modelled the above with hospital handover levels reduced to the 6,000 hours that the roster keys were predicated on: -

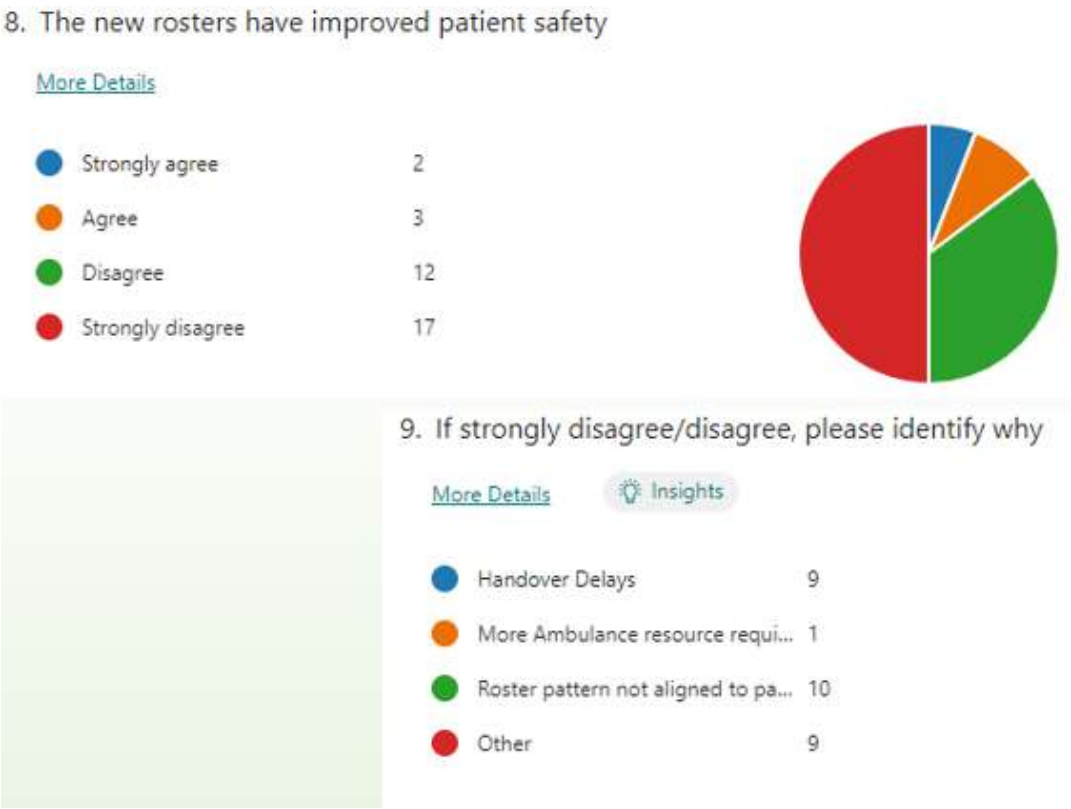
Scenarios (1 Jan 2022 - 24 Apr 2022)	RED Performance (% < 8 min)	AMBER1 Median (min)	AMBER1 95th (min)	AMBER2 Median (min)	AMBER2 95th (min)	Abandoned Demand * (%)
Historical	50%	1h 36m	8h 50m	2h 22m	15h 40m	-
"Partial funding" scenario **with Dec 2018 hospital & scene durations.**						
1A) Current rota	59%	25m	6h 36m	65m	7h 23m	0.0%
1B) Dec21++ rota	60%**	21m	6h 11m	49m	7h 02m	0.0%
Difference between rotas	*+1%*	*-4m*	*-25m*	*-16m*	*-21m*	-
"Full funding" scenario (95% UHP) **with Dec 2018 hospital & scene durations.**						
2A) Current rota	63%	20m	5h 39m	56m	6h 30m	0.0%
2B) Dec21++ rota	64%**	18m	5h 10m	45m	6h 12m	0.0%
Difference between rotas	*+1%*	*-2m*	*-29m*	*-11m*	*-18m*	-

* = the abandoned demand only applies to simulations. This is on top of any suppressed demand that is already excluded from historical responded data due to high Clinical Safety Plan (**CSP**) levels. In simulations, once an incident has been queued for 12 hours, there is 0.1% chance per minute that the incident gets abandoned (never responded to). Higher abandonment values indicate overwhelming resource utilisation.
** = the RED performance may be understated or overstated. This is highly dependent on the future CHARU dispatch rules, which are not fully understood yet. In these scenarios, CHARUs have been modelled as standard RRVs but with the restriction that they can only respond to RED and AMBER1 incidents.

Colour coding:	*Acceptable*	*Poor*	*Very Poor*	*Disastrous*

8.8 The roster keys deliver improved performance in both scenarios above and very good Amber 1 performance.

8.9 TU Partners feedback is more ambivalent on the patient safety impact of the roster keys. The staff survey on the EMS roster review also supports the TU Partner's position: -

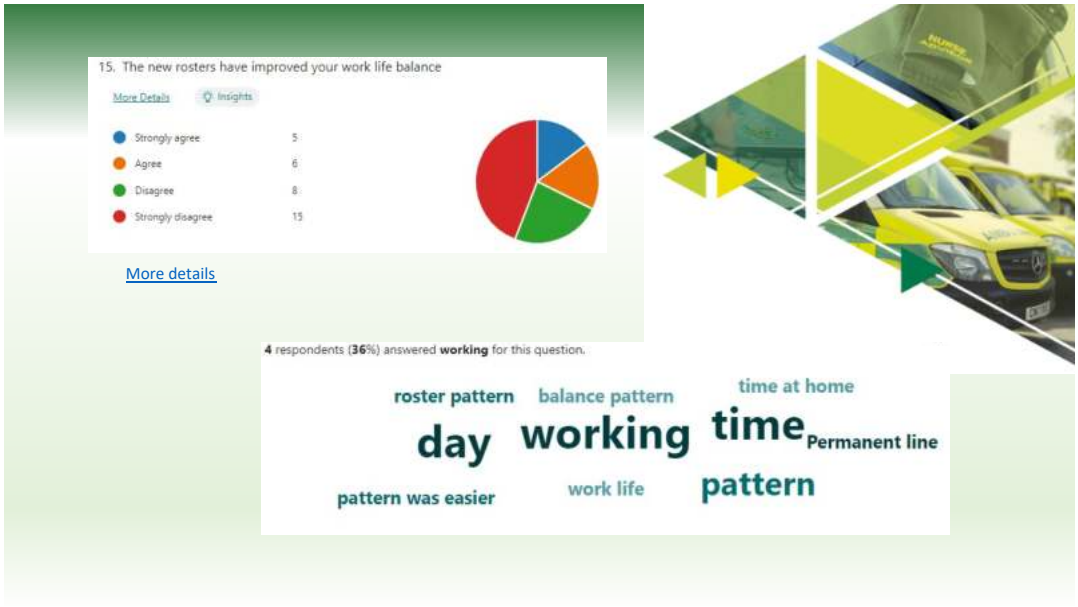


8.10 TU Partners have expressed a particular concern about the elapsed time between the roster keys used in the EMS roster review (provided by ORH in January 2020) and their implementation in Q3 2022/23; however, it should be noted that this was recorded as a risk and further modelling was undertake and revised keys produced by ORH. It should also be noted that ORH have not recommended, in the 2023 EMS Demand & Capacity Review, making any tweaks to the keys implemented, but a range of options for uplifting resource, reduced if the triangle is fully inverted and handover reduces.

8.11 It must also be noted that there were only 36 respondents to the survey.

- Staff Well-Being

8.12 The slide overleaf is an extract from the slide deck (write up) of the staff survey on the EMS roster review: -



8.13 These results suggest that affected staff's work life balance has not improved, however, as above there were only 36 respondents to the survey and it may be reasonable to assume that more disaffected colleagues may have completed the survey e.g. "silent majority".

8.14 The programme team also asked for an independently facilitated focus group to be conducted with a random pick of affected colleagues. The focus group was asked "what three things would you change?". The feedback was: -

What three things would you change?

- Delivery of information back to stations.
- More staff involvement other than just TU Reps and a nominated station rep.
- Implement Rota's at the start of year (April) to cause less problems around annual leave etc.
- Reinstate afternoon shifts. Reposition location of CHARU, in hindsight roster pattern to give greater work life balance.
- Staff able to build rotas

8.15 For the last one “staff able to build rotas” the Trust adopted a high staff engagement model via four working parties, using the ORH roster keys as a backdrop, and software that generates shift options based on these keys. In this sense staff were able to build their own rosters, short list the ones they were most in favour of and then formally vote on them. The above remark may hint at staff wanting to “build” the roster keys. The Trust’s position is that the building of the keys needs to be done through independent mathematical method and that this was done in collaboration with TU Partners through the 2019 EMS Demand & Capacity Review. It would be unworkable to have every locality working the roster keys.

8.16 The other major concern flagged by TU Partners was the impact of loss of USHs. The following table provides an analysis of the impact of the re-roster on USHs: -

	EA	UCS	Combined
Anuerin Bevan	-1.09%	-6.99%	-2.20%
Betsi Cadwalader	-0.26%	-2.09%	-0.49%
Cwm Taf	-0.89%	-4.67%	-1.58%
Cardiff and Vale	-0.31%	-2.70%	-0.61%
Hywel Dda	-0.21%	-3.50%	-0.73%
Powys	-0.06%	-22.20%	-1.53%
Swansea Bay	-0.13%	8.80%	0.61%
Wales	**-0.42%**	**-4.76%**	**-0.93%**

8.17 Clearly a reduction in USH payments would have a significant impact on a colleague’s well-being. The Trust acted within the agreed Core Principles and the rules and procedures of the Trust (which includes periods of protection, but acknowledges the timings of these losses, within the context of the cost-of-living crisis were unfortunate.

Review of Objectives

9.1 The programme PID contained 13 objectives and 41 sub-objectives. These are reviewed in the following table:-

No.	Objective	Delivery Work-stream	Desired Outcome	Achieved?
1.	Recruit and train FTE requirement and ambition of Demand and Capacity programme 2019 by March 2025	Recruitment and Training	Sufficient FTEs to keep pace with demand as modelled by ORH (subject to further modelling).	The FTEs were sufficient to close the relief gap, but not cope with the level of handover lost hours which increased from 6,000 hours to 34,000 hours at peak.
1a.	Recruit and train 2020-21 FTE requirement by March 2021	Recruitment and Training	52% FTE contribution to closing the relief gap.	Achieved
1b.	Recruit and train 2021-22 FTE requirement by March 2022	Recruitment and Training	Closure of relief gap adjusted for 46 ACA2s held open so adjusted total 217. 217 will be delivered, but option to smooth FTEs in 2022/23	Achieved & Exceeded
1c.	Smoothing option (rurality)	Further discussion required. (Report to EMT in November 22)	More equitable performance	Establishment aligned to modelled requirement to encourage smoothing, but rural recruitment remains challenging
1d	Recruit and Train plus 100 FTE's and SIP to match establishment	Recruitment and Training	A relief gap -64	Achieved
1e.	Recruit and train sufficient number of FTEs to close the relief gap	Recruitment and Training	No relief gap	Achieved against original roster keys, but CHARU keys required 153 FTEs v

				the 52 RRV FTEs in the original keys.
1f.	Improve the recruitment and training experience	Recruitment and Training	Positive staff experience feedback on "landing" in WAST.	Process clarified with recruits receiving much more timely information on base location, however, speed of recruitment led to base followed by transfer requests
2.	Adjust and deliver the EMS Response workforce plan (and recruitment and training plan) for the required number of FTEs based on strategic reconfigurations of NHS Wales's services.	Programme and other programmes.	Out of scope, but related, as workforce plan needs to adjust to take into account and programme needs to understand impact and that there are not negative consequences to the programme. SBAR on Ambulance Response FTE workforce plan currently being produced by WOD.	Out of scope
3a.	Adjust and deliver the EMS Response workforce plan (and recruitment and training plan) for the required number of FTEs based on the Grange University Hospital requirements.	Programme and other programmes.	Out of scope, but related, as workforce plan needs to adjust to take into account and programme needs to understand impact and that there are not negative consequences to the programme. Delivered close.	Out of scope
4.	Deliver Fleet requirement for response and training capacity in line with ambition of Demand and Capacity programme 2019 and implications of strategic reconfigurations of NHS	Fleet SOP Delivery Group	The correct and sufficient fleet for the additional FTEs being recruited and trained.	Achieved. Recent modelling confirms there is sufficient fleet for the Dec-21++

	Wales's services by March 2023, in particular, the CHARU requirement and the HD EA adjustment.		Avoidance of dropped shifts due to lack of ambulance availability.	keys and 2024/25 APP establishment.
4a.	Review and deliver agreed Fleet requirement in line with 2020-21 FTE requirement by March 2021	Fleet SOP Delivery Group	The correct and sufficient fleet for the additional FTEs being recruited and trained. Avoidance of dropped shifts due to lack of ambulance availability. Delivered close.	See above. Achieved.
4b.	Review and deliver agreed Fleet requirement in line with 2021-22 FTE requirement by March 2022	Fleet SOP Delivery Group	The correct and sufficient fleet for the additional FTEs being recruited and trained. Avoidance of dropped shifts due to lack of ambulance availability. Delivered close.	See above. Achieved.
4c.	Review and deliver agreed Fleet requirement in line with 2022-23 FTE requirement by March 2023, to include CHARU requirement and HD EA adjustment.	Fleet SOP Delivery Group	The correct and sufficient fleet for the additional FTEs being recruited and trained. Avoidance of dropped shifts due to lack of ambulance availability.	See above. Achieved.
5.	Deliver Estate requirement for response and training capacity in line with ambition of Demand and Capacity programme 2019 and implications of strategic reconfigurations of NHS Wales's services by March 2022	Estates SOP Delivery Group	Sufficient estate in the required locations to accommodate the uplift in FTEs being delivered by the programme.	Achieved.

5a.	Review and deliver agreed Estate requirement in line with 2020-21 FTE requirement by March 2021	Estates SOP Delivery Group	Sufficient estate in the required locations to accommodate the uplift in FTEs being delivered by the programme.	Achieved.
5b.	Review and deliver agreed Estate requirement in line with 2021-22 FTE requirement by March 2022	Estates SOP Delivery Group	Sufficient estate in the required locations to accommodate the uplift in FTEs being delivered by the programme.	Achieved
5c.	To review to there is efficient estate for the plus 100 FTE's	Heads of Service and SRO	Sufficient estate	Achieved
6	Transform Clinical leadership, education, and services within CCC	CCC Clinical Programme Board	See 6a and 6b.	Project delayed due to pandemic (escalation levels) .Transferred out of project as stand alone project reporting to STB
6a.	Achieve 10.2 % hear and treat rate by Dec-21	CCC Clinical Programme Board	Improved patient safety through a timely telephone "response". Increase in ambulances not dispatched as a result of achieving (exceeding) the 10.2% benchmark, freeing up ambulances to respond to higher acuity calls thereby improving patient safety. 10.4% achieved for 2021/22. Close	Achieved.
6b.	Achieve 17% hear and treat rate by DEC -22 – by increasing the establishment with plus 36	CCC Clinical Programme Board (linked to +36 FTEs uplift)	Improved patient safety through a timely telephone "response"	Remains an IMTP ambition. Now forms part of Clinical Model Transformation

	Paramedics and plus 5 MHP's		Increase in ambulances not dispatched as a result of achieving revised benchmark of 17%, freeing up ambulances to respond to higher acuity calls thereby improving patient safety.	Programme (Trust did achieve 15.1% in April 2024).
6c.	Code Set Change	CCC Clinical Programme Board	Improved patient safety through a timely telephone "response". Increase in MPDS codes directed straight to telephone triage through a change in the DCR process. Increased hear & treat rate.	Achieved
6d.	CSD Roster Review	CCC Clinical Programme Board	Improved patient safety through a timely telephone "response". CSD rosters aligned to demand (ORH roster keys). The new roster was implemented on the 31st January 2022.	Achieved
6e.	Physician Triage Assessment and Streaming (PTAS)	CCC Clinical Programme Board	Improved patient safety through a timely telephone "response" provided by health boards. Would be a separate measure in the AQIs and not part of hear & treat measure.	Health board dependent with support from JCC

7.	EMSC Reconfiguration	EMSC Reconfiguration Project Board		Project delayed due to pandemic (escalation levels). Transferred out of project as stand alone project reporting to STB
7a.	EMSC Restructure A career structure that demonstrates an ability to remain within EMS Coordination from a Band 3 Call Taker, through to the Head of Service provides a real opportunity to develop a career within the emergency call handling function.	EMSC Reconfiguration Project Board	Improve the ability to recruit, retain and develop those staff who want an emergency call handling career to remain within the department. This is also a supportive measure to ensure that EMSC are able to deal with issues raised by staff in a quicker timescale and with support offered at every level.	Project delayed due to pandemic (escalation levels). Transferred out of project as stand alone project reporting to STB
7b.	Roster Review Building a new model that rosters will support the demands on the service, but also align to the Single Allocator model	EMSC Reconfiguration Project Board	Reflective of the workloads across desks and during times when demand has dropped off significantly. The rosters will be developed in partnership with Trade Union Partners and staff to ensure that there is a proper balance between demand from the public and the need to consider the wellbeing of staff.	Project delayed due to pandemic (escalation levels) Transferred out of project as stand alone project reporting to STB
7c.	Boundary Changes ORH presented evidence 2017 and 2023 that there	EMSC Reconfiguration Project Board	Improved alignment between patient	Project delayed due to pandemic (escalation levels). Transferred out of project as stand

	remains an inequity in the management of work across desks within EMSC. Aside from the equitable spread of work this also provides some changes to the alignment of work across boundaries and recognises the flow of patients from one part of Wakes and into another.		demand / flow and the configuration of EMSC.	alone project reporting to STB
7d.	Single Allocator Model and Different Ways of Working Development of a Single Allocator Model – An original recommendation from the D&C review in 2017, and in line with practice across other Ambulances services in the UK.	EMSC Reconfiguration Project Board	The move to a single allocator model provides clarity in terms of ownership of the area and overall oversight of the work in a given area.	Project delayed due to pandemic (escalation levels). Transferred out of project as stand alone project reporting to STB
8	Review the EMS Response rosters	Roster Review (Response) Project	See 8a and 8b.	Achieved
8a.	Align the EMS response rosters to the demand pattern (ORH roster keys by Nov-22.	Roster Review (Response) Project	Response rosters aligned to demand which improved patient safety, delivers an efficiency of 72 FTEs not required and improves staff well-being through improved rota design.	Achieved
8b.	Improve staff welfare (work life balance) as part of the review of the roster keys (by Nov-22).	Roster Review (Response) Project	Response rosters aligned to demand which improved patient safety, delivers an efficiency of 72 FTEs not required and improves staff well-being through improved rota design.	The rosters themselves should have led to improved work life balance, but the level of shift overruns (handover lost hours) will have

				worked against a positive perception
8c.	Implementation of CHARU roster keys (linked to 12)	Roster Review (Response) Project	CHARU rosters aligned to patient demand. (Partially Funded at this time).	Achieved (against original programme objective).
8d.	Full implementation of CHARU roster keys by Jun-23	CHARU Task & Finish Group	CHARU rosters aligned to patient demand (by moving FTEs from EAs to CHARU lines).	74% July 2024. Rural recruitment a challenge
9.	Workforce Modernisation Project		Improve EMS resource availability through improved workforce working practices.	Direct negotiations between Execs and TUs
9a	Deliver an 8% sickness abstraction from EMS Response rosters by Mar-23.	Managing Attendance Programme	A contribution to delivering the UHP benchmarks of 95% for RRV, EA and UCS.	Achieved
9b	Deliver a 6% sickness abstraction from EMS Response rosters by Mar-24.	Managing Attendance Programme	A contribution to delivering the UHP benchmarks of 95% for RRV, EA and UCS.	Clear downtrend, but 6% not yet achieved. Separate programme of work
9c	Deliver an agreed revised approach to CPD (linked to audit on need to account of these hours) in time for re-roster go live.	Roster Review Project Team	Roster Review Core Principles include 52 hours CPD at source (36.5-hour week on rosters) with 52 hours recorded (probably on GRS)	Achieved
9d	Deliver an agreed revised approach to meal breaks by end December 22. • RTB Automation • (paused linked to IA negotiations)	Rapid Task and Finish Group	Optima has identified a 1.1% Red gain and Amber 1 95th -5-minute gain (nearest suitable station)	Achieved

10.	Management and support services reflect and increasing workforce.	Programme Board	1 – 15 DOM ratio 1 – 30 SP ratio Occupational Health ratio Other management and support services.	Achieved
12	Cymru High Acuity Response Unit (CHARU)	CHARU Task & Finish Group	Improved clinical outcomes (ROSC) CHARU parameters delivered in each health board (20 urban and 30 minute rural) 65% of Red incidents responded to in 8 minutes in each health board. These three outcomes will not be delivered unless the CHARU roster keys are fully funded. Decision (Jan-23) to move Paramedics across from EA lines to CHARU lines to fully deliver CHARU roster keys, with reduced EA UHP.	ROSC rate has seen improvement. Further improvement via Clinical Indicator Plan submitted to commissioners. See separate report to F&P Committee (17 Sep-24) on impact of CHARUs. Trust is reaching more red incidents, but denominator (red demand) is much higher. Now being taken forward by CMT Programme.
13	Rightsizing	To be Determined	A reduction in minus 3.5 EA's to support the uplift in APP's and CHARU.	Decision to run temporary relief gap instead. 23/24 uplift outside of programme, but achieved

Deviations from Approved PID

Has anything that was not documented in the business case been produced?

10.1 The detailed work on the large Excel document for calculating the fleet and estate requirements.

Has anything different been produced from how originally described? If so, why? And was this expected?

10.2 There were numerous versions of the PID, taking account of a range of in programme changes, in particular: -

i. The “HD Adjustment” i.e. no reduction in EAs, denoted as the first + on Dec-21++ roster keys, with Dec-21 being the original keys supplied by ORH.

ii. The removal of RRVs and introduction of CHARUs, the second + on Dec-21++.

iii. The move of 36 FTE Paramedic posts from EMS Response into CSD and reduction of 46 ACA2s to pay for this move.

iv. The change in consult & close benchmark from 10.2%, to 15% and then 17%.

v. The +100 additional FTEs uplift in EMS Response establishment.

vi. Updated modelling for the EMSC reconfiguration, updated from 2019 to 2023, to support the move to the single allocator model, dispatch desk workloads and dispatch desk boundaries; and

vii. Additional modelling undertaken by both OMDA (Optima) and ORH, in particular, the consideration of the level of Red demand on the programme; and the consideration of whether to go live with the roster keys within the context of extreme handover delays.

11. Review of Programme Products

11.1 The programme worked within the project & programme management framework of the Trust. The programme was supported by the usual set of documentation e.g. PID, programme risk register, issues log, highlight reports, programme governance map etc. This approach worked well, with substantial assurance almost being achieved in an internal audit of the programme and the Executives moving from SRO to Sponsors and dropping off the three weekly programme board.

11.2 The internal audit identified the formal connection between the programme and STB as an area of attention, in particular, agreements to PID amendments.

11.3 The joined-up data handling approach for recruitment, using MS365 worked well. This single data set reduced transactional communications, enabled timely occupational health, and assisted Clinical Audit with the issue of PINs.

11.4 The Excel database to give station level information on FTEs and fleet requirements provided a level of granularity the Trust had not previously had; however, it is recognised that a new live version is required: currently being built on a Power BI platform: NEXUS.

