

Bundle Finance and Performance OPEN 19 November 2024

Agenda attachments

- ITEM 00 OPEN Agenda
- 0 09:30 – OPENING ITEMS
- 1 Chair's Welcome, Apols and Quorum
- 2 Declarations of Interest
 - ITEM 02 Board Member Register of Interests–Updated 2024–09–30–Published
- 3 Minutes of the Last Meeting: 17 September 2024
 - ITEM 03 2024–09–17 Draft OPEN F and P Minutes
- 4 Item 4 Action Log & Matters Arising
 - 4.1 *September Committee AAA Report*
 - ITEM 04 Action log (Public)
 - ITEM 04.1 Finance and Performance Committee Highlight Report September 2024
- 5 09:35 – Operations Update Q2 (July–September 2024)
 - ITEM 05 Operations Quarterly Report for Committees 24–25 Q2 FINAL
- 5.1 FOR APPROVAL, ASSURANCE AND DISCUSSION
- 6 09:55 – Financial Position for Month 6, 24/25
 - 6.1a *Financial Position for Month 7, 24/25 – Presentation*
 - 6.2 *Monitoring return tables – Circulated by e mail*
 - ITEM 06 Finance Report Month 6 24–25 – FINAL
 - ITEM 06.1 Month 06 2024–25 – Welsh Ambulance Services NHS Trust – Monitoring Return – Final
- 7 10:10 – Monthly Integrated Quality Performance Report
 - ITEM 07 MIQPR SBAR FPC SEPT Oct24
 - ITEM 07.1 MIQPR FPC SEPT OCT 24
- 8 10:20 – Digital Reporting – Metrics for Digital Systems Infrastructure
 - ITEM 08 Digital Reporting November 2024 – Cover Paper
 - ITEM 08.1 Digital Reporting November 2024 – Metrics
- 9 10:30 – IMTP Delivery/Assurance – Progress Update
 - ITEM 09 241119 – Executive Summary – IMTP Delivery & Assurance Report FINAL1
- 10 10:40 – IMTP 2025/28
 - ITEM 10 241119 – Executive Summary – IMTP 25–28
 - ITEM 10.1 Appendix 1 IMTP 25–28 FPC update Nov 24
- 10.1 10:55 – COMFORT BREAK
- 11 11:10 – Information Governance Report
 - 11.1 *IG Toolkit*
 - 11.2 *Data Quality Internal Audit*
 - ITEM 11 Information Governance Reporting November 2024
 - ITEM 11.1 IG Toolkit Improvement Plan – Status Report (Oct24)
 - ITEM 11.2 Data Quality Internal Audit Report (Audit Committee Issue Final)
- 12 11:25 – Risk Management and Board Assurance Framework Report
 - ITEM 12 Executive Summary Risk Management Report FPC 191124
- 13 11:40 – Audit Tracker 2.0 – June 2024 (Q2) (and any relevant audits)
 - 13.1 – *Audit Tracker*
 - 13.2 – *Overtime Controls*
 - 13.3 – *Integrated Quality and Performance Management Framework*
 - 13.4 – *Review of Costs Savings Arrangements*
 - ITEM 13 SBAR Audit Tracker to Committees – Q2 Reporting – July–September Reporting – FPC Open
 - ITEM 13.1 Audit Tracker FPC
 - ITEM 13.2 Overtime Controls_Final Internal Audit Report
 - ITEM 13.3 QPMF Final Internal Audit Report
 - ITEM 13.4 WAST – 2023 Review of Cost Savings Arrangements
- 14 11:50 – Mobile Data and Vehicle Solution Feedback Initiative
 - ITEM 14 MDVS_Staff_Survey_Brief_FPC.Approved

- ITEM 14.1 MDVS Staff Survey Review and Action Plan
ITEM 14.2 ARP PDA__MDVS_WAST Summary_29102024
- 15 12:00 – Policies for Committee Attention
15.1 Records Management
15.2 NHS Wales Procedure for the Recovery of Overpayments – Salary & Expenses – For Noting (Circulated Separately)
ITEM 15 Policies for Committee Approval – FPC 191124
ITEM 15.1 Records Management Policy v2.0
ITEM 15.2a Gweithdrefn ar gyfer Adennill Gordaliadau
- 15.1 **CONSENT ITEMS**
The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.
- 16 Committee Priorities and Cycle Monitoring Report
ITEM 16 Finance and Performance Committee Priorities and Cycle Monitoring Report – November 2024
ITEM 16.1 FPC Monitoring Report
ITEM 16.1a Monitoring Report Notes
- 16.1 12:10 – CLOSING ITEMS
- 17 Reflections and Summary of Decisions/Actions
- 18 Any Other Business
- 19 Date & Time of the Next Meeting: 16 January 2025 at 09:30

Length of Meeting:		02:50	Agenda Status:	[OPEN] FINANCE AND PERFORMANCE COMMITTEE - 19 NOVEMBER 2024					Deadline: 08/11/24
Time	Mins allotted	Agendum	Title	Format	Item for	Item requested by	Paper prepared by	Item presented by	
OPENING ITEMS									
		1	Chair's Welcome, Apols and Quorum	Verbal	Information	Standing	n/a	Chair	
		2	Declarations of Interest	Verbal	To State Conflicts	Standing	n/a	Chair	
09:30	00:05	3	Minutes of the Last Meeting: 17 September 2024	Paper	Approval	Standing	n/a	Chair	
		4	Action Log & Matters Arising	Paper	Discussion	Standing	n/a	Chair	
		4.1	September Committee AAA Report (alerts)	Paper	Discussion	Standing	n/a	Chair	
09:35	00:20	5	Operations Update Q2 (July-September 2024)	Paper	Information	CoB	Ops	Lee Brooks	
FOR APPROVAL, ASSURANCE AND DISCUSSION									
09:55	00:15	6	Financial Position for Month 6, 24/25 Financial Position for Month 7, 24/25	Paper Presentation	Assurance	CoB	FinCor	Chris Turley	
10:10	00:10	7	Monthly Integrated Quality Performance Report	Paper	Assurance	CoB	SPP	Hugh Bennett	
10:20	00:10	8	Digital Reporting	Paper	Assurance	CoB	Digital	Jonny Sammut	
10:30	00:10	9	IMTP Delivery/Assurance - Progress Update	Paper	Assurance	CoB	SPP	Hugh Bennett	
10:40	00:15	10	IMTP 2025/28	Paper	Assurance	CoB	SPP	Hugh Bennett	
10:55	00:15	COMFORT BREAK							
11:10	00:15	11	Information Governance Report 11.1 IG Toolkit Improvement Plan 11.2 Data Quality Internal Audit	Paper	Assurance	CoB/Planner	Digital	Jonny Sammut	
11:25	00:15	12	Risk Management and Board Assurance Framework Report	Paper	Assurance	CoB	Gov	Julie Boalch	
11:40	00:10	13	Audit Tracker 2.0 - June 2024 (Q2) 13.2 Overtime Controls (Internal Audit) 13.3 Integrated Quality and Performance Management Framework (Internal Audit) 13.4 Review of Cost Savings Arrangements (External Audit) - Data Quality IA Report (to receive w/IG report above)	Paper	Assurance	CoB	Gov	Trish Mills	
11:50	00:10	14	Mobile Data and Vehicle Solution Feedback Initiative	Paper	Assurance	Ad Hoc	Digital	Jonny Sammut	
12:00	00:10	15	Policies for Committee Attention 15.1 Records Management - For Noting 15.2 NHS Wales Procedure for the Recovery of Overpayments – Salary & Expenses - For Adoption	Paper	Assurance	CoB	Gov	Julie Boalch	
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.									
12:10	00:00	16	Committee Priorities and Cycle Monitoring Report	Paper	Information	CoB	Gov	Trish Mills	
CLOSING ITEMS									
		17	Reflections and Summary of Decisions/Actions	Verbal	Discussion	Standing	n/a	Chair	
12:10	00:10	18	Any Other Business	Verbal	Discussion	Standing	n/a	Chair	
		19	Date & Time of the Next Meeting: 16 January 2024	Verbal	Information	Standing	n/a	Chair	
12:20	02:50	CLOSE							

LEAD PRESENTERS

Name	Position
Jayne Beeslee	Chair and Non-Executive Director
Hugh Bennett	Assistant Director of Planning and Performance
Lee Brooks	Executive Director of Operations
Julie Boalch	Assistant Director of Corporate Governance and Risk
Trish Mills	Director of Corporate Governance/Board Secretary
Jonny Sammut	Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources

Name	Position	Declaration	Interest Type	Date Interest Started	Date Interest Ended	Left Trust		
BEESLEE, Jayne	Non-Executive Director * Chair of the Finance and Performance Committee * Member of the Remuneration Committee	Employment for interim assignments via Public Sector Resourcing (an agency) regarding the review of major UK government programmes (remunerated net of tax via an Umbrella Company - Danbro Employment Umbrella Ltd)	Financial Interest	01 October 2023				
		Member Representative on the UK Civil Service Pension Board	Non-Financial Personal	01 October 2019				
		Governor on the Finance & General Purposes Committee of Cardiff and Vale Further Education College	Non-Financial Personal	01 February 2024				
		Fellow Chartered Institute of Personnel & Development	Non-Financial Personal	01 April 2006				
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				
		Trustee of Action for Children [1097940]	Position in Charity or Voluntary Organisation	01 February 2021				
CURRAN, Peter	Non-Executive Director * Chair of the Audit Committee * Member of the Finance and Performance Committee * Member of the Remuneration Committee	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				
		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				
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				
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	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				
		<i>[Previously called Homes of Excellence Healthcare Limited, Company name changed 12.08.2022 - #12513139]</i>	Directorships	12 March 2020				
		Company Director - Hawthorn Court Property Limited	Directorships	27 April 2022				
		<i>[Previously called My Choice Healthcare (Three) Limited, Company name changed 12.08.2022 - #13371375]</i>	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 - Glyncomel 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	Member of Academi Wales Expert Panel	Position in Charity or Voluntary Organisation	15 July 2024		

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)	Director of Corporate Governance/ 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		
		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		



GIG
CYMRU
NHS
WALES

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

**MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE
(OPEN SESSION) HELD ON 17 SEPTEMBER 2024 IN THE CARDIFF MAKE READY DEPOT
AND VIA TEAMS**

Meeting started at 09:30

PRESENT:

Peter Curran	Non-Executive Director (Chaired Meeting)
Jayne Beeslee	Non-Executive Director (Chair)
Bethan Evans	Non-Executive Director

IN ATTENDANCE:

Hugh Bennett	Assistant Director Commissioning and Performance
Julie Boalch	Assistant Director of Corporate Governance and Risk
Lee Brooks	Executive Director of Operations
Fflur Jones	Audit Wales
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
Liam Williams	Executive Director of Quality and Nursing

OBSERVER:

Rusna Begum	Graduate Management Trainee
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APOLOGIES:

Professor Kevin Davies	Non-Executive Director
Angela Lewis	Director of People and Culture
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Damon Turner	Trade Union Partner

64/24 PROCEDURAL MATTERS

Peter Curran advised the Committee that he was chairing the meeting on behalf of Jayne Beeslee who had recently joined the Trust. The Chair welcomed all to the meeting, particularly to Jayne Beeslee 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 16 July 2024 were considered by the Committee and confirmed as a correct record.

Action Log

This Action Item was transferred from the People and Culture Committee (PCC): *Cymru High Acuity Response Unit Report. Cymru High Acuity 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. This action was closed as a report was being presented at today's meeting.

RESOLVED: The

- (1) **Minutes of the meeting held on 16 July 2024 were confirmed as a correct record; and**
- (2) **The Action log was considered and updated as described above.**

65/24 FINANCIAL POSITION FOR MONTH FIVE 2024/25

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

The cumulative revenue financial position reported was a small underspend against budget of £0.031m, based on some key assumptions consistent with that within the Integrated Medium Term Plan (IMTP) financial plan and the Board approved budget for 2024/25. The underlying year-end forecast for 2024/25 was currently a balanced position.

In line with the financial plans that supported the submitted Annual Plan within the IMTP for this financial year, gross savings of £3.313m have been achieved against a target of £2.828m.

At Month five, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with Welsh Government (WG) for 2024/25 was £20.977m. This included £15.522m of All Wales Approved schemes and £5.455m for Discretionary schemes.

Public Sector Payment Policy was on track with performance, against a target of 95%, of 97.8% for the number, and 98.4% of the value of non-NHS invoices paid within 30 days.

Whilst the Trust continued to be broadly balanced at this stage of the financial year, it was key to also note there were several assumptions that were made at the outset of the financial year within the balanced financial plan and budget set, in reporting this current and forecast position.

Whilst there was a small surplus reported at month five there were some small variances between Directorates when compared to the budgets set at the outset of the financial year. Some of this was driven by staffing vacancies. These were minor in nature and will be closely monitored throughout the remainder of the financial year.

The total All Wales Capital Programme spend to month five was £0.956m, this was in part in relation to 2023/24 Fleet costs which were brokered internally at the end of 2023/24, and the purchase of the equipment for the EA vehicles. The Trust was expecting the expenditure to increase in month six when the invoices for the EA chassis' were accrued

Risks continue to be reviewed monthly and in reporting through to WG it was considered that there were currently no individual high likelihood risks but over the next few months these will be reviewed to ensure that the level of likelihood was assessed along with the financial value. The biggest single risk related to the costs associated with the business case submitted in respect of the EMT/Technician level posts. Ongoing discussions continued with the Joint Commissioning Committee (JCC) and WG regarding this funding. Currently the in year risk cost was in the region of £2.6m - £3m.

Peter Curran queried if there was any risk involved with regards to the potential rise in the cost of fuel for vehicles. Chris Turley explained that the Trust was able to minimise the risk slightly in that it was given a discount at particular petrol stations.

Peter Curran asked for further information regarding the risk should the funding for the EMT/technician posts not be forthcoming. Chris Turley explained there was a potential deficit of up to £3m if no additional funding was received. There were still several months left in the year, and many variables could change the financial outlook. Earlier in the year, there was a fundamental shift in the financial plan, influenced by negotiations with unions and revised national profiles for roles. Despite the funding uncertainty, the implementation of plans was ongoing, with efforts to confirm payment timelines for uplifts and arrears. The Trust will continue to manage the deficit risk citing potential solutions which included delaying certain activities, the potential for some balance sheet offsets, and ongoing discussions with WG and Commissioners over funding availability.

Following a query in terms of when it was likely to hear about the re-banding of the technician post, Chris Turley advised it was likely to be in the very near future.

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

66/24 FINANCIAL SUSTAINABILITY PROGRAMME POSITION PAPER

Chris Turley presented the report which set out the month four position for the Financial Sustainability Programme (FSP) and key areas of progress against key schemes within achieving efficiency and income generation. Chris Turley added that the Trust was broadly delivering on the targets set but stressed that next year would be very challenging. He emphasised the importance of the ongoing services review and the need to identify additional efficiencies and future potential income generation opportunities.

In terms of income generation, this has been an area where the Trust has focused on assessing the structures and gaps for delivering on future commercial ventures. Furthermore, the Trust's focus since March 2024 has been on developing a Head of Commercial position, whose responsibilities would include developing a commercial strategy for the Trust. This position will sit under the Strategy, Planning and Performance Directorate's portfolio.

Following a query in terms of recurrent and non-recurrent savings Chris Turley explained that one of the main points highlighted by Audit Wales in their review was the need to ensure that the Trust was not overly reliant on non-recurring savings year on year. He added there were genuine recurrent savings, genuine non-recurrent savings and an element of savings that which were technically non recurring in nature but in reality occur every year. The latter were not the same every year but followed a similar theme. An example was vacancy management within corporate functions, which, while varying in specifics each year, consistently contributed to savings.

RESOLVED: The Committee noted the Month 4 update regarding the Financial Sustainability Programme.

67/24 VALUE BASED HEALTHCARE REPORT

Liam Williams presented the report explaining that it set out the current position of the Value Based Healthcare Working Group, and the progress of the key workstreams encompassed within its portfolio.

He highlighted that a workshop was planned next week in which the Trust will be discussing the next steps. This workshop will be particularly valuable for colleagues who were new to the organisation.

Traditionally, the Trust has not focused on value-based healthcare at a whole pathway level. There was a need to demonstrate how investments in services can be measured, particularly in relation to patient experience and outcomes.

Peter Curan queried how the Trust intended to assess the funding for resources risk in those areas that were not green. Liam Williams explained that the Trust was entering into discussions next week with Digital Health and Care Wales (DHCW) to consider this issue, but that the resource issue was partly due to the capacity required to collate and work with data.

Bethan Evans commented that the paper demonstrates the organisation is at the start of its journey with value-based healthcare. She expressed assurance that the organisation is thinking carefully about its approach and looking at all areas. She looks forward to the next steps and appreciated the comprehensive consideration given to the topic.

RESOLVED: The Committee noted the current position and intentions regarding the delivery of Value Based Healthcare within the Trust.

68/24 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Hugh Bennett updated the Committee on the main points from the report:

There were certain Key Performance Indicators missing from the July/August 2024 Monthly Integrated Quality and Performance Report (MIQPR). These metrics included 111 clinical triage callback times (P1), National Reportable Incidents, timely responses to concerns within 30 days, implementation of the Duty of Candour, successful consult and close outcomes, NHS 111 dental calls, and consult and close volumes for NHS 111.

These identified data quality issues within the 111 system, Advanced Practice Paramedics, and other quality indicators were currently being addressed. Immediate efforts were in progress to resolve these data quality challenges, alongside ongoing recruitment to fill essential roles to further mitigate these issues.

Ambulance Response (safety / patient experience): the red 8-minute response performance for August 2024 was 51.75%, which remained below the 65% target however, the Trust was reaching more red patients in 8 minutes, but demand had also increased. The Amber 1 median in August was 1 hour 11 minutes and the Amber 1 95th percentile was 6 hours 7 minutes.

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 extreme level of lost hours to handover outside Emergency Departments remained the critical component of long waiting times and patient safety incidents. 17,545 hours were lost during August 2024. Cardiff & Vale University Health Board (CVUHB) 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 University Health Board (BCUHB) remained significantly high and just below its two-year average figure (7,700). Welsh Government have reiterated to Health Boards the critical importance of improvements in this area.

Ambulance Care (Patient Experience): Oncology performance in August 2024 was 76.6%, hitting the 70% target. Renal performance also remained above target at 72.8%.

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.

Peter Curran sought further information of when the metrics in terms of digital data and analytics were due to be developed. Jonny Sammut explained in addition to the digital plan metrics, the team was developing more operational digital measures, such as uptime and data quality. These measures will be refined over the next two to three months. Jonny Sammut provided additional assurance regarding data quality. The team was currently undertaking tactical work to address immediate data quality issues. Additionally, recruitment was underway for more data quality resources, which will focus on these specific tasks.

Bethan Evans sought an update on the recruitment of staff to bolster the impact on the upcoming winter pressures. Hugh Bennett advised that in terms of the Clinical Navigators it was his understanding that the recruitment of 28 Full Time Equivalent (FTE)s was in progress and were planned to be in place for the winter period. In respect of the Advanced Paramedic Practitioners (APPs): out of the target of 32 APPs, 22 or 23 have already been recruited. The next steps were to ensure that efforts were ongoing to recruit the remainder with a plan to ramp up recruitment in Quarter 4; potentially involving a course at Swansea University to meet the total target by the end of the year.

Lee Brooks added that proactively the Trust increased Clinical Service Desk (CSD) staff numbers in anticipation of a pull from CSD for the Clinical Navigator roles. There was a high level of interest from both CSD and 111 staff in the Clinical Navigator roles, which was positive. The recruitment process for the 28 Clinical Navigator posts was live, with interviews taking place. There were over 70 applications, indicating strong interest in the roles. Despite efforts to grow CSD numbers, there may still be some vacancies to fill after the clinical navigation process. It was anticipated some recovery will be needed for CSD numbers once the final positions were filled.

RESOLVED: The Committee received the July/August 2024 Integrated Quality and Performance Report and noted that it provided sufficient assurance for the Committee against progress against the performance indicators

69/24 DIGITAL REPORTING – METRICS FOR DIGITAL SYSTEMS INFRASTRUCTURE

Jonny Sammut provided an overview of the report and drew attention to the following areas.

There was an amber rating for 111 due to an outage in the public services broadband aggregation. This affected the wide area networks, impacting the ability for the public sector to connect to the internet across Wales. The outage was an external issue and not related to any internal systems within the Trust.

The Information and Communication Technology (ICT) Service Desk metrics showed a gap in contribution from the Robotics Process Automation (RPA). This was due to a configuration change within the Service Desk platform (Service Point), which passes appropriate tasks to the robot. The configuration change led to a significant increase in routine tasks, such as password resets, being managed manually. A new IT service management system, known as House on the Hill, was currently in test. The transition from the current platform to the new tool was planned for Q3.

Efforts around Data Sharing, Information Governance (IG) Strategy and IG Improvement were all ongoing and following a successful (third) round of recruitment; two new Data Protection Compliance Managers were expected to join the Trust in November.

The PowerBI migration initiative was the ongoing effort of transitioning the Trust's reporting and dashboards from QlikSense to PowerBI to help modernise, streamline and secure its intelligence. This was on track to complete in September (as per set deadline for QlikSense licensing) despite challenges earlier in the year with the Data & Analytics team's efforts being diverted to 111 CAS reporting.

The installation of the Mobile Data Vehicle Solution across the existing EMS & Ambulance Care fleet was complete, except for a few remaining incoming vehicles.

There has been a positive response to the recruitment efforts, particularly for senior roles, with over 60 applications for the Assistant Director position. Despite the positive response, there has been some slippage in the recruitment process for certain other roles. In the interim and to maintain the progress on key initiatives, the plan was to use agency and contract resources which will help ensure traction on these initiatives while the recruitment process continued.

Finally, the Clinical Model Transformation (CMT) programme will require substantial input from both the IT and Informatics teams. Much of the work involved shaping and building the programme. The specific impacts and mitigations were not yet fully clear. This was an early flag for the Committee to be aware that future discussions around prioritisation may be necessary. The team was working closely with the CMT programme to understand the requirements and how best to mitigate potential impacts. A more detailed update will be provided to the Committee in November.

Following a query from Peter Curran regarding recruitment, Jonny Sammut explained that not only has the volume of applicants been high, but the quality has also been impressive. Feedback from members of the British Computer Society suggested that the Trust was becoming an attractive place for digital specialists due to its ambition and planned work. Some specialist roles, particularly in cyber security, remain challenging to recruit for. However, the overall recruitment effort was progressing well.

Peter Curran sought an update on the use of Drones. Jonny Sammut explained that the Trust was engaged with the Drones Wales Highway Project, which aims to establish a drone network across Wales. Active testing was ongoing at some RAF bases this month.

The establishment of a surveillance drone capability with the Trust's Hazardous Area Response Team (HART) has begun. Furthermore, there has been engagement with suppliers for the purchasing of necessary equipment for the drone projects.

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

70/24 SPECIALIST OPERATIONS KEY PERFORMANCE INDICATORS 2023/24

Lee Brooks presented the report and explained that under the Hazardous Area Response Team (HART) / Special Operations Response Team (SORT) Service Level Agreement with Welsh Government, a report on the activities undertaken by the Trust's HART and SORT was submitted every quarter, and at the end of the financial year an annual report was submitted that provided an overview of the activities across the year.

The Committee reviewed the annual report, and it was noted that quarterly data is not meant to be a comparison with the previous quarter or any other quarter. It demonstrates the activity of the HART team during that period of time which is used to demonstrate how the Welsh Government funding is being spent. It was noted that HART's deployment has returned to pre-pandemic levels, and SORT staffing has improved from 131 to 138 operatives by Q1 2024/25. Training hours for HART operatives have remained consistent.

The Key Performance Indicator (KPI) report was based on reporting data collated from various sources including staffing, deployment, incident type, vehicle usage and resources. The quarterly reports were submitted through the Senior Operations Team (SOT) with assurance through Senior Leadership Team (SLT), prior to submission to Welsh Government. There has been no significant feedback or concerns received from Welsh Government on the submission.

RESOLVED: The Committee received and confirmed assurance of the annual HART/SORT KPI reports for 2023/24.

71/24 INTEGRATED MEDIUM TERM PLAN DELIVERY/ASSURANCE - PROGRESS UPDATE

Hugh Bennett explained that the purpose of the update was to provide the Committee with an update on the Integrated Medium Term Plan (IMTP) delivery and assurance following approval of revised arrangements for 2024-27. The revised arrangements were presented to the Strategic Transformation Board (STB) on 8 July 2024, 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.

The CMT Programme has been formally initiated and the first CMT Board convened on 29 July 2024 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 19 August 2024, and all former IMTP Programme Board meetings have been stood down. These will be replaced by CMT

Workstream Boards from 9 September 2024, with a strong focus on key intervention points in the patient journey, with objectives aligned to the Trust's overall strategic vision for integrated care. The overall status of the programme was 'yellow' (cautionary), which indicated that the Programme was on track, but that challenges were anticipated in some areas due to the scale and complexity of planned changes.

Peter Curran asked to what extent the Trust was integrating these reports into the Board Assurance Framework (BAF) which could help align operational metrics with strategic objectives and risks being developed. Hugh Bennett explained that there was always a need to align various reports and frameworks. The Trust often has multiple lenses on it, including dual accountability through Welsh Government and the Commissioning process. This report specifically focuses on the IMTP, which was the Trust's corporate plan. It was aligned with the deliverables, measures identified, and the Cabinet Secretary's requirements. Hugh Bennett highlighted the risk of potentially missing lines of inquiry if the report was altered to fit another framework. Therefore, it was important for this report to stand alone while ensuring it dovetailed and aligned with the BAF.

Trish Mills added that the simultaneous maturation of these processes was beneficial. The Trust Board needs to track progress against the long-term strategy, understanding how close or far it is from the 2027 goals, and identifying associated risks. These discussions must be integrated, not separate. The Strategic Transformation Board appears to be the most appropriate governance body to deliver the IMTP and adjust the strategic direction as needed. This ensures that conversations regarding progress and risk were unified and coherent. The aim was to draw these elements together in the coming months, with some external support to facilitate the process.

Jayne Beeslee asked whether there were any arrangements in place for any peer reviews of such programmes, given their extent of reporting and inquiring whether the Trust used Gateway or a similar process for this purpose. Hugh Bennett advised that there was an action to procure a third party, likely from the academic sector, to evaluate the Clinical Model Transformation (CMT) Programme. This evaluation would probably be phased over two to three years, providing assurance that the programme was delivering patient benefits.

Liam Williams provided additional assurance on the four phases being worked through to ensure correct alignment. These phases included clinical screening, navigation, remote integrated care, and subsequent steps. The CMT Programme Board, led by Jason Killens and other Executive colleagues, was providing strong scrutiny to ensure sufficient resources for delivery. The clinical governance aspect, overseen internally, was a significant area of focus for confirmation and challenge. Liam Williams explained that much of the work was being done remotely in partnership with Priority Solutions and as part of the International Academy. This partnership provides external scrutiny of clinical processes and governance. The innovative approach to pre-hospital urgent and emergency care was being evaluated through clear programme milestones and gateway reviews in collaboration with Commissioners.

RESOLVED: The Committee:

- (1) Noted the CMT Programme delivery and assurance arrangements and progress update.**
- (2) Noted the Directorate-led IMTP delivery and assurance arrangements and progress update.**
- (3) Noted the reporting against performance and outcomes measures linked to IMTP delivery.**
- (4) Noted the update against the Cabinet Secretary's priorities set out in the 2024-27 planning framework.**

72/24

CYMRU HIGH ACUITY RESPONSE UNIT REPORT

Lee Brooks provided a comprehensive overview of the Cymru High Acuity Response Unit (CHARU), highlighting its evolution, purpose, and current measurement. CHARU was introduced to transition from Rapid Response Vehicles (RRV), emphasising the shift towards a more clinically driven model rather than time-based targets. CHARU was designed to ensure paramedics with additional skills and equipment were dispatched to incidents quickly where they can provide the most clinical benefit.

CHARU's contribution to red performance has been significant, often matching or exceeding that of Emergency Ambulances in recent months. The majority of CHARU responses were for breathing problems, cardiac arrests, seizures, severe bleeding, and unconscious patients, when dispatched with CHARU often arriving first on the scene, providing both clinical and time benefits.

The operational focus to reduce unnecessary dispatches and stand-downs was discussed, aiming for optimal utilisation without compromising clinical priorities. Lee Brooks explained that ambulance resource utilisation, including CHARU, was an output metric reflecting the extent of resource deployment during service delivery. It was not a performance metric and does not measure the effectiveness or efficiency of that deployment. The primary concern for CHARU was to respond to appropriate incidents as determined clinically.

Lee Brooks added it was important to understand the nuances of the delivery model. Utilisation should not be used as a performance target, as it could have adverse effects on overall performance. The focus should remain on ensuring CHARU responds to appropriate incidents to improve patient outcomes.

Peter Curran asked, in terms of the Clinical Model impact of CHARU, about the key long term benefits. Lee Brooks added that if the Trust successfully delivered the proposed model, there will always be patients requiring an immediate response. The focus should be on providing a response that positively impacts patient outcomes. CHARU was powerful in this regard and should remain a part of the model. Returning to a "stop the clock"

approach would be detrimental, and maintaining a clinically focused CHARU was imperative for appropriate patient care.

Bethan Evans noted that utilisation figures have decreased by around 20% in every Health Board except Powys, indicating success in using CHARU as designed. This approach was about transforming how the Trust works, and the presentation shows the journey and progress made. The focus on clinical indicators justified the transformation and supported the continued development of this model.

The Committee noted that given the diversity in the nature of the Health Boards, expecting parity in response percentages across all of them can indeed be challenging. Each Health Board has unique characteristics, such as population density, geographic spread, and specific healthcare needs, which can significantly impact response times and resource utilisation. It was important to consider these factors when evaluating performance metrics.

The Committee agreed that utilisation rates should not solely drive dispatch decisions and focusing on increasing utilisation as a performance metric could have a negative impact on patient outcomes and potentially performance contribution as well.

The Committee agreed that utilisation rates should not solely drive dispatch decisions and focusing on increasing utilisation as a performance metric could have a negative impact on patient outcomes and potentially performance contribution as well.

The Committee found the presentation highly informative and particularly impactful, particularly with respect to utilisation and the cross-over to the clinical indicators being reported in the MIQPR.

RESOLVED: The Committee noted the update.

73/24 ENVIRONMENT, DECARBONISATION AND SUSTAINABILITY UPDATE

Chris Turley updated the Committee on the report advising that it also provided an update on the detailed reporting against the Trust's Decarbonation Action Plan.

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

It was acknowledged that the funding strategy was partially outside of the Trust's control, given the limited availability of All Wales Capital funding to support decarbonisation initiatives, and some recent bids have been unsuccessful due to rigid criteria associated with schemes.

The overall headline reported emissions for 2023/24 have decreased from 773,379 tCO₂e to 33,097 tCO₂e. However, some of the factors reported need to be taken into

consideration in reviewing these figures and the significant medical gas reporting variation noted.

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 several aspects. Some headlines from this for noting were 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 – 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 was required to understand why the rest of this increase has happened.
- d. Fleet – There was an increase in fleet emissions, due to an increase in diesel use (1%).

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

Following a query from Peter Curran regarding any grants that were available, Chris Turley explained there were public sector grants available outside of NHS Wales core capital funding. These can be very specific and often required careful alignment with the grant criteria. Many grants required match funding, meaning the Trust would need to invest its own capital to attract additional funds. Not all grants will be applicable due to specific criteria. Moving towards electric vehicles (EVs) was a great step towards sustainability, this aligned with broader environmental goals and can attract specific funding aimed at green initiatives. There was also the Environmental Financial Advisory Board (EFAB) Funding which was a separate capital funding stream.

Trish Mills suggested that the Committee should consider dedicating more time to environmental matters, possibly through a full board session or a specific Committee focus. She emphasised the importance of promoting and escalating these issues, given that they were currently reviewed annually. Following a further discussion, it was agreed that the Chair of FPC, Trish Mills and Chris Turley would discuss how best to present any further updates to the Committee and to consider any Committee development that may be required on this subject matter.

RESOLVED: The Committee received the update.

74/24 WASTE MANAGEMENT UPDATE – SEPTEMBER 2024

Chris Turley explained that this report presented the Committee with the annual Utility and Waste Management Report 2023/24 for review on the back of recent Internal Audit reports and has heightened the Trust awareness in such matters.

It also included 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.

Following an internal audit (Limited assurance opinion) on waste management processes in 2022 a Waste Management Policy has been rewritten and approved. Plus, negotiations were ongoing to amend the current clinical waste Service Level Agreement (SLS) with NHS Wales Shared Services Partnership (NWSSP), for collection of clinical waste across the Trust and provide robust legislative compliance and training.

RESOLVED: The Committee

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

75/24 ESTATES CONDITION AND BACKLOG MAINTENANCE UPDATE

Chris Turley explained this was the first report on the annual Estates and Facilities Performance Management System (EFPMS) report for 2023/24, along with an update on outstanding Backlog Maintenance.

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.

Five of these recommendations have now been completed, with two addressing the need to update the Estates Strategic Outline Plan (SOP), this update was 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 significantly impact on this.

The remaining two recommendations were related to communicating levels of backlog maintenance within the Trust's estate to this Committee.

Physical condition surveys were completed every five years, and updated annually after completion of essential works, or disposal. These surveys determined building condition, including compliance with fire safety requirements and statutory safety legislation, and presented those findings in condition ranking, A-DX, and produced risk rankings of Low, Moderate, Significant and High.

It was 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 was associated with statutory requirements and general wear and tear.

Backlog maintenance has reduced over the past five years because of the disposal of several high risk backlog sites, such as Blackweir, HM Stanley and Cefn Coed, and the substantial capital investment at Vantage Point House, 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.

Chris Turley proposed that there might be a need for a focused induction or development session for committee members to better understand the complexities of the estates condition and backlog maintenance. This was supported by Trish Mills who further explained that the Trust was aiming to streamline the reporting process to make it more efficient and meaningful for the Committee. Focusing on reporting by exception and reducing the volume of reports would help in providing clearer and more actionable data.

Peter Curran noted that maintaining estates can be high risk if not managed properly. It was great to hear that efforts were being made to reduce these risks. The benefits of a well maintained and modern facility go beyond just numbers, improved facilities can significantly boost staff morale and satisfaction, which in turn can enhance productivity and overall workplace culture. Keeping an overview of the estate strategy and its direction was crucial.

Bethan Evans added it was key to Identify and flag the key risk areas related to estates as this would help the Committee focus on the most critical issues without getting bogged down in operational details. The Committee should also maintain a high-level strategic oversight rather than delving into the minutiae.

RESOLVED: The Committee:

- (1) NOTED the Estates and Facilities Performance Management System Return for 2023/24, and**
- (2) NOTED the plan for further reducing backlog maintenance**

76/24 EMS OPERATIONAL TRANSFORMATION PROGRAMME

Hugh Bennett advised the Committee that this was a highly complex and significant programme with many moving parts and substantial achievements.

The EMS Operational Transformation Programme has been delivered, closed and evaluated. The Committee should note that this was a significant initiative driven by the 2019 Demand and Capacity Review. The full report will be presented to the Trust Board at its September meeting after which it will be submitted to Welsh Government and Trust Commissioners.

The scale of the programme, with 343 additional staff and 1615 elapsed days, highlighted the extensive effort and coordination required. The extensive stakeholder engagement, including 29 briefings and negotiations with Trade Unions, underscored the importance of communication and collaboration in such large-scale programmes. The Chief Executive's desire to publicly demonstrate the programme's success was a great way to build trust and transparency with stakeholders. Despite the challenges, the programme has delivered its outputs.

The Committee recognised the significant input and role of Hugh Bennett as the Senior Responsible Officer in its successful delivery.

RESLOVED: The Committee:

- (1) Noted the successful delivery of the EMS Operational Transformation Programme.**
- (2) Noted that whilst the programme achieved its deliverables it has not delivered the intended benefits to patient safety. The primary cause was the extreme levels of handover lost hours.**

77/24 INFORMATION GOVERNANCE REPORT

Jonny Sammut updated the Committee on the following areas from the report:

IG Toolkit 24/25: Following the previous annual submission (with an outcome of "standards not met") an improvement plan was developed to support achieving the "Minimum Expectations" standard across all categories this financial year. To satisfy the Confidentiality Advisory Group (CAG) this position needed to be achieved by November 2024.

Information Governance (IG) Training: the Trust was not compliant with its mandatory IG training requirements against the minimum 85% target across the Trust for 2024/25. Approximately 1000 individuals were identified as non-compliant, some with expiration dates of more than six years.

Significant progress has been made in reducing the number of weak passwords, with less than 20 remaining across the Trust, down from around 2,500 a year ago.

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: the Data Protection Officer Job Description has been evaluated, and the recruitment process will begin. Two Data Protection Compliance Manager vacancies have been through recruitment, with two offers made, and candidates were due to join the Trust in November 2024.

RESOLVED: The Committee noted the update.

78/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

Julie Boalch highlighted the following areas for the Committee:

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.

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.

Trish Mills added that the Trust has made significant progress in integrating enterprise and corporate risk management with strategic delivery through the IMTP. The strengthening of governance around risk articulation was a crucial step and moving towards a strategic BAF. The Board's role in overseeing strategic direction, holding the executive accountable, and ensuring well-articulated risks was vital for maintaining alignment and achieving the Trust's strategic goals.

The Trust was on a comprehensive journey to refine its risk management framework, especially with the development of Risk Appetite Statements. The involvement of an external provider such as BDO, and the collaboration with peers in Wales and England will provide valuable insights and best practices. The integration of digital tools to ensure that enterprise risk management and the BAF were aligned will enhance transparency and efficiency in the risk management processes.

Lee Brooks updated the Committee on risk 594 (The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death) advising that a revised approach was endorsed, and the document was now live and therefore might warrant a review of the score.

RESOLVED: The Committee noted the contents of the report.

79/24 AUDIT TRACKER 2.0 – JUNE 2024 (Q1)

Trish Mills presented the report and 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 were 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 and of these three were on their third revised date.

There was only one external audit action relevant to this Committee, action reference 121 regarding the Emergency Medical Services Clinical Contact Centre (EMSCCC) Patient Safety Review. This action was due in April 2024 and has been closed in quarter.

Trish Mills commented that the Trust was making solid progress in ensuring that changes and actions were well-justified and aligned with Specific Measurable, Achievable, Relevant and Time-Bound (SMART) criteria. The Audit, Risk and Assurance Committee (ARAC) was actively involved and that there was a clear focus on evidence and accountability.

RESOLVED: The Committee received and took assurance from the Audit Tracker June 2024 (quarter 1 2024/25) update report.

80/24 COMMITTEE PRIORITIES AND CYCLE MONITORING REPORT

The report was presented for information. No matters from the Cycle of Business Monitoring Report were escalated for the Committee's attention. The updates regarding the Committee Priorities were noted.

RESOLVED: The Committee noted the update.

81/24 REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

Trish Mills explained what detail would be contained in the Committee AAA report for the Board's attention.

Meeting concluded at 12:37

Date of Next Meeting: 19 November 2024.

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

Action Number	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
75/24	17 September 2024	Waste Management Update and Estates Condition and Backlog Maintenance	To consider with the Chair of FPC how best to present any further updates to the Committee and to consider any Committee development that may be required on this subject matter.	Trish Mills Chris Turley	19 November 2024	<u>Update for 19 November 2024</u> Verbal Update	Open
78/24	17 September 2024	Risk Management and Board Assurance Framework	To share the Risk paper and BDO presentation at the ARAC meeting on 12 September with Bethan Evans, Hannah Rowan and Jayne Beeslee (as NEDS who did not attend ARAC).	Julie Boalch	19 November 2024	<u>Update for 19 November 2024</u> The information (the risk paper and BBO presentation given to ARAC in September 2024) has been shared with the NEDs as described. The Action is complete.	Complete



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FINANCE AND PERFORMANCE COMMITTEE HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report. The papers for these meetings can be found by following this [link](#) to the Committee page on the Trust website.

Trust Board Meeting Date	26 September 2024
Committee Meeting Date	17 September 2024
Chair	Peter Curran (as Chair in lieu of Jayne Beeslee)

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. The board should be aware, as indicated in their documents, that certain **Key Performance Indicators** are missing from the July/August 2024 Monthly Integrated Quality and Performance Report (MIQPR). These metrics include 111 clinical triage callback times (P1), National Reportable Incidents, timely responses to concerns within 30 days, implementation of the Duty of Candour, successful consult and close outcomes, NHS 111 dental calls, and consult and close volumes for NHS 111.

Identified data quality issues within the 111 system, Advanced Practice Paramedics, and other quality indicators are currently being addressed. Immediate efforts are in progress to resolve these data quality challenges, alongside ongoing recruitment to fill essential roles to further mitigate these issues.

ADVISE

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

2. This was the first meeting for **Jayne Beeslee** who will take the chair of this committee from the November meeting. Peter Curran chaired this meeting.
3. Members **reflected** that the papers and presentations demonstrated the transparency, good teamwork and integration across all areas and the good progress being made. The CHARU presentation was particularly welcomed and clear. The potential for committee specific development on the environmental and estates issues will be explored further.

ASSURE

(Detail here assurance items the Committee receives)



The following items will also be presented to board at their 26 September meeting however members may benefit from the following points:

Financial Position for Month 5 2024/25

4. Members noted that the outcomes demonstrated strong and robust financial management given the challenging financial savings position.
5. Directorate budgets performance is encouraging with minimal overspends and budgets being closely adhered to across divisions. The financial pressure from fleet maintenance due to reduced capital budgets was noted, and the need for additional funding in the next financial year to address this. There is an Executive Financial Group on 18 September where the importance of reviewing financial forecasts and assumptions will be emphasised.
6. The EMT Band 5 business case has been submitted and the board will be updated on the pathway through external governance (Joint Commissioning Committee (JCC) and Welsh Government) following a JCC meeting that took place in parallel. The risks related to this were highlighted in the financial presentation and the Welsh Government monitoring return, and the committee heard that the cost impact has reduced in year due factors including education and training requirements moving into Q3/4, as well as the holding of vacancies and the use of overtime in those grades where appropriate. The non-recurrent nature of this was stressed and the fact that this would not be sustainable going into 2025/26.
7. Board will receive a request for contract approval in the closed session in September for vehicle conversion, with the committee noting that emergency ambulances and response vehicles have been ordered, including 20 plug-in hybrids and 10 fully electric vehicles. Given the capital funding for fleet this year was half of what was required, the fleet maintenance pressures for next year will be challenging.

Monthly Integrated Quality and Performance Report (MIQPR) for May/June 2024.

8. The indicators highlight that 111 has stabilised post the 111 CAS 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. Note the data quality issue set out in the Alert section above which was discussed at this item.
9. Members agreed that the new clinical model transformation is key given the continued handover delays (at 17,000). Assurance was provided on recruitment of clinical navigators and advanced practice paramedics.

IMTP Delivery and Assurance report for Q2 2024/25

10. Assurance was sought on external scrutiny and evaluation of the clinical model transformation. A new group has been formed to support clinical decision-making throughout the programme, offering



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independent critique and validation of clinical processes. There has also been engagement with external academic support for evaluating the programme, alongside Delphi reviews for clinical algorithms and pathways, involving international clinicians. The International Academy of Emergency Dispatchers ensures oversight of clinical governance for remote care, aligning with the latest evidence and best practices. Additionally, our commissioners via the Joint Commissioning Committee scrutinise the programme and phasing.

The following items were only presented to the committee and assurance is provided to the board as follows:

11. There were no escalations from the workstreams of achieving efficiency or income generation in the **financial sustainability report**, which is now divided into recurrent and non-recurrent, allowing better understanding of the year-on-year planning required to achieve the set savings targets. The ongoing work on the services review is expected to yield focused areas for financial savings for the next financial year and beyond. The development of a small team to enhance income generation and commercialisation efforts is underway, aiming to maximise income as a strategy to reduce core costs. There's a slight delay in the process due to job evaluation, but it is progressing and will be a focus in to 2025/26.
12. Members received the **Value Based Healthcare** Working Group report highlighting progress against key workstreams and outlining future plans that emphasise the Trust's desire to work towards a model that focuses on value over volume. The initiative involves collaboration with partners Digital Health Care Wales and will assess the data using the National Data Resource and demonstrate where services can be measured by building capacity and capability within the Trust to address potential resourcing challenges.
13. Lee Brooks provided a comprehensive overview of the **Cymru High Acuity Response Unit (CHARU)**, highlighting its evolution, purpose, and current measurement. The committee found the presentation highly informative and particularly impactful, particularly with respect to utilisation and the cross-over to the clinical indicators being reported in the MIQPR.
 - CHARU was introduced to transition from rapid response vehicles, emphasizing the shift towards a more clinically driven model rather than time-based targets. CHARU was designed to ensure paramedics with additional skills and equipment are dispatched to incidents quickly where they can provide the most clinical benefit.
 - CHARU's contribution to red performance has been significant, often matching or exceeding that of Emergency Ambulances in recent months. The majority of CHARU responses are for breathing problems, cardiac arrests, seizures, severe bleeding, and unconscious patients, when dispatched with CHARU often arriving first on the scene, providing both clinical and time benefits.
 - The operational focus to reduce unnecessary dispatches and stand-downs was discussed, aiming for optimal utilisation without compromising clinical priorities. Lee Brooks explained that ambulance resource utilisation, including CHARU, is an output metric reflecting the extent of resource deployment during service delivery. It is not a performance metric and does not measure the effectiveness or efficiency of that deployment. The primary concern for CHARU is to respond to appropriate incidents as determined clinically. The committee agreed that utilisation rates should not solely drive dispatch decisions and focusing on increasing utilisation as a performance metric could have a negative impact on patient outcomes and potentially performance contribution as well.



14. The **Digital KPIs** relating to data and analytics, ICT systems, digital services, projects & programmes, and progress against the recently refreshed Digital Plan were presented. Of note:
 - ICT systems availability show good performance across all critical systems for 2024/25 so far. Apart from some issues in August 'up-time' was still above the UK industry standard of 99.9% for the period
 - There is ongoing scoping work for various digital initiatives, including scoping the design requirements of an automated IPC tool and the migration to Power BI. MDVS installations are complete across the fleet, with a few exceptions for incoming vehicles.
 - Recruitment efforts continue for senior roles with good uptake. As set out above, the use of agency is being deployed to mitigate slippage in digital initiatives.
 - Potential impacts on IT and informatics from the clinical model transformation programme was flagged, indicating future discussions on prioritization might be necessary.
15. 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. The Committee reviewed the annual report at this meeting, and it was noted that 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 Welsh Government funding is being spent. HART's deployment has returned to pre-pandemic levels, and SORT staffing has improved from 131 to 138 operatives by Q1 2024/25. Training hours for HART operatives have remained consistent.
16. The **Information Governance Report** for Q2 highlighting ongoing efforts to enhance information governance and data protection within the Trust, addressing both compliance requirements and operational challenges. Of note for the board:
 - Progress is being made towards meeting the "Standards Met" on the IG toolkit by November 2024, with a detailed improvement plan in place. Failure to meet this standard could impact future research projects. This has been added to risk 623.
 - Currently, over 75% of employees are compliant with IG training, with efforts underway to increase this to meet the 85% target. Around 1,000 employees need to complete their training.
 - Significant progress has been made in reducing weak passwords, with less than 20 remaining across the trust, showcasing exceptional performance compared to other organizations.
17. The committee received the bi-annual **Environment, Decarbonisation and Sustainability update**, which included quantitative data on carbon emissions for 2023/24, highlighting challenges in tracking progress due to changing definitions and quantifying factors. Despite this, there's a general trend towards reducing gas-powered heating emissions and increasing electric-based systems, supported by investments in solar panels and PV systems.
18. WAST has been successful in securing a proportionately higher share of government funding for decarbonization projects, demonstrating efficient use of funds and delivery capabilities. Additionally, the service has been re-accredited with ISO 14001, marking it as the only ambulance service in the UK to hold this accreditation, reflecting its commitment to environmental management standards. The importance of continued efforts in decarbonization and sustainability was stressed, despite the challenges in measuring progress due to changing standards and definitions



19. The annual **2023/24 Estates Backlog Maintenance update** demonstrated a significant reduction in backlog maintenance from over £15 million a few years ago to the current levels, with a focus on reducing high and significant risk areas.

There are plans to continue targeting resources to areas of greatest need, including further investments in estate improvements and maintenance to reduce backlog maintenance further.

20. The **Waste Management Update 2023/24** included compliance with changes to waste legislation in Wales (April 2024) require the Trust to recycle into four segregated waste streams, a move from two previously. Challenges with the requirements of the new Act were noted, including issues experienced with the contractor in the roll-out. These are being resolved but have impacted on the ability of the team to provide a national picture of compliance with the new legislation thus far in the year.

An enhanced service level agreement with Shared Services has been established, improving compliance and futureproofing in waste management.

21. The Committee were assured that the **EMS Operational Transformation Programme** purpose has been delivered, closed and evaluated. The Committee noted that this was a significant initiative driven by the 2019 Demand and Capacity Review. The full report is before the Trust Board at its September meeting after which it will be submitted to Welsh Government and Trust Commissioners. The Committee recognised the significant input and role of Hugh Bennett as the Senior Responsible Officer in its successful delivery.

22. The Committee received the report on Q1 2024/25 of the **Audit Tracker**. It was noted that of the internal audit actions relevant to the Committee 24 of a total of 49 due in quarter were closed in quarter. Of the internal audit actions due in quarter 23 have been given revised dates. The importance of scrutinising the reasons and rationale for change where revised dates are proposed was noted. There was only one external audit action due in quarter which has been closed in quarter.

23. Members received the **Committee Cycle of Business Monitoring Report and Committee Priorities** update with no escalations.

24. In **closed session** members received an update on the cyber KPIs and audit recommendations, as well as a Special Operations Response Team business case approval.

RISKS

Risks Discussed: Members noted the risk activity this quarter which included:

The de-escalation of Risk 424 to the Directorate Risk Register for ongoing management, having achieved target from 12 (3x4) to 8 (2x4). This risk is linked closely with financial duties outlined in Risk 139 and a separate capital risk may be developed in the future.

The closure of Risk 619 from all registers having been fully mitigated. The risk had previously been reported in the closed sessions of Committee and Trust Board.



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Committee acknowledged the positive risk culture enabling discussions on specific risks throughout the agenda particularly in relation to Risks 223 and 224 and noted additional mitigating actions on Risks 623 and 594 which may result in reductions in risk scores in the next round of governance.

Members received a brief update on the direction of travel of the next phase of the Risk Management Transformation Programme which was fully outlined at and supported by the Audit, Risk and Assurance Committee. This included the development of a strategic Board Assurance Framework, risk appetite statements and a suite of strategic risks against the Trust's strategic objectives enabling progress against these to be clearly articulated.

COMMITTEE AGENDA FOR MEETING

Financial position Month 5 2024/25	Financial sustainability position paper	Value based healthcare
Monthly Integrated Quality and Performance Report	Digital reporting – metrics for digital infrastructure	Specialist Operations KPIs 2023/24
IMTP Delivery/Assurance progress update	Cymru High Acuity Response Unit (CHARU) report	Environment, Decarbonisation and Sustainability Update August 2024
Waste Management Update - September 2024	Estates condition and backlog maintenance update – September 2024	EMS Operational Transformation Programme
Information Governance Report	Risk Management and Board Assurance Framework Report	Audit Tracker 2.0 - June 2024 (Q1)
Committee Priorities and Cycle Monitoring Report		

COMMITTEE ATTENDANCE

Name	14 MAY 2024	16 JULY 2024	17 SEPT 2024	19 NOV 2024	16 JAN 2025	18 MAR 2025
Joga Singh (Chair)						
Jayne Beeslee (Chair)						
Kevin Davies		Chair				
Bethan Evans						
Peter Curran			Chair			
Chris Turley						
Rachel Marsh	Hugh Bennett	Hugh Bennett	Hugh Bennett			
Lee Brooks						
Liam Williams						
Angie Lewis						
Jonny Sammut						
Trish Mills	Julie Boalch					
Hugh Parry						
Damon Turner						

	Attended
	Deputy attended
	Apologies received
	No longer member



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Welsh Ambulance Services
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OPERATIONS DIRECTORATE QUARTERLY REPORT FOR COMMITTEES 2024-25 Q2 (July– September 2024)

National Operations & Support

IMTP

Volunteer Care Driver Oncology Pilot

Our volunteer oncology project currently has 20 volunteers who are classed as 'oncology priority'. These drivers have completed 1249 journeys (496 inbound/ 753 outbound) since April and are consistently meeting our measures for oncology (inbound 90% / outbound 94%). We have now moved onto the second phase of the pilot which is ensuring that our oncology patients are paired up with the same volunteer driver for the entirety of their treatment. This is proving to be very successful from both a measurement perspective, but more importantly from a patient experience perspective. We are currently working with PECCI colleagues collecting patient feedback and will be using this to assist us to measure the success of the pilot.

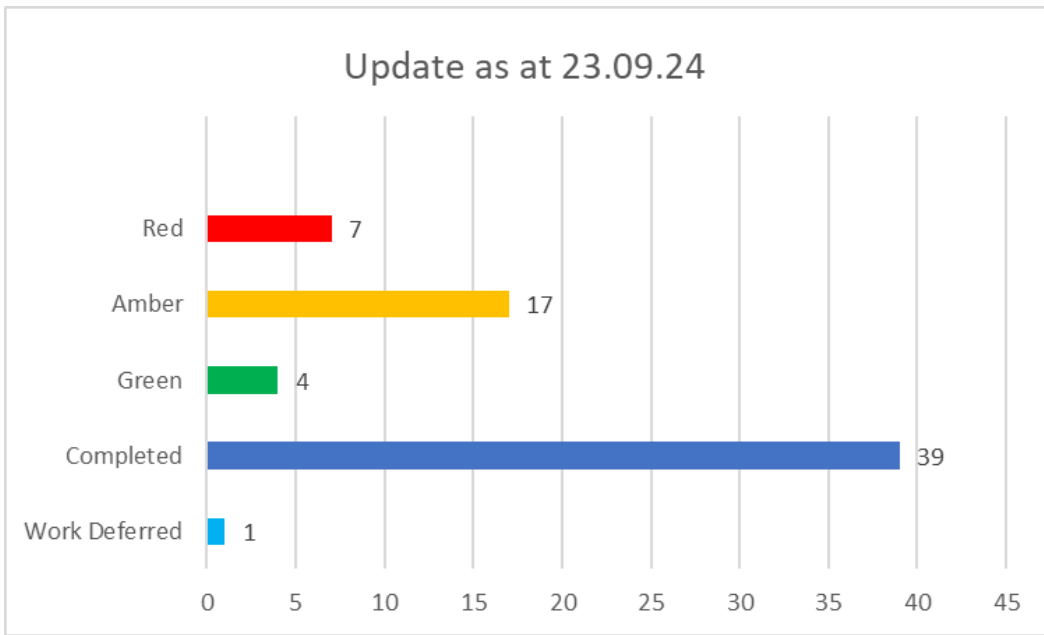
General Update

Volunteer Services OCP

Our Volunteer Management team have launched a period of Organisational Change (OCP), stepping away from a long-standing service-based model into a function-based model with a volunteer onboarding service, and support service across all volunteer roles. The consultation will run from September to October. Steps are also being taken to advance the volunteer pathway, commencing as a CWR, and progressing to CFR.

Manchester Arena Inquiry (MAI)

Progress against the 68 recommendations, directly or through partnership working, that relate to the Trust continues. The Trust has undertaken a detailed review of its provision as part of its obligation under recommendations 105 and 106 and has recently produced an evidence-based series of reports aimed at addressing the identified gaps. This has been supported further by the development of three Quality Impact Assessments that have been approved by the Clinical Quality Governance Group. The work identified 20 recommendations for which there is a financial dependency. The submission to commissioners of the Trust's reports relating to these recommendations has now occurred and the Trust awaits their considered response. The remaining recommendations continue to be progressed and it is anticipated these will conclude within the next six months. At the time of preparing this report, below is the status of recommendations:



To ensure the continued visibility of these report findings within the Trust, a corporate risk is being developed for inclusion in the Trust’s risk register. This will enable the alignment of outstanding MAI recommendations with a clearly defined business-as-usual framework, ensuring proper governance of capability gaps while awaiting financial decisions from commissioners and the implementation of necessary changes.

Major Incident Declaration Cardiff

On Thursday 29 August 2024 at 2317hrs, a major incident was declared in Cardiff following an initial call into 111 which was subsequently passed to 999. The call reported difficulty in breathing with reports suggesting that this incident was of a potential gas/carbon monoxide origin with several symptomatic patients. However, following further investigation from the multi-agency response, the incident was later confirmed not to be of airborne origin but because of a water borne issue. Multiple resources from WAST attended the incident including three managers, three emergency ambulances and the Hazardous Area Response Team. Four patients were conveyed to hospital, with no other casualties reported and the major incident was stood down at 0329hrs.

Operational Effectiveness

Operational effectiveness continues to progress, with performance closely monitored through regular Local Delivery Plan reviews and Performance, Demand & Capacity meetings with the Operations Senior Leadership Team. Upcoming Quality & Support days will focus on Mobilisation, Time Spent at Scene, and Clinician Travelling, aiming to assess the current state and identify opportunities for improvement. Subsequent sessions will target driving change and implementing enhancements. Recent Quality & Support days addressed the Multiple Attendance Ratio and Multiple Dispatch Ratio, with findings scheduled to be reviewed and shared.

Medical Emergency Response Incident Team (MERIT)

Correspondence has been sent to Welsh Government Health Strategy and Planning team to inform them of our organisational position that there is no longer a requirement to request MERIT to attend

the scene of an incident. MERIT are nurses from health boards who attend the scene of a major incident in two separate waves. The organisational position was confirmed following a review of MERIT skillsets alongside those now provided by WAST staff. WAST has previously provided training for MERIT and it was confirmed that this is not specifically commissioned. The letter sets out the discussions with both clinical and operational colleagues across the trust and the rationale on the position. The assessment determined that MERIT nurses provide lesser clinical response to that now provided by WAST clinicians.

Resourcing, EMS Coordination and Quality

Challenges

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

The Trust reported 5% non-compliance for the Medical Priority Dispatch System (MPDS) for Q1 24/25 which is under the 7% threshold, meaning the Trust is no longer in remediation status with the IAED for MPDS and maintains its status as an Accredited Centre of Excellence (ACE). This is following a 3-month period of remediation in Q4 23/24 where an action plan was submitted to and approved by the Senior Operations Team (SOT) and Senior Leadership Team (SLT). The Trust continues to work closely with Academy colleagues to sustain performance and feedback from the IAED has been positive with the improvements achieved. Monthly assurance memos were escalated to SOT and through to SLT during the period of remediation and the final memo was submitted in July 2024 which provided an update on removal from remediation status and a continued commitment to progress the actions approved in the associated action plan.

HM Coroners (HMC)

EMS Coordination/Operations Quality continues to receive coroner requests which has meant the backlog of statements has remained consistent. Capacity within Operations Quality (OQ) continues to be realigned where possible to support with the construction of statements and a robust QA process is in place to ensure that accurate statements can be reviewed and signed by the Service Managers/Head of Service for serving to HMC. At the time of preparing this report there are 24 outstanding coroner statements which is down from 34 in Q1. Of the 24 outstanding, 8 have breached the requested return date, however, these are all at some point in the QA process. Any requests from HMC to prioritise or final deadlines are prioritised dynamically. All other outstanding statements are not yet due, and the OQ team is completing these alongside other investigations (concerns and nationally reportable incidents (NRIs)).

Absence Abstractions EMDs

While we continue to actively recruit EMDs into the service, recently the overall number of absences due to sickness for EMDs is a concern. Absence Management processes are being followed and individuals are being supported, but consequently resource levels for the call handling function is sporadic with short term absence being particularly impactful. This said, we continue to deliver good overall performance levels with the call answering performance fluctuating between 93.4% and 96.4% of all calls answered within 6 seconds. In the context of focus on culture in EMS Coordination, rates of attendance appear at times not to be improving. A preliminary check of call handler utilisation has not presented levels that, on the face of it, are concerning.

Establishment

The current establishment in EMSC remains a challenge, although the situation is more favourable for EMDs (who are currently over-established). The under-establishment is largely due to the existing dispatch function, which is under-established due to changes required as part of the Organisational Change Policy (OCP), EMDs are trained to rotate through various functions to mitigate this issue. To mitigate the impact of the overall under establishment, two additional induction courses are scheduled for September. It is also anticipated that by the end of October / early November the OCP will have been complete, and the new structure will be in place that will resolve some of the existing shortfalls.

Resourcing

The current capacity in the Resourcing team is actively engaged in supporting various initiatives, including a number of transformation projects and service changes, all of which have implications for rostering. Notable activities include the Urgent Care Service (UCS) Review, development of the Remote Integrated Care Service (RICS), Rapid Clinical Screening, NEPTS Roster Review and Dispatch Roster Review. Although the roster review for the APP expansion has been paused, we have recruited new staff to address these needs. As a relatively small team this presents a challenge as there are competing pressures on the team to engage with the significant change that necessarily have rostering implications.

IMTP

Estates and Infrastructure

EMS Coordination has benefited from significant investment to improve the working environment for our centres in both Llangunnor and the relocation of staff from the existing Bryn Tirion site in North Wales. This work continues to move forward with Llangunnor moving to start works at the end of Q2, with the Ty Elwy and Snowdon House worked being likely to commence in Q3. Both these projects will improve significantly the environment for those colleagues working from those facilities.

EMSC Restructure and Reconfiguration

The restructure and reconfiguration programme is progressing well; The final organisational change (OCP) document was issued to EMS Coordination colleagues in July 2024, which marked the start of the implementation phase. All aspects of the project are on track with anticipated conclusion in Q3. The delivery of this programme will mark a new era in EMS Coordination with improved ways of working, with a much-needed progressive career structure, and capacity to better support our people.

Delivery of a function Resourcing Team model.

The options appraisal for the potential move of 111 Resourcing to the GRS system is currently being drafted and will be discussed with Integrated Care. Plans are underway to prioritise the transition of clinicians in alignment with the RICS model, while 111 Call Handlers will be reviewed based on demand, capacity, and roster considerations. This, together with the development of the 111 Resourcing Standard Operating Procedure will aid the intent to move to a function-based model for the Resourcing Department. At present the department largely works on a geographic basis, but there is an intent to move to a functional model that will service the needs of colleagues based on their department as opposed to their geographical location. The draft SOP for 111 Resourcing will

form the basis for the EMS Coordination Resourcing SOP. The overarching intent is to ensure we have clear processes set out for both 111 and EMSC that will enable the move to a single, integrated resourcing function for the 111/999 contact centres. This will ensure that there is consistency of approach across Wales for the 111 / 999 Centres, but also the other two main functional units, namely EMS and Ambulance Care.

Electronic Timesheets Project Scoping

A preliminary scoping exercise for the e-timesheets project, specifically the GRS Electronic Claim Form, is underway, with a workshop to follow in Q3. To support this, a visit to South West Ambulance Trust took place in August 2024 to learn from their implementation and rollout experiences.

General Update

Medical Transfer Protocol Suite (MTPS)

MTPS went live on the 30th July 2024 and external stakeholders were informed of the changes to inter-facility call processing. Up to end of August 2024, 820 incidents were processed on these new protocols. Of these, 330 were red calls. The MTPS task and finish group continues to meet and review data and internal/external feedback. There have been some concerns raised due to the increase in reds due to introduction of MTPS, as a result of which a focussed audit was undertaken in August 2024. Results showed a 23% non-compliance rate. Whilst this is higher than anticipated for the random audit, it is to be expected as these are brand new protocols and processes which take time to embed.

Learning identified during the audit is fed back to the individual Call Taker to ensure change to practice and any wider themes/trends identified during the audit process are being considered at the task and finish group. The use of the MTPS codes continues will be subject to further focused audits in September and further engagement will take place with Health Care Practitioners that access our services to ensure the appropriate coding and prioritisation of calls.

EMS Coordination Culture

As part of the non-pay annex aspect of the 2023 pay and conditions work, the Trust agreed to focus on the culture of EMS Coordination. An action plan has been created in partnership with Trade Union colleagues and more recently the Director of People and Culture conducted a series of visits across the three centres to listen to staff and their experiences. The feedback from these visits was shared with the EMSC Senior Leadership Team in early September 2024 with learning to be incorporated into the ongoing action plan.

Flexible Working SOP Development

The Flexible Working SOP Task & Finish Group is developing a framework to assist operational managers in reviewing flexible working requests. This SOP aims to ensure consistency in decision-making and explore alternative solutions that balance individual needs with service delivery requirements. It will also reinforce the need for a robust and periodic review process to maximise flexible working solutions for the expanding workforce.

Emergency Medical Service

Challenges

Lost Hours to Handover

Delayed transfer of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of emergency service with timely response to calls. The total amount of lost hours in July 2024 at 19,599, August at 17,540 and September to date at 16,050 (as at 25 September). While there has been some improvement over the past three months the transfer of care delays remains excessive and intolerable within existing rosters. The impacts of these delays and associated system pressures are regularly discussed at Committee and Trust Board.

Red and Amber Performance

As we notice a continued very poor position in transfer of care delays, this is ultimately being translated into a similarly poor red performance and delayed response to our most critical patients. On the whole, the red performance continues to fluctuate in the 45% to 50% range and also continues to fall well short of 65% in all Health Board areas. This is under constant scrutiny within EMS and EMS Coordination teams to improve the level of response in this area.

The Amber median trend continues to show overall response times not where we would like them to be. However, there have been slight signs of improvement in July 2024 but still above the average Amber response times for the last 12 months. A reduction in handover delays would support our response to these patients and prevent escalating through the Clinical safety Plan (CSP) with further response implications to this category of patients, especially amber 2 patients.

IMTP

End of Shift Overruns

While it is noted that the level of investigation of over 2-hour end of shift overruns has continued to improve, along with the uptake of utilising the options available to reduce the end of shift overrun, it is now evident that a number of these overruns are down to staff not correctly booking off duty, or undertaking the 'Hot Swap' MDT facility. However, to further support the wellbeing of staff and to report correctly we continue to work on a number of initiatives to further reduce end of shift overruns. Despite the continued level of handover delays, the average length of overrun has remained at levels lower than 12-15 months ago, with the over 2 hour overrun trajectory improving considerably.

CHARU Roll-out

CHARU recruitment and training courses are continuing to maximise the opportunities to fill remaining CHARU vacancies and to ensure parity of cover between urban and rural areas in line with the D&C review. Where some areas, particularly rural, have struggled to recruit into vacant CHARU lines, there is an imminent go-live with an EA/CHARU rotational model in Welshpool which could be a future model to adopt in difficult to recruit areas following evaluation. We are however now at a position where direct recruitment is likely required.

APP Recruitment

Two stages of APP recruitment have been completed to allow progression of the Modernisation Strategy. Firstly, both external qualified APPs and WAST existing funded MSc staff were recruited, and secondly, internal WAST staff were recruited to undertake funded MSc education to commence in September 2024. While the recruitment has progressed well, the desired numbers have not been fully achieved so a third APP recruitment process is likely to be undertaken again before the end of the financial year. This will allow staff to undertake a funded MSc education programme commencing in March 2025.

General Update

Quality & Support Days

The quality and support days continue to be undertaken across all areas of the operations team, however, to further support operational staff these days will be subject themed moving forward. In Q2 a quality and support day was held in July focussed on end of shift overruns and discussing the Shift Start and Finish SOP. This saw operational managers spending end of shift periods (morning and evening) embedded with EMSC to support the end of shift processes to enable, where possible, crews to finish on time or to reinforce plans for them to be relieved on scene or at hospital as soon as possible.

The following quality and support day held on 23rd August 2024 focussed on the impact and control of diesel fumes and the use of initiatives to reduce the impact of them. A third day in September is focussed on the operational effectiveness programme. Themes and trends will again be collated and fed back through the senior leadership team.

Financial Savings Plan 2024/25 Overtime Allocation

Financial report showing £104k surplus to date with EMS underspend mostly due to overtime not being taken up by staff. To support the routine day-to-day overtime allocation an 'Overtime Allocation SOP' is in use to support this business-as-usual process. Every attempt is being made to provide overtime opportunities in a timely manner to improve uptake and to increase UHP as a result. Non-pay showing a large overspend however fuel prices currently below budget. The application of the overtime process was subject to internal audit, with field work completed during Q2. The output of this audit is anticipated at Committee in Q3.

Ambulance Care

Challenges

UCS Transition

The UCS transition has remained challenging due to several factors that also affect the UCS team. While the modified code set which includes suitable calls has been agreed, the implementation will need to be timed to coincide with the new recruited EMS workforce that are operational from Mid-September. EMS crewing matrix and CSP (Clinical Safety Plan) are also linked to the change and discussions on both have taken place to ensure when the code set changes are implemented these factors are considered and activation plans are in place. This will allow the Service to continue to respond to appropriate calls by all the Operational teams.

IMTP

End of Shift OVERRUNS

The UCS ACA2 service have continued to monitor overruns jointly with our EMS colleagues has seen the number of 2hour overruns continue to improve as mentioned earlier by the EMS team. As the UCS ACA2 team are fewer in number to EMS we are moving into a different phase and will begin to focus on 90mins for all UCS ACA2 crews. We hope this move will support the ongoing support and welfare to the crews and may identify new trends and factors due to the shorter timeframe.

General Update

NEPTS Roster Review

The Trust has received the initial assessment carried out by ORH using updated data post pandemic, with the next steps and methodology being discussed and agreed with ORH. It is anticipated that we will have the refreshed roster keys in September 2024, to progress work with Total Mobile. The next steps will be to have a shadow project board set up, and this will be stepped up into a full project board in September 2024 when we have the initial roster keys.

There will be a recruitment process for a 12-month fixed term post as project manager to support this project once it has commenced. This is anticipated to start in October 2024

Integrated Care

Challenges

111 Call Handler Establishment

The CAS replacement project required all the Trust's training capacity and estate to be re-directed to that project resulting in a significant period where recruitment hasn't possible. Because of this, together with a small increase in attrition the current 111 Call Handler establishment is challenged. This is resulting in sub-optimal resourcing and therefore call answering performance. Integrated care has a clear and closely monitored recovery plan to achieve full establishment prior to the peak demand periods this coming winter; an improved position on that previously reported.

Sickness

Sickness absence remains stubbornly high across Integrated Care despite considerable efforts to target the causes of sickness absence. Absence due to stress and anxiety continues to be the highest category. Integrated Care is working with the Trust's workplace wellbeing psychologist to understand the key drivers of this rise and develop meaningful interventions.

Clinical Model Transformation

The Clinical Model Transformation programme has been a significant focus for the Integrated Care team. Work is underway to align 111 and CSD, develop the Remote Integrated Care Service (RICS) model, develop new pathways and test the 111-call handling software in the wider operational environment. Trials have taken place including:

- **CPSS of Green calls**

Phase 1 was a 3-day trial (9/10/11 July 2024, 0830-1630hrs each day) with two 111 Call Handlers sitting with 111 Specialist lead. Green calls which are normally triaged by 111 Clinicians were triaged by 111 Call Handlers using CPSS. Results were positive with approx. 25% closed by 111 Call Handlers. Phase 2 will be undertaken in September 2024 during which calls will be warm transferred from the 999 Call Handler to the 111 Call Handler. A high priority line will be used to avoid delays in 111 Call Handler answering. All 111 Call Handlers will take these calls for phase 2.

- **Electronic transfer from 111 Call Handlers to 999**

This trial took place in August over 3 days with 999 calls electronically sent from the 111 CAD to 999 CAD, followed by a phone call and confirmation of details. Post trial analysis showed an average of 50 seconds per call saved. This was implemented as BAU from 0900 on the 3rd of September 2024.

- **Managing Delayed 999 Responses using CPSS**

Trial to be undertaken in September 2024 which will include a dedicated CSD Clinician who will be sat side-by-side with a 111 Call Handler. The CSD Clinician will identify calls waiting for an ambulance response which may benefit from a CPSS assessment. When an appropriate call is identified, the 111 Call Handler will complete their assessment which can be validated clinically if appropriate.

111 Dental

The new urgent dental model for Wales went live in April. Following its first few months of operations outcomes and service quality indicators have been reviewed collaboratively with WAST and the Chief Dental Officer. This review found an extremely high level of outcome accuracy and service quality indicating that many more of the right patients were reaching the right service in a more efficient way than before. Work is now underway with the Six Goals Programme to develop the business case to role this model out into the Health Boards which WAST currently aren't commissioned to provide.

General Update

Police Clinical Support

Following an agreement at JESG to resume the police remote clinical assistance work, CSD have been working with South Wales, Gwent, and North Wales Police. This arrangement had previously been in place with South Wales and Gwent but will now expand to North Wales Police colleagues. As a result,

Police colleagues will be able to access remote clinical support from CSD colleagues and, in the future, the clinical navigation team.

Promoting Welsh Language calls in 111

Following an initial trial to offer Welsh call answering, the trial has been extended, allowing us more time to refine our processes and operations. We are pleased to announce a forthcoming meeting with the Welsh Language Improvement Lead to explore new strategies for increasing the number of Welsh Language speakers within the Trust. Additionally, the 111 service are actively seeking expressions of interest from call handlers who wish to receive extra training in Welsh. We are also working on further technical enhancements to the IVR queue system to allow patients greater choice to wait for a call handler who can answer in Welsh.

AGENDA ITEM No	6
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	3

Financial Performance as at Month 6 – 2024/25
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MEETING	Finance & Performance Committee
DATE	19 th November 2024
EXECUTIVE	Chris Turley (Executive Director of Finance & Corporate Resources)
AUTHORS	Edward Roberts (Interim Assistant Director of Finance) Steph Taylor (Assistant Head of Capital Planning)
CONTACT	Chris.Turley2@wales.nhs.uk

EXECUTIVE SUMMARY

This paper presents to the Committee the Financial Performance Report of the 2024/25 financial year, the reported position as at Month 6 (September 2024).

The is provided to the Committee this time for completeness, and which allows for the M06 Welsh Government Monitoring Returns to be shared, with the intention remaining that an update on the latest monthly financial position, that as at M07 2024/25, be presented to Committee by way of a slide deck on the day. The Committee is asked to review, comment, note and receive assurance on the financial position and 2024/25 outlook and forecast of the Trust, noting the risks to in year delivery in doing so.

RECOMMENDED that the Committee:

- (1) Notes and gains assurance in relation to the Month 6 revenue financial position and performance of the Trust as at 30th September 2024;**
- (2) Notes the delivery of the 2024/25 savings plan, and the context of this within the overall financial position of the Trust;**
- (3) Notes the capital programme for 2024/25, and**
- (4) Notes the Month 6 Welsh Government monitoring return submission included within *Appendices 1 – 2* (as required by WG);**

KEY ISSUES/IMPLICATIONS

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

- The Trust is reporting a small revenue surplus (£41k) for month 6 2024/25;
- In line with the balanced financial plan approved as part of the submitted 2023-26 IMTP, the Trust is currently forecasting to breakeven for the 2024/25 financial year;
- Capital expenditure plans are being finalised with plans to fully achieve in year;
- In line with the financial plans that support the IMTP, gross savings of £4.013m have been achieved in month 6 against a target of £3.369m;
- Public Sector Payment Policy is on track with performance, against a target of 95%, of 97.8% for the number, and 98.5% of the value of non NHS invoices paid within 30 days.

REPORT APPROVAL ROUTE

- FP&C – 19th November 2024

REPORT APPENDICES

Appendices 1 – 2 – *Monitoring return submitted to Welsh Government for month 6 – as required by WG*

Appendix 3 – *Savings performance*

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

FINANCE & PERFORMANCE COMMITTEE

FINANCIAL PERFORMANCE AS AT MONTH 6 2024/25

INTRODUCTION

1. This report provides the Committee with a summary of the revenue financial performance of the Trust as at 30th September 2024 (Month 6 2024/25), along with an update on the 2024/25 capital programme. This is provided to the Committee this time for completeness, and which allows for the M06 Welsh Government Monitoring Returns to be shared, with the intention remaining that an update on the latest monthly financial position, that as at M07 2024/25, be presented to Committee by way of a slide deck on the day.

BACKGROUND

2. The key points to note in relation to the **delivery of the Statutory Financial Targets for month 6 2024/25** (1st April 2024 – 30th September 2024) are that:
 - The cumulative revenue financial position reported is a small **underspend against budget of £0.041m**, based on some key assumptions consistent with that within the IMTP financial plan and the Board approved budget for 2024/25. The underlying year-end forecast for 2024/25 is currently a balanced position;
 - In line with the financial plans that supported the submitted Annual Plan within the IMTP for this financial year, gross savings of **£4.013m** have been achieved against a target of **£3.369m**. The future phasing of residual savings requirements as we progress through the financial year will be key to the continuing delivery of a balanced position and forecast. Now included within this paper is a more detailed analysis of savings including the recurring / non-recurring nature of their delivery;
 - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 97.8% for the number, and 98.5% of the value** of non-NHS invoices paid within 30 days.
3. As Committee members will be aware, the Trust did escalate one financial risk in its reporting to Welsh Government in month 2 – that in relation to EMT / technician level posts re-banding. Following detailed work over the past few months and the net impact of, in light of the Trust holding circa 100 WTE positions and thus the reduction in potential backpay for these elements, along with mitigation

associated with the roll out of the training wrap around this risk has been reduced to £0.5m, in relation to the 2024/25 financial year, in month. The level of risk and recurring funding required to support this development however remains as previously reported.

- As we know, no plan, forecast or reported delivery at this stage of the financial year is risk free. The risks included in the Welsh Government Monitoring Return at Month 6 are set in line with the submitted IMTP and summarised later in this report. As we go through the next few months these will continue to be scrutinised and amended accordingly, with mitigations and management plans in place, if required.

REVENUE FINANCIAL PERFORMANCE – MONTH 06 2024/25

- The table below presents an overview of the financial position for the period 1st April 2024 to 30th September 2024.

Revenue Financial Position for the period 1st April - 30th September				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-297,544	-144,472	-144,283	189
Expenditure				
Pay	213,251	103,282	102,769	-513
Non-pay	63,450	30,770	31,389	619
Total pay & non-pay expenditure	276,700	134,052	134,158	106
Depreciation & Impairments / interest payable & receivable	20,844	10,420	10,084	-336
Total	0	0	-41	-41

Income

- Reported Income against the initial budget set to Month 6 shows an underachievement of **£0.189m**.

Pay Costs

- Overall, the total pay variance at Month 6 is an underspend of **£0.513m**.

Non-pay Costs

- The overall non-pay position at Month 6 is an overspend of **£0.283m**.

Savings

- As above, the 2024/25 financial plan identifies that a minimum of **£6.421m** of planned savings (including Income generation) are required to achieve financial balance in 2024/25, this equates to c2.2% of the Trusts discretionary income. Of this, **£3.646m** is recurrent and **£2.775m** is currently deemed non recurrent.

10. Month 6 in month performance was plan of £0.540m and £0.699m achieved, therefore an over achievement of £0.159m (£0.111m recurrent and £0.048m non recurrent). Cumulative performance was plan of £3.369m and £4.013m achieved, therefore an over achievement of £0.644m (£0.455m recurrent and £0.189m non recurrent), as per the below table.

	Annual Plan £000	In Month			Cumulative			Forecast		
		Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Recurrent Schemes / Themes	3,646	339	450	111	2,086	2,541	455	3,646	4,326	680
Non Recurrent Schemes / Themes	2,775	201	249	48	1,283	1,472	189	2,775	2,555	-220
Overall Total	6,421	540	699	159	3,369	4,013	644	6,421	6,881	460

11. Hence, 52% of the plan has been phased in for Month 6 which is slightly higher than flatline and 62.5% of the 2024/25 overall plan value of £6.421m has been achieved.

12. Forecast year end position is an overachievement of £0.460m, this is made up of planned underachievement of non recurrent savings of £0.220m and a planned overachievement in year on recurrent savings of £0.680m.

13. **Appendix 3** provides the overall detail for Month 6 by theme. This is now further split over recurring and non-recurring schemes.