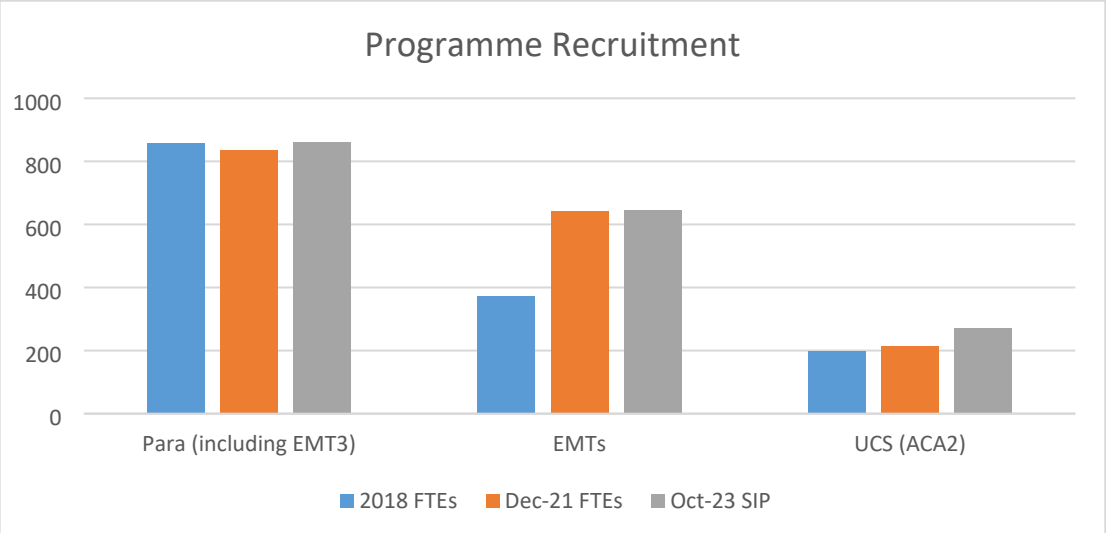
11.5 The Core Principles approach from the roster review has been reused for other roster reviews.

11.6 The voting arrangements for the EMS roster review were very problematic and required the use of ACAS to validate.

12. Programme Phase Review (including lessons learnt)

Recruitment & Training

12.1 The objective set by the EMS Demand & Capacity Programme for recruitment and training was to increase the EMS workforce by 363 additional FTEs between 2019 to 2022. By Oct-23 the Trust had achieved an uplift of 343 FTEs. This was a substantial uplift achieved on a short period in the middle of pandemic.



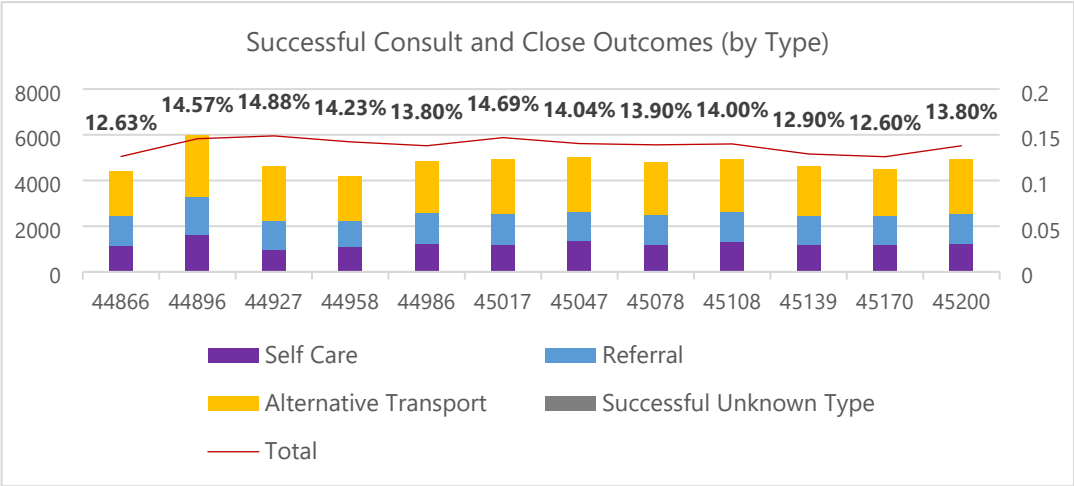
12.2 Whilst the programme delivered on the objective of increasing the establishment, the Trust often received funding within the financial year and on a payment on results basis. This caused a high degree of pressure i.e. short termism, on junior staff, involving working through weekends in order to deliver. Equally, it also meant that instead of trying to place the incoming FTEs in the right locations (and recruit the right level of staff) there was a mad rush to just hit the targets.

What worked? • The establishment of a dedicated project team within a wider programme. • The joined-up data handling approach for recruitment, using MS365 worked well. • Provision of FTE numbers from the 2019 Demand & Capacity Review at a station level.
What did not work? • The recruitment team at the time was very small and the workload, probably unnoticed, was excessive, involving junior staff working through weekends (no overtime or time off in lieu). • In year funding and payment by results created a high level of difficulty for the programme (are health board made to recruit like this?). • At the time of the programme there was no dedicated workforce planner in the Trust, for an organisation of +4,000 staff. The Trust was very reliant on one officer undertaking this work on top of her day job. • The ability to connect the recruitment requirements with station level capacity was problematic (see section on estate below).
What would you do differently? • Ensure that the recruitment team is sufficiently resourced (addressed?). • Ensure there is a dedicated organisational lead for workforce planning and avoidance of a SPOF (addressed). • Improve the Trust's integrated information on station capacity e.g. staff, lockers, car parking spaces.

<u>Clinical Review (Consult & Close element)</u>

12.3 The consult & close rate was an area of interest to the programme, but delivery was undertaken by a separate programme, however a connection was maintained due to the link to the 2019 EMS Demand & Capacity Review and the recruitment connection to EMS Response.

12.4 The original ambition was 10.2%, revised up to 15% and further revised up to 17%. The 10.2% was comfortably achieved, for a period of time the 15% was achieved, but the Trust has not yet achieved the 17% consult & close rate.



12.5 The 2023 Demand & Capacity Review identified a very rate of abstractions in the CSD. A review ty the NCCU identified 15 recommendations, which the Trust has accepted. The recommendations broadly fall into four categories: metrics, benefits realisation, future transformation, and health board related.

12.6 CSD received an uplift of 36 FTEs to its establishment and was also re-rostered.

12.7 PTAS was originally included in the PID objectives, but the programme did not undertake a transformation work in this area.

12.8 As above this project, whilst of interest to the programme, sat in another programme. A closure and evaluation report has not been completed to date. The lessons learnt will be updated on completion of the separate closure and evaluation report.

What worked? • A modelled benchmark for the consult & close rate.
What did not work? • The high pace of the recruitment coupled with the pandemic made focusing on the effectiveness of the recruitment more problematic. • The loss of a good project manager from SP&P, who was supporting the CSD team and the inability to resource further support in the short term: now addressed.
What would you do differently? • Project support to the CSD team.

<u>EMSC Reconfiguration</u>

12.9 The project was repeatedly delayed as a result of the pandemic and system pressures, in particular, the sustained period at REAP4. The re-roster of EMSC call takers was completed, but the rest of the project was paused. It has recently been restarted, based on updated modelling (August 2023) from ORH. The project's deliverables are: -

- **New management structures**: implementation of a new career structure that offers more opportunities for the development and retention of staff who want an emergency call handling career. This will also support the cultural transformation of the department.

- **Development of a single allocator model:** This will ensure greater efficiency in the allocation and dispatch function, in line with practice across other UK ambulances services.
- **Realignment of boundaries and dispatch desks:** Aside from an equitable spread of work this also provides some changes to the alignment of patient flows across health board boundaries and from one part of Wales and into another.
- **Building new rosters that align to these changes:** rosters should be reflective of the workloads across desks and during times when demand has dropped off significantly.
- **Target culture work**: working with our TU partners on culture change with clear action plans put in place to address key themes and issues across the area.

12.10 This is now the only remaining area of the programme that has not been delivered. It does not make sense to continue the programme for just one project, so it is recommended that this project now reports directly to STB, with the programme closing down. The lessons learnt will be completed on completion of the project.

12.11 EMSC Reconfiguration (The EMSC Reconfiguration Projects Lessons Learnt only captures the lessons from the Rosta Review for Call Takers due to the other Projects continuing post the closures of the Programme Board).

What worked? • Asking call takers to be involved in the process was hugely positive. • Positive on the whole. Really positive engagement from all involved. • The project team had strengths and weaknesses which were identified were utilised where required. • Core principles provided great framework to work to, regular diarised meetings and updates provided. Teams developing their own rosters based on the cover required – empowering teams.
What did not work? • Struggled to get engagement from the staff affected by the review. • Time in a room with resources could have helped issues/misunderstandings more quickly and sped up the process. • Project felt rushed due to time constraints. • Some CTs are still unhappy with the shift pattern.
What would you do differently? • Involve staff from the outset to ensure a collaborative message and information is shared with the wider team. • Project plan to include more time to allow the development of the rosters. • Resource team to be involved from the outset with regards to the roster designs.

<u>Roster Review (Response)</u>

12.12 The roster review (EMS Response) was the most contentious aspect of the programme, for example, the CEO delivered 29 stakeholder briefings and the review involved the use of ACAS.

12.13 In dialogue with TU Partners the project team agreed to work through each phase of the project providing a short narrative followed by key lessons learnt what worked, what did not

work, what do differently. If the SRO and TU positions are different, it was agreed to record any difference of view.

12.14 Both parties agreed that given the size and complexity of the EMS roster review it was an important part of the legacy of the review to leave a written record for roster reviews.

12.15 The roster review was delivered, and that was reputationally important for the Trust with its key stakeholders, with the lack of a completed roster review (non-delivery of efficiencies) being cited as reason for not giving further investment.

12.16 The number of variables that affect performance (OMDA have identified over 20) make is almost impossible to assess the impact of the roster review, but both OMDA and ORH modelling supported their implementation, with ORH not recommending any tweaks in the 2023 Demand & Capacity Review.

Roster Review - Forecasting & Modelling

12.17 The EMS roster review was underpinned by forecasting and modelling by ORH undertaken through the 2019 EMS Demand & Capacity Review. During the EMS roster review the project team were also able to use OMDA Optima to provide a second opinion on the keys. This proved particularly valuable when the project team was reviewing its risk register, with a key risk being that the keys were inaccurate. TU partners had raised a concern about Red demand. The project team were able to test ORH's keys with OMDA Optima.

12.18 This second opinion identified the need to boost the modelled 11 RRVs pan-Wales to 33 pan-Wales, with the information feeding up to Executives and the CASC and leading to the 2019 EMS Demand & Capacity Review being re-opened. This process led to the introduction of the CHARU resource.

12.19 Near the end of review, several iterations of modelling were undertaken, within the context of extreme hospital handover lost hours.

What worked? • Having access to two different emergency ambulance simulation software packages enabled a second opinion to be provided and increased assurance on patient safety.
What did not work? • Ideally, the time between the initial keys from ORH and implementation should be as short as possible. It was longer here due to the pandemic.
What would you do differently? • Keep the time between provision of the roster keys and implementation as short as possible.

Roster Review - Initiation & Procurement

12.20 Initiation really started with a nudge from the CEO to look into an external company that London Ambulance Service (LAS) had used to undertake a large-scale roster review. Initiation included contacting LAS and other UK ambulance services to find out more about undertaking a roster review via a third party.

12.21 The ELT decision to proceed with the EMS roster review and procure a third party, in principle, subject to a full PID, was taken in August 2020. An initial cost estimate of £250,000 for the use of a third party was decided upon, based on information from another UK ambulance trust. This estimate proved inaccurate, due to the time period elapsing between the UK ambulance trust's use of a third party.

12.22 A shadow project team was created, chaired by the SRO, the AD Operations EMS and with support from the AD Commissioning & Performance almost acting as a dual SRO, given the AD Operations EMS operational time commitments. This worked well. The project capacity was further supplemented by a project manager with specific expertise in roster design and further supported by xxx days of a third-party specialist roster design company.

12.23 TU Partners were at the table from the inception of the project team and were part of the selection panel for the procurement exercise, which is procured Working Time Solutions (WTS), now part of TotalMobile. TotalMobile were the only company to tender for the work. This enabled the project team to engage with TotalMobile during the procurement process e.g. almost like a negotiated route. This proved particularly valuable in gaining knowledge on the practicalities of undertaking a large-scale roster review.

12.24 Another key aspect of initiation was a meeting between the AD Commissioning & Performance (SRO of the EMS Operational Transformation Programme), programme colleagues and the CEO and sponsoring Executives. This meeting focused on the scale of change involved, in particular, the reduction in the RRVs from 60 to 11. On reflection there should have been more engagement with ELT on the scale of change including related analysis.

12.25 The initial PID was signed off by ELT at the end of the procurement process, with the recommendation to proceed with TotalMobile. The Executive Director of Operations also recommended the inclusion of a B7 Systems Officer to support the project.

12.26 The need to go to Finance & Performance Committee for PID approval and procurement approval did slow the project down (two months were lost).

What worked?

- Initial strategic leadership from ELT i.e. the nudge.
- The amount of organisational capacity that was put behind the project i.e. it was set up to succeed, including a dual SRO, the connection of the project into a wider programme, and a specialist third party.
- A dual SRO approach is considered a critical success factor.
- The use of specialist third party is considered a critical success factor.

• Engaging with TU partners at inception and involving them in the PID and procurement process.
What did not work? • The initial engagement on the understanding on the scale of the impending change i.e. it is not just an operational roster review. • The requirement to go to formal committee slowed the project down. • Initial third-party cost estimate was inaccurate.
What would you do differently? • Engage more with strategic leaders at the initiation stage (and pre-work stage). • Determine earlier whether committee approval is required. • Ensure the third-party cost estimate is current or reflects inflation. • The contract was unusual in terms of including the procurement of software licenses for the rostering software (for a three-year period) and the automatic renewal of these licenses was not recorded in the risk register, which caused problems at the end of the three years (now resolved, but this was not an ideal situation).

Roster Review - Pre-Work

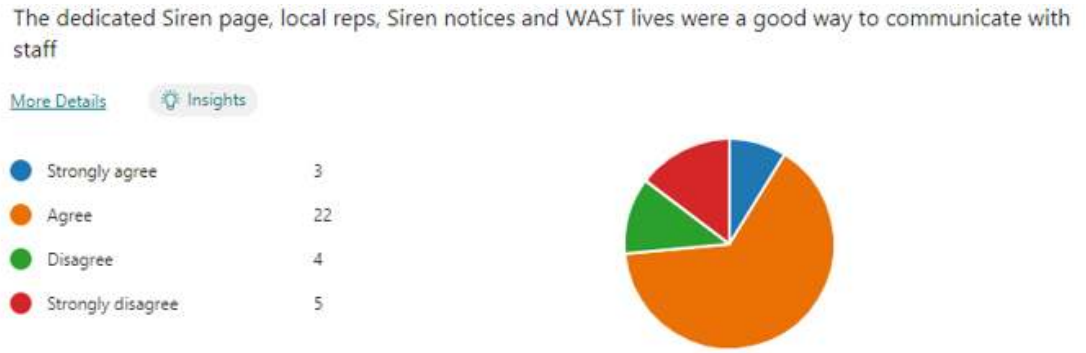
12.27 The key aspect of the pre-work was the appointment of the internal project manager. The project team considered whether to seek a colleague who was a trained generalist project manager or an expert on rosters who can be trained in project management. The latter was agreed, and a project manager was appointed from the Resource function and seconded out for the duration of the project.

12.28 The project manager was appointed in April 2021. The project manager received support from the AD Commissioning & Performance on project management, but never received any formal training, which was an omission.

12.29 Similarly, a project support officer was sought. There was no budget for this with the resource needing to be found. The officer came from within Strategy, Planning & Performance (Operations could not field a resource). The officer had previous Operations experience including ambulance response.

12.30 At this stage the project team was firmly established, meeting every three weeks formally and a quick fire 30-minute no agenda meeting every week.

12.31 The PID helped clarify thinking about who was required on the project team, which now included dedicated People & Culture Support (business partner) and a communications lead. A communications plan was produced including sign off on external communications and also the establishment of dedicated SIREN page. Feedback from affected colleagues on the SIREN dedicated project page was very favourable.



12.32 At this stage a sense check was undertaken on the ORH roster keys and there was engagement between the project manager and local EMS management on the project.

12.33 Pre-work also involved looking at the estate and fleet implications of the EMS roster review. Whilst these were picked up on separate projects within the EMS Operational Transformation Programme, any large-scale roster review must consider the estate and fleet consequences. Another UK ambulance trust had to stop a roster review because the lack of estate became a barrier.

12.34 On reflection there was scope for further engagement with Operations EMS heads of service and with Ops SLT and ELT. Had the project team done so the reduction in EAs in Pembroke may have been picked up, instead this was picked up after colleagues went to the press.

What worked? • The appointment of a dedicated specialist project management with specific experience in rostering is considered a critical success factor. • Finding a project support officer, one of your best administrators who has experience and knowledge of rosters is considered a critical success factor. • A clearly thought through project team connected to the PID. • A dedicated project SIREN page, supported by a project communications lead. • A People & Culture business partner assigned to the project. • Pre-work by the project manager and third party with local managers. • Prep-work as part of a wider programme on the estate and fleet consequences of a roster review i.e. have you got sufficient estate and fleet to handle the change.
What did not work? • The appointed project manager should have received some formal training on project management, although it should be noted he acquitted himself very well.
What would you do differently? • More engagement, as part of the pre-work, with EMS Operations Heads of Service, Ops SLT and ELT.

Roster Review - Core Principles

12.35 The project team were advised by other UK ambulance trusts and the Totalmobile that negotiating the Core Principles would take four months. There was some surprise by Executives on the length of time, but the project team was able to build in four months with

a fifth month as float, into its project plan. Negotiation took five months and used up the one-month project float. There were 25 negotiated Core Principles, an example is provided below: -

05	Working Time Compliance	All Rotas will be compliant with known legal requirements, such as European Working Time Regulations: • A minimum of 11 hours off between shifts, daily rest. • The WTR states "minimum of 20 minutes break for shifts of greater than 6 hours duration". Trust policy has a 30-minute unpaid meal break on shifts greater than 6 hours. • An average weekly rest of 1 day off in 7 (averaged over 2 weeks). The Trust has taken the decision, through the Resourcing Policy to combine this with the minimum 11hrs daily rest, therefore 35hrs minimum per week, however, the combined 2-week average has been set as 70hrs (11+11+24+24), over-and-above the WTRs themselves, or the combination of daily/weekly rest 59hrs (11+24+24). • Less than 48 hours per week average, over a 17-week reference period. ***CP05 SIGNED OFF/AGREED ON 20.05.21***

12.36 Future roster reviews should be quicker because the Core Principles can be recycled/amended.

12.37 The sustained involvement of the SRO AD Operations (EMS) through the negotiations was key. The approach of Core Principles was part of the methodology brought by TotalMobile with their external (independent) facilitation considered critical. The negotiations became protracted due to different positions between ELT and TU Partners on CPD, but intervention from the AD Commissioning & Performance (as the SRO for the wider programme) enabled both parties to reach agreement.

12.38 The Core Principles were, in effect, the rules for TotalMobile to go into the four-stage working party process with. Both management and TU Partners abided by the Core Principles through the project.

12.39 It took 15 two-hour meetings between April and August 2021 to agree the Core Principles. These were difficult and challenging meetings at times, but appropriately conducted by both parties.

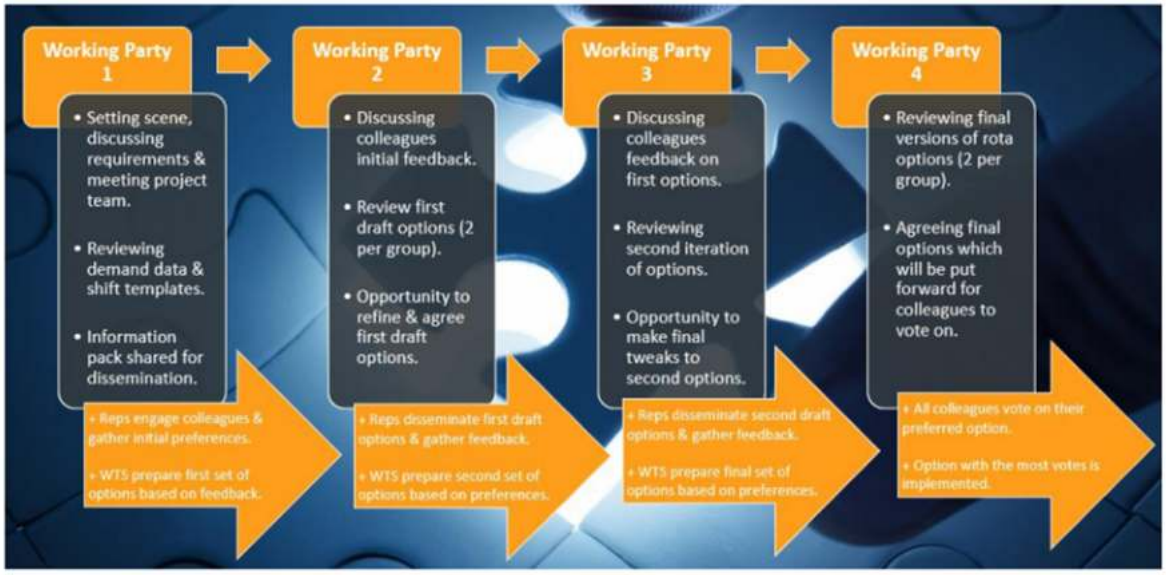
What worked?

- Negotiating Core Principles (the rules) for use during the roster design (working parties) stage of the project.
- Recognition that these negotiations will take four months (unless a previous set of Core Principles and can be recycled and updated).
- Senior leadership from the AD Operations (EMS) in attending these negotiations.
- External facilitation of the negotiations.

• A clearly written up set of Core Principles with emails from the SRO and each TU partner confirming agreement.
What did not work? • It took five months to negotiate the Core Principles.
What would you do differently? • Speed up the process of negotiation. This would be possible in future as the Trust can recycle the Core Principles into different roster reviews. This has already happened.

Roster Review - Working Parties

12.40 The working party process was a high engagement model recommended by TotalMobile:-



12.41 The project team ran this four-stage process across 15 areas aligned to the EMS localities. Each working party was facilitated by TotalMobile and was supported by their software which produces shift pattern options based on the roster keys, Core Principles, and number of staff. The project team adjudge this stage of the project to be when TotalMobile were at their most valuable.

12.42 The project team adjudged the working party process a success. TU Partners were supportive of the high engagement model as demonstrated by TotalMobile during the procurement process.

12.43 Feedback via the affected staff survey was more mixed: -

12.44 Feedback from the focus group identified the working parties as one of the areas that had worked, for example:
"station representatives, TUP, resource and management discussion, prior to station feedback"

"face to face sessions"

"numerous meetings, full staff involvement, ample time to feedback to road staff, numerous choices of rota".

12.45 A reflection is that more time could have been spend with the local station representatives and local TU reps briefing them on their roles and wider context of the EMS roster review.

12.46 Whatever your position on the EMS roster review, it is evidentially clear that shift patterns were not imposed nor the rules around the shift pattern design i.e. the Core Principles.

12.47 And whatever level of engagement is built into a process like this, inevitably there will be some colleagues who feel it is not enough.

12.48 Fundamentally affected colleagues were able to build their own rotas, within the construct of the roster keys supplied by ORH and the Core Principles negotiated with TU Partners. Some feedback from staff indicates building their own rotas should include the roster keys. This is just not considered workable by the project team. This would potential mean 15 different working parties gathering demand data and somehow undertaking simulation modelling of the ambulance resources required to service that demand.

What worked?

- The four-stage working party process provided a high engagement change model.
- External facilitation (honest brokers) of the working parties by the third party.
- The use of shift design software to develop shift pattern options.
- Working parties at a locality level.
- Working parties with station reps and local TU reps on the working party.