14. Main variances by scheme in Month 6 are as follows.

- Interest receivable overachieved in M6 by £0.062m, YTD now overachieved by £0.335m. FYF is an over achievement of £0.454m based on cashflow projections.
- Over achievement on corporate vacancies in M6 was £0.034m, YTD overachieved by £0.172m. FYF is assumed a slight overachievement of £0.001m due to the assumption that posts will be recruited into.
- Fuel forecourt prices continue to be lower than budgeted and hence has overachieved target by £0.061m for M6, YTD overachieved by £0.232m with a FYF of £0.448m .
- For the planned apprenticeship programmes, higher than anticipated income was received again in M6 (as happened in M5) which showed an overachievement of £0.014m, YTD overachievement of £0.017m and a FYF of £0.079m.
- Workforce efficiencies in M6 was an over recovery £0.012m with YTD and FYF reported as overachieving by £0.012m.
- Non pay local schemes in Corporate and Operations combined underachieved by £0.036m in M6, with YTD underachieving by £0.103 and a FYF underachievement of £0.172m.
- Fleet repair position continues to be challenging with current limited capital investment in vehicles. In M6 there is an overachievement of £0.012m, therefore reducing the YTD underachievement to £0.022m and FYF underachievement to £0.062m.

Financial Performance by Directorate

15. Whilst there is a small surplus reported at Month 6 there are some small variances between Directorates as shown in the table below, when compared to the budgets set at the outset of the financial year. Some of this is driven by staffing vacancies. These are fairly minor in nature and will be continued to be closely monitored throughout the remainder of the financial year.

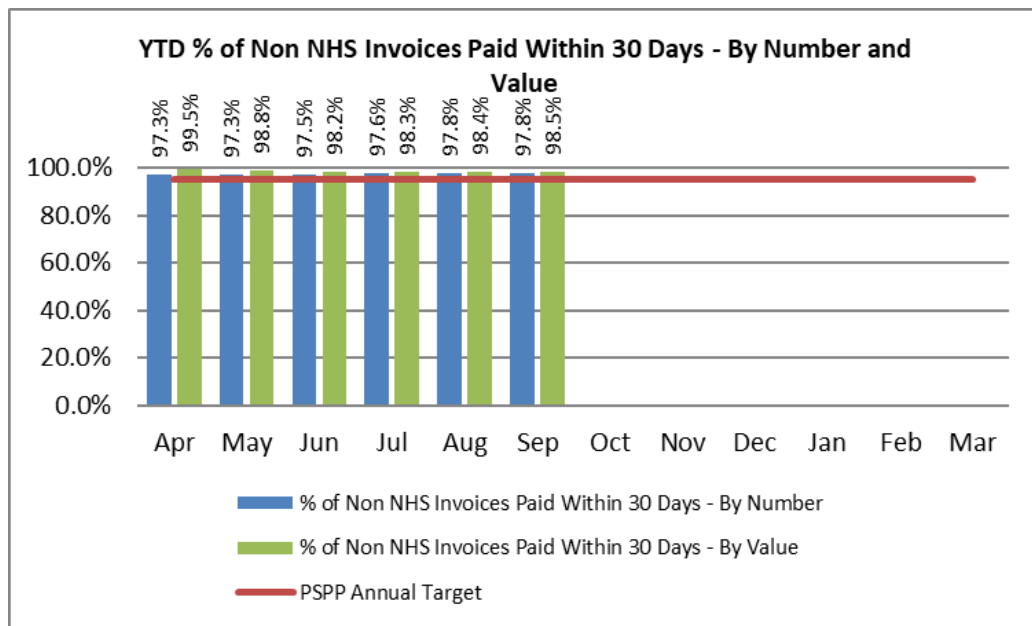
Financial position by Directorate @ 30th September	Annual Budget	Year to date			
		Budget	Actual	Variance	Tolerance 5%
	£000	£000	£000	£000	%
Directorate					
Operations Directorate	199,982	98,960	98,586	-374	-0.4%
Chief Executive Directorate	1,772	911	966	55	6.0%
Board Secretary	514	264	269	6	2.1%
Partnerships & Engagement Directorate	495	246	230	-16	-6.4%
Finance and Corporate Resources Directorate	35,396	17,766	18,104	338	1.9%
Planning and Performance Directorate	2,832	1,360	1,400	40	2.9%
Quality, Safety and Patient Experience Directorate	6,108	2,933	2,957	24	0.8%
Digital Directorate	14,963	6,811	6,744	-67	-1.0%
People and Culture	5,211	2,542	2,440	-102	-4.0%
Medical & Clinical Services Directorate	3,545	1,676	1,670	-6	-0.4%
Trust Reserves	6,086	126	188	62	49.6%
Trust Income (mainly JCC)	-276,905	-133,595	-133,595	0	0.0%
Overall Trust Position	0	0	-41	-41	

16. A brief commentary on significant key variances above is as follows:-

- Most directorates broadly in line with budget plan for Month 6;
- Operations (EMS Response) - Continue to develop modelling around the year end pay position considering workforce planning figures and overtime requirements. Elements of budgets for future cost pressures held in future months;
- Finance & Corporate Resources pressures on fleet maintenance budget linked to lengthened age of fleet;
- Reserves – Includes budget for IMTP developments which are reviewed as part of forecast exercise to identify any potential slippages. YTD variance is due to technical VAT adjustments on agency staff;

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

17. Public Sector Payment Policy (PSPP) compliance to Month 6 was **97.8%** against the **95%** WG target set for non-NHS invoices by number and **98.5%** by value.



2024-25 CAPITAL PROGRAMME

18. At Month 6, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2024/25 is **£20.977m**. This includes **£15.522m** of All Wales Approved schemes and **£5.455m** for Discretionary schemes.

19. The breakdown of the current confirmed All Wales Capital funding is shown below:

All Wales Capital Programme:	
Schemes:	
ESMCP - Control Room Solutions	157
Efab - Infrastructure	303
Efab - Fire	333
Efab - Decarbonisation	596
MDVS	(50)
2024-25 Ambulance Vehicle Replacement Programme	12,828
Maintenance Backlog 2024-25	635
Special Operational Response Teams (SORT) Enhancement Equipment	720
Sub Total	15,522

20. The approved discretionary allocation is as follows:

	2024-25 Planned Expenditure
	£'000
Discretionary Capital 2024-25	
Fleet Projects - 8810	
Fleet Safety Costs - repairs to vehicles	125
Asset De-recognition - engine replacement	125
Fleet Projects - 8810 TOTAL	250
ICT Projects - 8830	
2023-24 Projects	
Clinical equipment asset management system	110
iPad replacement	400
General replacement and new hardware	300
ICT Projects - 8830 TOTAL	810
Estates Projects - 8840	
2024-25 Projects	
Decarbonisation works	300
Estates Fees	150
Bangor Workshop replacement	500
Thanet House relocation to Matrix House	400
Estates topslice	300
2023-24 Projects	
North Wales CCC	500
Llangunnor CCC	500
2022-23 Projects	
Dolgellau	900
Monmouth	500
Estates Projects - 8840 TOTAL	4,050
Project Support Costs - salary paid from capital	180
Unallocated Discretionary Capital (incl NBV proceeds)	165
Discretionary Capital TOTAL	5,455

21. At the end of month 6 the Trust had £0.165m, unallocated however one business case has since been approved to allocate £0.032m for Airwave upgrades at the Trust's logistics hub, reducing the unallocated budget to £0.133m.

22. As at M06, most discretionary schemes are in their design, tendering and planning stages with expenditure expected in the coming months, and most schemes are progressing well, with the exception of the known and previously reported Thanet House relocation due to issues outside the Trust's control, however this is being mitigated with the acceleration of the programme at Llangunnor, thus reducing the planned expenditure in 2025/26.

23. A more detailed update on the Trust's 2024/25 Capital Plan, and in particular any other in year spend variations and how these are planned to be managed, is being provided separately to the Committee this time.

24. As is the case in most of the past financial years the spend to date against both the All Wales Capital Schemes and the discretionary is low in relation to the overall budget, however the expectation remains, as per previous years, that the capital plan will be fully spent by the end of the financial year, subject to any adjustments to the Trust's CEL.
25. Total AWCP spend to month 6 is **£2.719m** this is in part in relation to 2023/24 Fleet costs which were brokered internally at the end of 2023/24, and the purchase of the equipment and chassis for the EA vehicles.
26. The total true expenditure against the discretionary allocation year to date is **£0.286m** however this excludes c£0.685m VAT recovery credit for the 111 scheme, therefore the net "expenditure" per the monitoring return at month 6 is **-£0.399m**, As detailed in the separate update this time, this is largely due to the bulk of the budget being against Estates schemes which are in their design and planning stage, as these schemes progress through the coming months this expenditure will start flowing through the ledger.

RISKS AND ASSUMPTIONS

27. Risks continue to be reviewed on a monthly basis and in reporting through to WG it is considered that there are currently no individual high likelihood risks but, as we move through the next few months, we will continue to review the risks to ensure that the level of likelihood is assessed along with the financial value. Alongside ensuring that Trust Board and the Finance & Performance Committee remain fully appraised of such risks and any mitigating actions.
28. However, there are a number of risks that need to be documented within this reported financial position, which aligns to that fully described within the financial plan submitted as part of the IMTP. As always, the Trust will actively monitor these risks and adjust throughout the financial year when they can.
29. Given the increased requirement again in our savings target that has been required this financial year, to cover increasing cost pressures the Trust has included a risk around the identified savings and as we move through the financial year the aim will be to reduce these risks down once savings are achieved, given the good progress to date this risk has been reduced again this month by £0.100m in month.
30. Included in the table is a risk in relation to the current financial climate, this relates to the risk associated with energy and, in particular, vehicle fuel prices. Whilst we have seen a decrease in these recently, they remain volatile therefore a low risk has been included for these, following an assessment this has been reduced by a further £0.050m in month.
31. Given the pressures the Trust feels every winter, the Trust had included a figure of £1.000m to cover any unfunded winter pressures, however following discussions

with the commissioner this risk had been reduced to zero in month 4, however this will remain under review and subject to changes as we progress through the financial year.

32. A low-level risk is included re PIBS (Permanent Injury Benefit Scheme) of £1.000m. Matched funding for this highly volatile area is provided by WG on an annual basis..
33. As described above, a medium-level risk is included, now at a reduced level of £0.500m in year, in relation to costs associated with revised EMT / Technician level posts.
34. Also included are two remaining unquantified risks, aligned to some of the income and funding assumptions previously highlighted, and which relate to the following:
 - I. Costs associated with the Manchester Arena Inquiry, and subsequent recommendations, both Capital and Revenue costs have been identified and, if these recommendations are to be taken forward, additional funding would be required in order to deliver on them. An output relating to twenty recommendations has concluded our internal governance processes, and has also now been submitted into commissioners and WG (as is a requirement of the recommendations).
 - II. Cost associated with the previously submitted business case for the Connected Support Cymru project, which will only be progressed should the business case be supported and additional funding made available
35. As noted above, whilst there are therefore no current individually assessed high financial risks, when this is then considered alongside continuing significant service pressures and the likely balancing of this risk against patient safety, quality and experience, it is clear that, as expressed within the IMTP, this will need to remain a key focus for the Trust, despite the funding uplift that has been made available for 2024/25 and the reported good financial performance in M06.
36. Alongside this, the risk of non-delivery of statutory financial duties will also continue to be reviewed as part of the overall management of risks on the Trust's Corporate Risk Register.

RECOMMENDED that the Committee:

- (1) Notes and gains assurance in relation to the Month 6 revenue financial position and performance of the Trust as at 30th September 2024;**
- (2) Notes the delivery of the 2024/25 savings plan, and the context of this within the overall financial position of the Trust;**
- (3) Notes the capital programme for 2024/25, and**

(4) Notes the Month 6 Welsh Government monitoring return submission included within *Appendices 1 – 2* (as required by WG);

Appendix 1

Attached

Appendix 2

Circulated separately

Appendix 3

Welsh Ambulance Services NHS Trust

Savings Performance by Theme 24-25

Reporting Month

6

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Apprenticeships	200	17	31	14	100	117	17	200	279	79
Fleet Repair	80	7	18	12	40	18	-22	80	18	-62
Fuel Efficiencies	249	20	81	61	125	357	232	249	697	448
HEWCPD Provision	140	12	12	0	70	70	0	140	140	0
Interest Receivable	300	25	87	62	150	485	335	300	754	454
MSOffice VAT Rebate	300	0	0	0	0	0	0	300	0	-300
Non-pay Local Schemes - Corporate	600	57	24	-33	250	167	-83	600	448	-152
Non-pay Local Schemes - Operations	515	44	41	-3	264	244	-20	515	495	-20
Vacancy Management Corporate Teams	2,275	184	218	34	1,183	1,354	172	2,275	2,276	1
Workforce Efficiencies & Transformation	1,062	116	116	0	835	827	-8	1,062	1,054	-8
Workforce Efficiencies & Transformation Variable	700	59	71	12	352	372	20	700	720	20
Totals	6,421	540	699	159	3,368	4,013	644	6,421	6,881	460

Savings Performance by Theme 24-25 - Recurrent

Reporting Month

6

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Apprenticeships	0	0	0	0	0	0	0	0	0	0
Fleet Repair	80	7	18	12	40	18	-22	80	18	-62
Fuel Efficiencies	249	20	81	61	125	357	232	249	697	448
HEWCPD Provision	140	12	12	0	70	70	0	140	140	0
Interest Receivable	300	25	87	62	150	485	335	300	754	454
MSOffice VAT Rebate	0	0	0	0	0	0	0	0	0	0
Non-pay Local Schemes - Corporate	600	57	24	-33	250	167	-83	600	448	-152
Non-pay Local Schemes - Operations	515	44	41	-3	264	244	-20	515	495	-20
Vacancy Management Corporate Teams	0	0	0	0	0	0	0	0	0	0
Workforce Efficiencies & Transformation	1,062	116	116	0	835	827	-8	1,062	1,054	-8
Workforce Efficiencies & Transformation Variable	700	59	71	12	352	372	20	700	720	20
Totals	3,646	339	450	111	2,086	2,541	455	3,646	4,326	680

Savings Performance by Theme 24-25 - Recurrent

Reporting Month

6

	Annual	In Month			Cumulative			Forecast		
	Plan £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Apprenticeships	200	17	31	14	100	117	17	200	279	79
Fleet Repair	0	0	0	0	0	0	0	0	0	0
Fuel Efficiencies	0	0	0	0	0	0	0	0	0	0
HEWCPD Provision	0	0	0	0	0	0	0	0	0	0
Interest Receivable	0	0	0	0	0	0	0	0	0	0
MSOffice VAT Rebate	300	0	0	0	0	0	0	300	0	-300
Non-pay Local Schemes - Corporate	0	0	0	0	0	0	0	0	0	0
Non-pay Local Schemes - Operations	0	0	0	0	0	0	0	0	0	0
Vacancy Management Corporate Teams	2,275	184	218	34	1,183	1,354	172	2,275	2,276	1
Workforce Efficiencies & Transformation	0	0	0	0	0	0	0	0	0	0
Workforce Efficiencies & Transformation Variable	0	0	0	0	0	0	0	0	0	0
Totals	2,775	201	249	48	1,283	1,472	189	2,775	2,555	-220



GIG
CYMRU
NHS
WALES

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

Cadeirydd

Chair: Colin Dennis

Prif Weithredwr

Chief Executive: Jason Killens

Swyddfa Cyllid ac Adnoddau Corfforaethol

Finance and Corporate Resource Office

Mrs C Bowden
Head of NHS Financial Management
Welsh Government
North Wales NHS Financial Management
Sarn Mynach
Llandudno Junction
LL31 9RZ

11th October 2024

Your ref:

Dear Claire,

Re: SEPTEMBER 2024 (MONTH 06 2024/25) MONITORING RETURN

Please find attached the Monitoring Returns for the Welsh Ambulance Services University NHS Trust for September 2024.

All automatic validation rules incorporated in the reporting template have been successfully passed, and the Trust can confirm that the revised template has been used.

In line with our submitted IMTP, our opening budgets and financial plan for the year reflected the level of assumed funding, expenditure plans and savings requirement included and submitted and supported by our Commissioners and approved by the Trust Board in March 2024.

The Trust's performance against financial targets for Month 06 2024/25 is as follows: -

1. Actual Year to Date 2024/25 (Tables A, B & B2)

Income assumptions reflect those agreed within the IMTP, and are used to support cost pressures identified in the Trust's detailed budget setting. The key funding assumptions at the outset of 2024/25 being that the 2023/24 funding is, where applicable, fully recurrent, and the 2024/25 funding will include: -

- The nationally made available 3.67% uplift for core cost growth, which excludes any funding to meet the 2024/25 pay award costs, (which will be subject to a future additional funding allocation);
- Impact of previously agreed developments/other adjustments including income support, in line with support by Commissioners in previous and current IMTPs, along with funding for other nationally delivered projects.

Included within the income assumptions is the full pass through of 2023/24 pay funding including the VSM uplift, which was provided in the latter months of 2023/24.

Mae'r Ymddiriedolaeth yn croesawu gohebiaeth yn y Gymraeg neu'r Saesneg, ac na fydd gohebu yn Gymraeg yn arwain at oedi

The Trust welcomes correspondence in Welsh or English, and that corresponding in Welsh will not lead to a delay

www.ambulance.wales.nhs.uk

Pencadlys Rhanbarthol
Ambiwylans a Chanolfan
Cyfathrebu Clinigol

Regional Ambulance
Headquarters and
Clinical Contact Centre

Beacon House
William Brown Close
Llantarnam
Cwmbran NP44 3AB
Ffôn/Tel
01633 626262

It should be noted that the now approved and confirmed pay award is not currently reflected within these tables, however as confirmed by WG colleagues this will be fully funded, therefore these additional costs and subsequent income will be reflected in future months returns.

The resulting reported performance at Month 6 as per Table B, is a small underspend against budget / surplus of **£0.041m**

The reported total pay variance against plan as at Month 6 is an underspend of £0.513m, set against the budgets.

The non-pay position at Month 6 is a reported overspend of £0.283m.

Income at Month 6 shows an underachievement of £0.189m.

2. Movement (Table A)

The Movement table has been completed in accordance with the new guidance, incorporating the submitted Annual Plan (AOP) data.

Following your comment in the month 5 reply letter the FYE adjustment value has been eliminated from this month return. (Action Point 5.1)

3. Underlying Position (Table A1)

This table has been revised following the comments in the month 1 reply letter and the impact of the non-recurrent savings are now shown in column G.

4. Risk (Table A2)

The risks reported in Table A2 continue to be fully assessed, however at present it is considered that there are no individually high likelihood risks, but as we move through the next few months we will continue to review the risks to ensure that the level of likelihood is assessed along with the financial value. Depending on the outcome of some of the issues highlighted elsewhere in this return, we may be moving towards higher risks having to be reported in due course, alongside ensuring that the Trust Board and the Finance & Performance Committee remain fully apprised of such risks and any mitigating actions.

However, there are a number of risks that need to be documented within this reported financial position, which aligns to that fully described within the financial plan submitted as part of the IMTP, as always the Trust will actively monitor these risks and adjust throughout the financial year when they can.

Given the increased requirement again in our saving target that has been required this financial year, to cover increasing cost pressures the Trust has included a risk around the identified savings and as we move through the financial year the aim will be to reduce these risks down once savings are achieved, given the good progress to date this risk has been reduced again this month by £0.100m in month.

Included in the table is a risk in relation to the current financial climate, this relates to the risk associated with energy and, in particular, vehicle fuel prices, whilst we have seen a decrease in these recently, they still remain volatile therefore a low risk has been included for these, following an assessment this has been reduced by a further £0.050m in month.

In light of your comment around the opportunity given the reported £0.2m potential energy benefit reported in recent NWSSP tables, however the Trust has already been offsetting these savings/underspends against estates maintenance works on a month by month basis. **(Action Point 5.2)**

Given the pressures the Trust feels every winter, the Trust had included a figure of £1.000m to cover any unfunded winter pressures, however following discussions with the commissioner this risk had been reduced to zero in month 4, this will remain under review and subject to changes as we progress through the financial year.

A low-level risk is included re PIBS (Permanent Injury Benefit Scheme) £1m. Matched funding for this highly volatile area is provided by WG on an annual basis, arranged between Jillian Gill and Jackie Salmon.

EMT (Emergency Medical Technician) Risk

It is pleasing to be able to further reduce the remaining in year financial risk as a result of this issue, the detail of which has been fully articulated in previous month's returns, to c£0.5m. This is as a result of that detailed in last month's returns and further detailed scrutiny of both the likely in year costs in 2024/25, and any and all means we have to mitigate the impact of these, including a detailed review of all current forecast costs and budget variations at a meeting of the Executive Finance Group of the Trust on 18th September 2024.

As previously detailed, the vast majority, if not all, of the mitigations that have been available to offset some of this risk and cost impact within the 2024/25 financial year are non recurring and not sustainable in the longer term.

This reduced in year net cost impact was shared with the Chief Commissioner of the NWJCC on 18th September, and further discussions on how this residual in year risk is to be managed through the remainder of 2024/25, alongside the funding request for recurring funding support for this unavoidable cost development, are imminent.

Specifically in relation to the request in the Month 5 returns response covering letter re the governance processes that has been followed to approve the implementation of the changes outlined, I would highlight some of the following steps and issues in relation to this, which are by no means exhaustive and do so without seeking to significantly repeat that which is now included within the business case submitted to commissioners on 30th August 2024, or that which has been articulated on this issue in previous returns :

- The Trust's submitted IMTP for 2024-27, and the financial plan within it, was clear that the costs identified for 2024/25 and beyond did not include the unavoidable costs of this issue, should they materialise, and given the already significant financial savings delivery required by the Trust in 2024/25, (£6.4m or well in excess of 2% of budget) no further savings would immediately be available to offset. This financial plan and the main assumptions underpinning it was fully supported at the time by the CASC;
- Formal confirmation was then received from NHS Employers Wales that the new national job profiles published in England in November 2023 would apply in Wales as well as England and Scotland. The relevant staff councils have also endorsed;
- As has previously been described and is fully detailed in the subsequent business case, work continued to progress with our national TU full time officers to seek to enact this, in light of the unavoidable nature of this now given the above, in what would be both the most financially and service beneficial way, and certainly when compared to some of the historical alternatives some TUs were continuing to suggest;
- Throughout this period, the Trust ensured that WG and NWJCC colleagues, the Director of Ambulance and 111 Commissioning in particular, were kept fully informed on how this development was progressing, including through:
 - Regular updates from the CEO in discussions with both the CEO of NHS Wales and senior colleagues within the JCC;
 - In May, a detailed update and discussion with the head of NHS Employers Wales
 - Inclusion of the risk and detailed narrative to support the development of, and subsequent movement in the likely in year financial value of this, through these returns from M02 2024/25 onwards;
- Following the positive outcome of the resulting consultative ballot of all TUs for the proposed way forward (which again is fully detailed within the accompanying business case and in part has been fully described in previous returns so I again won't look to repeat here), the decision to enact that which had become unavoidable for us to do was taken by the Trust Board at its meeting on 25th July 2024, which included the endorsement of, and was made in the context of, the submission of a resulting business case for additional funding consideration;
- This business case was formally submitted to the NWJCC on 30th August 2024;
- Discussions on the case were held at the JCC meeting on 17th September 2024, with more to follow.

Also included within the risk table are 2 remaining unquantified risks at this stage, these are still being worked through internally, and relate to the following:

- Costs associated with the Manchester Arena Inquiry, and subsequent recommendations, both Capital and Revenue costs have been identified and if these recommendations are to be taken forward additional funding would be required in order to deliver on them. An output relating to twenty recommendations has concluded our internal governance processes, and has also now been submitted into commissioners and WG (as is a requirement of the recommendations).

- Cost associated with the previously submitted business case for the Connected Support Cymru project, which will only be progressed should the business case be supported and additional funding made available.

As noted within the returns, these are also highlighted at this stage as being low risk, and from a purely financial perspective they are, as costs have not been committed for these and are arguably not unavoidable – should these not be funded, costs for each of these cannot be incurred. However, the wider impact of such decisions may be argued as being of a higher than low risk, non-financially.

As noted above, whilst there are therefore no current individually assessed high financial risks at present, however when this is then considered alongside continuing significant service pressure and the likely balancing of this risk against patient safety, quality and experience, it is clear that, as expressed within the IMTP, this will likely be another challenging financial year, despite the initially reported good financial performance in M06, based on the assumptions made in reporting this.

Full consideration and management of all these risks will clearly be high on the agenda for the Trust Board and its relevant Committees, including Finance and Quality Committees. Alongside this, the risk of non-delivery of statutory financial duties is included, alongside a more detailed review of this risk on the Trust's Corporate Risk.

5. Monthly Profiles (Table B)

This table has now been completed in full, and in accordance with the guidance.

6. Pay and Agency/Locum (premium) Expenditure (Table B2)

Agency costs for Month 6 totalled £0.061m. The current percentage of agency costs against the total pay figure remains very small, at 0.4%. This is to cover a small number of vacancies, in areas across the Trust which the Trust is having difficulties recruiting into. It should also be noted that digital agency staff are also currently being scoped and hence may be used non recurrently through the rest of this financial year to assist in the delivery of agreed IMTP deliverables, again largely due to the difficulties in recruiting to such a specialist area.

7. COVID-19 (Table B3)

Table B3 has been completed (nil return) however as in the latter months of 2023/24 it assumes no costs or funding requirements going forward.

8. Saving Plans (Table C, C1, C2 & C3)

For Month 6 the Trust is reporting planned savings (including Income generation) of £3.369m and actual savings of £4.013m.

As can be seen from Table C3, the Trust overachieved its savings target in month 6 and is now forecasting to overachieve the total savings target for the year by £0.460m, this is made up of planned underachievement of Non recurrent savings of £0.220m and a planned overachievement in year on recurrent savings of £0.680m.

9. Income/Expenditure Assumptions (Tables D, E and E1)

These are set out in Tables D, E and E1.

10. Statement of Financial Position and Aged Welsh NHS Debtors (Table F & M)

At Month 6 there were 4 invoices and 1 credit notes over 11 weeks, however none of these invoices have queries registered against them, one of which is pending a credit note, and work is ongoing to ensure the payment of the other 3.

11. Cash flow (Table G)

The cash flow has been completed in accordance with the guidance, included below is the details of 'Other' receipts and 'Other' payments as shown within lines 10 and 22 of Table G.

	Apr £,000	May £,000	Jun £,000	Jul £,000	Aug £,000	Sep £,000	Oct £,000	Nov £,000	Dec £,000	Jan £,000	Feb £,000	Mar £,000	Total £,000
RECEIPTS													
other (specify in narrative)													
CRU Income	16	13	13	9	14	14	14	14	14	14	14	15	164
Other Non NHS Income	242	144	278	253	449	127	355	355	355	355	355	349	3,617
Pensions Agency	0	0	0	0	0	0	0	0	0	0	0	0	0
Vat Refund	754	0	112	200	522	454	656	350	350	400	350	427	4,575
Risk Pool Refund	0	0	975	0	55	0	0	0	0	0	0	0	1,030
Total	1,012	157	1,378	462	1,040	595	1,025	719	719	769	719	791	9,386

12. Public Sector Payment Compliance (Table H)

This table has been completed in accordance with the guidance. The Trust endeavours to ensure that NHS invoices along with Non-NHS invoices are paid within targets.

The quarter 2 cumulative percentage of Non-NHS invoices paid within 30 days by number was 98.1% against a target of 95%.

13. Capital (Tables I, J and K)

The capital tables have been completed in accordance with the guidance.

Detailed work is ongoing with Programme managers to establish updated cash flows that reflect the profiles of approved projects now for this financial year, however at present all schemes are progressing well, and a detailed review is currently being undertaken to ensure that schemes continue to deliver to programme, and any future potential schemes are identified.

14. Committee to receive Financial Monitoring Return

The Trust confirms that financial information reported in the monitoring return is entirely consistent with financial details reported internally, including details within Trust Board papers and that of its Committees.

The Month 6 Financial Monitoring Return will be presented to the Finance and Performance Committee on 19th November 2024.

Governance arrangements for formal sign off of the monitoring return narrative in the absence of the Director of Finance or Chief Executive will be delegated to their Deputies but in exceptional circumstances could be signed by a Senior Finance Manager and an Executive Director. Signatures on this return contain Chris Turley, Executive Director of Finance & Corporate Resources and Jason Killens, Chief Executive.

15. Other Issues

There are no other matters of major significance to draw to your attention at this stage.

If you would like to discuss any matter included in this monitoring return letter or attached tables, please do not hesitate to contact me.

Yours sincerely



Chris Turley
Executive Director of Finance & Corporate Resources



Jason Killens
Chief Executive

Enc cc:
Mr C Dennis, Chairman
Non-Executive Directors Executive Directors

AGENDA ITEM No	7
OPEN	OPEN
No of ANNEXES ATTACHED	1

**MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD –
September/October 2024**

MEETING	Finance & Performance Committee (FPC)
DATE	19 th November 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 **September/October 2024**.
2. The report aims to provide an integrated view of quality & performance, so is made available to all three committees, to give that overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators. The following indicators are for this committee:-

Slide Title	Slide Number
111 Call Answering/Abandoned Performance Indicators	3
111 Clinical Assessment Start Time Performance Indicators	4
999 Call Performance Indicators	5
Red Performance Indicators	6
Amber Performance Indicators	7
Patient Experience – Influencing Ambulance Care Indicators	8
Potential Patient Harm Indicators	16
Capacity - Ambulance Abstractions and Production Indicators	18

Shift Overruns	22
Ambulance Care Indicators	24
Finance Indicators	25
EMS Utilisation & Average Job/Shift Times	26
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators	27
Consult & Close Indicators	28
Conveyance to ED Indicators	29

3. Data quality issues have been identified and are being addressed within 111, APPs and throughout the quality indicators with the result that there are a number of Board approved metrics which are not available at this time.
4. The response times to 999 callers remains a key concern with red 8-minute performance at 50.40 % in October 2024 and Amber 1 median at 1 hour and 46 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 (93% in October, just short of achieving benchmark) and fully rolling out the CHARU service (84% in October, highest achieved to date); whilst also undertaking more transformative actions through the Clinical Model Transformation (CMT) Programme.
5. The Trust lost 21,880 hours to handover in October 2024. This level of lost capacity is difficult to compensate for, despite all the actions being taken by the Trust.
6. 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.
7. 111 call handling performance has stabilised post-delivery of the new 111 CAS and is improving, achieving the 5% abandonment rate in October 2024. 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 and sickness absence. The Trust anticipates that staff in post will be restored to commissioned levels by November 2024.
8. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance is unstable, with oncology remaining above target, however, renal performance dropping below target for the first time since March 2020. Both the NET Centre and NEPTS transport are due to be re-rostered in 2024/25 (on target), a key efficiency.

9. The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People & Culture Plan. Sickness absence was 7.43% in September 2024 maintaining 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. EMS absences were marginally above the 30% benchmark in October 2024 at 30.82%.
10. 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, in particular, remote clinical screening (RCS).

RECOMMENDATION

FPC is asked to: - Consider the September/October 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

14.11.24 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 **September/October 2024**.
2. The report aims to provide an integrated view of quality & performance, so is made available to all three committees, to give that overview, with more specific and detailed reports supplementing it. Whilst giving an integrated overview, each slide contains an icon denoting the lead committee for each set of indicators:-



BACKGROUND

3. This Integrated Quality & Performance Report contains information on key indicators at a highly summarised level which aims to demonstrate how the Trust is performing across four integrated areas of focus: -
 - Our Patients (Quality, Safety and Patient Experience);
 - Our People;
 - Finance and Value; and
 - Partnerships and System Contribution
4. 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

5. **Call answering** (safety): the speed at which the Trust is able to answer a 999 or 111 call is a key patient safety measure.
6. **999** call answering times declined in October with the 95th percentile at 25 seconds, compared to 18 seconds in September 2024. The 65th percentile and median performance remain consistently good in September 2024.
7. **111 call answering performance has improved over recent weeks**, and the call abandonment performance was at 5% in October, achieving the 5% target. 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 establishment position will be recovered by by November. 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%).

8. 111 demand in October 2024 was 0.8% higher than during October 2023, resuming the longer term upward trend. 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.
9. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 100%. One response time for lower priority calls also achieved the target this month, recording 91.6% and 87.0% for P2CT and P3CT respectively.
10. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for October 2024 was 50.40%, 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 October was 1 hour 46 minutes and the Amber 1 95th percentile was 7 hours 43 minutes. These long response times have a direct impact on outcomes for many patients.
11. Traditionally the main 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, elements of which will be implemented before winter. 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.

12. 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. The Trust achieved an 84% CHARU UHP in Oct-24, matching the highest it has achieved last month and is now seeking to close the remain gap through the recruitment of fully qualified paramedics.
13. 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. 21,880 hours were lost during October 2024. Cardiff & Vale's handover lost hours continue to remain comparably much lower, 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 above its two-year average figure (7,779). WG have re-iterated to health boards the critical importance of improvements in this area. The WG pan-Wales target of no handovers of more than one hour, equates to 7,500 lost hours.
14. **Ambulance Care (Patient Experience):** Oncology performance in October 2024 was 73.32%, hitting the 70% target. Renal performance dropped below target at 68.73%. Advanced discharge & transfer journey performance decreased compared to the previous month to 81% 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).
15. **National Reportable Incidents (NRIs) / Concerns Response:** the Trust reported four NRI's to the NHS Executive in October 2024, a decrease from the six reported in September 2024; and 14 serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In October 2024 complaint response times improved to 65%, an improvement on the 46% recorded in September 2024, but remaining below the 75% target, with cases remaining complex.
16. **Clinical outcomes:** The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 89.9% in September 2024, remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system and this improvement is being seen clearly in most of the clinical indicators. The return to spontaneous circulation (ROSC) compliance rate decreased to 19.4% in September 2024 compared to 24.2% in August 2024.
17. The Trust is now able to report on call to door times for Stroke and STEMI patients. For September 2024, these highlight call to hospital door times of two

hours and 34 minutes for stroke patients and two hours and twelve 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.

18. In October 2024, 10,867 patients **cancelled** their ambulance, and the Trust was unable to send an ambulance due to the application of the Clinical Safety Plan levels to approximately 806 callers. The Trust believes that 50% of this combined number is unmet demand and is likely to be presenting 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)

19. **Hours Produced:** The Trust produced 124,337 Ambulance Response unit hours in October 2024 and delivered an emergency ambulance unit hours production (UHP) of 93%, dropping just below the 95% target.
20. **Response Abstractions:** EMS abstraction levels increased to 30.82% in October 2024, just above the 30% benchmark figure. Response sickness abstractions stood at 7.60% (benchmark 5.99%).
21. **Trust sickness absence:** the Trust's overall sickness percentage was 7.43% in September 2024, a decrease on the 7.52% recorded in August 2024. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan. The 7.43% is above the 2023/24 IMTP ambition of 6%.
22. **Staff training and PADRs:** PADR rates did not achieve the 85% target in October 2024 but have been remaining consistent (77.22%). Compliance for Statutory and Mandatory training decreased slightly to 83.35%, just shy of the 85% target.
23. **People & Culture Plan:** the Trust launched its People & Culture Plan in April 2023 and workstreams are being delivered around behaviours, in particular, sexual safety, Freedom to Speak Up, 111 culture review, flexible working, and the introduction of a staff pulse survey tool. The Executive Leadership Team undertook another round of a pan-Wales of CEO Roadshows in October 2024 and collection of feedback is underway.

Finance & Value

24. **Financial Balance:** the reported outturn performance at Month 7 is a surplus of £42k and the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

25. We are not able to report on the consult & close rates as the 111 contribution is not available due to issues with system changes within the 111 CAS system. 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.
26. 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

27. Data quality issues have been identified and are being addressed within 111, APPs and throughout the 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 unstable due to high demand and increased system pressures with one headline metric remaining above target and one dropping below for the first time since 2020.

RECOMMENDATIONS

FPC is asked to: - Consider the September/October 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

September/October 2024

Annex 1 – Top Indicator Dashboard



GIG
CYMRU
NHS
WALES

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

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

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard



Top Monthly Indicators	Target 2024/25	Sep-24	Oct-24	2 Year Average	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	7.0%	5.0%	10.9%	G
111 Clinical Triage Call Back Time (P1)	90%	99.1%	100.0%	98.4%	G
999 Call Answer Times 95th Percentile	00:06	00:18	00:25	00:19	R
999 Red Response within 8 minutes	65%	49.0%	50.4%	49.2%	R
999 Amber 1 Median	00:18	01:43	01:43	01:23	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	75.3%	73.3%	72.4%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	82.1%	80.6%	81.7%	A
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	19.4%	N/A	18.6%	G
Stroke Patients with Appropriate Care	95%	89.9%	N/A	78.8%	A
Stroke Call to Hospital Door Times	Reduction Trend	02:34	N/A	9.5%	A
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	70.0%	N/A	47.2%	R
National Reportable Incidents reports (NRI)		6	4	4	TBD
Can't Send & Cancelled by Patient Volumes	Reduction Trend	9,440	10,867	9,010	A
Concerns Response within 30 Days	75%	46.00%	65.0%	44.5%	R
Enactment of the Duty of Candour Total		6	7	4	TBD
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	95%	93%	90%	A

Top Monthly Indicators	Target 2024/25	Sep-24	Oct-24	2 Year Average	RAG
Health & Well-being					
Sickness Absence (<i>all staff</i>)	6.0%	7.43%	N/A	8.03%	A
Mental Health Absence Rates	Reduction Trend	2.59%	N/A	2.23%	A
Staff Turnover Rate	Reduction Trend	8.21%	8.02%	9.00%	G
Statutory & Mandatory Training	>85%	83.79%	83.35%	75.48%	A
PADR/Medical Appraisal	>85%	75.89%	77.22%	73.22%	A
Number of Shift OVERRUNS	Reduction Trend	3870	3646	3,662	R
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	2.2%	1.9%	1.6%	G
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100.00%	100.00%	100%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	26.8%	27.3%	27%	A
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.29	2.25	2.33	R
NEPTS on the Day Cancellations	Reduction Trend	13.1%	13.9%	13%	R
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	9.7%	N/A	13.3%	TBD
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.44%	N/A	11.3%	G
Number of Handover Lost Hours	7,500	20,693	21,880	22,461	R
NHS111					
NHS111 Dental Calls	Increasing Trend	N/A	N/A	6,741	TBD
Consult & Close Volumes by NHS111	Increasing Trend	N/A	N/A	987	TBD

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)*)

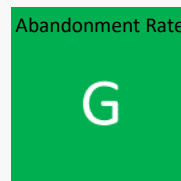
Red: Performance is less than 10% of target (*Indicates close monitoring or significant action is required*)

TBD: Status cannot be calculated (*To Be Determined*)

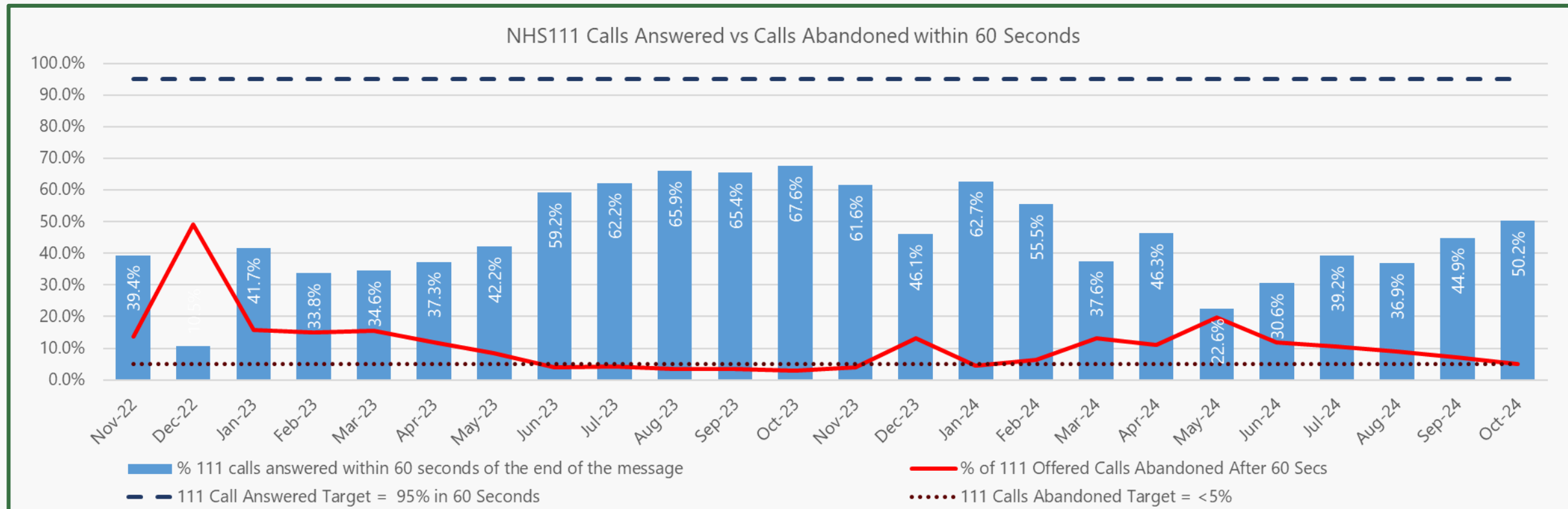
Our Patients: Quality, Patient Safety & Experience

111 Call Answering/Abandoned Performance Indicators

(Responsible Officer: Lee Brooks)



Influencing Factors – Demand and Call Handling Hours Produced



Analysis

The 111-call abandonment rate improved from 7% in September 2024 to 5% in October 2024, achieving the 5% target for the first time in 9 months. The percentage of 111 calls answered within 60 seconds improved, from 44.9% in September 2024 to 50.2% in October 2024, but continues to remain below the 95% target.

Performance declined during the middle part of the year, due mainly to the introduction of the new 111CAS system, which went live on 30th April 2024. In the run up to this implementation staff were abstracted for training, recruitment was paused and after go-live, staff were familiarising themselves with the system, all of which had an impact on efficiency. Since that time there has been a steady improvement in performance.

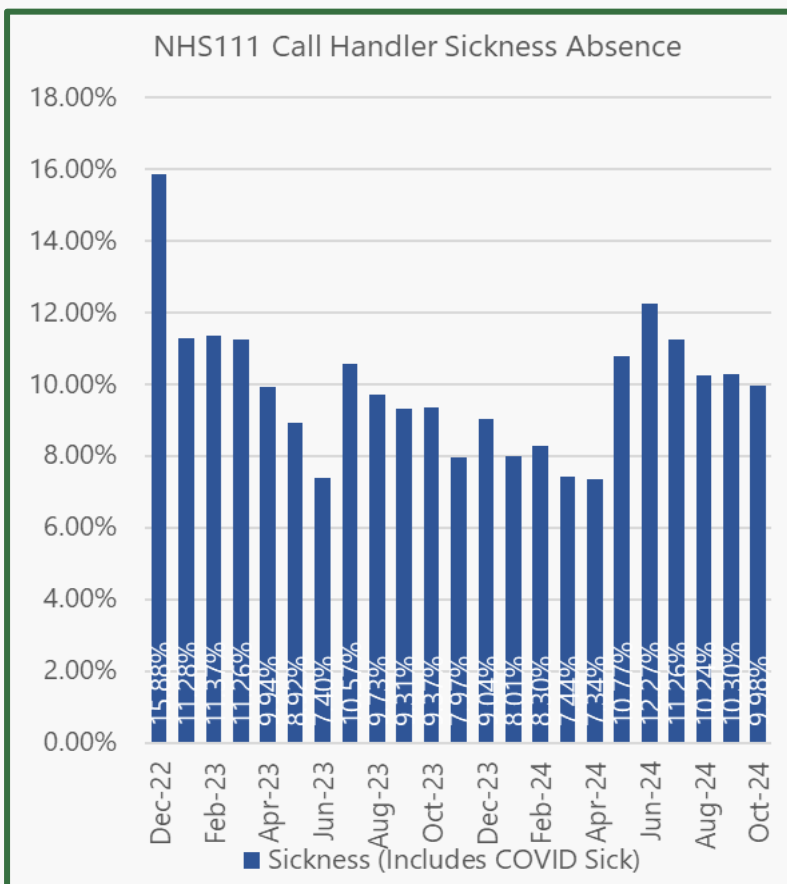
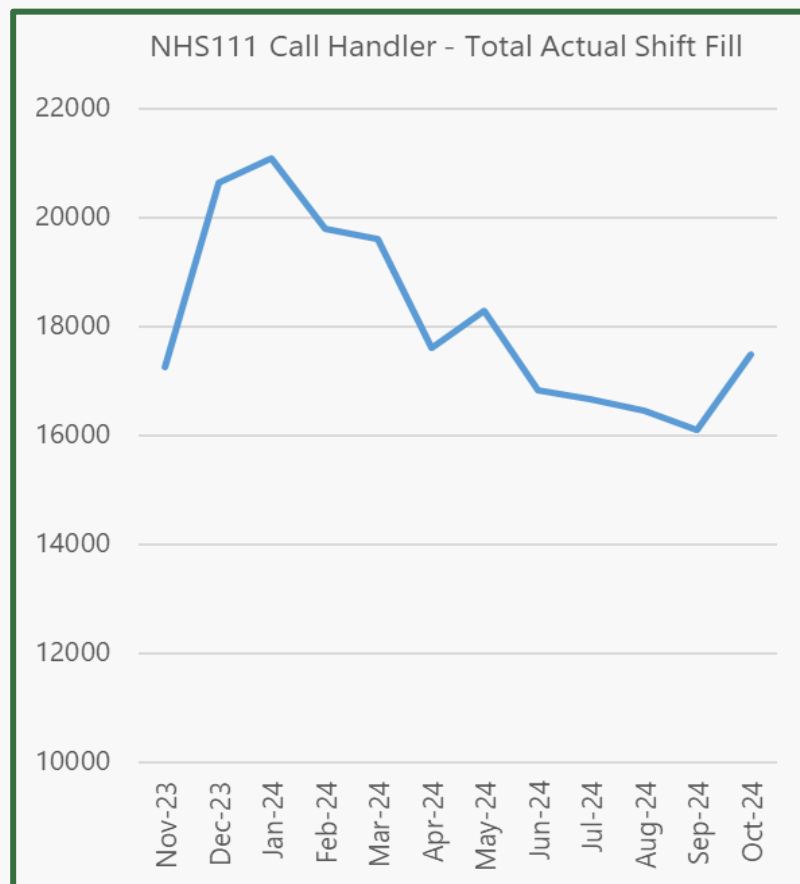
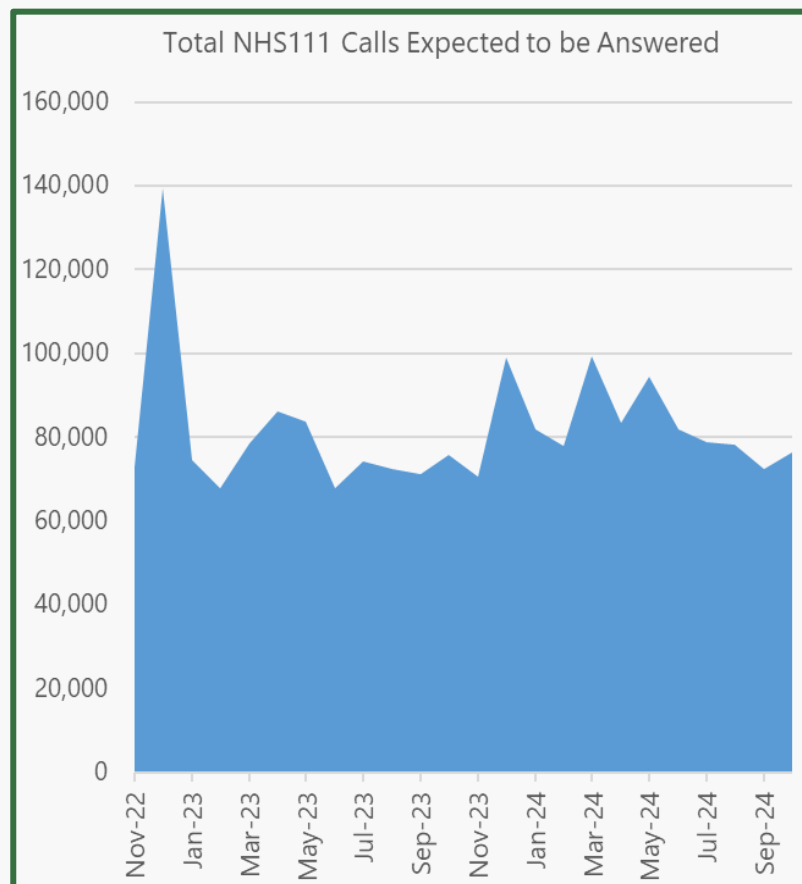
Remedial Plans and Actions

Key actions include:

- With cohorts starting over the summer the plan is to be at commissioned levels by November, a slip from the previous August deadline;
- Further action is being undertaken to try and improve the call handling position across the Winter months;
- 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 as the new system beds in and with the recruitment of additional staff, performance will continue to improve; however, there are risks including demand, levels of commissioned call handlers being lower than last year and an unknown impact of the new system.

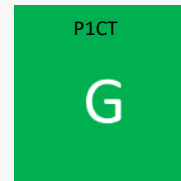


Our Patients: Quality, Safety & Patient Experience

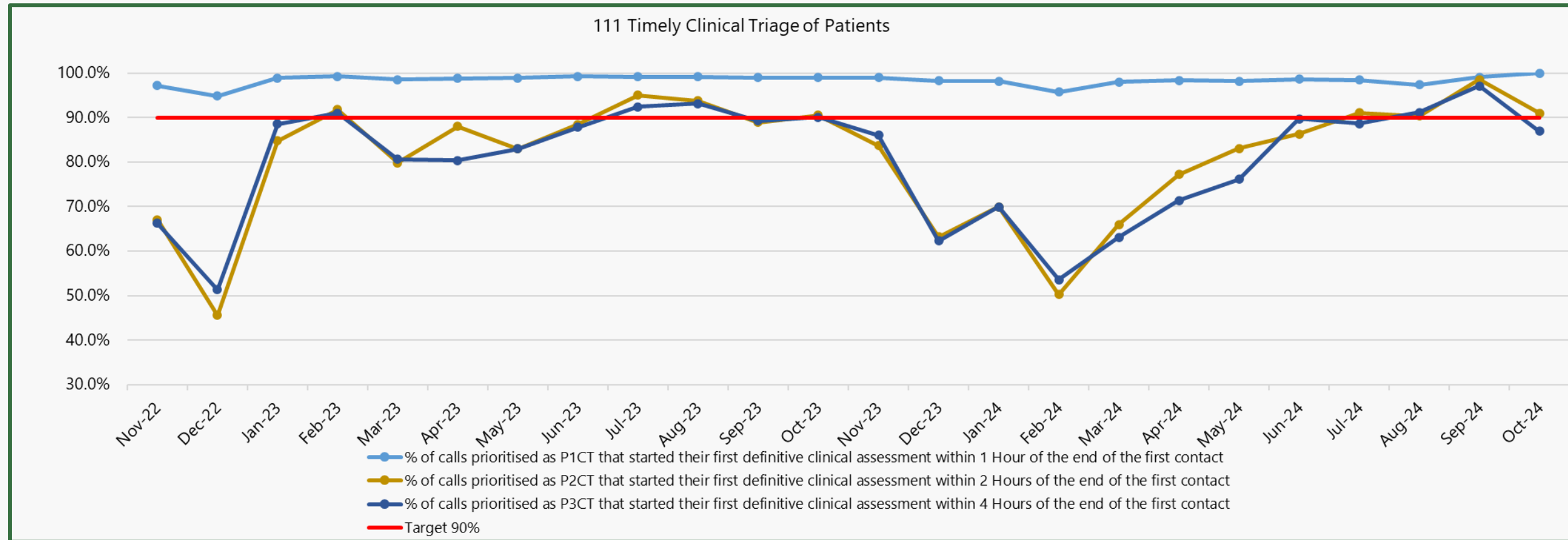
111 Clinical Assessment Start Time Performance Indicators

Influencing Factors – Demand and Clinical Hours Produced

(Responsible Officer: Lee Brooks)



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 100% in October 2024.

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

Numbers of clinician hours produced increased again in October 2024 for the fourth month in a row to 11,328. Clinician sickness absence also improved during the month to 13.24%.

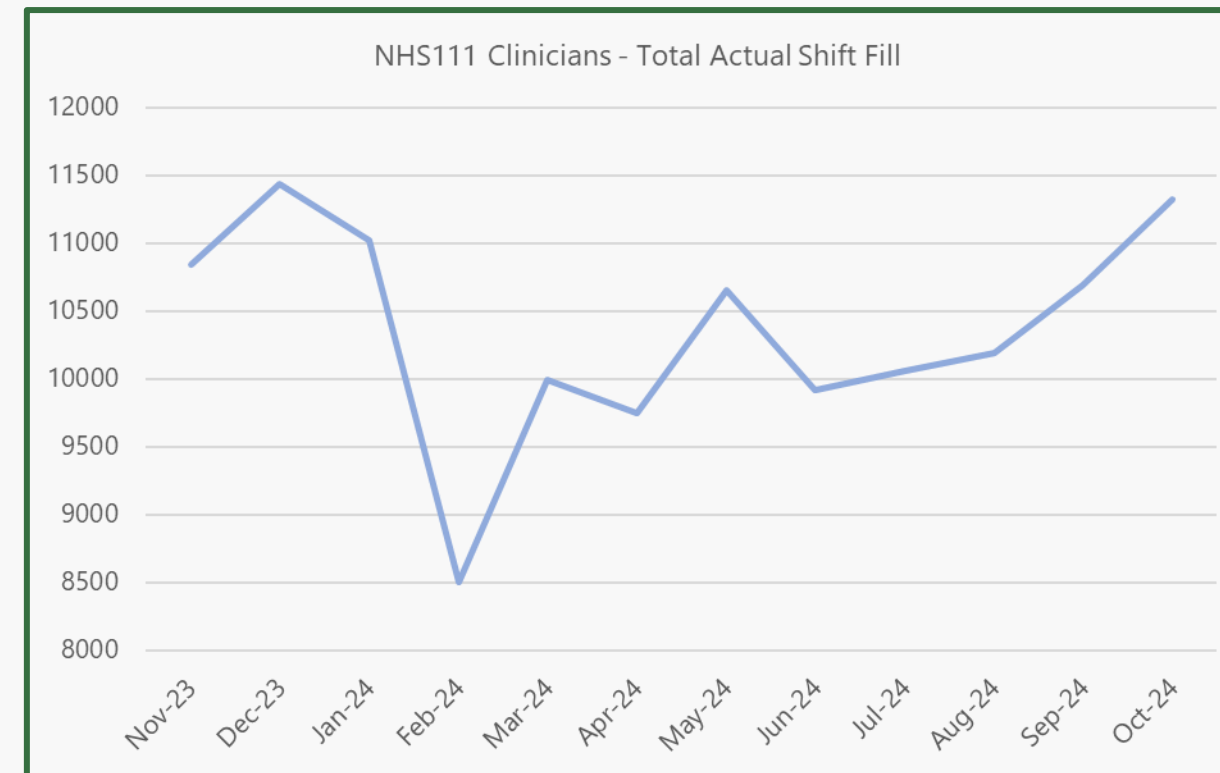
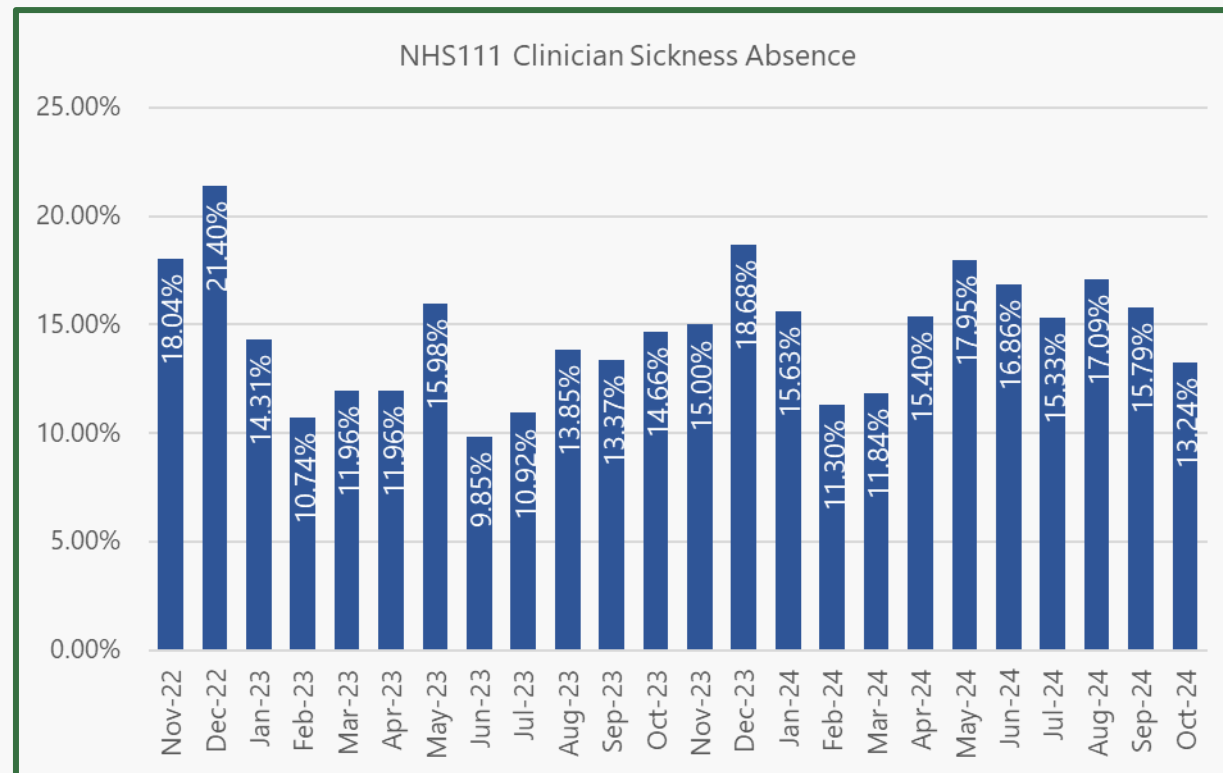
Remedial Plans and Actions

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

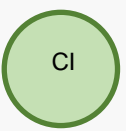
The new 111CAS will bring performance benefits. Welsh Government have asked that WAST model call handling performance through the winter. This is not the same as clinician performance, but should provide useful intelligence on what the Trust may achieve for clinical triage performance.



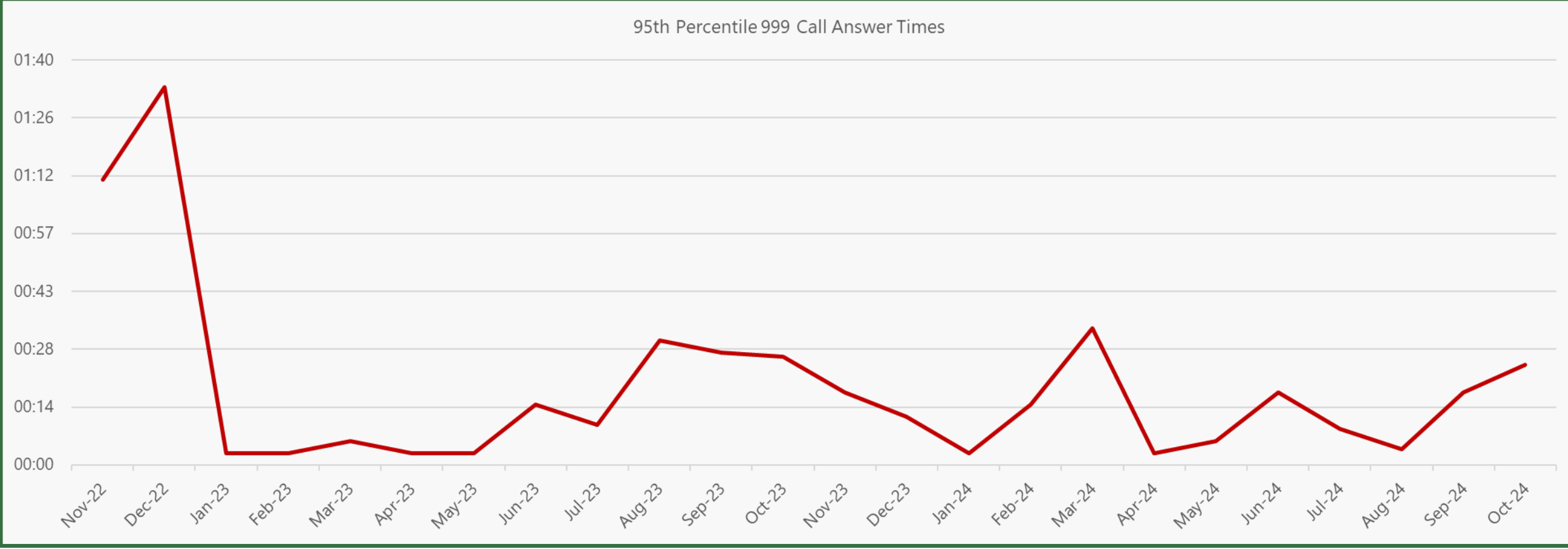
Our Patients: Quality, Safety & Patient Experience

999 Call Performance Indicators

(Responsible Officer: Lee Brooks)



Influencing Factors – Demand and Hours Produced



Analysis
 The 95th percentile 999 call answering performance did not achieve the 6 second target (00:25) in October 2024; however, the median call answer time for the 999-service remains consistently good at 2 seconds in September 2024.

There was an increase in demand in September 2024 to 44,000 calls from 42,707 in August 2024.

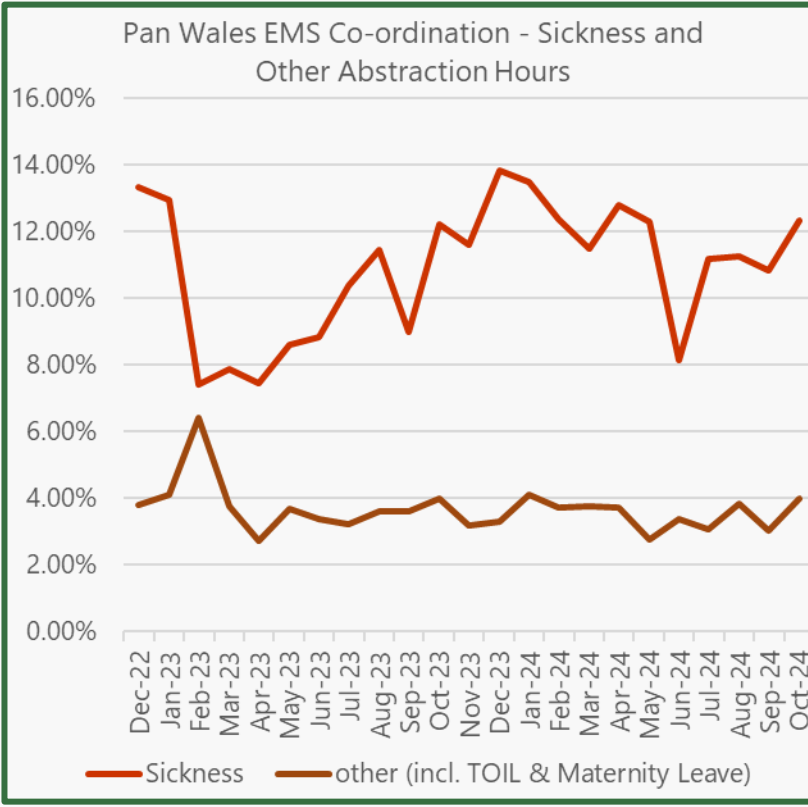
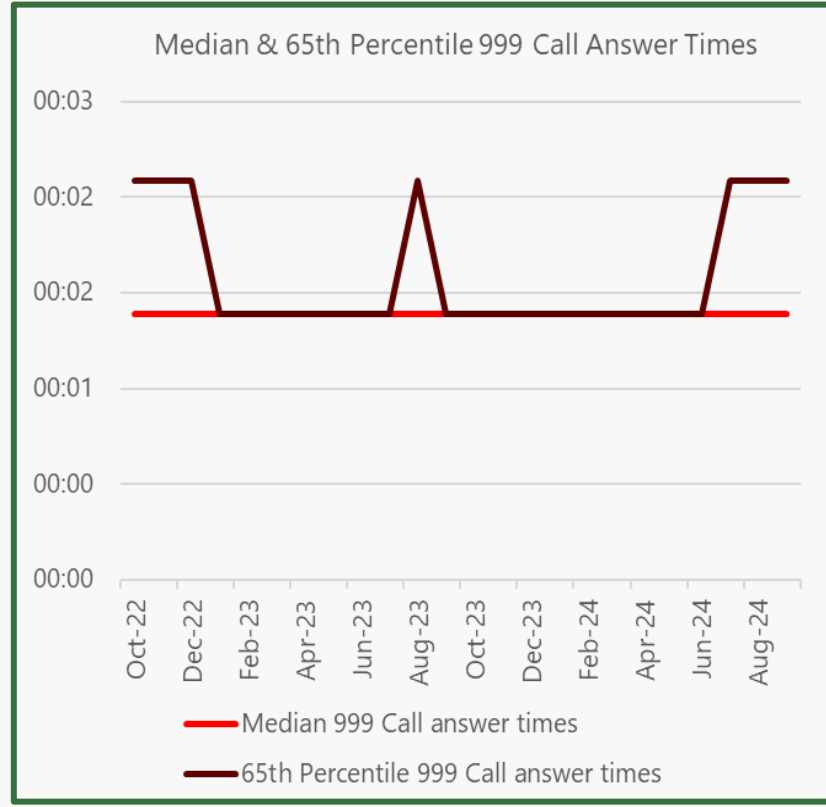
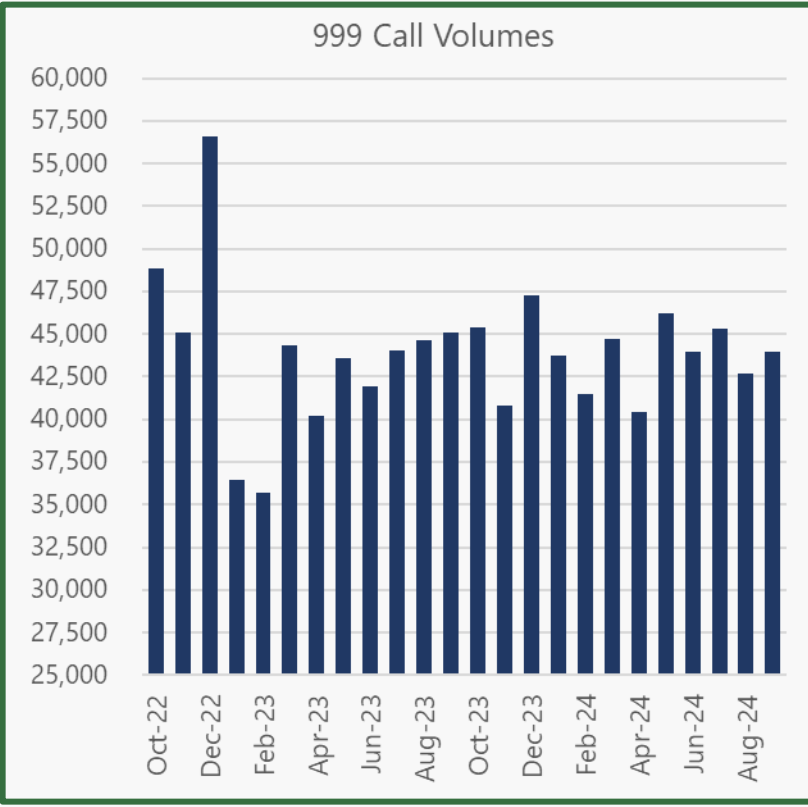
Sickness levels saw an increase from 10.82% in September 2024 to 12.34% in October 2024.

- Remedial Plans and Actions**
- Over establishment has been approved for EMSC by the Executive Director of Operations with call takers currently above establishment (105.76 FTEs v 122 WTEs).
 - Will continue to overrecruit for the next few months (as approved by the ADO and the EDOps) into the winter months which will also support potential losses from the Bryn Tirion move to ty Elwy.
 - Further recruitment drives in all three centres are planned for November, January & March with 12 per cohort.

A transformation programme is nearing conclusion (changes go live in Nov-24):

- **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.

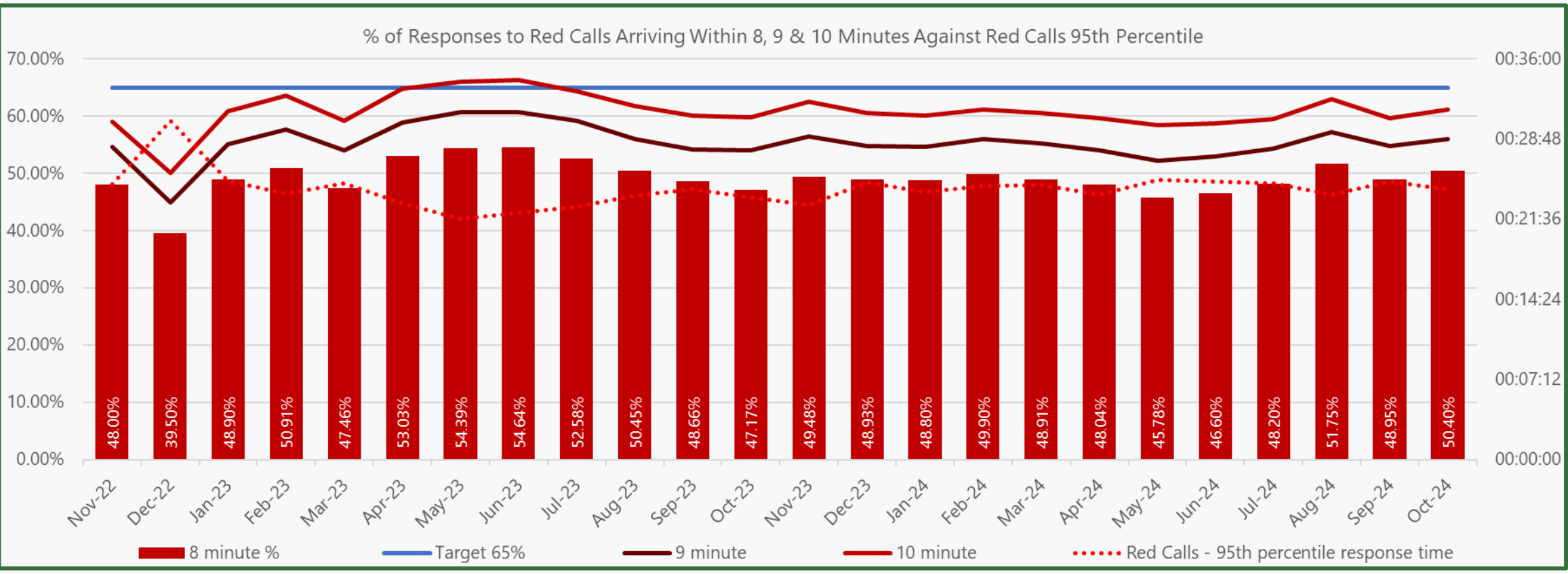
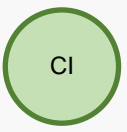
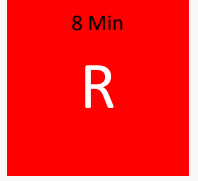


Our Patients: Quality, Safety & Patient Experience

Red Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)



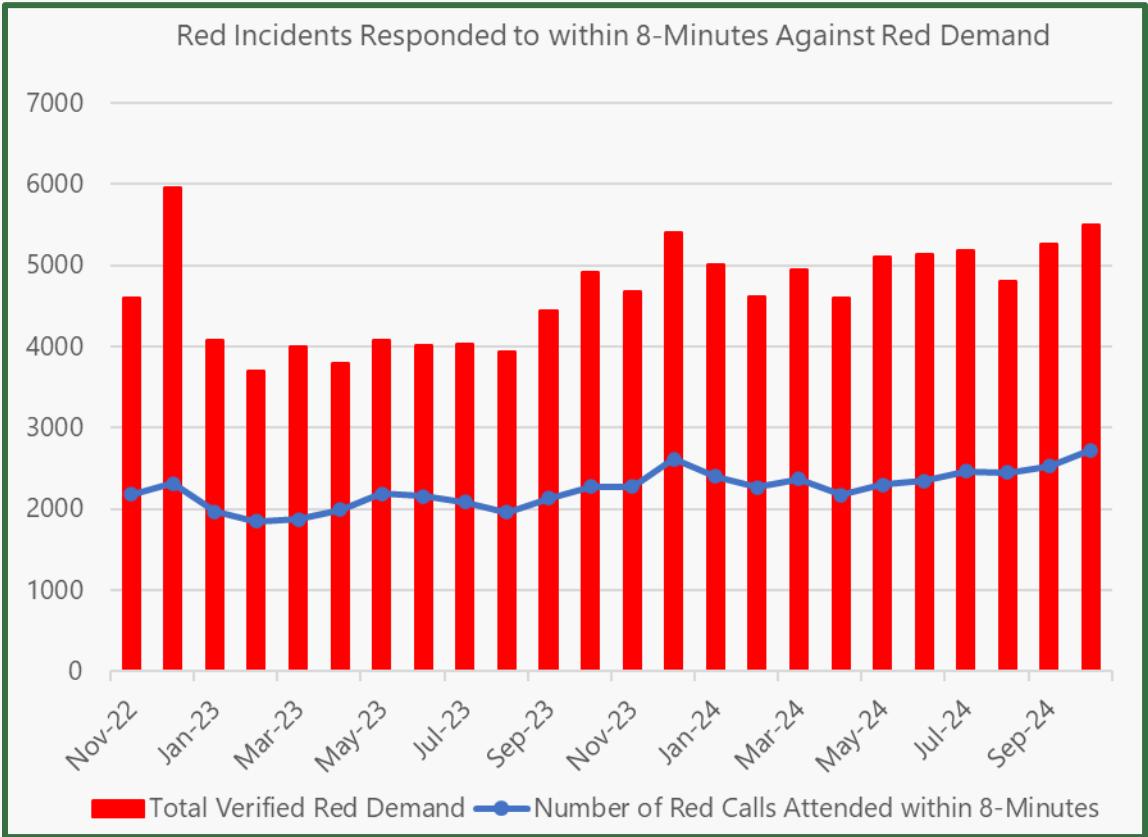
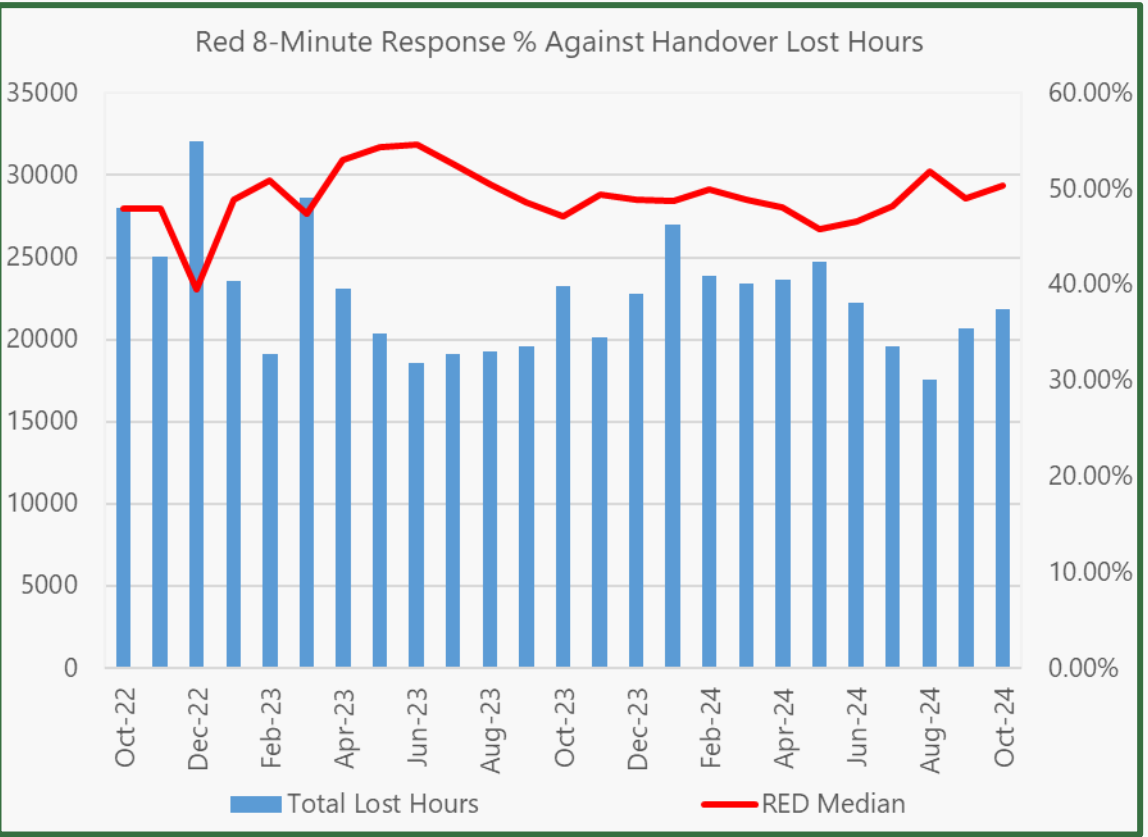
Analysis

Red 8-minute performance continues to remain below the 65% target increasing marginally during October 2024 to 50.4%.

Red 10-minute performance for October 2024 was 61.2%, 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 October 2024 being 11.8% higher than that seen in October 2023. As red demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for October 2024 of 2,723, being 19.5% higher than the figure for October 2023, and the highest figure yet recorded. 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**, which shows that as handover rates decrease, so red performance improves. There were 21,880 lost hours in October 2024.



Remedial Plans and Actions

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

- To maintain commissioned establishment in post levels overall.
- To recruit an additional cohort of 21 EMTs during November (linked to above).
- 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
- 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 winter has now been completed.

Our Patients: Quality, Safety & Patient Experience

Amber Performance Indicators

(Responsible Officer: Lee Brooks)

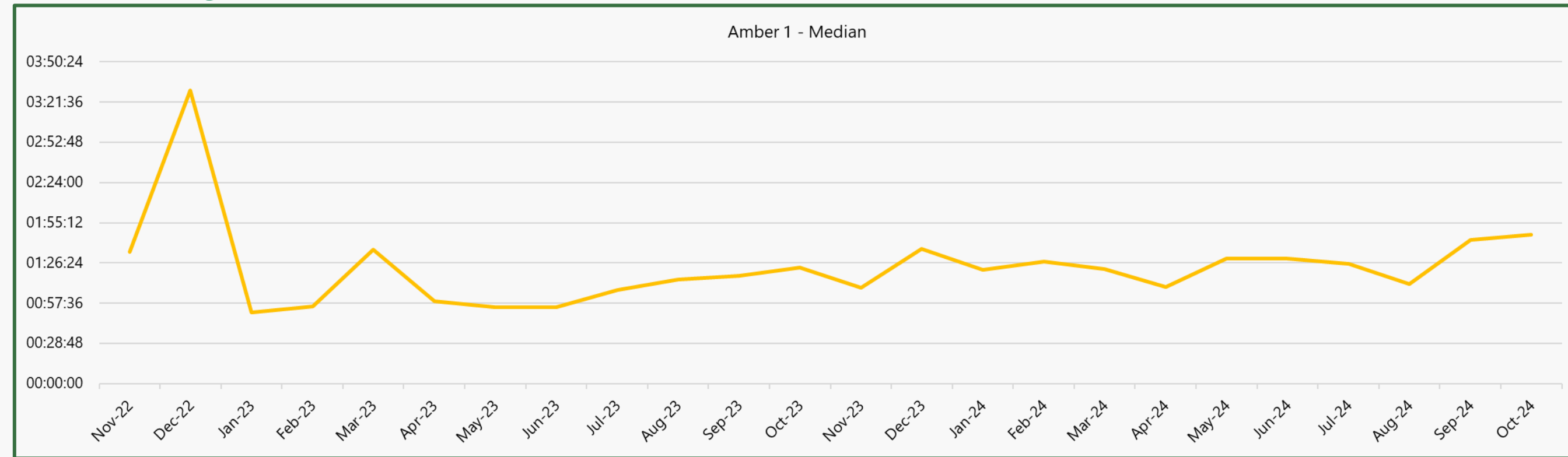
R

CI

FPC

QUEST

Influencing Factors – Demand, Hours Produced and Hours Lost



Analysis

The Amber 1 median performance time increased during October 2024 to 1 hour 46 minutes compared to 1 hour 43 minutes in September 2024. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile also increased during October 2024 to 7 hours 43 minutes, up from 6 hours 59 minutes in September 2024. This time remains far too long and remained above the 2-year average figure of 6 hours 35 minutes.

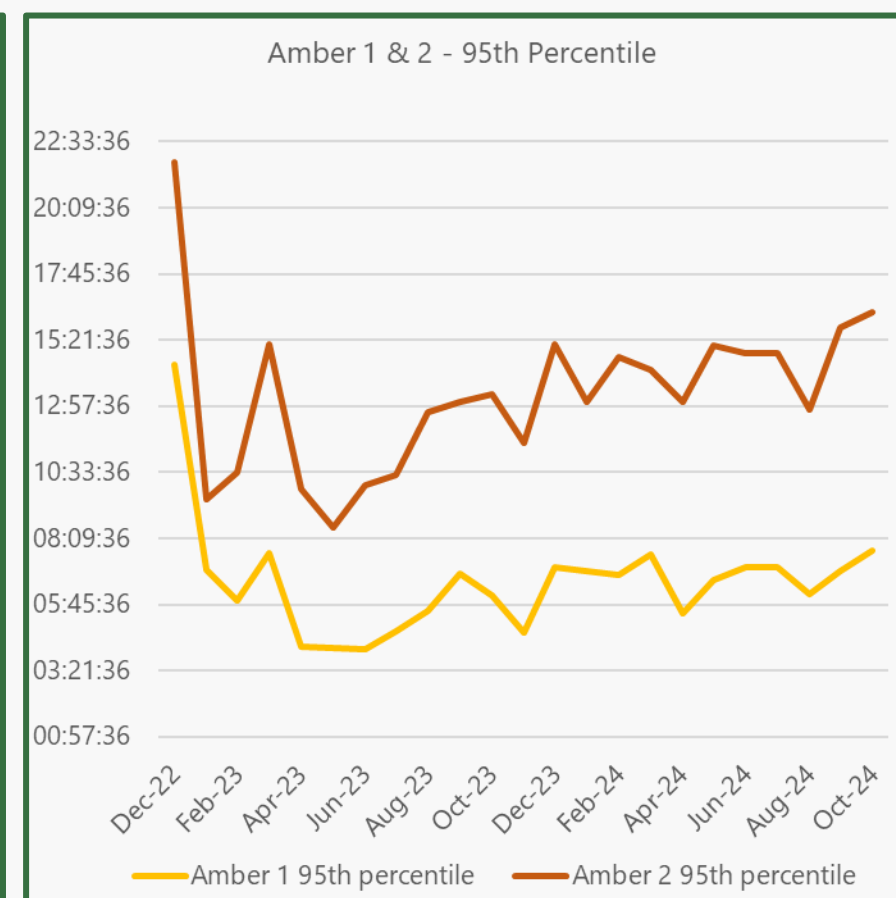
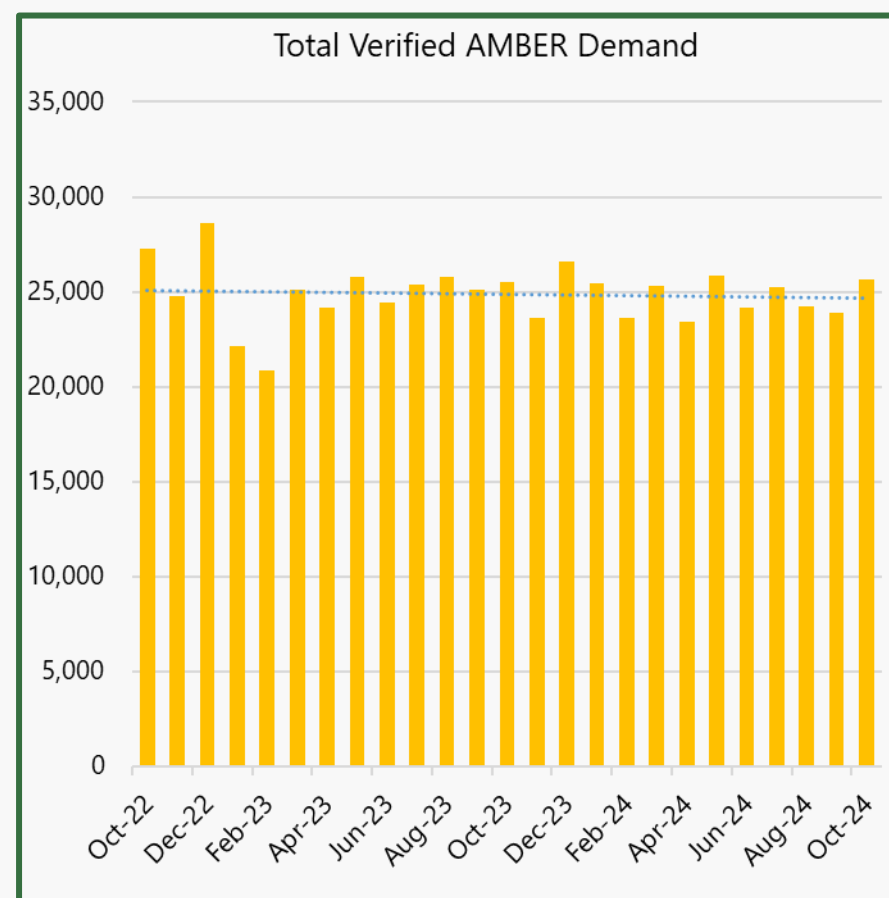
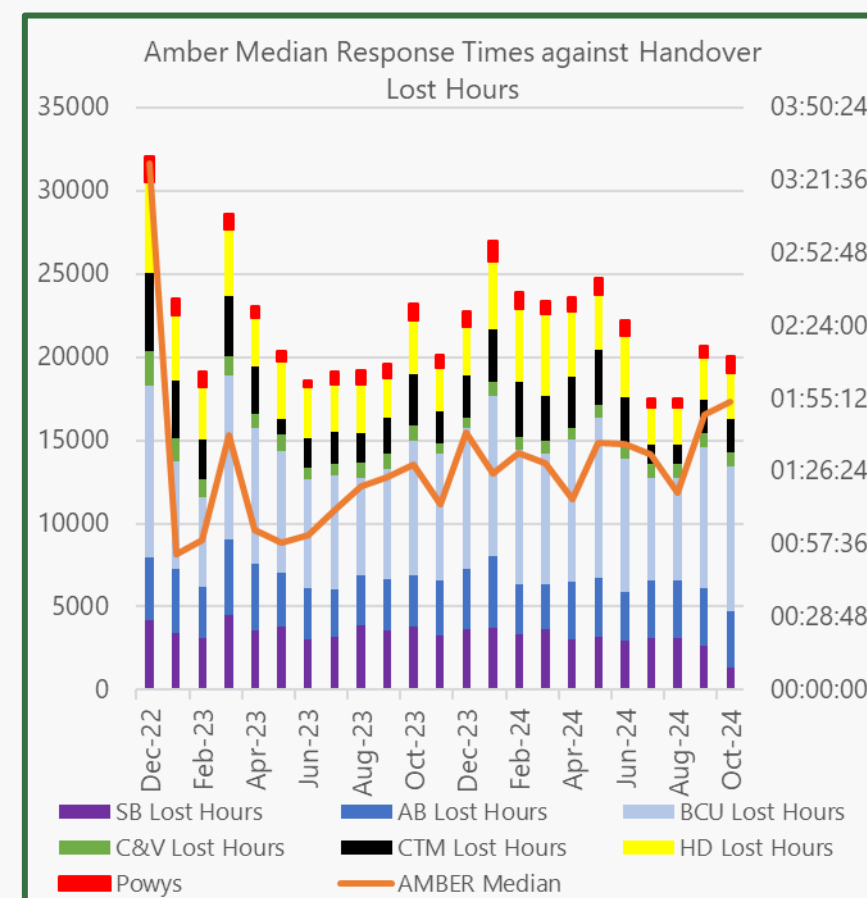
As with Red, there is a strong correlation between Amber performance and lost hours due to handover delays.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

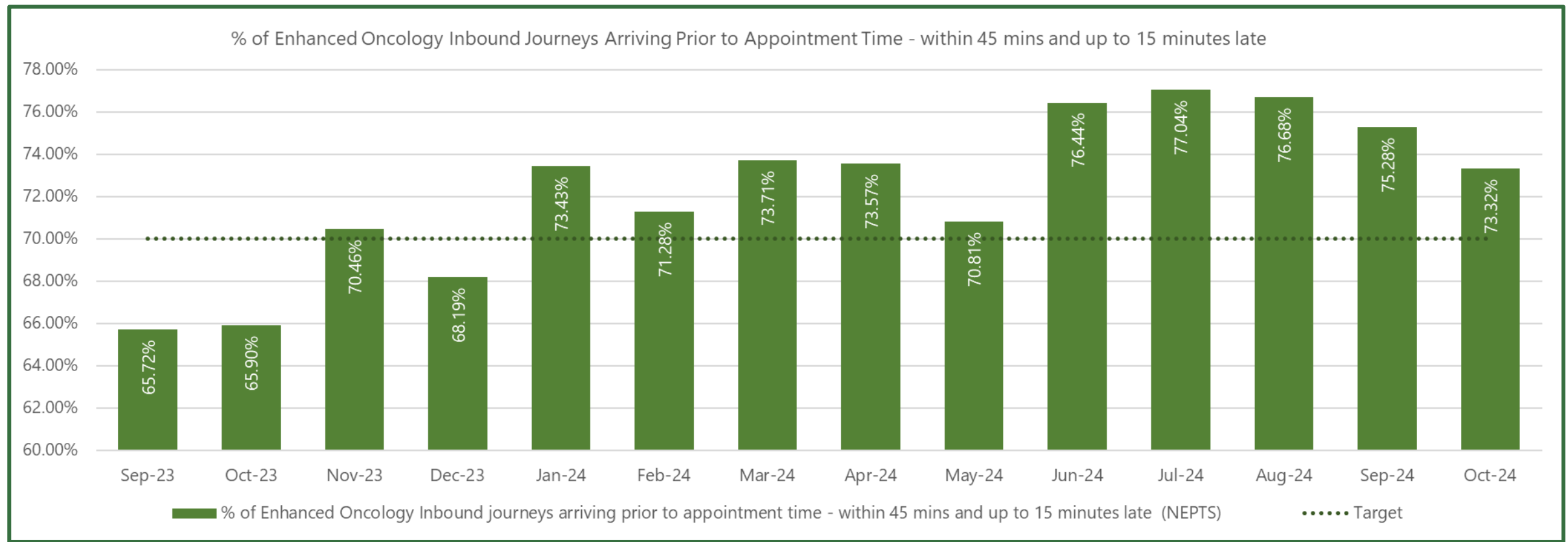


Our Patients: Quality, Safety & Patient Experience

Patient Experience – Influencing Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

D&T	Oncology	Welsh Calls
A	G	G
FPC	CI	



Analysis

73.32% of enhanced Oncology journeys arrived within 45 minutes prior and up to 15 minutes late of their appointment time, achieving the 70% target for the tenth 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 81% in October 2024, and a slight decrease from the 82% in September 2024.

Enhanced Renal journeys, decreased to 68.7%, which therefore did not achieve the agreed performance standard (70%) for the first time since March 2020 due to increased demand and increased system pressures.

Call volumes answered increased further in October 2024 to 20,465 compared to 17,662 in September 2024; however, the average speed of call answering improved from 4 minutes 55 seconds in September to 1 minutes 11 seconds in October.

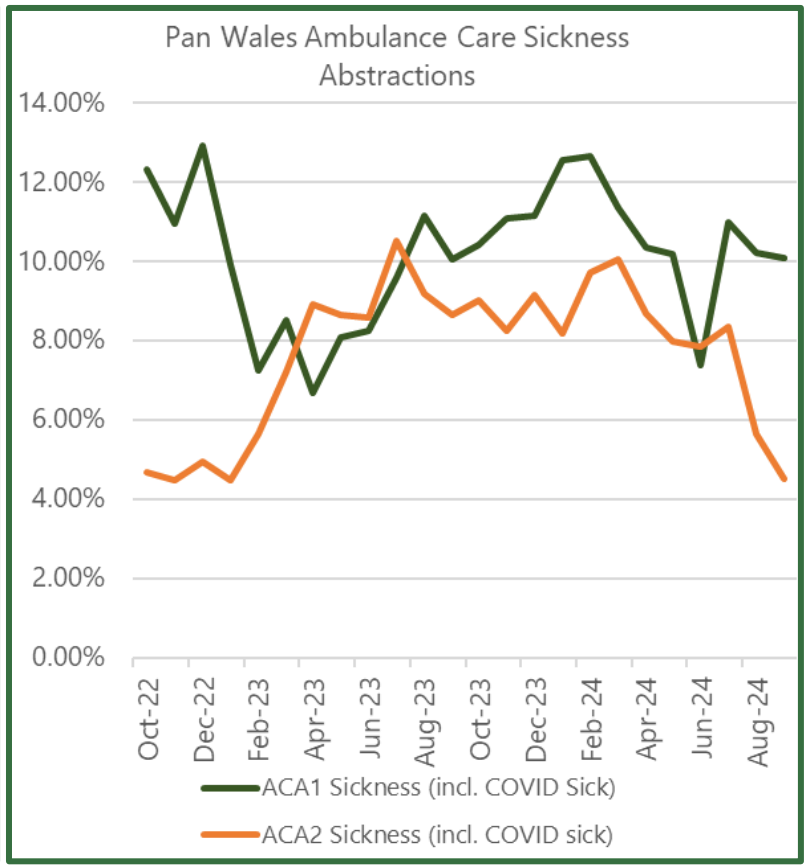
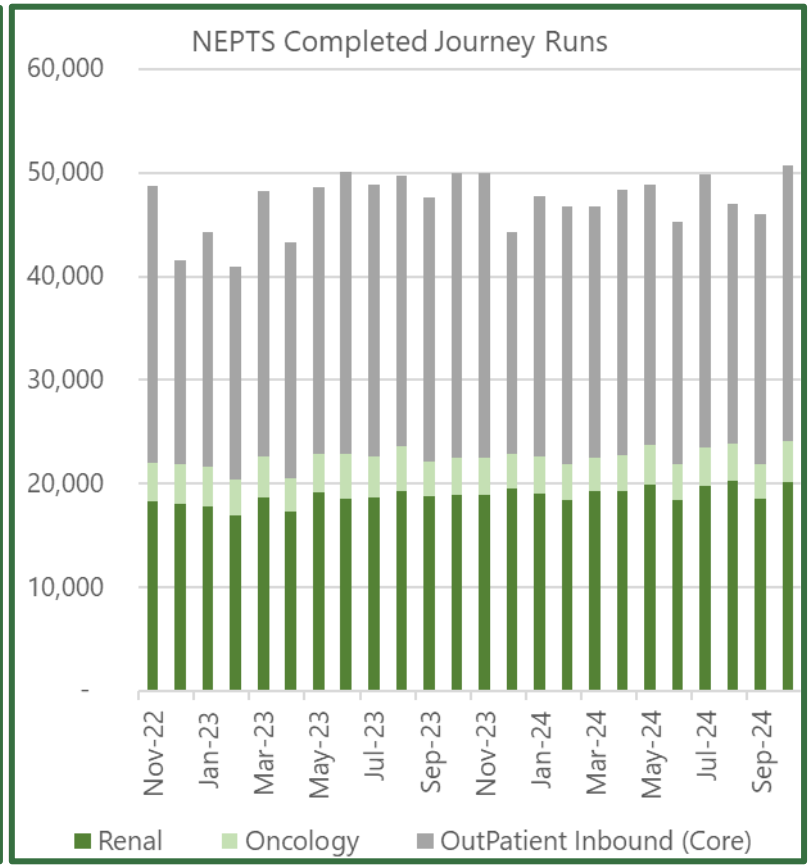
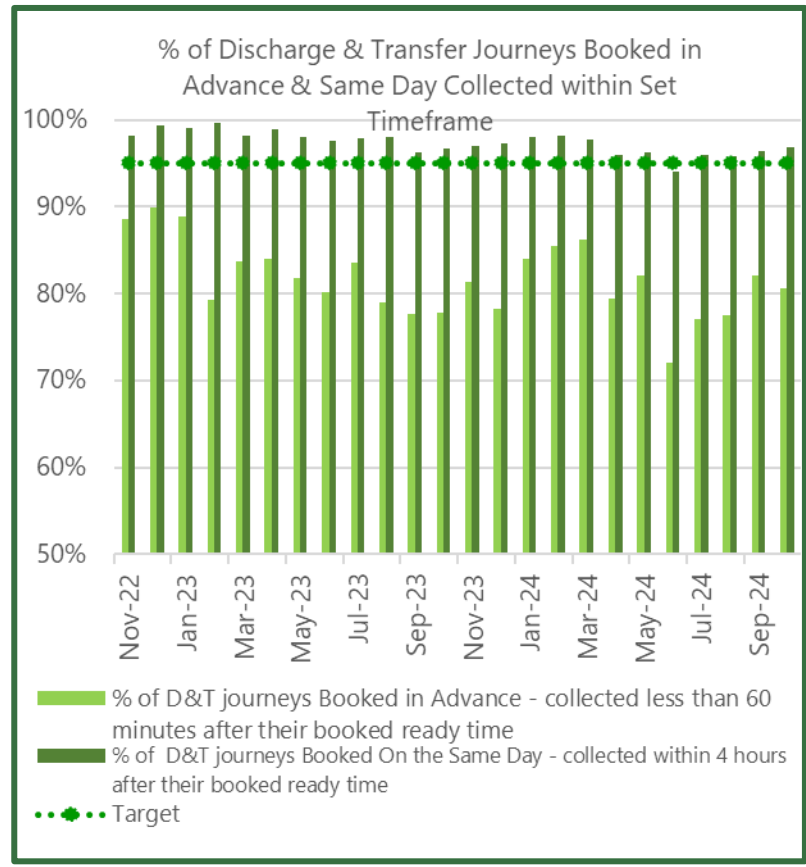
ACA2 sickness achieved the 5.99% target, attaining 4.51% in September 2024.

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

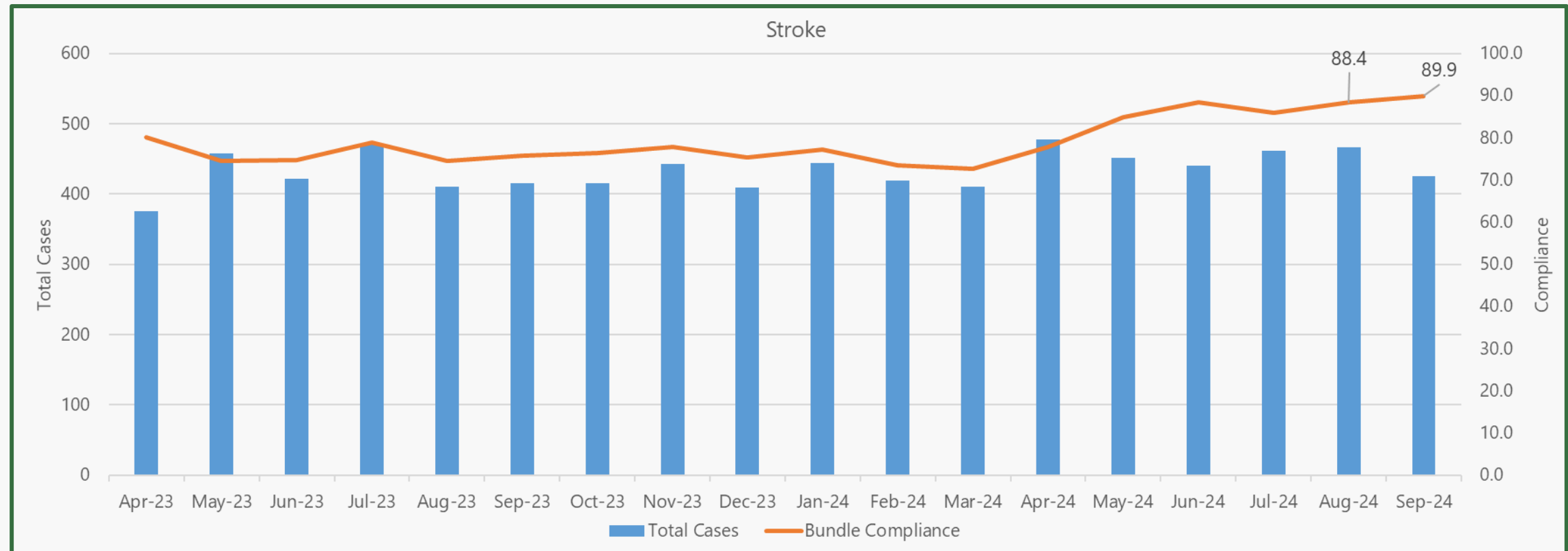
Clinical Indicators

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

Stroke	ROSC	STEMI	Self-Assessment: Strength of Internal Control: Moderate
A	G	R	

QUEST

(Responsible Officer: Andy Swinburn)



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

Stroke – 89.9%, an increase from 88.4% in August. A recent update to the scripting contributed to the improved compliance. 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 interventions.

STEMI (heart attack) – 70.0%, an increase from 59.0% in August. There was an improvement in all four criteria which contributed to the improved bundle compliance. User Interface changes for justified exceptions with GTN to improve electronic Patient Clinical Record completion and compliance will be implemented in October/November. A 'nudge' is also planned to improve compliance to Aspirin and GTN.

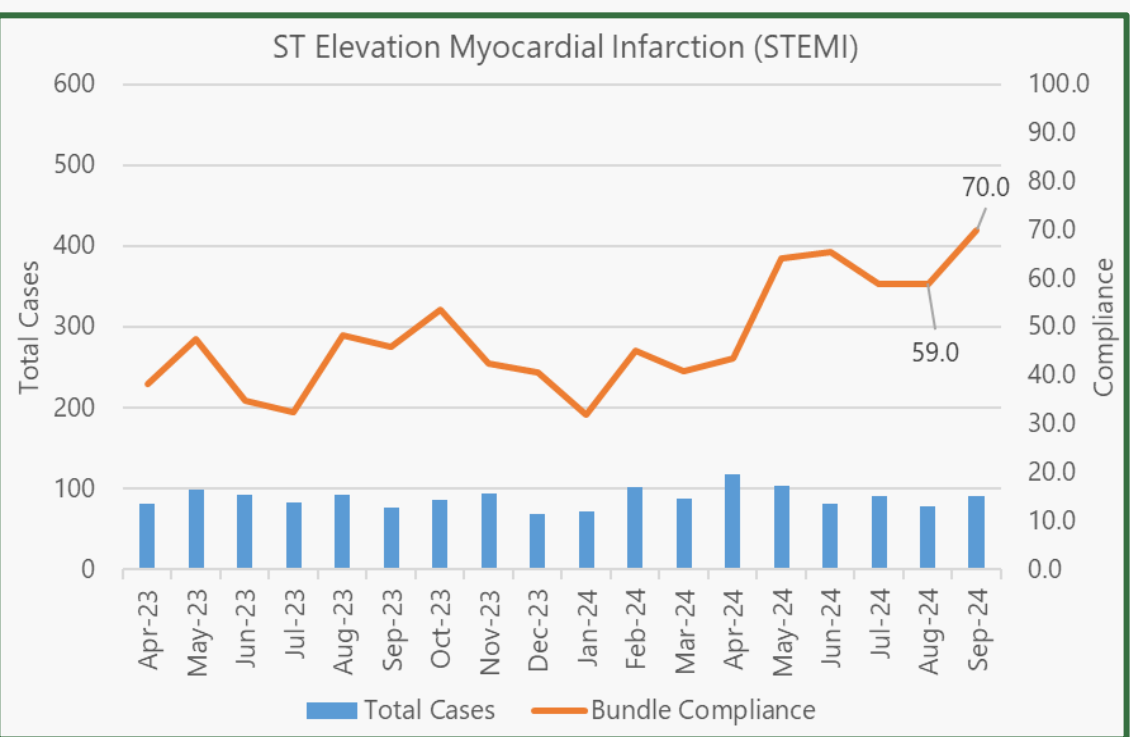
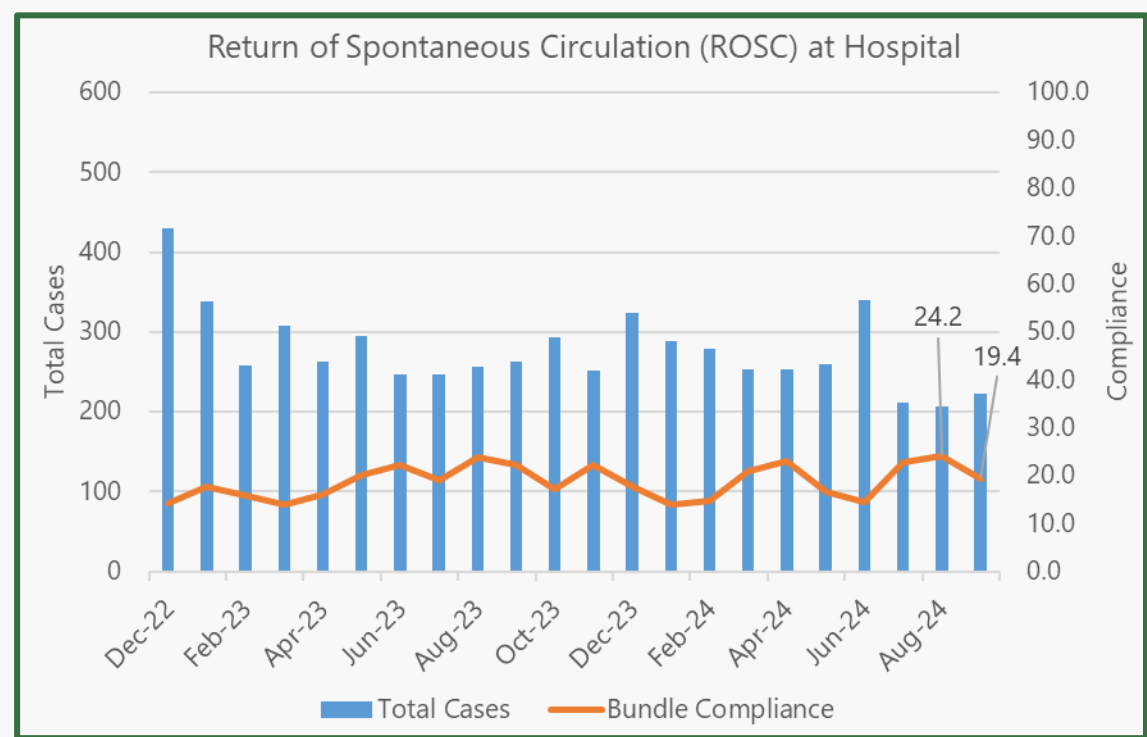
Return of Spontaneous Circulation at hospital (from cardiac arrest) – 19.4%, a decrease from 24.2% in August. Issues with the ROSC coding scripting were identified and subsequently updated from the July 2024 figures, which now shows a step change with August being the highest since ePCR was implemented.

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 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. 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.

Further electronic Patient Clinical Record User Interface changes are planned for the next ePCR update scheduled for Spring 2025 and the impact will be monitored.



Our Patients: Quality, Safety & Patient Experience

Clinical Indicators

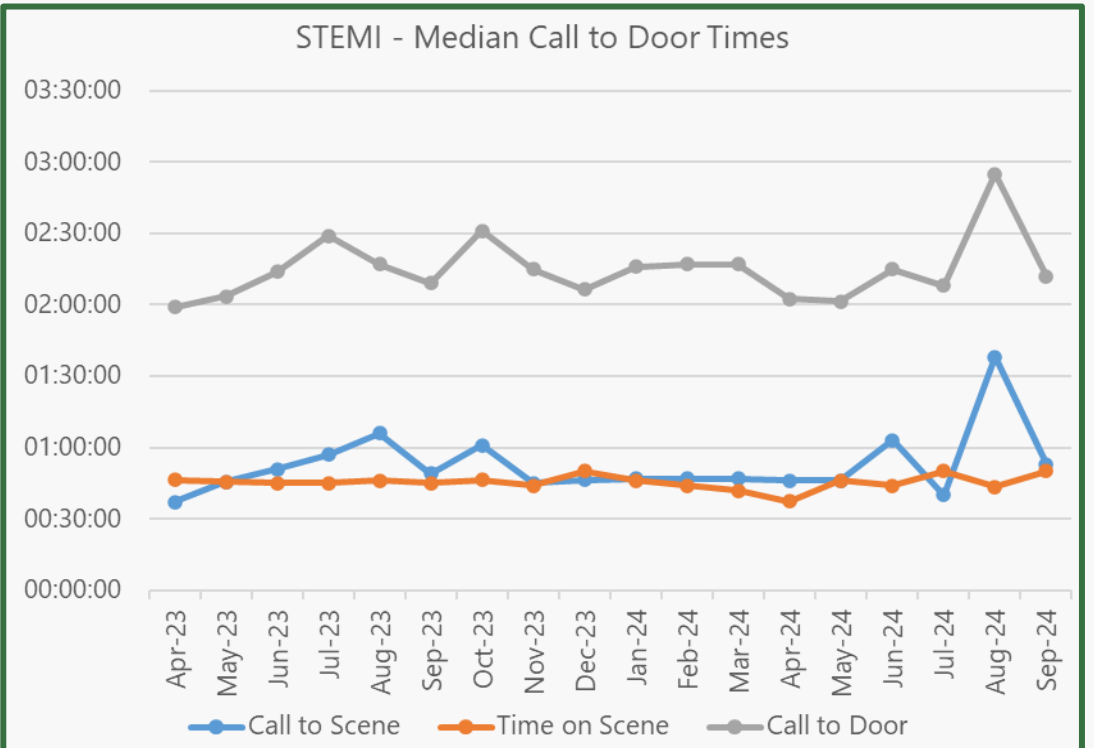
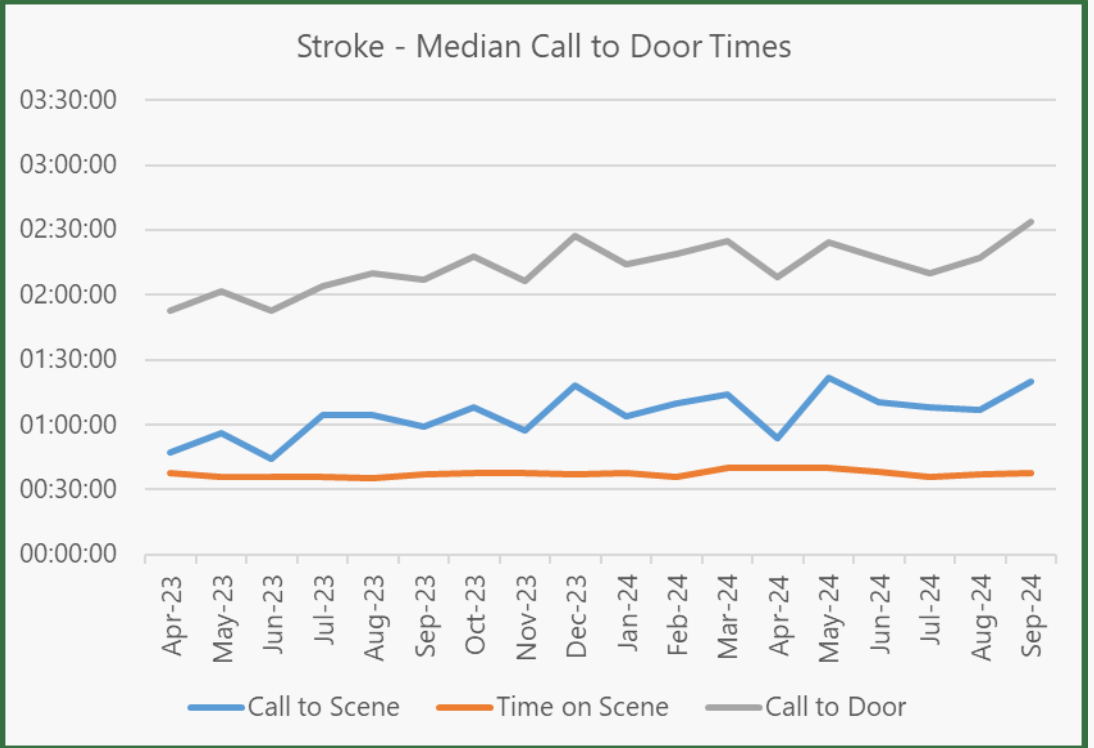
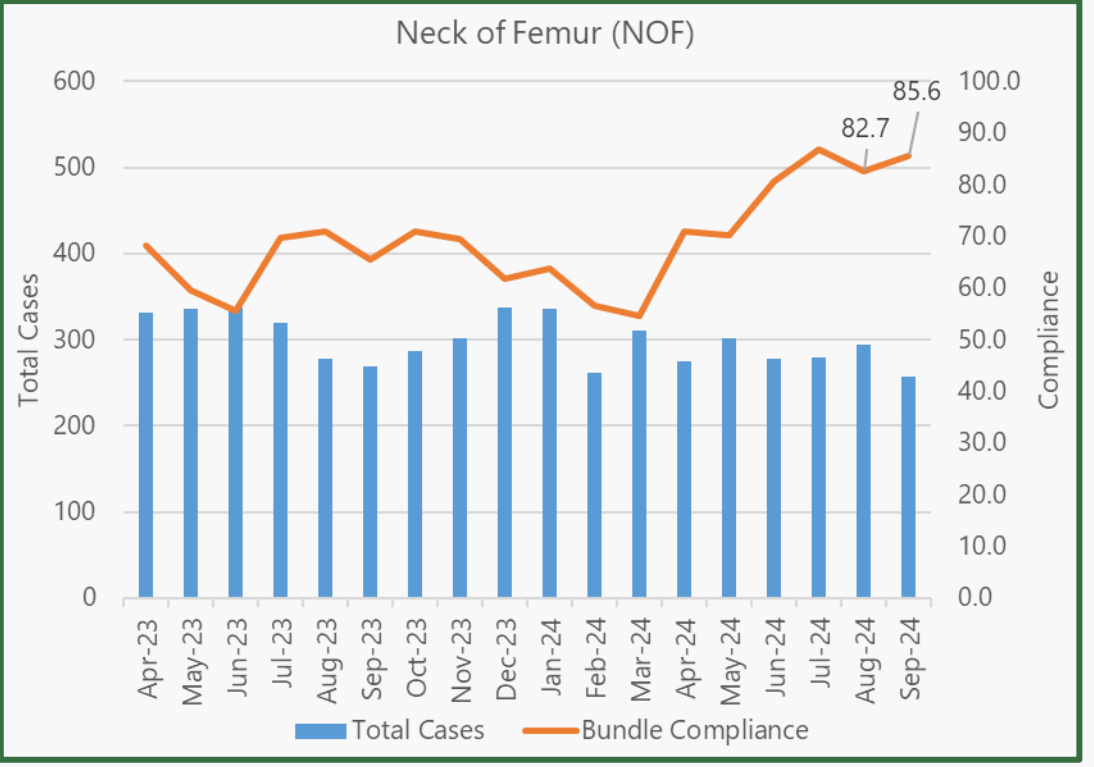
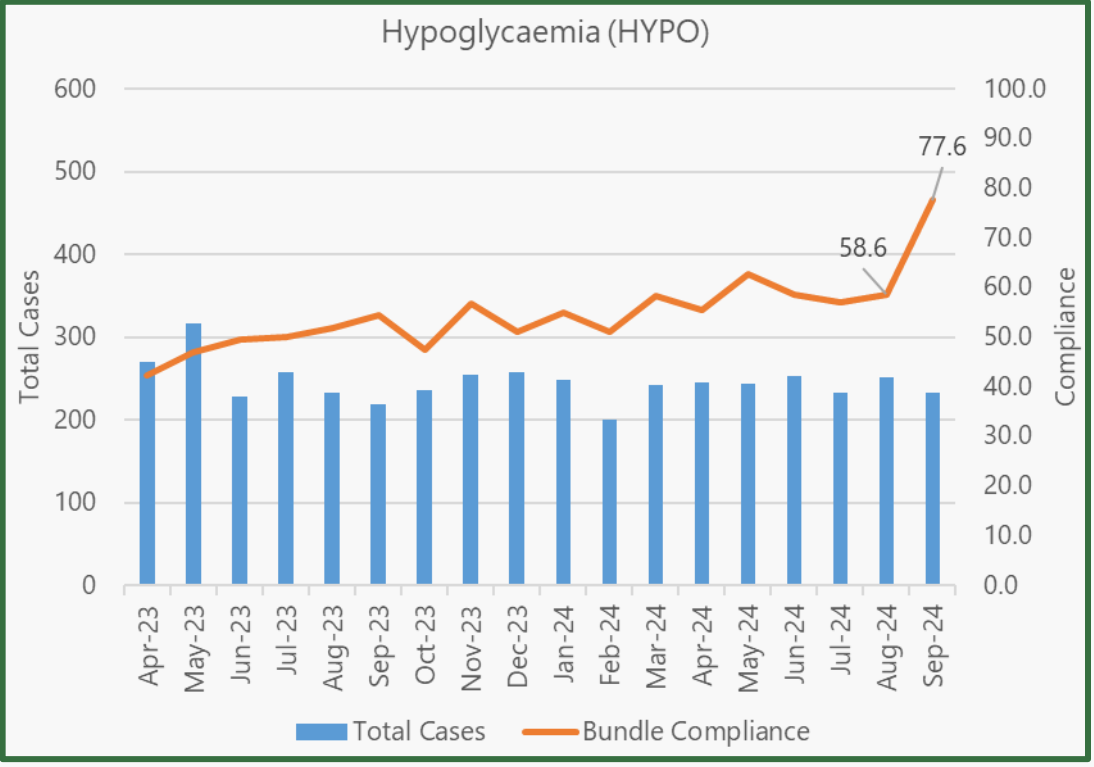
Hypoglycaemia, Fractured Neck of Femur (#NOF) and Time-Based metrics (Stroke & STEMI)

(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 **September 2024** was:

Hypoglycaemia (diabetic patients with low blood glucose) – 77.6%, an increase from 58.6 % in August. A recent update to the scripting contributed to the improved care bundle compliance. There has also been an increase in documenting each of the criteria for this care bundle; pre & post treatment blood glucose checks as well as treatment administered.

Fractured Neck of Femur (hip fracture) – 85.6%, an increase from 82.7 % in August. The use of a 'nudge tool' for analgesia implemented in June provided a prompt when important information is not documented. Compliance has consistently improved for this since then, with September analgesia being 96%, the highest since the electronic Patient Clinical Record was implemented.

Call to door times for Stroke and STEMI – the data has returned to a more consistent level for STEMI following the anomalies noted for August across WAST which were due to two incidents with a significantly extended incident cycle time.

Remedial Plans and Actions

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

- Focused 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.
- Following the success of the 'nudge' tool with analgesia for Fractured Neck of Femur (hip fracture), further 'nudges' are being implemented in a stepwise approach, those for Aspirin & GTN with STEMI, and aspects of ROSC are scheduled during October.

Expected Performance Trajectory

As a result of the work from the CI Recovery Group T&F group and the ongoing improvement interventions, a continued increase in compliance rates is expected and will be monitored by the Clinical Intelligence & Assurance Group.

Our Patients: Quality, Safety & Patient Experience

Patient National Reportable Incidents & Patient Concerns Responses Indicators

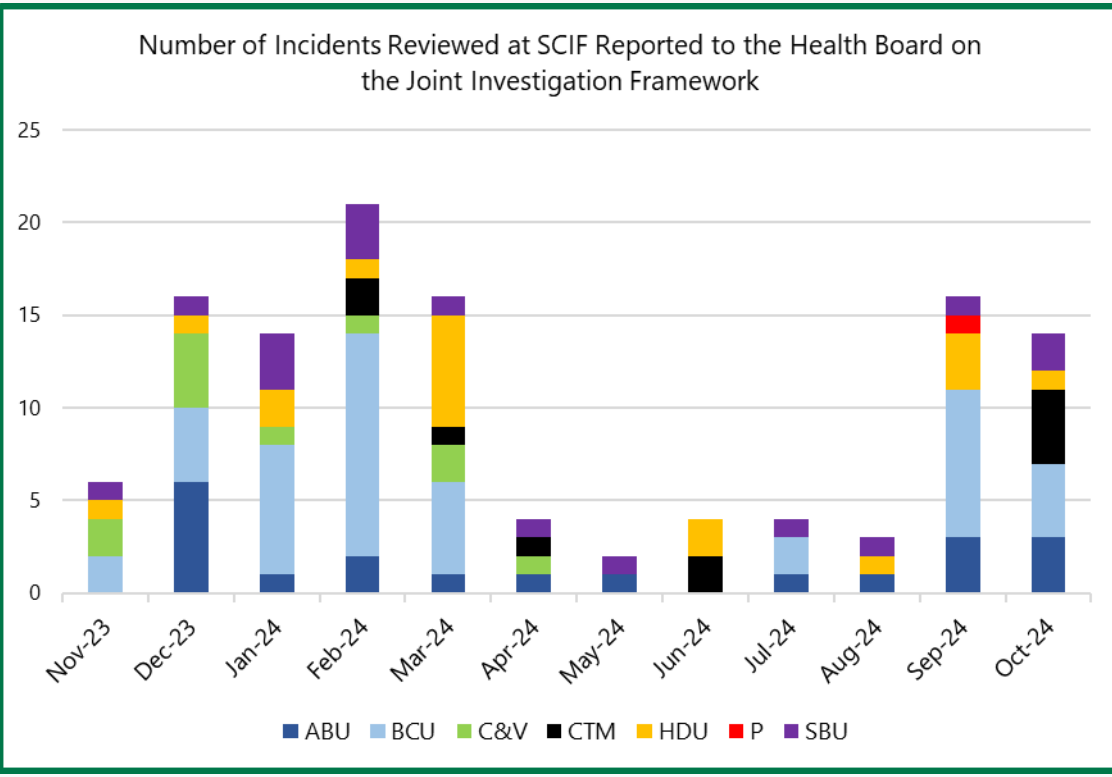
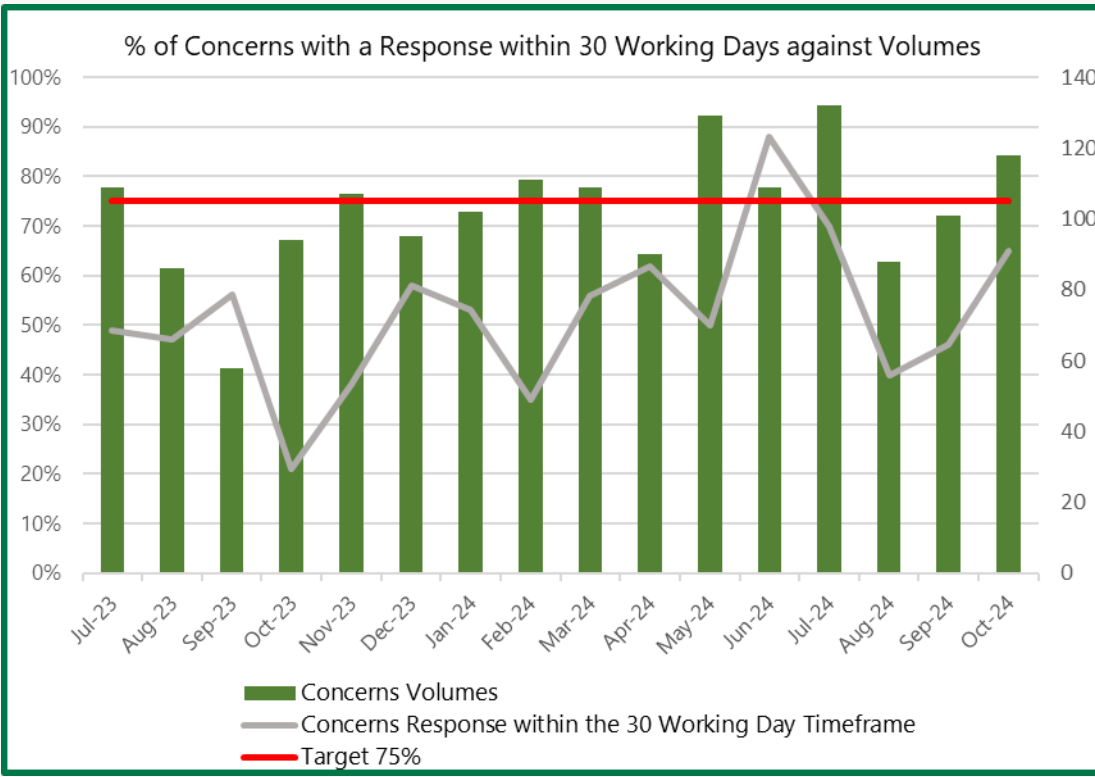
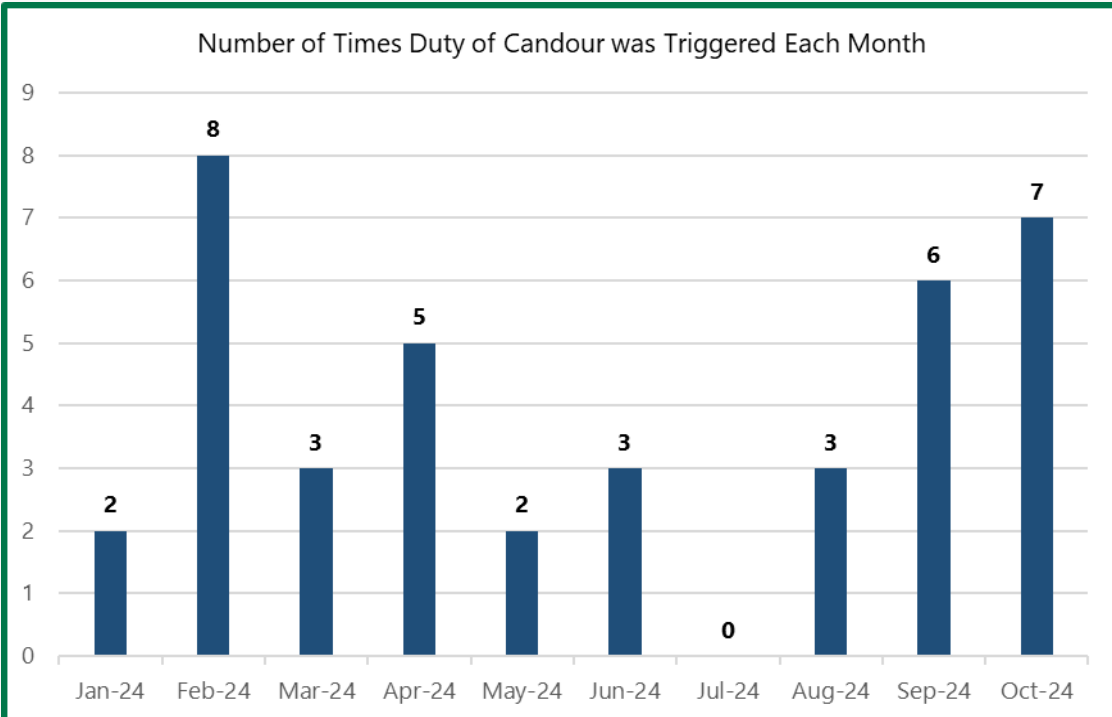
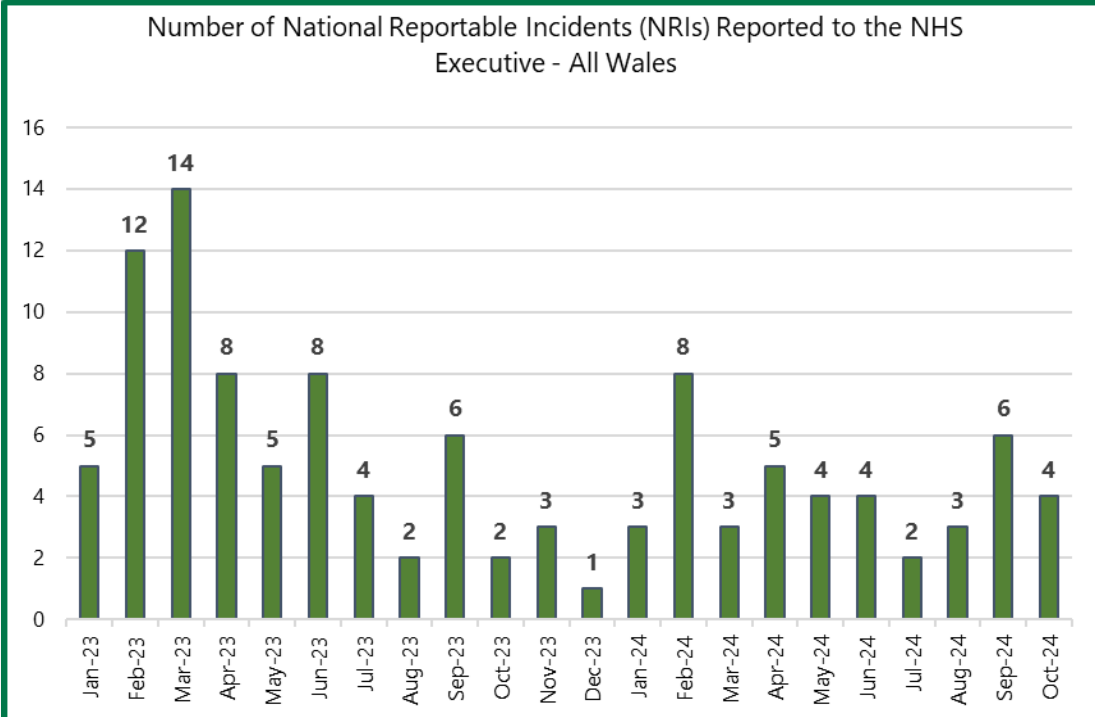
(Responsible Officer: Liam Williams)



Self-Assessment:
Strength of Internal Control:
Moderate



Health & Care Standard
Health - Safe Care / Timely Care



Analysis

The Trusts response to achieving 75%, 30 working day compliance has seen an improvement, increasing from 46% in September to 65% in October. This has been due to the teams focus on resolving long-standing complaints and the total number of open cases.

4 NRI's were reported to the NHS Wales Executive in the previous month.

Duty of Candour Regulations (2023): An "in-person" notification is made when the Trust becomes aware of notifiable adverse outcomes. 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. A 100% attempt to contact patients and families was achieved during October 2024.

Remedial Plans and Actions

- Recruitment to the full PTR establishment is completed.
- Continued improvement in achieving objectives within the Putting Things Right Recovery plan have been achieved in October 2024.
- The Family and Relations team will continue to focus on closing open cases along with identification of areas of improvement for concerns that missed 30-day compliance by 2 days.
- The PTR team has established "live call taking" which has seen an improvement in the 5-day acknowledgement, and improved customer service for our families and patients.

Expected Performance Trajectory

The PTR Department will, over the coming months, continue to focus on ensuring that recent improvements in the timeliness of complaint responses are sustainable and that we reduce the longest waiting complaints.

Full establishment and return of staff from sickness within the Patient Safety Team, has seen improvement in the timeliness in identification of NRI's, closure of NRI's and identification of moderate incidents requiring 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

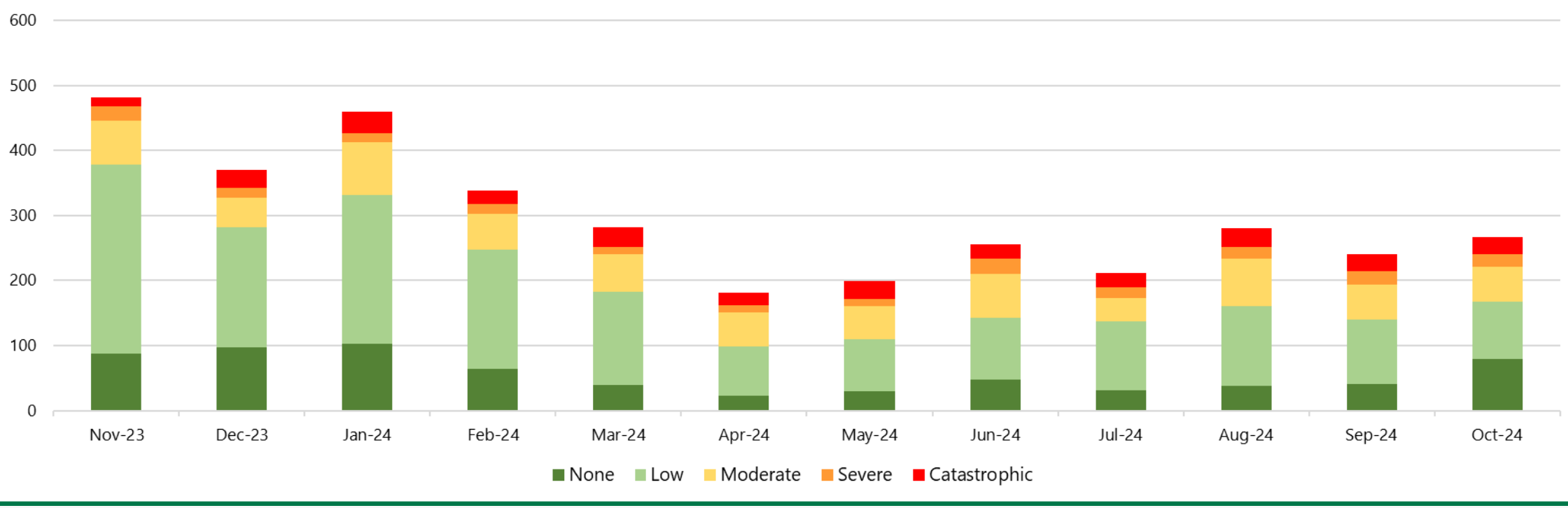
Self-Assessment:
Strength of
Internal Control:
Moderate

QUEST

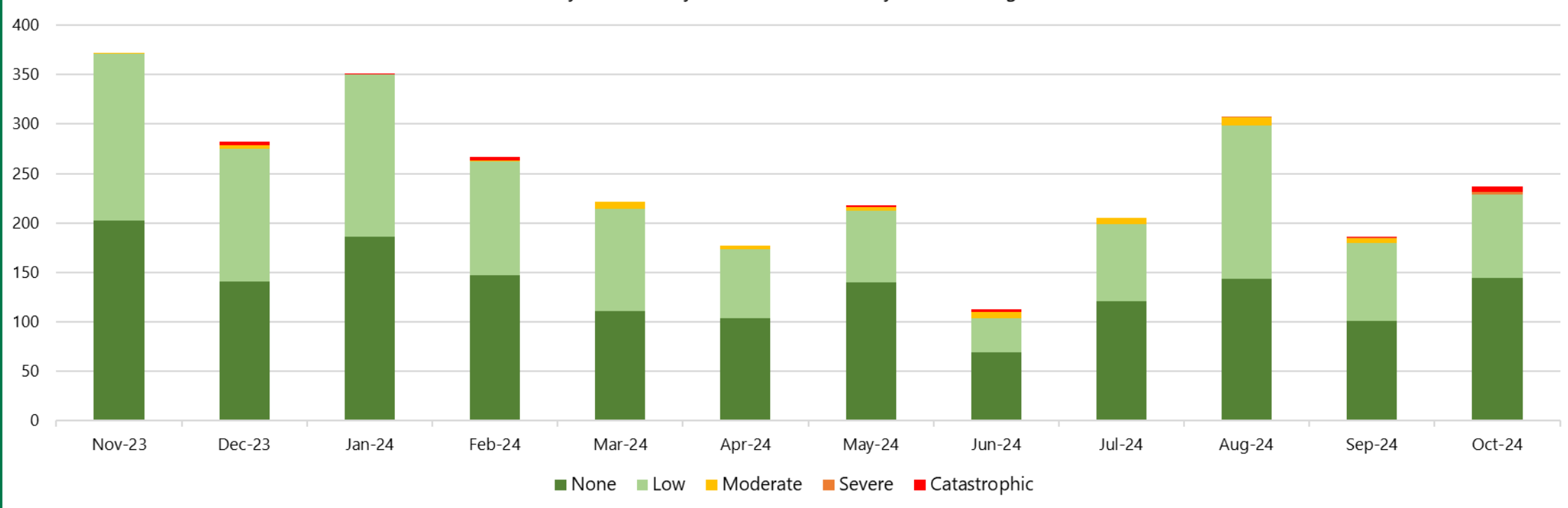
(Responsible Officer: Liam Williams)

Health & Care
Standard
Health – Safe Care

Number of Patient Safety Incidents Reported by Month by Initial Harm Assessment



Number of Patient Safety Incidents by Month Closed and by Post-investigation Harm Assessment



Analysis

An increase in incident reporting during October 2024 compared to September 2024 is observed across incidents where the harm grading is none, moderate and catastrophic with a minor decrease in harm reported as low and severe. 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) however the introduction of the Rejection SOP by the Quality Team has reduced the risk of duplication. Incident volumes include those reported internally by WAST staff but also those reported by Health Board colleagues about WAST services or care.

Harm levels for October 2024 were: -

- No harm or hazard - 79
- Low - 88
- Moderate - 54
- Severe harm - 19
- Catastrophic/Death - 26

This is an improved trajectory on September 2024. The patient safety team will continue to support the service areas, to improve the timeliness to closing of moderate and above patient safety incidents.

Remedial Plans and Actions

- The PTR team continue to focus on the priorities outlined in the departmental Recovery Plan to improve the Trusts position and performance across a number of quality metrics and Tier 1 targets.
- Work is progressing in respect of the development of dashboards and the aggregation of data 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.

Data source: Datix

Our Patients: Quality, Safety & Patient Experience

Coroners, Mortality and Ombudsmen Indicators

(Responsible Officer: Liam Williams)

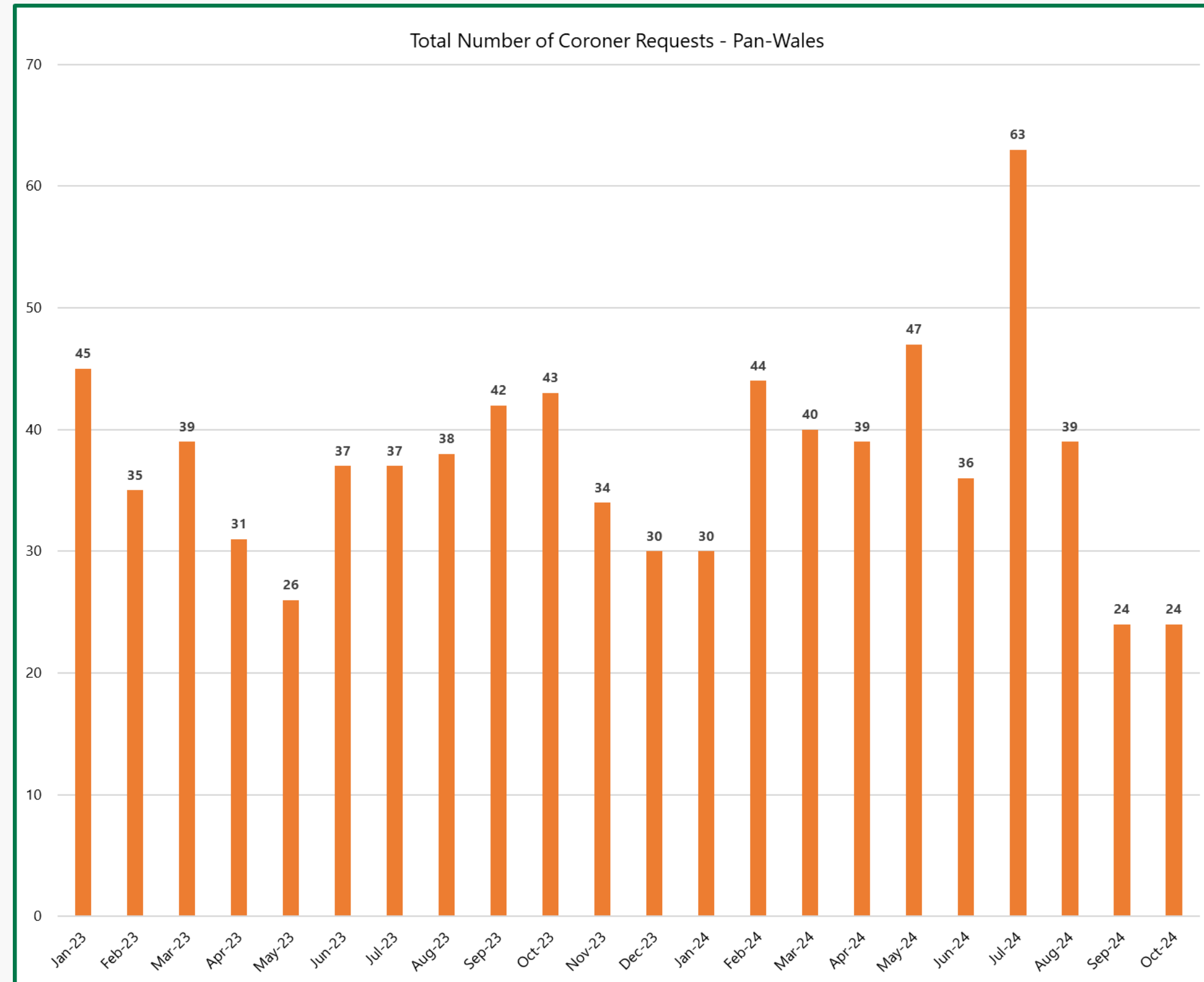
Coroners
Self-Assessment:
Strength of
Internal Control:
Moderate

Mortality
Self-Assessment:
Strength of
Internal Control:
Moderate

QUEST

Health & Care
Standard
Health – Safe Care

Total Number of Coroner Requests - Pan-Wales



Analysis

The number of coroners requests in October 2024 has been similar to September 2024 and a reduction in comparison to the last 15 months. However, the complexity of the cases remains high, with multiple statements and actions per approach.

The introduction of a dedicated Coroner's coordinator within the Operations Quality Team, has allowed for cross working, and a central point of access for the legal services team, which in turn has seen improvement in the quality in preparing regulation 28/learning statements. During October 2 Regulation 28 reports were received.

Mortality - Since September 2024, the Trust has started to receive cases from the medical examiner in relation to community deaths. The patient safety team, have completed a significant number of Level 1 mortality reviews, which is achieved by triaging cases on a weekly basis. The process is now embedded within both teams.

In October 2024, the first ME learning panel took place which was equivalent to the level 2 MDT screening panel outlined in the national Mortality Review Framework. During October 2 Public Interest Ombudsman Draft Reports were received from the PSOW. Public Interest Reports have not been received in relation to the Trust previously.

Remedial Plans and Actions

- As captured in the PTR recovery plan, the Ombudsman work has been moved from the Legal Services team to the family and relations team.
- Learning from Events (LFER's) has also been moved from the legal services team to the patient safety team.
- The legal services team will continue to develop robust processes with the operations quality team to continue to provide timely responses to coroners and explore opportunities for learning to prevent Regulation 28 reports.
- Mortality - The PTR team are continuing to work with our digital, Datix and once for Wales colleagues, to develop reporting metrics, capturing themes and trends in relation to learning from deaths.

Expected Performance Trajectory

With the Medical Examiners Service becoming a legislative body from September 2024, it is likely that the number of patients who die within the community and are referred to the Coroner will rise, thus there is the possibility of increased numbers of statement requests being sent to the legal services team. The removal of the Ombudsman and LFER's to other teams within the PTR function, has mitigated the risk of missing coroners' deadlines.

Our Patients: Quality, Safety & Patient Experience

Safeguarding, Data Governance & Public Engagement Indicators

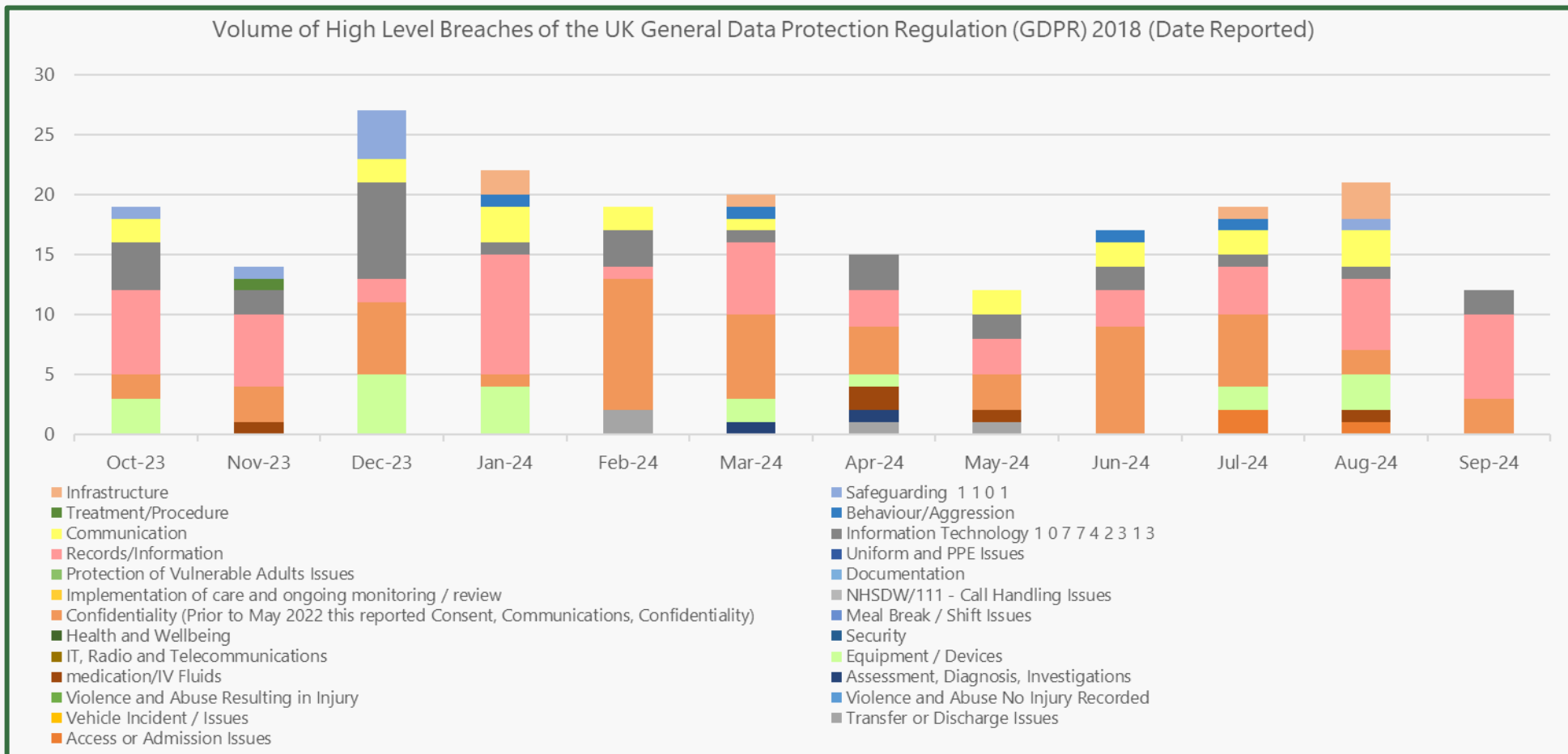
(Responsible Officers: Jonny Sammut & Liam Williams)

Self-Assessment:
Strength of Internal Control:
Strong

Health & Care Standard
Health – Safe Care

PCC

NB: Data quality issues have been identified within Safeguarding. 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 a 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 September 2024, there were 12 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 12 breaches, 3 related to IG/Confidentiality, 7 Records/Information, and 2 Information Technology.

Public Engagement: During September, PECCI attended 15 community engagement opportunities, engaging with approximately 1,628 people. This included attending the Cardiff 999 Emergency Services Day and North Wales Police Open Day. This month we also attended the Cardiff Metropolitan University and University of Cardiff Student Fresher Fayres. At these events we were able to talk to young adults about their experiences of using the service as well as promoting the safe and appropriate use of services, promote the NHS 111 Wales service and the Press 2 option for people struggling with their mental health. We continued to engage with colleagues from Llais and attended 2 meetings with regional branches.

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.

Data Governance: During the reporting period, of the 12-information governance related incidents reported on Datix, 0 incidents were reported to the Information Commissioner’s Office (ICO). The IG Team continues to review and provide advice on reported incidents where applicable.

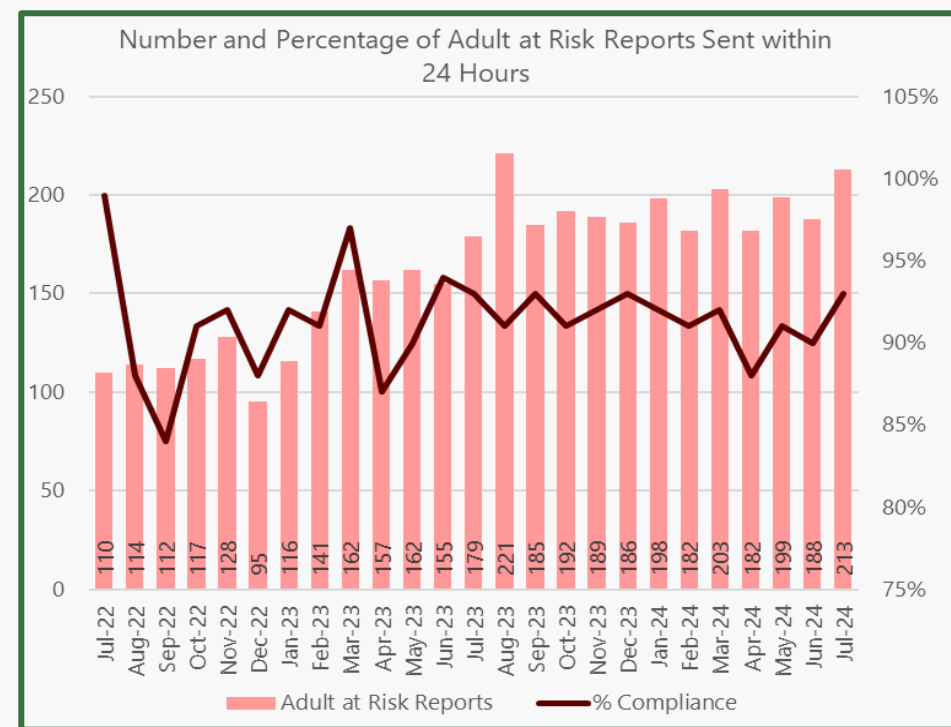
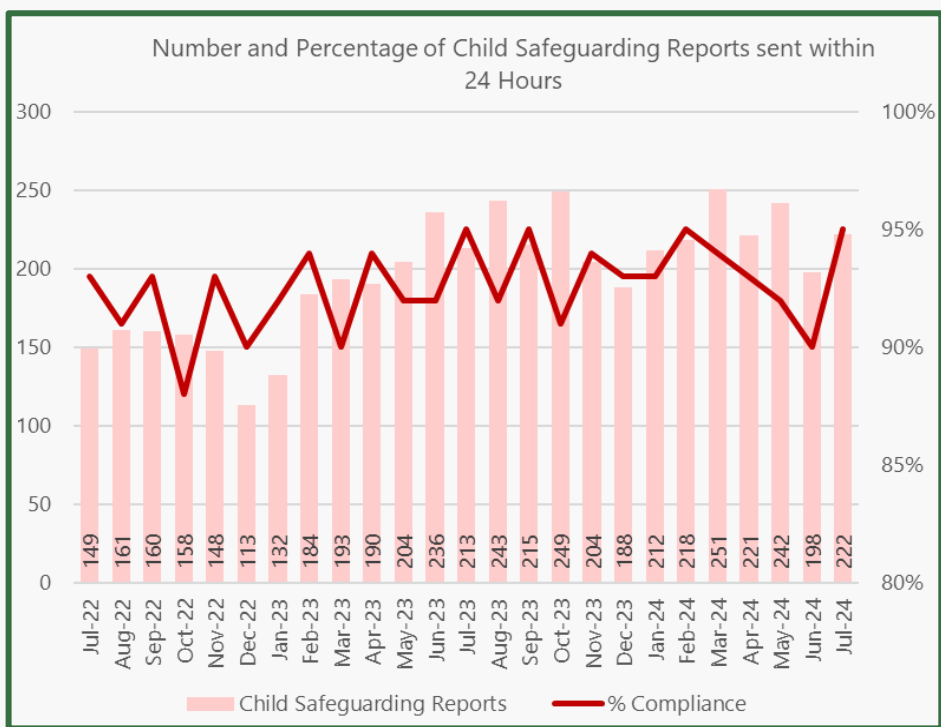
Public Engagement: The PECCI Team will continue to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve services they receive. We are actively working with colleagues across the Trust in a number of different departments to try and agree on solutions that would allow us to directly contact more patients to ask for feedback about their experiences with us.

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 status of the Action Plan is reported to and monitored by IGSG.

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 Safeguarding Data source: Doc Works

Our Patients: Quality, Safety & Patient Experience

Health & Safety (RIDDORS) Indicators

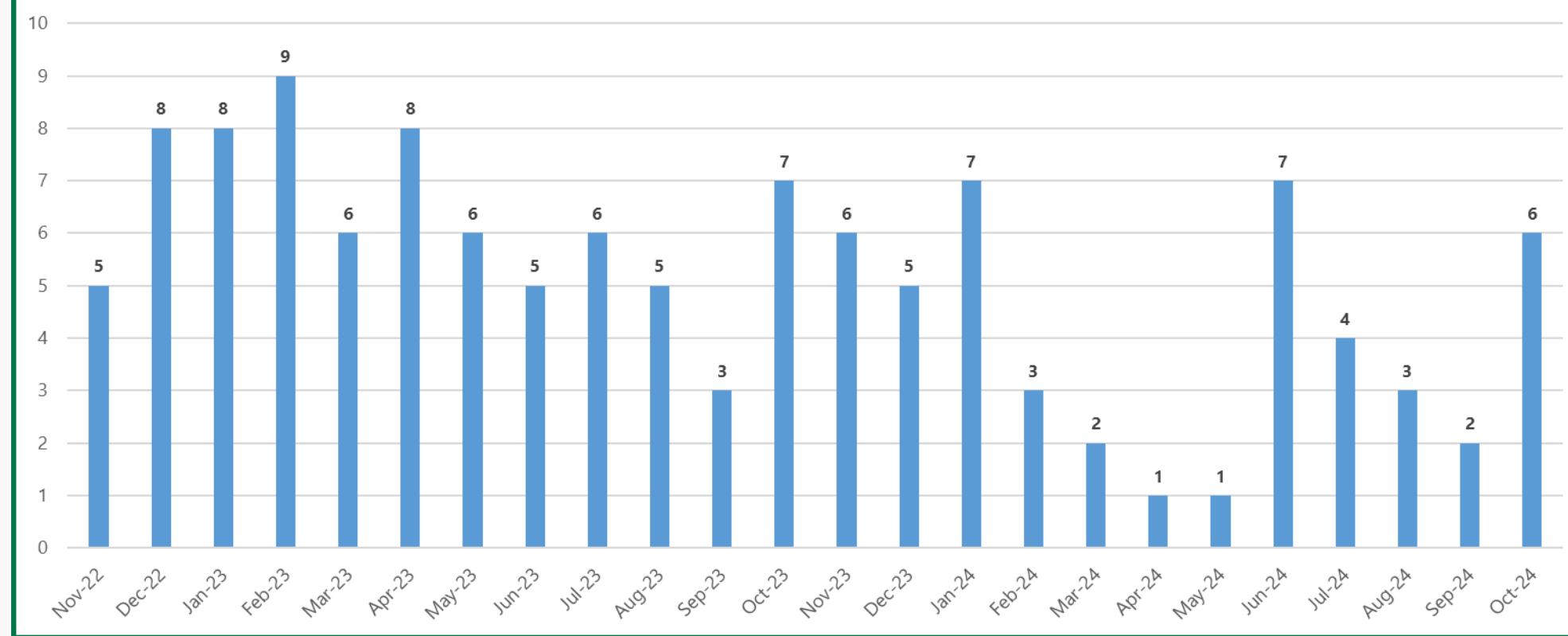
(Responsible Officer: Liam Williams)

Self-Assessment:
Strength of
Internal Control:
Moderate

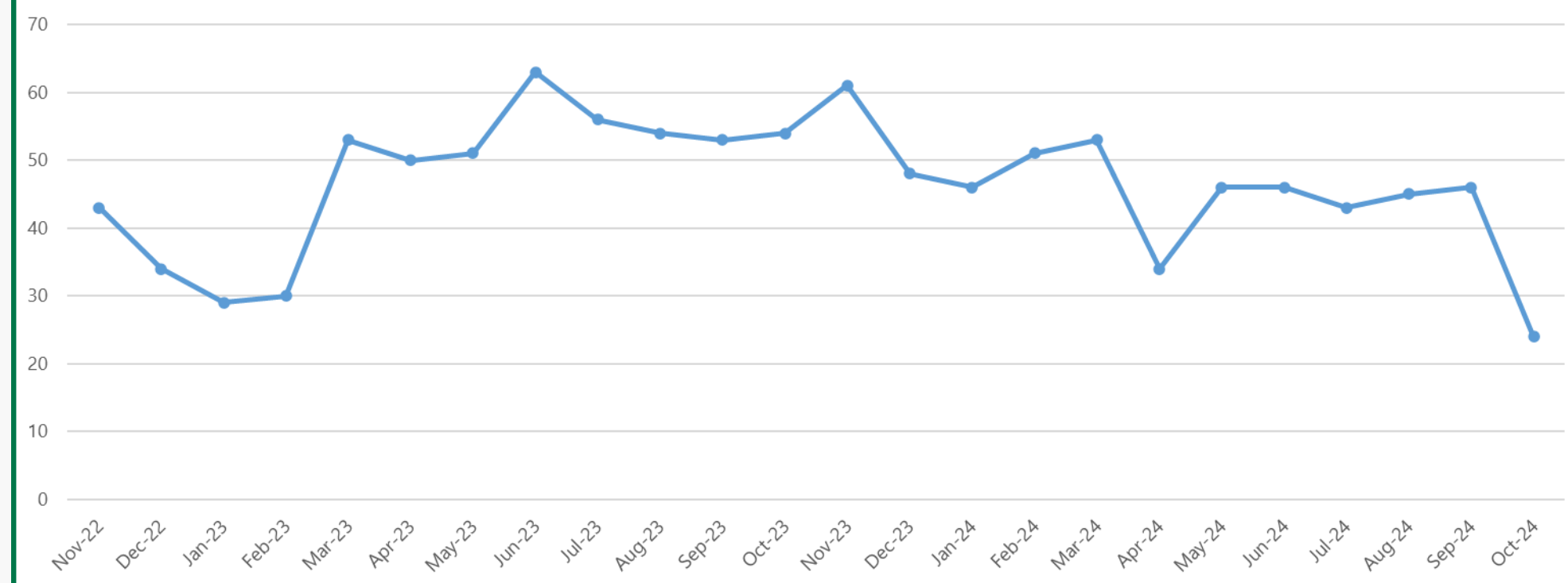
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Health & Care
Standard
Health – Safe Care

Volume of RIDDOR Reports by Month



Total Violence & Aggression Reports by Month



Analysis

RIDDOR: There were 11 incidents requiring reporting under RIDDOR during Quarter 2 2024. All were as a result of being unable to perform their normal duties for more than 7 days. Two RIDDOR's were submitted outside of HSE requirements due to handler delays

Additionally, changes to RIDDOR reporting increased the scope of requirements impacting on reporting times due to the time taken to communicate with staff ahead of submission.

Slips and Trips(6 RIDDORS) and Manual Handling Patients (3 RIDDORS) continue to be the most consistent theme for RIDDOR submissions.

Violence and Aggression: A total of 134 incidents have been reported of V&A in Quarter 2 2024.

8 Physical Assaults on staff were reported during the quarter with 126 incidents of verbal abuse.

26 incidents were reported as Moderate in harm; 29 noted as low harm and 3 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 function.