What did not work? • A four-stage working party process takes time. For other roster reviews it may, with agreement, be possible to shorten the process, but the project team do not believe that to be the case in this instance.
What would you do differently? • More engagement and training with station reps and local TU reps before the working party process commences.

12.49 It should be remembered that some of the working parties had to be conducted remotely because of the pandemic, which was far from ideal.

Roster Review - Voting & Validation

12.50 Having arrived at what options colleagues wanted to vote on, an A or B option, a voting process was commenced using MS Forms. The voting process was set for three weeks but extended to five weeks due to some concerns around colleagues' ability to vote (transfers and eligibility). The staff survey indicated strongly that colleagues were given the opportunity to vote: -

12.51 There was no negative feedback from TU Partners on the ability to vote, however, the EMS roster review project hit a major problem with regard to the voting validation process. The results produced a few surprises from a TU perspective and TU Partners fed back concerns regarding the validation process and wanted full access to voting results. Only two members of the project team had access to the votes.

12.52 Whilst the project team felt that the voting process was appropriate, ELT had to become involved in this stage of the project, with a pragmatic way forward being agreed, which was to ask ACAS to verify the votes.

12.53 ACAS identified 16 stations where the results provided to staff did not tally to the vote information checked by ACAS. These were reviewed and split into two types: -

- 13 low concerns (no impact on outcome of vote); and
- 3 more concern (potential change in the outcome of the vote).

12.54 It should be made clear that there was no suggestion of tampering with the votes. The project team was neutral on whether A or B for each roster was successful. Two examples of the voting issues encountered are detailed here: -

"**Rhyl EA**

- ACAS highlighted an issue with Rhyl in that there were more votes displayed to staff than there are in the data.
    - There was 1 duplicate, hence it being discounted.
- However, upon further review, we saw that there was an issue in the votes cast.
- Rhyl is split into 2 1x24/7 rotas (Team A and Team B)
- There were some leakages of votes from Team A into Team B
    - For example, staff in team A voting on team B and vice versa
- Once we had corrected the wrong here, and allocated all Team A's staff against the Team A vote etc, there was a different outcome in the winning rota for Team A.
    - For reference, both rota options for both teams are exactly the same, hence there is no issue lifting the Team A staff's votes from Team B
- **Recommendation is to correct the error and implement vote B for Team A, discussion to take place with LM and staff affected.**

Barmouth EA

- ACAS highlighted the winning roster was different in their information from the one sent to staff.
- Original votes showed that vote A has 6 votes and vote B has 5 votes.
- However, 2x staff in Barmouth who had originally voted for A had emailed the project group to say that they wished to change their vote to B. They had felt pressurised to make a decision early and upon reflection had decided to change their mind.
    - Original votes cast on 5th May; email received to project manager on 13th May.
- The alteration in 2 votes from A to B means overall votes where 4 for vote A and 7 for vote B.
- Question is whether to allow the requested change in vote or proceed with initial votes as the one counted. A different rota will be implemented dependant on the outcome.
- **Recommendation is to add to project board agenda for a decision."**

What worked?
• The process of voting on A and B options as agreed via the working parties.

What did not work? • Voting without independent validation (not a reflection on the internal colleagues).
What would you do differently? • Use someone independent, in agreement with TU Partners, to run the voting stage of a large-scale roster review. • Enable two TU Partners to have access to the votes. They must wholly outside of the process themselves (along with two members of the project team).

Roster Review - Implementation

12.55 It was at this stage that the project team started to receive Respect & Resolutions relating to the now very clearly emerging new rosters. The Trust received 12 R&Rs, 11 directly connected to the EMS roster review process and one within the project team. Of the 11 one was partially upheld and the one within the project team was upheld.

12.56 It would be ideal to have no R&Rs, but 11 within the context of 146 rosters,

Fleet

12.57 Detailed station level calculations were undertaken during the programme to determine whether there was sufficient fleet for the new rosters and where the fleet needed to be. Each Head of Service was given a breakdown on a station level basis of what fleet was required where.

What worked? • A task & finish group was formed to work on the fleet requirements (and estate). There was good collaboration and engagement by everyone involved. • The approach offers a guide to the future development of a live integrated database that can give granular station level information. • The formation of the Integrated Technical Planning Group to work on the technical workforce, estate, fleet and other, aspects of ELT ambition.
What did not work? • The programme SRO led on this aspect of the programme and this work continues now through ITPG. • There is no clearly identified analytical resource (post) in the Trust for fleet calculations.
What would you do differently? • The new Data Science & Simulation Modelling post in SP&P can undertake these calculations going forward. • Develop a live database that interacts between workforce, fleet, and estate. NEXUS currently in development.

Estates

12.58 The total required uplift in establishment was 353 FTEs (263 – 46 – 36 + 100).

12.59 A roster review in another ambulance trust had to be stopped mid-project because the trust did not have sufficient estate to cope with the implications of the re-roster. The potential lack of estate was identified as the biggest strategic risk to the programme.

12.60 Analysis work was undertaken by the Planning, Estates, and Operational Teams to identify and validate expected need over a six-to-nine-month period, and to review every impacted station. This detail was then condensed to identify areas most need of improvement, given restricted revenue, capital availability and staff resource to manage the project(s)

12.61 It was agreed by Trust Board on 9*th* August 2021, that five small projects would be initiated in response to this requirement. The five projects were:

- **Newport** – A facility for c46 staff which would cover the whole AB area to account for the total number recruited in 2020/22.
- **Whitchurch** – A facility for c42 staff to account for recruitment across the Cardiff and Vale area.
- **Swansea** – c33 staff to be accommodated in the Swansea area, which would provide capacity for anticipated AB recruitment.
- **Llanelli** – A facility for c14 staff, which would provide some capacity for anticipated recruitment in the Hywel Dda area (may be supported by smaller schemes given the geography of the region).
- **North Wales** – Capacity for an additional c50 staff which would be determined through further discussions with AOMs and potentially some smaller schemes given the geography of the region (Wrexham, Rhyl, and Denbigh currently under consideration).

Scheme	D&C Commitment	Staffing Increase (at the time of project initiation).	Type of Solution	Locker Capacity Increase	Additional Parking Capacity	Notes	Status
North Wales	Denbigh	2	Additional lockers	2	N/A	Site identified through local discussions but limitations to what could be delivered in space	Completed
	Rhyl	30	Site Improvements	50 (plus racking for kit bags)	8	Improvements to current site – locker rooms, storage, sluice area	Completed
	Wrexham	TBC	Site Improvements	3	N/A	Efficiency gains within existing space	Completed
	Amlwch	TBC	Additional Site	N/A	7		Completed
Swansea	Cwmbwrla	30	Site Improvements	TBC	TBC	Significant site improvements including additional space gained from relocation of other teams	Completed
	Gorseinon		Site Improvements	0	2		Completed
	Glynneath		Site Improvements	N/A	N/A	Originally identified as area of concern but subsequently confirmed that additional intervention was not required (to note, at time of writing this site has now undergone significant further investment and efficiency improvement works under the EFAB scheme for 23/24)	No longer necessary
Llanelli	Llanelli	14	Alternative Site	N/A	N/A	Following extensive discussions no site options could be identified either through the commercial market or partnership arrangements. This is now an AWC bid for 2024/25	To be re-visited
Whitchurch	Whitchurch	30	Additional Site	N/A	N/A	Local teams confirmed, following extensive discussions with partners including development of plans, that this facility was not required.	No longer necessary
Newport	Newport - Phoenix Park	50-60	Additional Site	42	20	New sites identified to accommodate Ambulance Care colleagues to create space for additional EMS colleagues within existing Newport Station	Completed
	Newport - Abercarn						Completed
	Bassaleg		Site Improvements	8	8		Completed
	Blackwood		Site Improvements	N/A	5		Completed

What worked? • Teams worked quickly to respond to the initial call for action. • Teams worked well together. • Good co-ordination by Project Manager. • Good record keeping • Good communication with local teams • Regular meetings established to keep track of moving requirements and emerging challenges. • Operational teams were looking for solutions and being proactive in responding to the challenges.
What did not work? • Information on numbers was projected. • Information on anticipated sites was limited and based on recruitment numbers which would not be available until much later, and not in time for any construction/renovation works to be completed. • An alternative view is that the FTE requirements were known (and provided), but the precise timing of the landing of the FTEs was not (due to recruitment). A more fundamental issue is that the information about our estate e.g. staff on site, car parking spaces, ambulance parking bays, is not readily available. This made identifying which sites were more at risk very difficult. • A number of scenarios were explored for a large number of sites which led to confusion and delays in decision making. • Lack of available funding, and anticipated schemes came back much higher following tender process. • Number of schemes at any one time was difficult to manage – a series of projects together which would normally be managed on a scheme-by-scheme basis – very complex.
What would you do differently? • Improve granular information on our estate to support on-going discussions around workforce and fleet (being taken forward by ITPG).

Leading Service Change Together (Modernisation Negotiations)

12.62 This project was initially focused on issues like return to base meal breaks/PPLHs. This was paused and taken out of the programme, initially to ADLT and then to ELT/ADLT during the industrial action negotiations.

Rural Performance

12.63 On-going concerns about rural performance meant that it moved into the programme. OMDA Optima undertook analysis, in particular, of Powys. The main finding from this analysis was that the roster keys being implemented were appropriate; however, the Trust struggled to recruit to these roster keys, for example, at the time of the analysis there was a gap between the modelled requirement and staff in post of 30 FTEs, with no CHARUs operating in Powys.

12.64 A rurality impact assessment was undertaken during the course of the programme and reported to ELT. This assessment did not find any issues i.e. the roster keys being implemented were equitable, but as above the ability to recruit into them was an issue.

12.65 The creation of a workforce planning team has definitely enhanced the Trust's ability to understand its workforce issues better and focus recruitment into the harder to reach areas. The ITPG has focused on ensuring the funded establishment matches the modelling, so that over-establishment and under-establishment can be better understood with an on-going process of "smoothing" i.e. aligning recruitment to the under-established areas.

12.66 The 2023 EMS Demand & Capacity Review specifically included rurality as an objective.

What worked? • Undertaking a rural impact assessment. • Undertaking an extra modelling on the rurality and the roster keys being implemented.
What did not work? • At detailed in the recruitment section the in-year funding of recruitment and payment by results worked against recruiting into more hard-to-reach areas.
What would you do differently? • If possible provide longer lead in times, which aids recruitment into more rural areas.

CHARU

12.67 The roster review project team held a risk workshop in the spring of 2021. A key risk identified was whether the roster keys about to be implemented were wrong. Trade union partners had also flagged this concern at the programme board. The agreed mitigation was to ask OMDA Optima to give a second opinion on the roster keys supplied by ORH. This identified that there were an insufficient number of RRVs in the proposed roster keys, approximately 20 short. There was nothing wrong with the ORH roster keys supplied per se, but post the ORH modelling Red demand materially increased, in particular, due to a change in the MPDS process for breathing difficulties.

12.68 Having identified this issue, the SRO flagged this with the Executive Sponsors, who in turn flagged it with the CEO and CASC. This led to the 2019 EMS Demand & Capacity Review being re-opened and a revised set of roster keys being issued by ORH. At the same time the Trust, in collaboration with the CASC and his team, agreed to switch off RRVs and move to a new resource: CHARUs.

12.69 The premise behind CHARUs was that critical incidents involving cardiac arrest and major trauma account for a small proportion of 999 calls received by the Trust. The infrequency of these calls and an expanding workforce means that often the individual exposure and experience is limited i.e. staff do not routinely attend to major trauma or obstetric emergencies. This means that the potential to deliver optimum practice can be reduced as the frequency of attendance and clinical management is comparatively rare.

12.70 CHARU is a dedicated resource staffed by a paramedic or Senior Paramedic who has successfully completed a three-day course developed by WAST clinical and education leads. The purpose of CHARU is to co-ordinate and provide optimal patient care, supporting decision making and delivering additional clinical care at incidents of a critical nature. They

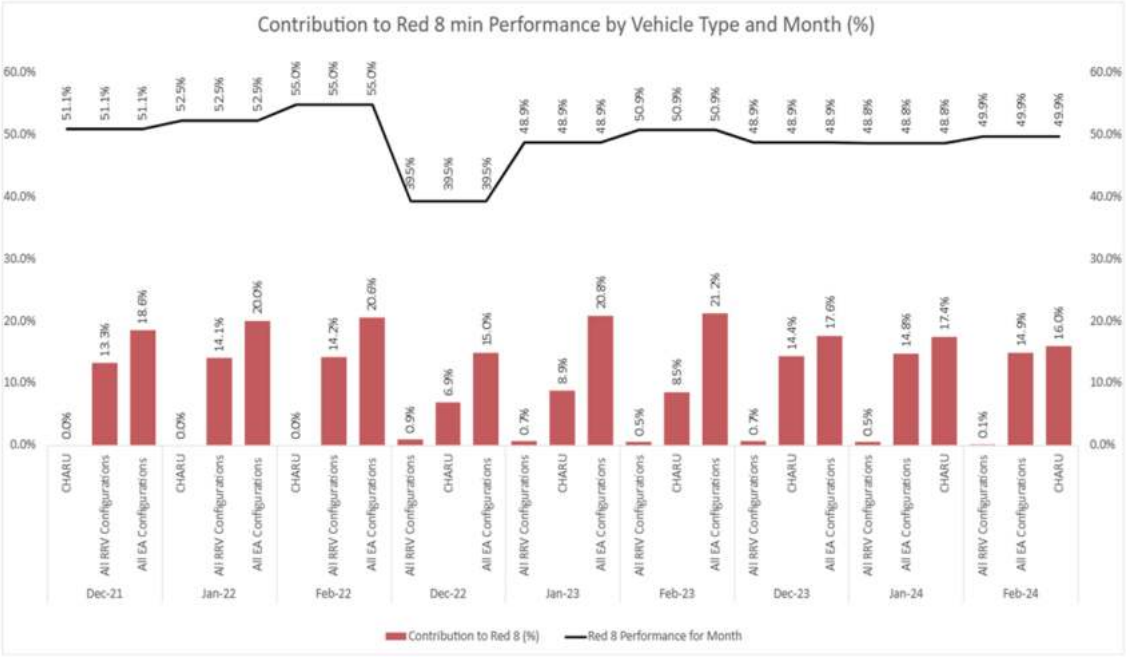
carry some additional medicines to manage pain and a mechanical CPR device for deployment in some circumstances.

12.71 The programme moved at pace, establishing a CHARU project team, with project support: changing a key responding resource is a major change.

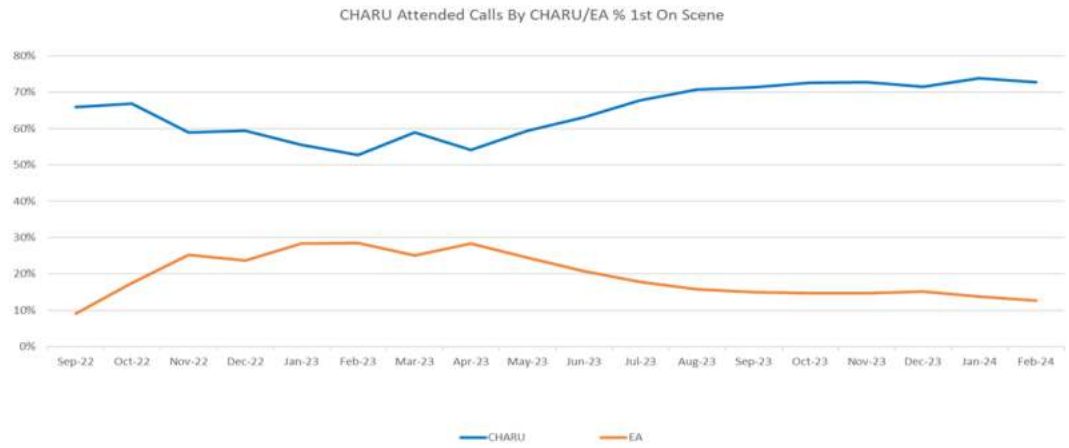
12.72 The modelled requirement for CHARU FTEs 153. Currently the Trust is at 74% against full roll out (100%).

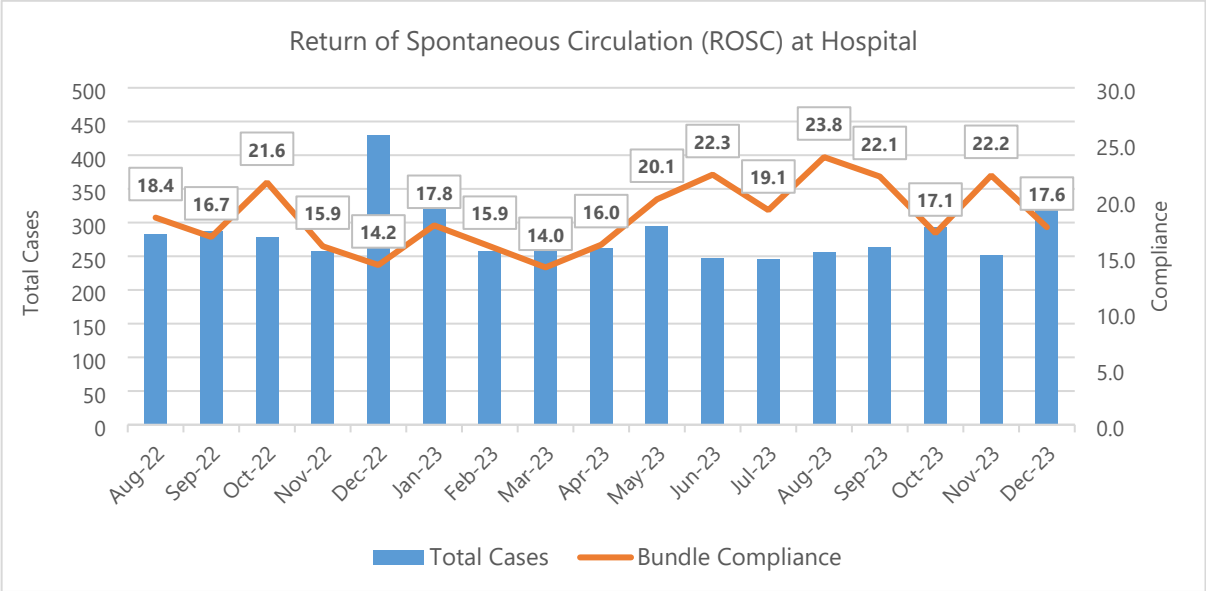
12.73 Whilst work continues on concluding the recruitment, the CHARU project team has been re-branded as one that focuses on benefits realisation. The primary focus of CHARU is the ROSC rate and on scene clinical leadership, not Red 8 minutes 65%, but the modelled number of 153 FTEs was considered sufficient (at the time) to deliver the Red 8-minute target, supported by the contribution from EAs (based on handover at 6,000 hours).

12.74 There are half the number of CHARUs, compared to RRVs: RRVs were stopping the clock, but there were insufficient EAs to convey patients (an indication of how a target can sub-optimise performance). Despite this planned reduction, the below graph shows how the CHARU contribution to Red 8 minutes is 16% in Feb-24, compared to 13.3% in Dec-21.



12.75 The graph overleaf shows that where a CHARU is dispatched it is first on scene over 70% of the time.





12.76 The ROSC rate has shown some improvement, with the Trust achieving its highest ever rate in Aug-23; however, performance remains mixed. It should be noted that the numbers involved are small, so this can drive performance variation, but benchmarking with English trusts indicates the Trust should be seeking a rate above 25%.

12.77 Whilst the above graphs give some reassurance about the effectiveness of CHARUs, further work is being undertaken on: -

- Checking the utilisation calculation and ensuring the actual rate in the Trust is consistently calculated between directorates.
- Further work on the month-by-month contribution of CHARUs to Red performance.
- Whether all CHARU suitable codes get a CHARU; and
- Checking the in-house utilisation calculation is comparable with ORH's definition.

What worked?

- Well, chaired with open and honest discussion requested with full participation of all parties. Good open and respectful discussions, clear agendas undertaken.
- Collaborative learning across different directorates
- Good opportunities to talk through the challenges, the time out to focus felt beneficial, particularly during the early stages of implementation.
- The breadth of 'applicable' knowledge the T&F group participants were able to contribute.
- Action Log 'actions' being dealt with promptly.
- Regular meetings that were well attended, resulting in agenda items able to be progressed.
- It was a positive experience to get a wide range of colleagues involved in the group who all contributed well to developing the resource. It was felt everyone contributed positively and all tasks were progressed promptly.
- Able to put across concerns. Frustrating that some concerns needed even more data before change.
- Recruitment training tracked well. Good engagement regarding ideas for recruitment and different approaches to rostering.
- Good to have the dedicated focus that a T&F provides - it did, however, exist for too long albeit understandable that the slow progress in recruiting the cohort required was a key reason for this.
- Group dealt well with understanding of the other departments pressures, and transparent, open, honest conversations were able to be had. Sharing information and identified some areas for improvements which were quickly actioned. Great collaboration once engaged.
- My initial interaction with the T&F group was due to me being a Senior Paramedic, at that point I felt I was made to feel welcome, and my opinions were valued. I transitioned into the Clinical Lead ePCR this changed the role I carried out on the group so I was unable to attend as frequently as I would have liked.
- Positive experience of the T&F group, it was laid out from the start what the group were aiming to achieve and what they thought this change would offer the organisation. The CHARU training courses that are now able to be offered to staff members are a well-rounded and vital part of the transition for colleagues and have received some great feedback from attendees. The group have successfully managed to implement a CHARU resource and provide a type of development opportunity for staff.
- T&F was well structured, robust TOR and clear governance for the group. The T&F group provide very good updates on recruitment, training, and options for vacancies that could not be filled through normal local processes.
  The T&F group also discussed challenges faced through operations both from EMS Ops and also EMS Co-ordination, with actions and tasks delegated throughout the membership to resolve and improve the clinician/allocator/dispatcher experience.
- SRO was always confident of delivery.

What did not work?

- Potentially communications could have been better especially with EMSC colleagues who following some engagement sessions were unaware of the rationale behind the resource and what it could offer.
- There was a tendency to drift into operational issues which took up time during meetings.

- A clearer understanding of the CHARU role as a whole would have been beneficial for all the participants.
- Some group participants provided little to no input into the group.
- The blanket 25% does not work effectively in all HBs and can create over production which has financial implications. 75% ops and bespoke split for each area could be a consideration or retaining a line/lines and SPs sharing that line as part of a rotation.
- There should be a shorter timescale with requirements for the exit plan of how to move from T&F/Pilot to Business as Usual incorporated into the work of the T&F group.
- In the beginning there was a lot of uncertainty as to the true numbers of CHARU staff needed. And especially the funding issue. The TUs were led to believe this was fully funded, apparently this was never the case. Note: the SRO was expecting the uplift to be funded, but we did not receive funding. No one was consciously misled. The numbers were modelled by Optima initially and then by ORH: some uncertainty is normal during a period of change.
- Improved leadership at a local level, we set up CHARU without robust monitoring of 1. activity, 2. incidents attended, 3. outcomes, 4. most importantly linking in with EMSC ensuring clarity on the role.

What would you do differently?

- Involve EMSC colleagues and any other relevant teams earlier on in the process.
- Keep topics at meetings relevant and aligned to the brief.
- Ensure communication and roles are clear to all involved.
- Ensure membership is relevant and necessary.
- Closure collaboration with other steering groups (Senior Paramedics Steering Groups).
- Have set timescales and plans for moving forward which need to be agreed and communicated to the group.
- Funding of the project and executive decisions were initially limited to existing RRV positions and until dynamic decisions were made on funding. Agree a fully funded project would of be a benefit from the start.
- Improved communication and monitoring would be beneficial. Along with analyst time and the production of datasheets.