Remedial Plans and Actions

RIDDOR: The vacant administrative role within the department has been filled and the new member of staff commenced duties in September 2024. They will be assisting in the collection of the information required for RIDDOR reporting to improve reporting times and data quality.

The DSE/Manual Handling Advisor is completing their findings into the manual handling injuries within the Trust, and these will be compiled within a paper to be processed through Trust governance routes detailing trending, causation analysis and recommendations for improvements.

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, 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 is sustained whilst moving patients is currently static with an average of 12 being reported each month.

Violence and Aggression: Whilst there has been a downward trend in V&A incidents the current performance remains steady in terms of numbers. The majority of incidents recorded are verbal in nature arising from our call centres.

Our Patients: Quality, Safety & Patient Experience

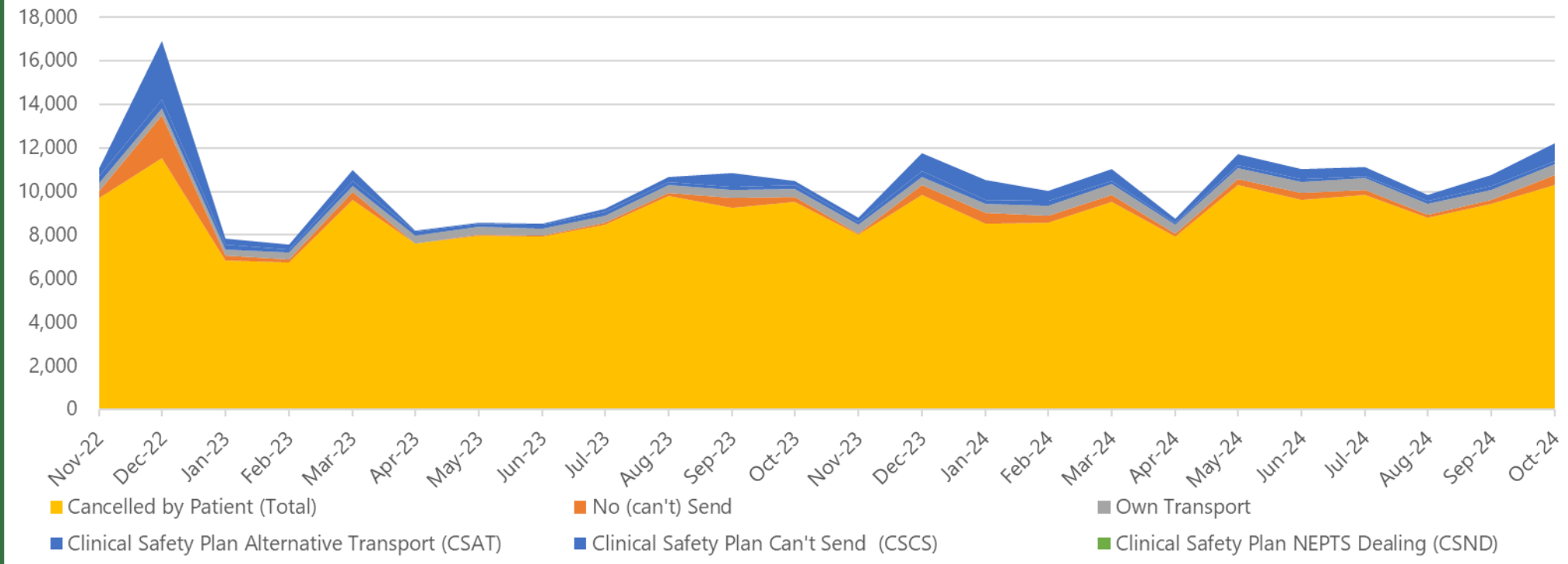
Potential Patient Harm Indicators

(Responsible Officer: Andy Swinburn)

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FPC

Numbers of Patients with No Send or Cancelling Ambulance



Analysis

In October 2024, 156 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 806 were stopped due to CSP 'Can't Send' options. In addition, 10,320 ambulances were cancelled by patients (including patients refusing treatment at scene) an increase from the 9,421 in September 2024.

There were 755 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in October 2024. Of these 165 were accepted and released in the Red category, with 8 not being accepted. Further to this, 144 ambulances were released to respond to Amber 1 calls, but 438 were not.

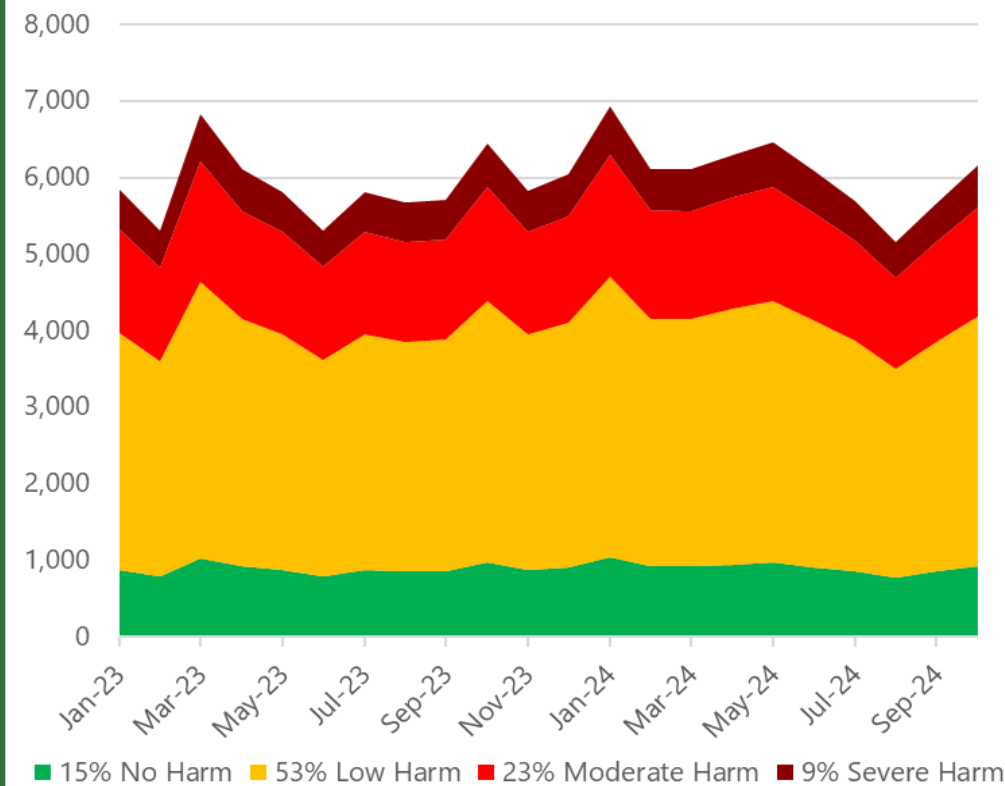
The graph in the bottom left shows that in October 2024 of the 6,168 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, the Trust could assume that 15% (925 patients) would experience no harm, 53% (3,269 patients) would experience low harm, 23% (1,418 patients) would experience moderate harm and 9% (555 patients) would experience severe harm.



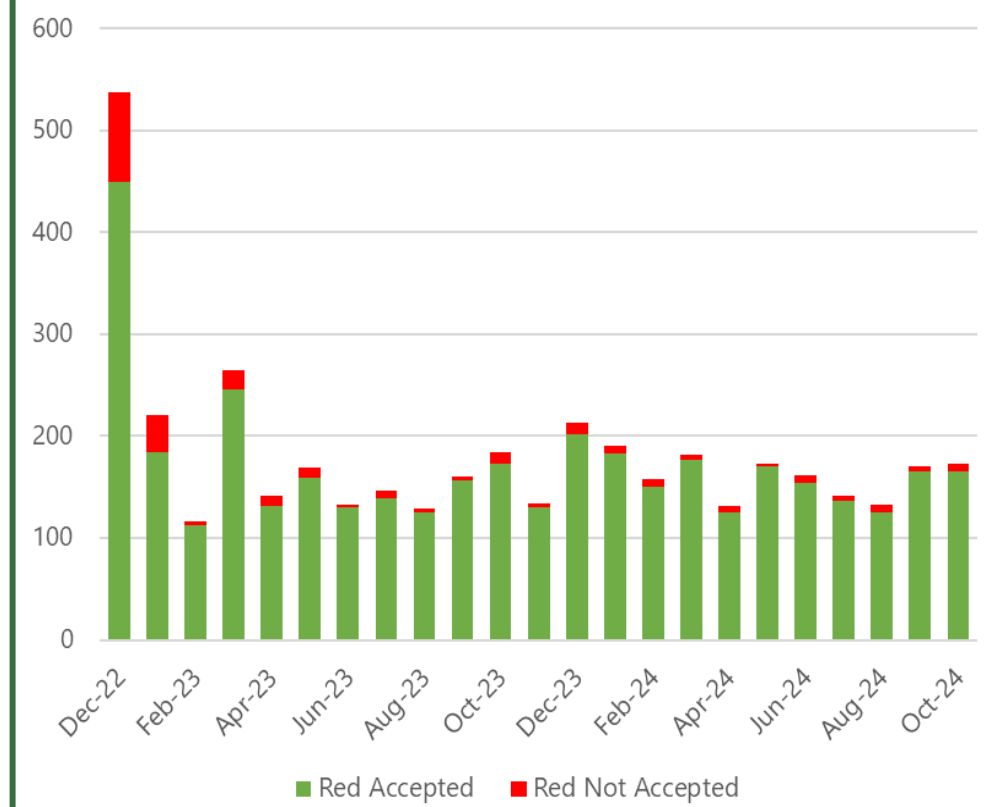
In October 2024 CSP levels for the Trust were:



Modelled Harm Coming to Patients Who Wait Over 60 Minutes for a Hospital Handover



Pan-Wales Immediate Red Release



Remedial Plans and Actions

Red immediate release is monitored weekly by the Chief Executive and reported through to Health Board CEOs with the expectation that there are no declines for Red Release from any of the 7 Health Boards. All health boards have agreed to this measure. Integrated Commissioning Action Plan (ICAP) meetings 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

September 2024		
NEPTS (161 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	82
Were you happy with the transport you received?	85	94
999 (23 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	54
The 999-call taker who answered your call explained what was going to happen next.	85	60
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	53
The length of time I waited for an ambulance to arrive was acceptable.	85	50
111 (18 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	65
Did you follow the advice given to you by NHS 111 Wales?	85	88
Would you consider using NHS 111 Wales again?	85	64
WAST Overall - Friends & Family Test	Ranked from very poor to very good.	
How was your overall experience with the service today?		
o Ambulance care	91.91% Good	3.68% Poor
o Integrated Care (NHS 111 Wales Telephone line only)	60.00% Good	26.67% Poor
o EMS (including CSD)	43.48% Good	43.48% Poor
o NHS 111 Wales Online	57.89% Good	21.05% 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 you received', came out above the 85-benchmark figure (n=94).

Two questions within the 999-section failed to achieve the benchmark, these being 'The 999-call taker who answered your call was reassuring' (n=54) and 'You felt confident in the call taker ability to manage your call and provide appropriate advice?' (n=53), whilst within 111 only one question 'Did you follow the advice given to you by NHS 111 Wales' achieved the benchmark (85) with 88, however the other questions failed to achieve the benchmark.

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 999 service users.
- Plans to place QR codes in the back of EMS vehicles to increase patient feedback are progressing and we have spoken to IPC and Fleet colleagues about what is needed to proceed.
- We 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. Plans are in place to duplicate this method of survey delivery with patients attended to by a CWR Volunteer.
- We continue to engage with the Once for Wales Programme Board who have updated the 'All Wales Patient Experience Question Set' and 'People's Experience Framework'. The Framework and new questions will be formally launched by WG in the coming months.

Expected Performance Trajectory

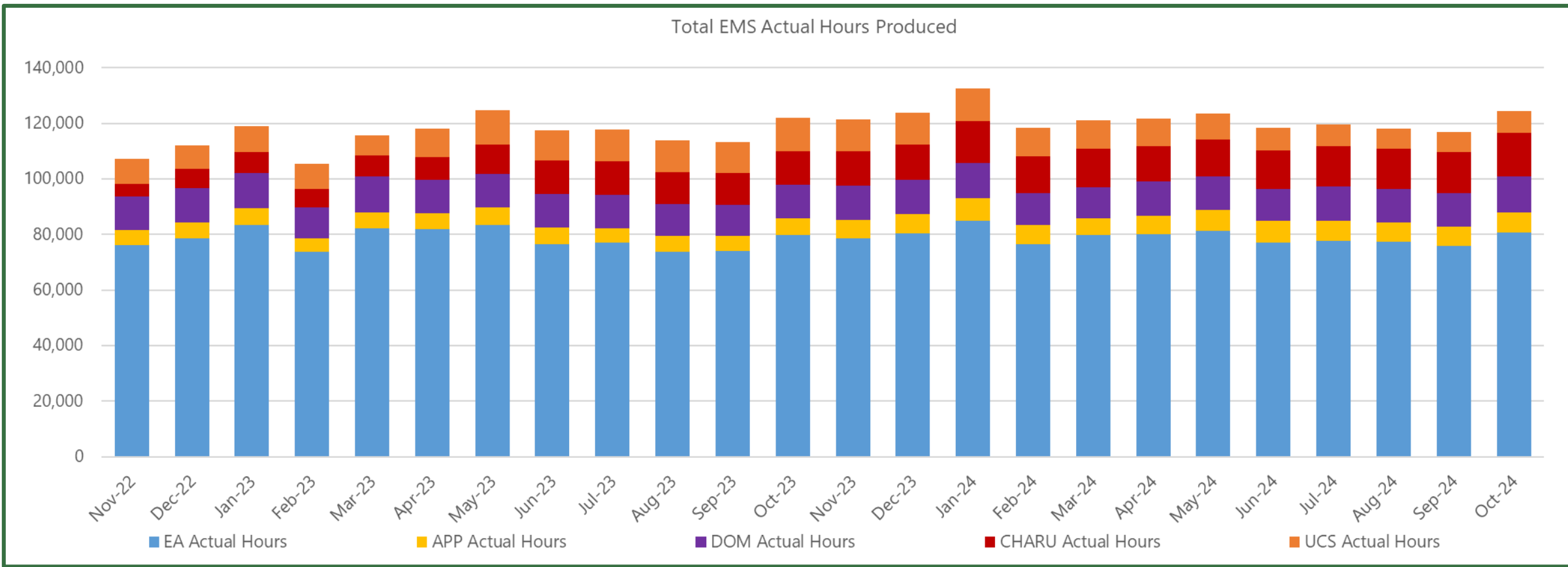
An overall aim of increasing visibility of experience surveys and maximising opportunities to capture patient experience data.

Our People Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions	CI	PCC
A	A		

FPC



Analysis

The total EMS hours produced is a key metric for patient safety. The Trust produced 124,337 hours during October 2024, an increase compared to the 122,046 hours produced during October 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. October 2024, saw a total EMS abstractions (excluding Induction Training) of 30.82%. This was a minimal increase on the 30.72% recorded in September 2024. The highest proportion of abstractions was due to annual leave at 12.19% followed by sickness at 7.60%.

Emergency Ambulance Unit Hours Production (UHP) achieved 93% in October 2024 which equated to 80,580 Actual Hours.

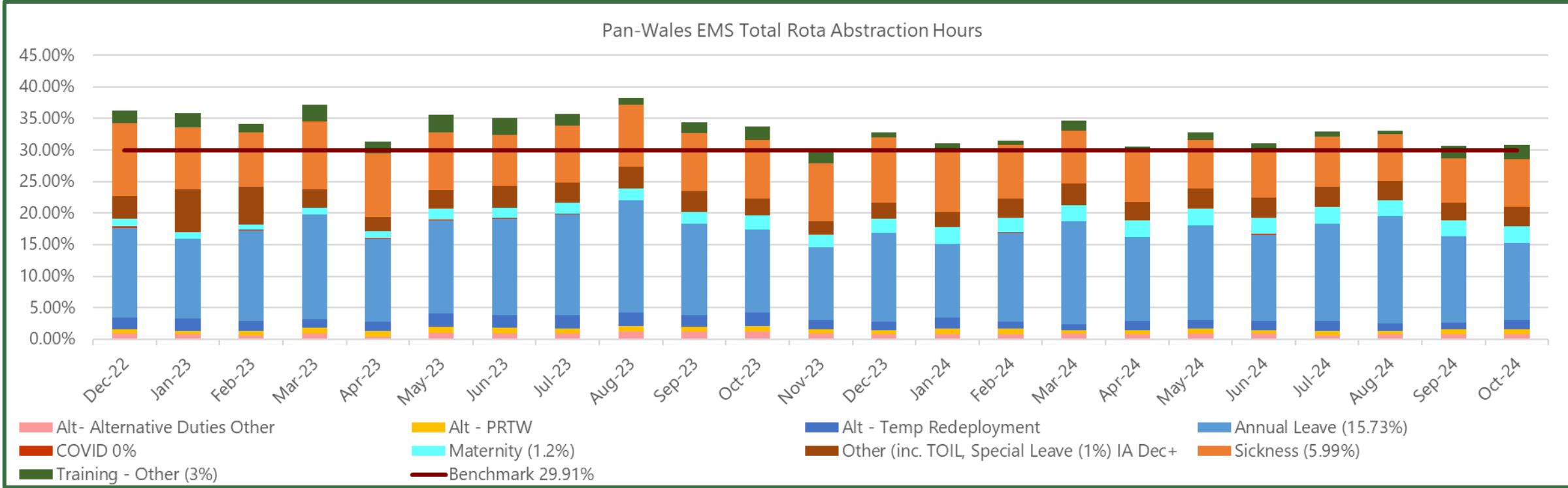
In October 2024 CHARU UHP was 84% against the full roll out requirement.

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.

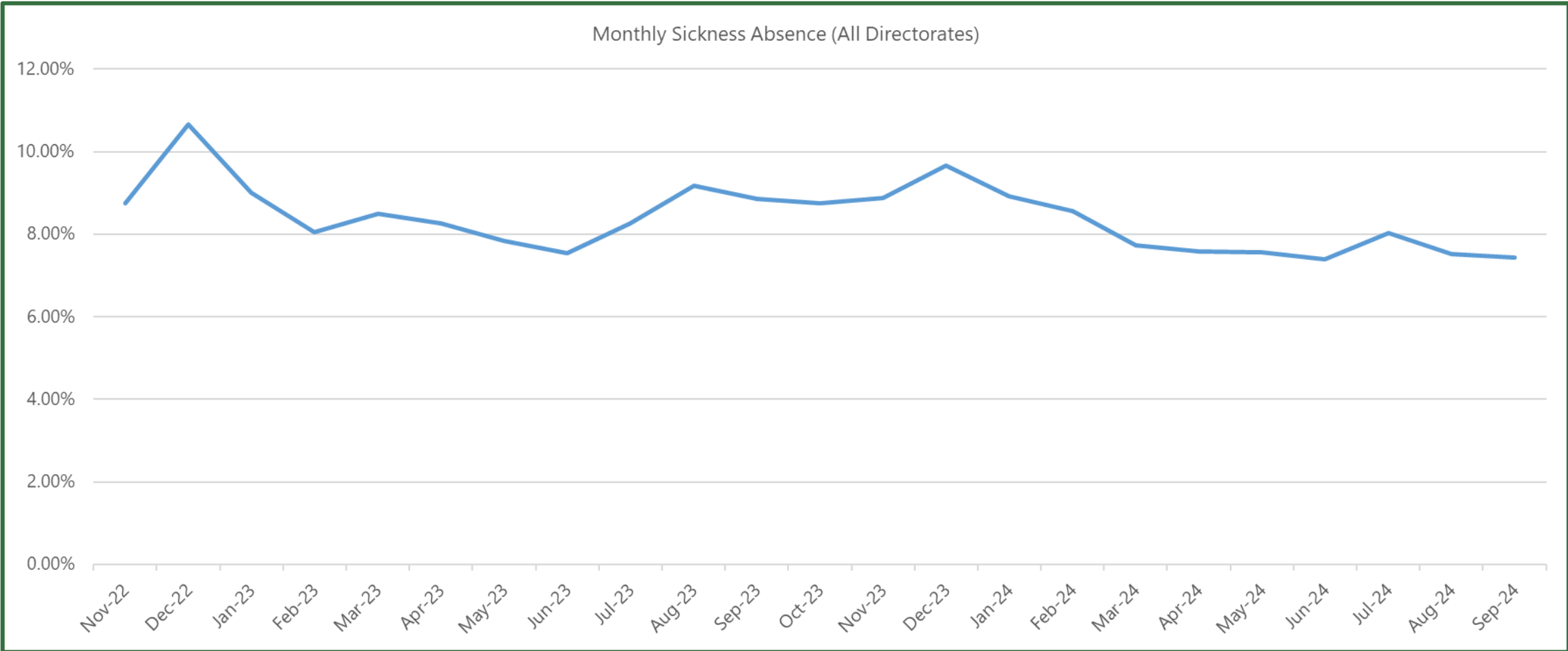


Our People Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)

Mental Health
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CI
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Analysis

There was a slight decrease in overall sickness absence rates between August 2024 and September 2024, dropping from 7.52% to 7.43%. Long term absence also decreased from 5.95% in August 2024 to 5.22 % in September 2024, while short-term absence increased slightly to 2.21% in September from August 2024 (1.57%).

The highest reasons for absence in September 2024 were Anxiety/ Stress/ Depression, back problems, other musculoskeletal problems and cold, cough, flu/influenza. Absence due to Mental Health increased from 2.52% in September 2024 to 2.59% in September 2024.

109 OH management referrals were received in September and the number of self-referrals is increasing, (30 self-referrals in September compared to 22 in August).

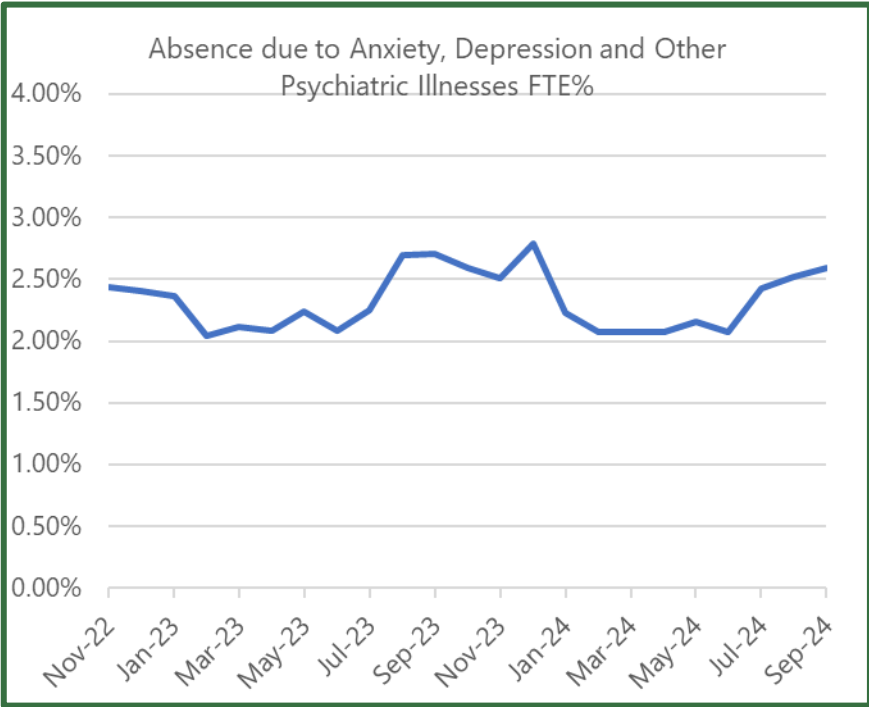
In September we received a total of 68 Wellbeing referrals, offered 81 assessment appointments and completed 51 wellbeing assessment appointments for signposting. There were 32 wellbeing management referrals, 16 self-referrals and 20 walk-in appointments.

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.

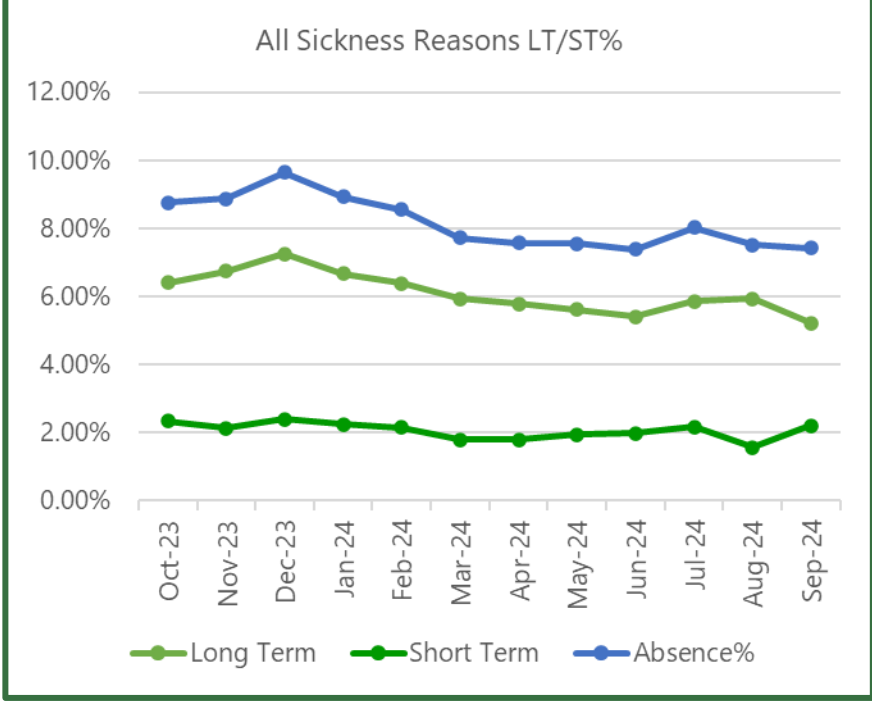
Expected Performance Trajectory

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



Average working days lost per FTE (Annual)	
18.64 days	
Single month Absence %	
7.43%	
Long Term	Short Term
5.22%	2.21%
Mental Health	Other MSK
(S10 Stress/Anxiety)	(excluding Back)
2.59%	0.90%

September 2024



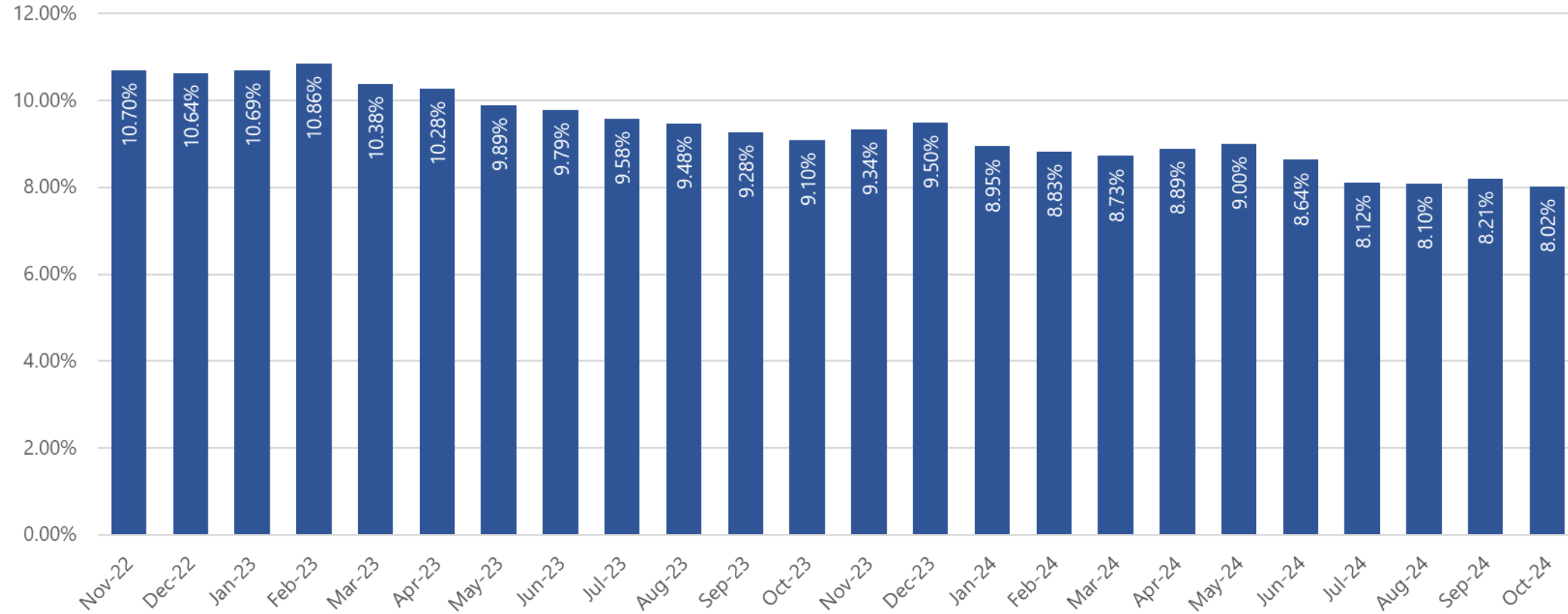
Our People Capacity - Turnover

(Responsible Officer: Angela Lewis)

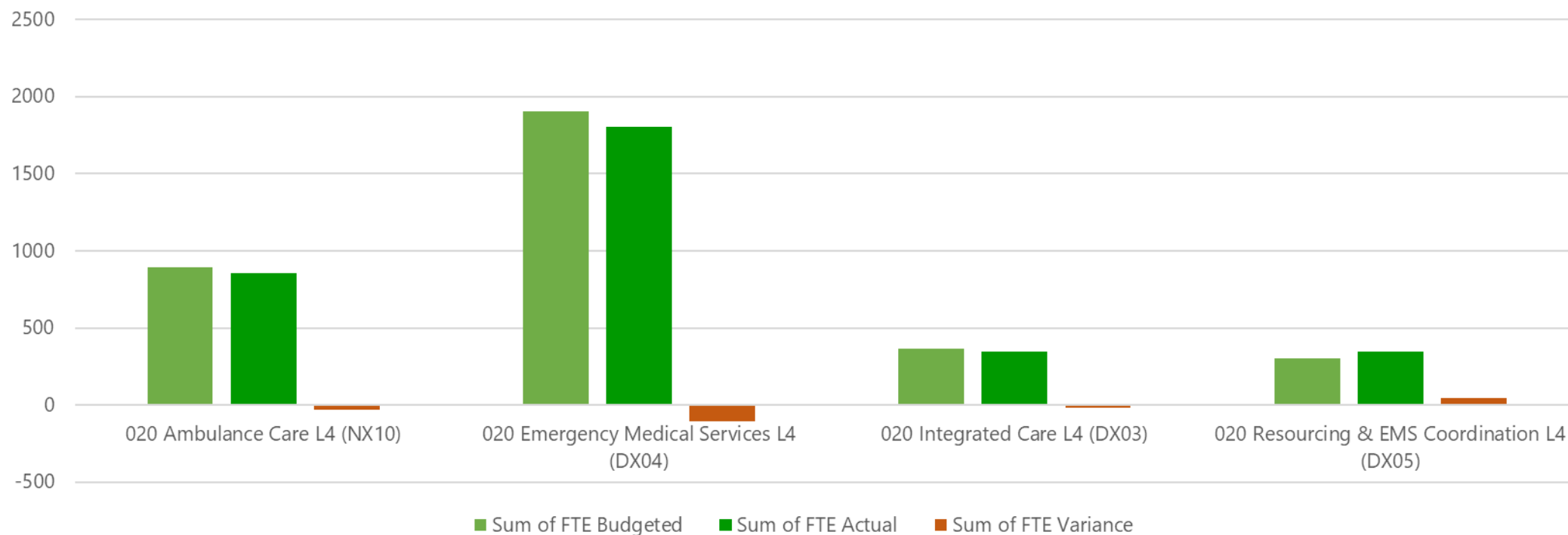
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Staff Turnover Rate FTE (% Employees leaving the Organisation) (12m)



FTE as of 31/10/2024



Analysis

Staff turnover rates in October 2024 were 8.02%, a slight decrease from the 8.21% recorded in September 2024. October saw 26 leavers (23.89 FTE). Turnover in months at the end of the quarter are generally higher. This was balanced with 58 joiners (55.30 FTE) in October, of those leaving, the group with the greatest number were Ambulance Care Assistant or Patient Transport Service Drivers (6 people).

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 29 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). The (All Wales) decision has been made to extend the contract with Civica for 1 year (as opposed to 2 years) for our MI system, Opas G2.
- The team continue to support staff by providing advice and guidance on how to use the MI system and have facilitated events.
- 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 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 Health and Wellbeing strategy for 2025/29 is out for consultation.
- The team have been working closely with the Clinical Directorate flu project team for the start of the 2024/25 flu campaign, they have been holding flu clinics across the regions, a full schedule of clinics is available on Siren.
- Working on re-evaluating plans/timelines to attain SEQOHS accreditation. A meeting with SEQOHS has been scheduled with a deadline of the end of November 2024.

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
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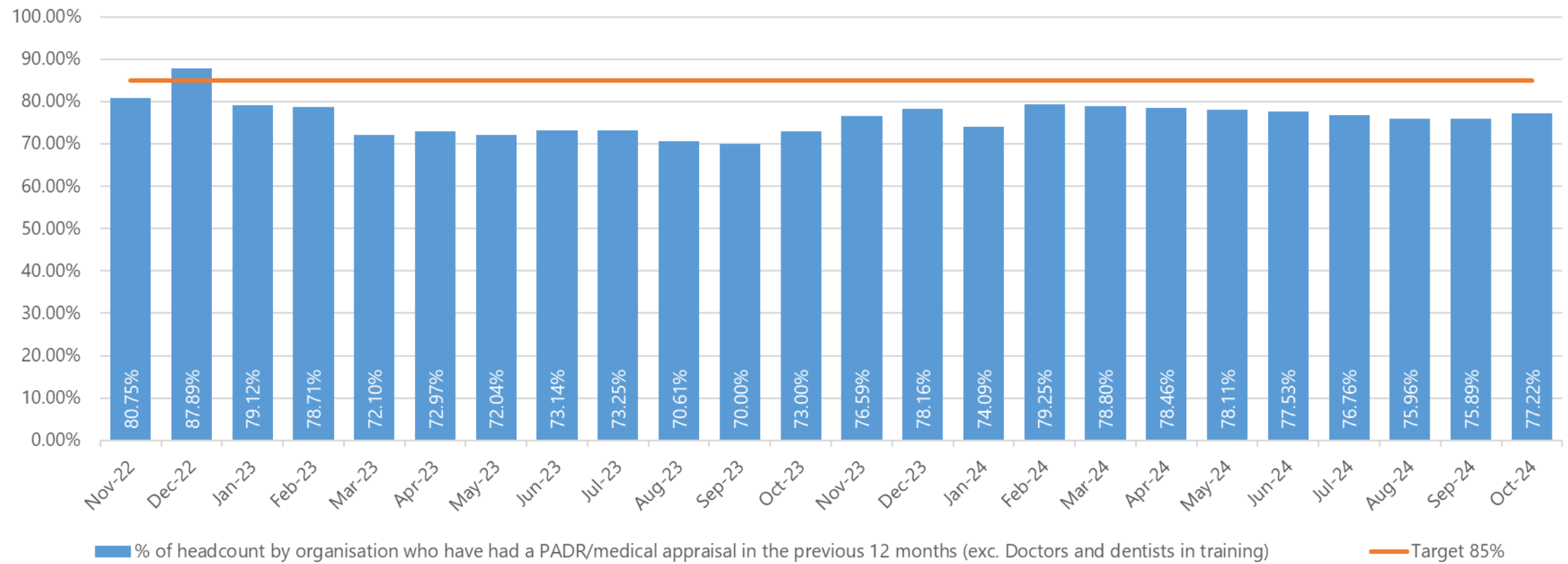
CI

PCC

Health & Care Standard
Health – Staff & Resources

Self-Assessment:
Strength of Internal Control: Strong

% of Organisation who have had a PADR/Medical Appraisal in Previous 12 Months



Analysis

PADR rates increased from 75.89% in September 2024 to 77.25% in October 2024, but remain below the 85% target. Over the reporting period this target has only been achieved once, in December 2022.

In October 2024 Statutory & Mandatory Training rates reported a combined compliance of 83.35%; which is the second time in 2 continuous months that here has been a decline. However, only Dementia Awareness (95.18%), Moving & Handling (92.97%) and Safeguarding Adults (85.39%), achieved the 85% target. Equality & Diversity (81.28%), Fire Safety (79.15%), Information Governance (76.62%), Paul Ridd (72.33%), Violence Against Women, Domestic Abuse & Sexual Violence (71.56%), Fraud Awareness (68.88%) and Welsh Language Awareness (66.54%) 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:

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, support better Communication between managers and employees and develop a culture of accountability and continual improvement.

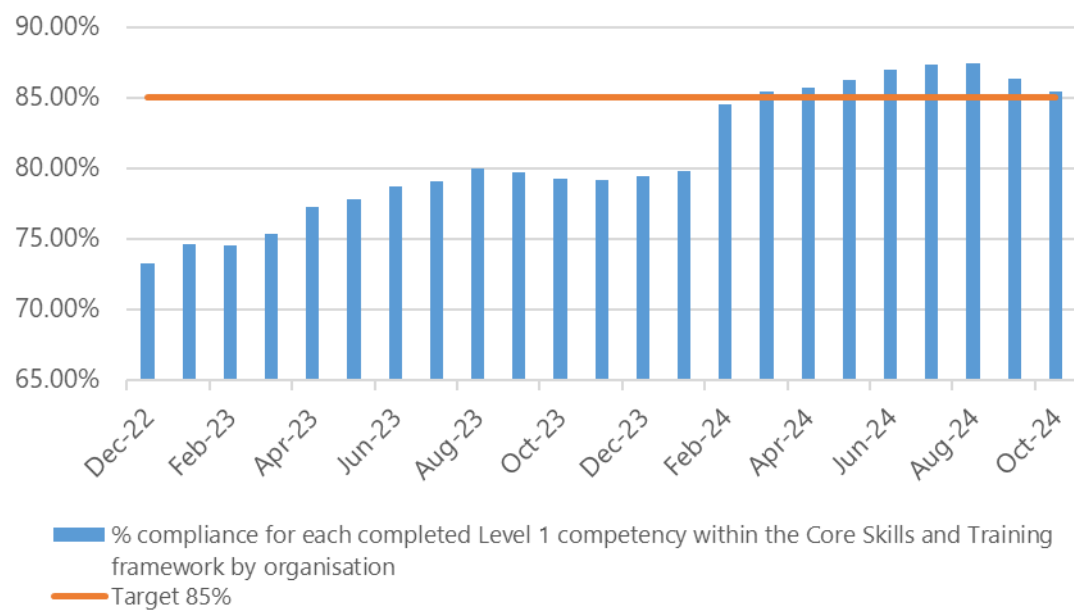
There has been a continuation of the climb toward achievement of the 85% target across the remainder of the Core Skills Training Framework competencies which is projected to continue to increase as more learning content is moved to the user friendly environment enabling easier access to these reportable competencies.

Expected Performance Trajectory

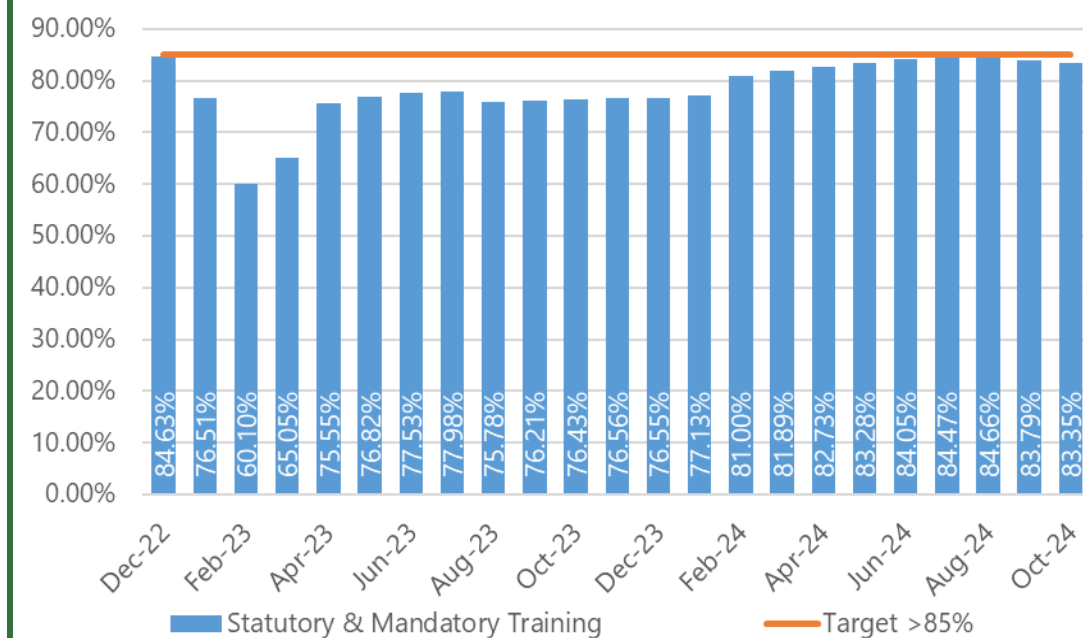
Performance is improving as compliance has risen.

Skills and training Framework	NHS Wales Minimum Renewal Standard
Equality, Diveristy & 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	Yearly
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
Enviroment, Waste and Energy (Admin & Clerical Staff only)	Yearly
Duty of Quality	3 years
Fraud Awareness	3 years
Prevent Awareness	No Renewal

% Compliance for each completed Level 1 competency within Core Skills & Training framework



% Compliance Statutory and Mandatory Training (10 CSTF Modules)



Our People

Health and Well-being – Shift OVERRUNS

(Responsible Officer: Angela Lewis)

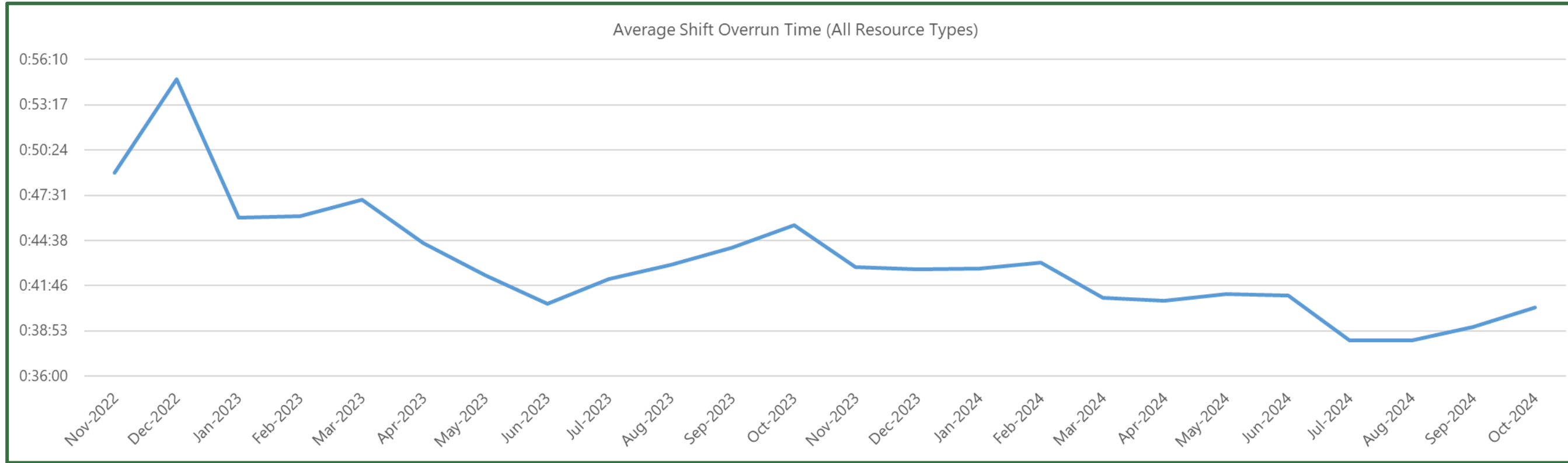
Overruns

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Analysis

The average overrun figure for October 2024 was 40 minutes and 22 seconds, a minimal increase from September 2024 (00:39:07). 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 75.5% of the total. 19.6% fall within the 61 to 120-minute category, 4.9% in the 121 to 180-minute category, 0.4% in the 181 to 240-minute category and 0.2% in the 241 minutes and over category.

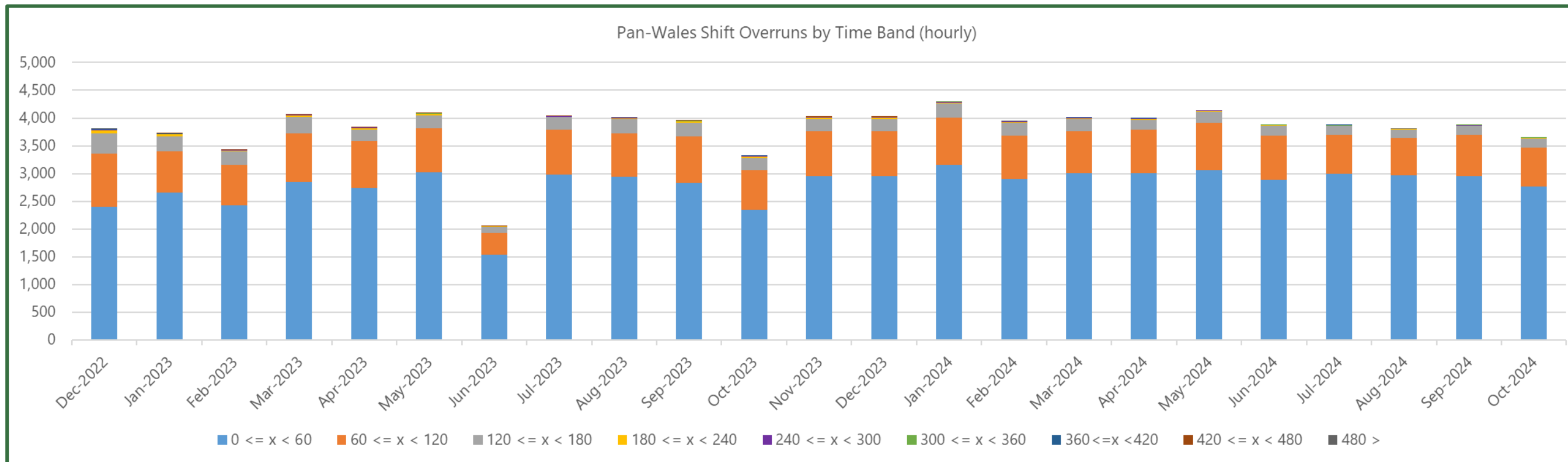
Remedial Plans and Actions

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.

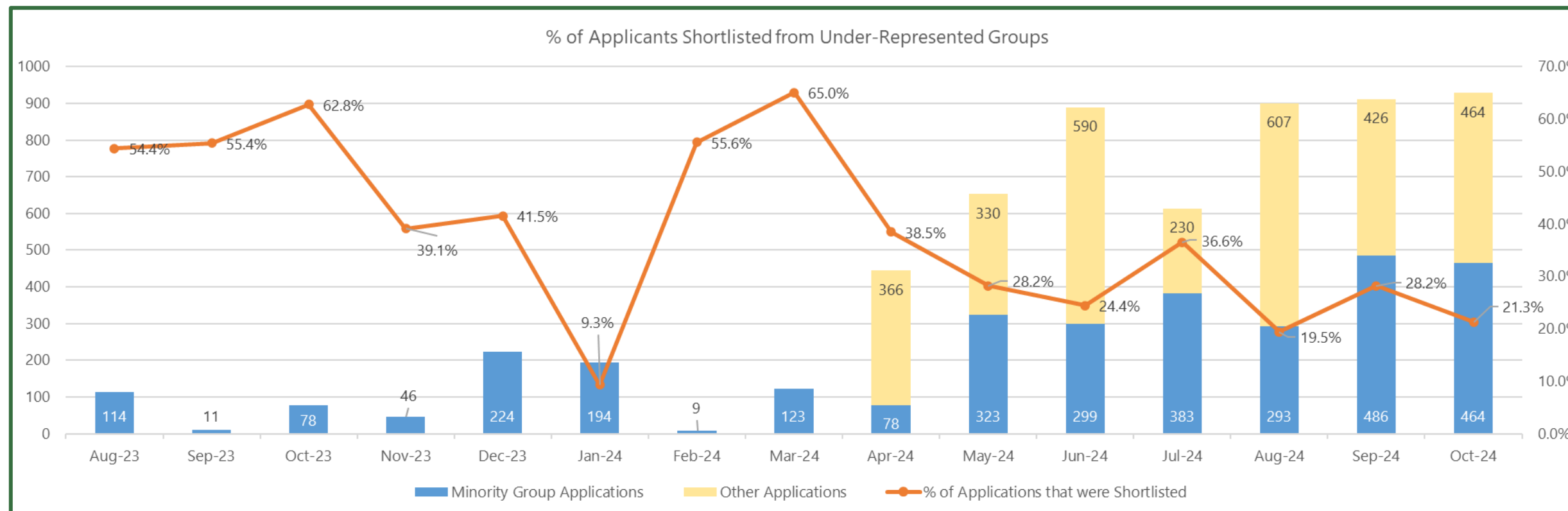
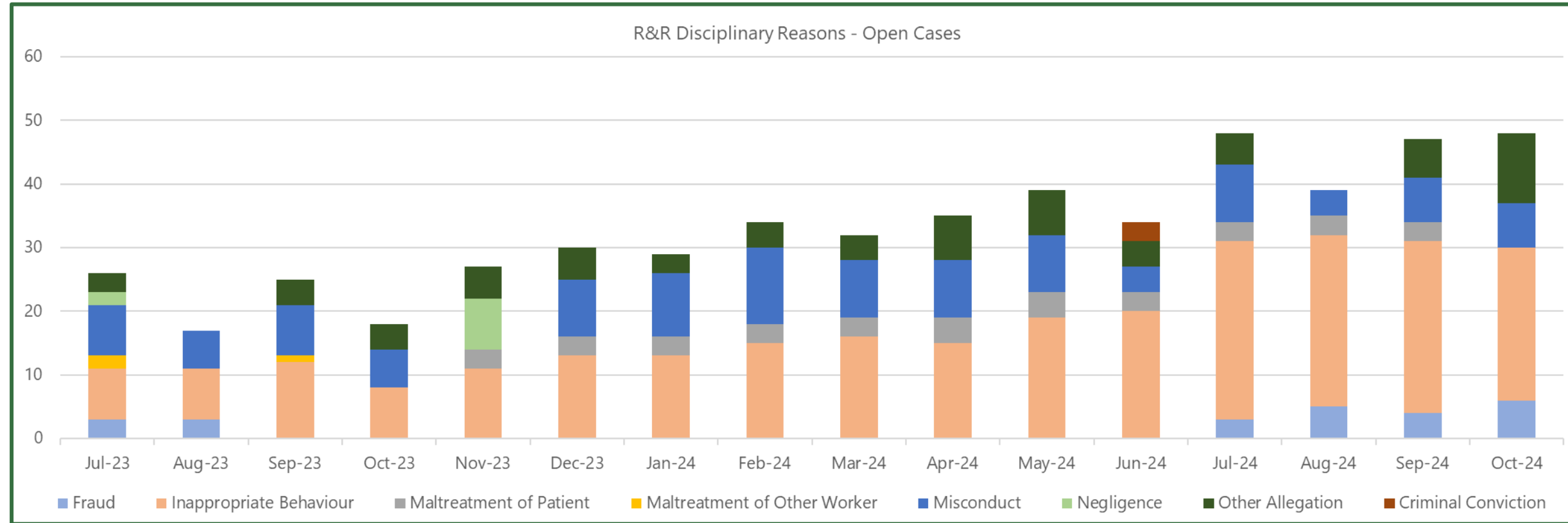


Our People

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



Analysis

There were 48 open formal disciplinary cases recorded at the end of October 2024, which was the highest number seen over the past 12 months; an increase compared to 47 in September 2024. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by misconduct.

There were 11 open formal Respect and Resolution cases submitted by employees in October 2024, two less than in September 2024. These are a mixture of both Respect and Resolution Grievances and Dignity at work.

The bottom graph shows that in October 2024, 815 job applications were processed, and 292 interviews were planned.

Of the 815 applications, a total of 351 were from under-represented groups with 186 in the category of Ethnicity, 79 within Disability and 86 within Sexual Orientation.

In October 2024, 28.8% (n=101) of all applications from under-represented groups made it through shortlisting and were invited for interview. This was an increase from the 21.3% in September 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. One workshops has taken place, with a second to take place in Nov-24 to recruit for Black, Asian and Ethnically diverse applicants into our digital roles.

Unconscious bias training is also being undertaken by managers in the Digital directorate to assist with recruitment.

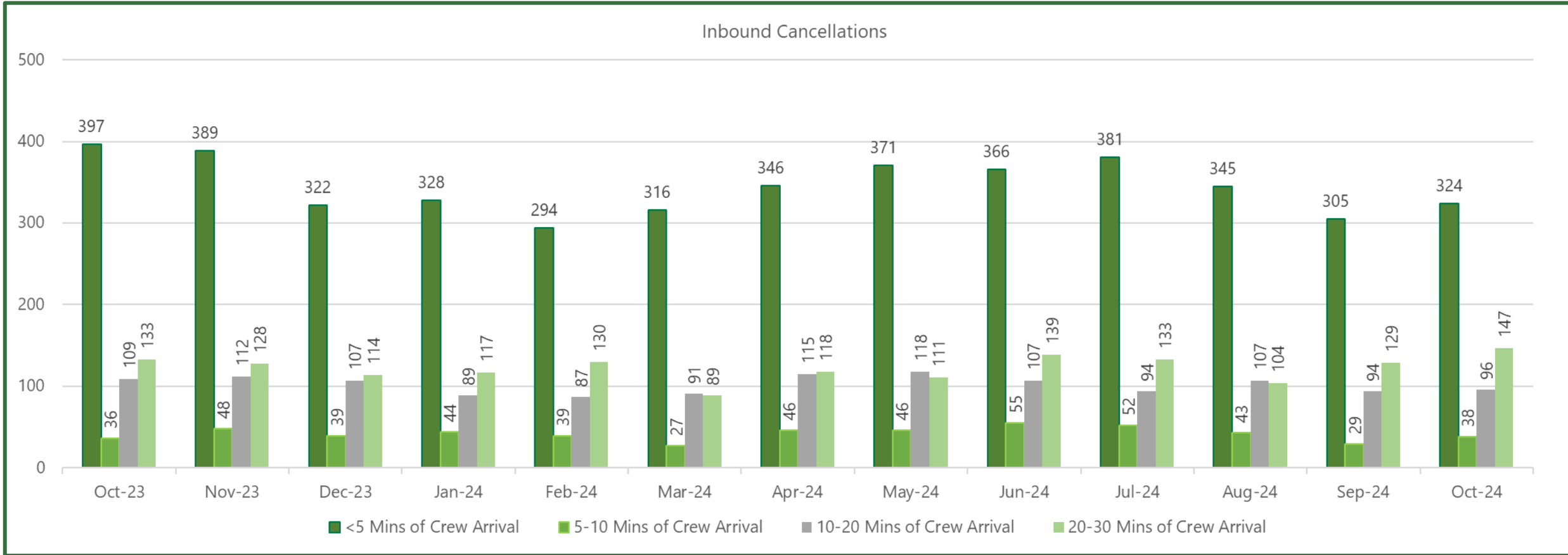
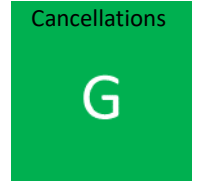
Expected Performance Trajectory

Continue to monitor levels, no trajectory for this measure.

Finance, Resources and Value

Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)



Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw an increase in October 2024 to 324, compared to 305 in September 2024. The total number of cancellations within 30 minutes increased from 557 in September 2024 to 605 in October 2024.

In October 2024 there were 74 travel bookings cancelled by patients, decreasing from 91 in September 2024.

The other top reasons for less than 5-minute cancellations included: 26 patients not located, 14 unwell/too ill to travel and 7 no appointment.

Same day cancellations increased slightly in October to 13.9% from September 2024 (13.1%).

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. Once in place this will allow for WAST to be notified once the health board cancels or alters an appointment.

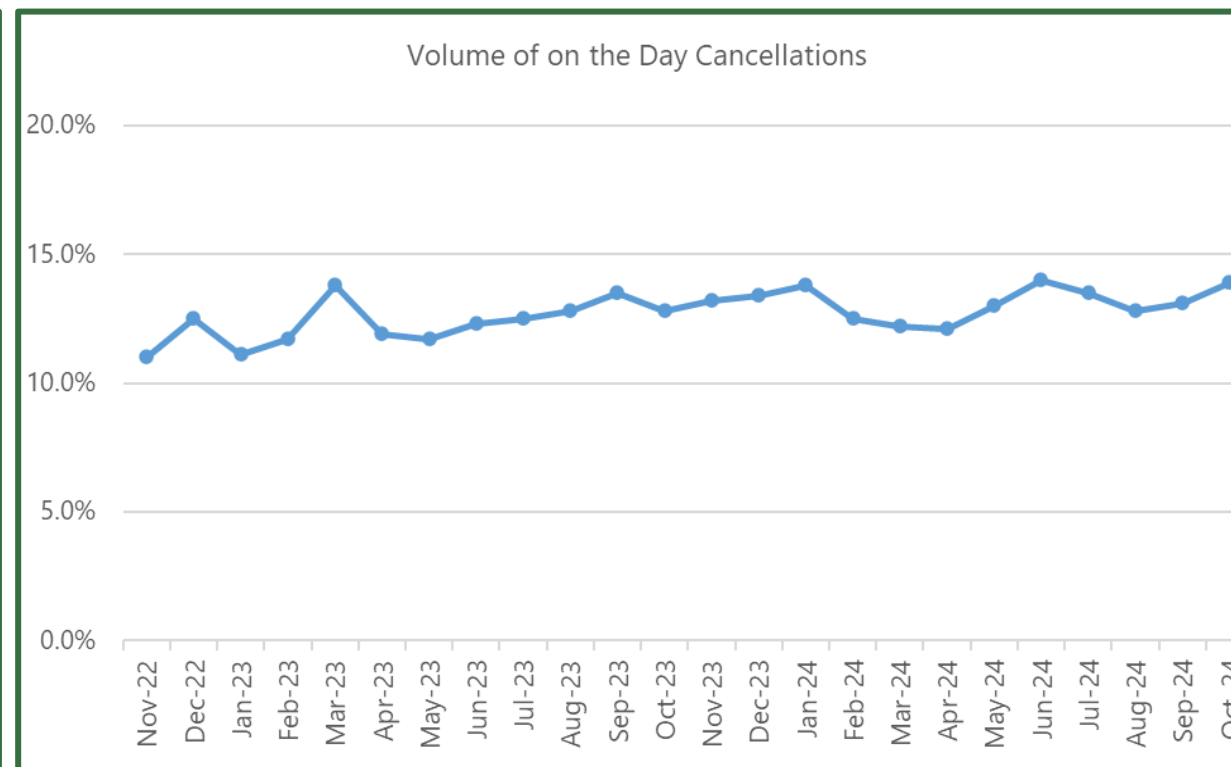
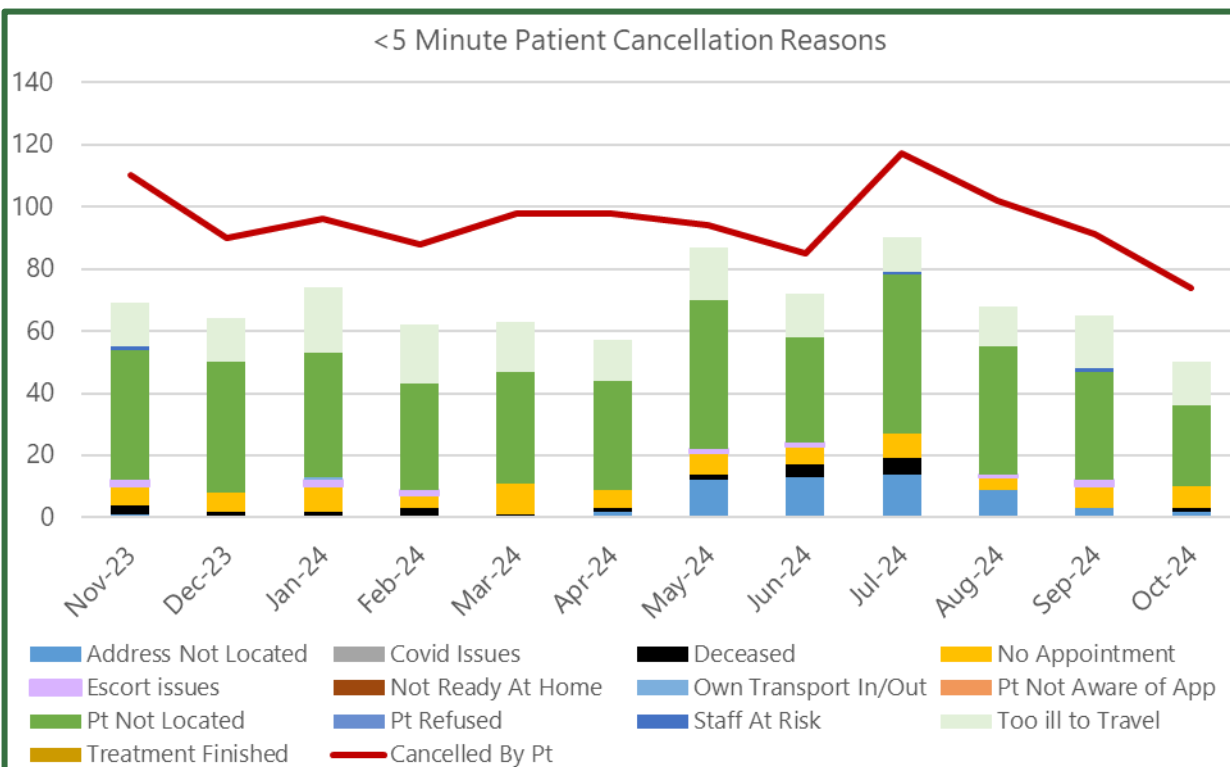
Work is also underway to enhance the service's text messaging options to improve notification to patients. This should be complete in Q2.

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.*



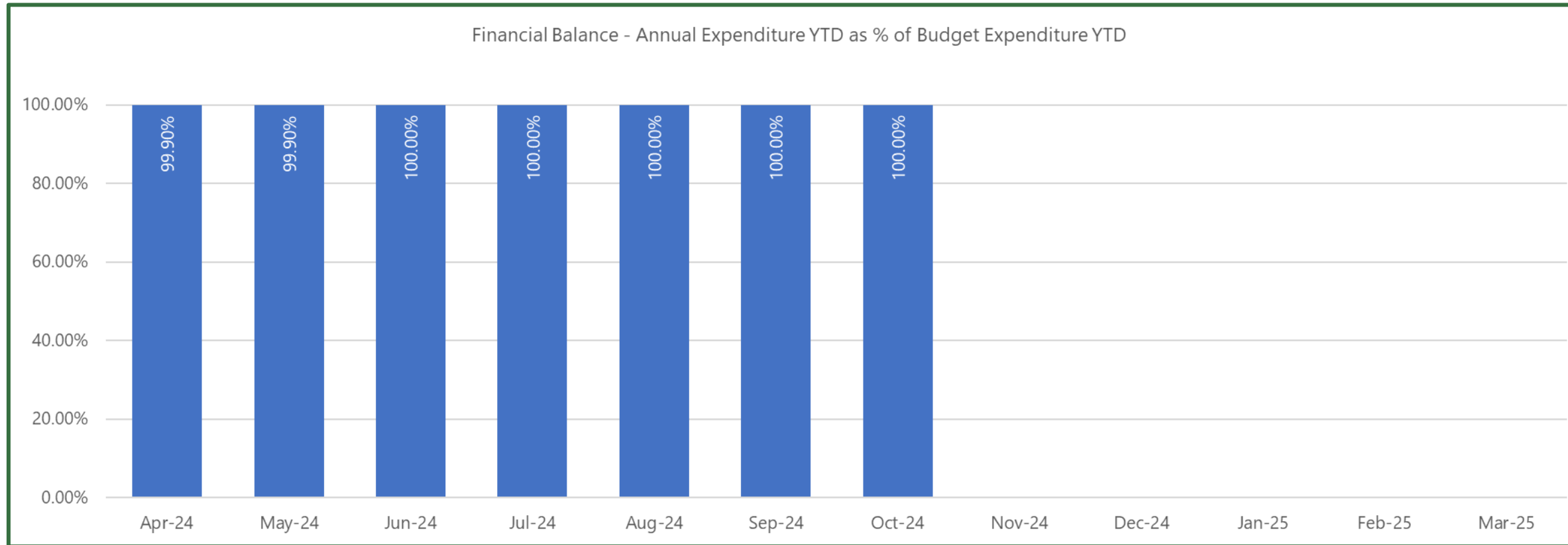
Finance, Resources and Value

Value - Finance Indicators

(Responsible Officer: Chris Turley)

G

FPC



Analysis

The reported outturn performance at Month 7 is a surplus of £42k.

For Month 7 the Trust is reporting planned savings of £4.124m and actual savings of £4.575m (an achievement rate of 110.9%).

The Trust's cumulative performance against PSPP as at Month 7 is 97.7% against a target of 95%.

At Month 7 the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

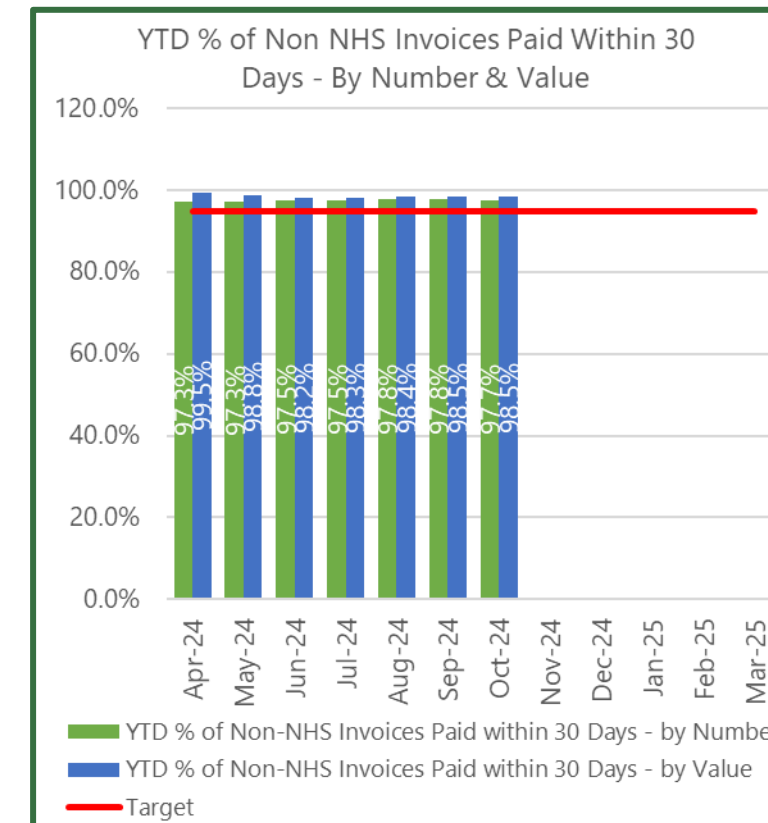
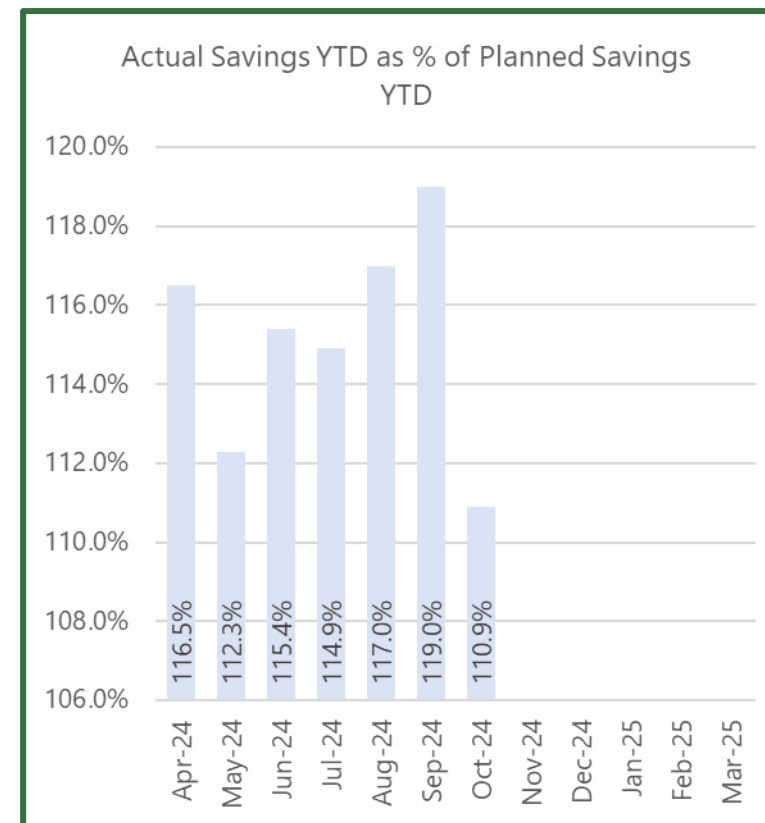
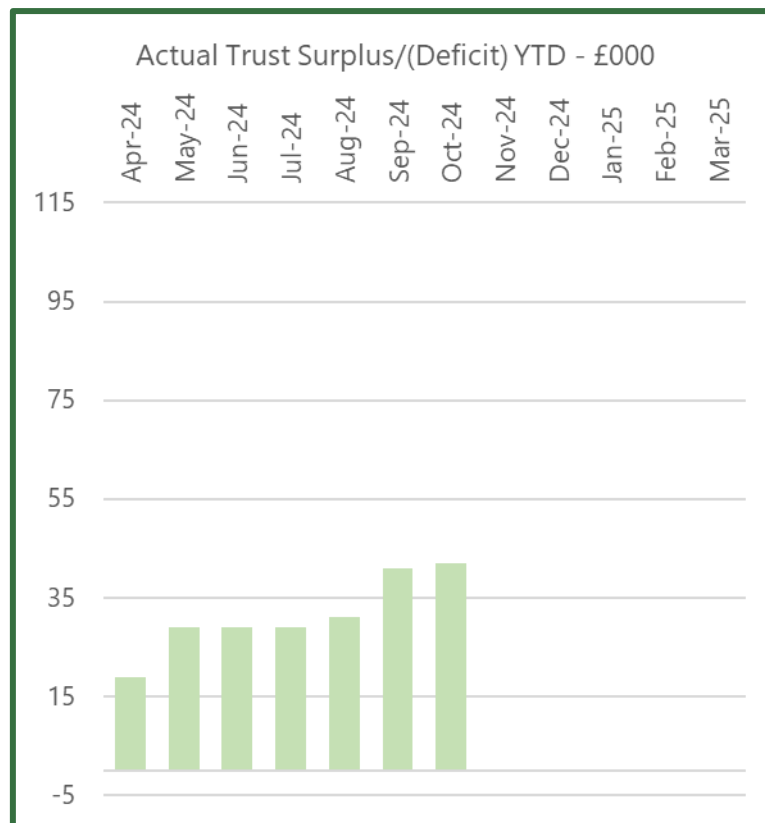
Remedial Plans and Actions

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

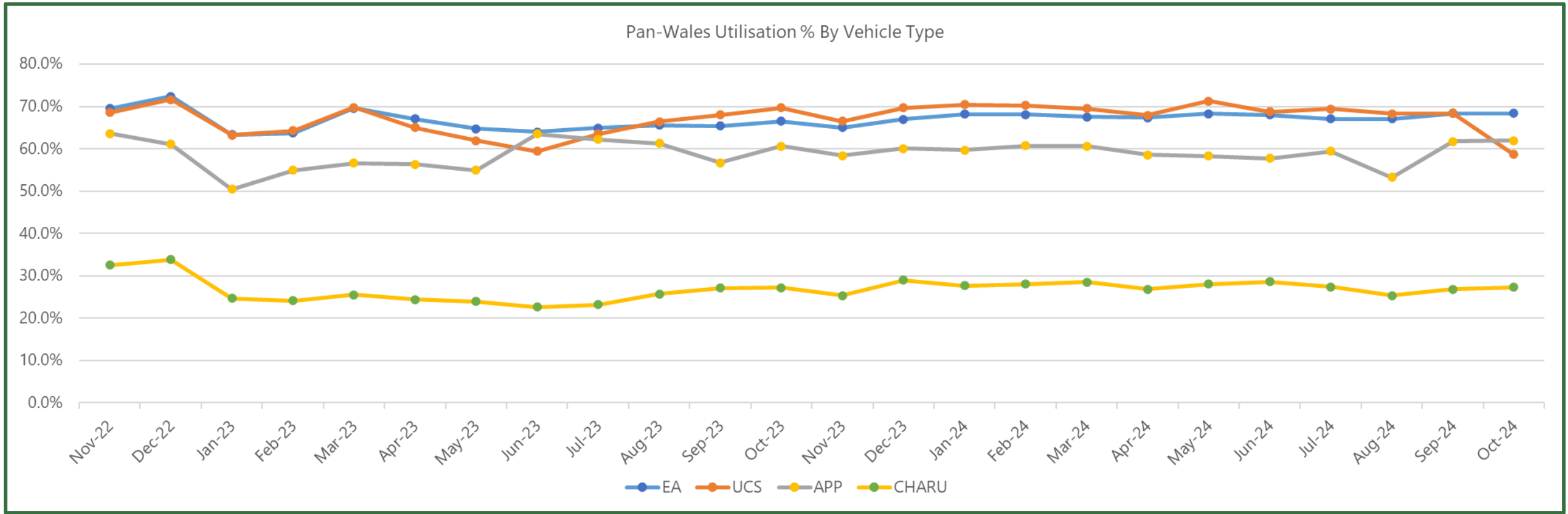
(Responsible Officer: Lee Brooks)

Jobs Per Shift
R

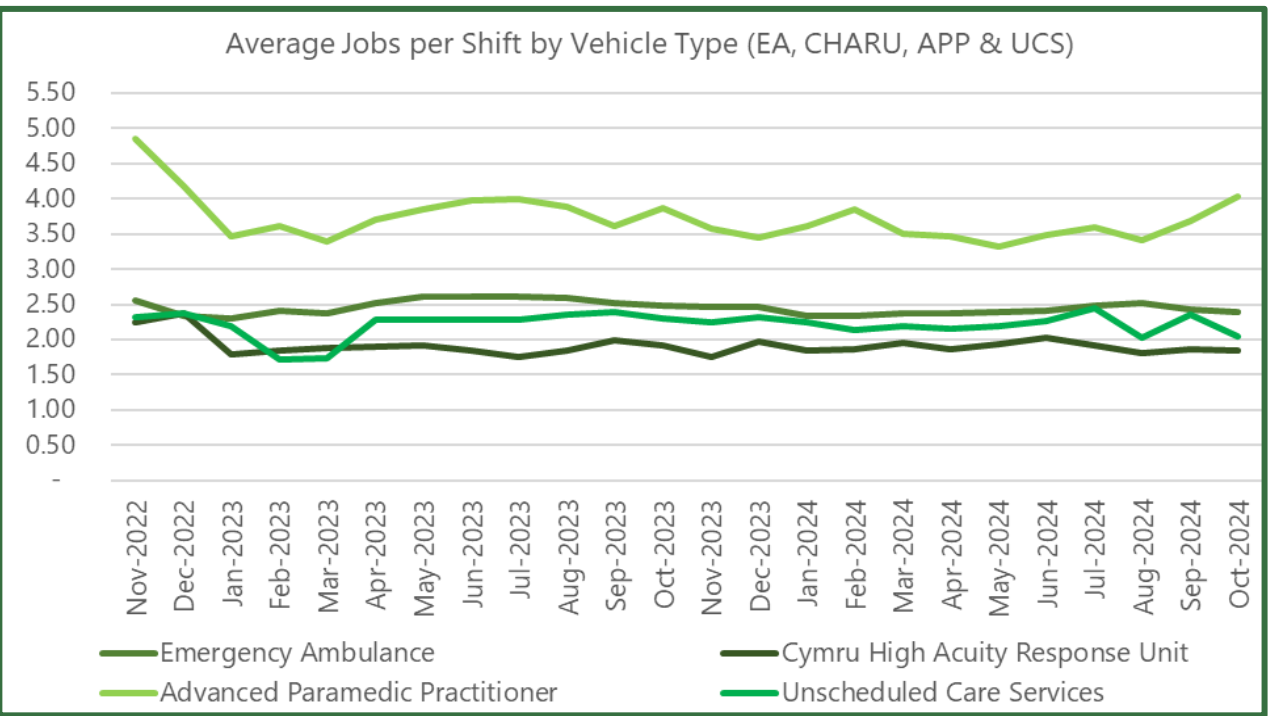
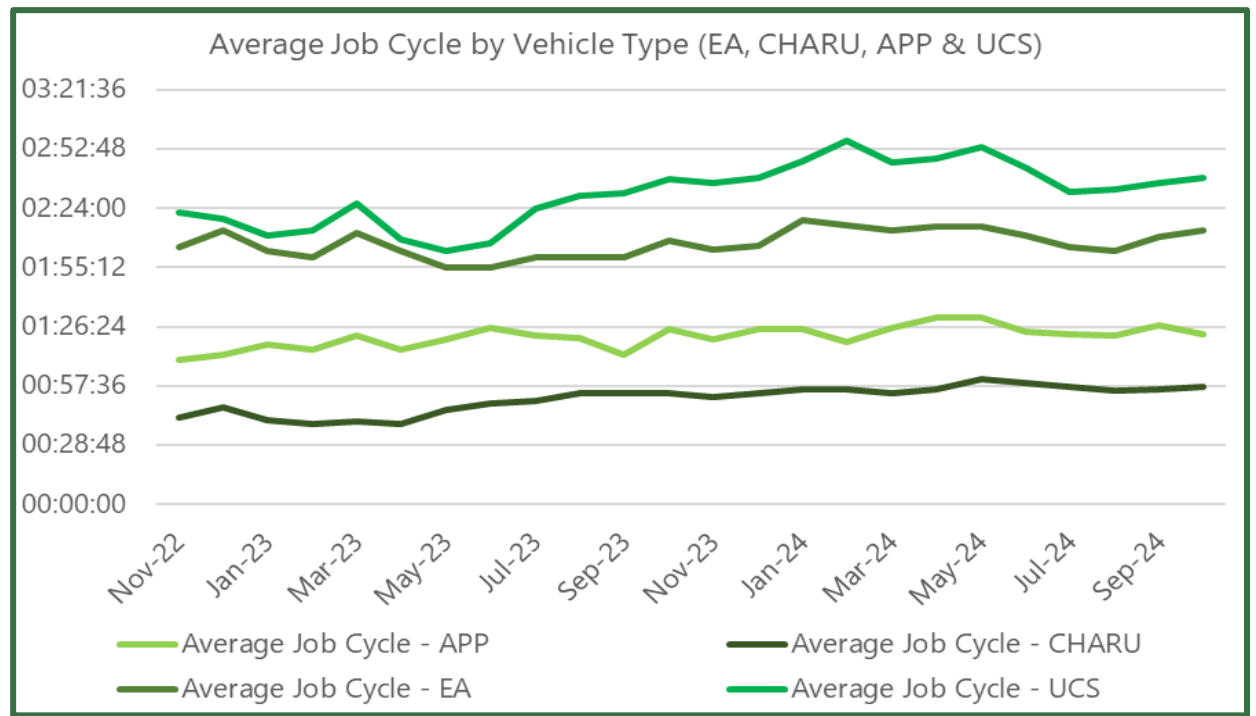
CHARU Utilisation
A

FPC

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



Analysis
Pan Wales Utilisation metrics in October 2024 were 57.4% for all vehicles types, decreasing slightly from 57.9% in September 2024. EA was the highest rate during the month at 68.4%, which has 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 increased in three categories in October 2024, 57 minutes for CHARU, 2 hours and 39 minutes for UCS and EAs to 2 hours 13 minutes. APPs decreased to 1 hour, 23 minutes.
 Overall average jobs per shift was 2.25 in October 2024, indicating a slight decrease from September 2024 (2.29). EAs averaged 2.40 jobs per shift and UCS crews 2.05 jobs per shift. This is more than what would be ideal and a product of handover delays.
 APPs attended on average 4.04 jobs per shift and CHARU's 1.84 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 October 2024, 60,779 calls were allocated into the 14 categories displayed in the graph opposite, an increase compared to the 57,093 seen during September 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 35.96% of all calls during October 2024, but there has been a material drop since the implementation of new 111CAS.