Programme Management Review

Internal Audit

13.1 The normal routine here would be to go through each phase of the programme e.g. PID, programme planning, risk management etc.; however, during the programme it was audited, so rather than repeat the process, the following bullets summarise the audit: -

- It received a "reasonable assurance", missing a substantial assurance rating because the PID was not up to date and the PID had not defined quoracy. These were minor technicalities within the context of the scale of the programme.
- The audit also identified that the connection between the programme and STB was not sufficiently robust, in particular, sign off of PID updates. The SRO did send PID updates to Executive Sponsors, but at the time STB was being re-booted, so this audit finding probably reflected the pace and flexibility the Trust was working to as it responded to the pandemic.

13.2 Whilst separate to the audit, the review originally had an 8A programme manager supporting it. When this officer left, the SRO was left with no support for a period of time and then a B6. This is a lot for a B6 officer to cope with.

13.3 The elapsed time of the programme was 1,615 days start to finish. This length of time was caused by pauses connected to the pandemic, but it also reflects the scale and difficulty of this programme.

Management of Risks & Issues

13.4 There were 36 risks recorded on the programme risk register at the time of closing the project. 33 of these risks are marked as closed with three risks remaining. The three risks are: -

Risk 30: There is a risk that staff and colleagues will lose confidence in the Modelling and Overall Plan

Risk 31: Insufficient FTES/funding to deliver CHARU keys.

Risk 32: Insufficient FTEs/funding to deliver revised HD keys.

13.5 These risks will transfer to the Integrated Technical Planning Group (ITPG). The ITPG is a standing group responsible for detailed technical planning across forecasting, modelling, workforce planning, recruitment, and rostering.

13.6 The first risk will be mitigated by the 2023 strategic Demand & Capacity Review. For the second risk the Trust has made the decision to recruit to the full CHARU roster keys, but this does leave a relief gap in EAs, which is also connected to the third risk. For the third risk it was agreed to reinstate a number of EAs in Pembroke, but the Trust is not in receipt of funding for these.

Programme Issues

13.7 Overall, there were 5 issues identified within the programme, all of which have been closed following the closure of the programme.

Programme Actions

13.8 Actions to be carried forward from overall programme; there are no actions from programme board action log to be carried forward.

Strategic Management

14.1 Previous roster reviews (this was the central project inside the programme connected to the recruitment uplift) have not always received strategic leadership, for example, the 2014/15 review did not actually review the rosters in AB and CT. In the 2017, these were picked up and completed, but the process was very slow.

14.2 For this EMS roster project review significantly, more capacity was placed behind the review i.e. it was set up to succeed. It was very clearly connected back to the strategic 2019 EMS Demand & Capacity Review.

14.3 There was Executive input during difficult stages of the EMS roster review, for example, the voting validation.

14.4 It should also be noted that there was also upward strategic management, with the programme team independently of Executives, undertaking additional modelling, which identified there was insufficient resource to service Red demand.

14.5 Also, the programme team received good informal support from the then Deputy Ambulance Services Commissioner, assisting the project team with wider system information, in particular, Welsh Government's position and intelligence on locality specific political issues.

TU Partner Engagement

15.1 TU Partners were engaged (on steering group) in the 2019 EMS Demand & Capacity Review, the pre-cursor to the programme. TU partners were also on the EMS Operational Transformation Programme from inception and were also on the EMS roster review from inception. For both the procurement of ORH and the procurement of WTS (now TotalMobile) TU partners were part of the decision-making process.

15.2 TUs worked in partnership with the programme team at every stage of the project.

15.3 There was a temporary pause in the partnership working due to an R&R within the project team. TU partners also withdrew from the 2023 EMS Demand & Capacity Review. TU partners are now back at the table. The pause in partnership working does not reflect that there was good partnership working for the bulk of this programme, with some difficult conversations, but both parties working through the issues e.g. CPD and voting validation.

15.4 TUs partners have participated in a lesson's learnt facilitated session on the roster review.

Stakeholder Management

16.1 The Trust identified stakeholders via a communications plan developed with the Communications Team. The Trust decided to pick off stakeholder concerns as and when they arose.

16.2 The programme team received good support from the CEO and Director of Engagement & Partnerships who fronted up 29 stakeholder briefings e.g. local authorities, Senedd political groups, Minister, health boards etc.

16.3 Rurality was a recurring theme through this stage of the project. The project team completed a rural impact assessment based on WG's geographic definition of rurality. The identified the impact as positive in each geographic location. The assessment was reported to ELT. Whilst positive, the Trust formally built rurality into the terms of reference for the strategic 2023 Demand & Capacity Review.

AGENDA ITEM No	**17**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

INFORMATION GOVERNANCE REPORTING

MEETING	Finance & Performance Committee
DATE	17th September 2024
EXECUTIVE	Jonny Sammut, Director of Digital Services / Senior Information Risk Owner
AUTHOR	Leanne Smith, Assistant Director of Digital
CONTACT	leanne.smith4@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report brings to the committee an update on the Information Governance (IG) of the Trust and related areas including information security, records services, Freedom of Information requests and data quality. This is the second time a report of this format has been presented to the Finance & Performance Committee (FPC). Information Governance Highlight Reports are presented monthly to the Information Governance Steering Group (IGSG) chaired by the Trust's Senior Information Risk Owner (Director of Digital Services), supported by the Caldicott Guardian (Executive Director of Quality & Nursing) and Data Protection Officer (Assistant Director of Digital: ICT). The IGSG reports directly to the Executive Leadership Team (ELT), preparing a AAA to support communication – these AAA's form the basis of this report to FPC.

2. This paper covers IG related matters as raised in IGSG for the partial Q2 2024/25 period of July & August. The main discussion areas from IGSG are as follows:

3. **IG Toolkit 24/25:** Following the previous annual submission (with an outcome of "standards not met") an improvement plan (see Appendix 1 for status report) was developed to support achieving the **"Minimum Expectations"** standard across all categories this financial year. To satisfy the Confidentiality Advisory Group (CAG) this position **needs to be achieved by November 2024**. Various elements and actions of the IG Improvement Plan are at risk, with targeted efforts and mitigations determined. In particular, a Training Needs Analysis is in development, and the Records Management Policy is to be reviewed. Monitoring against the

plan continues via IGSG, with progress and escalations also being shared with ADLT.

4. **IG Training:** the Trust is **not compliant with its mandatory IG training** requirements against the minimum 85% target across the Trust for 2024/25 (see Appendix 2 for KPIs and statistics). Approximately 1000 individuals were identified as non-compliant, some with expiration dates of more than 6 years.
   a. IGSG requested a rerun of all individual level compliance reports per Directorate – which have been shared with Directors – specifically highlighting those members of staff who have not completed training for several years.
   b. ESR reporting validity is also being investigated – there are some known cases where staff members listed as non-compliant are on long-term sick, maternity leave or have left the Trust. The targeted approach mentioned above will help quantify this data issue.
   c. The IG team are also spreading awareness to local teams and attended informal SOT to speak to the challenges around achieving compliance in Operations.

5. **Freedom of Information:** compliance to targets remains a challenge for Freedom of Information, however, the Corporate Governance team is optimistic that the position will improve later in the year as capacity is increased through additional resources and unlocking efficiency from a new system implementation. Efforts are ongoing to develop a procedure and guidance for those involved in any stage of an FOI request.

6. **Data Sharing & Impact to Transformation:** WAST has long faced challenges in sharing individual level data across NHS Wales, this is particularly difficult when trying to articulate the legal basis for secondary uses (e.g. data analysis or data linkage) as opposed to direct care. Important to note is that the situation is different for NHS England. IGSG previously discussed the requirement of various projects around the Trust for sharing of patient data with Health Boards, and that NHS Wales specific challenges may impact on our clinical transformation efforts – for example, gaining Section 251 CAG approval to share and link identifiable patient data across NHS Wales bodies can take significant time. Additionally, although progress with the National Data Resource (NDR) continues for all-Wales data sharing, focus for this programme is currently on direct care use cases, and less on analytics / evaluation / secondary use cases.

7. **Records Management Improvement Plan:** IGSG received and approved the records management improvement plan. However, due to ongoing resource constraints within the Records team, progress has not been made in recent weeks, and some actions are overdue. Recruitment is now underway in the Records team following the recent Digital investment, and the plan will continue to be monitored monthly by IGSG until efforts can resume and the plan is back on track.

8. **Information Asset Owner Group:** In December 2019, work commenced on an Information Asset Management project. Whilst the web-based register was successfully created and all known assets at the time were added, unfortunately the Covid-19 pandemic and resource shortages resulted in further work on Information Asset Management being on hold since March 2020. This has resulted in the current Information Asset Register being out of date. The group noted that this is referenced on the BAF – corporate risk 623 – and will be a significant undertaking across the Trust. Agreement was given to establish a sub-group of IGSG to progress this work.

Recommended: The Committee are asked to NOTE the contents of paper.

KEY ISSUES/IMPLICATIONS

9. **Risk 623 Failure to comply with Data Protection Legislation:** a risk to Data Protection Compliance was included on the Corporate Risk Register in April 2024 and has since been received by the Trust Board.
Progress of the actions for this risk: Data Protection Officer JD evaluated and recruitment process will begin. Two Data Protection Compliance Manager vacancies have been through recruitment, with two offers made, and candidates due to join WAST in November 2024.

10. **Emerging risk to gaining Confidentiality Advisory Group (CAG) approval:** As a sub-risk to 623, if WAST fail to comply to legislation, and are unable to produce a "minimum standards met" position by November 2024, there is risk to current and future research projects that require CAG approval.

REPORT APPROVAL ROUTE

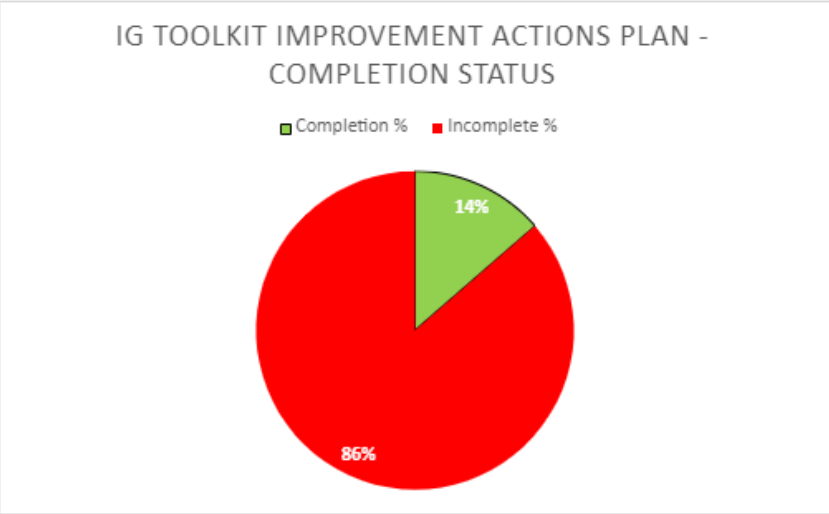
The points presented in this paper are taken from the Information Governance Highlight Reports presented at the July and August meetings of the Information Governance Steering Group (IGSG), and the resulting AAAs presented to ELT.

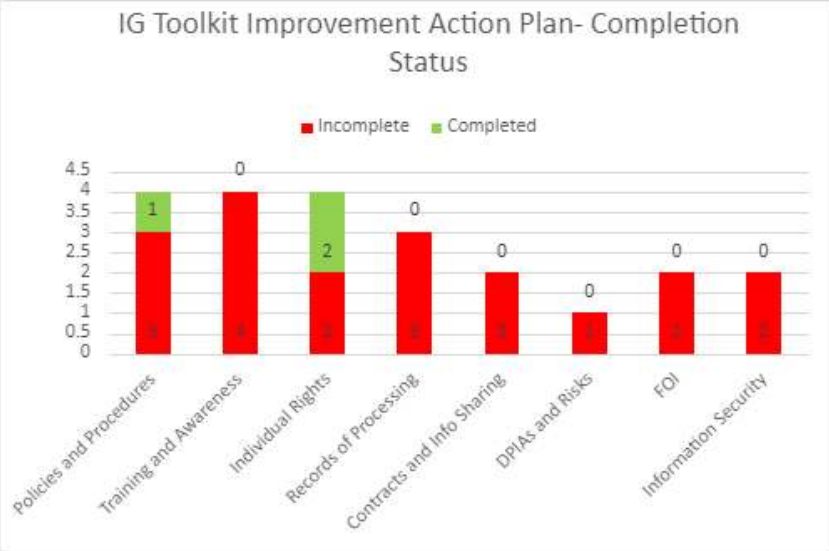
REPORT APPENDICES

Appendix 1 – IG Toolkit Improvement Plan – Status Report (Aug24)
Appendix 2 – Information Security & Governance KPI Report (Aug24 v2)

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

IG Toolkit Improvement Plan – Status Report
19/08/2024





Actions for Escalation:

1. The Training Needs Analysis has been submitted to IGSG for approval, which will close two pending actions which will bring the percentage to 23%. **Request is made to IGSG to approve this document.**
2. Privacy information - the 111 call queue messaging has still not been resolved and so privacy information is not being supplied to callers. Multiple 111 website privacy notice links also need to be resolved which has been chased with Comms Team and PECI team members. The website links have now been escalated to the Head of Comms. **Request is made to IGSG to formally escalate the rectification of the 111-call queue script.**
3. Records Management Policy – As previously reported, it was agreed in HISMT that the action will be taken forward by Records Business Support Officer, and IG team. To be able to move forward, feedback on the current policy is required by the Records Team members as the policy was last reviewed in 2018. However, due to low capacity, the Records Team have not been able to provide any feedback. The progression of the policy cannot move forward until feedback is received. **Request is made to IGSG to escalate the requirement for the policy to be reviewed and feedback to be received. On the balance of risk, a request is made that a day be set aside to complete the review, pausing records requests unless urgent.**
4. A nominated lead for documenting data disposal procedures is still required and until identified, the disposal procedures cannot move forward. *(For noting)*

5. The BYOD policy did not progress to Policy Group as queries were raised which require resolution. Policy is unable to move forward until these queries are resolved. This will mean the deadline for November 2024 will not be met; however, the aim is to still provide assurance by November 2024 by evidencing the policy is moving through the approvals process by this time. *(For noting)*.
6. FOI team have confirmed working on the FOI actions including procedure and guidance. Aim is to bring these items to September IGSG. *(For noting)*.
7. The Trust is still not achieving 85% IG training compliance. Sessions have taken place with Informal SOT and JCC to raise this. Individuals and their supervisors are being individually contacted to escalate the requirement for IG training to be completed. This will continue to be actioned and monitored. It was also identified throughout this initial phase of contacting individuals that employees on long-term absences, including career breaks are being including in the statistics. A request will be made for the September statistics for long-term absences to be excluded as a comparison. *(For noting)*.

Please note, this is not a summary of all actions. For a full update, please see the live action log IG Toolkit Improvement Action Plan v2.xlsx

INFORMATION SECURITY & GOVERNANCE KPI REPORTING

August 24 Report
Reporting period:
Apr-23 to Jul-24

IG TOOLKIT & IMPROVEMENT

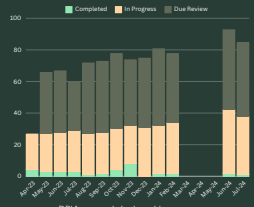
2023-24 IG Toolkit submitted Mar-24: **STATUS:** "standards not met"

2024-25 IG Toolkit completion due Mar-25: 14%

2024-25 Completion against the Toolkit categories and WAST improvement plan

- Leadership & Oversight
- Policies & Procedures
- Training & Awareness
- Individual Rights
- Transparency
- Records of Processing Activity
- Contracts & Info Sharing
- DPIAs & Risks
- RM & Security
- Breach & Monitoring
- FOI & EIR
- Information Security
- Business Continuity

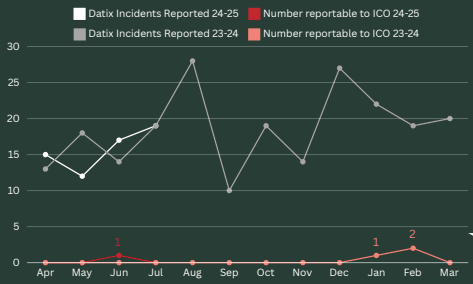
The **DPIA log** continues to be reviewed and updated weekly, including cloud security assessments.



DPIAs completed and in progress

Focus currently on Assemble, Lightfoot, & Flu campaign.

DATA PROTECTION BREACHES



IG related incidents reported on Datix

3 investigated incidents were reported to the ICO in 2023-24; 1 in Q1 2024-25

INFO SECURITY

Recent threshold changes to NIS regulations include confidentiality, integrity and availability of systems.

0 cyber incident reported to CRU under NIS regulations in Q1 of 2024-25

Last incident reported was in December 2023

<20 weak user passwords now remain across the Trust; reduced by >500 in Q1

RECORDS MANAGEMENT

Subject Access Requests

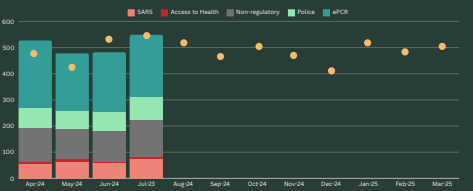
Must be responded to within 30 calendar days from receipt in line with GDPR.

Access to Health

Requests for personal information which fall under the Access to Health Records Act 1990 require response within 40 calendar days.

Other Requests

Requests which do not fall under either of the 2 other regulations must have a legal basis. These include requests from Police, Coroner etc.



Prev Year Total Cases

Apr-24 and May-24 saw ~10% growth on previous year

100%	100%	98%	99%	-	-	-	-	-	-	-	-
0	0	1	1								

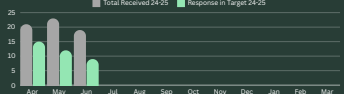
<< Compliance (%)
<< Breaches (#)

Breaches due to limited capacity in the team and long-term absence

DATA QUALITY

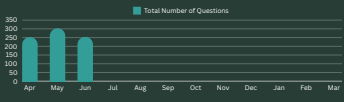
MEASURES OF DQ TO BE ESTABLISHED

FREEDOM OF INFORMATION



<< FOI compliance 24-25

<< FOI compliance 23-24



<< Total number of questions received in all FOI requests per month

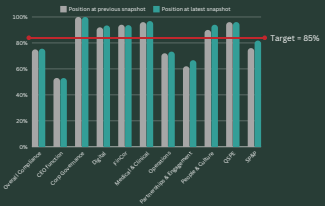
24/25 average questions per request >> 9

Freedom of Information

The FOI Act gives the public the right to access information held by public authorities. ICO target is for organisations to respond to **90%** within 20 working days.

AWARENESS & TRAINING

Mandatory ESR **Data Protection & IG training compliance** is still below the 85% target



"Our people are our last line of defence."

Completion rate of WAST **AI Awareness** course, launched April 2024

Completion rate of WAST **Social Media Awareness** course, launched May 2024

Completion rate of WAST **Physical Security** course, launched June 2024

Phishing campaign Jun 24

The campaign saw an email from "SharePoint" with a link that if interacted with would download "malware"

4871 users targeted by simulator Jun-24

51% (2508) opened / read the email

10% (501) reported the email

Feb-24 campaign saw only **6%** reported

Feb-24 campaign saw **>21%** click the link

17% (811) clicked the links

2% (121) supplied credentials

26% of the 811 (who clicked and/or gave details) completed training

In Feb-24 over **40%** completed training

AGENDA ITEM No	**18**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Finance & Performance Committee
DATE	17 September 2024
EXECUTIVE	Trish Mills, Director of Governance / Board Secretary
AUTHOR	Julie Boalch, Assistant Director of Governance & Risk
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, specifically those 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 risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3 with continual and dynamic focus on the highest rated risks scoring 15-25. Attention has been given to the risk ratings of each principal risk and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the standard and regular review of all controls, assurances, and any gaps.

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

6. 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 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, remain static at the highest score of 25. 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.

7. Despite a slight decrease in the number of handover lost hours in June and July 2024 the sustained and extreme pressure continues across the Welsh NHS urgent and emergency care system which is negatively impacting on patient flow and leading to avoidable patient harm and death.

8. The risks continue to be reported to the Trust Board, with a focus on the actions to mitigate these two risks that are within its control, and these are highlighted in the avoidable harm action plan which is presented at each Board meeting. Further mitigations and transformative actions are described in the Integrated Medium Term Plan (IMTP) to address these risks.

9. There are a range of efficiencies described in the report that the Trust has undertaken in mitigation of these two risks. Two key ones being the number of calls being closed safely and efficiently by clinicians through the Consult and Close initiative in the contact centres as well as a significant improvement in sickness and attendance levels.

10. Most of the Trust's actions in the action plan have been completed and a several efficiencies and improvements implemented that have stabilised performance; however, the Trust is unable to mitigate the scale of handover lost hours due to the environment which it is operating in or make improvements in performance because of the continued challenges in the urgent and emergency care system.

11. To support the continued, detailed review and mitigation of these risks, a workshop has been established for the 6 September 2024 with the Risk Owners and teams to consider a different approach to managing and monitoring those areas that are within the Trust's control and those that are not. The outcome of this will be reported through the next round of governance.

12. The Quality, Patient Experience and Safety Committee (QUEST) reviewed both risks at its meeting in August 2024 with the Agenda items reflecting the controls and mitigations discussed at this meeting. These risks continue to be escalated to the Board via the meeting's Alert, Assure and Advise (AAA) report.

13. Additionally, both risks were presented to the Finance & Performance Committee (FPC) and the People & Culture Committee (PCC) meetings in May 2024 to continue to ensure that all perspectives and elements of the risks are considered and reviewed.

14. **Risk 594** The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death remains at a score of 20 (4x5) reflecting the continued challenges across the unscheduled care system. Further work to determine resources following the Manchester Arena Inquiry remains underway.

15. **Risk 424** Resource availability (revenue, capital and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP) has reduced in score to 8 (2x4) and this will now be de-escalated to the Directorate Risk Register for ongoing management. This risk is linked closely with financial duties outlined in **Risk 139**.

16. All original actions are now complete in relation to **Risk 260** A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems; however, a review of the recent Cyber Resilience Unit (CRU) assessment is to be undertaken to identify any further actions. On this basis the score remains the same given continued activity by cyber actors due to wider world events. There is a general heightened alert for government and public sector bodies although no specific threat has been identified against NHS bodies.

17. **Risk 100** Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience and **Risk 139** Failure to Deliver our Statutory Financial Duties in accordance with legislation remain unchanged in this period.

18. **Risks 542** *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan* at a score of 16 (4x4) continues to be reviewed and remains unchanged, similarly, to **Risk 623** *Failure to comply with Data Protection Legislation* at a score of 15 (3x5).

19. Members are asked to note the closure of **Risk 619** relating to the replacement CAS System from all registers. This risk was reported in closed sessions of the Finance & Performance Committee and Trust Board; however, the risk has been mitigated in full and therefore closed.

20. Whilst there have been no further material changes made during this period, the BAF includes a commentary for each risk for the Risk Owner to describe the rationale for each of the risk ratings which is particularly important where ratings have remained static or increased

21. 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.

RECOMMENDATION: Members are asked to consider the contents of the report.

KEY ISSUES/IMPLICATIONS
22. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
23. The BAF was considered by: • Assistant Directors Leadership Team (22 July 2024)

- Executive Leadership Team (07 August 2024)
- Audit, Risk and Assurance Committee (12 September 2024)
- Trust Board (26 September 2024)

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

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

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death.	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Executive Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service.	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Executive Director of Quality & Nursing	**25 (5x5)** →
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.	Executive Director of Operations	**20 (4x5)** →
542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation	**IF** there is a lack of resources and available technology and infrastructure	Executive Director of Finance &	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
	Strategic Delivery Action Plan	**THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines **RESULTING IN** negative environmental and social impacts causing and reputational damage	Corporate Resources	
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems.	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**15 (3x5)** →
623 FPC	Failure to comply with Data Protection Legislation	**IF** the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality **THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used **RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an	Director of Digital Services	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage.		
100 FPC	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.	**IF** WAST fails to persuade EASC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered	Executive Director of Strategy Planning & Performance	**12 (3x4)** →
424 FPC **De-escalate to the DRR**	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	**IF** resources are not forthcoming within the funding envelope available to WAST (link to risk 139) **THEN** there is a risk that there is insufficient capacity to deliver the IMTP **RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing.	Executive Director of Strategy Planning and Performance	**8 (2x4)** ↓ **12 (3x4)**
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation.	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or	Executive Director of Finance & Corporate Resources	**8 (2x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		• does not receive an agreement with commissioners on funding (linked to 458) **THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage		

Annex 2 - Risk Scoring Matrix

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

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

Annex 3 - Frequency of Risk Review

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

Annex 4 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	25/06/2024	TREND	25 (5x5)
		Date of Next Review:	25/07/2024	➡	

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

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

IMTP Deliverable Numbers: 1, 2, 3, 4, 5, 6, 7, 8, 10, 14, 15, 20, 22, 24, 25, 27

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

Risk Commentary Q1 2024/2025

The risk score remains constant at 25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm and death because of the Trust not being able to reach patients in the community. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. **Handover lost hours in June were 22,230 and July 19,599.**

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

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

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

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Regional Escalation Protocol	1. Daily conference calls to agree RE levels in conjunction with Health Boards
2. Immediate release protocol	2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)
3. Resource Escalation Action Plan (REAP)	3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023.
4. 24/7 Operational Delivery Unit (ODU)	4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
5. Strategic, Tactical and Operational 24 hour/ 7 day per week system to manage escalation plans	5. Same as **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. 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. Whilst Consult and Close is in place, the action to increase compliance is detailed in the action plan.
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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	25/06/2024	TREND	25 (5x5)
		Date of Next Review:	25/07/2024	➡	

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

	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. **This is part of the IMTP Deliverables 2024-2027.**
9. Clinical Safety Plan	9. **Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group. 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.**
10. Recruitment and deployment of CFRs	10. **11 new onboarding courses for June to December with projection of 110 new CFRs by 3rd December 2024. Currently 400 volunteers supporting 6500 hours every month.** 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) **was** stood up for the duration of Winter 2023/24. **Christmas Planning Meetings established from April 2024 for winter period 2024/2025**.
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 vehicle 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. Virtual Ward – Connect Support Cymru	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 with a further extension in place. • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach and has now completed. • Work **ongoing** to recruit CWR volunteers with engagement taking place with organisations across Wales. • St John Ambulance Cymru virtual ward now extended to the end of **May**2024**.**
24. ARA – - **YGC**, **Swansea Bay and GUH**	24. **ARA in GUH finished 31st March 2024. Holding area in Swansea and YGC remains ongoing**.

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

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

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.	26. 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.
27. **Swansea Bay Winter Actions**	**27. 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.** • **Palliative Care Paramedics commenced on 15/01/2024** • **POS solution now in operation which is facilitating shift breaks. Palliative care paramedics have been deployed for a pilot in care homes and nursing homes.** **Significant reduction in overruns realised. In action, during last 2 months, 0 missed meal breaks recorded in Swansea Bay area.**

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morrison hospital has increased focus on handover delays with external partners and across the media. Some plans are in train (detailed in actions) following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.
2. Blockages in system e.g., internal capacity within Health Boards which affect patient flow	
3. Local delivery units mirroring WAST ODU	
4. Handover delays link to risk 224	
5. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 12 months there is a low confidence in attaining this.	5. 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	6. Performance targets for Handover with Health Boards have been introduced by the commissioner.
7. Access to Same Day Emergency Care (SDEC) for paramedic referrals	7. 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.
8. Mental Health users connecting via the 999 system to 111 press 2 services. Discrepancies in pathway between 111 and CSD – point of entry influences pathway.	
9. Volunteer Alternative Responder Scheme (VARS)	9. Live from June 2024 with further scheme due to rollout across Wales.
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. 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	**Superseded**	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. May24 - Initial bid unsuccessful however an action within the new IMTP to grow our APP workforce by up to 40 per year for the next 3 years. Updates will progress through the IMTP within quarters. Milestone changed from March 2024 to June 2024.
4. APP recruitment	Assistant Director of Operations	**March 2025**	Aug24 – Modelling of APP growth trajectory to be modelled through the APP recruitment Steering Group for approval at ELT. Numbers to be confirmed at point of approval.
5. **IMTP Deliverables 2027-2027 – implementation of new clinical model.**	**Assistant Director of Operations Transformation**	**March 2025**	**Phase 1 for winter** **May24 – Ops engagement commenced April 2024. Temporary ADO recruited to support winter actions. Plans to deployment between October 2024 and March 2025.**
6. 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.
7. New 2023 EMS Demand and Capacity (roster) review	Assistant Director of Planning & Performance	August 2024	ORH modelling underway. Initial findings January 2024, full report to Trust Board and EASC in March. May24 - The review is scheduled to be presented to Trust Board end of July 2024. Milestone changed from March 2024 to August 2024.
8. 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	**May 2024 (Phase 1 is finished)**	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 with a further extension in place **and further extended until May2024**

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	25/06/2024	TREND	25 (5x5)
		Date of Next Review:	25/07/2024	➡	

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

			• Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach and has now completed. Work is now ongoing to recruit CWR volunteers with engagement taking place with organisations across Wales.
9. Maximise the opportunity from Consult and Close: - Successful resolution without ambulance (double EMS) - Successful resolution without conveying to ED		March 2025	Trust ambition is to improve 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. Consult and Close compliance remains around 14%. Action plan activities therefore continue with a review of triage processes which may lead to shorter triage durations, along with increase in staffing, which together will enable more triages to take place, thus increasing the number of successful resolutions without a double EMS ambulance and numbers conveyed to an ED.
10. Development of new model of care	Head of Strategy Development	2024/25	**May24 – during May operationalisation has commenced with expected live date ahead of winter.**
11. Palliative Care Paramedic Unit	Assistant Director of Operations	Extended to May 2024 - **new date TBC**	Reducing demand via APPs – 15th January Start. 15/04/2024 - 3 Month Health Board funded trial ended. Whilst utilisation was low, the results demonstrated a circa 75% ED avoidance therefore local decision made to extend for a further 2 months, however, opening the trial up to wider community and crew referrals. **21/06/2024 - Unit still ongoing.**
12. 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	Q1 2024-2025	• Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Expected outcomes in 2023/24.
13. Royal Glamorgan Early Diagnostic	Executive Director of Operations	**August** 2024	• Initial data from Qlik shows that there has been no reduction in N2H times however data received from Health Board show indication of patient benefit to reach earlier diagnostic. Local meetings this month to discuss findings and explore opportunities. • **May24 – No improvement in N2H time. Local management having discussions with Health Board for review and next steps.**

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:	20/06/2024	TREND	25 (5x5)
		Date of Next Review:	20/07/2024	➡	

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

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

IMTP Deliverable Numbers: 1, 3, 8, 14, 15, 22, 23, 24, 25, 26, 27, 30, 31

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

Risk Commentary Q2 2024/25

- The risk score remains constant at 25 for quarter 2 2024/25 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. **JCC set a target of 15,000 hours lost by the end of Q2 and 12,000 hours lost by the end of Q3. Handover lost hours in April 2024 were 23,614 compared to 23,082 in April 2023. Eradication of handover waits of > 4 hours: there were 3,404 over four-hour patient handovers in April 2024, compared to 2,730 in April 2023. The expectation is that these would have been eradicated by end of 2023/24. Cardiff & Vale UHB has demonstrated material improvement and is a positive outlier when compared to other health boards. Recently, Welsh Government have re-iterated to Health Boards that the reduction in long handovers is a priority for this year with an expectation that over 1 hour waits would be reduced by 30% by December 2024.** 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 enquiries and redress / claims. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust received the first Prevention of Future Deaths Report in February 2024 relating to pressure damage, which is a joint Report with Swansea Bay University Health Board. On 22.02.2024 a Prevention of Future Deaths Report was sent solely to the Minister for Health and Social Services, Welsh Government in respect of delays responding to a patient in community which also references handover of care delays. 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. Given the long-standing nature of the system pressures and long handover times, we have commenced work to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and, Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for our ambulance trolleys.

Improvement actions led by Welsh Government and system partners include:

a) Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – (Welsh Government) ***by the end of April 2025***
b) National Six Goals programme for Urgent and Emergency Care: Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales. WAST is represented on the Clinical Reference Group by the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance.
c) The Trust also has a presence on all the individual goal boards. The Trust has been asked to provide a presentation on its offer to the system at the next Six Goals Programme Board (24 January 2024).
d) NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) ***revised to March 2023/24.***
e) 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.
f) 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)
g) Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer) – paused. **Health boards have previously been required to develop handover reduction action plans, which are monitored at their Integrated Quality, Planning & Delivery (IQPD) meetings by Welsh Government. Handover is also discussed at the Integrated Commissioning Action Plan (ICAP) meetings (currently paused as commissioning arrangements transition into the new Joint Commissioning Committee) which are held monthly between the CASC, the Trust and each Health Board.**

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
2. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and

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:	20/06/2024	TREND	25 (5x5)
		Date of Next Review:	20/07/2024	➡	

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

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

	Emergency Care' work. An event reviewing the effectiveness of the Joint Investigation Framework is currently being scoped nationally.
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.
5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership.	5. **Monthly Integrated Quality and Performance Report and WAST is represented on the Clinical Reference Group by the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance. The Trust also has a presence on all the individual goal boards**.
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. REAP has undergone an annual review with v4.1 released in November 2023.
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 Clinical Safety Plan 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. 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.
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. On Call cover is reviewed weekly at SLT Performance Meetings.
11. Escalation forums to discuss reducing and mitigating system pressures.	11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.	12. Monthly Integrated Quality and Performance Report (**April 2024** overall **82**% - Safeguarding is **78%** and dementia awareness remains over 91%).
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals.	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board **May 2024**) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	20/06/2024	TREND	25 (5x5)
		Date of Next Review:	20/07/2024	➡	

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

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

Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	
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 **May 2024** is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candour 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 2024/25.
	External Sources of Assurance Management (1st Line of Assurance)
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
	4. Internal Audit Report (April 2024) Serious Incidents: Joint Investigation Framework (WAST internal processes) provided 'Reasonable Assurance' with low to moderate impact on residual risk exposure until resolved. Improvement actions are monitored via the Audit Tracker.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures – recruitment in line with Organisational Change Process is progressing with full establishment expected by July 2024.	
2.	1. Implementation of the revised Joint Investigation process 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 56 overdue nationally reportable incident (NRI) investigations, with 63 NRIs open in total. 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.	2. 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.	3. 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.	4. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.

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:	20/06/2024	TREND	25 (5x5)
		Date of Next Review:	20/07/2024	➡	

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

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

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.

5. HIW approve and sign off WAST elements of recommendations.

External Gaps in Assurance

1. Lack of escalation and response to AQIs by the wider urgent care system and regulators

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	TBC – Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	Q3 2024/25	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available and access for the Patient safety Team is being explored. Work on-going with Health Informatics regarding patient safety and health board dashboards capacity in Health Informatics impacting and dates revised. • Local dashboards have been developed but requiring manual data extraction
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners.	Director of Paramedicine	Q4 2024/25	• **The Trust uplifted its APP establishment by a further 15.7 FTEs in** • **2023/24 (funded through internal movements). For 2024/25 the Trust** • **is funding a further uplift of 32 APPs (additional funding, not internal** • **movements).** • **• The above uplifts will increase the APP establishment to 120.7 FTEs.**
5. Overnight falls service extension and future modelling	Executive Director of Quality & Nursing	31.09.2024	• **Overnight falls service extension and future modelling** • **Night Car Scheme extension agreed to 31 September 2024** • **(2 regional resources)** • **Utilisation rates continue to be monitored:** • **Nighttime utilisation: -** • **Q2 65%** • **Q3 64%** • **Q4 to date 64%** • **April 2024 - 67%** • **Daytime utilisation: -** • **Q2 57%** • **Q3 56%** • **Q4 to date 58%** • **April 2024 – 54%** • **Combined day and night Q2-Q3 58%** • **Combined day and night Q4 to date 59%** • **Combined day and night April 2024- 55%** • **There is now also an additional Level1 nighttime resource through RPB and Gwent Resilience Plan ringfenced to ABUHB. AB dedicated level 1** • **62% for April 2024** • **The 2023 EMS Demand & Capacity Review has completed its modelling of falls level 1 and level 2 resources. This will now need to be considered further by the Trust, commissioners and health boards. There is an immediate focus on the contract beyond September 2024.**

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:	20/06/2024	TREND	25 (5x5)
		Date of Next Review:	20/07/2024		

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

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

			• **The 2023 EMS Demand & Capacity Review will be formally reported to Trust Board in July 2024**.
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. Quality Report development underway – mandatory requirement to publish 2024/25 (no fixed date for publication nationally).	Executive Director of Quality & Nursing	Q4 2024/25	• Monthly updates to progress against actions following the baseline assessment and readiness returns continued. • RL Datix Dashboards and KPIs under development nationally by National Quality & Safety Group. • Key policies updated and approved further updates following release of revised Putting Things Right Regulations which is delayed now expected release by Welsh Government in Autumn 2024 therefore timescale amended. • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly.
7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Executive Director of Quality & Nursing	Q2 2024/25	• **Currently awaiting WG feedback on the submitted business case.** • **Further meetings arranged with between the Executive Director of Quality & Nursing and Six Goals Programme/WG/. Trust has also approach WG with a smaller ask to facilitate 7 FTE CSD clinicians to** • **provide a continuation of the Luscii solution - this would enable a proof of value pilot to further inform a business case.**
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	Q2 2024/25	• 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 May 2024 (taking notice periods into account). Recruitment is progressing well with multiple applications for each post and some internal promotion opportunities. • Final posts due to be recruited to and in place by July 2024.
9. 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	Q2 2024/25	• Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support). • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. Expected outcomes in 2023/24. • The audit is proceeding. Trust awaiting the outcome. AD Commissioning & Performance has requested an update from Audit Wales. • Audit Wales have confirmed this has been reprofiled into 2024/25.
10. Patient handover actions.	Executive Team	Under review	• Some English ambulance services operate a system whereby handovers are mandated or forced after a certain period e.g. WMAS and LAS. This will be reviewed by the Executive team.
11. Work in progress to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for ambulance trolleys.	Executive Director of Quality & Nursing	Q3 2024/25	• Fundamentals of Care meeting, chaired by the Executive Director of Quality & Nursing held on 08.03.2024.
12. Trust to produce its own six goals plan (Goal 4 links to handover of care)	**Executive Director of Strategy, Planning &**		• **Trust to produce its own six goals plan (Goal 4 links to handover of care)**

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:	25/06/2024	TREND	20 (4x5)
		Date of Next Review:	25/07/2024	➡	

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

IMTP Deliverable Numbers: 1, 5, 6, 7,14, 15, 24

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary Q1 2024/2025

The challenges across the unscheduled care system**.** Handover lost hours in **June were 19,599 and July 23,220.** 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.

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Immediate release protocol	1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report provided weekly to the DG for Health & Social Services.
2. Resource Escalation Action Plan (REAP)	2. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023.
3. Regional Escalation Protocol	3. Daily conference calls to agree RES levels in conjunction with Health Boards
4. Incident Response Plan	4. The Incident Response Plan has been ratified via EMT
5. Mutual Aid arrangement with NARU	5. AACE National Policy on mutual aid in place
6. Clinical Safety Plan	6. CSP adopted by EMT and operational; reviewed annually by SLT 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.
7. Operational Delivery Unit 24/7 cover	7. Shift reports from ODU & ODU Dashboard received by Exec, SOT, and On-Call Team at start/end of shift and cover review at weekly performance meeting
8. In hours and Out of hours command cover	8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan. Cover review at weekly performance meetings
9. Notification and Escalation Procedure	9. Published procedure in operation, reviewed 3 yearly by SLT
10. Continued escalation of risk to partners and stakeholders	10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasised at the face-to-face COO Peer Group meeting on 14 April 2023.
	External Independent Assurance N/A
11. 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.	11. Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&VHB and ABUHB. This has been sustained form some months across C&V in a phased programme of improvement with no delays more than 2 hours. Programme of improvement underway in ABUHB commencing at 4-hour tolerance with a plan to reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs.
12. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration.	12. All Health Boards responded with assurance of plans except BCU.
13. Multi Agency Exercise to be arranged.	13. This exercise has taken place although Health Boards declined to incorporate vehicle release plans
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.

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:	25/06/2024	TREND	20 (4x5)
		Date of Next Review:	25/07/2024	➡	

IF	THEN	RESULTING IN
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

GAPS IN CONTROLS	GAPS IN ASSURANCE
Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.	The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.
	Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. 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).

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review of Manchester Arena Inquiry	Assistant Director of Operations	July 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. 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. A revised timeline for the governance process for the final MAI reports has been agreed, commencing in May 2024 and finalising at Trust Board the end of July 2024.
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	July 2024	Correspondence with Welsh Government remains ongoing. 22/02/2024 - Risk 594 has also been referenced in the context of MAI presentation to Welsh Government (6th Feb 2024). Further follow up will be provided as MAI progresses. Welsh Government has been and will continue to be kept up to date on the developing case, as have the JCC.
3. Request from COO network to share Action cards related to risk	Executive Director of Operations	Q1	**May 24 – LB will follow up with COO network on the sharing of their action cards to WAST.** March 24 – This risk was discussed at both EASC management and in the COO meeting.
1. Ref: Control 1 of 594 – Immediate Release Protocol	**Executive Director of Operations**	**Q2**	**WAST is currently reviewing the immediate release protocol and it is our aim to include the release schedule as agreed by COOs. The release protocol schedule for Health Boards to initiate in the event of a major incident is set out as follows:** - **50% of vehicles released within 10 minutes** - **75% of vehicles released within 20 minutes** - **100% of vehicles released within 30 minutes**

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	19/07/2022	TREND	16 (4x4)
		Date of Next Review:	19/08/2024	➡	

IF there is a lack of resources and available technology and infrastructure	**THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	**RESULTING IN** negative environmental and social impacts causing and reputational damage		Likelihood	Consequence	Score
			Inherent	5	4	20
			Current	4	4	16
			Target	2	4	8

IMTP Deliverable Numbers: 17, 18, 33

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

Risk Commentary

Challenges continue around resources and technology, and currently there is not an ability to reduce this score. Decarbonisation Programme Board will meet on 22nd July. Noting some progress on positive movement to actions within the DAP

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Oversight of implementation and delivery of Decarbonisation project and monitoring of action plan at Decarbonisation Programme Board and Capital Management Board	1. Regular meetings of the Decarbonisation Programme Board quarterly. Requirements of the Decarbonisation project have been presented to the Trust Board & Finance and Performance Committee. Challenges of the project have also been highlighted. Report goes regularly to FPC and then onto Trust Board
2. Capital and Estates directorate lead support – Director of Finance (DOF)	2. Regular briefings to DOF
3. Partnership working via Communications/Stakeholder liaison group with NHS Wales, Welsh Government and other bodies to gain support and knowledge- with the anticipation of working in collaboration.	3. Sharing of knowledge via partnership working through various forums is documented in minutes of meetings held. Requirements also form part of the action plan
4. Approach changed for heating/lighting/energy systems to become more energy efficient- replacing old inefficient plant with more sustainable technology such as natural gas boilers for air source heat pumps	4. (i) Estate Survey undertaken every 5 years. This is a 6-facet survey to understand where the back log is and the requirements for energy systems. (ii) Approved Estates SOP (iii) Estate Retrofit Guide and framework used to prepare schemes
5. Changing procurement practices for fleet, Estates, equipment, supplies, and ICT to reduce emissions	5. Fleet SOP shows move to ULEV vehicles. BJC 2024/25 details intention for move to EV for smaller and support vehicles
6. Board Development sessions with respect to Decarbonisation to raise awareness of decarbonisation requirements, additional sessions will be required.	6. Board Development session occurred on 8th November 2021 – presentation slides are available.
7. Finance & Performance Committee has oversight of decarbonisation project, decarbonisation to become a standard agenda item.	7. (i) Routine updates at every other FPC meeting (3 times a year) (ii) Annual report (which includes a Sustainability section) is approved by the Finance & Performance Committee
8. KPIs with respect to energy transmissions are communicated to Estates team annually by sustainability manager	8. KPIs to Estates team includes energy use at all WAST managed buildings
9. ISO14001 accreditation in place	9. ISO14001 – Annual audits are undertaken against the accreditation. Environmental Coordinators act as champions in the organisation.
10. Environment Strategy in place	10. Environment strategy has been approved by the Trust Board. This covers the next 5 years
11. Programme Board Risk Register	11. Programme Risk Register reviewed at every Decarbonisation Programme Board meeting
12. Reporting to WG via DCR reporting, qualitative, and quantitative reports and emissions reporting	12. Submissions to WG – quarterly DCR reporting. Annual qualitative and quantitative reporting
13. Membership of National Programme Board (WG), Transport Task and Finish Group and BELP Project Board	13. Minutes and papers of meeting
	External - Independent Assurance: • Sustainability section in Annual Report audited by Internal Audit. Annual audits by BSI on accreditation
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Establishment of further workstreams to address a Programme Plan to support strategy requirements	
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles	
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited)	

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	19/07/2022	TREND	16 (4x4)
		Date of Next Review:	19/08/2024		

IF there is a lack of resources and available technology and infrastructure	THEN there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	RESULTING IN negative environmental and social impacts causing and reputational damage		Likelihood	Consequence	Score
			Inherent	5	4	20
			Current	4	4	16
			Target	2	4	8

4. NED support ended April 2022

5. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Establishment of further workstreams to address a Programme Plan to support strategy requirements: Consider further workstreams required in support of delivering DAP actions, including grouping of similar actions	Capital Development and Estates Team	**Complete – will move to controls**	**Workstreams are set up to manage delivery of the EFAB projects and the transport element (Transport Project Board). Links are also made into ongoing work to develop the IMTP and develop longer term strategies e.g. Fleet Vehicle Procurement Strategy 2025 – 30.**
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles: develop an investment strategy/prioritised list of sites where further EV charging is required. Will need further investment.	Decarbonisation Programme Board	March 2025 (in line with the IA recommendation action)	
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited): development of specifications for vehicles considering achievable and safe ULEV options where possible. NOTE: will be dependent on confirmation of 2024/25 BJC funding	Fleet Team	March 2025	
4. NED support ended April 2022: A new NED will need to be nominated to champion this risk/project at Trust Board level	Director of Corporate Governance / Board Secretary	**30.09.24**	**To be further discussed with relevant Directors.**
5. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost: Development of an investment requirements schedule (also aligned to IA recommendations). Contribute resources to support the Decarbonisation Strategy action plan	Director of Finance & Corporate Resources	31.03.25	

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:	23/07/2024	TREND	15 (3x5)
		Date of Next Review:	23/08/2024	➡	

IF	THEN	RESULTING IN
there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	there is a risk of a significant information security incident	a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

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

IMTP Deliverable Numbers: 1, 15, 19, 24

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

Risk Commentary

The risk has been fully reviewed in the cycle and the score remains static. 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. **A deep dive of the risk was undertaken during the closed session of FPC on the 16.07.2024 with no concerns raised in respect to the management of the risk.**

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Appropriate policy and procedures in place for Information/Cyber Security	1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
2. Trust Business Continuity Procedure and Incident Response Plan	2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
3. IT Disaster Recovery Plan	3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
4. Relevant expertise in Trust with respect to information security	4. Staff undertake relevant training courses e.g., CISSP to increase knowledge and expertise
5. Data Protection Officer in post	5. In job description of Head of ICT
6. Cyber and information security training and awareness	6. Training statistics are available on ESR and from Phish threat module
7. Mandatory Information Governance training which includes GDPR	7. Training statistics reported on by Information Governance department
8. ICT tests and monitoring on networks & servers	8. Any issues would be identified and flagged and actioned
9. Information Governance framework	9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
10. Internal and NHS Wales governance reporting structures in place	10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.
11. Checks undertaken on inactive user accounts	11. Software in place to run check on inactive accounts as and when
12. Business Continuity exercises	12. Annual schedule of testing
13. Operational ICT controls e.g., penetration testing, firewalls, patching	13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when. 04/08/23 – Exploring procurement of additional penetration tests with the aim of annual testing of all critical systems.
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
15. Cyber/Info Security KPI are reported to senior management and committees	15. Monthly KPI reports now being generated routinely and fed into the Digital Leadership Group, ELT, IGSG and FPC
16. Regular cyber awareness campaigns are conducted	16. Cyber training is provided to staff and regular phishing campaigns are conducted. These are reported as part of the KPI reports

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:	23/07/2024	TREND	15 (3x5)
		Date of Next Review:	23/08/2024		

IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	THEN there is a risk of a significant information security incident	RESULTING IN a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

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

17 IT recovery Plan does include a cyber response	17. Cyber response incorporated into IT Disaster Recovery Plan
18.Information Security Policy refreshed and approved	
19. Suite of business continuity exercises that departments can undertake to test their plans are available via EPRR.	19.
20. The cyber risk is reviewed and monitored	20. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources via ICT security team and reported to AD of Digital and DPO. 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.
	External Independent Assurance NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of understanding and compliance with policy and procedures by all staff members	1.
2. No organisational information security management system in place	2. SIRO in place and ISMS evolving in line with refresh of Trust information Security Policy
3.	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	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Development of a Cyber Improvement Plan	Senior ICT Security Specialist	Next checkpoint date **26.08**.2024	Implementation of Cyber Improvement Plan actions ongoing and **regularly** reported into **ICT SMT, DLG**, IGSG **and FPC**.