As the bottom left graph highlights, in October 2024, 7,092 calls were 'Stopped at Source', with no onward referral, an increase from the 6,434 in September 2024. 15,479 calls were referred to 999/ED in October, an increase from the 14,450 in September.

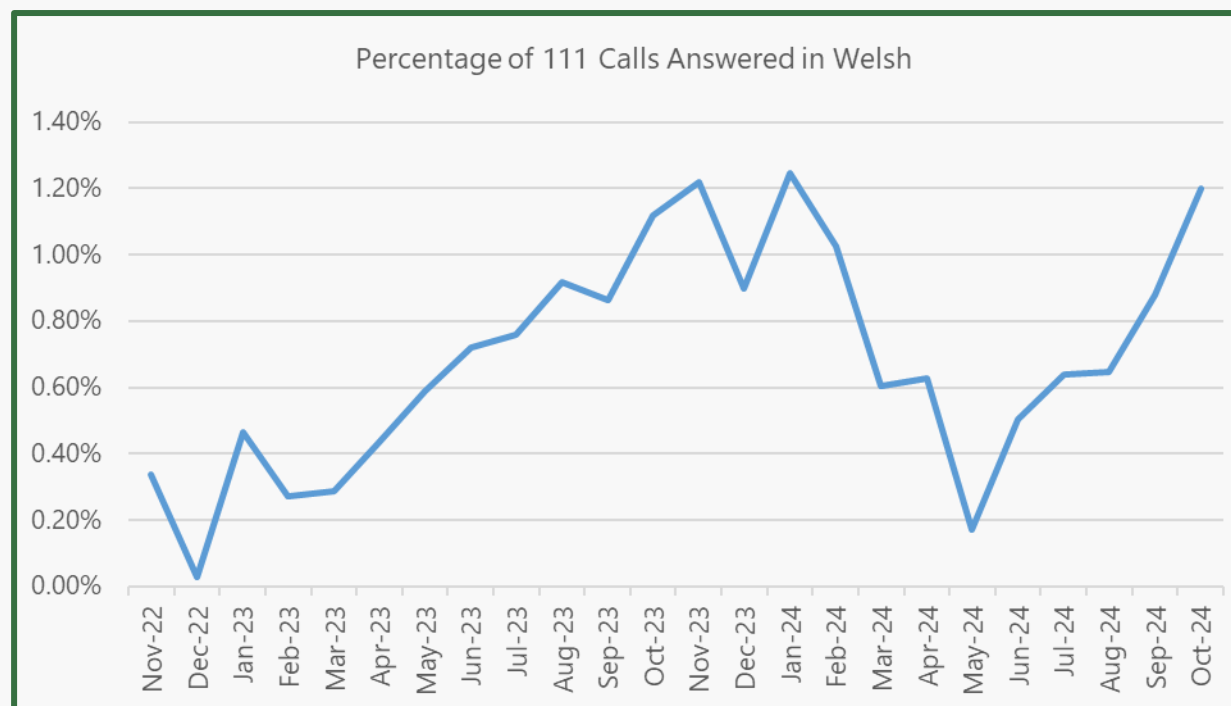
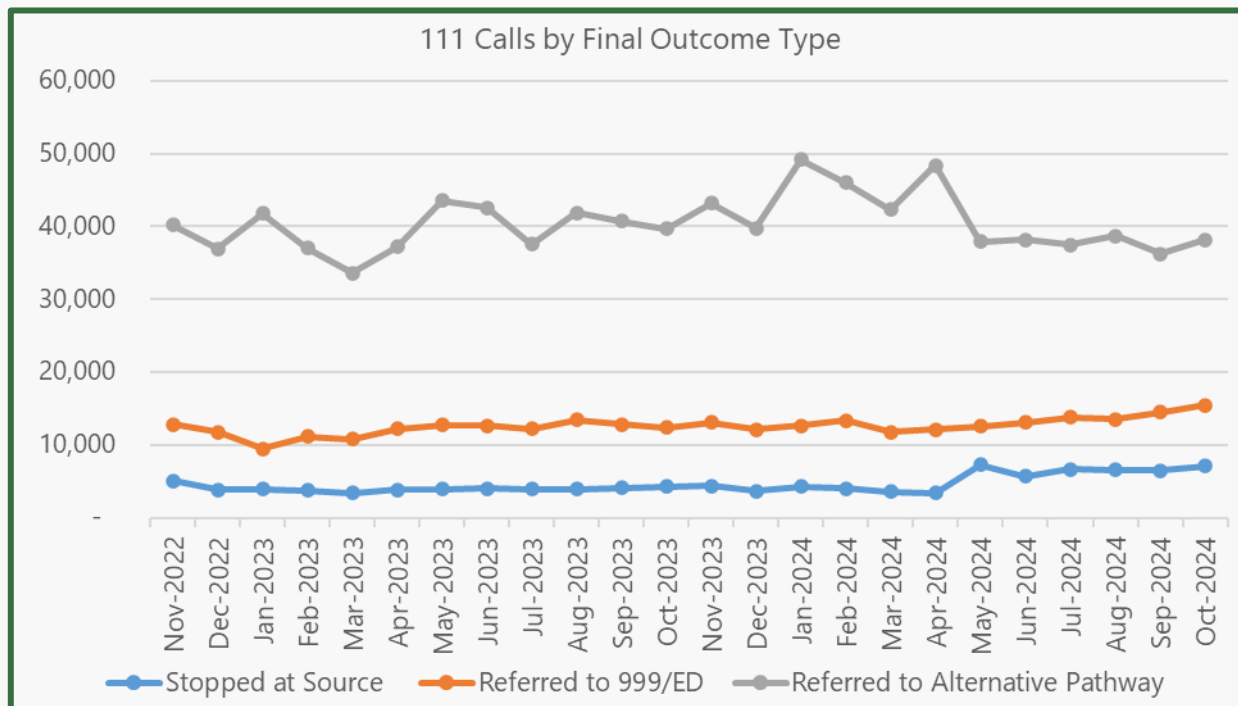
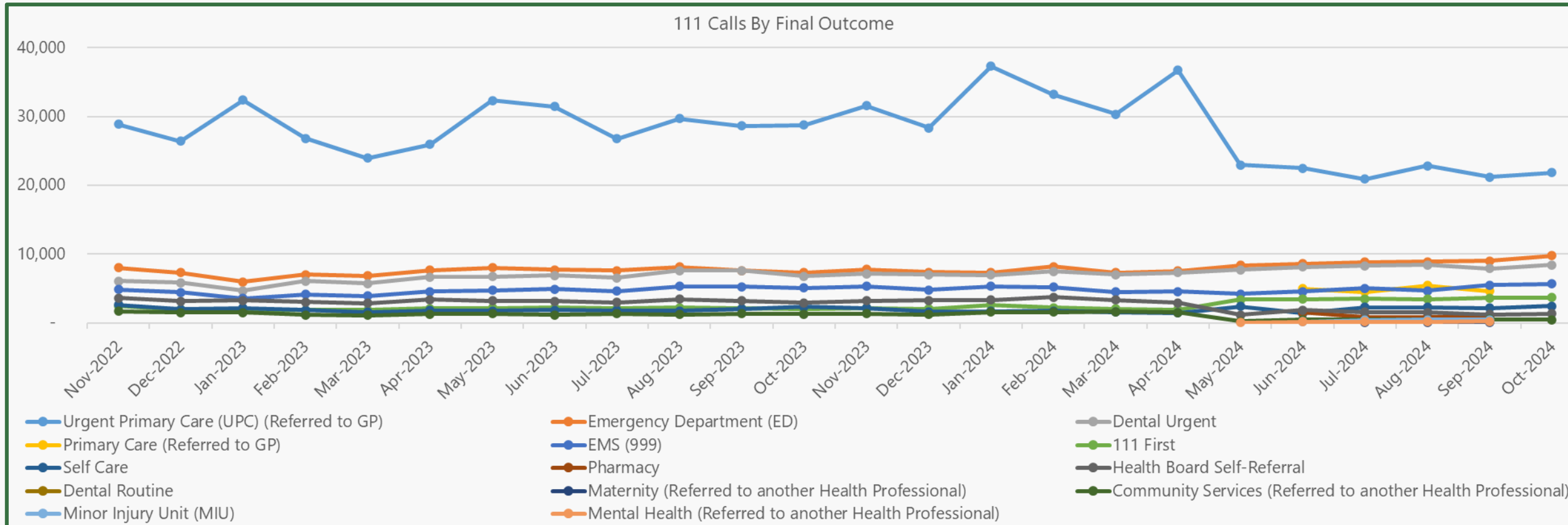
The percentage of 111 calls answered in Welsh increased from 0.88% in September 2024 to 1.20% in October 2024. This equated to 68% of all 111 calls being offered in Welsh being answered.

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.



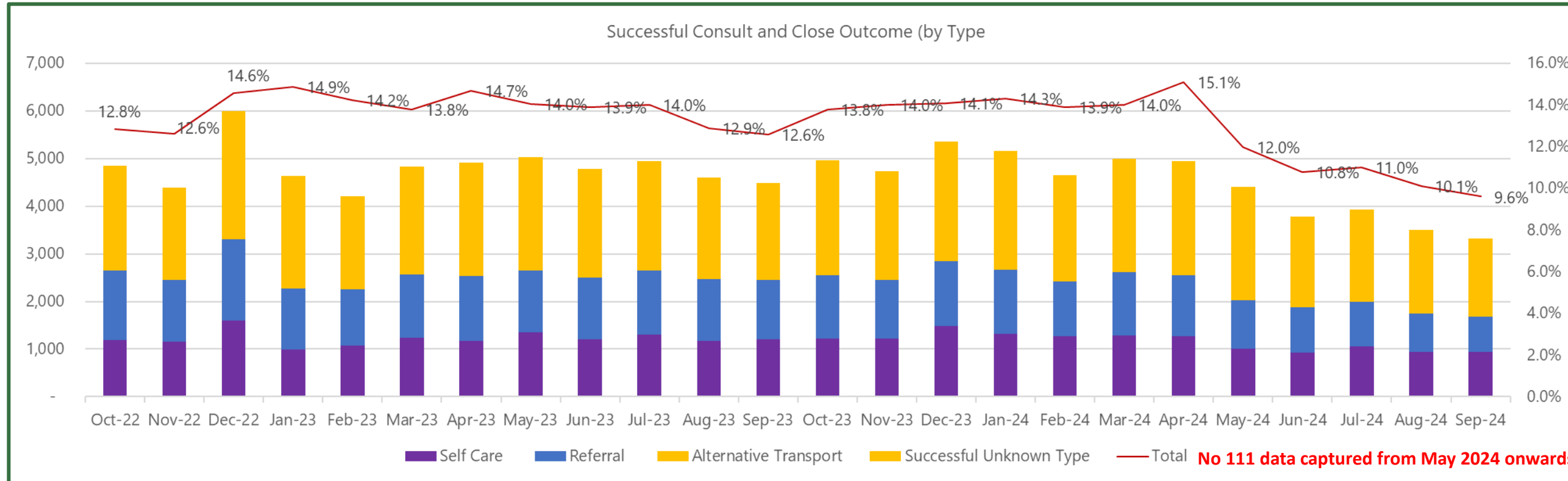
Partnerships / System Contribution Consult & Close Indicators

(Responsible Officer: Lee Brooks)

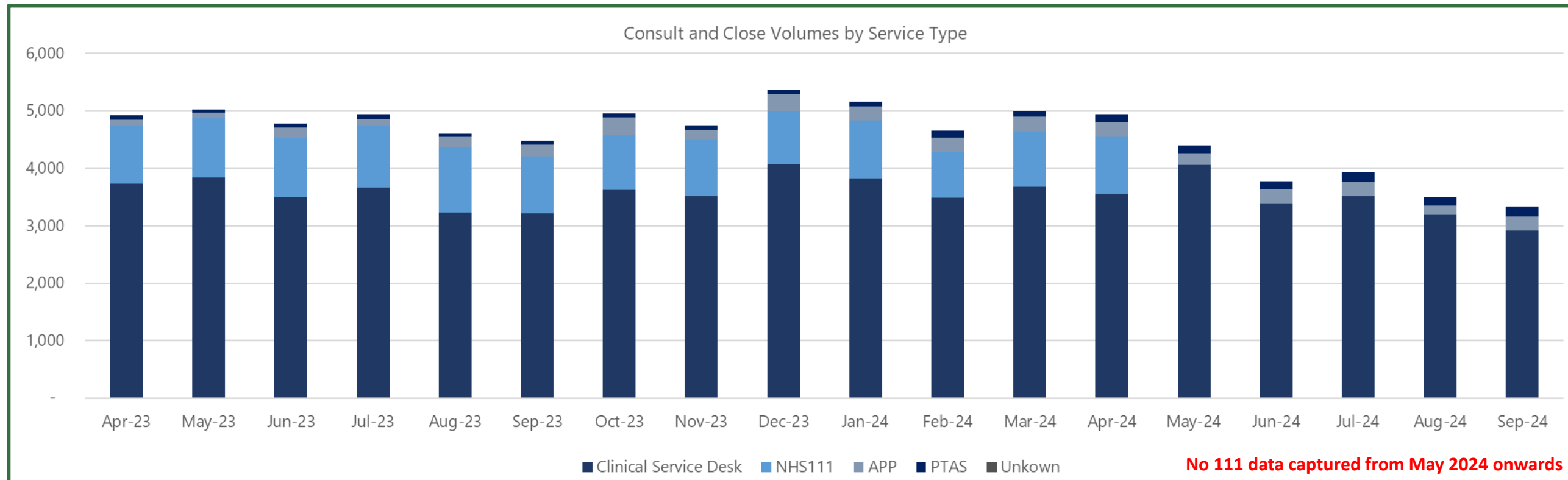
C&C
Outcomes

FPC

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



No additional analysis possible given no 111 data is currently available on these metrics.



Partnerships / System Contribution Conveyance to ED Indicators

(Responsible Officer: Andy Swinburn)

Conveyances

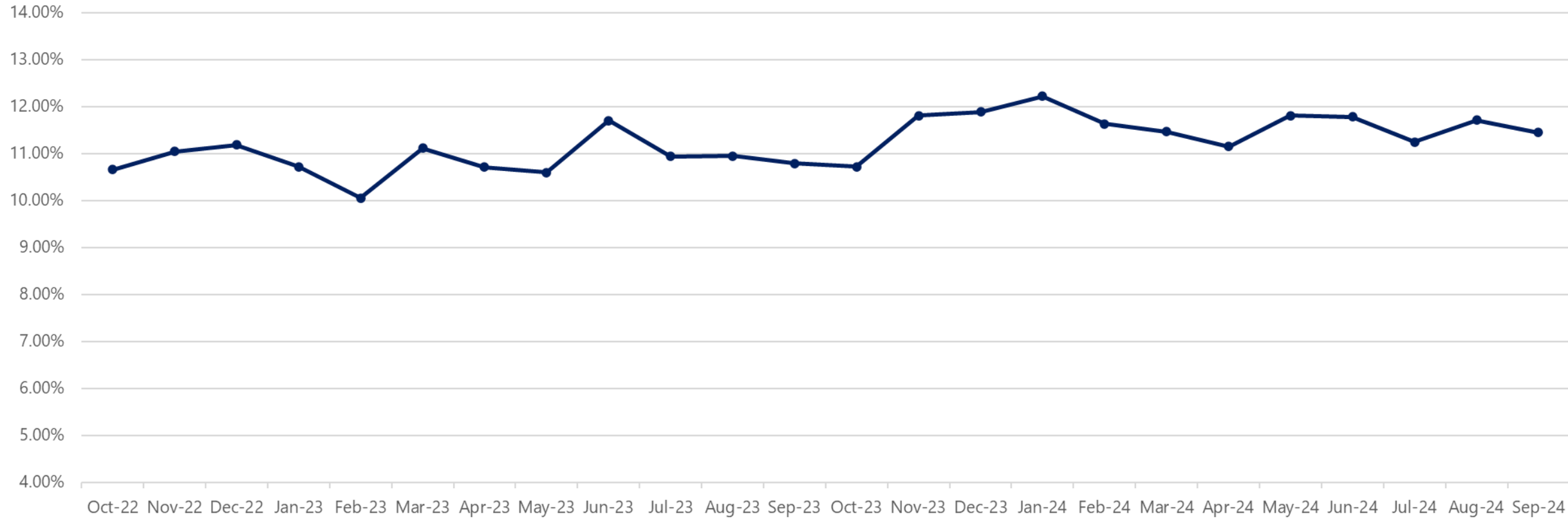
G

FPC

Ministerial Measure

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

% of Total Conveyances taken to a service other than a Type One Emergency Department



Analysis

In September 2024 11.44% of patients (1,537) were conveyed to a service other than a Type One ED, while 34.6% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers increased slightly, from 3,735 in August 2024 to 3,753 in September 2024.

The APP conveyance rate was 42.8% in September 2024 and continues to experience a generally increasing trend since March 2023; whilst the DCR table highlights by code the incidents where the preferred response should be an APP (if available). Pilot schemes are in place to clinically dispatch advanced and enhanced clinical resource to safely manage care closer to home, 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 0.12%.

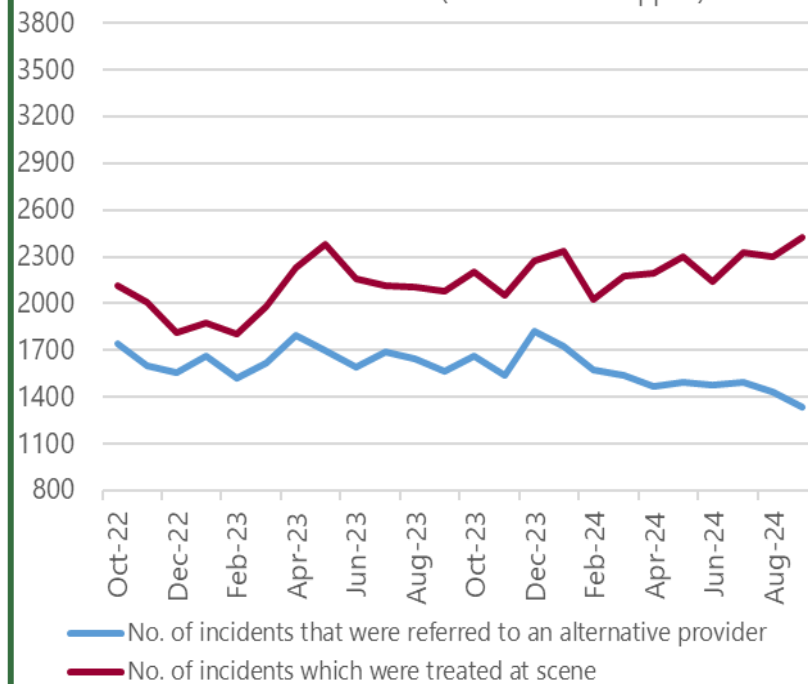
Remedial Plans and Actions

- Continued contribution to the SDEC strategy the 6 goals programme with HB actions around reporting measures from referral and bedding of SDECs in times of escalation. It should be noted that WAST data reflects a direct referral to an SDEC where some HB models require a conveyance to ED initially and then streaming to SDEC on this basis.
- Further investment in the APP workforce in 2024/25 (+32 APPs).
- Formal education support and induction package for APPs agreed trust-wide.
- Embedding the Urgent Care response within the Clinical Model Transformation, tasking optimisation (alongside HB partners if available), scheduling care and APP development and workforce.
- Inclusion of specific Frailty and Falls workstream within Urgent Care Response Service with involvement in the review of the All Wales Falls Response Framework alongside NHS Executive Colleagues.

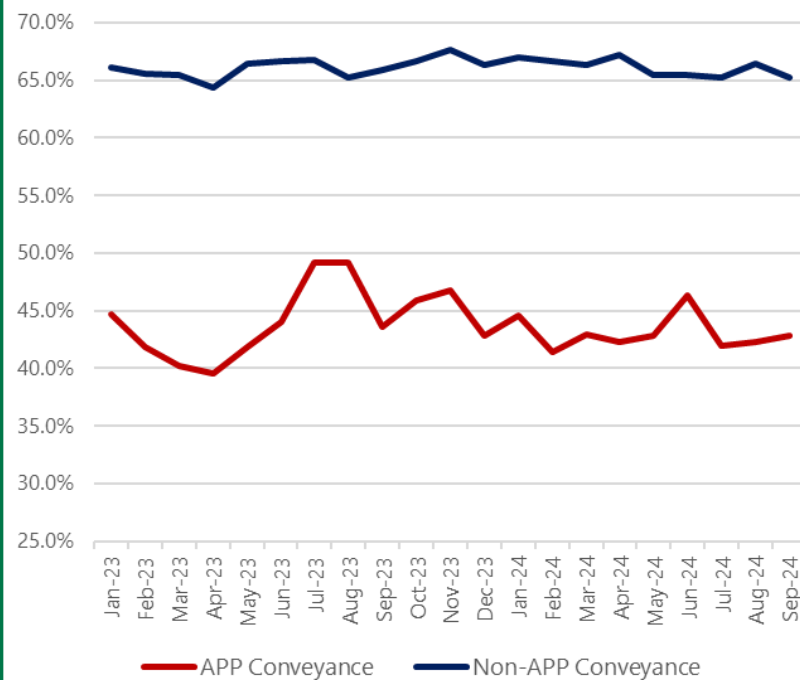
Expected Performance Trajectory

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. Seasonal modelling continues to be undertaken.

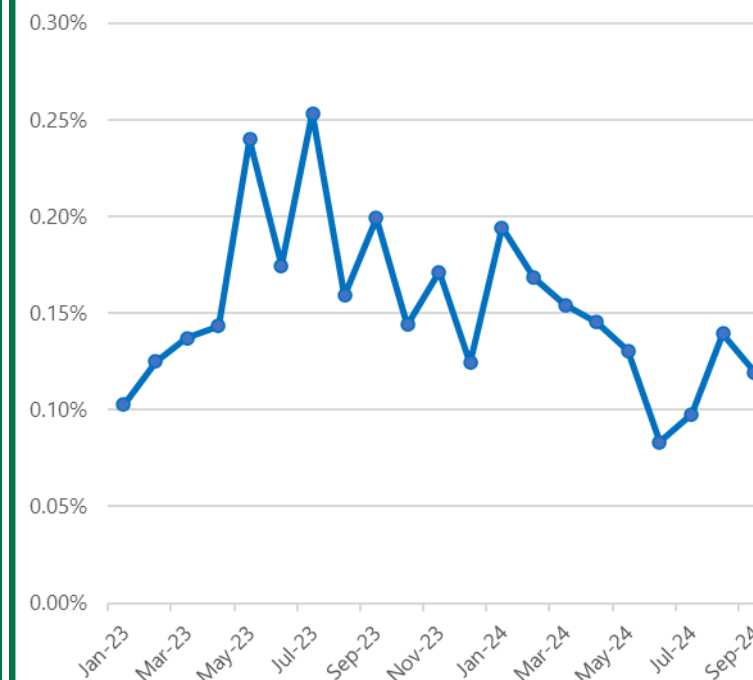
Incidents Treated at Scene VS Incidents Referred to Alternative Providers (Ambulances Stopped)



APP vs Non-APP Conveyance Rates



% Patients Conveyed to SDEC Units Pan-Wales



Partnerships / System Contribution Handover Indicators

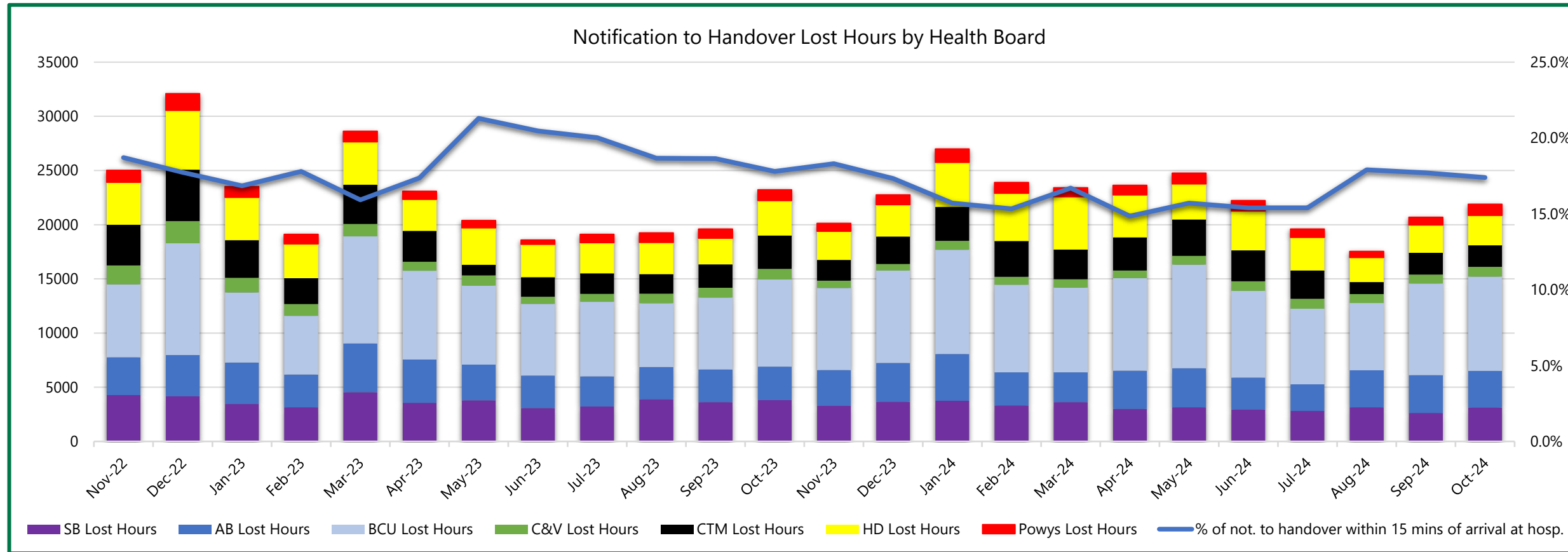
(Responsible Officer: Health Boards)

Lost Hours

R

CI

QUEST



Analysis

267,490 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (Nov-23 to Oct-24), compared to 271,609 hours over the same timeframe the previous year. There were 21,880 hours lost in October 2024, which is 5.8% lower than the 23,222 hours lost during October 2023.

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

- Maelor General Hospital (BCUHB) at 3,317 lost hours
- Grange University Hospital (ABUHB) at 3,214 lost hours
- Morriston Hospital (SBUHB) at 3,091 lost hours
- Ysbyty Glan Clwyd Hospital (BCUHB) at 2,643 lost hours

Notification to handover lost hours averaged 706 hours per day during October 2024 compared to 690 hours per day in September 2024.

In October 2024, the Trust could have responded to approximately 5,644 more patients if handovers were reduced, which highlights the impact these numbers are still having on the service.

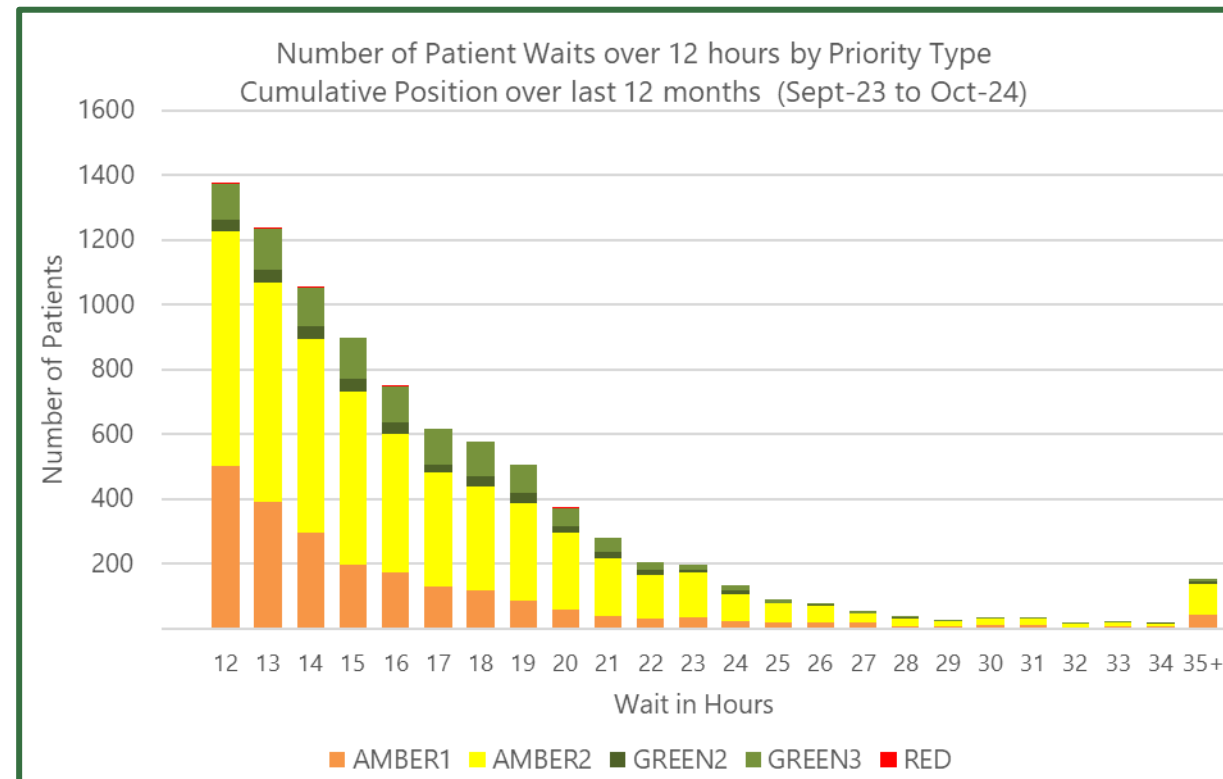
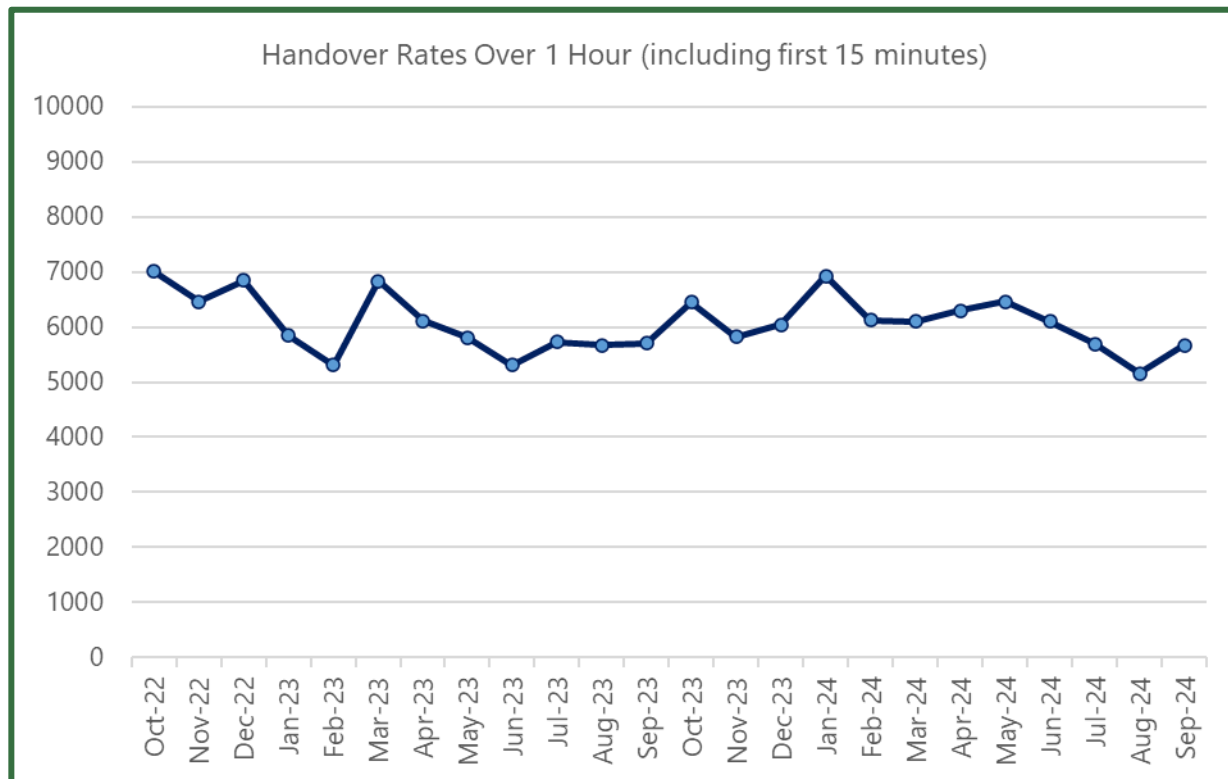
In October 2024, 796 patients waited over 12 hours for an ambulance response. In October 2024 85 compliments were received from patients and/or their families.

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

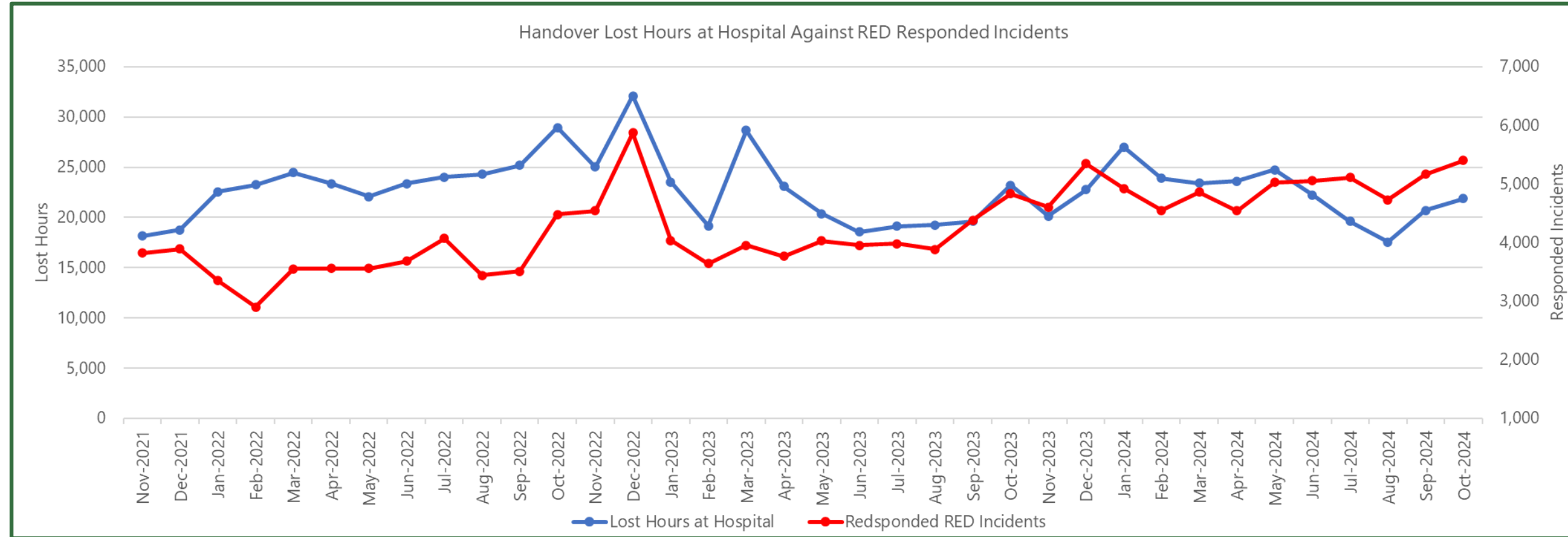
The Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,500 hours lost to handover delays per month. There would need to be a 60% reduction in current handover levels for this to be achieved.



Partnerships / System Contribution

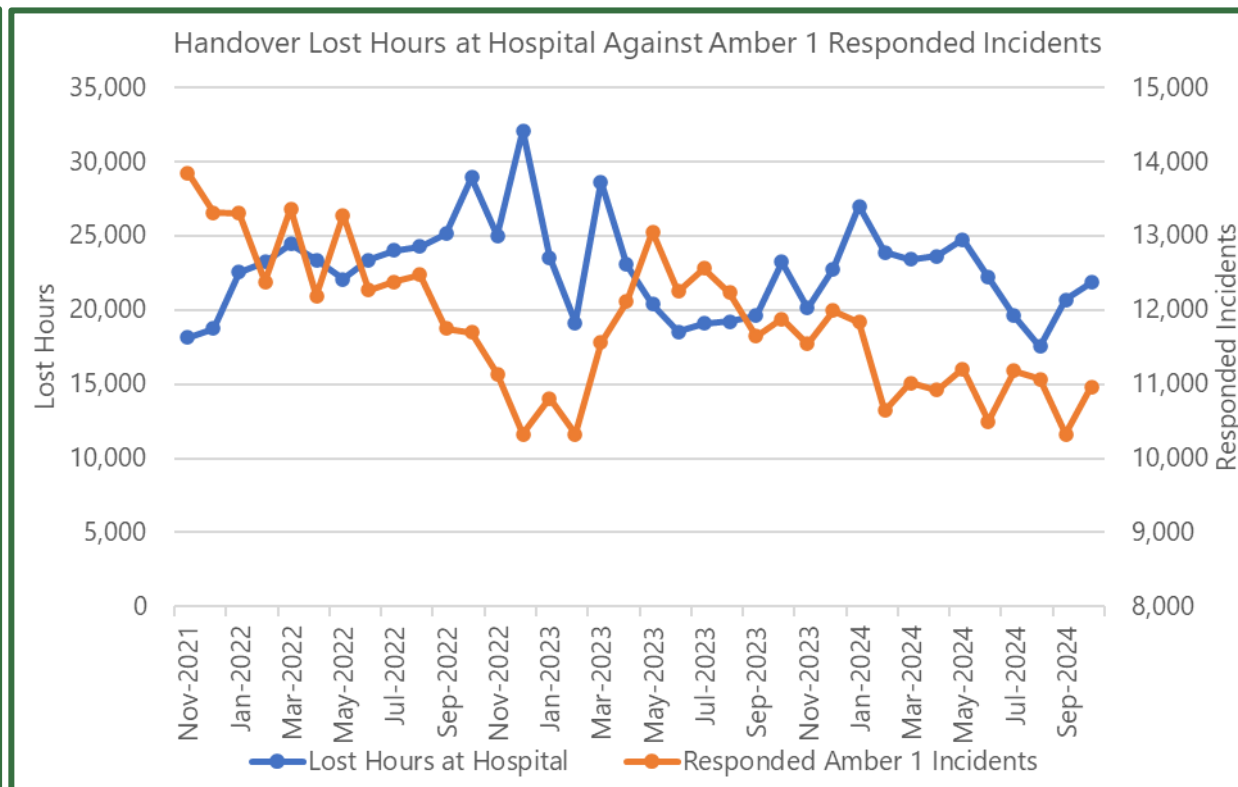
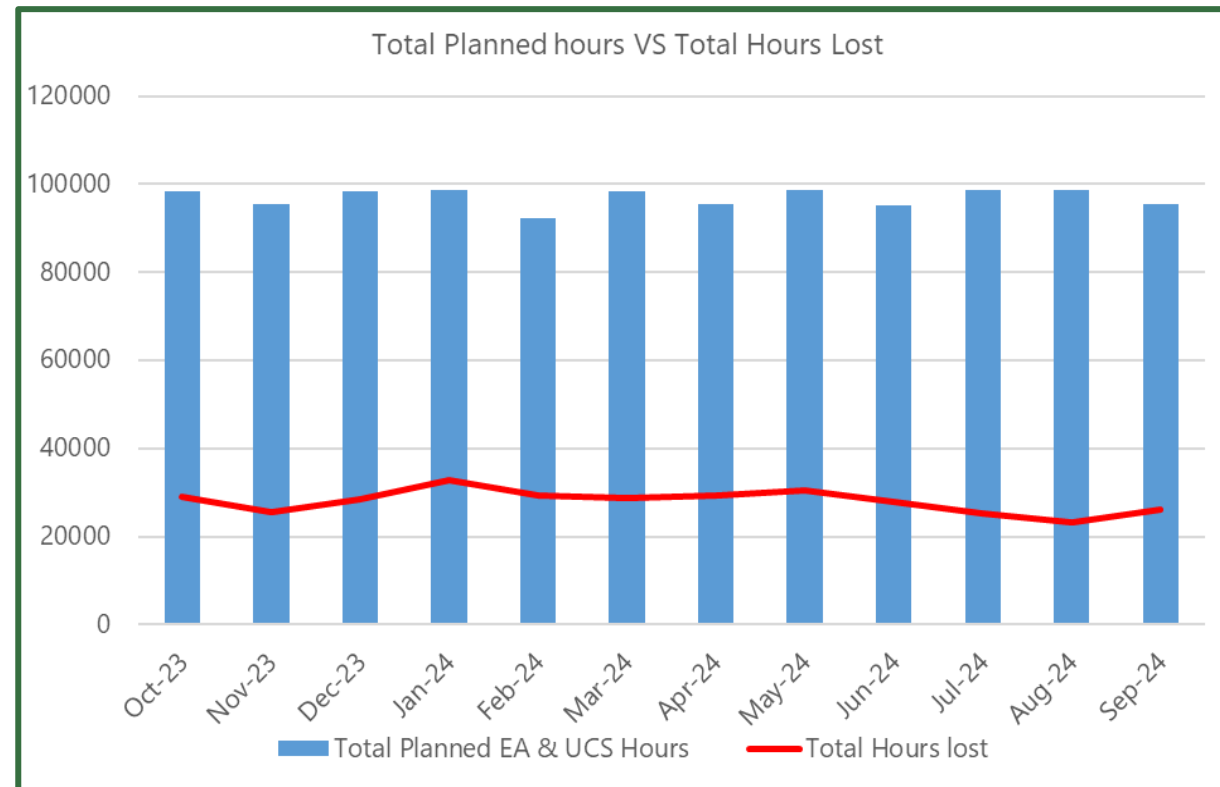
Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)



Analysis
 The top graph highlights that as handover lost hours have increased since November 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 right graph illustrates, there is a correlation between lost hours increasing and a decrease in the number of Amber 1 incidents being responded to, particularly at times of high demand, such as during December 2022. This is notwithstanding that some of these patients within the Amber 1 category will still be seriously ill.



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 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 21,800 hours, however handover in October 2024 was 5.8% lower than October 2023.

*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 care that 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	8
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

DIGITAL REPORTING

MEETING	Finance & Performance Committee
DATE	19 th November 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 30th September 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 spiked in September (up to an average of 40 days – although returned to steady levels under 30 days in October). This spike is due to a substantial existing backlog and reduced capacity in August due to summer holidays, which disproportionately affects small teams such as these. Additionally, the complexity of asks has been significant in recent months, with some data-related work for the 111 CAS Replacement still ongoing beyond project closure. The number of requests *received* continues to be higher than those requests that are *completed*, adding to the growing backlog / queue.
 - b. **Records Requests** continue to be received at a sustained high level – even beyond the trend of Q4 2023/24. Offers have been made to two new Records Officers who are due to join the team in the coming months. Due to long term sickness within the Records team, compliance to the target is also at risk, and many of the records management activities (from the

improvement plan and recent internal audit) have not been progressed. The exception to this is the Records Management Policy which was recently reviewed, received and accepted by Policy Group.

- c. The ICT **System Availability Metrics** show good performance across all critical systems for 2024/25 so far – with a short outage of the LifeX system in September impacting 999 telephony. However, even with these issues ‘up-time’ is still above the UK industry standard of 99.9% for the year-to-date period.

4. Service Provision:

- a. The **ICT Service Desk** metrics show a gap in contribution from the Robotics Process Automation (RPA) in recent months – this is due to a configuration change within the Service Desk platform (ServicePoint) which passes appropriate tasks to the robot. Work is ongoing to rectify the connection between the RPA and Service Desk platform. Additionally, a new IT service management system (known as House on the Hill) has gone live to replace ServicePoint, and is now being embedded within ICT processes and the team’s ways of working.

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). Some key points of note include:

- a. **Recruitment** into the new Digital posts following additional investment this year is progressing. Successful recruitment (offers accepted or people in post) includes the following: cyber specialist; principal analyst; senior analyst; 2 x records officers; 2 x data protection compliance managers; CCIO; and a new Assistant Director. Several other roles are progressing through Job Evaluation and Recruitment Control processes.
- b. Specialists across Digital are supporting the **Clinical Model Transformation** efforts, including various asks for baseline data, new categorisation reporting and visualisations, as well as telephony and CAD engineering work. The focus on this programme does mean progress on other projects as listed in the Digital Plan have slowed or paused, for example: automation projects; some data linkage work (the sharing of the OHCA data continues); 111 visual IVR, and the insight catalogue.
- c. The **PowerBI migration** initiative sought to transition our reporting and dashboards from Qlik to PowerBI to help modernise, streamline and secure our intelligence. More than 120 WAST colleagues have been trained on

the new PowerBI platform and products, supporting self-serve of intelligence, and a “playlist” of short training videos are being made available on SharePoint. This migration project is almost complete but a final dashboard to support commissioners in their daily access of WAST information needs to be developed – this is currently in scoping phases to ensure it meets the needs of the JCC but also considers IG and data protection requirements.

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

KEY ISSUES/IMPLICATIONS

7. The Clinical Model Transformation programme requires 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 new call flow and categorisation process. These requirements were not known at the time of writing of the Digital Plan and so many of the pre-agreed priorities and timelines for 24/25 are now paused or at risk.

REPORT APPROVAL ROUTE

Directorate Plan progress - reviewed at DLG 30th October 2024

REPORT APPENDICES

Main report – ‘Digital Reporting November 2024 - Metrics’

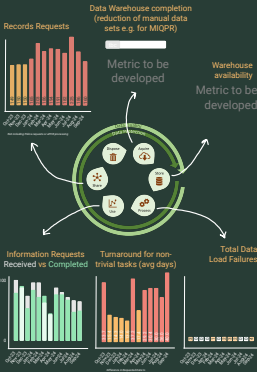
REPORT CHECKLIST

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

Digital: Data & Analytics

Data Lifecycle

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



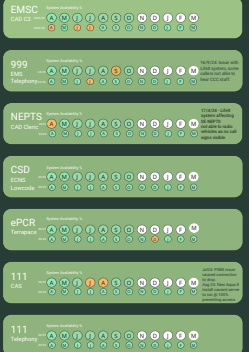
Data Protection & Data Quality metrics found in Information Governance and Security Report

Digital: ICT Systems

System availability metrics

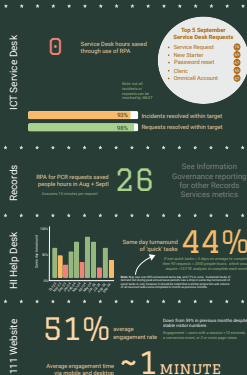
N.B. these are not reflective of SLAs, and do not yet differentiate supplier issues & resolutions

Definitions based on industry standards
 <math>< 22</math> mins downtime = 99.99%
 <math>< 25</math> and <math>< 4.8</math> mins = 99.9%
 <math>< 2.8</math> mins downtime = <math>< 99.8</math>%

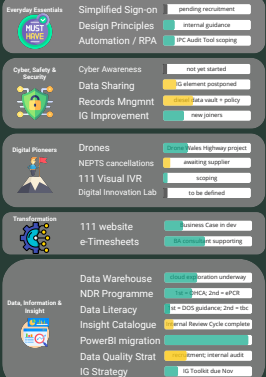


Digital: Service Provision

Quality, efficiency, and stakeholder feedback: SEPT 24



Digital Contribution 24/25



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

RAG and progress based on Directorate Plan Last updated 30/10/2024



GIG
CYMRU
NHS
WALES

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

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

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

MEETING	Finance & Performance Committee
DATE	19 November 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
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EXECUTIVE SUMMARY

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 paper provides an update on the Clinical Model Transformation programme and confirmed end of quarter 2 (Q2) position on the Directorate-led IMTP portfolio, including the Ministerial (now Cabinet Secretary) Priorities set by Welsh Government.

RECOMMENDED:

That the Finance & Performance Committee:

1. **Notes** the CMT programme progress update;
2. **Notes** the confirmed Directorate-led IMTP end of Q2 position
3. **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

Delivery and assurance arrangements for the CMT programme are now embedding within a 6-weekly business cycle aligned with the Strategic Transformation Board (STB). The CMT Board convened in mid-September to review updates from the five core workstreams, approve FY24/25 workstream plans, and the integrated governance map. A Programme Vision session was also held to shape the programme's identity, vision, and Leadership Principles for collaborative work, which are now under further development based on feedback. Programme documentation is progressing incrementally, with the Programme Definition Document (PDD) prioritised and set to be presented in draft for feedback at the November CMT Board.

The overall status of the programme (from a management perspective) 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

The Planning Team continues to work with Directorates to ensure assurance through directorate plans to the CEO and STB and enabling a structured approach to planning through the Integrated Planning and Development Group (ISPD).

The assurance report in Appendix 1 confirms the end of quarter 2 position (i.e. end of September position). A number of deliverables at directorate level remain **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 Digital and Strategic Workforce Plans (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.

Appendix 2 sets out how we are progressing against ministerial priorities set out in the last NHS Planning Framework.

Outcomes measures

In the last update to Finance & Performance Committee and Trust Board, the assurance report set out a number of measures that were included in this year's IMTP. Some of the metrics required for directorate led plans are still in development, where they are not already accessible in the MIQPR.

The Planning and Performance teams will be working over the next reporting period to determine whether these metrics will become available and as part of the refresh of the next IMTP review 'what good looks like' in the context of the current IMTP delivery and future plans emerging throughout the planning cycle.

REPORT APPROVAL ROUTE

Strategic Transformation Board 09 October 2024

REPORT APPENDICES

Appendix 1 - IMTP Delivery Assurance Report

Appendix 2 - Assurance against the Cabinet Secretary's priorities 2024/25

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

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. This SBAR sets out the Clinical Model Transformation Programme progress, directorate led IMTP delivery and our assessment against ministerial priorities.

Background

Clinical Model Transformation (CMT) Programme Management Progress Update and Next Steps

2. Delivery and assurance arrangements for the CMT programme are starting to embed, operating on a 6-weekly cycle of business aligned with the Strategic Transformation Board (STB). The CMT Board met for a second time in mid-September to consider updates from the five core CMT workstreams and change enabling groups. The Board also reviewed and approved CMT workstream plans mapping key milestones for delivery during FY24/25, and the integrated governance map for the programme.
3. A Programme Vision session was facilitated at the CMT Board to consider the programme identity and the vision statement for our future model. This included discussions around development of Leadership Principles to inspire the way that we work collaboratively across the programme. These are now being further developed, informed by feedback from the session.
4. As noted previously, development of programme documentation is being managed incrementally due to the pace and scale of project initiations across the programme. Development of the Programme Definition Document (PDD) has been prioritised as the cornerstone document for the programme and will be presented in draft at the CMT Board in November for initial comments and feedback.

Clinical Model Transformation (CMT) Workstream and Enabling Working Group Updates

CORE CLINICAL MODEL TRANSFORMATION (CMT) WORKSTREAMS	
DIGITAL FRONT-END	↑ Green
<p>On Track: Short-term funding has been approved to take forward plans on the Digital Front-End, including recruitment of 2FTE specialist contractors and procurement of an integrated Chatbot function through 'RoboticsAI'. Recruitment and procurement are now progressing and will enable the group to take forward several initiatives including content improvements to the existing website, identification of a content management solution, and Outline Business Case development to secure support and funding for recurrent costs and long-term developments.</p>	

RAPID CLINICAL SCREENING

↔ Green

On Track: Clinical Navigator interviews are complete and formal appointments are progressing with a total of 26.7FTE. Discussions are taking place on regional split of Clinical Navigators, due to lack of suitable candidates in the North. All training plans and arrangements are in progress with the aim for Rapid Clinical Screening to go-live in mid-November.

Clinical Quality Governance Group have approved the Quality Impact Assessment, and go-live planning is underway, including confirmation of go/no-go arrangements which will be presented to CMT Board for approval on 08/11.

REMOTE INTEGRATED CARE SERVICE (RICS)

↑ Green

On Track: Following successful testing, a streamlined process for 111 to 999 call transfers has been embedded into business-as-usual from early-September. The improved process enables 111 Call Handlers to electronically transfer the patient record to the EMS Coordinator, eliminating the need for details to be relayed verbally, reducing average handling time by approximately 50 seconds for this cohort of calls.

Planning for the Integrated Care Planning Desk trial is underway; aiming for Nov-24 go-live. Two further PDSAs of the use of the 111 call-handling system CPSS (Call Prioritisation and Streaming System) for the management of 999 originating activity have been completed with positive indicative results and next steps will be considered by the Project Group and RICS Workstream Board.

A Remote Assessment CAD Project Group has been established, to develop an effective Integrated Care CAD with enhanced capabilities including access to the Welsh Clinical Portal and Welsh Demographics Service, digital referral pathways, and Video Consultation. The group is currently developing a detailed delivery plan and will report to the RICS Workstream Board.

Hywel Dda have agreed to develop a 24/7 model of care with WAST, trialling a remote clinician operating in Health Board Clinical Hub(s), and testing processes for the management of complex patients. The Lusci test of change with BCU commenced on 21/08 with early positive feedback from the Remote Monitoring Clinician (RMC) on impact of observations on outcomes, dispositions, and clinical decision making.

URGENT COMMUNITY RESPONSE SERVICE (UCRS)

↔ Yellow

Yellow (cautionary status) overall: The Urgent Community Response Service (UCRS) has evolved from the formal Clinical Transformation Programme Board (under the legacy IMTP Delivery & Assurance structure). The previous programme has been fully reviewed and rescoped into four UCRS Projects with newly defined objectives.

These new groups met in early-October and will report into an overarching UCRS Workstream Board and Terms of Reference are now in development for all groups.

The 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 as noted in the previous paper, a way forward has been identified. A paper was taken to Operations Senior Leadership Team in mid-September and next steps agreed.

A Falls & Frailty Response Model Group has been established to review the impact of existing falls and frailty services with the purpose of designing efficient and sustainable urgent care service models that provide timely, appropriate, and effective care for patients across Wales.

A Tasking Optimisation Group will also be established to design the optimum configuration of our Urgent Community Responders, including APP Scheduling and operationalisation of the Mental Health Response Vehicle (MHRV). These projects were identified as Phase 1 CMT priorities and are progressing well with the recent completion of PDSA Cycle 4 for APP Scheduling to test the use of MS Teams Shift Planner, and 2FTE Mental Health Practitioners appointed (commencing 21/10) to deliver the first phase of the MHRV model. The first MHRV went live in the South East on the 3rd November.

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. Reports have been developed against these new protocols and continue to be reviewed to support process refinement.

The draft outcome report from the NEPTS Vision Setting event held by the Joint Commissioning Committee (JCC) was received and presented to STB for discussion. It was noted that the proposal focused more on incremental service improvements rather than transformative change and feedback was encouraged on the draft document, particularly around the level of ambition and future-forward visioning.

CHANGE ENABLING WORKING GROUPS

CALL CATEGORISATION

Complete

Complete: The Task & Finish Group was commissioned to collaboratively design and develop a revised Call Flow and Call Categorisation approach and met for a third on 23/09. Following internal confirmation of the call categorisation model and formal engagement and initiation with Commissioners, Welsh Government, and MIS (system supplier), a recommendation was made by the Task & Finish Group and approved by the CMT Board on the 27/09 that the Task & Finish Group would be closed and that a Call Flow Implementation Group would be established to oversee delivery of the agreed model.

A Call Flow Implementation Group has subsequently been established under the Emergency Response Service Workstream and will report directly to the CMT Board, taking forward plans for call flow and category changes.

The proposed call category changes for existing 999 activity were approved by Clinical Quality Commissioning Group on 17/09, including a timeline for phased implementation. Following this approval, several external dependencies (including Welsh Government and Joint Commissioning Committee recommendations, and developer-led capacity) have resulted in a revised go-live approach and timeline as follows:

PHASE 1: Launch the Rapid Clinical Screening (RCS) function with responsibility for Remote Clinical Support, Queue Safety, and High Acuity Live Review of the existing RED category, transitioning these duties from the Clinical Support Desk (CSD) to the RCS function.

PHASE 2: Phased deployment of RCS for the existing GREEN and AMBER categories whilst maintaining RED response categories and reporting measures to ensure stability.

Tranche 1: GREEN; expected 03/12

Tranche 2: AMBER2; expected 10/12

Tranche 3: AMBER1; expected 28/01

Further phases may then be undertaken in the next financial year.

QUALITY & PERFORMANCE METRICS

↑ Green

On Track: The group is currently focused on implementation of ARREST category reporting (which does not change service model), however there is a dependency on MIS (system supplier) to complete CAD development to enable technical specification development and dashboard development to commence.

An external, independent evaluation will be commissioned to ensure a robust and structured approach, and an evaluation specification is currently in draft for presentation to the CMT Board (08/11).

The Programme will adopt a structured approach to benefits realisation and will implement a Logic Benefits Model (LBM) for each of the five core workstreams. This hybrid template, combining elements of a traditional Logic Model and a Benefits Dependency Map, will clearly outline the relationships between workstream activities, outputs, outcomes, and the realisation of associated benefits. A further workshop was convened on 25/10, and a proposal and template LBM developed for presentation to the CMT Board (08/11).

CHANGE MANAGEMENT

↓ Yellow

Yellow (cautionary status) overall: The Change Management Working Group has now been established and met on the 19/09. Change Management Principles have been agreed; however, the status reflects the need to begin applying change management principles to the existing workstreams. The intention is for each CMT Workstream to be supported by a dedicated Change Lead, however the process to identify and secure this support is ongoing. Change Leads will be selected from the Trust's Change Community, comprising colleagues who have been supported

to undertake accredited Change Management Training. This request (including estimated level of commitment required) is being discussed with respective Directors, seeking full support.

PARTNERSHIPS & ENGAGEMENT

↔ **Green**

On Track: Engagement is ongoing with Welsh Government and Joint Commissioning Committee.

STB was asked to note that the Trust is receiving an increase in requests from external stakeholder groups to formally present the emerging Clinical Service Model. These requests are being received by colleagues from across the organisation, making it highly challenging to co-ordinate effectively and manage the engagement process. The Programme Engagement Plan (PEP) was presented to the CMT Board in September and is currently being refined following feedback. The PEP included the identification of 'Talking Heads' with responsibility for communication and engagement with external stakeholders to support a consistent and coordinated approach.

Directorate-led IMTP Delivery & Assurance Approach

1. 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.
2. Existing Directorate Business Meetings will be utilised, and assurance will be provided to the Strategic Transformation Board and onward to the Committee and Board.
3. 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.
4. The current update in this paper is the confirmed end of quarter 2 position, following an interim updated position provided to the Committee in September.

Operations

IMTP Objective	IMTP Actions / Deliverables Q2	Progress / RAG
High quality, immediate or timely on scene assessment, care and conveyance where needed	<ul style="list-style-type: none"> Fully roll out CHARU 	<ul style="list-style-type: none"> 75% recruited. Courses running in November to maximise uptake. Steering Group providing oversight
Immediate 999 call answering, and efficient and effective dispatch of the right resource	<ul style="list-style-type: none"> New management structure EMSC 	<ul style="list-style-type: none"> Final OCP document issued in July, Project in implementation stage
Rapid call answering, initial triage and onward referral	<ul style="list-style-type: none"> New remote clinical assessment service clinical leadership team 	<ul style="list-style-type: none"> In process of recruiting clinical navigators and locality manager.

A flexible, user centred Non Emergency Patient Transport Service with the right capacity in place to meet demand	<ul style="list-style-type: none"> • UCS Review Implemented 	<ul style="list-style-type: none"> • On track to deliver in Q3
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Our People

IMTP Objective	IMTP Actions / Deliverables Q2	Progress / RAG
Capability	<ul style="list-style-type: none"> • No specific milestones in Q2 • Ongoing work: People Development plan, People Management Essentials and PADR check ins 	<p>People Development Plan (RED) delayed due to developing the Strategic Workforce Plan; it was therefore agreed the PDP won't be delivered this year.</p> <p>PADRs (GREEN): Stakeholder meetings are underway, focusing on three key areas: the purpose of PADR, what is valued, and how it can be improved. Insights from these meetings will inform the development and improvement of the process. A scoping exercise due to commence to identify PADR/PDR processes in use across NHS Wales and also outside sector where the focus is on enabling meaningful performance and development conversations.</p> <p>Managers Essentials: (GREEN) Framework developed. Currently working with external provider (Leaderful Action) to prepare supporting interactive brochure and toolkit.</p>

Capacity	<ul style="list-style-type: none"> • Delivery of Strategic Workforce Plan (Q1 milestone) • Ongoing work: Health & Wellbeing Plan, Retention work plan, eTimesheets 	<ul style="list-style-type: none"> • Strategic Workforce Plan (Blue - complete) - approved at Trust Board in September, launch currently underway. Health and Wellbeing Plan: (GREEN) Going to People and Culture Committee on 14th November for approval following extensive
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		<p>consultation and development. Retention Plan: Green, all elements on track.</p> <ul style="list-style-type: none"> E-Timesheet: AMBER: The SMA App has now rolled out and has been live from 1st September 2024. We are linking in with the Health Informatics Team To develop an electronic trigger - raised a support request as directed by the HI Team, and the HI Team were going to determine who would be best to support with work.
Culture	<ul style="list-style-type: none"> No specific milestones in Q2 Ongoing work: Allyship and Bystander training, Employee offer, Culture Champions & Change Network, impact of culture toolkit 	<p>Allyship and Bystander Training: GREEN: Allyship and Bystander Training review completed and schedule of training in place for 2024-2025.</p> <p>Culture Champions: GREEN: 25 new members in September (total: 147; 68% Operational, 32% Corporate). Area hotspots analysis underway. Training: "Demystifying Culture" session 1 done (25 attendees); session 2 on 13th November. Toolkit: Bi-monthly Spotlight Mini-Series launched with flexible materials for on-the-go use. Engagement: NHS Staff Survey Drop-Ins held; recruitment events ongoing. Recognition: 65+ "SHOUT-OUT" posts; new QR code for easy access.</p> <p>Change Community: GREEN: 60 members; excellent engagement at October meeting where members were provided with the opportunity to apply learning to scenarios. Change Leads for CMT Programme workstreams have been identified from this pool and are currently being linked up with their respective workstreams.</p>

		Culture Toolkit: RED : No further progress made due to capacity issues in the team.
Strengthen Welsh Language compliance	<ul style="list-style-type: none"> Welsh language standards baseline established Recruitment strategy developed to attract and evaluate candidates based on their Welsh language proficiency 	<ul style="list-style-type: none"> Developed and approved by PCC on 30/08/24. Ongoing – will form part of the Workforce Strategy

Our Digital Roadmap

Objective	IMTP Action/Deliverable	Progress / RAG
Develop & agree digital plan	Q2 Refresh plan against five cornerstones below: <ul style="list-style-type: none"> Everyday essentials Security, Safety & Cyber Digital Pioneers Transformation Data, Information & Insight 	Complete. Plan signed off at July Trust Board.

Our Infrastructure

IMTP Objective	IMTP Actions / Deliverables Q2	Progress / RAG
Developing and implementing our plans for Environmental Sustainability and Adaptation*	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> No specific Q2 milestone – delivery of wellbeing objectives published by end Q4 	<ul style="list-style-type: none"> Group to be convened to develop wellbeing objectives by end of Q2
University Trust Status in collaboration with WG, embracing a 'democratised	<ul style="list-style-type: none"> Academic Partnership priorities updated and published 	<ul style="list-style-type: none"> Paper going to next APC at start of October

culture' of learning, research and innovation		
Well-placed to influence system thinking/strategy development	<ul style="list-style-type: none"> Structured engagement commenced with stakeholders & public 	<ul style="list-style-type: none"> 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

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.	<ul style="list-style-type: none"> Employ 16 APPs completing masters 	<ul style="list-style-type: none"> 11 funded MSc students have been recruited. Also recruited an additional 11 external/self-funded APPs so 22 in total have been recruited for the year.
Systems that meet the requirements of the Duty of Quality and Duty of Candour	<ul style="list-style-type: none"> Establish a Quality Improvement Hub 	<ul style="list-style-type: none"> 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.
A culture of quality improvement with robust quality management systems		
High quality Putting Things Right, Safeguarding and Health & Safety systems	<ul style="list-style-type: none"> Implement bespoke training materials 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> CIVICA enhancement 	<ul style="list-style-type: none"> Report completed Surveys in CIVICA to Welsh Government Launch of the SMS text service is wholly dependent on the IG issues / legality around consent.

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	<ul style="list-style-type: none"> No milestones for Q2 – implementation of Strategic BAF by end of Q3 	<ul style="list-style-type: none"> Ongoing – Strategic BAF template in hand – meeting with peers, paper presented to Sept ARAC. Next steps workshop in November 2024 on risk appetite
An integrated governance Framework	<ul style="list-style-type: none"> Governance structures mapped out 	<ul style="list-style-type: none"> Ongoing – presentation of the map at ADLT on 23/10

Value & Sustainability

IMTP Objective	IMTP Actions / Deliverables Q2	Progress / RAG
Developing and implementing our plans for Environmental Sustainability and Adaptation	<ul style="list-style-type: none"> Establish a cross-organisational Adaptation Planning group (Q1 Milestone) 	<ul style="list-style-type: none"> In progress off track. Awaiting national toolkit from WG to progress, but discussed at ADLT on 02.09.2024. Agreed attendance at national Adaptation Planning event in October before convening Adaptation Planning Group internally within WAST. Reset Milestone to Q3.
Sustainable savings & efficiencies	<ul style="list-style-type: none"> Service Review across the Trust completed with recommendations by Q2 	<ul style="list-style-type: none"> In progress off track. Business area summaries have been produced for each service line, with a report due at ELT on 23.10.2024
Generate income alongside our core commissioned functions	<ul style="list-style-type: none"> Develop commercial strategy based on outcome of market analysis exercise in Q2 	<ul style="list-style-type: none"> 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

Recommendation

- That the Finance & Performance Committee:
 - Notes** the CMT programme progress update;
 - Notes** the confirmed Directorate-led IMTP end of Q2 position.

Appendix 2

Assurance against the Cabinet Secretary's priorities 2024/25

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.

The following table sets out the key areas for WAST against the priorities, and the milestones to be achieved in quarter 2 (confirmed end of quarter 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	<ul style="list-style-type: none"> Group established to consider and develop scope for 111 MDT skill mix 	<ul style="list-style-type: none"> Scoping paper to commissioners 	<ul style="list-style-type: none"> Off track. The paper has not yet been presented to commissioners.
	111 Pathways	<ul style="list-style-type: none"> 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 		<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Level 1 falls - Assessment of the demand & capacity modelling undertaken Level 2 falls - Undertake evaluation of our existing services 	<ul style="list-style-type: none"> Presentation of L1 options and benefits Present evaluation and options for sustainability of L2 services going forward 	<ul style="list-style-type: none"> 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
	999 Pathways: Digitised pathways	<ul style="list-style-type: none"> Evaluate the effectiveness of the new digital solutions to make referrals to existing pathways and usage 	<ul style="list-style-type: none"> Develop further opportunity for digital notifications with Welsh portal 	<ul style="list-style-type: none"> A new digital transformation and innovation programme has been set up to manage and prioritise digital

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Progress
	999 Pathways: Connected Support Cymru (CSC)	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<p>workstreams that fall outside the clinical transformation programme – this is progressing</p> <ul style="list-style-type: none"> Six Goals clinical review of CSC business case was not as positive as hoped and view from Six Goals Board that technology enabled 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: <ul style="list-style-type: none"> 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 scalability and sustainability of the solution Difficulty progressing recruitment of partnership organisations due to management capacity (which is unfunded) so currently on hold

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Progress
Urgent and Emergency Care, with a focus on delivery of the 6 goals programme	Goal 2: New 111 System	<ul style="list-style-type: none"> Full implementation of new CAS system 30th April Decommission old system 	<ul style="list-style-type: none"> Realise benefits in line with business case 	<ul style="list-style-type: none"> CAS system implemented on time - complete
	Goal 2: 111 website & symptom checkers	<ul style="list-style-type: none"> Scoping exercise to review requirements of a 111 website – and develop options appraisal accordingly 	<ul style="list-style-type: none"> Development of business case Review and develop requirements to improve symptom checkers, with potential requirement for procurement. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> No Q1 milestone 	<ul style="list-style-type: none"> Agreement with commissioners to proceed 	<ul style="list-style-type: none"> Review of rostering practices. Agreement from commissioners to commence Review of rostering practices. Procurement process ongoing
	Goal 3: <ul style="list-style-type: none"> Develop the remote clinical assessment speciality Develop a fully remote working clinician offer (operations/training/digital) Develop Pre-Dispatch Outcome Risk Stratification 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 	<ul style="list-style-type: none"> Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report 	<ul style="list-style-type: none"> Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report 	<ul style="list-style-type: none"> 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
	SDEC Pathways	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Implementation of SDEC criteria across WAST 	<ul style="list-style-type: none"> 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. However, actions around SDEC activity currently sit with Health Boards within their 6 goals delivery. WAST will continue to engage and respond to requests to work collaboratively to improve uptake of direct referrals
	Goal 4: CHARU	<ul style="list-style-type: none"> Complete CHARU recruitment by end Q2 Improve utilisation rate to modelled benchmark by end Q2 (work ongoing during Q1) 		<ul style="list-style-type: none"> 75% actual to establishment as at the end of July. Steering Group established to oversee recruitment and utilisation
	Goal 4: Rural variation	<ul style="list-style-type: none"> 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 		<ul style="list-style-type: none"> Recruitment in rural areas remains challenging. We are focussing EMT recruitment in rural areas where there are gaps. 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	<ul style="list-style-type: none"> Ongoing continuation of managing attendance and implementation of the health and wellbeing plan throughout year 		<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Development of reporting against new protocols within the CAD post MTPS implementation Agree outline service model for further engagement with Health Boards. 	<ul style="list-style-type: none"> 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

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Progress
		allocate transfer resources more effectively	<ul style="list-style-type: none"> Develop business case/principles for All Wales service. Develop business case for 24/7 Major Trauma Desk following outcome of Gateway 5 review. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Continue with NEPTS Demand & Capacity work, in particular, undertake NEPTS transport roster review by end Q3 		<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Establish expected outcomes & principles to develop enhanced oncology service 	<ul style="list-style-type: none"> Develop action plan to deliver the required change 	<ul style="list-style-type: none"> Continued working group to establish role of the hub to support the three oncology centres. Creation of draft SOP/Core working practice between liaisons and Hub. Consultation with Oncology Centres to identify of improvements.
	Quality assurance of external providers	<ul style="list-style-type: none"> No specific milestone in Q1 	<ul style="list-style-type: none"> Welsh Ambulance Quality Standard award implemented 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Completion of 111 CAS system implementation to aid improvement in 111 press 2 	<ul style="list-style-type: none"> New CAS system will provide resolution to Press 2 pathway 	<ul style="list-style-type: none"> CAS implementation complete Review with health boards effectiveness of press two and where there is opportunity to improve
	Mental Health Response Vehicles	<ul style="list-style-type: none"> Collating and presenting evidence from pilot within AB, discussing outcomes and options for further pilots 	<ul style="list-style-type: none"> Undertake further pilot (pending agreement) Continuing to engage with national evidence across UK 	<ul style="list-style-type: none"> See assurance report in appendix 1 – this forms part of the Clinical Transformation Programme
	Right Care Right Person	<ul style="list-style-type: none"> Engaging with Police Services in Wales, NHS partners, Local Authorities and third sector providers on changes affecting response to people in crisis 	<ul style="list-style-type: none"> Assess impact to WAST Possible update to 2023 EMS Demand & Capacity Review results. 	<ul style="list-style-type: none"> Modelling can be undertaken but requires further clarity on the likely level of activity

Cabinet Secretary Priority	Area for WAST	Milestones Q1	Milestones Q2	Progress
	Mental Health Practitioners in CSD	<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> Share plan with commissioners for further discussion 	<ul style="list-style-type: none"> 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.



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

Integrated Medium Term Plan (IMTP) 2025/28 Progress Update

MEETING	Finance & Performance Committee
DATE	19 November 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	alexander.crawford2@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this paper is to provide Finance & Performance Committee with an update on the IMTP 2025/2028.

IMTP 2025-28

The next iteration of the IMTP planning is underway and an update will be given to the Committee in January as we progress towards the **first draft of the plan by the end of January**. The Planning Team will be working with the **Board at Development sessions in November and December** to determine Board priorities for the plan going into 2025, as well as bringing through priorities from directorate level plans and the CMT programme. A draft of the IMTP will be circulated to the Board ahead of governance and approval through February and March.

RECOMMENDED: That the Finance & Performance Committee notes the update on the IMTP 2025/2028

KEY ISSUES/IMPLICATIONS

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REPORT APPROVAL ROUTE

Strategic Transformation Board 09 October 2024

REPORT APPENDICES

Appendix 1 - an overview of progress so far in developing the IMTP.