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	07/07/2024	TREND	15 (3x5)
		Date of Next Review:	07/08/2024	➡	

				Likelihood	Consequence	Score
IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	**THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	**RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage	**Inherent**	4	5	20
			Current	3	5	15
			Target	2	5	10

IMTP Deliverable Numbers: 1, 13, 14, 18, 19

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

Risk Commentary

The consequences of this risk depend on the worst-case scenario which crosses of a number Domains on the Risk Scoring Matrix e.g. Loss of, or access to mass clinical data, the reputational damage this would cause, subsequent high-level involvement of ICO, Regulatory Body and Government involvement the subsequent fall out, fines and reduction in the level of clinical care. The likelihood would be small NB Just like pandemics. However, there are lower consequences of failure of statutory compliance which would warrant a higher level of likelihood even daily but in this case like near misses they indicate the need for change/improvement to demonstrate managing the risks. Therefore, the consequences will always be 5 but improvements are needed to lower the risk, and should we demonstrate meeting Statutory Requirements even if a serious incident/event/failure arises evidence provided would reduce / mitigate against the consequences.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Data Protection Expertise: 1 FTE Data Protection and Compliance Manager (DPCM); 1 FTE Information Governance Officer, 1 FTE Cyber Security Officer	1. Two Data Protection and Compliance Managers have been employed on a consultancy basis to provide cover and support backlog clearance (E). **Funding for one of these contractors ceased in June 2024, and so only one additional contractor remains with the team (contract end date September 2024)**
2. Temporary Data Protection Officer position held by Head of ICT	2. Temporary Data Protection Officer
3. Data Protection and Information Governance Policies and Procedures (Incl. DPIAs and Cloud Assessments) a. **Procedure for auditing Welsh Clinical Portal usage (by WAST staff) has been updated (Jun24).**	3. Monthly Information Governance Steering Group which includes progress DPC, DSA and DPIA reviews (I) IG Training IG Toolkit (System for providing a level of assurance of compliance (I) Incident Reporting Accountability to ELT Development of reporting (dashboard) which supports IGSG, ELT and **Finance & Performance** Board Committee for scrutiny.
4. Contracts and agreements: Data processing, Data Sharing and Employment & Consultancy	
5. Register of information assets and data flows (outdated)	
6. Staff training on updated training module (Apr 2023)	
7. Incident Reporting and management (DATIX)	
8. NIIAS **for auditing access to personal information**	
9. Digital Notices / comms **Ongoing (see Siren & recent Lock-screen notices)**	
10. Proactive engagement outbound (not inbound to team)	
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. WAST has been carrying a DPCM vacancy since January 2023. There have **now** been **two** unsuccessful attempt to fill the position which has led to capacity constraints**. - There are now two DPCM vacancies (following additional investment in the Digital team for 24/25) and the post has been readvertised for a third time – interviews are taking place in July 2024.**	1. See 21. Further Actions (1)

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	07/07/2024	TREND	15 (3x5)
		Date of Next Review:	07/08/2024		

IF	THEN	RESULTING IN
IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	THEN the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	RESULTING IN unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage

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

2. Unfilled and unfunded **permanent DPO** position which is required to meet Article 39 UK GDPR 2018. *The DPO must also be independent, an expert in data protection, adequately resourced, and report to the highest management level* [DPA 2018].	2. This is a stop gap.
3. Resource capacity constraints to update, implement or monitor the controls; and lack of engagement by management and staff which either bypass the requirements or stalled engagement.	3. Even with increased capacity without engagement by managers and staff to meet their compliance requirements there will continue to be information reported to IGSG which will demonstrate low levels of assurance i.e. Reports on DPIA log, DSA log, Training Levels, IG Toolkit, and Implementation Plan
4. Personal identifiable information (PII) is being processed or shared with no data processing contracts (DPC) or data sharing agreements (DSA) when legally required; or incomplete DPC or DSA due to stalled engagement.	4. Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase IT systems, hire document scanning companies, external data consultants and analytical firms and bypass WAST's controls for appropriate due diligence or legislative required controls in managing these risks.
5. New data, or new data processes which have either bypassed the controls or there are no information asset owner and therefore doesn't get on to the asset register or the dataflow is not mapped and creates a weakness in assurance (See 3)	5. Data Protection and Compliance Risks not fully realised.
6. Currently not meeting levels of IG staff training.	
7. Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase IT systems.	
8. The Confidentiality Advisory Group (CAG) notified WAST (via DHCW) in June 24 that for organisations with a 23-24 IG Toolkit outcome of "standards not met", any CAG approvals for research & non-research requests are likely to be rejected unless the organisations' IG Toolkit Improvement Action Plan can be met and evidenced by Nov 24 (instead of the original target date for this plan of Mar 25).	8. **The Confidentiality Advisory Group (CAG) required WAST to submit an IG Toolkit Improvement Action Plan (via DHCW) with adjusted timelines to show a path to a "minimum standards met" position by Nov 24. The Improvement Action Plan has been adjusted and shared, and internal stakeholders notified. This will be managed by ADLT and monitored via IGSG.**

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Recruitment of Data Protection and Compliance Manager(s) – funding agreed	Leanne Smith	Q2 2024/25	**Interviews 01 May 2024 were unsuccessful.** **Next round of interviews due July 2024 – expected in post Q3**
2. Seeking funding to recruit/upskill/resource DPO who will encourage engagement**.** **Additional funding into Digital for 24/25 will allow a permanent DPO position to be created within the structure – a JD is yet to be developed.**	Jonny Sammut	Q3 2024/25	**Expected** Recruitment and in post Q3
3. Ensure compliance with the appropriate IG level training across all Directorate and Departments a. Demonstrate a regular series of comms on IG and DP b. Regular monitoring of training compliance through IGSG c. Targeted training compliance reporting to line manager on individuals to ensure that 85% target is reached. **d.** BAU on Siren training notices and specific guidance or advice	Leanne Smith	Q2 2024/25	Lock screen issued 04/24 in relation to WhatsApp and training. This will be refreshed in 06/24. Siren notice drafted for ELT 05/24. **IG training compliance still below 85% target. An Action Plan for training has been created, and a training needs analysis being progressed with L&D team. Procedures, such as audit of Welsh Clinical Portal usage, has been updated.** **Paper to ADLT Jun24 seeking support for increased awareness & training compliance**
4. Report on physical security to IGSG – working with fleet and estates team	Leanne Smith and Aled Williams	Q2 2024/25	Reporting to IGSG and FPC
5. **Assurance of "standards met" for all IG Toolkit requirements: gain support of all Directorates' leadership to complete the IG Toolkit Improvement Action Plan and ensure compliance for the 24-25 IG Toolkit submission**	**Leanne Smith**	**Nov 24 for IG Toolkit Improvement Action Plan (with evidence to CAG)**	**Paper to ADLT Jun 24 seeking support for completion of the IG Toolkit improvement action plan.** **To ensure no impact to CAG approvals for WAST research, this improvement action plan must now be met and evidenced by Nov 24.**

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	26/06/2024	TREND	12 (3x4)
		Date of Next Review:	16/09/2024		

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
WAST fails to persuade JCC/Health Boards about WAST ambitions	there is a risk of a delay or failure to receive funding and support	a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered	Inherent	4	4	16
			Current	3	4	12
			Target	2	4	8

IMTP Deliverable Numbers: 7, 9, 11, 12, 14, 15, 20, 24, 25, 32

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

Risk Commentary

From the 01 April 2024 111, emergency ambulance and Ambulance Care are all commissioned by the Joint Commissioning Committee (JCC). This is viewed as a positive development by the Trust, supporting the development of an organisational ambition.

The ambition is appropriate levels of patient safety and good working conditions for our staff **across the 111 pathway, emergency ambulance care pathway and Ambulance Care pathway**. 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 26,000 (Jan-24). EASC has an ambition to achieve 12,000 handover lost hours by the beginning of quarter four 2023/24, which has not been achieved, 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 this is an internal movement of staff, not an increase in establishment. Similarly, the Trust has made the decision (delivered) to recruit another intake of APPs, an additional 16 FTEs, but this is also being funded through internal movements, with a planned temporary relief gap to fund these internal movements. **A further funded 32 APPs are being recruited in 2024/25 along with 23.2 FTEs to Integrated Care. The 111-call abandonment rate has not been achieved for the last four months. Ambulance Care performance is stable.**

The 2023 EMS Demand & Capacity Review is live with an estimated completion date of **July** 2023 **Trust Board (on target) with the draft results received by end of 23/24 and in time for the 2024-27 IMTP.** 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. If handover levels remain unchanged **and a traditional conveyance model is used to meet demand,** the review is indicating **an unacceptably high-level modelled staff requirement. The Review estimates a more reasonable figure of +100 FTEs, if handover can be reduced to 7,000 hours (handovers within one hour) supported by the evolved clinical response model.**
The Trust has some limited room for manoeuvre in its 2024/25 budget (see above) to put more resource into **supporting the evolution of the clinical response model**, but if further funding is not forthcoming, post the 2023 EMS Demand & Capacity Review, the risk may need to be revised upwards.

NEPTS is also commissioned via EASC (it is commissioned at NEPTS, not Ambulance Care), with agreement that in Q1 2024/25 there should be a joint collaborative workshop between the Trust, the JCC and health boards (completed).

The previous controls are currently transitioning into the new JCC arrangements, so are currently a bit fluid. Quarter 2 should see the arrangements stabilise.

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CONTROLS	ASSURANCES
	Internal & External Management (1st Line of Assurance)
1. **JCC**/WAST Forward Plan for EMS and NEPTS in place and monitored at JCC 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 (sub-**committees currently under review as part of move into JCC).**	2. Minutes of meetings and a standard agenda item
3. Weekly catch up between **Interim Director of 111 & Ambulance Commissioning** /CEO	3. Meetings are diarised every week
4. Collaboration between JCC and WAST on specific projects e.g. Evolving **clinical model.**	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 **(currently paused as part of move into JCC).**	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

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	26/06/2024	TREND	12 (3x4)
		Date of Next Review:	16/09/2024		

IF WAST fails to persuade JCC/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

7. Programme structure has been established for **evolving the clinical model** including **commissioners**	7. 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.
8. Commissioning intentions.	8. In year progress reported each quarter to the relevant commissioning meeting and 24/25 commissioning intentions approved for 111Wales and expected to be approved by Mar-24 EASC **(approved).**
9. Governance arrangements for 111 commissioning: 111 Board, 111 Commissioning Board + 111 DAG etc.	9. Minutes of meetings and a standard agenda item
	External Management (1st Line of Assurance) 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. JCC remit is wider than just ambulances and will reduce the agenda time dedicated to WAST's three patient pathways.	1. **A shorter provider brief will go to the JCC with more detailed discussions taking place at its sub-committees.**
2. Governance coordination between **the** JCC) and WAST to be improved.	2. Identified need for a governance meeting between **JCC** and WAST to manage the overall commissioner/provider interface. Actioned, but has lapsed due to capacity and resourcing in NCCU team. This will be further reviewed as the JCC goes live in April-**24 (period of transition likely to extend through Q1). This has lapsed at this time, but request to re-establish it sent to commissioners.**
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 with significant pressure being applied to health boards through the NHS Leadership Board and NHS Executive accountability arrangements. **The Welsh Government target is no waits > one hour, which equates to 7,000 lost hours.**
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 JCC in Q2 2024/25, with initial findings already shared. On advice from the CASC, formally reporting the findings of the review has been re-programmed into Q2 2024/25, for the new JCC. JCC dates to be determined**.**

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence **JCC**/Health Boards that sufficient funding to be provided to WAST	CEO WAST	NEW 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. 16.04.24 Recurrent funding for +100 FTEs now secured. 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. The reception of the Trust's offer was mixed. A key area of focus in the 2024/25 IMTP will be data linking that enables the Trust to better prove the value of investing in the Trust; (16/04/24) and the development of system metrics dashboard that enables the Trust to track its impact on the wider system **(currently under development).** **26.06.24 Funding for a 32 FTE APPs secured for 2024/25 and 23.2 FTEs into Integrated Care.** **06/08/24 WAST briefing on evolved CRM and 2023 EMS Demand & Capacity Review to JCC Board Development session in Aug-24.**
2. Agree and influence JCC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	NEW 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. The emerging 2023 EMS Demand & Capacity Review models the level of resource required with no handover reduction and the level of resource required if there is a handover reduction to 12,000 hours 26/04/24 This modelling has been further supplemented by modelling the Ministerial target of no handovers of more than one hour.

Risk ID 100	Failure to persuade JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	26/06/2024	TREND	12 (3x4)
		Date of Next Review:	16/09/2024		

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

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

			26/06/24 May-24 levels at 24,000, which is higher than 2023 and concerning as an indicator of the winter the Trust may expect. Trust moving at pace to evolve clinical response model, with Welsh Government full sighted on impact of handover hours on the Trust.
3. Increased understanding of NEPTS by JCC	Executive Director of Strategy Planning and Performance	02/08/23 **30/06/24** **20/08/24**	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, which will now be taken forward into a collaborative workshop with commissioners in Q1 2024/25. 16/04/24 Workshop arranged for April 2024 **(completed).** **26/06/24 Workshop results reported to newly established Interim Ambulance Commissioning Committee.** **06/08/24 The WAST briefing to the JCC Board Development session in Aug-24 includes coverage of five workstreams, one of which is Health Transport, which includes NEPTS and UCS.**
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. As the Trust moves into the new JCC from 01 April 2024 there will be a further opportunity to address this control. 16/04/24 The new commissioning arrangements are in transition and still quite fluid at the moment. **26/06/24 Request to commissioners to re-establish this meeting.** **06/08/24 Meeting now re-established.**
5. Develop and roll out the Stakeholder Influencing Plan	Director of Partnerships & Engagement AD Planning & Transformation	Q2 24/25 onwards	15/03/24 This action is captured in Risk 201 on the CRR. The reputation audit being repeated in Q1 will inform the development and roll out of this plan in Q2.

Risk ID 424	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	19/07/2024	TREND	8 (2x4)
		Date of Next Review:	19/09/2024		

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	2	4	8
			Target	1	4	4

IMTP Deliverable Numbers: All

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

Risk Commentary

It is recommended that the risk score be reduced to **8** based on a reduction of likelihood score. There is funding allocated within the IMTP financial plan for support to deliver key areas of work that has been agreed with commissioners. The **vacancies in the central** Transformation team have been **filled** so there are better levels of support for delivery of key workstreams and delivery of mitigations listed in this BAF. **Alongside this each directorate involved directly in the transformation has identified resources to support the programme. Programme structures have been revised to focus on delivery of key elements of the IMTP utilising the resources that have been put in place. There remains** risk **due to the need for financial savings to be delivered so this risk** will remain under review as we consider any further controls **required** but also taking account of the new commissioning landscape, financial context and our strategic developments.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Prioritisation of IMTP deliverables	1. Prioritisation session held with ADLT/ELT on 14th February 2024
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 for ISPG, TSAG and STB
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) - Project and Programme Management Framework to be replaced with Project Path Framework, with toolkits, training, and networks in place to support consistency of project delivery across the Trust	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
9. Head of Transformation	9. Head of Transformation in Post
10. Project and programme management (PPM) framework published	10. **Project Path Framework (sharepoint.com) – on Siren**
	Independent Assurance (3rd Line of Assurance) 2. Subject to Internal Audit
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of a commercial contractual relationship with Commissioners (link to risk 458)	1. Benefits have not been fully linked at programme level through to benefits realisation plan.

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Develop Benefits Realisation plans in line with Quality and Performance Management framework	Assistant Director of Planning/Assistant Director, Commissioning & Performance	Extended from 30.09.22 – to 31.03.23. Further extend to 31.06.23 and then to 30.09.23 in line with milestone for delivery 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.	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. The PPF has a clear template for benefits realisation plans, and benefits maps will be developed in Q1 to enable programmes and directorates to develop their benefits realisation plans.

Risk ID 424	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	19/07/2024	TREND	8 (2x4)
		Date of Next Review:	19/09/2024		

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	2	4	8
Target	1	4	4

		As above extend to end of Feb. Extend to 30.06.24 as further resources become available / return to enable this work to be done. **30.09.2024**	**Structured assessment recommendation to put this in place. Confirmation to the Board that we will have something aligning delivery to outcomes in the next Board reporting cycle.**
2. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)	Director of Finance	Complete	**Complete in that the recurrent funding risks in the IMTP have been covered e.g. 100 WTE frontline EMS staff. Any additionality requires separate business cases.**

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	08/07/2024	TREND	8 (2x4)
		Date of Next Review:	08/10/2024	➡	

IF the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)	**THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	**RESULTING IN** potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage

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

IMTP Deliverable Numbers: 9, 12, 15, 18, 24, 25, 30, 31, 32

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

Risk Commentary: **Q1 2024/25**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 **year to date to Month 3 of the 2024/25 Financial Year**. The score **is consistent with that of Qtr. 4 2023/24 due to a presented opening balanced financial plan for 2024/25 and the Month 3 2024/25 financial performance and positive savings delivery.** It must be noted though that clear monitoring of a potential **financial** risk around workforce re-banding of **EMT staff and the ability to fund / receive income may impact on the delivery of the financial plan for 2024/25.** The current challenging financial climate for all public sector organisations may also impact on WAST financial performance especially as the financial year progresses.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at FPC, and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	
3. Budget management meetings	3. Diarised dates for budget management meetings
4. Regular financial reporting to ADLT, EFG, ELT, FPC and Trust Board in place	4. Diarised dates for EFG and FPC and monthly reports
5. Welsh government reporting	
6. Monthly review of savings targets	6. ADLT monthly review
7. Regular review monitoring and challenge via WAST and CASC quality and delivery meeting with commissioners.	
8. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.	8. Diarised dates for ICMB meetings with regular monthly report
9. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications	9. Regular PSPP communications (Trust wide) on Siren
10. Forecasting of revenue and capital budgets	a) Monthly monitoring returns to ADLT, EFG, ELT and FPC (b) Reliance on available intelligence to inform future forecasting.
11. Business cases and benefits realisation (both revenue and capital)	11. Business cases – scrutiny and approval at senior management team which are submitted to ADLT, ELT, FPC prior to Trust Board for approval as appropriate according to value.
	External Assurances Management (1st Line of Assurance)
	5. Monthly Monitoring Returns to Welsh Government
	7. EASC management meetings. Monthly meetings with EASC and DAG for NEPTS.
	8. Bi-monthly Capital CRL meetings with Trust and WG capital leads
	9. Regular P2P meetings diarised (bi-monthly)
	10. Monthly monitoring returns into Welsh Government
	Independent Assurances (3rd Line of Assurance)
	1-10 Internal audit reviews covering
	1-10 External audit reviews
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Lack of formalised service contracts between Commissioner and WAST as a commissioned body	**11.** None identified.

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	08/07/2024	TREND	8 (2x4)
		Date of Next Review:	08/10/2024	➡	

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

IF the Trust does:
- not achieve financial breakeven and/or
- does not meet the planning framework requirements and/or
- does not work within the EFL and/or
- fails to meet the 95% PSPP target and/or
- does not receive an agreement with commissioners on funding (linked to 458)

THEN there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)

RESULTING IN potential interventions by the regulators, qualified accounts, and impact on delivery of services and reputational damage

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/24 31/03/25	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 31/03/25	The Financial Sustainability Program (FSP) continues to be a key vehicle for the Trust to fully identify its savings program. Over delivery was achieved for the 23/24 financial year and the point of strong delivery is further highlighted with the programs ability to fully identify the 24/25 £6.4m savings plan before the start of the financial year.
3. Embed value-based healthcare working through the organisation	Executive Leadership Team and Value Based Healthcare Group	31/03/24 31/03/25	Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.
4. 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 31/03/25	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. Ad hoc reports are received from Shared Services on WAST's progress in switching more expenditure to Welsh suppliers to keep the Welsh pound in Wales.

Key - List of Strategic and IMTP objectives

Strategic Objective 1: Providing the right care or advice, in the right place, every time		***BAF risks***
1.	A modern, easily accessible, user-friendly and integrated digital offer	223, 224, 623, 260, 201,163, 424
2.	Rapid (111) call answering, initial triage and onward referral	223, 424
3.	Timely, high quality clinical assessment, advice and referral	223, 224, 424
4.	Seamless transfer of 111 callers to wide range of available pathways	223, 424
5.	Immediate 999 call answering, and efficient and effective dispatch of the right resource	223, 424
6.	High quality, timely, clinical triage, assessment and consultation, with personalised response	223, 424
7.	High quality, immediate or timely on scene assessment, care and conveyance where needed	223, 100, 424
8.	A range of 24/7 pathways available for further assessment or treatment, closer to home	223, 224, 424
9.	A flexible, user-centred Non-Emergency Patient Transport Service with the right capacity in place to meet demand	100,139, 424
10.	A dedicated and timely transfer & discharge service supporting HBs with their transformation agendas	223, 424
11.	A clear vision for Ambulance care services that supports wider health and care transformation	100, 201, 424
12.	A high quality, safe (NEPTS) service with improved patient experience	100, 139, 424
Strategic Objective 2: Enabling our people to be the best they can be		
13.	Culture: • Enhance and strengthen internal capacity for delivering culture change • Develop amplify employee voice to increase employee engagement • Continue the implementation of our compassionate practices approach	160, 558, 623, 201, 163, 424
14.	Capacity: • Implement our Strategic Workforce Plan • Continue to embed a culture of positive attendance management • Continue our focus on 'getting the basics right.'	100, 160, 163, 223, 224, 424, 558, 594, 623
15.	Capability: • Grow and develop our leadership and management capability • Reinforce and promote career pathways and professional development. • Create an environment centred around effective, ongoing conversations ('Check Ins')	100, 139, 160, 223, 224, 260, 594, 424
16.	Strengthen Welsh Language compliance through strong leadership, enabling Welsh language to flourish	201, 424
Strategic Objective 3: Being at the forefront of innovation and technology		
17.	The right buildings in the right place, enabling our staff to provide the best and safest care across Wales	542, 424
18.	The right fleet in the right place, enabling our staff to provide the best and safest care across Wales	139, 542, 623, 424
19.	Develop & agree Digital Plan • Everyday essentials • Security, Safety & Cyber • Digital Pioneers • Transformation • Data, Information & Insight	163, 260, 623, 424
Strategic Objective 4: Developing services in collaboration		
20.	Well-placed to influence system thinking / strategy development	100, 223, 424
21.	Meet the requirements of the Wellbeing of Future Generations Act	558, 424
22.	University Trust Status in collaboration with WG, embracing a 'democratised culture' of learning, research and innovation	160, 163, 223, 224, 424
Strategic Objective 5: Being quality driven and clinically led		
23.	Systems that meet the requirements of the Duty of Quality and Duty of Candour	224, 424
24.	Excellent clinical leadership	100, 139,160, 223, 224, 260, 594, 424
25.	A culture of quality improvement with robust quality management systems	100, 139, 160, 201, 223, 224, 424
26.	High quality Putting Things Right, Safeguarding and Health & Safety systems	160, 224, 558, 424
27.	Meaningful engagement and co-production with communities	223, 224, 424
28.	A risk management framework as a key enabler of our long-term strategy and decision making	No corporate/principal risks
29.	An integrated governance framework	No corporate/principal risks
Strategic Objective 6: Delivering exceptional value		
30.	Sustainable savings & efficiencies	139, 163, 224, 424
31.	Generate income alongside our core commissioned functions	139, 224, 424,
32.	A Value-Based approach across the organisation which is embedded in culture	100, 139, 163, 424
33.	Developing and implementing our plans for Environmental Sustainability and Adaptation	542, 424

AGENDA ITEM No	**19**
OPEN or CLOSED	**OPEN**
No of ANNEXES	**1**

AUDIT TRACKER 2.0 – JUNE 2024 (Q1)

MEETING	Finance and Performance Committee
DATE	17 September 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Alex Payne, Corporate Governance Manager
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

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

2. Of those internal audit actions relevant to this Committee**,** 24 actions which were due in quarter have been closed in quarter of a total of 49 due (49%). There are two actions closed in quarter which were not due in quarter. Of the actions relevant to this Committee 23 (47%) have been given revised dates in quarter (marked in blue) and of these three are on their third revised date.

3. The Committee's attention is drawn to action reference 567, which is on its third revised date but it yet to be completed. There is further detail on this action in the report and this was drawn to the attention of the Audit, Risk and Assurance Committee on 12 September.

4. There is only one external audit action relevant to this Committee – action reference 121 – regarding the EMSCCC Patient Safety Review. This action was due in April 2024 (a second revised date) and has been closed in quarter.

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.

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 no audit reports to be received by the Committee on this occasion.

   (b) Monitor management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue). It is noted that the actions against the Cyber-Security and Technical Resilience internal audit will be received in closed session.

KEY ISSUES/IMPLICATIONS
As set out above.
REPORT APPROVAL ROUTE
Tracker presented to ADLT via email in July 2024.

REPORT APPENDICIES
Annex 1 – Tracker 2.0 –April - June 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.

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 one 2024/25 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.

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.

Internal Audit

13. Of those internal audit actions relevant to this Committee**,** 24 actions which were due in quarter have been closed in quarter of a total of 49 due (49%). There are two actions closed in quarter which were not due in quarter. Of the actions relevant to this Committee 23 (47%) have been given revised dates in quarter (marked in blue) and of these three are on their third revised date.

14. The actions on their third revised date are as follows: - actions 645 and 646 from the Savings and Efficiencies internal audit (revised dates are for completion in Q3) and action 654 from the Records Management audit (revised date for completion in Q2). Of the internal audit internal audit actions, 13 of the 66 (20%) are not yet due.

15. The Committee's attention is drawn to action reference 567, which is on its third revised date but it yet to be completed. This action, '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', is on its third revised date and is yet to be completed.

16. The self-assessment has been completed; however, the Operations Directorate senior leadership wish to seek a peer review of the self-assessment before finalisation, to be assured of its accuracy. Colleagues in the Operations Directorate are in the process of organising the peer review requested by the Operations Senior Leadership Team (SLT). When this peer review has been completed the self-assessment will return to the Operations SLT for assurance.

External Audit

17. There is only one external audit action relevant to this Committee – action reference 121 – regarding the EMSCCC Patient Safety Review. This action was due in April 2024 (a second revised date) and has been closed in quarter.

Management and Development of the Tracker

18. 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 two with a view to closing down or revising as many as possible.

19. With respect to the Committee's responsibility to scrutinise the impact of actions, in 2023 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.

20. The current version of the tracker is now open for Directorate review for actions due in July to September 2024/25. These updates will then be reported to the Committee at its meeting in November 2024. The team will work with Directorate contacts to ensure a smooth transition between Tracker 2.0 and 3.0.

21. 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

22. The Committee is requested to:

(a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. There are no audit reports to be received by the Committee on this occasion.

(b) Monitor management actions to address recommendations in the Tracker, noting any revised dates for actions (in blue). It is noted that the actions against the Cyber-Security and Technical Resilience internal audit will be received in closed session.

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

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	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	Closed in Quarter	080724: Updated status to closure proposed based on IT update/DoD confirmation. 170624: ICT Update- Launch of new service desk for ICT staff will commence 01/07/2024 with a rollout of incident and problem management modules along with CMDB. Service portal for user will be launched during August with the service catalogue to follow in September. This is superseded by 621(2) which covers the same requirements for a service catalogue but with additional details such as RPO/RTO. Agreed by DLG to close this and track via 621(2) due September 2024. Propose to close. Revised date of September 2024 in Q4. 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	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	080724: Meeting to be arranged with internal audit for closure discussion. To be arranged. Last updated (ICT) 17/06/2024 - ICT have been in dialogue with the supplier and further investment is required of circa £25k to upgrade the software and end-of-life hardware. An internal meeting is being arranged with stakeholders to review options available. 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. Due date moved to September 2025 in Q4 23/24. 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.
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			Closed in Quarter	040724: (AP) Updated to closure proposed; completed in May 2024 as received at TB. 260624: Update from Mark Harris: A new service specification and SLA has been agreed with AB and was approved at Trust Board this month. This action can now be closed. 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.
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	Closed in Quarter	310524: (AP) Updated status to closure proposed in line with update provided. Last Update 23/05/24: report catalogue now live via a PowerBI report. This displays all report & dashboard assets, along with a classification (Gold, Sliver, Bronze) to inform the review cycle, and information asset owners. The catalogue will be governed locally, through the weekly HI Change Advisory Board (CAB). Action is complete, and PROPOSE FOR CLOSURE Update 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. Updat 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.

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
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	Closed in Quarter	310524: (A) Updated status to closure proposed in line with updated provided. Last Update 23/05/24: A Microsoft Form has been developed to formally capture the request and requirements for new reports or dashboards. Once a Form is submitted this enters the HI queue (or backlog) and is reviewed frequently (typically weekly) and cross-checked with the new Information Asset Register and report catalogue (of Action 522). The Digital Sharepoint site has also been updated to help signpost colleagues and stakeholders to this new Form or other data requests. PROPOSE FOR CLOSURE. Update 22/03/24: 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 alignement 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	Closed in Quarter	040624: (AP) Updated to closure proposed based on update provided. Additional detail from LS regarding the collection of feedback: t*"he review cycle will be an important element of the feedback - capturing how well the report meets needs ofter a significant period of use, ensuring we have a way of discovering changing requirements and a way of checking our live reports remain useful and easy to use."*. It should be noted that this is in addition to utilisation statistics we already collect, and in addition to a brief feedback survey which we have long been sending to requesters and stakeholders after implementation or completion of a request. This new review cycle schedule and checklist together create a more formal and steady way of checking usage (via quantitative stats and reviewing access) and usefulness (other qualitative checklist items and conversations with stakeholder). Last updated 23/05/24: linked to action 522, the Information Assest Register now has an accompanying report catalogue which identifies reports due to review as part of a formalised schedule. As a report is due for review, a newly developed "checklist" is used by the reviewer to check current utilisation of the report (via a Report Usage dashboard) and if the report is still meeting needs of the original owner (stakeholder) and adding value to the organisation. PROPOSE FOR CLOSURE. Update 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.
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.		**A risk-assessment** will be conducted to understand the exposure to WAST of Qlik Sense being out of vendor support. This platform is not internet facing (i.e. for internal users only, not on a publicly accessible web url), and not believed to present an information security risk, but pending ICT assessment, we will devise a mitigation plan, or an options appraisal for maturity - **due March 23**. In the meantime, there is already a programme of work to migrate reports and dashboards to **PowerBI.** However, this is a lengthy and high-capacity activity, and is not prioritised highly at this current time - due March 24.	Mar 24	Not Met	Oct-24			Open	12042024: Board Sec reveiew - 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. Additioanlly, 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		Closed in Quarter	120624: (AP) Reviewed update and accepted; updated to closure proposed. Email from Leanne Smith received regarding the relevant sections of the Data Quality Policy and the consideration of data accuracy and errors. The Trust did not commit to defining the quality (accuracy) level and acceptable error rate (s) for all data fields, however the respective definitions and approach have been included in the revised Data Quality Policy. Last Updated 23/05/24: Data Quality Policy was approved at Finance & Performance Committee in May 2024 and formally published. Additionally, 2 new posts in Data Quality have been approved to be added to the HI establishment and support future development in the Data Quality Management field. Job Descriptions are in development. Propose for Closure. 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. The approval of the policy will close this action. Update 02/10/23: Data Quality Policy review not yet started - this is agreed to be part of the 2024-25 policy workplan. (Digital are reviewing 3 other higher priority policies in 2023-24.). Date for approval of the Data Quality Policy aimed at November 2024 QUEST.

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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		Closed in Quarter	120624: (AP) Reviewed update and accepted; updated to closure proposed. Email from Leanne Smith received regarding the relevant sections of the Data Quality Policy and the consideration of data accuracy and errors. The Trust did not commit to defining the quality (accuracy) level and acceptable error rate (s) for all data fields, however the respective definitions and approach have been included in the revised Data Quality Policy. Last Updated 23/05/24: Data Quality Policy was approved at Finance & Performance Committee in May 2024 and formally published. Additionally, 2 new posts in Data Quality have been approved to be added to the HI establishment and support future development in the Data Quality Management field. Job Descriptions are in development. Propose for Closure. 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. The approval of the policy will close this action. Update 02/10/23: Data Quality Policy review not yet started - this is agreed to be part of the 2024-25 policy workplan. (Digital are reviewing 3 other higher priority policies in 2023-24.) Date for approval of the Data Quality Policy aimed at November 2024 QUEST
567	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		2.1 The Trust should undertake a self-assessment agains the NARU key lines of enquiry review document. This could support any future "critical friend" review undertaken		The Trust accepts this recommendation and is committed to undertaking a self-assessment aginst the NARU review document	May-23	Not Met	Mar-23	Mar-24	Jun-24	Open	120724: Action not yet complete. SOT requested peer review and a number of actions have been passed to SOT and EPRR team to complete prior to it going back to SLT for assurance/approval. Third revised date not met. Indicated for review by FPC and ARAC. Update will be provided to the Corporate Governance Team as soon there are updates. 270624:Current Situation - submitted self assessment as per recommendation and planned management response, Sent through SBAR, Self Assessment and agenda Bundle/Triple A. Will be going back through SOT on 2nd July and SLT on 9th as SLT have not yet seen the full self assessment (just the SBAR due to error). Will need this to remain open untill assurance provided to SLT via SOT this week. 040624: Self Assessment and accompanying SBAR will be going through Formal SOT on 18th June 2024. 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 Assesment 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.
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 Met	Mar-25			Open	080724: Revised date of March 2025 added in Q1 24/25 in line with update. 170624: ICT Update - Launch of new service desk for ICT staff will commence 01/07/2024 with a rollout of incident and problem management modules along with migration of assets into the new system CMDB. To update the asset register the Trust has invested in additional licences to allow for remote scan of equipment connecting to network and work is ongoing to reconcile this data and we will utilise this reconciliation exercise to virtually audit this equipment. We are unlikely to physically audit equipment at remote workers homes and discussions are ongoing as to the availability of non-ICT staff to undertake a physical audit of equipment located at Trust sites if this is deemed necessary. Revised date of March 2025. 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
624	22/23	FPC	IM&T Infrastructure	Reasonable	Wyn Morris	Jonny Sammut	Medium	3.1	The process for clearing all PRTG/system alerts should be formalised and documented. It would typically include •A shared mailbox, all alerts go to one place •Prioritisation guidelines for all calls. •Scheduled review times for technicians and managers. •Process for storing cleared alerts for periodic analysis to 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	Aug-24		Open	080724: Revised date of August 2024 added in Q1 24/25 in line with update. 170624: ICT Update - Launch of new service desk for ICT staff will commence 01/07/2024 with a rollout of incident and problem management modules along with migration of assets into the new system CMDB. Automation of incidents form alerts is planned to be in place from mid-July. Revised date August 2024. 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 PRTG 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 superseded 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	170624: ICT Update - Launch of new service desk for ICT staff will commence 01/07/2024 with a rollout of incident and problem management modules along with migration of assets into the new system CMDB. Switches will be included as assets in the new system 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.

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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			Closed in Quarter	080724: Closure proposal accepted based on DoD confirmation and status updated. 170624: ICT Update - Patching procedure including switches along with PO for replacement switches presented to DLG 18/06/2024. Old switches have been replaced and the associated process is in place as well. Propose closure. 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.
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			Closed in Quarter	080724: Closure proposal accepted based on DoD confirmation and status updated. 170624: ICT Update - Patching procedure including switches along with PO for replacement switches presented to DLG 18/06/2024. Old switches have been replaced and the associated process is in place as well. Propose closure. 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.
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	Nov-24	Open	050724: Update from JC: due to a revised NHS Wales rollout of the new Qliksense reporting tool and BI dashboard now planned for November 2024 then this training will be delayed until then to ensure all budget holders receive consistent training. Request third revised date of November 2024 in Q1 24/25. 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 incoporate 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	Nov-24	Open	050724: Update from JC: due to a revised NHS Wales rollout of the new Qliksense reporting tool and BI dashboard now planned for November 2024 then this training will be delayed until then to ensure all budget holders receive consistent training. A list of those trained continues to be added too but full list will be available when Qliksense training is provided. Request third revised date of November 2024 in Q1 24/25. 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 allign with new finance system
650	22/23	FPC	Records Management	Reasonable	Jonny Sammut	Jonny Sammut	High	1.1	Management should ensure that a full review of current resources, how resource is used and time required to complete all legislative duties is undertaken, to identify gaps and risk areas upon which capacity and resilience can be measured.	1.1	Previous time & motion study showed significant variance in the tasks undertaken, and similar pressure is felt across records service community in NHS Wales with increasing complexity. A risk will be captured around legislative duties. Exploration of digital tooling to support better tracking of activity in the RM team is already being taken forward, and the ways of working of the team is under continuous review for improvement.	Dec-23	Not Met	Jan-24	May-24		Closed in Quarter	210624: (AP) Evidence received from Digital includes evidence of the risk on Datix, evidence of the discussions at the HI SMT meeting in relation to this risk. CGT aware of the receipt / approval of the resources committeed within the Digital Plan (evidence received). Accepted closure proposed on the basis that the action has been completed and recruitment is underway. Last Updated 19/06/24: The risk is now logged on Datix, and being monitored locally by the team, and monthly at the Health Informatics Senior Management Team meeting (chaired by Assistant Director for Data & Analytics). As part of the Digital Plan refresh, investment has been confirmed for two additional Records Officer posts in this function to support the increase in demand witnessed year on year. This action is now addressed, and so is proposed for closure. 12042024: Revised date of May 2024 (in quarter 4) added following update below. Update 22/03/2024: risk drafted and reviewed by Health Informatics Senior Management Team. To be logged on Datix - this will close the action. Target date moved in Quarter 4 to May24. Update 18/12/23: Risk register training conducted for team in Dec, to enable creation of this risk. Digital tooling has been explored and is progressing through procurement process. A demo is to be arranged for the team in January-24. Expected risk action to be completed in January-24 (after passing through relevant governance routes within Digital).
653	22/23	FPC	Records Management	Reasonable	Leanne Smith	Jonny Sammut	Medium	2.1(a)	A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust.	2.1(a)	Additional fixed-term support will be sought to conduct the assessment and craft an improvement plan. The risk of not developing an improvement plan in 2023-24 will be included in the risk being developed as per action 1.1.	Sep-24	Not Yet Due				Open	080724: Business note taken to IGSG in June 2024 as intended; rescheduled to July 2024. Revised date of August 2024 applied in Q1 24/25, therefore. Intended that once this is received at IGSG in July this action will be closed. Last Updated 23/05/24: A records management improvement plan has been developed and prioritised, and is due to be passed through the Information Governance Steering Group in June 2024 for approval (May meeting of IGSG was cancelled).
654	22/23	FPC	Records Management	Reasonable	Judith Birkett	Jonny Sammut	Medium	2.1(b)	A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust.	2.1(b)	A Digital Notice re records management will be published on the intranet to increase awareness of individual staff responsibility.	Dec-23	Not Met	Jan-24	Apr-24	Aug-24	Open	080724: Business note taken to IGSG in June 2024 as intended; rescheduled to July 2024. Revised date of August 2024 applied in Q1 24/25, therefore. Intended that once this is received at IGSG in July this action will be closed. Last Updated 23/05/24: A records management improvement plan has been developed and prioritiesed, and is due to be passed through the Information Governance Steering Group in June 2024 for approval (May meeting of IGSG was cancelled). Additionally, a training package has been published on the Digital Sharepoint site to increase awareness - this has also been delivered virtually to specific teams who required targetted training. Propose that approval of the improvement plan at IGSG in June 2024 will close this action. Update 25/03/24: a Records Managment Improvement Plan has been developed, approved by Assistant Director of Digital, and is already being progressed. This will be shared with Information Governance Steering Group for awareness in April 2024. Date changed in Q4 to April24. Target date moved in Quarter 3 to January-24. Update 18/12/23: materials have been developed to help raise awareness of records management. These are being finalised, with a plan to share and put on the Records Siren page with a living FAQ sheet. Plan to release this in January-24.

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655	22/23	FPC	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	3.1(a)	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.	3.1(a)	Additional temporary resource to be sought (from Jan-24) to conduct review of DCC stored boxes and retention schedules. A forecast of storage requirements at DCC will be created to inform a decision on if/when it will be possible to move these records into WAST-managed storage (e.g. at VPH).	Apr-24	Not Met	Sep-24			Open	080724: Revised date of September 2024 added in Q1 24/25. 190624: LS Update - Due to some sickness within the small team this action has not been able to be complete. Work continues on reviewing the records held in DCC, and as per retention schedules, an instruction for disposal has been issued for some boxes. Linked with Action 657, it is believed that following a review of the storage facilitiy in VPH, as the requirement for external storage at DCC has decreased, we may be able to transfer remaining boxes to WAST storage instead. Propose that this date is extended to September 2024, and sequenced after action 657.
656	22/23	FPC	Records Management	Reasonable	Judith Birkett	Jonny Sammut	High	3.1(b)	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.	3.1(b)	Should [following the review at 3.1a being evaluated] we still need space at Denbigh County Council then we will pursue an agreement with them for those storage, retention and disposal. In the meantime, we will ask for the policies and procedures the Council have in place for their receipt, retention and destruction of records and confirm that this is the way they treat our records. That should provide some assurance on the issues in the matter arising.	Sep-24	Not Yet Due				Open	
657	22/23	FPC	Records Management	Reasonable	Leanne Smith	Jonny Sammut	Medium	4.1	Records should be moved into the new storage area.	4.1	RSAM to review suitability of the VPH storage facility and access management arrangements. If appropriate, secure transfer of the records from Pontypool to VPH will require budget approval beyond the funds available for Records Services (to be discussed with Corporate Governance & Finance).	Jan-24	Not Met	Jun-24	Aug-24		Open	080724: Revised date of August 2024 added in Q1 24/25. Last Updated 19/06/2024: Due to some sickness within the small team this action has not been able to be progressed. The Records & Archives Manager plans to visit VPH in person to conduct this suitability review. Completion of this action will support with Action 655. Propose that this date is extended to August 2024, and sequenced before action 655. Date changed in Q4 to June 2024 in line with update. Last Updated 25/03/24: request for date extension to Jun-24. VPH storage facility still to be assessed for feasibility.
658	22/23	FPC	Records Management	Reasonable	Judith Birkett	Jonny Sammut	Medium	5.1	The records management improvement plan noted in MA2 should include a programme of identification and assessment of all records storage areas within the Trust.	5.1	The risk of not fully assessing storage areas in 2023-24 will be acknowledged in the risk being developed as per action 1.1. A Trust-wide request will be made to gather intel on what paper records are being stored across the organisation and where. This will inform the improvement plan of how to assure these storage areas.	Sep-24	Not Yet Due				Open	Last Update 25/03/24: a risk has been developed regarding the overall compliance of records management. Further risks are in development, to capture the specifics of storage areas.
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			Closed in Quarter	080724: (SW) A detailed review of BLM has been undertaken to sense check and data cleanse the information held in our CAFM system in relation to BLM including both capital investment works and revenue schemes where improvements to the estate have been completed. This work was undertaken whilst waiting for confirmation of the EFPMS definitions and reporting template for this year's EFPMS report. SES provided confirmation of the definitions and reporting template on 25th June and despite having had verbal confirmation that we were working to a new criteria (reporting buildings over the 1000sqm separately and then the rest of the Estate as a whole – essentially 12 submissions, with 11 over the 1000sqm threshold) the template provided by Craig Morgan on 26th June is the same format used for previous year's submissions i.e. split into regions. This was followed up and reviewed further at a meeting with Craig 4th July where the criteria for this year's submission was approved. Guidance therefore sought and detailed review of backlog maintenance completed, and action proposed for closure. Emali received from Estates Manager confirming the activity taken in respect of the BLM backlog review. Action closed and updated as closure proposed 150724. 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			Closed in Quarter	110724: Evidence of email exchange between Trust and NWSSP received. Updated to closure proposed. 080724: (SW) Having had time to review the definitions confirmed on 25th June, we can advise the risk categorisation for the BLM and subsequent EFPMS report remain the same with no change to the structure. Guidance/position therefore sought, and action proposed for closure. 050724: (AP) Update from RD: Detailed WAST review and sence check of BLM report has taken place to ensure all risk is at appropriate level, awaiting definitions from NWSSP, these have been requested on several occasions. Evidence to be sent to AP; which will mean action can be closed. AP updated to pending evidence. 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			Closed in Quarter	110724: Evidence of email exchange between Trust and NWSSP received. Updated to closure proposed. 080724: (SW) We attended a working group session with SES in November 2023 (see email summary of meeting discussion points attached) to discuss the scope of future 6 facet surveys and whether any changes to the requirements/output of the surveys would be needed when the quinquennial surveys are next due (2025/26). SES are yet to make a decision on how future 6 facet surveys are procured, either a more robust specification needs to be provided to ensure they are more structured and the detail in a format which is more appropriate, or the process be managed and centralised within NWSSP SES. SES to review feedback and produce options for discussion at the next working group. Proposed for closure. 050724: (AP) Update from RD: As per attached email, we have attended a working group with SES to discuss future 6 facet surveys. RD will send over additional narrative to AP for inclusion in the Tracker; subject to which can be propsed for closure. 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 Met	Sep-24			Open	050724: (AP) This report will be prepared and submitted no later than the 31 August 2024. This will be taken to the Finance and Performance Committee in September 2024 for assurance and will be built into the FPC CoB going forward. This report submission to the FPC, with ongoing inclusion in the FPC CoB will close this action. Revised date of September 2024 added in Q1 24/25 following discussion with Directorate.
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	