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	✓

Welsh Ambulance Services University NHS Trust

IMTP 2025-28

Progress report FPC 19.11.2024



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University NHS Trust

IMTP update – FBC
Version 1.0
Released: November 2024

by IMTP Project Team
amb_planning_and_perfromance@wales.nhs.uk



Overall Progress



The IMTP is developed through 6 stages or workstreams:

- 1. Gathering intelligence** from a range of sources, including a PESTLE analysis and a State of the Nation Report
- 2. Engaging** with stakeholders
- 3. Developing priorities** for the next 3 years
- 4. Technical planning**, including workforce, finance, capital and digital plans
- 5. Writing the plan**
- 6. Taking the plan through governance and approval**

IMTP Workstream	RAG	Comments
Gathering intelligence	Green	On track
Engaging on the plan	Green	On track but need a plan for engaging on priorities
Developing our 3-year priorities	Yellow	Directorate priorities being finalised during November 2024 to inform next steps
Integrated Technical Planning	Green	Commence Q4
Writing the Plan	Green	Commence Nov
Governance and approval	Grey	Feb/March

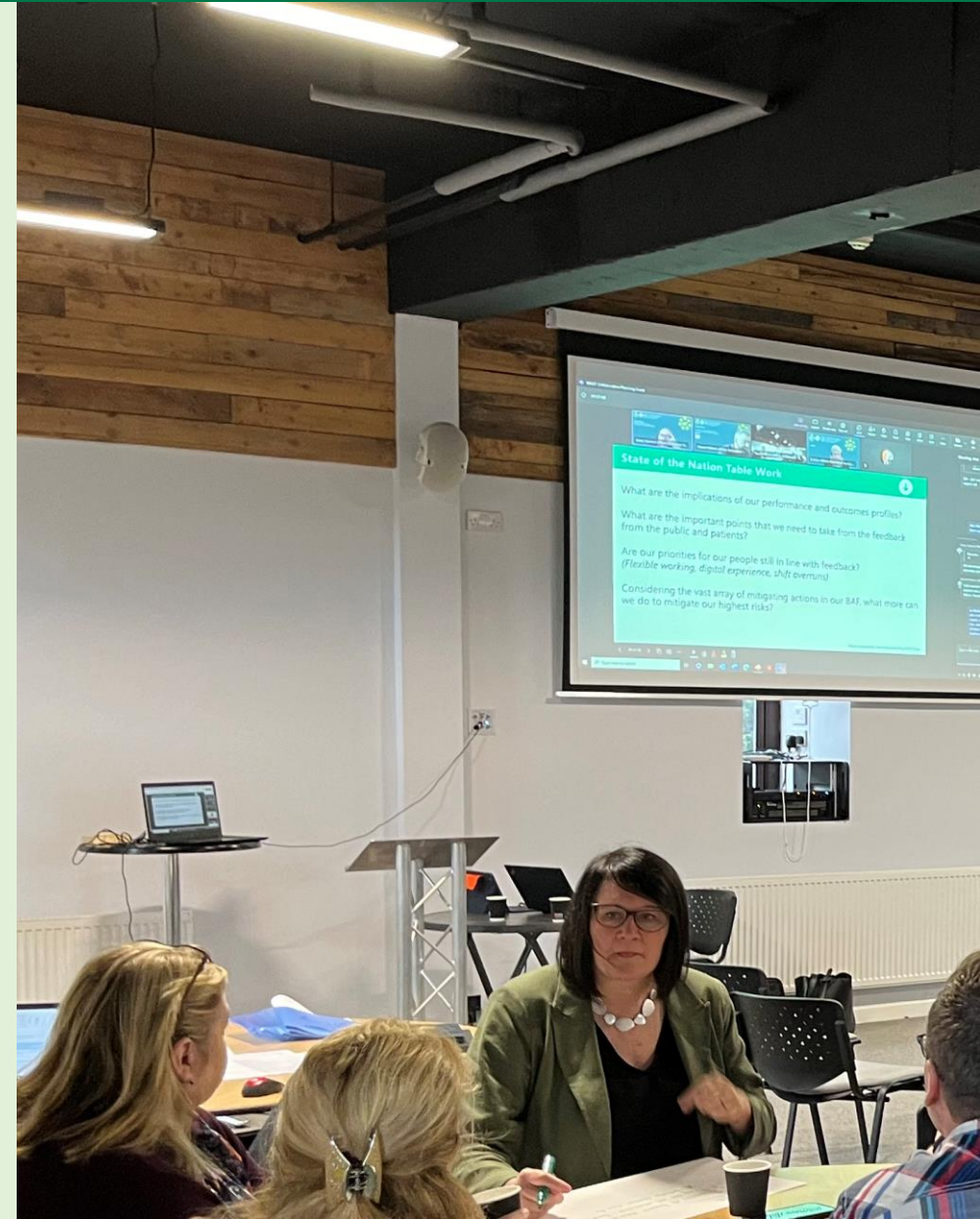


embed focus
consolidate
realistic
prioritise

Feedback from collaboration event – 3rd Oct '24



- Updated PESTLE analysis completed
- We should consolidate what we're already doing
- Risk focus – prioritisation against our highest risks
- Understanding of what is affordable in Wales
- What is over the horizon – what are the unseen risks?
- A lot of BAU work goes under the radar – balance between BAU and transformation
- Partnership working/collaboration – making it more effective
- Capacity of our managers to support change
- What type of organisation do we want to be - particularly thinking about our people
- Tying back to Delivering Excellence – the journey



Framing the IMTP



Strategic Objectives

- S01 Providing the right care or advice, in the right place, every time
- S02 Enabling our people to be the best they can be
- S03 Being at the forefront of innovation and technology
- S04 Developing services in collaborative
- S05 Being quality driven and clinically led
- S06 Delivering exceptional Value

Service **transformation** will be described in **S01**

We will need to develop **Wellbeing Objectives** that align to these strategic objectives

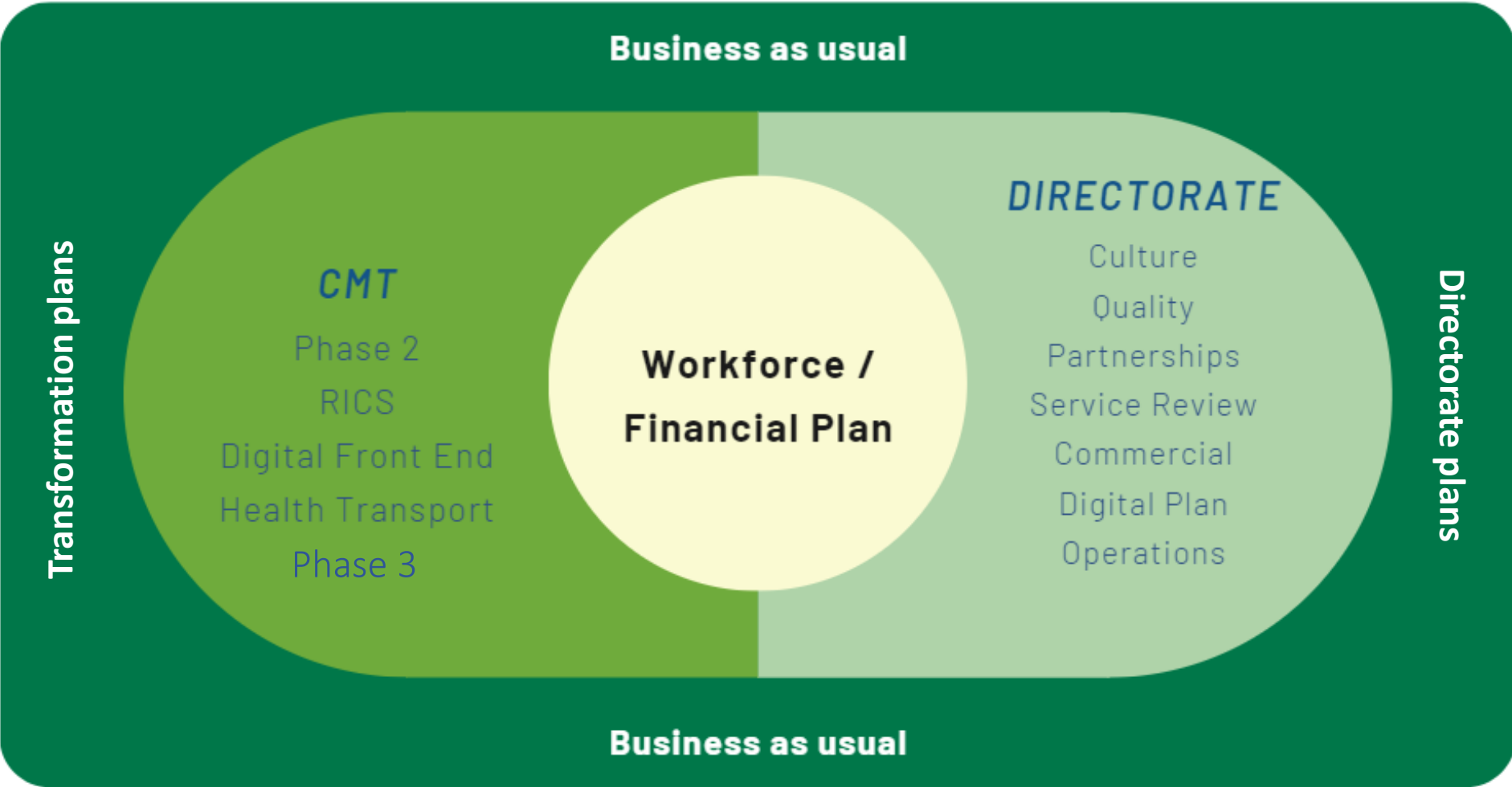
We will have to demonstrate the **'Five Ways of Working'** throughout the plan



Involvement Collaboration Long-Term

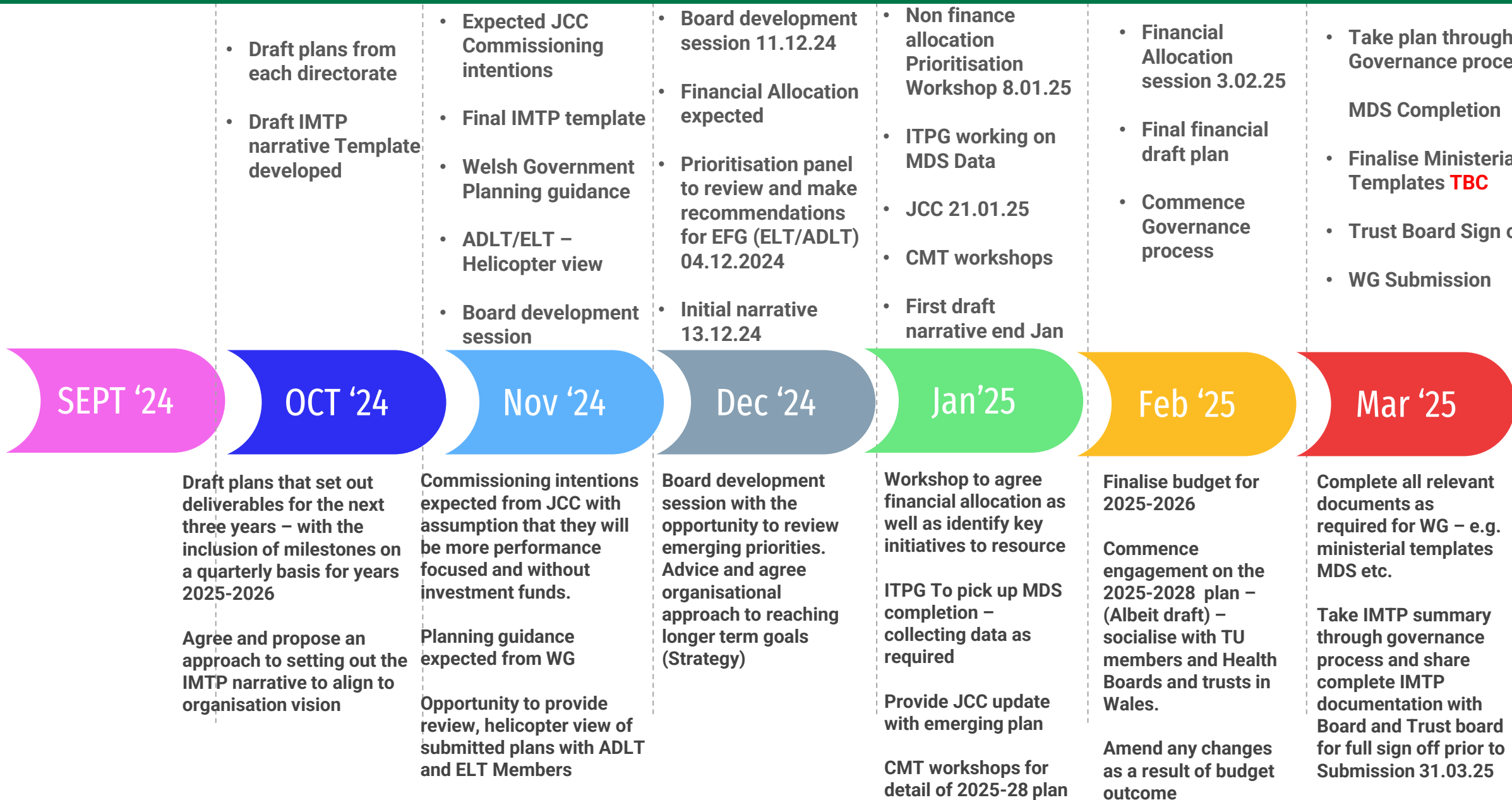


Integration Prevention



Creating a balance between **routine business** capacity, **transformation** and **directorate led improvement** to drive our workforce and financial plans

Next stages



Thank you for listening

For any questions and/or support, please contact the Planning Team.

amb_planning-performance@wales.nhs.uk



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FPC IMTP update

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

INFORMATION GOVERNANCE REPORTING

MEETING	Finance & Performance Committee
DATE	19 th November 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. 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 meetings in September and October 2024 (specific data and insights may refer to earlier periods). 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 end of November 2024** (rather than the original target date of March 2025) or risk rejection of new or existing research projects requiring CAG approval. The Trust is currently at 32% completion (22/10/24) with 4 actions on the improvement plan which must be complete within the month (see Appendix). Monitoring against the plan continues via IGSG, and these actions also

support those referenced under Corporate Risk 623 (see paragraph 10 and 11 in Key Issues section below).

4. **IG Training:** the Trust is **not yet compliant with its mandatory IG training** requirements against the minimum 85% target across the Trust for 2024/25, standing at 76.5% (as of 08/10/24) but steadily increasing and now surpassing the previous 75% target of 2023/24.
5. **Freedom of Information:** Data for August 2024 shows that after initially receiving 21 requests, where 3 were either then paused or withdrawn, the Trust responded to 13 of the remaining 18 requests within the 20-working day timeframe, resulting in 72.2% compliance. This is a significant improvement on recent trends, and the team are optimistic of further improvement around the FOI process to come once an OCP and recruitment is complete. A high-level guidance document has been developed and published to support colleagues in understanding the way FOI requests are received and managed within the Trust and more easily follow procedure.
6. **Records Management:** Although some progress has been made with actions in the plan (e.g. review of the Records Management Policy), the plan itself and the timelines have not been able to be updated for several months due to a long-term absence in the team and increasing demand for records. To provide assurance and visibility, a check against the original audit actions will be carried out in readiness for the November meeting of IGSG to check for any potential risks emerging from delays in progress.
7. **Data Quality Internal Audit Report:** The Data Quality Internal Audit report was received with reasonable assurance, and two high-priority recommendations identified: 1) reviewing the information asset register, and 2) improving data quality reporting. These recommendations align with existing plans to set up an information asset owners' group as agreed by IGSG. The small Data Quality function already has plans to develop data quality metrics for IGSG, coinciding with the audit recommendations. It has been agreed that IGSG will monitor progress of the actions for this particular audit via an extract of the Trust's audit tracker, and so will be a standard agenda item going forward.
8. **Recruitment:** The full-time and permanent Data Protection Officer vacancy is now at advert (live end October) and interviews are expected to be conducted late November. Two Data Protection Managers have now joined WAST (early November), doubling the size of our specialist IG team. Offers have also been made to two new Records Officers who are expected to join the Trust in the coming months. Finally, two new Data Quality posts are due to go to advert in November.

9. RECOMMENDATION:

The COMMITTEE are asked to NOTE the contents of paper.

KEY ISSUES/IMPLICATIONS

10. **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 post is at advert. Two Data Protection Compliance Manager positions have recently been filled.
11. **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.
12. **Risk of Physical Security:** The group discussed the risk of physical security, with a draft risk being presented, covering areas such as loss and theft of equipment. The draft risk was rated at 12 and will now be progressed through usual risk management cycles.

REPORT APPROVAL ROUTE

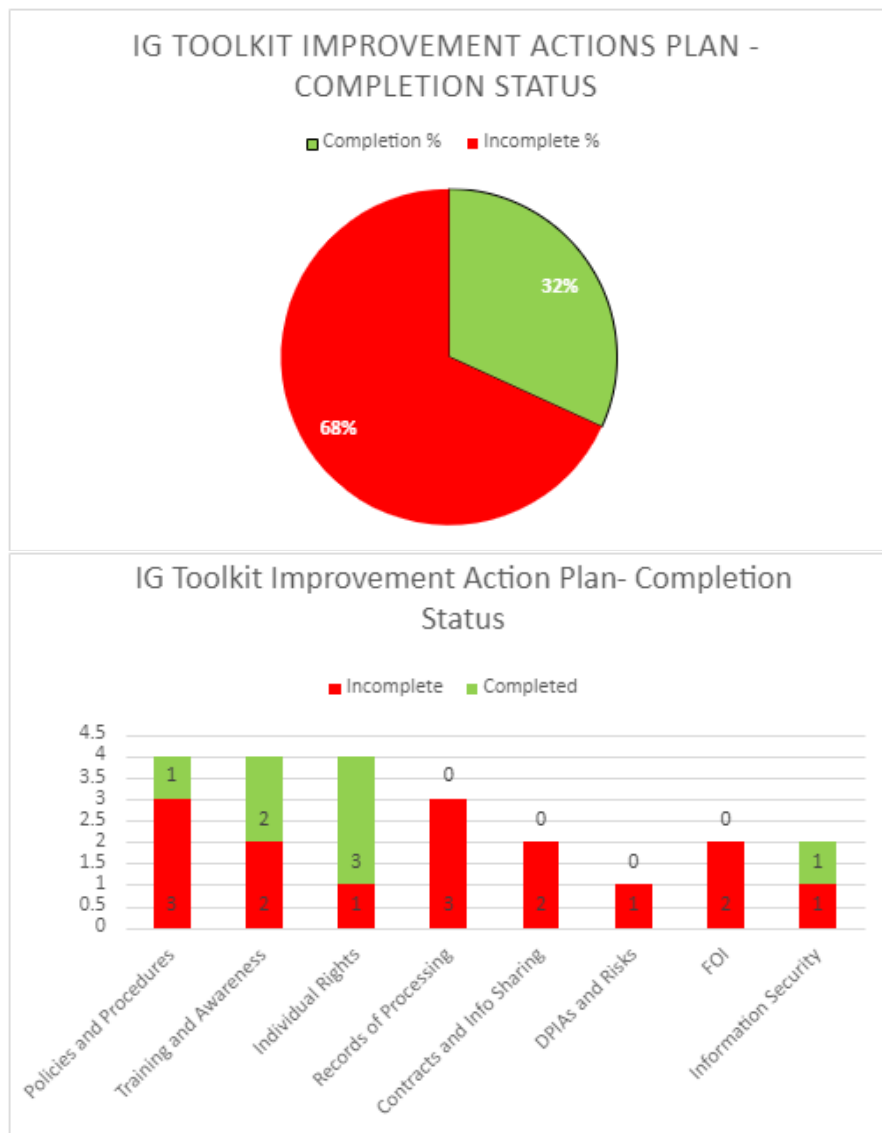
The points presented in this paper are taken from the Information Governance Highlight Reports presented at the October meeting of the Information Governance Steering Group (IGSG), and the resulting AAA presented to ELT.

REPORT APPENDICES

Appendix 1 – IG Toolkit Improvement Plan – Status Report (Oct24)

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



Actions for Escalation:

1. The BYOD policy has not progressed since the previous report. **Request is made to IGSG that due to the time constraints, an interim statement/notice on BYOD is agreed and produced.**
2. Not all current IT system suppliers have cyber security certification. To be able to provide assurance for the Toolkit, a **request is made for ICT/Cyber to identify which IT suppliers do not have cyber security certificates and determine the risk level, as other controls such as cloud security assessments may still provide appropriate assurance.**

For Noting:

1. The Trust is still not achieving 85% IG training compliance. To resolve this the following actions have been taken: -
 - a. Targeted communications have been sent to individuals who have never completed training, along with individuals who have expired training for 6 years or longer.
 - b. Individual non-compliance reports per Directorate have been shared with Directors and escalated by the SIRO.
 - c. We have been communicating with NWSSP to request the ESR IG package to port into WAST’s LMS365, however NWSSP are unwilling to provide the content due to ‘version control’ requirements.
 - d. We have been liaising with Jo Kelso and Claire West in L&D and agreed we will create an IG ‘refresher’ course

to be hosted on LMS365 to help improve efficiencies in accessing and completing IG training.

2. The Records Management Policy has been reviewed by RM and IG and minor changes made. It will be presented to Policy Group on 23.10.2024. It is anticipated that the policy will be completed by the November deadline.
3. Evidence of DPO training is currently outstanding. The DPO has acknowledged the requirement and has provided assurances that the training will be completed by the November deadline.
4. The FOI procedures are due to be presented at this October's meeting, where it is anticipated that the associated Toolkit FOI actions can then be closed.
5. A physical security risk has been drafted along with physical security checklist. A physical security audit was undertaken in October at Ty Elwy, completing the associated physical security Toolkit action. Other spot check audits will continue to be scheduled throughout the year.
6. Consent forms and related processes continue to be reviewed and updated where necessary. Only Comms and PTR forms are left to review along with some changes to the PEI Patient Story consent form, following which the two actions related to consent will be closed.
7. Pre and post procurement checks – WAST needs to provide assurance that pre and post procurement checks on suppliers, contractors, data processors and third parties are carried out. To achieve this, the internal and WAST-NWSSP procurement process will need to evidence that new proposed procurements are flagged to Cyber and IG. Template due-diligence checklists for IG and Cyber to be in place. Contact has been made with NWSSP to resolve.

The following actions on the Improvement Plan are not required to be completed until March 2025, as they are new additions for the FY24/25 question set rather than improvement actions from the previous year's deficiencies.

- Review of Information Risk Policy/Procedure – this review has started. No issues or obstacles to completion are anticipated.
- Identification and review of any processing relying on legitimate interests – no issues or obstacles to completion are anticipated.
- Review the Records of Processing Activity Log to ensure processing is covered in WAST's privacy notices. No issues or obstacles to completion are anticipated.
- Data disposal procedures - model procedures have been obtained from Government publications. A nominated lead for documenting data disposal procedures in line with WAST requirements is still needed.

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](#)

Data Quality

Internal Audit Report

October 2024

Welsh Ambulance Services University NHS Trust

Contents

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1. Introduction.....	4
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Review reference:	WAST-2425-15
Report status:	Final
Fieldwork commencement:	29 May 2024
Fieldwork completion:	20 August 2024
Debrief meeting:	27 August 2024
Draft report issued:	04 September 2024
Management response received:	24 September 2024
Final report issued:	01 October 2024
Auditors:	Osian Lloyd, Head of Internal Audit Martyn Lewis, Senior IM&T Audit Manager Sian Harries, IM&T Audit Manager
Executive sign-off:	Jonny Sammut, Director of Digital
Distribution:	Leanne Smith, Assistant Director of Digital Services: Data & Analytics; Jon Hopkins, Head of Information
Committee:	Audit, Risk & Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk & Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Services University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Welsh Ambulance Services University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To review the structures and processes for ensuring data quality and accurate reporting within the Trust.

Overview

We have issued **reasonable** assurance on this area. Overall, the Trust recognises the criticality of data quality and its commitment to improve is highlighted in the recently refreshed Digital Strategy and Data Quality Policy.

The focus within the Trust, due to capacity, has been on the EMS CAD system, which is the main driver of national reporting, however, there is recognition that there is a need to strengthen data quality processes and controls across the other data sets and systems.

The Trust is forging a good data culture through its quality assurance processes, however, the matters requiring management attention below are aimed at strengthening current position:

- Out-of-date policies and guidance;
- Lack of assessment of staff digital literacy skills, and data quality specific training;
- Incomplete Information Asset Register; and
- Improvements required in respect of data quality assurance reporting.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Trend

N/A

First Review

Assurance summary¹

Objectives	Assurance
1 Data quality guidance	Reasonable
2 Quality assurance checks	Reasonable
3 Monitoring and reporting	Limited

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

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
1	Policies & Guidance	Operation	Medium
2	Data Quality Training	Design	Medium
3	Information Asset Register	Operation	High
4	Data Quality Reporting	Operation	High

1. Introduction

- 1.1 The Welsh Ambulance Services University NHS Trust (the Trust) recognises the importance of data being of sufficient quality to enable robust decision making. High quality data is important to any organisation. Within the NHS it can lead to improvements in patient care and patient safety. Quality data plays a role in improving services and decision making, as well as being able to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services. Data quality measures how well suited a dataset is to serve its specific purpose, with measures of data quality being based on characteristics such as accuracy, completeness, consistency, validity, timeliness and precision.
- 1.2 The Trust uses a variety of data types, with processes being different for each. The key data types that the audit seeks to provide assurance over are:
- Data warehouse layer;
 - Reporting and Dashboarding layer; and
 - Manual data points.
- 1.3 The potential risks considered as part of this review were as follows:
- poor decision making;
 - failure to achieve performance measures and organisational objectives;
 - patient harm; and
 - exposure to financial loss and reputational damage.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	1	-	1
Operating Effectiveness	2	5	2	9
Total	2	6	2	10

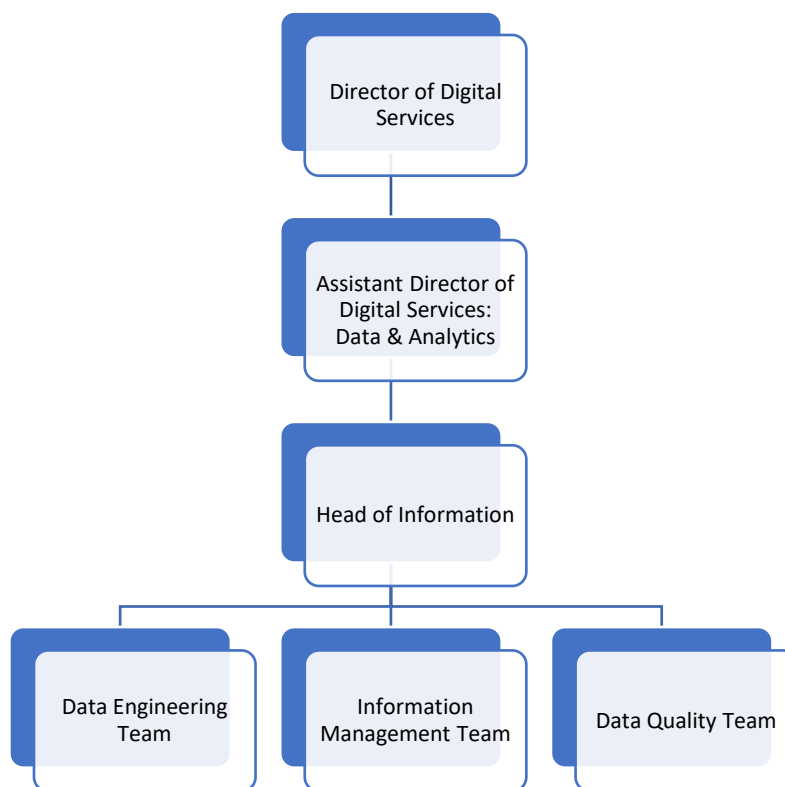
- 2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in [Appendix A](#).

Objective 1: Guidance is in place that sets out the requirements and responsibilities for data quality across the Trust.

- 2.3 To provide the very best patient-centric care, the importance of data quality cannot be overstated. Informed decision-making, precise diagnostics, and personalised patient care heavily rely on reliable data. Data quality assurance encompasses a set of practices aimed at enhancing data accuracy, completeness, and consistency.

During the course of our review, we interviewed a number of individuals - mainly from the Digital Team, and we positively note that the importance of data quality is well understood, and proactive efforts are being made to identify and correct data quality issues as they arise. The Trust's recognition of the criticality of data quality and its commitment to improve is highlighted in the recently refreshed Digital Strategy and Data Quality Policy.

- 2.4 In July 2024, the Board approved the updated Digital Strategy, which commits to enhancing the data quality provision and assurance strategy under one of the five identified key pillars; Data, Information and Insight. In May 2024, the Trust approved the revised Data Quality Policy which sets out the framework for the management of and accountability for data quality, with a commitment to secure a culture of high data quality throughout the organisation.
- 2.5 The Policy sets out the definitions for the key data quality characteristics (Validity, Completeness, Consistency, Precision, Accuracy and Timeliness), and during the course of our review we have considered how each characteristic is assured.
- 2.6 The Data Quality Policy states that it is underpinned by a suite of legislation and guidance, however, our review noted that some of these policies are out of date including:
- Information Governance (IG) Policy, due for review October 2021.
 - Records Management Policy, due for review October 2021.
 - Freedom Of Information (FOI) Policy is still in development.
- 2.7 We further note that the Trust's policies are not published on their website. Whilst the Trust's Publication Scheme was updated in April 2024 and notes under *Data Protection, Records Management and Caldicott Guardian*, that policies relating to Information Security, Data Protection, Records Management and Confidentiality Code of Conduct are available on request to the FOI Team, they should be published on the Trust's website as per the Information Commissioner's Office's Model Publication Scheme. **See Matter Arising 1 at Appendix A.**
- 2.8 Within the Trust, data quality is considered under the wider umbrella of Information Governance. The Data Quality Policy sets out the Trust-wide expected roles and responsibilities and notes that the Data Quality Lead and Head of Information will regularly monitor to ensure that measures to control data quality risks are being fully implemented and remain effective. This includes the regular and continual review of exception reporting and liaising with other Trust services.
- 2.9 The Trust's Data Quality Team is part of the wider Health Informatics (HI) Directorate as depicted below.



2.10 The breakdown of the HI teams is as follows:

- five engineers within the Data Engineering Team.
- eight analysts in total within the Information Management Team (IMT), 4 of which are ringfenced to other areas such as Power BI development, Ambulance Care, Medical and Clinical, and Joint Emergency Services Group. We were informed that recruitment of a further two HI analysts posts will begin imminently.
- 0.4 whole time equivalent (WTE) Data Quality Lead (DQL) within the Data Quality Team.

2.11 During the course of our review, we have noted that the Trust is data rich with many pools and silos. As established in detail under objective 2, the data collated to inform the Official Statistics submission to Welsh Government (WG), and Ambulance Service Indicators reportable to the NHS Wales Joint Commissioning Committee (JCC) are subject to rigorous data quality checks and assurance processes. However, due to the capacity of the HI team, in particular the Data Quality Team, scrutiny of other data sets is limited. Resource shortfalls within the Digital Directorate were highlighted as part of the recent Digital Plan Refresh process, and the Trust has recognised that it will need to address these gaps to ensure the successful implementation of the new Strategy.

2.12 Comprehensive guidance is in place within HI, such as step-by-step guides to completing the Official Statistics Report and a living document providing Technical Guidance on addressing data quality issues within the Emergency Medical Services Computer-Aided Dispatch System (EMS CAD). As the 111 system has recently

moved to the same provider as EMS CAD, the Data Quality Lead is looking to develop similar guidance. Whilst we would expect guidance in place for all systems used within the Trust, we have only focussed on a sample of systems due to capacity, for this review.

- 2.13 From our review of the data warehouse, which is noted in detail under objective 2, we observed that guidance documents in relation to the EMS CAD are out of date. The Data Engineering Team are aware, however, due to capacity constraints they have not been able to review and update. **See Matter Arising 1 at Appendix A.**
- 2.14 We noted that currently there is no specific training on data quality, however, it is touched upon within the mandatory IG training for all staff. As at March 2024, the compliance figure for this module was at 73.34%, which did not meet the 75% 'Minimum Expectations' compliance requirement. As of 1st April 2024, the minimum requirement has increased to 85% in line with Welsh Government recommendations. The Data Quality Policy has identified that training and awareness provision needs to be in place to make an explicit improvement, and states that the understanding of all staff and partners shall be assessed and appropriate training and guidance provided as necessary. As data quality is business critical, all staff should be explicitly made aware of its importance, how to follow acceptable standards of data quality throughout their everyday work and why what they do matters. We also note from our meetings with key contacts that the general digital literacy of operational staff could be improved, which would positively impact upon the quality of data at point of entry. We have established that is a common theme amongst other NHS Wales organisations. **See Matter Arising 2 at Appendix A.**
- 2.15 From meeting the Data Quality Lead, Principal Information Analyst and Principal Clinical Information Officer we noted that where data quality issues are found, training, guidance and support is offered to staff. Where persistent issues are found, processes are in place to escalate as appropriate. The EMS Coordination Systems Manager also sends out best practice bulletins with themes identified through investigations.

Conclusion:

- 2.16 The Trust recognises the importance of data quality and has recently refreshed its Digital Strategy and Data Quality Policy, however, some of the underpinning policies are out of date. We noted that there is limited capacity within Health Informatics, particularly the Data Quality and Data Engineering teams, to scrutinise all of the Trust's systems for data quality issues to the same level as the EMS CAD. Whilst data quality is touched upon in the mandatory IG training, it would be beneficial for all staff to have stand-alone training to ensure that they fully understand how and why data quality is business critical. Consequently, we have concluded **reasonable** assurance for this objective.

Objective 2: There are adequate quality assurance checks to ensure the data reported is complete, valid, timely, accurate, consistent and precise.

- 2.17 The HI teams manage data from various systems including telephony, EMS CAD, Electronic Patient Clinical Record (ePCR), 111 Clinical Assessment Service (CAS), Emergency Communication Nurse System (ECNS), Cleric (Ambulance Care), select ESR, the Trust website, Datix, Global Rostering System (GRS), and internal web applications. We were informed that there are other data silos in Finance, Estates, Fleet, Wiin (Innovation Network), ICT, and vehicle Mobile Data Terminal, among others. The Trust recognises that it does not hold a complete central record of all its data sources. Whilst we understand that an Information Asset Register is in existence, we were not provided with a copy but were informed that it is incomplete. **See Matter Arising 3 at Appendix A.**
- 2.18 Data quality assurance encompasses a set of practices aimed at enhancing the data characteristics defined under objective 1: completeness, validity, timeliness, accuracy, consistency and precision. We positively note that good communication is used as a tool between teams to collectively resolve data quality issues, and we noted enthusiasm for continuous improvement from key contacts interviewed.
- 2.19 Our approach to this review was to examine three data types; manual entry, data warehouse, and dashboard and reporting, to establish the quality assurance processes in place. We selected the ePCR and EMS CAD systems and reviewed their data layers. We further looked at the known silo of data within the Fleet Department to understand how their data quality is assured.

Fleet Data

- 2.20 The Fleet Department predominantly use a Fleet Management Tool called Chevin FleetWave. Data quality is mainly enforced through validation at the point of entry. The system has been developed to avoid the use of free text fields and uses mandatory fields. Data entry is mostly limited to predefined lists of acceptable values, implemented using dropdown lists or tick boxes, which is considered data quality best practice.

Electronic Patient Clinical Record (ePCR)

- 2.21 TerraPACe ePCR is a software-based application and was deployed in the Trust in December 2021 to replace traditional handwritten notes. The application allows frontline emergency crews to manually record information on an iPad, enhancing the precision of data compared to the former DigiPen system, which also facilitates the sharing of real-time information with healthcare partners.
- 2.22 After an incident has been resolved, the ambulance crew member should close the ePCR record. Following closure, the data warehouse will pull the data from TerraPACe every hour. If the crew fails to close the record, it will stay open in the system. However, there are safeguards to ensure that it will automatically close after a maximum of 12 hours without activity. Due to the nature of incidents dealt with by ambulance crews, there are no mandatory fields within the application and data is not cleansed or transformed prior to data warehouse transfer. As records are required to be a true account, they become sealed records of care following

closure. Cleansing of source data is not performed for this reason, and a "lift and shift" approach is used to transfer data into the warehouse.

- 2.23 As noted in a previous audit of the ePCR Clinical Compliance (WAST-2324-008), a number of PowerBI dashboards have been developed, with bespoke user group access and refresh schedules. One dashboard in particular looks at ePCR compliance, with the purpose of monitoring staff interaction with the application and to improve data quality by highlighting areas that may require targeted guidance and / or training. The ePCR Compliance Dashboard is refreshed daily with a 2-day lag and monitors incident recording compliance such as whether crews have appropriately closed down the records, how many incidents have been auto-closed, whether crews have validated automatic Welsh Demographic Service (WDS) patient lookups and whether the closure page has been completed in full.
- 2.24 Whilst this review is not intended to be a follow-up of the previous audit, as part of our fieldwork we positively noted that a review of the dashboard's terms and nomenclature has been undertaken and additional clarifying information has been added as recommended, for example, references to 'total ePCRs' signifies the total number of crew-closed ePCRs.
- 2.25 We requested a data warehouse extract of ePCR data from 25 July 2024 - 30 July 2024 to undertake testing of the figures presented within the ePCR Compliance Dashboard and we can confirm that no issues were found, and our analysis concluded with the same information as presented. We further note that we observed steady improvement in compliance across all metrics since ePCR was implemented to the current average of approximately 85%. The dashboard is monitored by the Clinical Intelligence and Assurance Team (CIAT) and Clinical Information Assurance Group (CIAG).
- 2.26 CIAT monitor and review ePCR data for clinical purposes and will identify and flag any quality issues with the Records Team. As incidents cannot be amended following closure, the team will add an annotation to the record highlighting the issue. CIAT perform audits and deep dives of reportable Clinical Indicators such as patients presenting with fractured neck of femur (#NOF), Stroke, ST segment elevation myocardial infarction (STEMI), Hypoglycaemia, and Return of spontaneous circulation (ROSC) at hospital in Cardiac Arrest.
- 2.27 By adopting a deep dive approach, CIAT have identified that there are data quality issues within ePCR and as such, there has been an iterative approach to improving the user interface and system architecture through change requests, which are overseen by the ePCR Clinical Reference Group (CRG). Recent changes include field validation to restrict fields to defined acceptable values. For example, range limits have been deployed for observation fields such as pulse rates, respiratory rates and blood pressure.
- 2.28 Furthermore, a moderate risk with a current score of 8 was raised by CRG and recorded on Datix in August 2023 noting that *'poor awareness of the implications to ePCR Data Quality due to human factors and systematic issues could impact on secondary data use including the improvement of patient care'*. The impact has been described as *sub-optimal ePCR data quality in terms of, Consistency,*

Accuracy, Timeliness, Efficiency, Validity and Completeness. This will impact on the ability to identify trends and patterns, draw comparisons, predict future outcomes and evaluate services. Consequently, risking missing opportunities to improve decision making and improve services.'

- 2.29 Current controls include extra assistance offered to staff who would like to improve their digital literacy and reminders are circulated on ePCR completion best practice. Barriers to data quality were stated as *'heavy workload, mobile workforce, lack of detailed information for specific secondary use and research, no standard terminology definitions, limited retrieval / reporting capabilities, large amounts of unstructured data, challenges with patient identification and matching, problems with data extraction and unfamiliar with data quality assessment.'* Whilst the risk has not been reviewed since November 2023, efforts to mitigate the risk and improve data quality have continued.
- 2.30 In June 2024 a new function (nudge tool) on the ePCR was activated to provide crew members with a reminder in the absence of important clinical information. This occurs at the point of closure, and the record cannot be closed until the information is recorded. We noted from the published Clinical Directorate Clinical Notice on 18 July 2024, that the function was tested for analgesia in #NOF. If crew members attempt to close a record without recording analgesia, a prompt appears reminding them to either do so or record a reason why they were unable to as a justified exception. The Clinical Notice states that compliance with documented analgesia for #NOF has improved and following positive feedback and successful testing, nudges for other areas of the ePCR will be implemented. Following implementation of the tool, the ePCR Compliance Approval Group (CAG) has been established to ensure that appropriate processes and governance are in place for the approval of internally managed changes resulting from utilising the 'at point of ePCR closure' capability. The CAG is responsible for the approval, monitoring and reporting for the effectiveness of the changes, and for the cessation of implemented changes as required. Activity to improve data quality in a system-wide approach is ongoing.
- 2.31 Whilst we have noted the issues with data quality, these have been acknowledged by the Trust; a risk has been raised with planned actions to address and improve. This matter was also raised as high priority finding in our recent ePCR Clinical Compliance review, therefore, we have not raised an additional matter arising. The Trust acknowledges that further work is required to reduce the significant use of free text fields, and note that this will also require a big shift in terms of culture.

Data Warehouse

- 2.32 Data is collected from source systems within the Trust and loaded into the warehouse, either via the Data Academy X-Series or SQL Server Integration Services (SSIS) warehousing tools used to perform data transformations and integrations. Data from systems such as ePCR and ESR are loaded via SSIS, and data from EMS CAD, Datix, CAS 111, GRS and telephony systems are loaded via Data Academy, initially into a staging environment where transformations take place to configure data into a standardised format ready for the warehouse end

tables. Typically, load orchestrations run nightly and should any fail the Data Engineering Team receives notifications via a shared mailbox to investigate further.

- 2.33 We selected the EMS CAD which holds the 999 calls dataset to review in more detail. Data cleansing is undertaken to ensure completeness, consistency and accuracy. For example, within the CAD system the patient age field is free text and therefore, not inputted in a consistent way. Capturing this accurately is essential for reporting purposes, therefore, the data is cleansed to become an integer. We established that new loads and transformations undergo quality assurance and testing through collaboration between the Data Engineering Team, Data Quality Lead and Information Management Team (IMT) to ensure proper data flow. Specific flags, determined by the operational team and IMT, must be set to confirm that fields are correct for official reporting. Whilst many metrics are calculated in the warehouse and are accurate at the time of initial setup, we established that there is a lack of an audit process to verify their continued accuracy. HI teams regularly attend meetings to stay informed of operational changes which typically require approval from several change management boards, however, some changes may be overlooked, highlighting the benefit of an automated process to ensure data integrity over time. **See Matter Arising 4 at Appendix A.**

EMS CAD

- 2.34 The Trust operates a C3 CAD System in support of its 999 EMS operations across its three Clinical Contact Centres. The primary focus of the Data Quality Lead has been to improve the data quality of 999 calls as the data is reportable as part of the Trust's Official Statistics return to WG and Ambulance Quality Indicators (AQIs) to the JCC. In April 2024, a new 111 CAS was implemented utilising the same provider as the C3. We note that data quality issues have been identified in the new system, as reported via the Monthly Integrated Quality & Performance Dashboard to the Finance and Performance Committee (FPC) in July 2024 and that these are being addressed. We established that the Data Quality Lead, in collaboration with wider Health Informatics teams, is reviewing ways in which the data quality issues can be resolved with ongoing scrutiny in the same manner as the CAD. **See Matter Arising 5 at Appendix A.**
- 2.35 Handling a 999 call is often a time of heightened emotion and it is inevitable human error will occur when navigating a system with urgency. The Data Quality Lead recognises this and has taken the approach to sit with call handlers during live calls to fully understand where and how errors can be made. The same approach is currently being adopted for the new 111 CAS system.
- 2.36 The Data Quality Lead also sits in on Clinical Prioritisation and Assessment Software Group meetings, which reviews the clinical aspect of answering calls. Any intended changes such as implementation of new Medical Priority Dispatch System protocols or clinical process changes can affect official reporting. This insight informs discussions with the wider HI teams to offer training and guidance and to develop exception handling reports to ensure the issues are captured and rectified if required.

- 2.37 An *'Incidents with Cause for Concern'* webpage is in place, which is refreshed daily and lists the records that appear to have anomalies which require further investigation and / or correction. Duty Managers should check the page daily and either correct the source record in the CAD or confirm that it has been reviewed with no correction required. Incidents remain open for a maximum of five days before they are automatically locked with a password. After this time, a password and a reason for access must be entered to view or alter a record and only select members of the EMS Coordination Systems team (EMSC) are able to do so. The reason is recorded as an audit trail on the record with a date/timestamp and user. We were informed that on the whole incidents are investigated in a timely manner and resolved within the 5-day window, although there is no routine assurance reporting in this respect, and those that remain often require further investigation with the assistance of the DQL and / or EMSC Systems Manager to reach resolution. **See Matter Arising 5 at Appendix A.**
- 2.38 Complementing the report are a series of exception handling reports built by the IMT for the Data Quality Lead to run on a weekly and monthly basis, and share with the EMSC Systems Manager and EMSC Systems Administrator for collaborative investigation. The combination of data quality checks is key to enabling the accurate reporting of verified incidents as part of the Official Statistics submission to WG and AQIs to the JCC. The reports flag records with anomalies such as:
- Hospital name missing
 - Incidents with no outcome
 - Long handovers with lost hours
 - Longest response times
 - Manual alterations that affect performance
 - Method of call HCP not used
 - Non-verified incidents with attendance at scene
- 2.39 The above flags can impact on verified incident counts therefore, accuracy and timely resolution is essential. To avoid double-counting incidents, if multiple calls have been received relating to a single incident, only one incident should be counted. Verified incidents are calculated in the data warehouse by counting all incidents recorded in the CAD system, but excluding the following stop codes;
- Incidents closed as Duplicate (DUPL);
 - Information call only (INFO);
 - Call entered in error (ERRO);
 - Call passed to another Ambulance Service (OTHE); and
 - Test call (TEST).
- 2.40 It's important to note that not all flagged incidents require correction following investigation, particularly for matters such as high lost hours and longest response times, as although they may look anomalous the figures can be accurate reflecting the impact of wider system pressures. We selected a sample of incidents for each flag from the April 2024 Exception Report and met with the EMSC Systems Manager to ascertain if the records had been investigated and / or corrected. Out of 10

incidents reviewed, only 3 required correction and had been appropriately resolved. The other 7 had been investigated and deemed correct.

- 2.41 We established that once a record has been corrected, the incident is closed, and the update is flagged in the CAD with a corresponding date and time. During the next data warehouse load, the updated information will be pulled in as an incremental load. We confirm that for the 3 corrected incidents, the updated information was successfully loaded into the warehouse.
- 2.42 Whilst the sample of data quality exceptions tested during the audit had been appropriately investigated and resolved, and we note that audit trails of amendments can be downloaded on demand, there is no routine assurance reporting of data quality exceptions. It would be beneficial for the Trust to understand the number and nature of data quality issues recorded, and to demonstrate that they have all been appropriately investigated along with their outcomes to inform trend analysis, interface improvement work and demand and capacity reviews. **See Matter Arising 5 at Appendix A.**
- 2.43 We established that in addition to reactive correction of data quality issues, the EMSC team will proactively check for trends in errors. If for example, it is identified that the same call handler is repeatedly making the same error, they will inform their manager and advise to converse with them and offer guidance if appropriate. If there are wider learnings to be made, then the EMSC team will send out coaching bulletins to the Control Centres.
- 2.44 As part of the collation of data to submit to WG, the IMT perform a further series of data quality checks on each reportable measure. As incidents remain open for investigation and correction for 5 days, the team don't begin their checks until the 5th of each month to ensure that all incidents are resolved from the previous month.
- 2.45 Every incident recorded in the CAD system generates an incident ID in sequence. The initial check is to verify that incidents are in sequence and that the clock start calculation is working correctly to ensure that there are no gaps, for example due to a system outage. For "Red" incidents, clock start times are recorded when the patient's location and the chief complaint has been established. For "Amber" and "Green" incidents, clock start times are recorded when the patient's location and the dispatch code have been established from the call. The clock start is the starting point for response time targets and the team will check that each incident is within an hour of the previous incidents clock start time and investigate if they are not.
- 2.46 Further checks are conducted such as verification of incidents marked as "out of area", as they are not reportable by the Trust and excluded vehicles at the time of reporting, such as test vehicles. A data extract is then taken from the data warehouse and compared against the CAD source data to ensure precision. Once the statistics have been collated, they are sent to the rest of the IMT with a minimum of two analysts performing quality assurance checks. Once the statistics have been deemed correct, they are then disseminated internally in the form of a

pre-release for final sign off by the Principal Information Analyst and Head of Information prior to being uploaded to the WG portal and officially submitted.

- 2.47 We selected 3 measures from the submitted June 2024 Official Statistics report as below and requested to be shown how the figures were obtained. The Principal Information Analyst performed an SQL Query via screen-share against the data warehouse, and we can confirm that the returned figures matched those that were reported as below.

Date	LHB	Measure	Number
Jun24	All Wales	RED Incidents	5127
Jun24	All Wales	RED incidents resulting in an emergency response	5044
Jun24	All Wales	RED incidents resulting in an emergency response at the scene within 1 minute	255

- 2.48 The Trust's official performance statistical outputs are defined as National Statistics and are required to comply with the Code of Practice for Official Statistics. We can confirm that the Trust have met all WG submission deadlines over the last 18 months.

Conclusion:

- 2.49 Our review has highlighted that the Trust is aware of the importance of good data quality, evidenced by its recent update of the Data Quality Policy. Whilst our audit has included focus across the three data types outlined in the introduction section, our work has been limited to looking at these aspects across only a small number of the key systems used by the Trust.
- 2.50 We noted robust quality assurance processes are in place to scrutinise EMS CAD data sets to ensure that they meet the defined data characteristics, however, it is recognised that there is a need for the same level of control and scrutiny over other systems such as the 111 CAS and ePCR. Proactive actions are being taken to prevent data quality issues, such as the exception handling reports for EMS CAD data and the iterative approach of improving the ePCR user interface. However, there is a lack of routine assurance reporting to demonstrate that exceptions have all been appropriately investigated and managed.
- 2.51 Through targeted training, guidance and support the Trust is beginning to forge a good data quality culture, however, this could be strengthened by improving the general digital literacy of operational staff and ensuring that they understand the concept of good data quality; why it is important, what the data is used for and how staff can improve on their current position.
- 2.52 We noted that the Trust has an IAR, however, we understand that this is incomplete. Whilst we acknowledge that current capacity is limited with ever-changing priorities and business-as-usual work, capturing all information assets within the Trust will provide a clear overview, facilitating better organisation and data management, of which data quality is a fundamental part.
- 2.53 Whilst many metrics are calculated in the warehouse and are accurate at the time of initial setup, it would be beneficial to have an automated audit process to verify

their continued accuracy. Accordingly, we have concluded **reasonable** assurance for this objective.

Objective 3: There is appropriate monitoring and reporting of data quality within the Trust.

- 2.54 As established in detail under objective 2, the Trust has many ways of monitoring and reporting the quality of its data, and some data is subject to more robust scrutiny than others. Also noted under objective 2 are the Groups with oversight of the data quality within their respective areas, such as CIAG for the ePCR. CIAG is a sub-group of the Clinical and Quality Governance Group (CQGG) which is accountable to the Executive Leadership Team (ELT).
- 2.55 In wider terms, the Information Governance Steering Group (IGSG) which meets monthly, has delegated authority from ELT to cover all matters of information security, information governance, records management compliance and Caldicott Principles. IGSG reports directly to ELT by way of an Alert, Advise, Assure (AAA) highlight report. Our review of IGSG agendas, papers and minutes from February 2024 – April 2024 noted limited discussion of data quality matters, and that data quality does not appear as a standing agenda item. **See Matter Arising 5 at Appendix A.**
- 2.56 Broader digital topics inclusive of Digital Key Performance Indicators (KPIs) relating to Data & Analytics, ICT Systems, Digital services, projects & programmes, and progress against the IMTP items with Digital involvement, are reported to the FPC, which meets bi-monthly and provides highlight reports to the Board. Our review of FPC papers and highlight reports from January 2024 – July 2024 confirms that adequate detail relating to data quality matters, such as the identified issues with the new 111 CAS system, is received and reported. However, our review of the Digital KPIs noted a lack of metrics specifically relating to Data Quality. **See Matter Arising 5 at Appendix A.**
- 2.57 Our review of Board papers from November 2023 to March 2024 noted that it was informed of matters relating to data quality through the aforementioned FPC highlight report, and a Monthly Integrated Quality & Performance Dashboard report.
- 2.58 As noted under objective 1, the Trust's recently approved Digital Strategy commits to enhancing the data quality provision and assurance strategy under one of the five identified key pillars; *Data, Information and Insight*. The initiative focuses on the strategic use of data, analytics, and visualisation tools to generate actionable insights and transforming raw data into meaningful information that guides the Trust's actions and policies. In July 2024 the FPC received the refreshed Digital Plan and were asked to endorse for implementation. Following its full approval, the Trust should ensure that its implementation is fully monitored and reported upon.

Conclusion:

- 2.59 Our review has highlighted that data quality is overseen in many forums and that the Board is kept informed on related matters. Whilst data quality is considered under the umbrella of Information Governance, we noted a lack of detail being

received by the IGSG. The Finance and Performance Committee receives updates on broader digital topics and data quality issues by exception, however, our review of the Digital KPIs noted a lack of metrics specifically relating to Data Quality. Consequently, we have concluded **limited** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policies and Guidance (Operation)		Impact	
<p>The Data Quality Policy states that it is underpinned by a suite of legislation and guidance, however, our review noted that the Trust's IG Policy and Records Management Policy are out of date and have not been reviewed since 2018. We further note that there is currently no Freedom of Information Policy in place but understand that this is currently in development.</p> <p>The Trust's policies are not published on their website. Whilst the Trust's Publication Scheme notes under <i>Data Protection, Records Management and Caldicott Guardian</i>, that policies relating to Information Security, Data Protection, Records Management and Confidentiality Code of Conduct are available on request to the FOI Team, they should be published on the Trust's website in line with the Information Commissioner's Office (ICO) Model Publication Scheme.</p> <p>We noted that Data Warehouse guidance relating to the EMS CAD are also out of date. As the 111 system has recently moved to the same provider as EMS CAD, the Data Quality Lead is looking to develop similar guidance. Whilst we would expect guidance in place for all systems used within the Trust, we have only focussed on a sample of systems due to capacity, for this review.</p>		<p>Potential risk of:</p> <p>Failure to update policies and procedures in line with new legal requirements can lead to non-compliance, financial penalties and security breaches and reputational damage.</p>	
Recommendations		Priority	
1.1	Management should ensure that policies and guidance which underpin the Trust's commitment to improving data quality are reviewed and / or developed and aligned with new legal requirements and current best practice.	Medium	
1.2	Management should ensure that current written protocols for delivering the Trust's functions and responsibilities are proactively published on the Trust's website or otherwise made available as a matter of routine.	Medium	
Agreed Management Action		Target Date	Responsible Officer

1.1	<p>The Trust’s Data Quality policy was reviewed, approved and published earlier in 2024.</p> <p>The Records Management Policy is currently under review and due for submission for approval in November 2024, in order to support the IG Toolkit Improvement Action Plan.</p> <p>The Information Risk Policy is scheduled for Policy Group in December 2024.</p> <p>The Confidentiality and Code of Conduct policy is scheduled for Policy Group in February 2025.</p> <p>The Information Governance Policy is still tba.</p>	November 2024	Assistant Director of Digital Services: Data & Analytics
1.2	<p>As it is not current practice to publish any Trust policies on the public website, this recommendation is not one that can be actioned without a significant and disproportionate change to procedure in WAST.</p> <p>Policies are available on Siren (intranet) for all staff, and for the public / non-WAST employees a copy of any policy can be requested.</p> <p>There is a plan, led by the Corporate Governance Directorate, to begin reviewing the approach to policy publication in 2025/26. As such, no action will be taken specifically for data-related policies until completion of this wider review.</p>	N/A	N/A

Matter Arising 2: Data Quality Training (Design)		Impact	
<p>We noted that currently there is no specific training on data quality, however, it is touched upon within the mandatory IG training for all staff. As at March 2024, the compliance figure for this module was at 73.34%, which did not meet the 75% 'Minimum Expectations' compliance requirement. As of 1st April 2024, the minimum requirement has increased to 85% in line with Welsh Government recommendations. The Trust has identified through its Data Quality Policy that training and awareness needs to be in place make an explicit improvement in this area. Whilst bespoke on-demand training and guidance is offered to staff where data quality issues have been identified, it would be beneficial to develop data quality awareness training for all staff and included within the induction of new staff to ensure conformance with required standards.</p>		<p>Potential risk of: Poor quality data, which could lead to:</p> <ul style="list-style-type: none"> • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage. 	
Recommendations		Priority	
2.1	Management should consider assessing the digital literacy of all staff and developing data quality awareness training to complement the newly updated Data Quality Policy.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	A full programme for assessing & improving Digital Literacy is planned for Tranche 2 (i.e. 2025-26) under the refreshed Digital Plan. In the meantime, a Data Quality awareness training module will be made available across the Trust via an existing platform (i.e. ESR, LMS365 or MetaCompliance – tbc) to minimise any additional cost.	December 2024	Head of Information

Matter Arising 3: Information Asset Register (Operation)		Impact	
<p>The HI teams manage data from various systems including telephony, EMS CAD, Electronic Patient Clinical Record (ePCR), 111 Clinical Assessment Service (CAS), Emergency Communication Nurse System (ECNS), Cleric (Ambulance Care), select ESR, the Trust website, Datix, Global Rostering System (GRS), and internal web applications. We were informed that there are other data silos in Finance, Estates, Fleet, Wiin (Innovation Network), ICT, and vehicle Mobile Data Terminal, among others. The Trust recognises that it does not hold a complete central record of all its data sources. Whilst we understand that an Information Asset Register is in existence, we were not provided with a copy but were informed that it is incomplete.</p>		<p>Potential risk of: Poor quality data, which could lead to:</p> <ul style="list-style-type: none"> • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage. 	
Recommendations		Priority	
3.1	Management should ensure that the Information Asset Register accurately reflects the Trust's information landscape to ensure that a singular, consistent catalogue of information assets is in place to monitor compliance and efficiency.	High	
Agreed Management Action		Target Date	Responsible Officer
3.1	IGSG has already agreed to establish an Information Asset Owners Group. This sub-group will be responsible for the further development and ongoing maintenance of the Trust's Information Asset Register. Until the two vacant Data Protection Compliance Manager posts are filled (expected November 2024) there is not capacity within the IG function to help establish and run such a group.	April 2025	Assistant Director of Digital Services: Data & Analytics

Matter Arising 4: Automated Audit Process (Operation)		Impact	
<p>We established that new loads and transformations undergo thorough quality assurance and testing through collaboration between the Data Engineering Team, Data Quality Lead and Information Management Team (IMT) to ensure proper data flow. Specific flags, determined by the operational team and IMT, must be set to confirm that fields are correct for official reporting. Whilst many metrics are calculated in the warehouse and are accurate at the time of initial setup, we established that there is a lack of an audit process to verify their continued accuracy. HI teams regularly attend meetings to stay informed of operational changes which typically require approval from several change management boards, however, some changes may be overlooked, highlighting the benefit of an automated process to ensure data integrity over time.</p>		<p>Potential risk of: Poor quality data, which could lead to:</p> <ul style="list-style-type: none"> • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage. 	
Recommendations		Priority	
4.1	Management should consider utilising an automated data quality tool to develop automated audit processes to reduce the need for manual intervention and improving overall data accuracy and consistency.	Low	
Agreed Management Action		Target Date	Responsible Officer
4.1	Implementation of a new tool is a significant digital project, however, some functionality may be available in existing platforms which would offer a minimum viable product. Action is to conduct a gap analysis on automated data quality functionality within the Trust and make a recommendation to IGSG for a way forward.	January 2025	Head of Information



Matter Arising 5: Data Quality Reporting (Operation)		Impact
<p>The Information Governance Steering Group (IGSG), which meets monthly, has delegated authority from ELT to cover all matters of information security, information governance, records management compliance and Caldicott Principles. ISGS reports directly to ELT by way of an Alert, Advise, Assure (AAA). Our review of IGSG agendas, papers and minutes from February 2024 – April 2024 noted limited discussion of data quality matters, and that data quality does not appear as a standing agenda item.</p> <p>Whilst broader digital topics are routinely reported to the Finance and Performance Committee (FPC) and members are informed of data quality issues such as those identified in the new 111 CAS system, we noted that there are no reportable KPIs in relation to data quality.</p> <p>Whilst the sample of data quality exceptions tested during the audit had been appropriately investigated and resolved, and we note that audit trails of amendments can be downloaded on demand, there is no routine assurance reporting of data quality investigations. It would be beneficial for the Trust to understand the number and nature of data quality issues recorded, and to demonstrate that they have all been appropriately investigated along with their outcomes to inform trend analysis, interface improvement work and demand and capacity reviews.</p>		<p>Potential risk of: Poor quality data, which could lead to:</p> <ul style="list-style-type: none"> • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage.
Recommendations		Priority
5.1	Management should ensure that reporting arrangements for Data Quality are reviewed and formalised with a clear route to ELT and the Board.	High
5.2	Management should ensure that the progress to address 111 CAS data quality issues and arrangements for ongoing scrutiny are appropriately reported.	Medium
5.3	Management should ensure that assurance in relation to data quality exception handling and the Incidents with Cause for Concern is appropriately reported.	Medium
5.4	Management should ensure reportable data quality KPIs are developed and are appropriately reported.	Medium

5.5	Management should consider developing a standard reporting template for data quality matters.		Low
Agreed Management Action		Target Date	Responsible Officer
5.1	Standard Digital reporting on plans, systems and compliance, has a passage through to Finance & Performance Committee bi-monthly. In addition to this, DQ is an element of the IG reporting which goes to IGSG by exception and for broader discussion on a monthly basis. These reporting routes are articulated in both the TORs of FPC and IGSG.	October-24	Assistant Director of Digital Services: Data & Analytics
5.2	An update on the 111 CAS reporting and data quality efforts will be offered in future IG Highlight reports which pass to IGSG.	November-24	Head of Information
5.3	Following recent investment in the Digital Directorate, two new Data Quality JDs have been submitted for evaluation to support recruitment of additional expertise into this function. Once in post, as per the TOR, DQ representation will resume in IGSG, and we expect any large-scale / system level data quality issues such as this to be brought to the group for awareness and support in a timely manner.	March-25	Assistant Director of Digital Services: Data & Analytics
5.4	A monthly KPI report passes through IGSG, already with a placeholder for Data Quality metrics. The development of these metrics is dependent upon recruitment into the proposed new DQ posts.	April 2025	Assistant Director of Digital Services: Data & Analytics
5.5	Following recent investment in the Digital Directorate, two new Data Quality posts are planned to be created. Capacity to build standard DQ reporting is dependent on having more than the current 0.4 FTE, and so this action is to demonstrate movement towards a more resilient Data Quality team with the development of a template form to ensure a standardised method of recording, escalating and resolving Data Quality issues as they are discovered.	December-24	Head of Information

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services

NHS Wales Shared Services Partnership
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Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

AGENDA ITEM No	12
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	4

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT
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MEETING	Finance & Performance Committee
DATE	19 November 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. All principal risks were presented to the Trust Board on 26 September 2024 and have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3.
6. Updates are highlighted in blue on the BAF which show changes to the narrative, mitigating actions, controls, and assurances.

7. The Trust's two highest scoring risks **223** (*the Trust's inability to reach patients in the community causing patient harm and death*) and **Risk 224** (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*) scoring 25 remain unchanged because of sustained and extreme pressure across the Welsh NHS urgent and emergency care system which is negatively impacting on patient flow leading to avoidable patient harm and death.
8. Despite a slight decrease in the number of handover lost hours between June and July 2024 the sustained and extreme pressure continues to have an impact.
9. The Trust Board continues to 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.
10. 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.
11. 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.
12. To support the continued, detailed review and mitigation of these risks, a workshop took place on 06 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.
13. **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.
14. 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.

15. **Risk 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 and **Risk 139** Failure to Deliver our Statutory Financial Duties in accordance with legislation remain unchanged in this period.
16. **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).
17. 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.
18. 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
19. 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:

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

KEY ISSUES/IMPLICATIONS

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

REPORT APPROVAL ROUTE

22. 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.	<p>IF significant internal and external system pressures continue</p> <p>THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community</p> <p>RESULTING IN patient harm and death</p>	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.	<p>IF patients are significantly delayed in ambulances outside A&E departments</p> <p>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</p> <p>RESULTING IN patients potentially coming to harm and a poor patient experience</p>	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.	<p>IF a major incident or mass casualty incident is declared</p> <p>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</p> <p>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.</p>	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	<p>THEN there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines</p> <p>RESULTING IN negative environmental and social impacts causing and reputational damage</p>	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.	<p>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</p> <p>THEN there is a risk of a significant information security incident</p> <p>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</p>	Director of Digital Services	15 (3x5)
623 FPC	Failure to comply with Data Protection Legislation	<p>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</p> <p>THEN the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used</p> <p>RESULTING IN unauthorised data breaches/loss, financial or compensatory penalties, an</p>	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 JCC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience.	<p>IF WAST fails to persuade JCC/Health Boards about WAST ambitions</p> <p>THEN there is a risk of a delay or failure to receive funding and support</p> <p>RESULTING IN a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered</p>	Executive Director of Strategy Planning & Performance	12 (3x4) 
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation.	<p>IF the Trust does:</p> <ul style="list-style-type: none"> • 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) <p>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)</p> <p>RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage</p>	Executive Director of Finance & Corporate Resources	8 (2x4) 

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	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.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
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.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
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	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 significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	5	5	25	
			Target	2	5	10	
IMTP Deliverable Numbers: 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							
<p>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.</p> <p>The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.</p> <p>Improvement actions led by Welsh Government and system partners include: -</p> <ul style="list-style-type: none"> 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) Alternative 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 Care (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.					

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	
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. <ul style="list-style-type: none"> • 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							12

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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			

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				Inherent	4	5	20	
				Current	5	5	25	
				Target	2	5	10	
								<ul style="list-style-type: none"> 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:				March 2025				<ul style="list-style-type: none"> Successful resolution without ambulance (double EMS) Successful resolution without conveying to ED <p>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.</p>
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				<ul style="list-style-type: none"> 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				<ul style="list-style-type: none"> 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				<ul style="list-style-type: none"> 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 patients continue to be significantly delayed in ambulances outside Accident and Emergency Departments	THEN there is a continued risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised	RESULTING IN patients coming to significant harm and a poor patient experience		Likelihood	Consequence	Score	
			Inherent	5	5	25	
			Current	5	5	25	
			Target	3	2	6	
IMTP Deliverable Numbers: 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							
<ul style="list-style-type: none"> 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. <p>Improvement actions led by Welsh Government and system partners include:</p> <ol style="list-style-type: none"> 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 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. 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). NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) revised to March 2023/24. 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. 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) 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			

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		Inherent	5	5	25	
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		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 <i>Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026</i> . Goal 4 incorporates the reduction of handover of care delays through collective system partnership.			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 <i>Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover</i> (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.			14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report 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.			

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			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		<table border="1"> <thead> <tr> <th></th> <th>Likelihood</th> <th>Consequence</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Inherent</td> <td>5</td> <td>5</td> <td>25</td> </tr> <tr> <td>Current</td> <td>5</td> <td>5</td> <td>25</td> </tr> <tr> <td>Target</td> <td>3</td> <td>2</td> <td>6</td> </tr> </tbody> </table>		Likelihood	Consequence	Score	Inherent	5	5	25	Current	5	5	25	Target	3	2	6	
	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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> Monthly meetings continue to be held and networking through EDoNS. 																		
4. Recruit and train more Advanced Paramedic Practitioners.		Director of Paramedicine	Q4 2024/25	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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. 																		

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	Likelihood	Consequence	Score																			
Inherent	5	5	25																			
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Target	3	2	6																			
				<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 &		<ul style="list-style-type: none"> 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 Dated 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		➔	
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			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 11 th 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 Morryston 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 (6 th 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: <ul style="list-style-type: none"> - 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			Date of Review:	19/07/2022	TREND →	16 (4x4)
	Plan			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 22 nd 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 BERP 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	THEN	RESULTING IN	Likelihood	Consequence	Score		
there is a lack of resources and available technology and infrastructure	there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	negative environmental and social impacts causing and reputational damage	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 there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	THEN there is a risk of a significant information security incident	RESULTING IN a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	3	5	15
			Target	2	5	10
IMTP Deliverable Numbers: 1, 15, 19, 24						
EXECUTIVE OWNER		Director of Digital Services	ASSURANCE COMMITTEE		Finance and Performance Committee	
Risk Commentary						
<p>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.</p>						
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		➔		
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	
IMTP Deliverable Numbers: 1, 13, 14, 18, 19								
EXECUTIVE OWNER		Director of Digital Services	ASSURANCE COMMITTEE		Finance & Performance Committee			
Risk Commentary								
<p>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.</p>								
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 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. <i>The DPO must also be independent, an expert in data protection, adequately resourced, and report to the highest management level [DPA 2018].</i>		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 <ul style="list-style-type: none"> 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
			Date of Next Review:	16/09/2024		(3x4)
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
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						
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>The previous controls are currently transitioning into the new JCC arrangements, so are currently a bit fluid. Quarter 2 should see the arrangements stabilise.</p>						
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	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)
100			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 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
			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	<p>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.</p> <p>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.</p> <p>16/04/24 Workshop arranged for April 2024 (completed).</p> <p>26/06/24 Workshop results reported to newly established Interim Ambulance Commissioning Committee.</p> <p>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.</p>				
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	02/08/23 Checkpoint Date	<p>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.</p> <p>16/04/24 The new commissioning arrangements are in transition and still quite fluid at the moment.</p> <p>26/06/24 Request to commissioners to re-establish this meeting.</p> <p>06/08/24 Meeting now re-established.</p>				
5. Develop and roll out the Stakeholder Influencing Plan	Director of Partnerships & Engagement AD Planning & Transformation	Q2 24/25 onwards	<p>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.</p>				

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: <ul style="list-style-type: none"> 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		<table border="1"> <thead> <tr> <th></th> <th>Likelihood</th> <th>Consequence</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Inherent</td> <td>3</td> <td>4</td> <td>12</td> </tr> <tr> <td>Current</td> <td>2</td> <td>4</td> <td>8</td> </tr> <tr> <td>Target</td> <td>2</td> <td>4</td> <td>8</td> </tr> </tbody> </table>		Likelihood	Consequence	Score	Inherent	3	4	12	Current	2	4	8	Target	2	4	8
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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																		
<ul style="list-style-type: none"> Lack of formalised service contracts between Commissioner and WAST as a commissioned body 				10. 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	→																	
IF the Trust does: <ul style="list-style-type: none"> 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		<table border="1"> <thead> <tr> <th></th> <th>Likelihood</th> <th>Consequence</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Inherent</td> <td>3</td> <td>4</td> <td>12</td> </tr> <tr> <td>Current</td> <td>2</td> <td>4</td> <td>8</td> </tr> <tr> <td>Target</td> <td>2</td> <td>4</td> <td>8</td> </tr> </tbody> </table>		Likelihood	Consequence	Score	Inherent	3	4	12	Current	2	4	8	Target	2	4	8
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Target	2	4	8																			
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:																		
1. Continuing negotiations with Commissioners		Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/24 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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



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Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
University NHS Trust

AGENDA ITEM No	13
OPEN or CLOSED	OPEN
No of ANNEXES	1

AUDIT TRACKER 2.0 – SEPTEMBER 2024 (Q2)

MEETING	Finance and Performance Committee
DATE	19 November 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 Finance and Performance Committee (FPC).
2. Of those internal audit actions relevant to this Committee, 20 have been closed in quarter of a total of 30 due in quarter (67%). Of the actions that remain open 11 actions have had a change in date proposed (marked in blue). There are five actions on their third revised date.
3. There is one open action on its third revised date which is yet to be complete - action 567 (HART internal audit). This action was discussed by the Committee and by the Audit, Risk and Assurance Committee (ARAC) at their respective meetings in September 2024.
4. The Committee’s attention is drawn to action 470 from the ‘Asset Management RAM System’ internal audit, and the narrative for the rationale for closure which has been included in the Tracker. It is noted that the actions from the Cyber-Security and the Technical Resilience audit will be received in the closed session.
5. There are no open external audit actions assigned to FPC. The current version of the tracker is now open for Directorate review for actions due in October, November and December 2024. These updates will then be reported to the Committee at its meeting in March 2025.



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University NHS Trust

RECOMMENDATION

6. The Committee is requested to:

(a) Receive and review any Internal Audits and Audit Wales reviews within their remit where relevant. review any Internal Audits and Audit Wales reviews within their remit where relevant. These are the following *Internal and External Audits*:

- Internal Audit: Data Quality;
- Internal Audit: Overtime Controls;
- Internal Audit: Integrated Quality and Performance Management;
- External Audit: Review of Cost Saving Arrangements (2023/24).

(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 on the 14 October 2024.

REPORT APPENDICIES

Annex 1 – Tracker 2.0 –July–September 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 Finance and Performance Committee (FPC).

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 two 2024/25. A copy of the Tracker is reproduced at Annex 1 filtered to the actions assigned to this Committee for oversight. There are two tabs; one for the internal audit actions and one for the external Audit Wales and Health Inspectorate Wales actions.
11. The team continues to work on the development of the SharePoint solution for Tracker 3.0 with colleagues in the Digital Directorate. It is intended that this solution will be ready to implement / use later 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.
13. Of those internal audit actions relevant to this Committee, 20 have been closed in quarter of a total of 30 due in quarter (67%). Of the actions that remain open 11 actions have had a change in date proposed (marked in blue). There are five actions on their third revised date. It is noted that the actions from the Cyber-Security and the Technical Resilience audit will be received in the closed session.
14. There is one open action on its third revised date which is yet to be completed, action 567 (HART internal audit). This action was discussed by the Committee and by the Audit, Risk and Assurance Committee (ARAC) at their respective meetings in September 2024. There are no open external audit actions assigned to the Committee.
15. The Committee's attention is drawn to action 470 from the Asset Management RAM System internal audit and the narrative for the rationale for closure which has been included in the Tracker. It is noted that the actions from the Cyber-Security and the Technical Resilience audit will be received in the closed session.
16. With reference to action 470, in consultation with Internal Audit colleagues, it has been mutually agreed that it is acceptable to close the action on the basis that this work has been accounted for within the Trust's current Digital Plan and subject to the following actions:
- That the position be clearly articulated on the Tracker and be brought to the attention of the ARAC and FPC in the next reporting period;
 - That this position clearly state that the work is subject to funding of the relevant Tranche 2 of the Digital Plan;
 - That the associated risks be held in the Digital Directorate Risk Register, in lieu of the action's inclusion on the Tracker;
 - That the Corporate Governance Team ensure that the action is scheduled for review by the FPC and ARAC in September 2025 (which is the date of completion on the Tracker).

Management and Development of the Tracker

17. 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.
18. 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.
19. The current version of the tracker is now open for Directorate review for actions due in October to December 2024/25. These updates will then be reported to the Committee at its meeting in March 2025. The team will work with Directorate contacts to ensure a smooth transition between Tracker 2.0 and 3.0.
20. 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

21. The Committee is requested to:
 - (a) Receive review any Internal Audits and Audit Wales reviews within their remit where relevant. review any Internal Audits and Audit Wales reviews within their remit where relevant. These are the following *Internal and External Audits*:
 - Internal Audit: Data Quality;
 - Internal Audit: Overtime Controls;
 - Internal Audit: Integrated Quality and Performance Management;
 - External Audit: Review of Cost Saving Arrangements (2023/24).
 - (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	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. Proposed justification for the delay
470	21/22	FPC	Asset Management RAM System	Reasonable	Aled Williams	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		Closed in Quarter	011024: (AP) Corporate Governance met with Internal Audit to discuss this action and it has been mutually agreed that the action could be closed on the basis that this work has been accounted for / included in the Trust's newly approved digital plan, subject to the following: <ul style="list-style-type: none"> That the position be clearly articulated on the Tracker and be brought to the attention of the ARAC and FPC in the next reporting period; That this position clearly state that the work is subject to funding of the relevant Trance 2 of the Digital Plan; That the associated risks be held in the Digital Directorate Risk Register, in lieu of the action's inclusion on the Tracker; That the CGT ensure that the action is scheduled for review by the FPC and ARAC in September 2025 (which is the date of completion on the Tracker). Closure proposed and accepted/updated status 011024. 270924: (AIW) Following internal meeting ICT have meeting arranged with supplier 16 October to plan upgrade RFID servers and develop plan to roll-out tags across identified high value assets 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.
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	26/09/24 (LS): Qlik migration work is still on track and expected to complete early October with comms and training currently being offered to colleagues before decommissioning and to support with uptake of PowerBI platform. 12042024: Board Sec review - recommended extension to October based on the update given, and that once this programme is completed and evidence received can be closed. Target date moved in Q4 to October 2024. Last updated 22/03/24: Risk assessment complete and on Datix, and monthly meeting in place between Cyber and Data Engineering experts to review the risk and track any vulnerabilities. This is managed through the 'national vulnerability management dashboard' reported through to Closed FPC. Additionally, a migration workstream for moving all dashboards from Qlik to PowerBI is in progress, with completion date of September 2024. Update 02/10/23: Risk assessment completed and in Datix. A 12-month secondment has been created for a PowerBI specialist to start the work of migration from Qlik before decommissioning. March-24 is likely unrealistic, but a roadmap will be developed once the secondment begins (November-23). Previous update 27/06/23: Qlik is considered a low IS risk. Work is already ongoing to move reports into powerBI but due to capacity constraints within the team will take most of 2023-24 to complete
567	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		2.1 The Trust should undertake a self-assessment against the NARU key lines of enquiry review document. This could support any future "critical friend" review undertaken.		The Trust accepts this recommendation and is committed to undertaking a self-assessment against the NARU review document	May-23	Not Met	Mar-23	Mar-24	Jun-24	Open	171024 (AP): Additional update - This will be taken to SOT on the 05 November (the 22 October was cancelled). Once it's been to SOT this action can be proposed for closure, in line with the below update. 270924 - Peer Review scheduled for 7th October on the HART Self Assessment. Findings of the peer review will be reported to Formal SOT on the 22nd October for approval of assurance. Evidence of the Agenda item and Triple A from SOT will be provided to update Audit Committee on the decisions following the Peer Review. Once this completed (by the end of October) we will propose closure. 120724: Action not yet complete. SLT 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 until 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 Assessment is scheduled to go through SOT meeting on 9th April. Once meeting takes place, we will send over minutes of discussions for evidence of closure. Update 11.03.2024 Self assessment been completed, majority of areas compliant with. Next steps will be ongoing annual review to be carried out. Recommend closure. Update 24.01.2024 - Date set to undertake an internal review as mentioned on 22.11.2023. Date confirmed as: 19th February 2024. Update 22.11.2023 We are looking to undertake an internal review carried out by the Specialist Operations Locality Manager against the same criteria that the English Trusts are reviewed against to ensure interoperability is maintained. Update 27.09.2023 NARU still unable to support due to capacity limitations. HART uplift currently rolled out in England which is NARU's current focus. To ensure this action is undertaken an internal review will now take place in line with this action. Last Updated: 26.06.2023 NARU has been approached, but they are not able to support this at the moment due to staff shortages. Although they are supportive of the Trust in this. Proposed completion date changed from Mar23 to Mar24.

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	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
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	270924 (AIW) - workpressures have resulted in a delay, HotH service desk go-live is now 300924. ICT are planning to utilise tools available to conduct a full audit of equipment by Q4 2024/25 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	Mar-25	Open	270924 (AIW) - Service desk will launch 200924 which will see the automated vreation and managemnt of alerts. This work is therefore not yet complete and revised date requested to March 2025. Revised date to March 2025 in Q2 24/25. 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		Mar-25	Open	270924 (AIW) - New service desk will launch 300924 which will include a revised asset schedule that will include switches. This work is therefore not yet complete and revised date requested to March 2025. Revised date to March 2025 in Q2 24/25. 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.
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	Closed in Quarter	071024: (AP) Closure accepted and updated in Q2 24/25. Evidence of the training materials provided. Update 021024: Advise that this is now closed as all budget holders were sent training packs for core budget manager training and for the new all wales QlikSense finance system during week ending 27/09/24. 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 QlikSense finance tool to all organisation which will incorporate BI dashboards and WAST Finance Team will deliver the formal training alongside training for this new package. Informal support continues as all Budget Holders / Managers are assigned a Senior Finance Business Partner as first line of contact.
646	22/23	FPC	Savings & Efficiencies	Reasonable	Jason Collins	Chris Turley	Medium	2.2	Training records should be maintained to confirm attendance, which should be monitored to identify non-attendance so this can be followed up.	2.1	Schedule of Training and who has attended to be recorded.	Dec-23	Not Met	24-Mar	Jun-24	Nov-24	Closed in Quarter	071024: (AP) Closure proposal accepted and updated in Q2 24/25. Evidence of the training record received. 020124: Advise this is now closed. All training packs have been sent to budget holders and responses received via a MS forms when these are read / understood. 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 align with new finance system

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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-23	Not Met	Aug-24			Closed in Quarter	230724: (AP) IGSG received and approved the records management improvement plan at its 23 July 2024 meeting. Due to resource constraints in the records management team the dates of actions were not updated, however it was agreed that the plan was appropriate and that the plan would be a standing agenda item on IGSG until the improvement plan is completed. It was felt that that would give sufficient oversight of revised dates for the plan when resourcing issues are resolved. CLOSURE PROPOSED. Status updated to closure proposed by AP 090824. 080724: Business not 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	Closed in Quarter	111024: (AP) Closure proposal accepted and status updated. 26/09/2024: LS update - IGSG received a copy of the Records Management Improvement Plan for discussion in July 2024 (evidenced by AAA), and given slippage in target dates for actions in the plan (due to unexpected long-term absence of a key Records expert) agreed to continue monitoring at IGSG with escalation route to ELT if required. This was noted in August AAA of IGSG too, and is a standing item on the agenda for forthcoming months. Propose closure of this action. 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). 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 targeted training. Propose that approval of the improvement plan at IGSG in June 2024 will close this action. Update 25/03/24: a Records Management 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 April 24. 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.
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	Mar-25		Open	011024: (AP) Revised date of March 2025 in Q2 24/25 added in line with update. 26/09/2024: LS update - this work has not been able to be progressed due to long-term absence of a key expert within the Records Team. This pressure on team capacity is expected to remain until January and until this time focus remains on Records Requests (not management and storage) and maintaining compliance with regulatory targets. As such, propose to extend due date to March-25. 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 facility 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 Met		Mar-25		Open	011024: (AP) Revised date of March 2025 in Q2 24/25 added in line with update. 26/09/2024: LS update - this work has not been able to be progressed due to long-term absence of a key expert within the Records Team. This pressure on team capacity is expected to remain until January and until this time focus remains on Records Requests (not management and storage) and maintaining compliance with regulatory targets. As such, propose to extend due date to March-25.
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	Mar-25	Open	011024: (AP) Revised date of March 2025 in Q2 24/25 added in line with update. 26/09/2024: LS update - this work has not been able to be progressed due to long-term absence of a key expert within the Records Team. This pressure on team capacity is expected to remain until January and until this time focus remains on Records Requests (not management and storage) and maintaining compliance with regulatory targets. As such, propose to extend due date to March-25. 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 Met	Mar-25			Open	011024: (AP) Revised date of March 2025 added in line with update. 26/09/2024: LS update - this work has not been able to be progressed further due to long-term absence of a key expert within the Records Team. This pressure on team capacity is expected to remain until January and until this time focus remains on Records Requests (not management and storage) and maintaining compliance with regulatory targets. As such, propose to extend due date to March-25. 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.
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			Closed in Quarter	071024: (AP) This business was taken to FPC in September as planned. Closure proposal accepted on this basis in Q2 24/25 in line with the update given in July. This evidence, with the edits to the FPC CoB is sufficient to close off this action. Updated to closure proposed. 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.

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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 Met	Mar-25			Open	091024: (AP) Update from Estates: Further time required to allow for the review of the SOP, in line with the Estates Strategy. The Trust is waiting for the outcome of a NHS Wales capital prioritisation process from Welsh Government, which will inform the review of the SOP. Revised date of March 2025 applied in Q2 24/25 in line with the update provided.
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	Met				Closed in Quarter	091024: (AP) Evidence received and status updated to closure proposed. 091024: Estates Update: Pre-planned maintenance schedule which demonstrates how we manage our high and significant backlog maintenance is maintained. This action is not actually a revision to the Estates Strategy; it is indicating that any future revisions - which may inform changes to the estates maintenance plan - are effected, as required. The annual planner identifies any high risk maintenance which may need addressing; the performance indicator isn't a KPI - it indicates the level of risk with respect to the maintenance and therefore attention required. Evidence of the planner and the items on the planner has been received. Closure proposed.
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		Closed in Quarter	071024: (AP) This business was taken to FPC in September as planned. Closure proposal accepted on this basis in Q2 24/25. This evidence, with the edits to the FPC CoB is sufficient to close off this action. Updated to closure proposed. 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	30.08.2024-Collaboration Agreement: so marked as 'no further action'. We cannot proceed with this until the JCC moves from transition to a more settled state. The 111 & Ambulance Commissioner was appointed this month, so we may expect progress on Q3, but currently paused. 260724: Discussion w/HB; will discuss the position with the Interim Director for Commissioning and 111, to understand whether there will be a new collaboration agreement following the implementation of the JCC. AP to discuss with TM to consider whether - should there not be - this is acceptable. Potential action for discussion with IA. 050724: (AP) The Trust will revisit this recommendation in June 2025 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 can 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		Closed in Quarter	151024: (AP) Following receipt of the Tracker at ADLT on the 141024 it was agreed that respective ADLT colleagues would ensure that the position with the FEP (and how it relates to/with the Fire Safety Policy) will be reviewed and that the action (as a formal action from ADLT), in addition to the ongoing management by the Policy Group, would serve as additional evidence and assurance that the risks identified here have been mitigated. 111024: (AP) Copies of the updated CSP and Fire Evacuation Procedure received. Closure proposal accepted and updated to closure proposed. 30.08.24 - HB confirmed that CSP & Fire Evacuation completed. It is on Siren and the action can be closed. HB confirmed he has chased but will chase again. 26724: Discussion w/HB; HB to review position with review of the Plans and provide as evidence. Agreed that owhen these have been reviewed and republished this action can be closed. This is being progressed by the Head of Service for 111. HB to feed back to AP asap. 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 can 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		Closed in Quarter	151024: (AP) Following receipt of the Tracker at ADLT on the 141024 it was agreed that respective ADLT colleagues would ensure that the position with the FEP (and how it relates to/with the Fire Safety Policy) will be reviewed and that the action (as a formal action from ADLT), in addition to the ongoing management by the Policy Group, would serve as additional evidence and assurance that the risks identified here have been mitigated. 111024: (AP) Copies of the updated CSP and Fire Evacuation Procedure received. Closure proposal accepted and updated to closure proposed. 30.08.24 - Publication of the above: so one is on Siren, there is a Fire Evacuation procedure on Siren, but this is the one that needs updating. 26724: Discussion w/HB; HB to review position with review of the Plans and provide as evidence. Agreed that owhen these have been reviewed and republished on Siren this action can be closed. This is being progressed by the Head of Service for 111. HB to feed back to AP asap. 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 can be progressed / closed. 260624: Updated and communicated. (KL to monitor response from Paul greatorex and Peter Brown re evidence in HB absence 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		Closed in Quarter	101024: (AP) Update from SPP: 111 commissioning has now passed to the JCC (old EASC with other things as well) and relations are mature so it not believed that such an arrangement is still required. It is noted that a number of our Execs attending the JCC Board Development session in Aug-24, which is a form of time out. Given the position has moved on, it is proposed that this action be closed. Closure accepted and status updated. 30.08.24 - Post implementation benefits: 111 commissioning has now moved onto the JCC, so this action relates to our old commissioners. It may be that we need a time out with the new 111 & Ambulance Commissioner, but there are no plans by either party to do so, as relations are mature and established going back to 2015. 250724: Discussion w/HB; the commissioners with whom this action was agreed no longer exist; we're not planning to have a time-out specifically, but there are planned discussions (in line with the update below on the 26 June below). Not otherwise planning to do anything in this space beyond those regular touch points around the clinical model, and there is a JCC Board Development Session in August 2024 that the Trust has been invited to. Given these arrangement, this hasn't has been proposed for closure. 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 can 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.