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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	Sep-24		Open	050724: (AP) Update from RD: A number of the high and significant issues are already addressed through last years revenue investment and also through more recent EFAB funding, with a further available this year. This is considered on an annual basis within the production of the EFPMS submission. This is due to be taken to FPC in September 2024 (as with action 630). Once that report is received by FPC and evidence of ongoing review included in FPC CoB, action can be closed. Revised date of September 2024 added in Q1 24/25 following discussion with Directorate, as with action 630. Date changed in Q4 to April 2024.
635	23/24	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 Met	Jun-25			Open	050724: (AP) The Trust will revisit this recommendation in June 2024 to ensure that roles and responsibilities are clear for NHS111. Revised date of June 2025 added in Q1 2024/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: No further action with the collaboration agreement at this juncture.
638	23/24	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 Met	Jun-24	Sep-24		Open	050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: Policies updated. Action closed.(KL emailed HB to confirm the policies she had found were the most up to date versions - so these could be forwarded to Alex 27.6.24) 170424: New date added in Q4 of June 2024.
639	23/24	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 Met	Jun-24	Sep-24		Open	050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: Updated and communicated. (KL to monitor response from Paul greatorex and Peter Brown re evidence in HB adbsence 28.6.24) 170424: New date added in Q4 of June 2024.
640	23/24	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 Met	Jun-24	Sep-24		Open	050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: The Trust has been meeting regularly with the Interim Director of 111 & Ambulance Commissioning on the evolving clinical model (which includes 111, EMS and Ambulance Care), with the meetings being positive and supportive. 170424: New date added in Q4 of June 2024.
642	23/24	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	Sep-24		Open	050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 250624: Reporting of commissioning intentions to STB re-established and 23/24 year end reporting to commissioners complete. Close action. (EVIDENCE - HB confirmed year end reporting to commissioners 20/05/2024. Reporting of commissioning intentions restablished are evidenced in STB minutes KL to send over extraction of STB minutes) 170424: New date added in Q4 of June 2024.
643	23/24	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	Sep-24		Open	050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: The JCC arrangements are not yet sufficiently developed for this to be actioned. 170424: New date added in Q4 of June 2024.
644	23/24	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	Sep-24		Open	050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: Updated and complete. (EVIDENCE - HB confirmed he had updated BAF - https://nhswales365.sharepoint.com/:w:/r/sites/CORPORATEGOVERNANCETEAM/Shared Documents/General/Risk Management/BAF 130624 v1.docx?d=w17516e57ff4a435aace4a0eb4f9fc63e&csf=1&web=1&e=33eTya 170424: New date added in Q4 of June 2024.
645	23/24	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	Sep-24		Open	050724: Revised date of September 2024 added in Q1 24/25. CGT to discuss with SPP; to understand how the recommendation 635-645 on the basis of the new JCC arrangements cam be progressed / closed. 260624: HB checking with Kelsey Rees-Dykes. 170424: New dated 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	

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647	23/24	FPC	Strategy Development	Reasonable	Estelle Hitchon	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 Met	Sep-24			Open	08.07.24 - The revised engagement framwork delivery plan is completed. **Presentation to STB will be evidence of closure** of this item. Date changed to September 2024 to allow this to take place. 25.06.24 - Work with the Consultation Institute concluded in May-24 having undertaken work to review the stakeholder groups and phasing as set out in the high level Engagement Delivery plan. Work is continuing to reprofile the original delivery plan that was approved by the Board in Jan 2023. This reprofiling has now led to a change in phasing to prioritise key (mission critical stakeholders) and staff, differentiated by those most affected and staff more generally affected. (EH) Revised date of August 2024 proposed in Q1 24/25.
648	23/24	FPC	Strategy Development	Reasonable	Estelle Hitchon	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 Met	Sep-24			Open	08.07.24 - The revised engagement framwork delivery plan is completed. **Presentation to STB of the workstreams that will oversee implementation and monitoring of the internal and external elements of the plan will be evidence of closure of this item**. Date changed to September 2024 to allow this to take place. 25.06.24 - Engagement activity has commenced with the key stakeholders identified with 'High Levels of Influence' including direct engagement with JCC, Commissioning Team, Welsh Government via JET & IQPD. Internal communication commenced in April with a month long internal communications campaign, further work required to embed a pipeline of regular communication activity. To date there has been no formal engagement / communications with the wider public and service users. (EH) Revised date of August 2024 proposed in Q1 24/25.
649	23/24	FPC	Strategy Development	Reasonable	Estelle Hitchon	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 Met	Sep-24			Open	08.07.24 - The revised engagement framwork delivery plan is completed and include periods of pause and reflect. Aligned to action 647, **Presentation to STB will be evidence of closur**e of this item. Date changed to September 2024 to allow this to take place. 25.06.24 - Periods of 'Pause & Reflect' have been factored into the high level Engagement Delivery Plan. The plan will be monitored by TSAG (whilst in operation) pending the transition to the revised Programme structures & governance processes. The programme architecture is being revisited in line with the rest of the programme (EH).
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	Met				Closed in Quarter	050724: Closure proposed accepted on the basis that this will be going to STB in July 2024. 25.06.24 - An internal review of the Programme structures and governances process has been undertaken following considered engagement and consultation with key internal stakehodlers. A proposed future structure has been developed and is currently being consulted on, pending implementation over the next 2-3 months. During the initial phase of transitioning to the new programme arrangements TSAG will be re-set to the role of the Clinical Model Transformation Programme Board. (JH) Proposed for closure.
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	25.06.24 - A proposed future programme structure has been developed and is currently being consulted on, pending implementation over the next 2-3 months. During the initial phase of transitioning to the new programme arrangements TSAG will be re-set to the role of the Clinical Model Transformation Programme Board, followed by the changes to the current Programme Boards and project work streams. (JH)
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	Met				Closed in Quarter	100724: FSDG meeting held on the 270624. The reviewed FSDG ToR and the papers presented to the FSGF meeting received, wtih the revised PID document (agreed by the FSDG), confirmation of review of the ToR for the FSDG by the FSGD, and the decision-record from the FSDG mtg in June which evidences approval of the updated PID received as evidence. Closure proposed accepted in quarter and updated. 30/05/24: ToR, PID and Business Case have all been reviewed. The outcome was reported to May FSDG held on 29th May. The Group acknowledged that it was comfortable with the controls in place, and roles and responsibilities and how these linked to the Trust's overarching structures. Not proposing to introduce delegation of financial tolerances. Agreed that end stage reporting will be updated to reflect a move from stages of the project, to the project being a stage of the programme. E.g the 2024/25 vehicle replacement project will be a stage of the vehicle replacement programme in totality. Slide pack from FSDG to be provided to TM. Relevant project documentation to be updated for June FSDG at which point this action will be closed. 27/03/2024: Update from Capital Development: 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	Met				Closed in Quarter	310524: AP updated to closure proposed following receipt of update and evidence. 30/05/24: Review undertaken as planned in April 2024 and reported to FSDG on 29th May. Benefits are still valid. Timescales will change for assessing realisation of benefits to ensure more streamlining of timelines for measurement of benefits realisation given the sequential nature of vehicle commissioning. This will include aspects of benefits or otherwise of vehicle retention compared to vehicle replacement. Propose to close. Slide pack to be provided to TM. 27/03/2024: Update from Capital Development: 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	Met				Closed in Quarter	100724: Updated PID (including narrative on sign off process of specification agreement) submitted to FSDG meeting on 27th June. Supporting document / process map subsequently being circulated to FSDG. FSDG pack from 270624, updated PID document, vehicle specification document, and vehicle specification process map and decision-log for FSDG received as evidence. Action completed in quarter and closurep proposed accepted. 30/05/24: process reviewed and supporting documentation is being developed. Proposed to take to FSDG in June. 27/03/2024: Update from Capital Development: 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	Met				Closed in Quarter	100724: Updated PID (including narrative on inspection / quality acceptance process) submitted to FSDG meeting on 27th June. Supporting document / process map also being circulated to FSDG. The FSDG pack from 270624, updated PID document, and the vehicle commissioning sign-off process, and decision-log for FSDG received as evidence. Action completed in quarter and closure proposed accepted. 30/05/24: process reviewed and narrative being developed. Document is work in progress linked to previous action. Will go to FSDG in June. 27/03/2024: Update from Capital Development: 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 procurement and contractual arrangements to obtain best value from strategic partnering.	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	30/05/24: enhanced narrative included in 24/25 BJC documentation. To be developed further for 2025/26 business case process. To note - December 2024 is the deadline for this but we may aim to submit the relevant documentation to Trust Board in January 2025, so the date will need to change accordingly to capture approval and evidence of this as an action. 27/03/2024: Update from Capital Development: 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	Met				Closed in Quarter	100724: FSDG meeting held on the 270624. The reviewed FSDG ToR and the papers presented to the FSGF meeting received, wtih the revised PID document. The FSDG pack from 270624, updated PID document, and and decision-log for FSDG received as evidence. Action completed in quarter and closure proposed accepted.30/05/24: Narrative will be updated in the next PID, and this document will be received at FSDG in June. Update from Capital Development: 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 meatime, in April 2024 the Project Intiation Docment 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 Met	Jul-24			Open	310524: Revised date added by AP in Q1 24/25 as the changes required are not due to be taken to the ARAC and TB until the end of July (25 July). As such this won't be closed off in the Q1 reporting period, and a revised date is required. 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.

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
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 BJCs 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 approved awaits likely to be received through 2024 of the Fleet	Mar-25	Not Yet Due				Open	29.05.24 - 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	Met				Closed in Quarter	080724: Closure proposal accepted; evidence of oversight of contracts on Digital SMT work programme rec'd. DoD provided assurance and agreement in support of closure of this action. Last updated 17/06/2024 - The contract manager has provided two walkthroughs of the SOP at SMT the last on 05/06/2024 along with a Q2 forward look on renewals. Contracts are a standing monthly item on the Digital Directorate SMT and it therefore now 'business as usual'. Propose closure.
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	Met				Closed in Quarter	080724: Closure proposed accepted and status updated. Last updated 17/06/2024 - The contract manager has resigned from the Trust as of the 14/06/2024 but prior to his departure the contract manager has brought the contract register up to date. The ADoD - ICT will ensure the register is kept up to date moving forward. Propose closure.
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				Closed in Quarter	080724: Closure proposal accepted. Excerpt of the Contract Register rec'd as evidence as well as the record of an example supplier performance meeting. DoD provided assurance and agreement in support of closure of this action. Last updated 17/06/2024 - The contract manager has resigned from the Trust as of the 14/06/2024, but has provided and action note template for use by senior management in future supplier meetings as way of formal recording. Notes will be stored in the contract register. Propose closure.
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	Last update 17/06/2024 - The contract manager has resigned from the Trust as of the 14/06/2024. Senior management will undertake necessary meeting with suppliers with priority on key and high value contracts until a replacement is recruited.
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	Met				Closed in Quarter	080724: Closure proposal accepted and status updated. Excerpt of the Contract Register rec'd as evidence. Last updated 17/06/2024 - The contract manager has resigned from the Trust as of the 14/06/2024 but prior to his departure the contract manager has brought the contract register up to date and ranked the contracts H/M/L. The ADoD - ICT will prioritise meetings with key suppliers or High value contracts are undertaken until a replacement contract manager is recruited. Propose closure.
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	Met				Closed in Quarter	080724: Closure proposal accepted. Evidence rec'd - template agenda for the supplier review meetings (an end of Contract review meeting is yet to be held). DoD provided assurance and agreement in support of closure of this action. Last updated 17/06/2024 - The contract manager has resigned from the Trust as of the 14/06/2024, but has provided a template for use by senior management at end of contract reviews with suppliers. Notes will be stored in the contract register. Propose closure.

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

Track Rec No	Audit Wales or HIW Report	Year	Committee Assigned to	Report Title	Responsible Officer	Director	Priority Level	Rec No in Audit	Recommendation	Recomm n no. in Audit	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 inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status
121	HIW	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 T		Not Met	Jan-24	Apr-24		010724 - sent through SBAR for EMSC Restructure (OCP) including Siren link to all notices and comms relating to the recongifuration. Conlcuded implementation due in October 2024 following final outcome of OCP. Close proposed on this basis; accepted and updated to closure proposed 080724. 22.03.2024 Propose to move revised date to April 2024. Date moved in Q4 to 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 Update 030823: The EMS Configuration Programme recommended in Q1 2023 following being paused due to Industrial Action and Operational Pressures. Roster Reviewv 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. 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.	Closed in Quarter

AGENDA ITEM No	**20**
OPEN or CLOSED	**Open**
No of ANNEXES	**1**

Committee Priorities and Cycle Monitoring Report

MEETING	Finance and Performance Committee
DATE	17 September 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary Alex Payne, Corporate Governance Manager
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report updates the Committee on progress against the priorities it set for 2024/25 and progress against the agreed cycle of business for the Committee. There is nothing to escalate on the cycle of business monitoring report.

RECOMMENDATION

2. The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable.

REPORT APPENDICES

Annex 1 – FPC Cycle of Business Monitoring Report

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

COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING FOR 2024/25

SITUATION

3. This report updates the Committee on progress against the priorities it set for 2024/25 and progress against the agreed cycle of business for the Committee. There is nothing to escalate on the cycle of business monitoring report.

BACKGROUND

4. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2024 and will be tracked quarterly.

5. The Committee's cycle of business was approved by the Committee in May 2024. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

6. The monitoring report is at Annex 1. The 'pre-agenda setting' key indicates that items in green show where they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports.

7. The 'post-agenda setting' key indicates that items in blue were either on the agenda as scheduled or is an *ad hoc* item which was discussed in agenda setting and scheduled. The orange indicates where an item was programmed for receipt but has been deferred to a future meeting.

ASSESSMENT

8. The Committee priorities, and progress against them is as follows:

Priority	Progress
• The development and approval of the Digital Plan.	<u>2024/25 Progress</u> • At its meeting on in May 2024 the Committee received the Digital Plan Refresh 2024-29 and considered the options presented. The Committee noted that the funding for this Plan was included in the digital revenue allocation approved by the Executive Finance Group and included in the 2024/25 IMTP submission.

	• At its meeting in July 2024 the Committee received final Digital Plan 2024-29 which was endorsement, and it was approved by the Trust Board on the 25 July 2024. This priority has been fulfilled by the Committee. <u>2023/24 Progress</u> • A Digital Strategy Plan update was given to the Committee at its meeting on the 18 September 2023 by the Interim Director of Digital Services. This report gave a snapshot of the current position and relevant data from the period 01 April 2023 – 31 July 2023. • At the September 2023 meeting the Committee also endorsed the related metrics as presented by the Interim Director of Digital Services. The metrics for digital systems infrastructure will be received (in line with the agreed reporting) on 13 November 2023. • In September 2023 the Committee noted that the recent appointment of the new Director of Digital Services may affect the strategy implementation timeline. • In November 2023 the Committee noted that an update on the progress against the Digital Strategy would likely be programmed for either the January or March 2024 meeting of the Committee. • Receipt of an update on the implementation of the Digital Strategy *was* programmed for the March 2024 meeting of the Committee (a position confirmed with the Director of Digital Services early in 2024).

	2024/25 Progress • At its meeting on in May 2024 the Committee received the Digital Plan Refresh 2024-29 and considered the options presented. The Committee noted that the funding for this Plan was included in the digital revenue allocation approved by the Executive Finance Group and included in the 2024/25 IMTP submission. • At its meeting in July 2024 the Committee received the final Digital Plan 2024-29 which was endorsement, and it was approved by the Trust Board on the 25 July 2024. This priority has therefore been fulfilled by the Committee.
• Oversight of the potential commercialisation streams in the Financial Sustainability Programme.	• Receipt of a regular Financial Sustainability Programme report is included on the Cycle of Business for each meeting of the Committee. The update received by the Committee at this meeting notes that commercialisation workstream will be progressed later in 2024/25. • It has been agreed that an update on the Financial Sustainability Programme will be received at every other meeting of the Committee, and as such has been programmed for September 2024 and January 2025. • It is noted that no report was programmed for the July 2024 meeting; a related update was included in the Finance presentation.
• Focus on the new elements of its terms of reference relating to Information Governance and Information Security.	• Receipt of the Information Governance Toolkit and Information Governance (IG) Reports have been included on the Committee's Cycle of Business for 2024/25. The IG Report will be received at each meeting of the Committee in open session.

	• The Committee received a deep-dive item on cyber-security risks in closed session at its meeting in July 2024. It is noted that the wider cyber-security and resilience reporting is in development and will be considered through the meeting agenda setting meetings throughout the year.

RECOMMENDATION

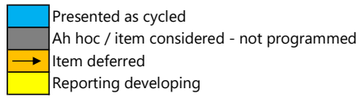
9. **The Committee is asked to note the update.**

PAPER	PRE-C'EE FORUM	FREQUENCY	MAY	JUL	SEP	NOV	JAN	MAR	LEAD	PURPOSE	COMMENT/COMPLIANCE
FINANCE AND PERFORMANCE COMMITTEE - CYCLE OF BUSINESS 2024/25											
TERMS OF REFERENCE NOTED IN RED TEXT											
FINANCE											
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 (Closed, if so)	TBC	As required							EDOF	Endorsement	July 24: Potentially item to take to Closed FPC.
IMTP financial plan	STB/ELT	Annually							EDOF	Endorsement	
Value Based Healthcare Report [Note 2]	TBC	Every other meeting		→					EDOF	Assurance	July 24: Agreed to defer to September 2024.
Assurance paper on PIR process	TBC	One off and then cyclical							EDSPP	Assurance	July 24: Assurance rec'd in 2023 and no PIRs to bring forward.
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	July 24: Agreed not to programme; inc update in the Finance PPT instead. Consideration of every other meeting from September 2024.
PLANNING											
Refreshes of 2030 Delivering Excellence	ELT	Ad Hoc							EDSPP	Endorsement	
Service or Directorate Specific Plans: New & Refreshes [Note	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. July & September 2024: no update required.
Demand and capacity reviews [Note 6]	ELT	Ad Hoc	→						EDSPP	Endorsement	Received in July 2024.
PERFORMANCE											
Monthly Integrated Quality Performance report	ELT	Each meeting							EDSPP	Assurance	
MIQPR review of metrics	ELT/Board Committees	Annually	→						EDSPP	Endorsement	Not received in May 2024.
Annual HART KPI report	TBC	Annually		→					EDO	Assurance	Deferred from July to September 2024 as not available.
IMTP progress updates	STB/ELT/Board	Each Meeting							EDSPP	Assurance	July 24: To include transition plan to Future Clinical Services Model.
QPMF update report	QPMF Steering Group	Bi-annually							EDSPP	Assurance	July 24: Update not required yet; implemention being overseen by the ARAC.
ESTATES AND FLEET											
Estates and fleet strategy refreshes	TBC	Periodically as required							EDOF	Approval	July 24: FinCor to provide update for Board in onward paper in July.
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	
ENVIRONMENTAL AND SUSTAINABILITY											
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	No sustainability report for 23/24 therefore nothing to schedule.
DIGITAL SYSTEMS AND STRATEGY											
Digital Plan - new and refreshed [Note1]	STB	Periodically as required							DD	Review and Endorse	July 24: Taken back to FPC with external facing doc prior to Board.
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	
BUSINESS CONTINUITY AND CYBER											
WG Annual Emergency Planning Report	ELT/Board	Annually							EDO	Assurance	Was deferred from July as it wasn't ready (at commissioning), but then it was available to take to the July 2024 mtg. MR updated.
Incident Response Plan Report [Note 5]	ELT	Annually							EDO	Assurance	
Business Continuity Annual Report [Note 5]	ELT	Annually							EDO	Assurance	July 24: BS annual Report and Annual EPRR report (with WG self-assessment) and MAI update in closed.
Cyber Resilience and Cyber Security Reporting (Closed)	TBC	TBC							DD	Assurance	May 24: Cyber risk deep dive deferred to July (taken in closed).
INFORMATION GOVERNANCE AND INFORMATION SECURITY											
Information Governance Toolkit	IGSC	Annually	→						DD	Assurance	May 24:Verbal update for May; full report to be received in July. July: Programmed.
Information Governance Report	IGSC	Each meeting	→						DD	Assurance	
POLICIES											
Report from policy group	Policy Group	Annually							BS	Assurance	
Policies for review and approval	Policy Group	Ad Hoc							BS	Approval	
CORPORATE RISKS AND AUDIT											
Board Assurance Framework	Board	Each meeting							BS	Assurance	
Corporate Risk Register	Board	Each meeting							BS	Assurance	
Audit Recommendation Tracker	ADLT	Each meeting							BS	Assurance	
Audits within purview of Committee	Audit Committee	Ad Hoc							Relevant Director	Assurance	
STANDARD ITEMS											
Quarterly operations update	TBC	Each meeting							EDO	Information/Discussion	Sept 2024: Not required for Sept mtg as Q1 taken to July.
GOVERNANCE											
Committee effectiveness review and annual report	Audit/Board	Annually							Board Sec.	Approval	
Review of Terms of Reference	Audit/Board	Annually							Board Sec.	Approval	
Committee cycle of business refresh	N/A	Annually							Board Sec.	Approval	
Committee Cycle of Business review	Audit/Board	Each meeting							Board Sec.	Approval	
Committee Review of Annual Priorities	None	Every other meeting							Chair	Review	
SUB-GROUPS											
Where applicable	N/A	Ad Hoc							N/A	N/A	No sub-committees - but may set up task and finish groups from time to time
PROMPTS											
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

Key: Post-agenda setting


Presented as cycled
Ah hoc / item considered - not programmed
Item deferred
Reporting developing

1	**Digital**	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 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 FPC = reporting on technology & process related metrics i.e. where Digital Directorate is responsible oE.g. Provision of training, provision of exercises / campaigns, infrastructure, physical barriers etc. oThis would include near misses related to software, suppliers, network, technology.
2	**Value Based Healthcare**	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.
3	**Commissioning**	Review of commissioning standards is the commissioning intentions met as part of IMTP. AQIs published monthly to EASC. Key AQIs included in the 28 KPIs.
4	**MIQPR**	FPC is primary Committee for review of performance across all four quadrants of the MIQPR. The Committee will commission deep dives or refer such deep dives to other Committees
5	**Emergency Preparedness**	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 - Assess local risks and use this to inform emergency planning - Put in place emergency plans - Put in place Business Continuity Management arrangements - 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 - Share information with other local responders to enhance co-ordination - Co-operate with other local responders to enhance co-ordination and efficiency CCA Part one devolved to Wales. 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. Internal Audit on Major Incidents - September 2022 AC - raised F&P review of incident response plan when reviewed next. 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 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 above; exercises carried our and planned; learning from incidents/exercises/debriefs.
6	**Demand and Capacity**	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
7	**Decarbonisation**	WAST Decarbonisation Action Plan (DAP) supports delivery of the national NHS Wales Decarbonisaton Strategic Delivery Plan. IMTP sets out DAP details. Every second year IMTP must include copy of DAP and update - next 24-27. Decarbonisation reporting to WG as follows, however the reporting to FPC will draw from these reports and may or may not append them: (a) WG Public Sector Carbon Report (annual quantitative 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. (b) 2 x Qualitative 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 complied 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. (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. (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 sectoin of the website. This developed from the data provided in the Quantitative Report above.
8	**Fire safety reporting**	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.
9	**Service or Directorate Plans**	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
10	**Information Governance**	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. 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&C Standards x 3 related to IG and identified metrics against these (see annual report). 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 demonstrates 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 FOIAct).