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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		Closed in Quarter	091024: (AP) Accepted closure but sought additional evidence re the reporting to STB (confirmation of forward programme). Examples of reporting to ELT has been received. 211024: (AP) ELT Forward Programme received (confirming that this is on the Planner for future ELT mtgs). Closure proposal accepted. 30.08.2024 - Reporting progress on commissioning framework: our response was that we would ensure regular reporting of progress against the commissioning intentions. HB has evidenced Q1 reporting, with Q2 not due until post September 2024. Action completed and proposing for closure. 260724: Discussion w/HB; this has been completed (in line with the June update below). AP asked that HB send over the report as evidence (in addition to the STB mins extract). AP also asked for STB work programme as evidence (if available) of future reporting against agreed commissioning intentions. HB to send additional evidence and feedback and to advise whether work programme is available. 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 can 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 re-established 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	Dec-24	Open	101024: (AP) Revised date applied of December 2024 in Q2 24/25. 30.08.24 - Escalation arrangements i.e. between ourselves and commissioners: HB has drafted a letter, which is what we agreed to do, which is now with RM, but only this week. 260724: Discussion w/HB - AP said to HB that likely still required and the new commissioning arrangements do not supersede this action (in terms of process), but AP will verify with TM that position and then feed to HB. If agreed HB will prepare the letter in order to close off the action. 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 can 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		Closed in Quarter	101024: (AP) Closure accepted and status updated. SPP content that risk updated to reflect change. 30.08.24: Risk Register reflects 111 is now commissioned. Risk 100 on the Corporate Risk Register is now updated and therefore the action is complete. Proposed for closure. 260724: Discussion w/HB - AP to check with Julie when this will be/ has been agreed; by the end of September 2024 and reporting to Board this will have been completed (and received by all relevant forums) and can then be closed. Timing aligns to revised date of September 2024. 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 can be progressed / closed. 260624: Updated and complete. (EVIDENCE - HB confirmed he had updated BAF - https://nhs.wales365.sharepoint.com/:w:/f/sites/CORPORATEGOVERNANCETEAM/Shared Documents/General/Risk Management/BAF 130624 v1.docx?d=w17516e57ff4a435aace4a0eb49f63e&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		Closed in Quarter	101024: (AP) Update from SPP: Close on the basis that this programme has now transitioned into a new programme, with some elements of G2C not moving across. For those that moved across the appropriate risk log for the relevant Clinical Model Transformation Programme workstream is now in place and structures in place to review. The CMT Risk Register has been submitted as evidence. Closure accepted and updated to 'closure proposed'. 30.08.24 - G2C risk register to be updated: programme closed with new much bigger programme; CMT Programme now open. 260724: Discussion w/HB - The GTCP has ceased to exist, there is now a different reporting structure - the nearest replacement is the Remote Integrated Care Service Workstream. HB to check what the current arrangements are regarding developing of a Risk Register for this workstream. Action to be closed on the basis that this programme board no longer exists, however need to provide assurance that the related new workstream risks are being managed. 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 can 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	
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			Closed in Quarter	091024: (AP) Evidence accepted and status updated to closure proposed. 091024: (AP) Update from JH/EH: Since the July update the Trust has formally stood up the Clinical Model Transformation Board which is overseeing delivery of our Clinical Model and is the main reporting / approvals board for the Partnership & Engagement work (where these actions sit). This has superseded STB as the place where this business is received. The relevant business was taken to CMT in September, and the draft Programme Engagement Plan (PEP) was received. The PEP is the functional plan for us to deliver our engagement activities both internally and externally to support the Clinical model. This is a replacement product of its predecessor the Engagement Delivery plan (referenced previously in the audit tracker). The draft PEP was supported by the CMT Board, subject to some further tweaks; however the plan is currently 'live' and being delivered, and will be subject to continued refinement and adjustments to suit any changes in the broader landscape. Action proposed for closure. The CMT agenda and papers provided as evidence. 08.07.24 - The revised engagement framework 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.

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	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
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			Closed in Quarter	091024: (AP) Evidence accepted and status updated to closure proposed. 091024: (AP) Update from JH/EH: Since the July update the Trust has formally stood up the Clinical Model Transformation Board which is overseeing delivery of our Clinical Model and is the main reporting / approvals board for the Partnership & Engagement work (where these actions sit). This has superseded STB as the place where this business is received. The relevant business was taken to CMT in September, and the draft Programme Engagement Plan (PEP) was received. The PEP is the functional plan for us to deliver our engagement activities both internally and externally to support the Clinical model. This is a replacement product of its predecessor the Engagement Delivery plan (referenced previously in the audit tracker). The draft PEP was supported by the CMT Board, subject to some further tweaks; however the plan is currently 'live' and being delivered, and will be subject to continued refinement and adjustments to suit any changes in the broader landscape. Action proposed for closure. The CMT agenda and papers provided as evidence. 08.07.24 - The revised engagement framework 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			Closed in Quarter	091024: (AP) Evidence accepted and status updated to closure proposed. 091024: (AP) Update from JH/EH: Since the July update the Trust has formally stood up the Clinical Model Transformation Board which is overseeing delivery of our Clinical Model and is the main reporting / approvals board for the Partnership & Engagement work (where these actions sit). This has superseded STB as the place where this business is received. The relevant business was taken to CMT in September, and the draft Programme Engagement Plan (PEP) was received. The PEP is the functional plan for us to deliver our engagement activities both internally and externally to support the Clinical model. This is a replacement product of its predecessor the Engagement Delivery plan (referenced previously in the audit tracker). The draft PEP was supported by the CMT Board, subject to some further tweaks; however the plan is currently 'live' and being delivered, and will be subject to continued refinement and adjustments to suit any changes in the broader landscape. Action proposed for closure. The CMT agenda and papers provided as evidence. 08.07.24 - The revised engagement framework delivery plan is completed and include periods of pause and reflect. Aligned to action 647, 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 - 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	Met				Closed in Quarter	111024: (AP) Closure proposal accepted and updated status. 071024: (AP) Update from SPP: It has been achieved in so much as the IMTP is now reporting against the metrics set out in the plan (i.e. 'What good looks like'). Evidence is the Trust Board paper on IMTP delivery from September 2024. A Benefits Realisation Framework has been agreed, but rather than strict compliance what has been prepared is translating the IMTP benefits realisation into an IMTP outcomes report that has been prepared for Trust Board. It still requires iteration but one does not exist, which allows us to track whether we are delivering on the ambitions in then IMTP. Closure proposed. 30.08.24 - HB confirmed that this action sat with him. That the action was currently on target for Trust Board in September with a draft report being held by HB.
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	Met				Closed in Quarter	071024: (AP) Update from SPP: Programme structures are now in place and have been reported to Finance & Performance Committee. Evidence is the last paper to FPC on the 17 September 2024. 091024: (AP) JB to review the evidence provided; will feed back before finalising this action. 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 Met	Dec-24			Open	071024: (AP) Update from SPP: There is work ongoing to develop benefits realisation plans for the programme, alongside a piece of work to develop CMT Quality and Performance Metrics to support the benefits realisation plan. Not met, revised date of December 2024 applied in Q2 24/25.
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	27/09/24: Update from Capital Development - No further update to be provided as not yet due and relates to SOP Rewrite and next BIC. 30/05/24: enhanced narrative included in 24/25 BIC 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.
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			Closed in Quarter	021024: (AP) CGT updated to closure proposed. This change to the Standing Orders was taken to the Trust Board for approval in July, as stated in the update provided by the Estates Team. Evidence of papers to TB on the website: https://ambulance.nhs.wales/files/trust-board-papers/papers-25-july-2024/ . 27/09/24: Update from Capital Development - understood that this was progressing for approval July 2024 and could be closed, Corporate Governance progressing and to update further and confirm. 31/05/24: 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.

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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	270924 (AIW) - Appointment made to the Contract Manager role. 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.

Overtime Controls

Final Internal Audit Report

November 2024

Welsh Ambulance Services University NHS Trust

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Review reference:	WAST-2425-10
Report status:	Final
Fieldwork commencement:	22 July 2024
Fieldwork completion:	20 September 2024
Debrief meeting:	23 September 2024
Draft report issued:	10 October 2024
Management response received:	1 November 2024
Final report issued:	5 November 2024
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Henry Wellesley, Audit Manager
Executive sign-off:	Lee Brooks, Executive Director of Operations
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Committee:	Audit, Risk & Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk & Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Non-Executive Directors or officers including those designated as Accountable Officer. They are prepared for the sole use of the Welsh Ambulance Services University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Welsh Ambulance Services University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To provide assurance on the adequacy of the processes in place to control and monitor the level of overtime allocation, in line with the Trust's Financial Savings Plan.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Review of the communication of the overtime allocation amendments; and
- Consideration of an automated process in the payment of overtime.

Report Opinion

Reasonable



Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Trend



2016/17

Assurance summary¹

Objectives	Assurance
1 Processes and procedures	Reasonable
2 Determination and authorisation of overtime allocations	Reasonable
3 Overtime payments	Reasonable
4 Reporting and monitoring	Reasonable

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

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
1	Overtime allocation amendments	2 Operation	Medium
2	Overtime payment process	4 Design	Medium

1. Introduction

- 1.1 The Welsh Ambulance Services University NHS Trust's (the Trust) Operations Directorate has a Standard Operating Procedure in place for 'Overtime Allocation'. As stated in this procedure, *the Operations Directorate receives a set annual budget to support the provision of overtime allocation. The allocation of overtime within Emergency Medical Services (EMS) (managerial and clinical) may be called upon to support a safe level of service provision for patient/scene response, clinical outcomes, and patient experience.*
- 1.2 It is vital that a clear and robust process is adopted for the allocation of overtime to ensure that overtime spending remains within budget.
- 1.3 The Trust's Financial Savings Group has worked to identify the Operations Directorate's contribution to the Trust's broader savings target. In June 2023, an Operations Directorate Official Notice was published which detailed that *...there must be controls of overtime spending. Overtime allocations have been provided to each Health Board area of EMS in a targeted approach determined by the needs of the service, and within the available financial envelope.*
- 1.4 Embedding a transformative savings plan and regular reviews of savings targets are included as key controls to manage the following major risk (139), "*Failure to Deliver our Statutory Financial Duties in accordance with legislation*" detailed within the Corporate Risk Register.
- 1.5 The potential risks considered as part of this review were as follows:
 - Financial loss due to unnecessary usage or incorrect payment of overtime;
 - Staff are working unsafe and unsustainable hours which could affect their wellbeing and/or lead to patient harm; and
 - Failure to achieve planned savings.
- 1.6 This audit only covers planned overtime and did not include within its scope a review of unplanned overtime such as overruns, for example where ambulance staff are delayed by patient handover.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	1	-	1
Operating Effectiveness	-	2	-	2
Total	-	3	-	3

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

Objective 1: Documented processes and procedures are in place for the allocation and authorising overtime.

2.3 The Trust has a Resourcing Policy, which is dated 2014, and provides guidance on the methodology for approval of overtime. The detail of this policy is subject to a separate audit and we will not replicate the recommendation regarding the need for review/update at this report.

2.4 In March 2024, the Operations Directorate put in place an Overtime Allocation Standard Operation Procedure (SOP), following a pilot of the operations between July 2023 to March 2024. The purpose of the SOP is to provide assurance that a robust and financially viable process is in place for the allocation of overtime within budget. It was sent to senior managers on 6 March 2024, to be disseminated to locality managers who would operate the SOP.

2.5 The SOP currently relates only to the overtime allocation for Emergency Medical Services (EMS) within the Operations Directorate and describes the process that all localities within each Service area of EMS must follow, to enable the allocation of overtime within the allocated financial envelope.

Conclusion:

2.6 The Trust's Resourcing Policy includes overtime; however, it has not been reviewed in the last ten years. There is a SOP in place which details the procedures for allocating overtime within EMS of the Operations Directorate, which has been issued to senior managers. However, this has only been recently introduced and will take time to mature. Therefore, we have provided **reasonable** assurance in this area.

Objective 2: Overtime allocations are appropriately determined and authorised; and are considerate of the savings targets applied.

2.7 As per para 2.5, a clear process for the allocation of overtime was developed for use by EMS from 2024/25.

2.8 The SOP lays out the process for the annual allocation of overtime and the end of month review process in-year. Overtime allocations are provided to each Health Board area of EMS in a targeted approach determined by the needs of the service, and within the available financial envelope; which is £2.4m in 2024/25. The EMS Head of Service lead, works closely with the finance and resourcing leads to determine the initial monthly overtime budget profile (see paras 2.25 and 2.26), for the forthcoming financial year:

- To support setting the overtime budget, a recruitment plan (including vacancy numbers) for the whole financial year is provided by the Workforce Transformation and Planning Business Partner as this has a direct impact on the financial envelope.
- The Resourcing Manager provides information to determine the historic abstractions and production (UHP) in each area, which is combined with known seasonal implications i.e. abstractions go up in July and December, experience of likelihood of overtime being taken, additional demand forecast around events and key dates.

2.9 This information, combined with the number of current staff vacancies by Health Board area, is used to provide intelligence to plan the overtime allocation for each area, from the overall budget, on a month-by-month basis.

2.10 Each month the Head of Service of EMS along with the Resourcing Manager and Senior Finance Partner conducts a review of overtime allocation, in order to determine the underspend or overspend of previous month's overtime allocation. Justification is determined for any variance, and the balance is brought forward to adjust individual Health Board area allowances to ensure the planned overtime remains within budget.

2.11 A spreadsheet is maintained which is updated each month with the allocated overtime, versus used allowance across the seven Health Board localities and is used to inform the individual Health Board overtime allocation percentage for the following month. The breakdown in the following three tables details the allocation, as budgeted for at the start of the year, for April, May and June 2024, across the seven areas:

Apr-24	per day	557	30	Per month	16710
Health Board	OT Allocation %	OT Hour Month	OT Weekly Hours	Shifts Per Week	Shifts Per Day
BCU	38%	6,349.80	1,481.62	129	18
Powys	15%	2,506.50	584.85	51	7
C&V	9%	1,503.90	350.91	31	4
AB	9%	1,503.90	350.91	31	4
CTM	9%	1,503.90	350.91	31	4
SB	9%	1,503.90	350.91	31	4
HD	11%	1,838.10	428.89	37	5
	100%	16,710.00	3,899.00	339	48

	May'24	per day	557	30	Per month	16710
Health Board	OT Allocation %	OT Hour Month	OT Weekly Hours	Shifts Per Week	Shifts Per Day	
BCU	38%	6,349.80	1,481.62	129	18	
Powys	15%	2,506.50	584.85	51	7	
C&V	9%	1,503.90	350.91	31	4	
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CTM	9%	1,503.90	350.91	31	4	
SB	9%	1,503.90	350.91	31	4	
HD	11%	1,838.10	428.89	37	5	
	100%	16,710.00	3,899.00	339	48	

change the percentage attributed the hours will update						20.05.2024
	Jun-24	per day	685	30	Per month	20550
Health Board	OT Allocation %	OT Hour Month	OT Weekly Hours	Shifts Per Week	Shifts Per Day	
BCU	30%	6,165.00	1,438.50	125	18	
Powys	15%	3,082.50	719.25	63	9	
C&V	11%	2,260.50	527.45	46	7	
AB	10%	2,055.00	479.50	42	6	
CTM	11%	2,260.50	527.45	46	7	
SB	10%	2,055.00	479.50	42	6	
HD	13%	2,671.50	623.35	54	8	
	100%	20,550.00	4,795.00	417	60	

2.12 Post the monthly meetings, Heads of Service and Service Managers are provided with an updated allocation, for the following month. Review of these updates noted such doesn't detail the rationale for the changes to the initial budget i.e. additional allocation to achieve a certain UHP level, help manage vacancies or higher sickness absence rates in another area, support required for a large event. See **Matter Arising 1**

2.13 A review of the allocation spreadsheet up to July showed that whilst overall usage across the seven areas balanced with the allocated (budgeted hours), some areas were considerably over their allocated hours these are summarised below:

Table 1: Overtime hours against allocation

Health Board Area	Allocated Hours (Apr – Jun) ¹	Hours used	Variance	Variance %
Betsi Cadwaladr	14,838.00	15,250.25	(587.01)	(4%)
Hywel Dda	4,949.12	7,275.90	(2,249.38)	(45.5%)
Swansea Bay	4,620.82	5,043.50	(422.68)	(9%)
Powys	5,927.58	3,987.25	1,940.33	32.7%
Aneurin Bevan	3,990.15	3,060.25	929.89	23.3%
Cardiff & Vale	3,990.14	3,831.00	159.14	4%

Health Board Area	Allocated Hours (Apr – Jun) ¹	Hours used	Variance	Variance %
Cwm Taf Morgannwg	4,460.96	4,231.00	229.96	5.2%
Total			0.25	

¹ The allocated hours are different than those the tables in para 2.8, as the May and June allocation was amended as per the SOP, to reflect changing intelligence.

- 2.14 The allocation process includes an additional contingency of 10% which is unallocated, but can be drawn on by Heads of Service or Service Managers if facing any specific challenges, to mitigate any in month overspend. This meant that when the Pan Wales position was balanced for the period April to June, the contingency budget/allocation remained untouched and overall savings were overachieved in the first quarter. From review of the monthly overtime allocation updates, there was no indication of consideration for amendments to address the locality variances. See **Matter Arising 1**.
- 2.15 We also reviewed the systems in place to ensure compliance with Working Time Regulations. The Global Resource System (GRS) has reports in place to identify breaches in addition to an alert in the system should there be an attempt to allocate a shift to a member of EMS which would cause a breach i.e. if there was a lack of an 11-hour break between shifts. However, we note that the reporting functionality of the system is not routinely used – the detail of which has been addressed within a separate review (see para 2.3) and we will not seek to replicate the recommendation at this report.

Conclusion:

- 2.16 Whilst some of the variances of overtime used versus allocated overtime in some areas was significant, overtime allocations were found to be appropriately determined and were reviewed in consultation with Heads of Service and Service Managers. Allocations were recalculated each month, based on the process outlined in the SOP, and where necessary allocations were transferred between areas. However, there was minimal documentation to support the rationale for these amendments. We have therefore determined **reasonable assurance** in this area.

Objective 3: Overtime is appropriately paid at the correct rate.

- 2.17 Where the SOP applies, the process followed requires locality managers to prioritise shifts and for these shifts to be made available via the Trust's Global Resourcing System (GRS) ten days in advance. Staff have access to the GRS system and can volunteer to fill shifts. If shifts have not being filled, Resourcing will send a blanket text out to staff to ask for volunteers.
- 2.18 The Emergency Medical Technicians (EMT) workforce is band 4 and Paramedics are typically a band 6. These shifts are described as emergency ambulance shifts and can be undertaken by either, when the opportunity arises. Despite the difference in banding (4 & 6) any overtime undertaken is paid at the individual's band; and

this has been confirmed through sample testing undertaken at this review (see para 2.18).

- 2.19 Band 7 staff, such as Duty Operations Managers and more Senior Paramedics, can undertake overtime at their own roles and attract overtime at the same pay grade. However, as these groups of staff are also clinicians (i.e., EMTs and paramedics) they can also undertake overtime at their respective clinical grade, but will only be paid at the clinical grade that they work. To allow these staff to work overtime as clinicians and to attract the correct rate of pay, they are issued with secondary assignment numbers. Their overtime timesheet for the clinician grade will be against their secondary assignment number.
- 2.20 Band 8's and above cannot attract overtime at their substantive grade. However, as described above, a large number of these managers are also clinicians, so if they desire, they are able to undertake overtime at their clinician grade, using a secondary assignment number.
- 2.21 To establish if overtime had been paid at the correct rates, we tested a sample of 20 employment payments between March and July 2024 across the Operations Directorate, which were largely focused on EMS. Each payment was checked to confirm:
- the Salary Return Spreadsheet sent to Payroll matched the timesheet;
 - the overtime payment was made within the correct Agenda for Change range of rates; and
 - timesheets were authorised.
- 2.22 In one instance, it was identified that an employee had not been paid at the enhanced overtime rate for the full shift. It was also noted that a member of clinical contact centre staff was working a grade higher in their bank role, however, such had been approved.
- 2.23 Through completion of our testing, it was noted that the process is largely manual, from paper timesheets which need to be checked and input into spreadsheet payroll returns, which are then keyed into the payroll system. It was observed that the level of manual input is time intensive and increases the risk of error, although it is acknowledged that it would require considerable resource to automate the system (**Matter Arising 2**).

Conclusion:

- 2.24 Testing has confirmed that overtime was authorised, timesheets match the payroll returns sent to Payroll and matched the payments made, with one minor exception noted. The process is very manual and time consuming, and we recognise that it would require significant development to become more automated. We have therefore provided **reasonable assurance** in this area.

Objective 4: Appropriate, accurate and timely reports on overtime are produced and distributed to budget holders and other relevant groups or committees within the Trust, and are subject to effective scrutiny with actions taken where required.

- 2.25 We were able to confirm that there is a reporting framework in place within the Operations Directorate. The framework includes monthly updates to Heads of Service, and quarterly updates to the Senior Operations Team and SLT. From SLT reporting goes to the People and Culture and the Finance & Performance Committees.
- 2.26 The Head of Service lead produces an annual profile report, that is presented to Senior Operations Team (SOT) and ratified by the Senior Operations Team (SLT). For 2024/25, this was completed in April 2024. There is subsequent quarterly reporting to SOT and SLT to detail the overtime usage for the previous quarter, including analysis against budget, and to highlight the overtime allocation position for the following quarter.
- 2.27 In addition to the quarterly updates, there are monthly updates to Heads of Service (see para 2.10).
- 2.28 Narrative updates from SLT are provided to both the People & Culture Committee and the Finance & Performance Committee. We note an action was raised at the January Finance and Performance Committee to seek assurance that the overtime reduction in EMS was not exacerbating the problem of system pressures and ambulance delays, i.e. impacting the capacity and ability to respond to emergency requests. We note the response provided stated that *'the Operations Directorate review Unit Hours Production (UHP) on a daily and weekly basis and the overtime reductions during that period were focused and more efficient in that the need for overtime was monitored and efforts were focused on maintaining a good UHP'*. However, as per **Matter Arising 1**, there is scope to better demonstrate the linkage as the thought process/rationale isn't documented clearly at present.

Conclusion:

- 2.29 Appropriate, accurate and timely reports on overtime are produced and distributed to budget holders, the Senior Operations Team, the Strategic Leadership Team and to Board-level committee. However, there is scope to better demonstrate the linkage of the review of hours with the rationale being applied to amendments in overtime allocation. Accordingly, **reasonable assurance** has been determined.

Appendix A: Management Action Plan

Matter Arising 1: Allocation amendments (Operation)		Impact	
<p>Overtime allocations are updated on a monthly basis, with details of the updates communicated to the Heads of Services and Service Managers.</p> <p>The detail provided is quantitative, with minimal qualitative information provided regarding the changes to the initial budget i.e. additional allocation to achieve a certain UHP level, help manage vacancies or higher sickness absence rates in another area, support required for a large event.</p> <p>Further, whilst recognising the variances of actual vs allocated balances pan Wales was balanced, there was no indication of consideration for amendments to address the individual locality variances – Hywel Dda being the most significant at 45.5% for the period April to June 2024.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Inefficient use of resources. 	
Recommendations		Priority	
1.1	The reporting of amendments to overtime allocations should be strengthened and supported by a documented audit trail of the rationale applied.	Medium	
1.2	Recognising the individual variances, against allocations reported at health board areas, consideration should be given to their re-mapping to a more reasonable expectation.		
Agreed Management Action		Target Date	Responsible Officer
1.1	SOT will consider and agree a formal mechanism to capture any changes to allocations in month. This will be recorded at SLT and documented through the AAA reporting process to SLT.	December 2024	Liz Wedley, Head of Service
1.2	SOT will review and reassess the overtime allocation at Health Board levels, recognising the variable nature of all that may affect allocations.	March 2024	

Matter Arising 2: Overtime payment process (Design)		Impact	
<p>In the 20 payments checked we identified one, non-material, payment which was not at the correct rate.</p> <p>However, from review of the process undertaken, it was noted that the system is largely manual, from paper timesheets which need to be checked and inputted into spreadsheet payroll returns, which are then keyed into the payroll system. It was observed that the level of manual input is time intensive and increases the risk off error, although it is acknowledged that it would require considerable resource to automate the system</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Increased risk of error. • Inefficient use of resources. 	
Recommendations		Priority	
2.1	Consideration should be given to whether it would be possible to automate parts of the process, to reduce the amount of manual input by managers.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	The Trust accepts this recommendation. Electronic timesheet development and implementation is a feature of the current IMTP. Scope work has begun in this financial year, however progress on implementation is expected to be in 2025/26 provided it is included in the forthcoming IMTP.	March 2026	Jon Edwards, Assistant Director Operations

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.



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Integrated Quality & Performance Management Framework

Final Internal Audit Report

November 2024

Welsh Ambulance Services University NHS Trust



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Review reference:	WAS-2425-05
Report status:	Final
Fieldwork commencement:	8 July 2024
Fieldwork completion:	13 September 2024
Draft report meeting:	30 September 2024
Draft report issued:	27 September 2024
Management response received:	7 November 2024
Final report issued:	8 November 2024
Auditors:	Osian Lloyd (Head of Internal Audit); Felicity Quance (Deputy Head of Internal Audit); Lisa Harte (Audit Manager)
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Distribution:	Kate Blackmore (Senior Quality Governance Lead); Hugh Bennett (Assistant Director of Commissioning & Performance); Trish Mills (Board Secretary)
Committee:	Audit, Risk & Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Welsh Ambulance Services University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To review the deployment of the Quality & Performance Management Framework (Framework) and assess the extent it is being embedded across the Trust.

Overview

We have issued reasonable assurance on this area.

Reporting to the September 2024 Audit, Risk & Assurance Committee (ARAC) highlighted the resource constraints that has impacted the development and progress with the QPMF's work programme. Improvements are being made as a result of recent appointments, but at the conclusion of our review, there was a post that still required backfilling.

We note that there is also a balance in delivering priorities while recognising the challenges the Trust faces with the wider system pressures for urgent and emergency care, which are not always within its control. This could negatively impact on patient flow and lead to avoidable patient harm and death.

The matters requiring management attention include:

- Review of the Communication Plan and the Quality & Performance Management Framework's work programme to ensure that actions are clearly defined and achievable.
- Review of the governance structure to ensure there is sufficient oversight over the Framework.

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Trend

N/A

Assurance summary¹

Objectives	Assurance
1 Embedding Arrangements	Limited
2 Performance Monitoring & Reporting	Reasonable
3 Governance Arrangements	Reasonable

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

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
1	Framework Delivery	Design	High
2	Communication Plan	Design	Medium
3	Governance Arrangements	Operation	Medium

1. Introduction

- 1.1 A core value detailed in Welsh Government's, '*A Healthier Wales: our Plan for Health and Social Care*' (2021) is, "*putting quality and safety above all else – providing high-value evidence-based care for our patients at all times.*" The Health and Social Care (Quality and Engagement) (Wales) Act 2020, which came into force in April 2023, places an enhanced duty of quality and an organisational duty of candour on NHS bodies to strengthen their approach in providing high quality and safe care.
- 1.2 During 2022/23, an Audit Wales' review of Quality Governance arrangements identified weaknesses in the reporting arrangements at the Welsh Ambulance Services University NHS Trust (the Trust) and its capturing of outcomes for patients. As per the latest position on the Trust's recommendation tracker, we note that one of the recommendations relating to quality performance reporting and learning has not been fully implemented.
- 1.3 We have held discussions with Audit Wales to understand the themes arising from their work in relation to their follow up review of Quality Governance Arrangements at the Trust.
- 1.4 One of the key elements of the Trust's Quality Strategy is to develop and embed Quality Management Systems, the Quality & Performance Management Framework forms part of this. Audit Wales reported in its Structured Assessment (November 2023) that the "*Framework, approved in March 2022, is comprehensive and sets out clear roles and responsibilities for staff. The Quality and Performance Management Steering Group oversees the ongoing development of the framework which includes trialling and reviewing best approaches for effectively incorporating the new requirements placed by the Duty of Quality and Duty of Candour. Despite this, operational performance remains extremely challenged due to increased demand, wider system pressures and the consequential inefficiencies. Together, these challenges are leading to avoidable patient harm.*"
- 1.5 The Trust's Integrated Medium-Term Plan (IMTP) 2024 – 2027 details the following key objective, "*Being Quality Driven and Clinically Led,*" and key actions in relation to quality that will be implemented over the three-year period, which include the deployment of the Quality & Performance Management Framework.
- 1.6 The risk considered in this review is that quality and safety governance arrangements are ineffective with issues not escalated to and addressed by the Trust, potentially resulting in poor quality services and / or patient harm.
- 1.7 The audit has reviewed the oversight of quality governance arrangements within the Trust, but not encompassed the operational reporting at directorate/service level nor the external reporting arrangements, e.g. to the commissioner.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	3	2	-	5
Operating Effectiveness	-	3	-	3
Total	3	5	-	8

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

Objective 1: The Trust is effectively embedding its Quality Strategy and Quality & Performance Management Framework across the organisation, providing clear direction and structure for its quality governance arrangements.

- 2.3 The Quality Strategy for 2021-2024, framed around the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, was approved by the Trust Board on 27 May 2021. Reporting to the Quality, Patient Experience & Safety Committee (QuESc) (13 August 2024) requested an extension of the current Strategy for the current financial year (2024/25) and noted the proposed approach to developing the Quality Plan 2025-2028 to support the Trust’s overall Strategy, ‘*Delivering Excellence: Our Vision for 2030*’. Audit Wales noted in their follow up review of Quality Governance Arrangements (see paragraph 1.3) that staffing capacity, “*has impacted the Trust’s ability to deliver all of the actions of its Quality Strategy at the pace it intended.*”
- 2.4 The Quality & Performance Management Framework (Framework), a key element of the Quality Strategy, was approved by the Trust Board on the 24 April 2022. The Framework details that it will be formally reviewed every three years but that the responsibility for the ongoing development will be discharged to the QPMF Steering Group, which is detailed within their terms of reference.
- 2.5 We acknowledge this ongoing development and note that the Framework has been reviewed during 2023 to ensure the duty of quality was appropriately reflected and embedded in the Framework. The amended version was submitted to the Executive Leadership Team (ELT) (22 May 2024). At the conclusion of our review, arrangements for formally reviewing the Framework are being considered.
- 2.6 The Framework sets out 24 organisational requirements and the Steering Group has undertaken a corporate self-assessment against these principles, which was reported to ELT (22 May 2024). Reporting to Audit, Risk & Assurance Committee (ARAC) (12 September 2024) noted that, “*the Trust has strong arrangements for quality & performance at the corporate level, but there is more variation at a*

directorate/service level (there is some very good practice), whilst at an individual staff level, the vast majority of staff receive an appraisal". Where areas for improvement have been identified within the self-assessment, they have been incorporated into the QPMF work programme, which is monitored and updated by the QPMF Steering Group monthly.

- 2.7 The organisational self-assessment had not been reviewed since it was initially completed, and there was not always a clear link between earlier versions of the work programme and the self-assessment, e.g. OR4, 12 and 21. However, we are satisfied that the latest version of the work programme (29 August 2024) has rectified these issues and advise that the organisational self-assessment is reviewed periodically to alleviate any further issues.
- 2.8 There are 18 actions on the QPMF work programme (29 August 2024) with only two actions recorded as being completed to date:

	29 August 2024	27 June 2024	2 January 2024
Completed	2	5	2
Paused/Delayed	2	2	3
Open	14	9	9
Total	18	16	14

- 2.9 The work programme would benefit from a review to confirm that actions have the correct status (an earlier version of the work programme (27 June 2024) recorded five actions as completed); that actions have a defined timescale (three were recorded as, 'continuous' or 'dependent on learning'); realistic timescales are recorded (five had missed their target date for completion); and that the work programme details the original time frame for completion as well as any revisions, e.g. the action detailing the completion of three self-assessment pathfinders is currently recorded with a timeframe of 31 March 2025, but earlier versions of the work programme recorded this as 31 December 2023 for the completion of two pathfinders (see **Matter Arising 1**).
- 2.10 The Framework details that the work programme will be reported to ELT and Finance & Performance Committee (FPC). While ELT received a copy of the work programme (22 May 2024) and there was reporting to ARAC (12 September 2024), who have oversight over the Framework's implementation, there have not been regular updates on the progress with the programme's delivery (see **Matter Arising 1**).
- 2.11 The Framework details that both corporate and operational managers will be required to assess their own systems and processes, culminating in their arrangements for quality and performance management being documented in a series of local frameworks. Further work is needed to determine exactly what these

frameworks will entail and the number of self-assessments that will be required within the Trust (see **Matter Arising 1**).

- 2.12 The Resource Service pathfinder, supported by a work programme, is currently the only self-assessment to be completed, but timescales for improvement actions are not always defined (see **Matter Arising 1**). Four further self-assessments are due for completion by 31 March 2025 for Governance, Emergency Medical Service Co-ordination (EMSC), Strategy, Planning and Performance; and Quality, Safety & Patient Experience.
- 2.13 Reporting to the Quality, Patient Experience & Safety Committee (QuEST) (13 August 2024) detailed the work that has been undertaken to strengthen the quality management arrangements within the Trust, including the appointment of senior quality leads following the internal Organisational Change Process (OCP); developing a Quality Improvement Hub; delivery of a Quality Event (2 July 2024) introducing the Framework; and the inclusion of Duty of Quality and Duty of Candour training on the Learning Management System (LMS 365) to mitigate previous issues experienced, e.g. measuring compliance with attendance. We note that Audit Wales has raised a recommendation in relation to increasing compliance rates for Duty of Quality and Duty of Candour training as part of their follow-up review of Quality Governance Arrangements (see paragraph 1.3).
- 2.14 A Communication Plan (June 2024) has been developed to ensure there is regular communication and engagement of the Framework that includes completed actions such as having visibility of Duty of Quality, Duty of Candour, and the Framework on the Trust's intranet.
- 2.15 Noting that the Communication Plan is now a standing agenda item for the QPMF Steering Group (effective from September 2024), the action plan would benefit from an update to ensure that the status of actions is clear (one action had no status; and the other detailed 'to be discussed'); there are clearly defined timescales (some actions had timescales recorded as 'ongoing' or nothing recorded); and there are robust actions to cover the later phases of the Framework (75% of actions were recorded for Phases 1-3) (see **Matter Arising 2**).
- 2.16 The Executive Director of Quality & Nursing explained that it was not only staffing capacity that has impacted on the embedding of quality management arrangements within the Trust, but also data limitations. We were advised that these digital issues are being addressed separately to the Framework's implementation.

Conclusion:

- 2.17 Resource pressures have clearly impacted on the embedding of quality management arrangements across the Trust including the development of local frameworks and putting in place an appropriate level of communication and engagement of the Framework. While there has been investment in staffing resources, including the recent appointments of the senior quality leads and a Senior Performance Analyst, which will provide dedicated support to strengthen the structure for quality management, capacity to progress the work programme

has been an issue. Enhancements to the reporting of the work programme will ensure there is appropriate oversight where delivery of the Framework is at risk. We assign this objective **limited** assurance.

Objective 2: Key indicators have been identified to support the monitoring of the quality of services and patient outcomes.

- 2.18 Audit Wales reported in its Structured Assessment (November 2023) that, *“the Trust has reasonable performance management and monitoring arrangements, operational performance continues to be extremely challenging”*. It also noted that, *“despite consistent performance issues the Board continues to provide challenge and scrutiny that seek to encourage improvement. The Trust reviewed its approach for performance reporting in May 2023. This led to an improved and more rounded set of performance metrics”*.
- 2.19 One of the key principles of the Framework is to develop a coherent set of performance measures and targets and it also details that measures should be FAST (frequently discussed, ambitious, specific and transparent) and have clear milestones for delivery. Actions in relation to this have been documented within the QPMF work programme, e.g. developing scorecards, completing self-assessment pathfinders (see paragraph 2.11), and publishing the Monthly Integrated Quality & Performance Report (MIQPR) on the Trust’s intranet.
- 2.20 The Quality and Performance Management Steering Group commissioned a MIQPR Dashboard from the Health Informatics Team with the aim of providing a consistent set of metrics for use within the Trust. The first phase of this Dashboard has been published and is available on the intranet.
- 2.21 There is also regular oversight and monitoring of performance through reporting the MIQPR to the Quality Management Group, QuEst, People & Culture Committee (PCC), FPC, ELT, and the Board. The MIQPR metrics have been reviewed recently and presented to both FPC and the Board (July 2024). A new metric, ‘length of lie’ for fallers, will be incorporated in reporting going forward. Further adjustments to the metrics will be considered as the Trust evolves its clinical model and continues to address the Duty of Quality.
- 2.22 MIQPR reporting (June/July 2024) to QuEst (13 August 2024) noted that:
- *“The red 8-minute response performance for July 2024 was 48.2%, remaining below the 65% target; however, the Trust is reaching more red patients in 8 minutes, but the denominator (demand) has also grown”*. This could lead to avoidable patient harm, but the Trust was continuing to work on actions within its control to mitigate this risk.
 - *“Handover outside Emergency Departments remains the critical component of long waiting times and patient safety incidents. 19,596 hours were lost during July 2024”*.
 - Data quality issues have been identified in 111, which are currently being addressed. 111 call handling performance has stabilised post-delivery of the

new 111CAS system, but the abandonment rate was at 11.9% in June 2024 and off target (5%), although demand was 4.76% higher than June 2023.

- Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance was stable.
- Staff sickness absence was 7.44% in July 2024 and the IMTP ambition is to reach 6%. PADR rates did not achieve the 85% target in July 2024 but have been improving (76.76%) (this was a recommendation within Audit Wales' Quality Governance (2022) review, which is still recorded as 'in progress'). Compliance for Statutory and Mandatory training increased to 84.47%, just below the 85% target.

2.23 Benchmarking of performance has been carried out, e.g. Operational Research in Health (ORH) were commissioned to carry out an independent review of frontline operations and EMSC with their performance compared to other organisations.

Conclusion:

2.24 There are several mechanisms for monitoring the performance of the quality of services and patient outcomes within the Trust, and frequent reporting to senior management, the Trust's Board and its various committees on the wider quality management arrangements. Wider consideration of other performance measures is being pursued as part of the Framework to ensure that there are appropriate measures at every level of the Trust. Therefore, we provide **reasonable** assurance for this objective.

Objective 3: An appropriate governance framework is in place to provide oversight of quality and safety issues within the Trust, ensuring key risks and issues are reported and escalated where necessary.

2.25 There is a Quality Management Group (QMG), chaired by the Senior Quality Governance Lead, whose role includes assisting in embedding an effective quality management system across the Trust. The QMG's terms of reference have been recently reviewed and submitted to the Clinical Quality Governance Group (CQGG) for discussion (15 August 2024) who has oversight of the Group. The amended terms of reference were due to be presented for approval at the next meeting (September 2024).

2.26 The meetings have a different area of focus each week rotating between Emergency Medical Service (EMS), Ambulance Care, Integrated Care, and Resourcing and Corporate Services. Review of three QMG meetings held during July 2024 confirmed that they are well managed as both the action and decision logs are updated following each meeting and Alert, Advise, Assure (AAA) reports have been regularly submitted to the CQGG. Improvement is needed as there were several verbal updates rather than written reports provided. However, we note that arrangements are embedding, and this has already been identified as an improvement area by the Chair, therefore we are not raising a recommendation.

- 2.27 The Senior Quality Governance Lead also attends the QPMF Steering Group, which has oversight over the Framework. The Group is chaired by the Director of Strategy, Planning & Performance, but also includes other executive representation as both the Executive Director of Quality & Nursing and the Board Secretary attend the monthly meetings as well as relevant assistant directors. Their terms of reference have been reviewed and approved by ELT (22 May 2024), who has oversight of the Steering Group.
- 2.28 While an action log was maintained and written reports supplied for agenda items at the QPMF Steering Group, enhancements are needed to the administration of these meetings. Reporting to ELT (22 May 2024) noted that meetings have been cancelled several times in recent months and that quoracy has been an issue so decisions cannot be made; and the decision log has not been populated (see **Matter Arising 3**), which we understand forms part of a wider issue within the Trust.
- 2.29 Terms of reference for the Steering Group require that AAA reports should be submitted to ELT on a monthly basis, but the process has not yet embedded. For the period January to August 2024, reporting had been undertaken for March and April (to the May Steering Group); and June and July (to the August meeting). We note that January's meeting was cancelled, but there was no AAA report submitted following the February or May meetings; and AAA reporting for March does not detail the attendance of members to confirm quoracy (see **Matter Arising 3**).
- 2.30 Similarly, there has been a lack of oversight of the Framework's implementation at committee level (see **Matter Arising 3**). When the Framework was originally approved by Trust Board (22 March 2022), it was recommended that there would be annual reporting of the Framework and the Steering Group's work. While there was initial reporting to FPC (14 November 2022), the governance arrangements were revised to ARAC overseeing the Framework's implementation, with FPC to have oversight of its effectiveness following implementation. The Steering Group's terms of reference was amended to reflect this detailing that they will receive regular reporting on the implementation of the Framework.
- 2.31 ARAC's cycle of business details that it will receive bi-annual reporting of the Framework. However, there has been minimal reporting with ARAC receiving a verbal update in November 2023; and a written report in September 2024 (following a deferral from the March 2024 meeting) providing an update on progress with the delivery of the Framework and the associated work programme.
- 2.32 As per para 2.6, it has been recognised that further enhancements to the wider governance arrangements within the Trust are required particularly with operational governance. An integrated governance map, mapped to the Framework's objectives, is being developed, which includes principles that aim to ensure there is effective oversight and accountability across its meetings; provide clarity over roles and responsibilities; and improve the administration of meetings.
- 2.33 Audit Wales identified in its review of '*Quality Governance Arrangements*' (August 2022) (see paragraph 1.3) that while the QuEST Committee is well served with
-

quality information, there were opportunities for improvement, e.g. develop a system to triangulate learning themes across its quality assurance reports, develop patient outcome measures to support its existing quality measures, etc.

- 2.34 Their Structured Assessment (November 2023) detailed that the Trust is focussing on service quality, with good committee oversight. This included QuEST continuing to appropriately review key quality information, focussing on the high level of risk of patient harm, applying constructive challenge, and is escalating concerns such as these to the Board.
- 2.35 There has been regular reporting to ensure that senior management, committees and the Trust Board receive information on quality and patient safety including updates to QuEST on the Quality Strategy, Duty of Quality, and Duty of Candour implementation, MIQPR reporting (see paragraph 2.22), and annual reporting of the Duty of Quality. There is a specific paper that the Chief Executive Officer presents to each Board meeting, which the Trust is considering refreshing, that includes quality and performance information by directorate.
- 2.36 The Trust Board and committees regularly focus on their highest rated risks 223 (the Trust's inability to reach patients in the community causing patient harm and death) and 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). The risk score remains at 25 due to the sustained and extreme pressure that is negatively impacting on patient flow and leading to avoidable patient harm and death. Further mitigations of these risks have been undertaken, but there is recognition that there are areas that are not under the Trust's control and therefore, an ambition to consider these risks differently in terms of how they are managed.

Conclusion:

- 2.37 Noting that arrangements are continuing to embed, there is currently a lack of oversight over the implementation of the Framework and the administration of the Steering Group meetings needs enhancing to confirm decisions made and ensure there is prompt escalation of key risks and issues to ELT. However, there is regular monitoring and reporting on wider quality and safety issues, including through QMG. Further developments are planned to strengthen existing structures with the implementation of integrated governance and the changes to the management of the Trust's highest scoring risks in relation to patient harm. Therefore, we assign this objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter Arising 1: Framework Delivery (Design)	Impact
<p><u>Work Programme:</u> A work programme was developed to provide focus on the delivery of actions in line with the Quality & Performance Management Framework. Progress with implementing the actions has been impacted by capacity issues:</p> <ul style="list-style-type: none"> Of the 18 actions detailed on the latest version (29 August 2024), 11% of actions have been completed; 36% of actions have missed their original timescale for completion; and 21% of actions did not detail a defined timeframe, e.g. 'continuous' or 'dependent on learning'. While the latest version of the work programme (29 August 2024) has been updated to include revised timeframes, it does not fully capture the length of time it has taken to implement improvement actions. The actions would also benefit from a review to confirm that they have the correct status (actions in relation to OR3, OR6 and OR10 were shown as 'complete' on an earlier version of the work programme but have now been re-opened), or whether new actions should be created for further enhancements to be made. The Framework details that the work programme will be reported to ELT and Finance & Performance Committee. While ELT received a copy of the work programme (22 May 2024) and there was reporting to ARAC (12 September 2024), there have not been regular updates on the progress with delivery. <p><u>Local Frameworks:</u> Capacity issues have also impacted the development of the process for local frameworks, e.g. the design of the framework and what should be incorporated within it and determining how many self-assessments will be required within the Trust. The Resource Service pathfinder's work programme did not always clearly define the timescales for implementing actions.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> Performance is not effectively monitored or reported impacting on the Trust's quality of services and patient outcomes and delivery of the Quality & Performance Management Framework.
Recommendations	Priority
<p>1.1 The Quality & Performance Management Framework's work programme should be reviewed and incorporate SMART criteria to define success and provide realistic timescales for delivery. Similarly, any work programmes that are designed to support the pathfinder, e.g. Resource Service, should provide realistic timescales for delivery.</p>	<p>High</p>

1.2	Regular performance reporting should provide effective oversight of progress with the delivery of the QPMF’s work programme that clearly defines risks and enables prompt action to be taken where issues are escalated.		
1.3	The development of the process for local frameworks should be concluded and incorporate the areas of the Trust that will require a framework to be implemented; and take account of the design and content of the frameworks through providing guidance and templates.		
Agreed Management Action		Target Date	Responsible Officer
1.1	<p>The current work programme has recently been reviewed, including amendments based on IA feedback during the audit. It continues to be reported into Q&PMF Steering Group each month. Timescales are considered realistic, but subject to on-going performance management.</p> <p>An annual review will also be undertaken, with time-out in December programmed to start to build programme for 2025/26.</p>	<p>November 2024</p> <p>March 2025</p>	Assistant Director, Commissioning & Performance
1.2	ELT to be supplied with AAA after every Q&PMF Steering Group, with the AAA including progress on the work programme.	March 2025	Assistant Director, Commissioning & Performance
1.3	The Trust is not planning to develop local frameworks for every area of the Trust. The approach is proportionate. Every area is required to complete a self-assessment, governance map, cycle of quality & performance business and work programme. Timetable to be developed to ensure completion across Trust.	December 2024	Assistant Director, Commissioning & Performance

Matter Arising 2: Communication Plan (Design)

Impact

A Communication Plan (June 2024) has been developed to ensure there is regular engagement of the Framework. The Plan details the progress with delivery of sixteen actions across six phases with 31% of actions completed (in Phases 1 and 2):

Potential risk of:

- Opportunities to raise internal and external awareness may be missed.

	Actions Completed	Actions Paused	Actions on Target	Actions off Target	Status Unclear	Total
Phase 1 – Awareness of Framework	2	2	1	0	0	5
Phase 2 – Understand the Concept	3	0	1	0	1	5
Phase 3 – What Does it Mean to Me?	0	0	2	0	0	2
Phase 4 – Where to Find Information & Support	0	0	1	0	0	1
Phase 5 – How Framework Is Being Made to Happen	0	0	0	1	0	1
Phase 6: Importance of Framework	0	0	1	0	1	2

18% of actions detailed within the Plan, encompassing six phases, were either off target, had no status, or detailed 'to be discussed'. Some actions had timescales recorded as 'ongoing' or nothing recorded so it was unclear if deadlines for completing actions had been missed. Alert, Advise, Assure (AAA) reporting to the Executive Leadership Team (ELT) (14 August 2024) detailed the delivery of actions had been mainly within Phase 1 (Awareness of Framework), but focus was now required on the later phases (12 of the 16 actions contained within the Plan were for Phases 1-3).

Recommendations		Priority	
2.1	The Communication Plan’s action plan should be revised to include additional actions pertaining to the later phases. SMART criteria should be incorporated to clarify the current status of actions and provide realistic timescales for delivery.	Medium	
2.2	Following the amendments, the plan should be shared at an appropriate forum and appropriate staff engagement should be carried out to ensure that arrangements continue to be embedded.		
Agreed Management Action		Target Date	Responsible Officer
2.1	Communications Plan to be updated accordingly.	December 2024	Assistant Director, Commissioning & Performance
2.2	Q&PMF Steering Group will approve the communications plan.	December 2024	Assistant Director, Commissioning & Performance

Matter Arising 3: Governance Arrangements (Operation)	Impact
<p>There has been a lack of oversight of the Framework’s implementation and the work of the QPMF’s Steering Group to both committees and the Executive Leadership Team (ELT).</p> <p><u>Reporting to Committee:</u></p> <p>When the Framework was originally approved by Trust Board (22 March 2022), it was recommended that the Finance & Performance Committee (FPC) receive a six-month update on the Framework and a short annual report. A written report was presented to the FPC (14 November 2022) providing a six-month update of progress.</p> <p>A verbal update was provided at FPC (15 May 2023) advising that as the QPMF was a framework for assurance, it would be more appropriate for it to be reviewed and endorsed by the Audit, Risk & Assurance Committee (ARAC). The FPC would continue to monitor performance; however, the ARAC will oversee the implementation of the Framework. Subsequently, a verbal update was provided to ARAC (30 November 2023), and a written report was also supplied (12 September 2024) providing an update on the work of the Steering Group, their Terms of Reference, and progress with the work programme.</p> <p>Clarity of both the FPC’s and ARAC’s role for the Framework was provided to FPC (19 March 2024) by the Board Secretary. ARAC’s cycle of business confirms that reporting of the Framework will be bi-annual but notes that it was agreed that an update on the Framework was not required for the March 2024 meeting.</p> <p><u>Reporting to ELT:</u></p> <p>Terms of reference for the QPMF’s Steering Group require that Alert, Advise and Assure (AAA) reports should be submitted to ELT after each meeting, but this has been done intermittently, e.g. there were no AAA reports prepared following the Steering Group’s February and May 2024 meetings; delays in AAA reporting to ELT following the Steering Group’s March and June 2024 meetings; and the attendance at Steering Group is not always recorded (March 2024). This would assist in monitoring quoracy which has been highlighted as an issue in AAA reporting to ELT.</p> <p>Administration of the Steering Group meetings could be further enhanced by ensuring that the decision log is populated and formulating the arrangements for formally reviewing the Framework.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> Unclear roles and responsibilities or ineffective reporting could result in poor decision making and a lack of accountability and oversight.

Recommendations		Priority	
3.1	There should be regular reporting to both the Executive Leadership Team and at committee level to ensure there is effective oversight of the Quality & Performance Management Framework.	Medium	
3.2	Attendance and key decisions arising from the QPMF Steering Group meetings should be appropriately recorded.		
3.3	Both the Framework and the Steering Group’s terms of reference should be updated to clarify arrangements or reflect any amendments.		
Agreed Management Action		Target Date	Responsible Officer
3.1	Production of AAA after each Q&PMF Steering Group and onward supply to ELT. It has been agreed by ARAC that one further update will be provided this financial year and thereafter 6 monthly reports to FPC.	November 2024	Assistant Director, Commissioning & Performance
3.2	The AAA does record attendance, but production of the AAA to date has been intermittent. See 3.1 above.	March 2025	Assistant Director, Commissioning & Performance
3.3	The ToR has been through several iterations and updates and is considered up to date, however, there is a F2F Q&PMF workshop planned for Dec-24, which will provide a further opportunity for review. Going forward the review will be at least annually.	March 2025	Executive Director of Strategy, Planning & Performance

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.



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Review of Cost Savings Arrangements – Welsh Ambulance Services University NHS Trust

Audit year: 2023

Date issued: August 2024

Document reference: 4448A2924

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Introduction

- 1 NHS Wales is facing unprecedented financial challenges. The legacy of the COVID-19 pandemic on service demand, the rising costs associated with staffing, energy, medicines, maintaining an ageing estate; and tackling the increasingly complex health conditions associated with an ageing population all contribute to the worsening financial situation across the NHS.
- 2 Despite the Welsh Government making an additional £425 million available to the NHS in October 2023, the 2023-24 year-end audited position for NHS Wales was a collective deficit of £183 million. Whilst some NHS bodies were able to achieve year-end financial balance, the position for others - particularly some Health Boards - was challenging with several not being able to deliver the control total deficit expected by Welsh Government.
- 3 The position for 2024-25 is equally, if not more challenging. Health bodies will need to ensure that they have robust approaches in place to identify and deliver in year cost improvement opportunities and to also take a longer-term approach to achieving financial sustainability that moves away from short-term approaches to ones where savings are achieved by transforming service models and ways of working.

Objectives and scope our work

- 4 Given the challenges outlined above, the Auditor General has undertaken a programme of work examining NHS bodies' approaches to identifying, delivering, and monitoring sustainable cost savings opportunities. Whilst our more detailed work has been targeted at health boards, we have also undertaken high level work at Special Health Authorities and NHS Trusts, linked to the specific functions of those bodies. The findings from that high level work at the Welsh Ambulance Services University NHS Trust (the Trust) are set out in this report.
- 5 The work has been undertaken to discharge the Auditor General's statutory duty under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Trust has proper arrangements in place to secure economy, efficiency, and effectiveness in its use of resources.
- 6 We undertook the bulk of our work between February 2024 and May 2024. The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

- 7 Overall, we found that **the Trust exceeded its overall 2023-24 savings target and continues to enhance its arrangements for identifying, delivering, and monitoring efficiencies and sustainable cost savings. However, opportunities exist for the Trust to reduce its reliance on non-recurrent savings, strengthen financial capabilities across the organisation, and refine its savings reporting to Board.**
- 8 The findings that support our overall conclusion are summarised below under the following headings:
- Identifying cost improvement opportunities.
 - Delivering cost improvement opportunities.
 - Monitoring and overseeing cost improvement opportunities.

Identifying cost improvement opportunities

- 9 The Trust has a good understanding of its cost drivers, which are clearly set out in its 2023-24 Financial Plan. Its key cost drivers include pay, utilities, vehicle fuel, general non-pay inflation and costs related to service pressures, particularly those created by ambulance handover delays. In January 2023, the Trust introduced a Recruitment Control Process as one of the levers within its wider Financial Sustainability Programme (FSP) to deliver on its statutory duty to achieve financial balance. Whilst we recognise that vacancy management supports the Trust's overall approach to controlling high spend areas, there are risks associated with being overly reliant on non-recurrent savings of this nature to achieve its overall savings targets. We discuss this further in **paragraph 12.**
- 10 The Trust appropriately uses data from a wide range of sources to inform its approach to identifying cost improvement opportunities. For example, at the time of our work, the Trust had recently completed an Administrative Services Review and was in the process of finalising its organisation-wide Services Review. These reviews drew on internal data and benchmarking, including data from its Wales Improvement and Innovation Network (WiiN)¹, to identify key actions which, when implemented, should identify additional efficiencies and areas for savings. Whilst Trust staff can currently submit ideas and suggestions via the WiiN portal, the Trust intends to further enhance staff engagement by providing clearer information about

¹ The Trust launched WiiN in 2017 to drive consistent quality improvement across the organisation. The cross-directorate network, coordinated by the Quality Improvement Team, supports staff with quality improvement projects, training, and communications. The network is also a key link for improvement bodies and teams across other organisations and health bodies, aiding cross working.

the savings process on SIREN² and strengthening the way in which the FSP works in conjunction with WiiN.

- 11 The Trust has a clear approach to selecting cost improvement schemes through a risk based three-phase process³. This approach enables the Trust to identify the benefits of savings schemes as well as to assess their risks and impacts on patients and quality. As part of this process, the Trust deselects schemes where the impacts outweigh the benefits. The Trust's initial 2023-24 Financial Plan included a savings target of £6 million, which in March of 2023 had £2.6 million of unidentified savings. However, it had identified sufficient savings schemes to cover this shortfall by Month 3 2023-24. To deliver a balanced financial plan for 2024-25, the Trust has set itself a savings target of £6.4 million or 2.2% of its cost baseline. At the time of publishing its 2024-25 Financial Plan in March 2024, it had identified all these savings. Whilst there are challenges associated with the non-recurrent nature of some of the savings schemes this approach to quickly identifying savings opportunities should give the Trust sufficient time to identify further schemes if agreed savings schemes start to fall behind their planned delivery during the year.

Delivery of cost improvement opportunities

- 12 The Trust has a good track record of achieving its overall savings target, although it does this largely through delivering non-recurrent savings. In 2022-23, the Trust achieved its cost savings target of £4.3 million, and in 2023-24 it exceeded its £6million savings target by £0.5 million. However, over 55% of the savings delivered by the Trust in 2023-24 were non-recurrent with a significant proportion (39%) of these being vacancy management savings. There is a risk that an over reliance on non-recurrent savings will ultimately become unsustainable and put pressure on the Trust's services and future financial plans. (**Recommendation 1**)
- 13 The Trust's planning arrangements for the delivery of its savings and cost improvements are continuing to improve. The Trust's FSP has two key areas of focus: savings / efficiencies and income generation. Underpinning this programme is a Financial Sustainability Delivery Framework (FSDF). Whilst the FSDF has provided a necessary framework for the delivery of its financial efficiencies and savings, the Trust recognises that it needs to improve aspects of its planning for savings through, for example, ensuring that there is greater alignment between the FSP and workstreams delivering operational efficiencies and Value Based Health Care.
- 14 One of the Trust's key learnings from its end of year evaluation of the FSP recognised that it needed to invest in developing financial literacy and

² 'SIREN' is the Trust's internal intranet portal.

³ The three phases of the savings process are: 1. The 'Identification Phase' of savings opportunities; 2. The 'Viability Phase' where the opportunities are assessed to determine if they are viable; and 3. The 'Project Phase' where viable opportunities are implemented.

competencies across all levels of staff to enable them to effectively contribute to the organisation's financial sustainability. The evaluation also identified that there was a lack of expertise and capability in some specific areas, such as commercial income generation. It will be important, therefore, for the Trust to ensure that it addresses any gaps in its financial literacy, competencies, and expertise if it is to maximise the identification and delivery of savings and efficiencies in 2024-25 and beyond. **(Recommendation 2)**

Monitoring and oversight of cost improvement opportunities

- 15 The Trust has effective arrangements for overseeing the delivery of its Financial Sustainability Programme. A well-established Strategic Transformation Board (STB) is in place which provides senior-level oversight of key programmes, such as the FSP. Collectively, these programmes support delivery of the Trust's Long-Term Strategic Framework and 2024-2027 Integrated Medium-Term Plan (IMTP). There is regular oversight of financial spending and savings performance at both Executive and Board level. Board members clearly understand the current financial situation and continue to provide an appropriate level of scrutiny and challenge to support improvement in meetings of the Board and its Finance and Performance Committee (F&PC).
- 16 However, the Trust's internal reporting arrangements on savings has the potential to cause confusion. Whilst the Trust regularly reports on its savings performance to both the Board and F&PC, there are examples of where the figures used within these reports are different. For example, for the March 2024 Board meeting, the Monthly Integrated Quality and Performance Report for Month 11 2023-24 stated that the Trust had achieved £4.949 million of savings. However, the Month 11 2023-24 Finance Report to the same meeting stated that £6.079 million of cost improvements had been achieved. This is due to the fact that the latter report included savings generated from income generation. Whilst both of these figures were technically correct, there is a potential that reporting different figures may lead to confusion and undermine confidence in the robustness of the Trust's savings reporting. **(Recommendation 3)**
- 17 More broadly, the Trust has improved the clarity of the way it reports savings to the STB, the Executive Management Team, and the F&PC. In 2023-24, these reports did not include sufficient detail on the split between recurrent and non-recurrent savings to support effective monitoring and oversight. However, since Month 3 2024-25, these reports now include this level of detail which should aid understanding of the sustainability of the Trust's savings schemes and their ability to help address the Trust's future financial challenges.
- 18 The Trust has recently reviewed the key risks for its FSP, and these now form part of the new FSP 2024-25 Tracker Plan. The Trust's FSP is also recognised as both a key control and source of assurance for two of the Trust's key corporate risks

around its funding levels and achieving its statutory financial duties. These risks are regularly reviewed by the Audit, Risk and Assurance Committee and F&PC which, in turn, provide an additional level of assurance to the Board that the Trust is taking the necessary steps to meet its financial duties through its delivery of savings.

- 19 The Trust has a proactive approach to learning and applying lessons to improve its approach to savings. As noted above, the Trust has recently undertaken a detailed evaluation of its progress on delivering its 2023-24 savings through the FSP. This proactive evaluation has provided a helpful end of year progress update on each savings scheme area and has also identified several other key points of learning, including the need to make improvements in areas such as process, communication, documentation, developing key skills, and exploring the reasons behind why some schemes did not deliver as anticipated. Undertaking this type of reflection is positive and embedding the learning should strengthen the Trust's arrangements for identifying and delivering its savings. **(Recommendation 4)**

Recommendations

- 20 **Exhibit 1** details the recommendations arising from this audit. The Trust's management response to our recommendations is summarised in **Appendix 2**.

Exhibit 1: Recommendations

Recommendations	
R1	The Trust should strengthen its approach to identifying and delivering recurrent savings. This will enable it to reduce its reliance on non-recurrent savings in areas such as vacancy management and place its financial savings plans on a more sustainable footing. (Paragraph 12)
R2	The Trust should ensure it takes forward work to address gaps in staff skill sets in respect of the identification and delivery of savings and efficiency opportunities. (Paragraph 14)
R3	The Trust should ensure that its savings reports to Board and F&PC, are consistent or provide a clear explanation of the differences between the reported savings performance. This will aid understanding, reduce confusion, and maintain the credibility of the Trust's savings reporting. (Paragraph 16)

Recommendations

- R4 The Trust should ensure that it fully implements the learning from its recent gateway review of its Financial Sustainability Programme. This will ensure that it further strengthens its savings arrangements and maximises its savings opportunities. **(Paragraph 19)**

Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below

Element of audit approach	Description
Documents	<p>We reviewed a range of documents, including:</p> <ul style="list-style-type: none">• Board and Committees agendas, papers, and minutes.• Key organisational strategies and plans.• Savings benchmarking data.• Key risk management documents, including the Board Assurance Framework and Corporate Risk Register.• Key reports and plans relation to organisational finances and savings.• Reports prepared by the Internal Audit service.
Interviews	<p>We interviewed the following senior officers:</p> <ul style="list-style-type: none">• Executive Director of Finance and Corporate Resources

Element of audit approach	Description
	<ul style="list-style-type: none">• Deputy Director of Finance and Corporate Resources• Executive Director of Operations• Senior Programme Manager (Financial Sustainability Programme)• Director of People and Culture• Deputy Director of People and Culture

Appendix 2

Management response to audit recommendations

Exhibit 3: Welsh Ambulance Services University NHS Trust management response to our audit recommendations.

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Trust should strengthen its approach to identifying and delivering recurrent savings. This will enable it to reduce its reliance on non-recurrent savings in areas such as vacancy management and place its financial savings plans on a more sustainable footing. (Paragraph 12)	There will always be an element of non-recurring savings in relation to the theme of corporate vacancy management savings due to historic time to advertise, recruit and appoint when posts become vacant. Recommendations from the services review will be assessed and, where possible, any recurrent efficiencies via organisational structural changes will be implemented. 2024/25	31 st March 2025	Executive Director of FinCoR

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		<p>currently has a split of 56.7% recurrent and 43.3% non-recurrent savings, with any in year over delivery being helpfully in recurring as opposed to non-recurrent schemes.</p> <p>The 2025/26 Financial plan savings target will aim for a minimum of c65% recurrent themes.</p>		
R2	The Trust should ensure it takes forward work to address gaps in staff skill sets in respect of the identification and delivery of savings	The outcome of the recent Administrative & Corporate Services Review highlighted need for additional training and investment in colleagues, which is currently being actioned via ADLT-owned Action	Next detailed reviews: <ul style="list-style-type: none"> - ADLT re Admin Review – 31st March 2025 - Following appointment of Head of 	Director of P&C (as SRO for FSP) and Executive Director of SP&P

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	and efficiency opportunities. (Paragraph 14)	Plan, and the upcoming finalisation of the Service Review is also expected to highlight areas of under or over resourced service ensuring most appropriate investment of resource in the right areas. Specifically focussing on the income generation and commercialisation agenda, included in the 2024/25 financial plan is c£0.250m to directly support this. This will include recruitment of dedicated resources to drive this forward, including the investment in a Head of Commercial post alongside Commercial structure to enhance specialist knowledge. This project and recruitment is underway.	Commercialisation – 30 th June 2025	(as lead for commercialisation)

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R3	The Trust should ensure that its savings reports to Board and F&PC, are consistent or provide a clear explanation of the differences between the reported savings performance. This will aid understanding, reduce confusion, and maintain the credibility of the Trust's savings reporting. (Paragraph 16)	Finance Reports from M03 2024/25 to Trust Board and F&PC include further detailed analysis reporting of savings which includes split of recurrent and non-recurrent themes. WAST Monthly Monitoring Returns (MMR) submitted to WG also flow through committees and board. Further classification included in the proforma to be completed now include further breakdowns (i.e. Income Generation) so this allows clearer reconciliation for 2024/25 and beyond.	Actioned – as at 31 st August 2024	Executive Director of FinCoR
R4	The Trust should ensure that it fully implements the learning from its recent gateway review of its Financial	The Gateway Review provided opportunity to self-assess the successes and challenges of the	Various – as per the attached.	Various, but led by Director of P&C as SRO for FSP

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	Sustainability Programme. This will ensure that it further strengthens its savings arrangements and maximises its savings opportunities. (Paragraph 19)	<p>Financial Sustainability Programme at the end of Financial Year 2023/24. With this self-assessment are 11 key lessons, all of which are reviewed on an ongoing basis, and many of which underpin the FSP's 2024/25 objectives.</p> <p>Overall, the FSP has implemented a number of recommendations to date, including improved communication and engagement, and enhanced investment in a financially sustainable future, including a commercial structure in-house. Those recommendations not yet implemented will either be done before the end of the 2024/25 financial year, or will look to be</p>	Likely next detailed review / Gateway post 2024/25 – 30 th June 2025	

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		<p>included in the operational plan of the incoming Head of Commercial Role.</p> <p>Attached as an appendix is the full list of lessons learnt, including an update as to current position as of August 30th, 2024. We will look to provide regular updates as we progress throughout the year, via both the Finance and Performance Committee, Strategic Transformation Board, and Audit, Risk and Assurance Committee as part of the wider set of recommendations.</p>		



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AGENDA ITEM No	14
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	2

Mobile Data and Vehicle Solution Feedback Initiative

MEETING	Finance and Performance Committee
DATE	19/11/24
EXECUTIVE	Jonny Sammut, Director of Digital Services
AUTHOR	Anwen Stevens, Senior Project Manager
CONTACT	Anwen.stevens@wales.nhs.uk

EXECUTIVE SUMMARY

Following the MDVS roll out to all operational vehicles, a staff survey was shared with all users. The feedback gathered raised 5 main issues that need to be addressed and where possible resolved.

The categories are the 'voice accept' functionality, routing issues, not being able to view text on the MDT screen when responding to an incident, "update" being voiced but with no apparent update heard and specifically to NEPTS crews, the inability to view their runs for the whole shift.

Through staff engagement and targeted communications whilst working with stakeholders (such as Ambulance Radio Programme) these issues will be addressed and where possible resolved.

Recommendation: The MDVS Project Team would like the Finance and Performance Committee to acknowledge that the valid issues that operational crews have raised are being addressed but accept that to comply with the Road Traffic Act, some changes to practice, perception and colleague satisfaction cannot be met within the constraints of the Act.

KEY ISSUES/IMPLICATIONS

Operational colleagues were not content with the new solution in some instances. The need to adhere to the Road Traffic Act has meant an imposed change to the way in which information is shared with operational vehicles when moving. The MDVS solution ensures that our vehicles are responding to incidents, be they planned or emergencies in a safe way.



REPORT APPROVAL ROUTE

DLG 30/11/2024
OCP Programme Board 31/11/2024

REPORT APPENDICES

Appendix 1 – Review and Action plan of MDVS User Survey
Appendix 2 – ARP PDA Feedback

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



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Situation

The new Mobile Data Vehicle Solution (MDVS) solution was installed into all EMS and Ambulance Care vehicles between October 2023 and June 2024. The new system, although similar to the legacy MDT solution, is different in many ways. The need to comply with the Road Traffic Act, following the removal of the existing exemption, has meant that data on the screen is not visible to the crew when travelling above 7mph, the improved quality of the mapping also led to a decision by the fleet department to remove the Garmin sat nav screen.

In July 2024 the MDVS Project Team shared a survey (MS Forms) via Siren with all operational colleagues to gather feedback about the solution. For some areas the new solution had been in situ for some time and in other it was still very new.

Background

From the survey results it was apparent that some crews were not content with the new solution. Most of the feedback was negative although the positives such as the details in the mapping (house numbers etc.) and the modern look and feel of the new system were also acknowledged. The impact of the change to what has become standard practice must also be taken into account.

Assessment

The feedback was reviewed with an action plan developed (appendix 1) and fell into 5 main categories.

Voice accept – the crew were frustrated that the ‘voice accept’ function didn’t always work as expected.

The project team have undertaken testing with the operational crews and witnessed the voice accept function being used when it is not designed to be active i.e. when the vehicle is stationary. The project team along with ARP at the positive days of action held in October 2024 have shared communications to reiterate when the voice accept function is actively listening for a voice prompt from the crew.

Crews also highlighted that the routing to incidents wasn’t always the fastest or ‘best’ route. Crews stated that they were having to rely on local knowledge more than they needed to previously. Following discussion with Terrafix it transpires that the 20mph speed limit introduced in Wales has had more of a negative effect on the choice of route generated by the National Mobilisation Application than expected. Terrafix have made a change in the algorithm to try and overcome the challenge faced, this will be released to the Trust for testing before the end of the year.

In addition, the Ordnance Survey maps used in the application may not always be up to date, and Terrafix consider this a business-as-usual activity to update. Map updates are available each quarter, and any issue raised will be updated and made available in the next release. As the project closes, we will be reliant on crews raising examples of



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the given route not being optimal and the reasons why to ensure we keep our maps as up to date as possible.

Not being able to view all the written text previously available on the legacy system was a concern for operational colleagues. The Road Traffic Act dictates that while driving, only symbols may be seen unless the text relates to the location of the vehicle. Even the reflection of the MDT screen in the window could be deemed a distraction to the driver. To ensure all Trusts comply with the law, the NMA application has been developed to ensure it is fully compliant with the Road Traffic Act.

An interface between the NMA and the Terrapace system was developed and implemented to enable EMS crews to view the written text that was not deemed 'critical' and therefore not voiced by the system on their iPad. As this doesn't seem to be widely used by operational EMS colleagues, a pilot of the NMA Incident Viewer will take place with colleagues involved asked to feedback.

EMS crews can hear the word "update" regularly while en-route to an incident. If the information has been deemed critical from the JCC the NMA will voice the message for them to hear the information and enable them to 'acknowledge' the message verbally by staying "voice accept". If a message has been shared by a text message or is deemed noncritical, the crew will still hear "update", but the message won't be voiced. Through clear communications both in person from ARP in the 'days of action' week and written comms it is hoped that the understanding of the "update" will be clearer for operational crews.

Finally, Ambulance Care crews were disappointed that they could no longer see the work that was planned for their whole shift. The system had been designed to the specification supplied by Ambulance Care colleagues but based on feedback from the crews the development to enable crews to see all their future 'runs' at any point during a shift is being developed and available soon.

Recommendation: The MDVS Project Team would like the Finance and Performance Committee to acknowledge that the valid issues that operational crews have raised are being addressed but accept that to comply with the Road Traffic Act, some changes to practice, perception and colleague satisfaction cannot be met within the constraints of the Act.

Appendix 1 -Review and Action plan of MDVS User Survey

Appendix 2- ARP PDA Feedback

WAST MDVS User Survey (Combined)

CoPilot Results & Management Response/Actions

NOTE: CoPilot is a generative AI language model and AI-generated content may be incorrect. Findings should be validated, and if quotes are required, refer back to the original survey responses not the CoPilot generated output.

Where **bold italics** are used throughout this document, this is content that we have chosen to add in to supplement the information, and is not generated by CoPilot.

Q1 – MDVS navigation function experience

Here's a summary of the document:

Main ideas:

- **The document is a collection of survey responses:** The document contains responses from over 100 people who were asked to rate their experience of the MDVS navigation function.

Issue No	Comment/Response	Action	Owner	Completion Date	Status (R.A.G)
1.	The Trust is pleased and encouraged by the high number of responses to the survey and draws and assumption that the new MDVS solution is a highly emotive issue for staff.	A further survey should be conducted in 6 mths to determine whether the issues identified and concerns expressed through the survey have been addressed adequately.	MDVS Project Manager		Closed

- **The majority of the responses are negative:** Most of the respondents expressed dissatisfaction with the system, citing issues such as poor GPS signal, screen freeze, voice recognition failure, inability to access messages or updates while driving, and inaccurate or unsafe navigation routes.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
2.	Each of the above issues will be addressed in more detail in subsequent issue/actions points.	No specific action to this point.			Closed

- **Some of the responses are positive or neutral:** Some of the respondents said that the system was easy to use, had some useful features, or was a nice design.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
3.	The above responses will be considered in more detail in subsequent issue/actions points.	No specific action to this point.			Closed

- **The respondents suggested some improvements for the system:** Some of the respondents mentioned that the system could be improved by allowing the attendant to use the screen, having an option to mute or dim the voice or screen, reading out all messages and updates, using a better mapping system, and having an "I am the passenger" option.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
4.	Each of the above issues will be addressed in more detail in subsequent issue/actions points.	No specific action to this point.			Closed

Of the negative responses, what are the main themes? List these in order of most frequently mentioned.

According to the document: Here are the main themes of the negative responses, listed in order of most frequently mentioned:

1. Poor navigation and mapping system
2. Inability to access messages or updates while driving
3. System freezing or shutting down [5]()
4. Poor voice recognition or [20]() voice command failure
5. Inability for the attendant to use the screen [52]()

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
5.1	An update to the navigation system will be released as part of vrs 4.5.1 that will address issues with GPS lag. Furthermore, WAST is deploying a WiFi solution that will enable over the air (OTA) mapping updates which will address mapping accuracy issues.	WAST to conclude deploying vrs 4.5.1 update and expedite the deployment of WiFi to enable mapping updates ASAP.	MDVS Project Manager & ICT Network Manager	Sept/Oct 2024	Green

		WAST has now deployed software vs. 4.7.1			
5.2	Legislation prevents such messages to be displayed on the MDVS screen once the vehicle reaches 7MPH as to do so could potentially result in distraction of the driver. WAST has no influence over this legislation and no exception is permitted. Therefore, WAST has provided as an alternative means for the attendant to access messages and updates whilst the vehicle is moving via the crew iPad and EPCR solution.	WAST to assess and review the ARP incident viewer solution as an alternative to the EPCR option.	MDVS Project Manager & TU partners.	Pilot planned for Oct / Nov 2024	Amber
5.3	The issue of the screen freezing/shutting down is a known problem with a fix available as part of the vrs 4.5.1 release. WAST has deployed the updated vrs to in excess of 450 vehicles.	WAST to conclude deployment of vrs 4.5.1 and review the frequency of screen freezing/shutting down incidents within 6 weeks. WAST has now deployed software vs. 4.7.1	MDVS Project Manager, ICT Service Desk Manager & ARP Service Manager	Sept / Oct 2024	Green
5.4	The voice recognition systems has been tested and validated to 97% accuracy by ARP.	WAST should perform its own voice recognition testing under real terms conditions. Testing has been completed and identified that the system is working as intended.	MDVS Project Manager		Green
5.5	The Road Traffic Act legislation stipulates that the driver must not be distracted even through reflection, WAST therefore believes the use of the MDVS screen centrally located on the vehicle dashboard could cause such a distraction to the drive when used by the attended.	WAST should consider whether the EPCR solution provides all the information required by crews. WAST will test as part of Incident View pilot.	MDVS Project Manager		Amber

Give 3 examples of the poor navigation feedback.

According to the document: Here are 3 examples of poor navigation feedback:

1. "Poor sat nav taking you down routes not suitable for ambulances, longer routes, closed roads.[1]()"
2. "Sat nav not as good."
3. "The GPS is sluggish and slow compared to the old satnav."

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
6.1	The Sat Nav system has various configurable configuration options / preferences, the system should be configured to optimise major roads and speed.	In addition to deploying the latest system update and mapping update WAST should review the configuration setting ensuring they are optimised accordingly. WAST has engaged with ARP & TRFX and determined that the 20mph limit is having an impact on routing. TRFX will issue an software update to address and resolve this issue.	MDVS Project Manager & WAST Critical Systems Manager	Jan 2025	Green
6.2	A fix for the slow/sluggish navigation will be addressed through the release of vrs 4.5.1 and a map update.	WAST to complete the deployment of vrs 4.5.1 and WiFi solution for the deployment of the latest mapping releases. WAST has now deployed latest software vrs 4.7.1 Progress with deployment of WiFi at workshops is complete.	MDVS Project Manager & ICT Network Manager		Green

Expand on the topic of inappropriate road choices - what is the underlying issue?

According to the document: The underlying issue of inappropriate road choices is the inaccuracy of the navigation system. The navigation system often takes longer, narrower, and more dangerous routes, which can cause delays and safety concerns for the crew and patients.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
7.	See above issues (Ref 5.1; 6.1 & 6.2)				Closed

What are the main positive experiences mentioned, list in order of most frequently mentioned.

According to the document: There are very few positive experiences mentioned in the document. Here are the main positive experiences mentioned, listed in order of most frequently mentioned:

1. The system can navigate to most addresses.
2. The houses are numbered very well and are easier to see compared to the previous system.
3. The map is clear.
4. The navigation is generally good.
5. The navigation is manageable.
6. The system works well on the whole.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
8.	WAST welcomes the positive feedback received.	No action required.			Closed

How many people think that it was an improvement on the previous system?

According to the document: Only **one** person mentioned that the MDVS navigation function is an improvement on the previous system.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
9.	WAST acknowledges that only a single (1) positive response.	WAST should repeat the staff survey in 6mths in order to understand whether the navigation function has improved. ARP supported WAST at the CEO roadshows and held "a day (4days	MDVS Project Manager		Amber

		Mon 14 th – 17 th Oct) of action” which engaged directly with staff, these have been received well and will help address a number of the issues including those relating to staff awareness of how the new system works.			
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What are the main areas for improvement and what actions should be taken?

According to the document: There are several areas for improvement in the MDVS navigation function, including:

1. **GPS and Navigation:** The system is slow to respond, takes longer routes, and is inaccurate in rural areas. -
2. **Voice Recognition:** The system does not always respond to voice commands, and the volume is too low even when turned up. -
3. **Messages and Updates:** Messages and updates are not always read out, and the system auto-acknowledges messages without the user being able to read them. -
4. **Screen and Design:** The screen is too low, and the design is not user-friendly. The system also freezes and shuts down frequently.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G)
10.1	Refer to previous navigation points (Ref 5.1; 6.1 & 6.2)		MDVS Project Manager		Closed
10.2	Refer to previous voice recognition issues (Ref 5.4). In regards to the volume WAST should review the main system settings to ensure they are set appropriately.	WAST to review the volume settings on the Mobile Device Admin Management (MDAM). The latest software release provides greater adjustment of the volume settings.	MDVS Project Manager & Critical Systems Manager.		Green
10.3	The MDVS system provides a function which converts critical text messages entered into the CAD to be voiced by the device. It has been previously identified that the EMS-C staff entering the messages were selecting the wrong option resulting in an alert message but no voiced message/details. An EMS-C briefing was issued.	WAST EMS-C to re-issue the briefing and consider the training needs of staff. Staff notices have been re-issues to address this requirement and the EMS-C training lead is developing a specific	MDVS Project Manager and EMS Critical Systems Manager.		Amber

Commented [AS1]: Not sure it's too detailed for here but the volume will be set to it's loudest form Monday wit comms on Siren yesterday and in the weekly round up today.

		training package to provide additional support.			
10.4	WAST acknowledges that the retrofitting of screens in a vehicle will always present some compromise, though the locations where screens have been installed has been done in-line with legislation relating to the vehicle construction and use, reviewed by a broad section of users and technical experts including TU, Operational Managers and Driver Training leads and represents the optimised location across the fleet. In regards to the system freezing refer to issue Ref 5.3.	No specific action.			Closed

Actions that could be taken to improve the system include:

1. Improving the GPS and navigation system to provide more accurate and efficient routes.
2. Enhancing the voice recognition system to respond better to commands and increasing the volume.
3. Ensuring that all messages and updates are read out and that the user can read them before acknowledging.
4. Redesigning the screen and overall system to be more user-friendly and fixing the issues that cause the system to freeze and shut down.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G)
11.1	Refer to issues Ref 5.1; 6.1 & 6.2				
11.2	Refer to issue Ref 5.4 & 10.2				
11.3	Refer to issue Ref 10.3				
11.4	Refer to issue 10.4				Closed

[Similar question] Were any improvements suggested by the survey respondents, and if so, what actions should be taken?

According to the document: Yes, several improvements were suggested by the survey respondents. Here are some of the suggested improvements and actions that could be taken to address them:

1. **Update the mapping software:** Many respondents mentioned that the mapping software is not up to date, inaccurate, and lacks detail. Updating the mapping software to a more accurate and detailed version could improve the navigation experience.
2. **Improve the responsiveness of the system:** Several respondents mentioned that the system is slow to respond, lagging, and has a delay. Improving the responsiveness of the system could help prevent missed turns and improve the overall navigation experience.
3. **Improve the route selection:** Many respondents mentioned that the system chooses poor, inappropriate, or dangerous routes. Improving the route selection algorithm to take into account factors such as road size, speed limits, and vehicle dimensions could improve the navigation experience.
4. **Improve the position and visibility of the screen:** Several respondents mentioned that the screen is situated in a position that obscures other vehicle controls, is too low, or is difficult to see. Improving the position and visibility of the screen could improve the navigation experience.
5. **Provide live traffic data:** One respondent mentioned that the system does not account for live traffic data. Providing live traffic data could improve the accuracy of the estimated time of arrival and improve the navigation experience.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G)
12.1; 12.2 & 12.3	WAST has plans to issue updates to the MDVS software and mapping. Refer to issues Ref 5.1; 6.1 & 6.2		MDVS Project Manager		
12.4	WAST is developing plans to integrate the MDVS system into the infotainment system of new vehicle (2025/26) which will remove the need for a separate standalone screen. For existing vehicles refer to Ref 10.4.	WAST to explore options to integrate the MDVS solution into the infotainment system of new vehicles. <i>WAST has engaged with ARP and system supplier to explore next steps. WAST understand there will be no option but to follow an integrated model with may vehicle types due to the manufacturer not providing any option</i>	WAST ICT Communications Manager. (AW)		Amber

Commented [AS2]: Should this be green? the December build vehicles will have the infotainment system screens.

		but a large screen as part of the base model.			
12.5	WAST is a member of the ARP MDVS National Review Group which is tasked to consider new and emerging developments.	WAST to propose to the ARP MDVS National Forum the development of live traffic updates.	MDVS Project Manager		Amber

****Do any of the responses mention being distracted whilst driving. If so, list the reasons for the distraction.**

According to the document: Yes, several responses mention being distracted whilst driving. The reasons for the distraction include:

1. The screen is situated in a position that obscures other vehicle controls and requires taking eyes off the road to look at directions.
2. Icons and text are incredibly small and difficult to read.
3. The screen cannot be swivelled towards the user.
4. The volume gets turned down by some crews, so the driver has to look at the screen if they haven't noticed the volume has been turned down.
5. The screen is too low to look at when driving.
6. The screen sits too low, taking the driver's attention off the road.
7. The driver has to physically take their eyes off the road to follow navigation.
8. The orientation of the screen makes it difficult to see details while driving.
9. The purple number showing the next exit on a roundabout is hard to read in certain lighting.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G)
13.1	Refer to issue Ref 10.4		MDVS Project Manager		Closed
13.2	WAST should engage with ARP to understand if the icons and text can be increased in size.	WAST to explore potential to increase icon/text sizing.	MDVS Project Manager.		Red
13.3	WAST considered during engagement sessions with TU, Operational managers and the Driver Training Leads the potential to swivel the screen determining that a fixed position would provide the best outcome.	No action.			Closed
13.4	The volume settings can be configured from within the MDAM. WAST should consider setting the	WAST to review the MDAM volume settings	MDVS Project Manager.		Green

	volume to the optimised limit. (refer to issue 10.2)	and adjust accordingly to optimise the volume.			
13.5 & 13.6	Refer to issues 10.4				Closed
13.4	Refer to issue 10.4. WAST SOPs stipulate that "Satellite Navigation systems are fitted with voice directions and the driver should use these when responding to an emergency rather than using visual prompts. If the vehicle has an attendant they should assist the driver with direction where possible".	WAST to issue communications that remind staff that the primary method for using a navigation system is based on the voiced directions over the visual ones.	MDVS Project manager & Driver Training Lead.		

****[Asked again about reasons for distractions]**

10. Difficulty in getting job details when driving alone in RRV.
11. Screen at the wrong height, causing the driver to take their eyes off the road.
12. Incoming messages and volume of siren sound can be startling when driving.
13. The screen is too low, causing the driver to take their eyes off the road.
14. Lack of a mute function, causing two voices to talk at once.
15. Voice commands not being accepted by the device.
16. Screens are lower, causing the driver to take their eyes off the road.
17. Screen going blank when on a red call.
18. Unexplained alarms and beeps going off for no obvious reason.
19. System being distracting and unable to gain information if on route to an incident.
20. Not being able to see warning markers on address.
21. Not being able to see information about the job.
22. Poor maps and poor information.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
13.10	The Road Traffic Act legislation is intended to reduce the distraction caused by devices when driving, in the case of solo drivers the level of distraction and therefore risk is arguably greater requiring an even greater level of concentration. It is therefore WAST opinion that solo responders focus should primarily be on driving with visual distractions reduced to an absolute minimum. The MDVS solution provides a "splash screen" by means of an incident update that flashes up on the screen on arrival at the incident location which should provide adequate detail to assist the	No specific action.	MDVS Project Manager		Closed

	responder. Furthermore, the capability to provide the solo responder verbal updates and or request to speak with the EMS-C remain.					
13.11	Refer to previous issues Ref 10.4					Closed
13.12	Refer to previous issue Ref 13.4					
13.13	Refer to previous issues Ref 13.4					
13.14	The option of a mute button should be considered and proposed to the ARP National MDVS Forum as a road map item.	WAST to request ARP develop a mute function.	MDVS Project Manager			Amber
13.15	Refer to previous issue Ref 5.4					
13.16	Refer to previous issue Ref 13.4					
13.17	Refer to previous issue Ref 5.3					
13.18	WAST to explore what alarms / bleeps are being heard.	WAST to test the system under real world conditions.	MDVS Project Manager.			Amber
13.19	Refer to previous issue Ref 10.3					
13.20 & 21	Warning markers and incident information should be visible via the EPCR solution.	WAST to confirm that the details necessary to ensure staff safety and plan any patient intervention is available via the EPCR. Refer to previous Ref 5.2.	MDVS Project Manager			Amber
13.22	Refer to previous issue Ref 5.1; 6.1 & 6.2					

How many responses mention the screen being at the wrong height?

According to the document: There are **3** responses that mention the screen being at the wrong height.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
14.	WAST acknowledges that only three (3) response indicated the screen position is at the wrong height. WAST considers the actions taken in determining the best location for the siting of the screen meets with the Trust	No further actions required.			Closed

	ambition to ensure an optimised position.				
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NOTE: this has not been validated, there may be more than 3 references.

Q2 – Voice Accept function experience

Here's a summary of the document:

Main ideas:

- **The document contains survey responses about the voice accept function of MDVS:**

The document is a collection of over 100 survey responses from users of the Mobile Vehicle Data Solution (MDVS) in the vehicles. They were asked to rate and explain their experience of the voice accept function, which allows them to accept messages and incidents by voice command.

Issue No	Comment/Response	Action	Owner	Completion Date	Status (R.A.G.B)
15.	The Trust is pleased and encouraged by the high number of responses to the survey and draws and assumption that the new MDVS solution is a highly emotive issue for staff.	A further survey should be conducted in 6 mths to determine whether the issues identified and concerns expressed through the survey have been addressed adequately. Refer to issue no 1.	MDVS Project Manager		Closed

- **The majority of the responses are negative and report poor performance of the voice accept function:** Most of the users expressed dissatisfaction, frustration, and stress with the voice accept function. They reported that it often does not work, does not recognize their voice, takes multiple attempts, or accepts things they did not say. They also complained that the function does not read out the messages or updates, so they have to pull over and stop to read them on the screen.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
16.	Each of the above issues will be addressed in more detail in subsequent issue/actions points.	No specific action to this point.			Closed

- **Some of the responses suggest that the voice accept function is unsafe, unnecessary, or against the law:** A few users raised concerns about the safety and legality of the voice accept function. They argued that it is distracting, risky, or against

the highway law to use voice commands while driving. They also questioned the point or benefit of the function, as they preferred to press the screen or have a double crew member to handle the messages.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
17.	Each of the above issues will be addressed in more detail in subsequent issue/actions points.	No specific action to this point.			Closed

• **A minority of the responses are positive or neutral about the voice accept function:**

Only a handful of users gave positive or neutral feedback on the voice accept function. They said that it works well, better recently, or most of the time. They did not report any major issues or complaints with the function.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
18.	The Trust appreciates the positive feedback on the voice accept function.	No specific action to this point.			Closed

Where respondents mention feeling unsafe, list the reasons for this.

According to the document: Respondents mentioned feeling unsafe using the voice accept function for the following reasons:

1. It is stressful and distracting from emergency driving **[this is in relation to having to repeat commands multiple times.]**
2. It is difficult to use when there is a lot of road noise, making the process of being stood down and allocated to a red call lengthy
3. It does not always work, resulting in having to pull over in dangerous places
4. It is difficult to use when there is any background noise, control/radio comms, vehicle radio, lights and sirens
5. It is not possible to know what you are accepting until you stop
6. It is not possible to access messages when double crewed
7. It is not possible to access or hear messages clearly when mobile
8. It regularly fails to accept a voice command, leading to the need to pull over to get updates or response information
9. It requires too many voice accept commands
10. It has at times voice accepted a stand down when not ready to turn off blue lights.

One response says: “The principle of voice accept is good as it means the driver cant be distracted by pressing a button, but you then cant know what you’re accepting until you

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G.B)
19.1; 19.2; 19.3; 19.4; 19.7 19.8 & 19.9	The Trust acknowledges the difficult and challenging environment created when driving under emergency conditions, and believes the MDVS solution provides a solution that seeks to reduce driver distraction.	WAST will look at any further developments that can be made to the voice accept capability to enhance the user experience and reduce further distraction. WAST will perform user testing on the 02.08.24 to understand whether there are further areas for development. This is linked to issue 10.3	MDVS Project Manager		Amber
19.5 & 19.6	The MDVS system provides a function which converts critical text messages entered into the CAD to be voiced by the device. It has been previously identified that the EMS-C staff entering the messages were selecting the wrong option resulting in an alert message but no voiced message/details passed across. An EMS-C briefing was issued.	WAST EMS-C to re-issue the briefing and consider the training needs of staff. Refer to issue 10.3	MDVS Project Manager and EMS Critical Systems Manager.		Amber
19.10	Acceptance of a stand-down message does not necessarily mean that the blue lights should be switch off. The driver should determine when it is safe and appropriate to switch off the blue lights and revert to driving under normal road conditions, at the earliest opportunity following notification of the standdown.	No specific action required.			Closed

stop. Surely it must be possible that if you have signed on as a double crew, then the attendant can accept & read out messages?”

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G)
20.	There is no reason why an attendant can't voice accept messages/alerts, however, the MDVS system is designed to comply with the Road Traffic Act and as such limit distraction to the driver	WAST will review the incident summary details being provided via the iPad / EPCR ensuring the information meet the	MDVS Project Manager.		Amber

	therefore allowing text messages to be visible on the MDT screen is not permissible in law. However the attended should be able to access the incident details via their iPad and the EPCR application and brief the driver accordingly. Furthermore, a "splash" screen is visible on arrival at the incident and when the vehicle speed drops below 7mph which provides a summary of the incident details.	operational needs, furthermore WAST will investigate the ARP Incident Viewer capability. Ref Issue 5.2			
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****Do any of the responses mention being distracted whilst driving because of the voice accept function? If so, list the reasons for the distraction.**

According to the document: Yes, several responses mention being distracted while driving because of the voice accept function. The reasons for the distraction include:

1. Having to repeat the command multiple times, sometimes in different tones, for it to be recognized
2. The device not recognizing speech due to engine noise, radios, poor signal, sirens, etc.
3. The system regularly failing to accept a voice command, leading to the need to pull over to get updates or response information
4. Updates requiring too many voice accept commands
5. The voice accept function not working well when there is a lot of road noise, making the process of being stood down and allocated to a red call lengthy
6. The voice accept function not always working, resulting in having to pull over in dangerous places
7. The voice accept function accepting a stand down when not ready to turn off blue lights
8. Not being able to know what is being accepted until the vehicle is stopped

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G)
21.1; 21.2; 21.3; 21.4; 21.5; 21.6;	WAST acknowledges the difficulties and frustrations staff are reporting with the voice accept function. WAST notes the reference made to "pulling over in dangerous places" . WAST would ask, encourage and remind staff and drivers in particular to ensure that when driving that they take the safety of other road users, themselves, colleagues and patients into account and that any manoeuvre including pulling over is done in a safe way.	WAST will look at any further developments that can be made to the voice accept capability to enhance the user experience and reduce further distraction. Refer to issues 19.1 – 19.9	MDVS Project Manager.		Amber

21.7	Refer to issue 20.				
21.8	Refer to issue 19.5 & 19.6				

What are the main positive thoughts about the voice accept function?

According to the document: There are a few positive thoughts about the voice accept function mentioned in the document:

- It works better recently
- It works most of the time ,
- It generally works well
- Some users have never had an issue with the voice accept function

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G)
22.	WAST acknowledges the positive response.	No further actions required.			

Q3 – most frustrating aspect

Here's a summary of the document:

Main ideas:

- **Common frustrations with the MDVS/NMA system:** The document contains survey responses from ambulance crew who were asked about the most frustrating aspect of using the new Mobile Data Vehicle Solution (MDVS) / National Mobile Application (NMA) system. The most common complaints were about the voice accept function, the inability to access or hear messages and updates when driving, the poor navigation and mapping, and the system crashes and errors.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G)
23.	WAST acknowledges the frustration felt by staff when using the MDVS system and will seek to resolve, where possible the issues reported above.	WAST will undertake a further review in 6mths in order to determine whether the actions described above have indeed addressed staff frustrations.	MDVS Project Manager		

- **Impact of the system on response time and patient care:** Many respondents expressed that the system was not fit for purpose, and that it caused delays in response time and patient care. Some of the reasons were the lack of pertinent information, the need to stop the vehicle to read or accept jobs, the inability to see or hear critical updates, the slow reroute and voice over, and the ridiculous routes to scenes. Some

respondents also said that the system was stressful, distracting, and dangerous to use, especially on blue lights or high speed drives.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G)
24.	<p>Once again WAST acknowledges the frustration felt by staff when using the MDVS system and will seek to resolve, where possible the issues reported above.</p> <p>WAST would ask that any staff who feels the MDVS system adds additional stress come forward in order that we can better understand the stress factors.</p> <p>However, WAST contests the view that the system is "Dangerous to use" as the system have been designed, developed and installed by subject matter and technical experts with specific experience and expertise in providing mobilisation/navigation technology solutions to the UK ambulance and emergency services sectors. Furthermore, the solution has been rigorously tested and was live Piloted by WAST prior to deployment which did not identify such concerns.</p>	<p>WAST will undertake a further review in 6mths in order to determine whether the actions described above have indeed addressed staff frustrations.</p>	<p>MDVS Project Manager</p>		Amber

- Comparison with the previous system:** Some respondents compared the new system with the previous one, and said that the previous system was far superior, easier to use, and more user-friendly. They said that the new system was a step backwards, and that it needed changing or improving. They also suggested some features that they would like to see in the new system, such as a voice mute/pause button, a one button fits all

option, a page with full details on one screen, an OS map, and a screen that shows all jobs at the beginning of each shift.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G)
25.	Once again WAST acknowledges the frustration felt by staff when compared to the previous system. Furthermore, WAST welcomes the features suggested for development.	WAST will undertake a further review in 6mths in order to determine whether the actions described above have indeed addressed staff frustrations. WAST will work with ARP to consider if these suggestions can be developed.	MDVS Project Manager		

****Did any of the responses mention being distracted whilst driving? If so, list the reasons for the distraction.**

According to the document: Yes, several responses mention being distracted while driving. The reasons for the distraction include:

1. The need to take eyes off the road to follow directions from the navigation system, as the voice function is slow when telling you to turn left/right/take an exit.
2. Constant noise from the system regarding updates without actually stating what the update is. ***"particularly annoying when you're on CHARU trying to field calls from control/EMRTS, navigate on blue lights and theres constant noise from the system regarding updates without actually stating what the update is."***
3. The screen timing out and crashing, causing a white screen, which requires the system to be turned off and reset.
4. The poor route selection and lag on the SatNav. ***"The sat nav is making me incredibly anxious if I don't know an area, the positioning lag doesn't help."***
5. The navigator function is especially poor.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G)
26.1; 26.4 & 26.5	Deployment of software vrs 4.5.1 which includes fixes for navigation lag are believed will address this specific issue.	Refer to issue Ref 6.2.	MDVS Project Manager		
26.2	Refer to issue 5.4	Refer to issue Ref 5.4	MDVS Project Manager		

26.3	Deployment of software vrs 4.5.1 has specific fixes to address the white/blank screen issue.	Refer to issue Ref 5.3	MDVS Project Manager		
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How many of the distraction issues are for solo responders?

According to the document: There are several parts of the document that mention distraction issues for solo responders. These include parts [**references given**] In total, there are **4** parts of the document that mention distraction issues for solo responders.

How many parts of the document mention distraction issues but are not in relation to solo responders?

According to the document: There are several parts of the document that mention distraction issues for responders, but not in relation to solo responders. These include parts [**references given**]. In total, there are **13** parts of the document that mention distraction issues but are not in relation to solo responders.

Q4 – most helpful aspect

Here's a summary of the document:

Main ideas:

- **Survey responses on the new MDVS / NMA system:** The document contains survey responses from ambulance crew who were asked about their experiences with a new Mobile Data Vehicle Solution (MDVS) / National Mobile Application (NMA) system.
- **Most respondents find the new system unhelpful or worse than the old system:** Out of 107 respondents, 54 said nothing or none when asked what they find the most helpful aspect of the new system. 14 said they do not think the new system carries any benefits or is worse than the old system. Only 39 respondents mentioned some positive features of the new system, such as navigation, linking with EPCR, ease of use, or improved layout.

Issue No	Comment/Response	Action	Owner	Date	Status (R.A.G)
27.	WAST is pleased that a little over a 3 rd of respondents mentioned some positive features with the MDVS system, though acknowledge 2/3 rd mentioned no positives or indeed that the systems is worse than the previous one. WAST is therefore hopeful	WAST will re-run the Staff Survey in 6mths to gauge whether the issues have or are being addressed.	MDVS Project Manager		

	that the actions described above will address these issues and improve the experience of staff.				
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Note: No further management responses / actions are recorded as from this point forward as the issues recorded are repeated and addressed above.

- Some common issues with the new system are lack of information, glitches, and poor functionality:** Many respondents complained that the new system gives less information, such as incident log, time at scene, leave scene, etc. Some also reported glitches, such as not registering with control, not showing job details, or not working at all. Others criticized the poor functionality, such as the need to place the screen in a specific area of view, the inability to message when moving, or the difficulty to find stations and hospitals.

Give more information on the positives. What are the most commonly mentioned helpful aspects listed?

According to the document: Some of the most commonly mentioned helpful aspects of the new MDVS / NMA system are:

- Navigation:** Many respondents found the navigation feature to be helpful.
- Ease of use:** Several respondents mentioned that the new system is easy to use.
- Improved layout:** Some respondents appreciated the improved layout, design, and functionality of the new system.
- Linking with EPCR:** A few respondents mentioned that the new system links well with the Electronic Patient Care Report (EPCR).

Expand on the reasons for why people find the navigation feature helpful.

This response isn't based on the document: Some possible reasons why people find the navigation feature helpful could be:

- Improved accuracy:** The new navigation system may provide more accurate directions and routes, helping ambulance crews to reach their destinations more quickly and efficiently.
- Real-time traffic updates:** The navigation system may provide real-time traffic updates, allowing ambulance crews to avoid traffic congestion and take the fastest route to their destination.
- Ease of use:** The navigation system may be user-friendly and easy to operate, allowing ambulance crews to quickly input their destination and receive directions.
- Clearer display:** The navigation system may have a clearer and more detailed display, making it easier for ambulance crews to follow the directions and navigate to their destination.

****Do any of the responses here mention being more or less distracted whilst driving?**

According to the document: None of the responses in the document mention anything about being more or less distracted while driving.

Q5 – features we want to see

Here's a summary of the document:

Main ideas:

- **The survey question and the number of respondents:** The document contains survey responses from over 100 ambulance crew who were asked about their features they would most like to see with the new Mobile Data Vehicle Solution (MDVS) / NMA system.
- **The most common feature requests:** The most common feature requests were: the ability for the passenger to use the screen when the vehicle is moving, a better navigation system that avoids narrow or inappropriate roads, and the use of ordinance survey maps for more detail.
- **The other feature requests:** The other feature requests included: a rear saloon view, a messaging system that reads or repeats the messages, a position or tilt adjustment for the screen, a mute or pause button for the voice, and a simpler or streamlined interface.
- **The negative feedback on the new system:** Some respondents expressed negative feedback on the new system, such as: it delays mobilisation, it sends them to the wrong area or dead ends, it shuts down while driving, it does not show all the jobs or updates, and it is over engineered or distracting.
- **The preference for the old system:** A few respondents indicated that they preferred the old system, which had features such as: OS mapping, full access when moving, real time map updates, and a better position and clarity of the screen.

****Are any of the feature requests related to being more or less distracted whilst driving?**

According to the document: Yes, several feature requests are related to being less distracted while driving. Some of these requests include:

- The ability for the passenger to use the screen when the vehicle is moving.
- A better navigation system that avoids narrow or inappropriate roads.
- The use of ordinance survey maps for more detail. ***“A position or tilt adjustment for the screen. Position higher up looking down all time at map is distracting , also the ability to tilt the screen left or right.”***
- A mute or pause button for the voice.
- A voice command system.
- Messages read out.
- Better positioning of the screen.
- Ability to see the address more clearly when driving.
- Ability for the passenger to use the screen whilst in transit.

- Messages being read aloud.
- A function where any messages can be read out on command and repeated if need be.
- Less talking from the system. **"7mph limit removed"**
- All messages to be read aloud when the vehicle is moving.
- Improved voice functionality.
- Volume features to reset upon sign off/on.
- OS maps at near incident level.
- Repeat button for voice description of the job.
- A streamlined journey update process.
- A fix to missed messages when driving.
- Option to get MDVS system to read out all the info from the job or messages received.

Q6 – any other feedback

Main ideas:

- **Survey responses from ambulance crew about new MDVS:** The document contains feedback from over 100 ambulance crew members who were asked to share their opinions on a new Mobile Data Vehicle Solution (MDVS) that replaced the old MDT system.
- **Most respondents are dissatisfied with the new system:** The majority of the feedback is negative, with many respondents expressing frustration, dissatisfaction, and safety concerns about the new system. Some of the common complaints are: poor sat nav functionality, lack of voice activation, inability to access messages and updates while driving, distraction and stress caused by the system, and loss of reversing and rear cameras.
- **Some respondents suggest improvements or alternatives for the new system:** A few respondents offer some suggestions for improving the new system, such as adding a second screen in the rear, enabling voice commands, using different navigation software, tilting the screen to avoid sun glare, and having a split screen option. Some respondents also prefer the old system or question the need for changing it.
- **A minority of respondents are satisfied or neutral with the new system:** Only a few respondents express satisfaction, appreciation, or neutrality with the new system. Some of them mention the benefits of the system, such as sending updates to CCC, seeing the proximity to hospital, or having more options for patient disposition. Some of them also say they have no feedback or problems with the system.

****Do any of the responses mention being distracted whilst driving? If so, list the reasons for the distraction.**

According to the document: Yes, several responses mention being distracted whilst driving. The reasons for the distraction include:

- Increased frustration due to the system not functioning correctly
- Poor sat nav functionality

- Having to look down to see the navigation
- Having to stop/repeatedly say 'voice accept'
- Random bong noises while driving
- Warning beep for Duties - Unavailable
- The system being more distracting
- Screens being low, causing eyes to move from road to screen
- The screen shutting off and showing a 'white' screen whilst driving
- Constantly glancing down to see the map
- The system making the working day harder/more stressful
- The system binging out notifications at times
- Trying to drive safely, communicate with CCC and navigate to the address

Do the respondents seem to understand why the new system was implemented?

According to the document: Some respondents seem to understand why the new system was implemented, while others do not. Some respondents express frustration with the new system and question why it was implemented when the old system was not broken . Others express understanding of the need for the new system due to legislative changes . One respondent even states that it is a great system .



NHS

Ambulance Radio
Programme

ARP Positive Days of Action

WAST 14th – 17th Oct 2024





Introduction

- ⊕ Thanks to the valuable support provided by WAST teams and Ops staff during this activity.
- ⊕ ARP Positive Days of Action (PDAs) scheduled in Wales to run in parallel with the WAST CEO Workshop sessions across Wales.
- ⊕ Team of 12 members of the ARP MDVS Delivery Group and Service and support teams undertook visits to Ambulance stations and Hospitals across Wales.
- ⊕ Visited 14 locations across 4 days (14th - 17th October), both rural, urban and Hospital locations from morning to evening to cover various Crew shift handovers.
- ⊕ Open ended request for feedback – recorded and categorised.
- ⊕ User conversations to capture Observations, Suggestions and Improvements.
- ⊕ 154 items of feedback documented and reviewed.



WAST Locations

WAST - MDVS Action Days
Sites across WAST for ARP visits on MDVS action days.
11 views
Last edit was seconds ago

☰ Add layer 👤 Share 👁 Preview

Untitled layer

📄 Individual styles

- 📍 WREXHAM AmbStn - WAST
- 📍 CARDIFF AmbStn - WAST
- 📍 SWANSEA AmbStn - WAST
- 📍 Carmarthen Station - WAST
- 📍 1 Wrexham Ramada Plaza
- 📍 2 Llandudno- Venue Cymru
- 📍 3 Builth Wells - Royal WelshS...
- 📍 4 Carmarthen - Golf Club&Ra...
- 📍 5 Bridage End - Waterton Tec...
- 📍 6 Cardiff North - Mercure Hotel
- 📍 7 Cwmbran - Parkway Hotel ...

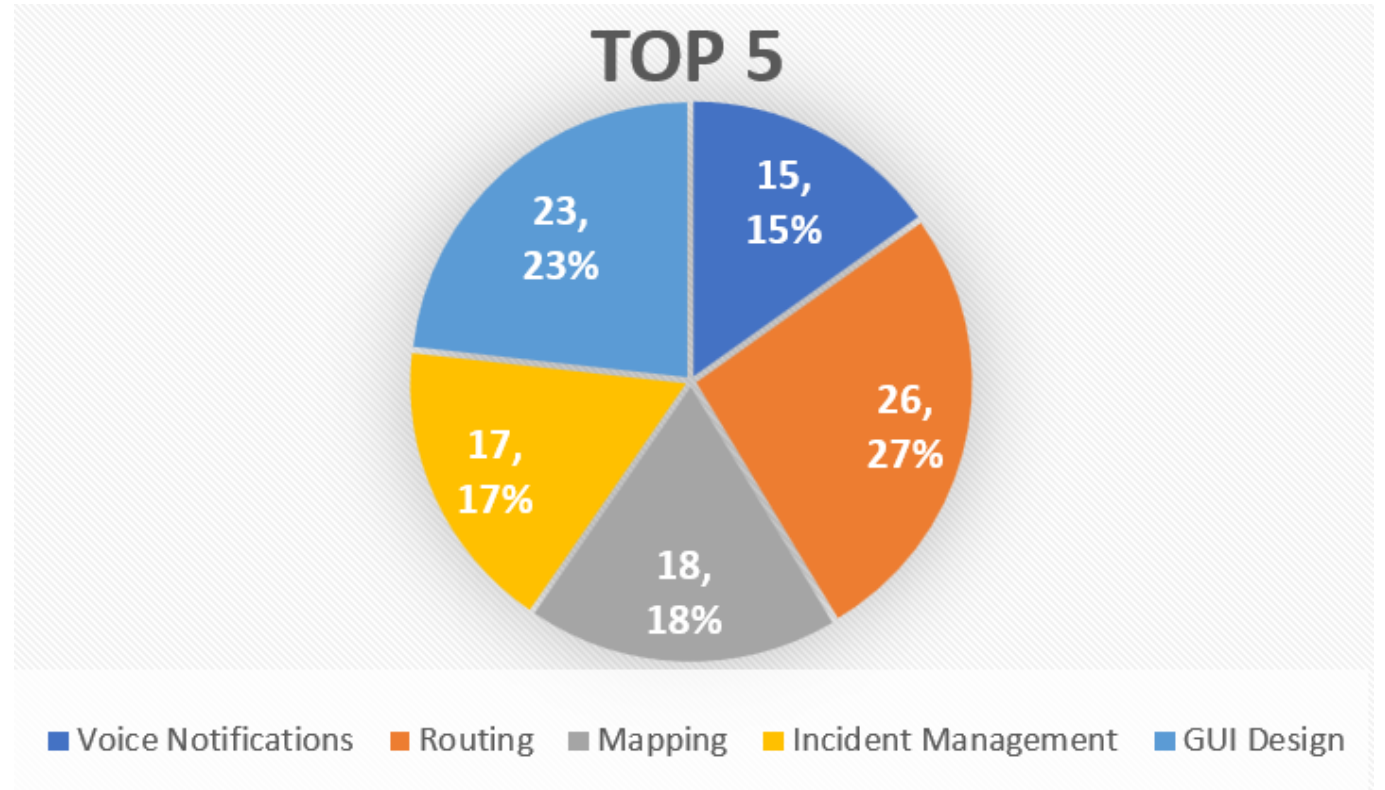
Base map



Summary – Top 5 areas

- ⊕ Valuable feedback from crews, DOMs and staff at WAST on NMA/MDVS
- ⊕ Positive feedback overall with suggestions and observations captured against 154 comments.
- ⊕ ARP Presence appreciated and staff keen to engage across Wales.

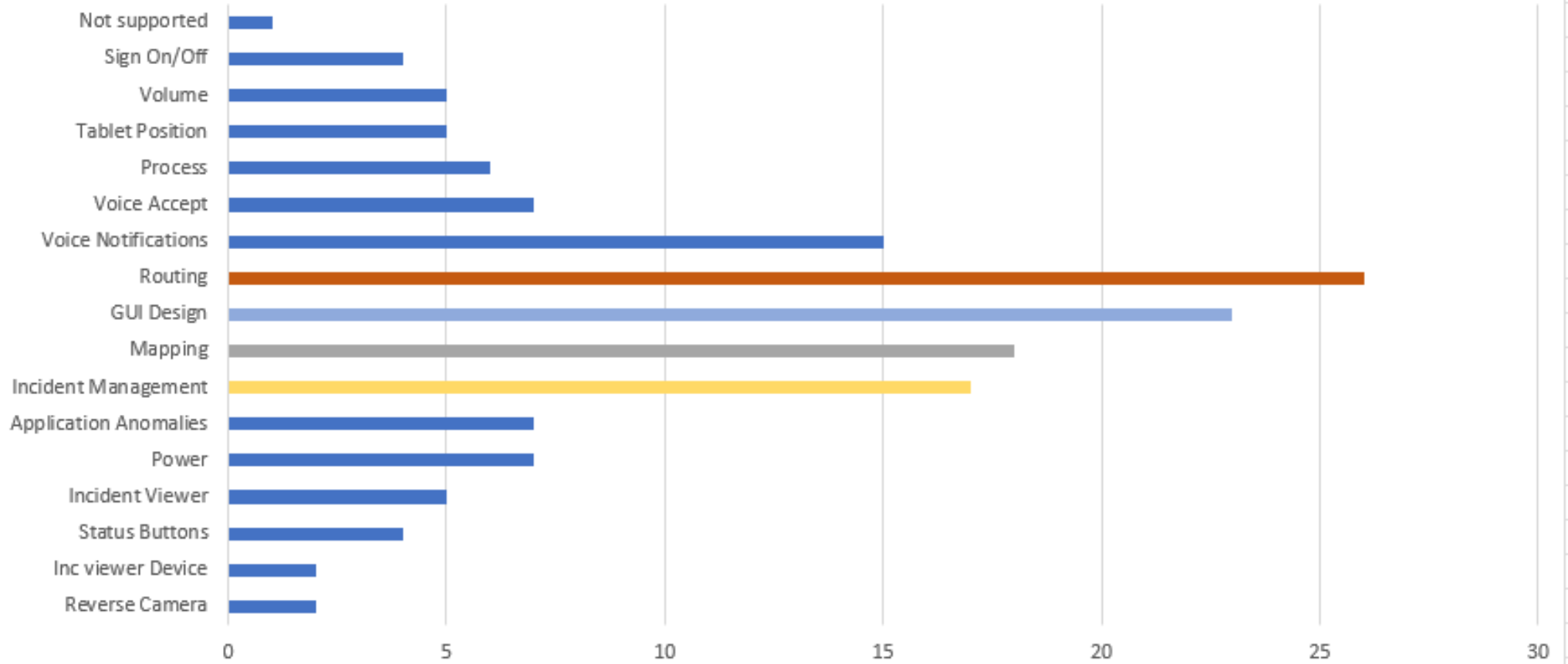
- ⊕ Main underlying trends:
 - Mapping and routing
 - Incident updates and notifications
 - Understanding of Voice Activation
 - Experience levels of crews and expectations of NMA





Category Breakdown

Category Total



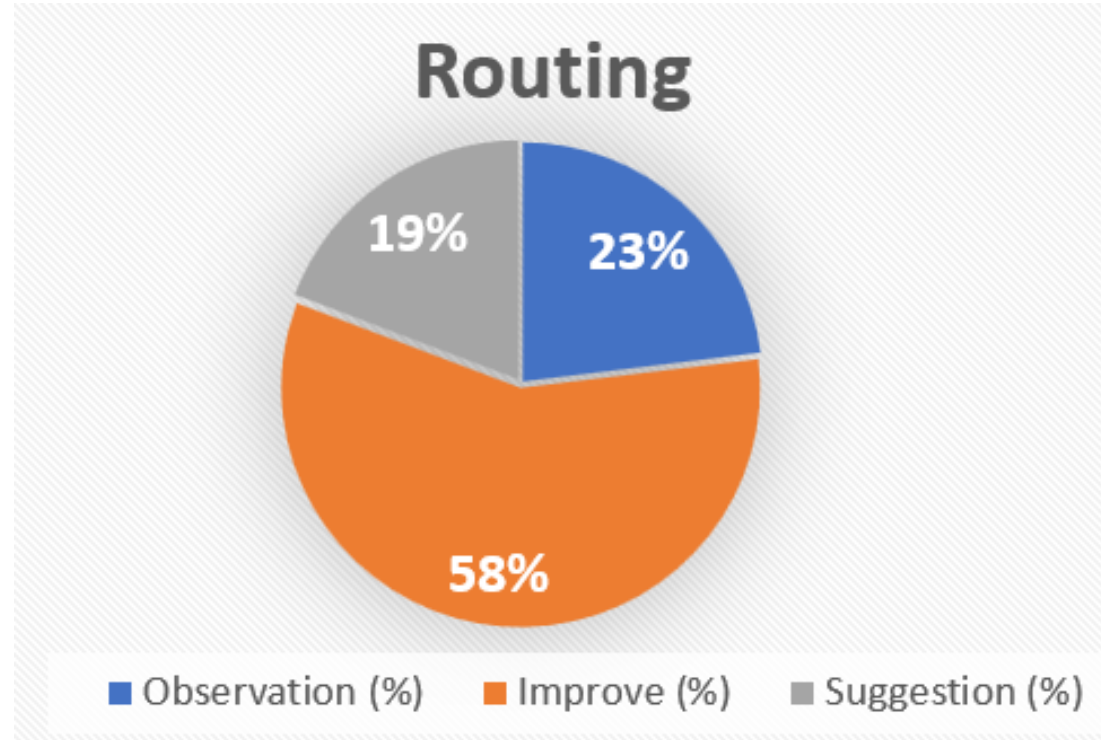


1. Routing (26)

- ⊕ Observation
 - Not always optimum route
 - Use of B roads over A roads

- ⊕ Suggestion
 - Change ETA for other routes
 - Include Live Traffic
 - Select other destinations

- ⊕ Improve
 - SatNav settings
 - Route options





2. GUI Design (23)

⊕ Observation

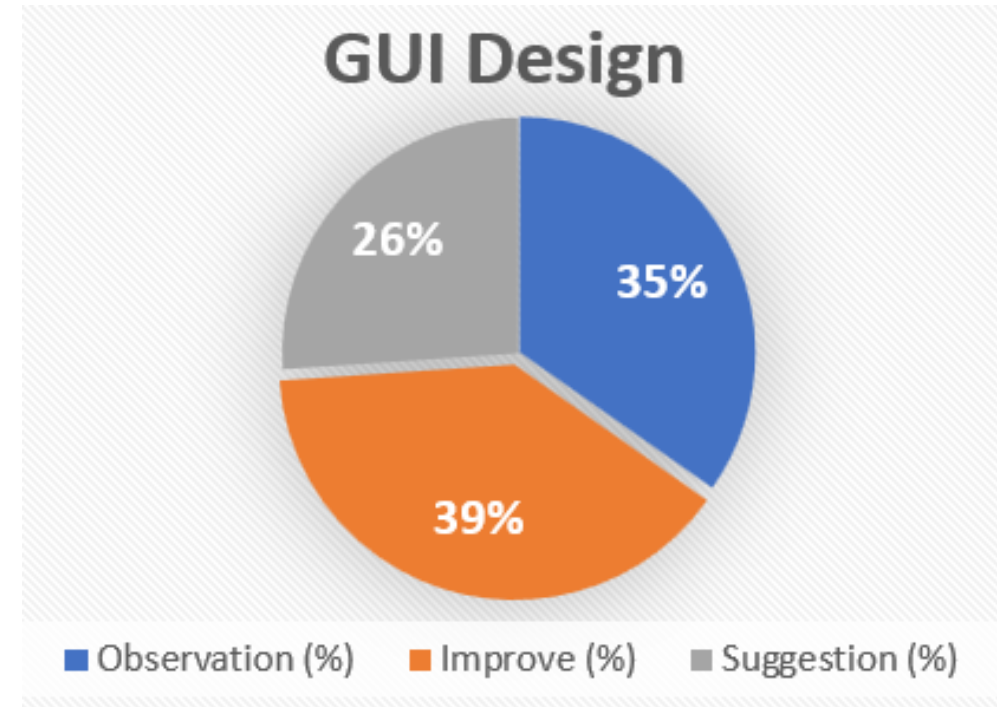
- Main Icons easy to use
- Drop downs too small
- Use of Night screen

⊕ Suggestion

- Include Inc number/address
- Filter to show A&E addresses

⊕ Improve

- Review shift time options
- Button size on drop downs
- Future runs for NEPTS



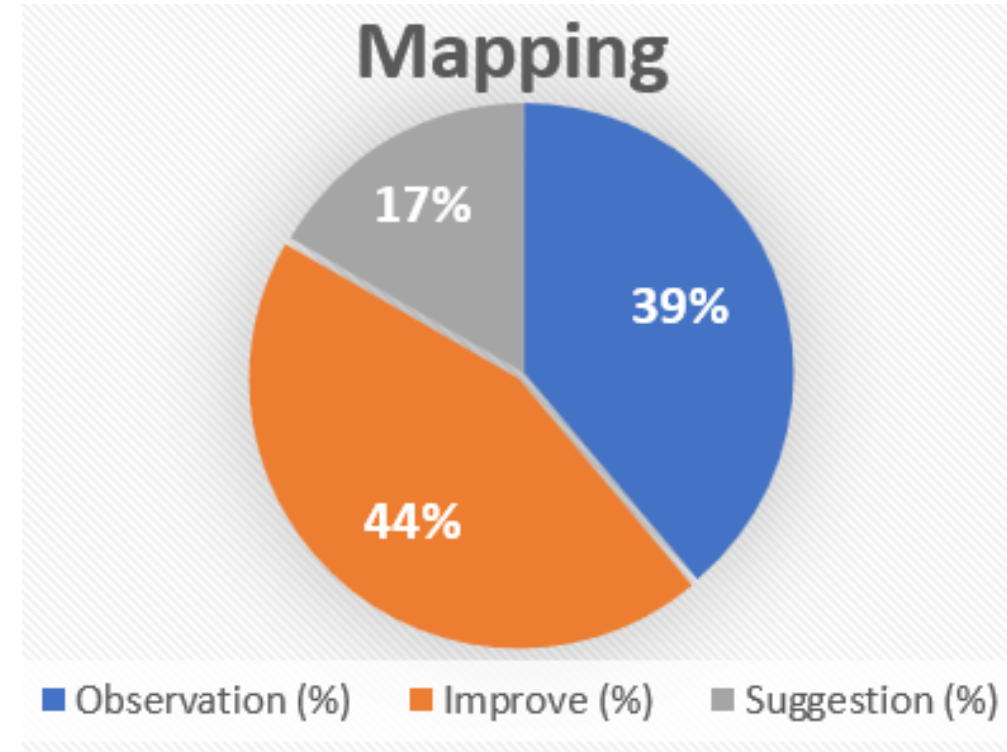


3. Mapping (18)

- ⊕ Observation
 - Magnification of Maps
 - Updates to Maps

- ⊕ Suggestion
 - Zoom Mapping feature
 - Live traffic updates

- ⊕ Improve
 - Mapping errors
 - Zoom function



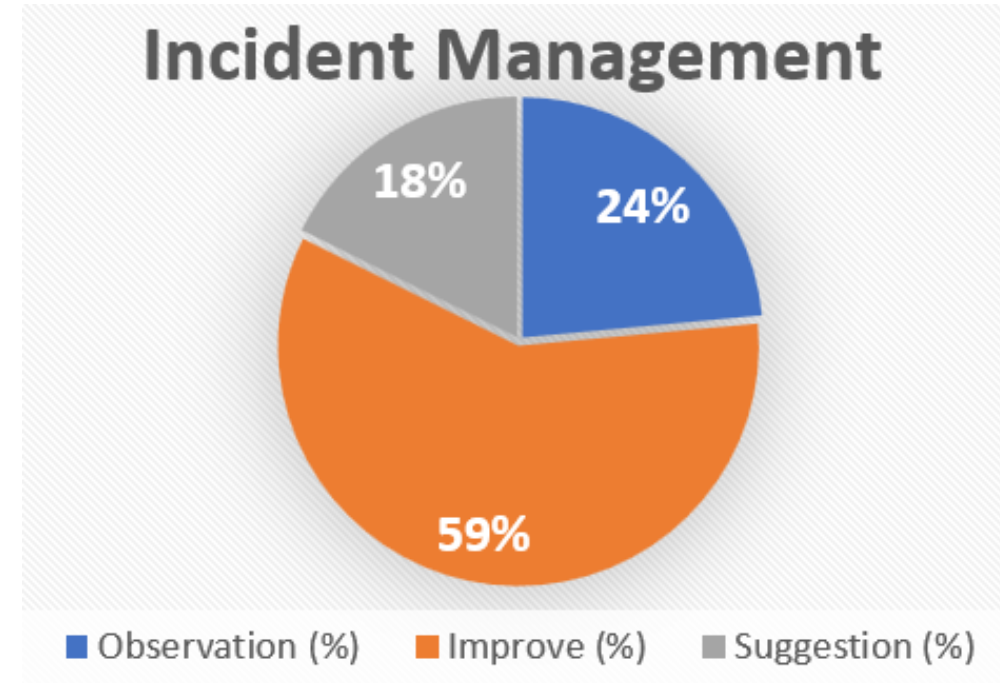


4. Incident Management (17)

- ⊕ Observation
 - Insufficient job information
 - Radio calls when MDT voicing

- ⊕ Suggestion
 - Provide feedback at end of jobs
 - Use of critical messages
 - Reading of job information

- ⊕ Improve
 - Set up of Critical messages
 - Option to repeat messages
 - Number of status options



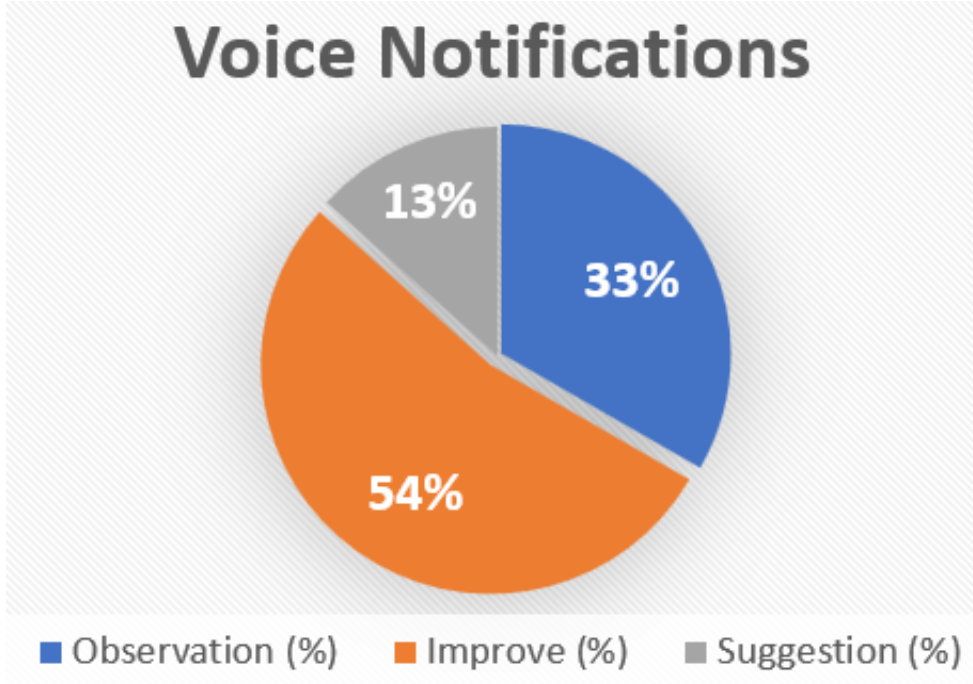


5. Voice Notifications (15)

- ⊕ Observation
 - Duplicate information, Radio/NMA
 - Not always voicing critical messages
 - Volume level not reset at logon

- ⊕ Suggestion
 - Voice accept during message

- ⊕ Improve
 - Voicing of critical messages
 - Length of message details





Next steps

- ⊕ Review high level feedback from initial data from WAST
- ⊕ Detailed review at project level with WAST team
- ⊕ Review and agree impact and priorities based on feedback
- ⊕ Agree Top 10 action plan and continued improvement activity
- ⊕ Outline product features that require development or future Roadmap review.
- ⊕ Highlight positive areas of NMA/MDVS delivery and improve key Operational areas



Themes - Training/Awareness

- ⊕ Voiced Messages will continue until complete before Voice Accept active
- ⊕ Teal banner available to accept
- ⊕ Review use of Scene safety information/messages
- ⊕ Use of Radio calls on mobilisation to allow for messages to be voiced

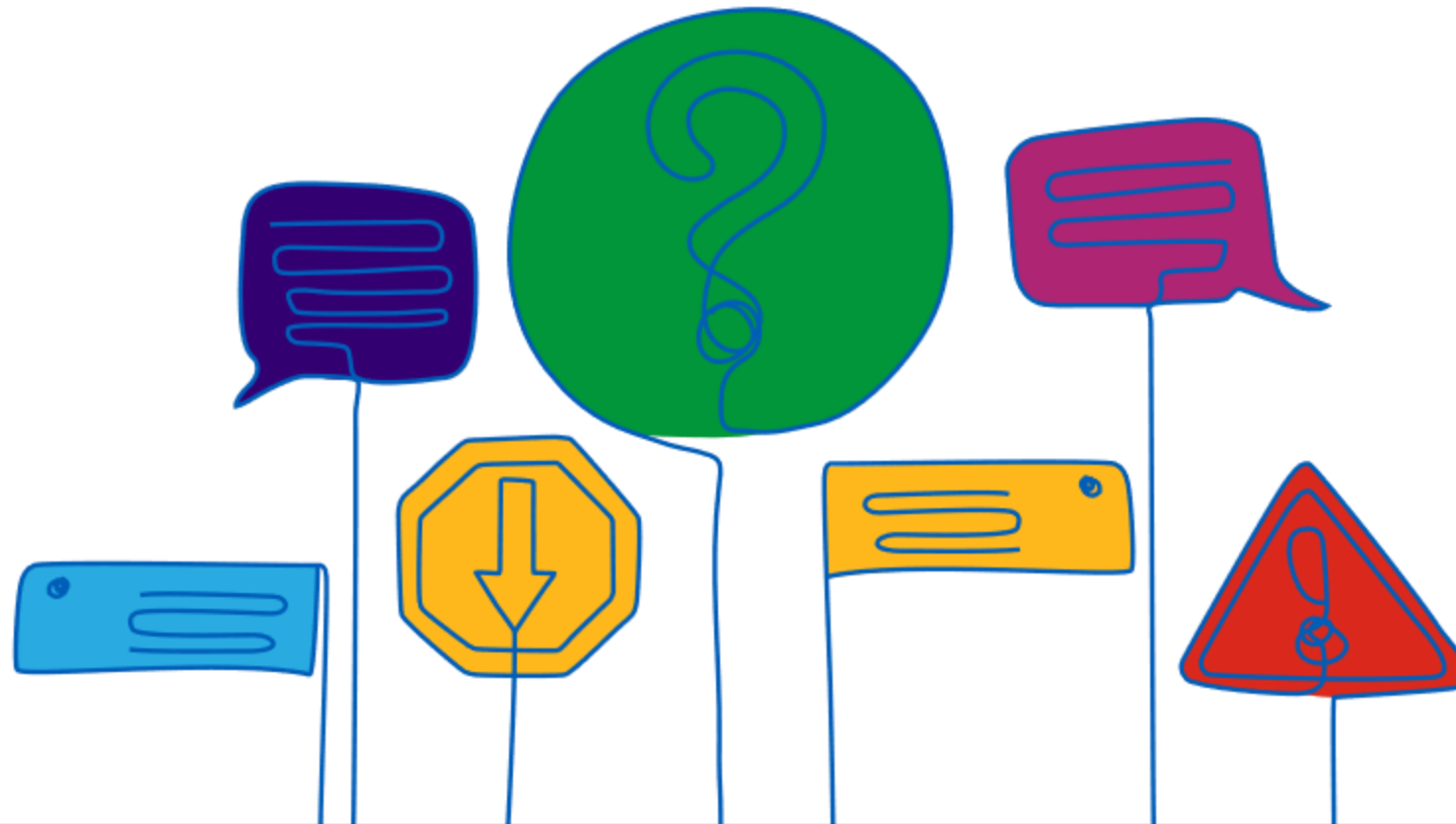


Improvements to discuss

- ⊕ Process for update of critical messages
- ⊕ Option for Live Traffic
- ⊕ Review SatNav settings and mapping
- ⊕ Route options for navigation to jobs
- ⊕ Shift time options for crews
- ⊕ Options for Zoom on navigation
- ⊕ Scene Safety/Temp road closures
- ⊕ Review Size of drop down buttons
- ⊕ Time of incident on screen



Any Questions?



POLICIES RECOMMENDED FOR COMMITTEE APPROVAL AND ADOPTION

Committee	Finance and Performance Committee	Date of Meeting	19/11/2024
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Presenting Officer	Julie Boalch, Assistant Director of Corporate Governance and Risk [Chair of Policy Group]
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Policy Name	Directorate	EqlA	Date of Policy Group	Date of ELT	Points of Note
Records Management Policy	Digital	Completed No Issues	23/10/2024	07/11/2024	Minor changes. Approved by Policy Group for a further 3 years.
NHS Wales Procedure for the Recovery of Overpayments – Salary & Expenses (September 2024)	Finance and Corporate Resources	Completed No Issues	23/10/2024	07/11/2024	For Adoption



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Records Management Policy

Policy Number:	008	Version No:	2.0	Supersedes:	1.1
Date of Approval:	23/10/2024	Review Date:	23/10/2027	Impact Assessments Completed:	Yes
Classification of Document:	Corporate	Type of Document:	Policy	Approved by:	Policy Group
Brief Summary of Document:	This document explains the records management arrangements adopted within WAST				
Scope:	This policy applies to WAST Non-Executive Directors and employees. For the purpose of this policy the term 'employees' encompasses individuals who are not direct employees of WAST and includes consultants, agency workers, specialist contractors, those who have an honorary contract with WAST, secondees who carry out work for WAST but are not directly employed by it, NHS Wales trainees on placement with WAST, jointly appointed staff and volunteers.				
To be read in conjunction with:	Freedom of Information Policy, Adverse Incident, Hazard Reporting Policy, Investigation & Learning Policy, Data Protection Policy, Access to Personal Information Policy				
Owning Committee	Finance & Performance Committee (FPC)				
Policy Lead:	Judith Birkett	Job Title:	Records Services & Archives Manager		
Trade Union Lead:	Damon Turner		Trade Union Partner		
Executive Director:	Jonathan Sammut	Job Title:	Director of Digital Services		

Version Control Sheet

Version	Date	Author	Summary of Changes
1.0	02/10/2017	Judith Birkett	New Document – Draft Version
1.1	02/01/2020	Eva Schubmehl	References to FOI Policy were removed due to being disbanded.
1.2	05/09/2024 08/10/2024	Judith Birkett Leanne Smith	Changes to responsible owners and job titles / reporting structures; addition of reference to other policies; updated references and links to external documents.
1.3	18/10/2024	Lisa Trounce	Final check and formatting prior to submission to Policy Group
1.4	29/10/2024	Kelly Holding	Final changes following Policy Group.
2.0	31/10/2024	Lisa Trounce	Final formatting prior to presentation to ELT and Committee for noting, and publication on the intranet.
Keywords	Records management, archiving, storage, information, data, information governance, data protection, data quality.		

Impact Assessment Reviews

Area	Date of Review	Name of Reviewer
Data Protection	11/09/2024	Kelly Holding
EqIA / Welsh Language	24/10/2024	Charlotte Jones / Kat Cobley / Melfyn Hughes
Environment	N/A	N/A
Quality	N/A	N/A



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Task and Finish Group Members

Name	Job Title
Judith Birkett	Records Services & Archives Manager
Kelly Holding	Information Governance Manager
Leanne Smith	Assistant Director of Digital Services
Charlotte Jones	Information Governance Officer
Damon Turner	Trade Union Partner

Policy Approval Route

Meeting Title	Meeting Date	Purpose/Outcome
Health Informatics Senior Management Team (HI SMT)	09/10/2024	Approval of draft changes
Policy Group	23/10/2024	To approve or recommend to ELT for approval by committee. Minor Changes – Approved by Policy Group for further 3 years.
ELT	07/11/2024	Noting
Finance & Performance Committee	19/11/2024	Noting

Disclaimer

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

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1. INTRODUCTION AND AIM

The Welsh Ambulance Services University NHS Trust (WAST/the Trust) recognises the importance of sound records management arrangements for both clinical and corporate records produced in support of the Trust's purpose to improve the health and well-being of our communities, by working with the NHS and allied agencies to deliver high quality services appropriate to the changing needs of the population.

The Trust's records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public who have dealings with WAST. They support consistency, continuity, efficiency and productivity and help deliver services in consistent and equitable ways.

Records management, through the proper control of the content, storage and volume of records, reduces vulnerability to legal challenge or financial loss and promotes best value in terms of human and space resources through greater coordination of information and storage systems.

The key components of records management are:

- Record creation;
- Record keeping;
- Record maintenance (including tracking of record movements);
- Access & disclosure;
- Closure and transfer;
- Appraisal;
- Archiving;
- Disposal.

The Trust is committed to the ongoing improvement of its records management functions as it believes that it will gain a number of organisational benefits that include:

- Compliance with legislations and regulatory standards;
- Better use of staff time;
- Accurate, up to date and accessible patient, staff and organisational records;
- Improved control of valuable information resources;
- Better use of physical and IT network/server space;
- Reduced costs.

The Trust will only retain records as long as there is a legal obligation to do so. Unless agreed for extended preservation, all records will be securely destroyed on expiry of minimum retention periods as listed in the retention schedules.

The aim of this policy is to promote a records management culture that ensures:

- Records are available when needed: from which the Trust is able to form a reconstruction of activities or events that have taken place;
- Records can be accessed: records and the information within them can be located and displayed in a way consistent with its initial use, and that the current version is identified where multiple versions exist;
- Records can be interpreted: the context of the record can be interpreted: who created or added to the record and when, during which business process, and how the record is related to other records;
- Records can be trusted: the record reliably represents the information that was actually used in, or created by, the business process, and its integrity and authenticity can be demonstrated;
- Records can be maintained through time: the qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the record is needed, perhaps permanently, despite changes of format;
- Records are secure: from unauthorised or inadvertent alteration or erasure, that access and disclosure are properly controlled and audit trails will track all use and changes. To ensure that records are held in a robust format which remains readable for as long as records are required;
- Records are retained and disposed of appropriately: using consistent and documented retention and disposal procedures, which include provision for appraisal and the permanent preservation of records with archival value;
- Staff are trained: so that all staff are made aware of their responsibilities for record keeping and record management.

2. SCOPE

This policy covers all records held by the Trust relating to information, created or received in the course of business, and captured in a readable form in any medium, electronic or otherwise, providing evidence of the functions, activities and transactions of the organisation. They include:

- Health records
- Personal data as defined by the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR);

- Corporate and administrative records (including personnel, estates, financial and accounting records, contract records, litigation and records associated with complaint-handling)
- Electronic mail
- Photographs, slides and other images
- Microfilm (i.e. fiche/film)
- Audio and video material

They do not include copies of documents created by other organisations which are kept for reference and information only.

All records created in the course of the business of the Trust are corporate records and are public records under the terms of the Public Records Acts 1958 and 1967. This includes email messages and other electronic records.

2.1 Objectives

- To provide a framework for the systematic management of all health and corporate records created and used by the Trust throughout their lifecycle.
- To provide assurance that records will be accessible but secure and produced to an acceptable quality.
- To encourage awareness of the importance of records management and the need for responsibility and accountability at all levels.
- To be in compliance with legal and statutory requirements.
- To achieve efficiency and best value through improvements in the quality and flow of information.
- Through effective information management to reduce the risks associated with the handling of sensitive records such as health and personal material and documents that are protectively marked.

3. RECORDS MANAGEMENT

3.1 Definitions

Record: Recorded information, in any form, created or received and maintained by the Trust in the transaction of its business or conduct of affairs and kept as evidence of such activity.

Health Record: A single record with a unique identifier containing information relating to the physical or mental health of a given patient who can be identified from that

information and which has been recorded by, or on behalf of, a health professional, in connection with the care of that patient.

Records Management: The field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and disposition of records, including processes for capturing and maintaining evidence of and information about business activities and transactions in the form of records [BS ISO 15489-1:2001(E)].

Information Lifecycle: The life of a record from its creation/receipt through the period of its 'active' use, then into a period of 'inactive' retention (such as closed files which may still be referred to occasionally) and finally either confidential disposal or archival preservation.

3.2 Legal & Professional Obligations

All NHS records are Public Records under the Public Records Acts. The Trust will implement all necessary measures to comply with its legal and professional obligations for public records as set out in the Records Management Code of Practice for Health and Social Care 2022, in particular:

- Public Records Act 1958
- Data Protection Act 2018
- UK General Data Protection Regulations
- Freedom of Information Act 2000
- Caldicott Review of Patient Identifiable Information (PII) 1997
- Confidentiality: NHS Code of Practice

And any new legislation affecting records management as it arises.

3.3 Records Creation

Records are created to ensure that the business of the Trust is carried out effectively and information is available to:

- Support the care process and the continuity of care.
- Support day to day business which underpins delivery of care.
- Support sound corporate and managerial decision making and provide evidence of decisions taken.
- Meet legal requirements, including requests from service users under access to health records legislation.

- Assist with clinical and other audits and learn lessons from past experience.
- Support improvements in clinical effectiveness through audit and research.

3.4 Quality of Records

All records must be fit for purpose, complete and accurate and the information they contain reliable with its authenticity guaranteed. Failure to ensure that data is of good quality and is up to date could have a detrimental effect on the Trust, its employees, its relationship with other Trusts and the community it serves. The Trust aims to ensure that:

- The right information is created at the right time.
- The information is reliable and accurate.
- The information has been created in an appropriate format.
- Information has been captured which describes its purpose, its content, who created it and when it was created (known as metadata).

Except where indicated below all records, such as Corporate Records will be created electronically and or stored electronically. The Trust will aim to manage electronic records to show proof of their validity and authenticity so that any evidence derived from them is clearly credible and authoritative.

Paper records will primarily be health and other manually completed forms and records which are required to be kept in hard copy for legal purposes such as signed contracts. It is recommended that where possible all manually completed paper records must be written clearly and legibly using black ink ballpoint pen. Records should be dated and signed with time of entry and any alterations should be visible and initialled. When forms are self-duplicating staff must ensure that all written entries are legible on all copies.

3.5 Management & Tracking of Records

Accurate recording and knowledge of the whereabouts of all records is essential if the information they contain is to be located quickly and efficiently.

3.6 Storage, Handling & Security

The storage of paper records will be kept to a minimum and applies primarily to health records which have not been scanned. Health records will be stored securely.

The location of paper records will be controlled to ensure that a record can be easily retrieved at any time. Storage accommodation for records must be clean and tidy in

order to prevent damage to the records. Equipment used for these records should provide storage that is safe from unauthorised access and that meets fire regulations but that allows maximum accessibility to the information commensurate with its frequency of use.

Staff must ensure that all records, in particular patient confidential data (PCD), are kept secure at all times when being handled and/or transported between Trust locations and externally. All portable devices containing electronic records must be encrypted and the transportation of patient confidential paper records, particularly externally, must be kept to a minimum and not stored externally except under controlled conditions.

Records will be kept secure from unauthorised or inadvertent alteration or erasure and will be held in a robust format which remains readable for as long as records are required.

In the majority of cases the record will be electronic and hard copies will only be kept on a temporary basis for local use. Electronic records will be stored in their respective databases or, in the case of unstructured data, on network drives with restricted access where required, especially with regard to PCD. Electronic documents must not be kept on local hard drives as there is a risk that they may be lost, they are not controlled, and this prevents access to others.

3.7 Disclosure & Retrieval

Records and the information within them will be accessible so they can be efficiently retrieved by those with a legitimate right of access, for as long as the records are held by the organisation.

Trust records will only be disclosed by WAST in compliance with the appropriate legislation and regulations. No such personal identifiable information must be disclosed through social media websites and when making contact with the media all staff must follow Trust Corporate Policies and Procedures.

Any secondary use of records will be anonymised wherever this is sufficient for purposes and disclosure of PCD to a third party will be limited to the minimum information required to satisfy the purposes of disclosure. Any bulk or regular transfer of PCD between the Trust and other Trusts and agencies will be controlled and monitored through an Information Sharing Agreement (ISA). The Trust has a template for an ISA and all ISAs are considered for approval by the Information Governance Team before

they are signed off by the Trust's Caldicott Guardian or Data Protection Officer. The Information Governance Team maintains a register of all approved ISAs.

3.8 Retention, Disposal & Destruction

The Trust will develop a consistent and documented approach to retention and disposal which will include retention and disposal schedules as set out in appendix II of the NHS Wales Records Management Code of Practice 2022.

<https://www.gov.wales/sites/default/files/publications/2022-03/records-management-code-of-practice-for-health-and-social-care-2022.pdf>

4. TRAINING AND IMPLEMENTATION

Records Management is part of Information Governance and training is available via the Learning & Development Team.

This policy will be disseminated by the following methods:

- Published on the Trust Website;
- Directors and Senior Managers – to cascade to managers and staff in their areas;
- Newsletter/Team briefings – SIREN;
- Awareness raising by the Record Services & Archives Manager.

WAST is committed to providing high quality evidence-based education to an engaged and skilled workforce operating within an organisational culture and framework that enables colleagues to work to the top of their skill set to deliver high quality care and services with competence and confidence. Staff are encouraged to discuss any concerns or queries regarding education and training with a member of the Education and Training Team, by telephoning the Learning & Development Hub on 0300 123 2319 or via email at amb_LDHub@wales.nhs.uk

Records Management training is also available on Siren under the Digital Directorate pages: [Records Management Awareness](#)

Further advice can be offered by the Records Services team by request to amb.records@wales.nhs.uk

5. IMPACT ASSESSMENTS

5.1. Equality Impact Assessment

In accordance with the Equality Act 2010, all policies will be subject to an EqIA. This enables resources to be targeted effectively and can help to reduce inequalities. The EqIA is a process to find out whether a policy will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights.

Evidence gathered at the initial stages, by undertaking an initial screening, determine the relevance of policies and how they affect people as service users, members of the public and as employees of the Trust and has indicated that a full EqIA is not required.

Equality Impact Assessment forms and procedures for completion as part of policy development are available on the Trust's intranet Policy page under [Supporting Documents](#). Further information on the development and value of EqIAs can be found on the Trust's Intranet site and via the following link:
www.eiapractice.wales.nhs.uk/home.

5.2. Welsh Language Impact Assessment

Under the The Welsh Language (Wales) Measure 2011 the Trust's Welsh Language Scheme will be replaced by standards. This means that the Trust, when formulating new policies or reviewing or revising existing policies, will be required to assess what effect a policy decision would have on opportunities for persons to use the Welsh language and on treating the Welsh language no less favourably than the English language. Further guidance can be obtained from the Welsh Language Officer.

In order to comply with the Welsh Language Standards and the Trust's Compliance Notice, the Trust is required to publish several policies in Welsh; particularly those that relate to:

- behaviour in the workplace;
- health and well-being at work;
- salaries or workplace benefits;
- performance management;
- absence from work;
- working conditions;
- work patterns

5.3. Environmental Standards and Impact Assessment

This policy will put the relevant requirements in place (such as waste management plan, reduction of CO2 emissions & reduction of carbon footprint) in order to ensure that the Welsh Ambulance Services NHS Trust ongoing commitment to reduce its impact on the environment is maintained and to become a more sustainable organisation in line with Trust policy and Environmental Governance System.

A Records Management Plan (2024) details activities to move the Trust away from paper records to digital records and reduce not only paper waste and fire hazards in the long-term, but also continuously reduce physical storage facility requirements.

5.4. Counter Fraud

Anti-Fraud and Corruption Concerns

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

5.5. Information Governance

Information Governance (IG) is an overarching term used to describe all aspects of information management. The Trust and its staff shall ensure that they provide satisfactory assurance to stakeholders as to how the organisation fulfils its statutory and organisational responsibilities in relation to the management of information. It will enable management and staff to make correct decisions, work effectively and comply with relevant legislation and the organisations aims and objectives.

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

This Policy should be read and applied in conjunction with the Data Protection Policy to ensure lawful and effective information governance.

6. ROLES AND RESPONSIBILITIES

6.1 The Trust Board

The Trust Board is collectively responsible for ensuring that the information risk management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives.

6.2 Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation. The Chief Executive is ultimately responsible for the confidentiality and security of patient, staff and corporate information. Implementation of, and compliance with the policy is delegated to the Caldicott Guardian for patient and staff information.

6.3 The Director of Digital Services

The Director of Digital Services is the executive lead of this Policy and has overall responsibility for the development and regular review of policies within their areas of responsibility. The Director of Digital is the Trust's Senior Information Risk Officer (SIRO) and has a responsibility to:

- Oversee the development of an Information Risk Policy and its implementation;
- Take ownership of the risk assessment process for information risk;
- Review and agree action in respect of identified information risks alongside Information Asset Owners (IAOs);
- Ensure that the Trust's approach to information risk is effective in terms of resource commitment and execution and that this is communicated to all staff;
- Provide a focal point for the resolution and/or discussion of information risk issues;
- Ensure the Board is adequately briefed on information risk issues;
- Successfully complete strategic information risk management training at least annually.

6.4 The Executive Director of Quality & Nursing

The Executive Director of Quality & Nursing is the Trusts Caldicott Guardian and has responsibility to:

- Promote clinical governance;
- Actively supporting work to enable information sharing where appropriate to share;
- Advising on options for lawful and ethical processing of information;

- Representing and championing confidentiality and information sharing requirements as well as issues at senior management level.

6.5 The Director of Corporate Governance / Board Secretary

Has a responsibility to:

- Ensure organisational procedures and processes are in place to comply with the Freedom of Information (FOI) Act 2000;
- Report the Trusts compliance with the Freedom of Information (FOI) Act and for reporting Freedom of Information issues to the Board (or equivalent);
- Work closely with the Board/Executive Team in the planning of Board and Committee meetings in which information governance arrangements are often discussed.

6.6 The Data Protection Officer

Has responsibility to:

- Provide information and guidance to the Executive Team and SIRO on the processing of all personal data and any risks associated;
- Oversee the work plan relating to the Information Asset Owners (IAO) and Information Asset Register;
- Ensure there is a process to co-ordinate and report on any issues in relation to this policy to the Information Governance Steering Group (IGSG).

6.7 The Information Governance Manager

Has responsibility to:

- Implement the Information Governance (IG) agenda whilst coordinating the IG work programme;
- Develop and maintain IG policies and procedures to provide staff with direction and guidance on how to comply with IG requirements;
- Raise awareness and promote IG throughout the Trust;
- Work closely with the Data Protection Officer, Records Services and Archives Manager, Senior Information Risk Owner (SIRO), Caldicott Guardian and Information Asset Owners (IOAs) to ensure information risk is managed effectively within the organisation.

6.8 The Records Services & Archives Manager

Has responsibility to:

- Establish a proactive and integrated approach to Records Management through creating, developing and maintaining robust and effective strategies, policies, systems and processes that ensure the function is embedded across the Trust;
- Provide specialist knowledge, advice and training around Records Management, including information rights, confidentiality and information security;
- Provide senior management support in the delivery of an effective Records Management Service across the whole Trust;
- Act as the Trust Lead with senior responsibility for raising awareness of Records Management and the associated training and awareness raising across the Trust. This will involve the development and deliverance of relevant training programmes.

6.9 Information Asset Owners (IAOs)

Have a responsibility to:

- Lead and foster an information security culture with values, protects and uses information for the success of the organisation and benefit of its patients;
- Know what information comprises or is associated with the asset, what enters and leaves it and why;
- Know and authorise who has access to the asset, whether system or information, why they need the access, and ensuring access is monitored;
- Understand and address risk to the asset, whether system or information, and why;
- Ensure the asset is used for the public good, including requests for access from others;
- Notify the IG Team of any changes to existing assets and ensuring that new information assets are added to the asset register and any redundant assets removed.

6.10 Line Managers

Have a responsibility to:

- Ensure all current, new and temporary staff are instructed of their IG responsibilities and made aware of this policy in addition to other IG related policies and procedures;
- Ensure staff received IG training that is appropriate for their role;
- Investigate and take relevant action on any potential breaches of this policy supported by IAOs and the IG Team in line with existing procedures.

6.11 All Staff

Have a responsibility to:

- Adhere to the Access Control Policy and all other IG related policies, procedures, including the Confidentiality Code of Conduct;
- Adhere to the relevant legislation in relation to information governance;
- Undertake IG training that is appropriate to their role;
- Raise any concerns in relation to IG with their line manager or the IG Manager.

7. AUDIT AND MONITORING

To achieve compliance with the NHS Wales Information Governance Toolkit & Health and Care Standards requirements, regular audits of record keeping standards and practice will be undertaken, coordinated by the Records Services & Archives Manager and Internal Audit where necessary.

An effective records management programme depends on the knowledge of what records are held, in what form they are accessible and their relationship to organisation functions. An information audit has been undertaken to establish a Trust wide information asset register so as to meet this requirement as well as to help promote control over records and provide valuable data for developing records appraisal and disposal procedures.

Regular programmes of audit of compliance with records management standards will be established. The results from these audits will be reported to FPC with evidence of action on the audit results to improve and maintain the organisations performance on records management.

The audit will:

- Identify areas of operation that are covered by the Trust's policies and identify which procedures and/or guidance should comply with the policy;
- Follow a mechanism for adapting the policy to cover missing areas if these are critical to the creation and use of records, and use a subsidiary development plan if these are major changes to be made;
- Set and maintain standards by implementing new procedures, including obtaining feedback where the procedures do not match the desired levels of performance;
- Highlight where non-conformance to the procedures is occurring and suggest a tightening of controls and adjustment to related procedures.

8. REFERENCES

The following documents were used to prepare this strategy:

- The Data Protection Act, 2018;
- The Freedom of Information Act, 2000;
- Human Rights Act, 1998;
- The Public Records Act, 1958;
- The Access to Health Records Act, 1990;
- The Access to Medical Records Act, 1998;
- Health and Care Standards; <http://www.wales.nhs.uk/governance-emanual/health-and-care-standards>
- Records Management – Code of Practice; <https://www.gov.wales/sites/default/files/publications/2022-03/records-management-code-of-practice-for-health-and-social-care-2022.pdf>
- NHS Confidentiality Code of Practice; <https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice>
- The National Archives website: Standards and best practice for records managers; <https://www.nationalarchives.gov.uk/information-management/>
- The UK General Data Protection Regulations.

GWEITHDREFN AR GYFER ADENNILL GORDALIADAU - Cyflogau a Threuliau

Statws y Weithdrefn: TERFYNOL - WEDI'I CHYMERADWYO
Dyddiad Cyhoeddi'r Weithdrefn: Medi 2024
Dyddiad Gweithredu: Hydref 2024
Dyddiad Adolygu: Hydref 2027

Gweithdrefn ar gyfer Adennill Gordaliadau

Mynegai

1. Cyflwyniad
2. Datganiad Gweithdrefn
3. Nodau
4. Cydraddoldeb
5. Amcanion
6. Cwmpas
7. Proses Adennill Gordaliadau
8. Datrys Anghydfod
9. Hyfforddiant ac Ymwybyddiaeth
10. Llywodraethu Gwybodaeth

Atodiad A - Rolau a Chyfrifoldebau

Atodiad B – Y rhesymau pam mae gordaliadau yn digwydd

Atodiad C – Llythyr Addasiad Cyflog

Atodiad D – Templed Incwm a Gwariant

Atodiad E - Map Proses Gordaliadau

Atodiad F – Llythyr Gordaliad 1

Atodiad G – Llythyr Gordaliad 2

Atodiad H – Llythyr Gordaliad i'w anfon at y Rheolwr Llinell

Atodiad I – Awdurdodi Didyniad Cyflog

Atodiad J – Ffurflen Asesu Atal Twyll

1. Cyflwyniad

Ysgrifennwyd y Weithdrefn hon i sicrhau dull unedig o ran sut y dylid ymdrin â gordaliadau ar draws GIG Cymru. Bydd y weithdrefn Cymru gyfan hon yn disodli unrhyw brosesau lleol presennol er mwyn sicrhau cysondeb rhwng Gwasanaethau'r Gyflogres Partneriaeth Cydwasanaethau GIG Cymru (PCGC) a Sefydliadau GIG Cymru pan fo gordaliad yn dod i'r amlwg.

Diffinnir gordaliad fel unrhyw arian a dalwyd ar gam i gyflogai presennol neu cyn-gyflogai drwy'r system gyflogres.

2. Datganiad Gweithdrefn

Bydd pawb sy'n ymwneud â gweithredu'r weithdrefn yn cael eu trin â pharch ac urddas drwy gydol y broses.

Cydnabyddir nad gweithwyr neu gyflogeion sydd i'w beio fel arfer am ordaliadau. Mae'r weithdrefn hon yn ceisio cefnogi'r rhai sydd wedi cael gordaliad trwy sicrhau bod y gordaliad yn cael ei adennill mewn modd teg a rhesymol.

Mae gordaliadau yn deillio'n bennaf o "gamgymeriad ffeithiol" (pan fo taliad yn anghyson â'r ffeithiau e.e. oherwydd gwall clercyddol, mewnbwn cyfrifiadurol neu wall gweithdrefnol). Mae gan Sefydliadau GIG Cymru hawl gyfreithiol i adennill unrhyw ordaliadau sydd wedi deillio o gamgymeriad ffeithiol.

Rhaid i Sefydliadau GIG Cymru geisio adennill pob gordaliad, waeth pwy sydd ar fai. Daw gordaliadau'r GIG allan o gronfeydd cyhoeddus ac felly mae rhwymedigaeth ar Sefydliadau GIG Cymru i'w hadennill, er bod yn rhaid gwneud hynny mewn ffordd deg a rhesymol.

Bydd anghenion unigol ac amgylchiadau ariannol yn cael eu hystyried.

3. Nodau

Nod y weithdrefn hon yw safoni'r broses o adennill gordaliadau er mwyn sicrhau cysondeb ar draws GIG Cymru.

Mae hefyd yn anelu at sicrhau bod pob gordaliad yn cael ei adennill yn effeithlon ac mor gyflym â phosibl heb achosi caledi. Yn ogystal â sicrhau bod cyflogeion, cyn-gyflogeion, gweithwyr a chynweithwyr yn cael eu trin yn deg ac yn gyson a heb achosi unrhyw straen neu bryder diangen iddynt.

4. Cydraddoldeb

Nod GIG Cymru yw darparu amgylchedd diogel heb wahaniaethu a man lle caiff pob unigolyn ei drin yn deg, ag urddas ac mewn modd sy'n briodol i'w anghenion. Cydnabyddir bod cydraddoldeb yn effeithio ar bob agwedd ar weithrediadau o ddydd i ddydd. Mae pob polisi a gweithdrefn yn destun Asesiad Integredig o'r Effaith ar Gydraddoldeb (EqIIA) ac Asesiad o'r Effaith ar yr Iaith Gymraeg.

Byddwn yn sicrhau ein bod yn cyflawni'r weithdrefn hon yn unol â gofynion Safonau'r Gymraeg, yn benodol:

- Sicrhau bod ein gwasanaethau sydd ar gael yn Gymraeg yn gyfartal â'r gwasanaethau Saesneg a ddarparwn drwy wneud y canlynol:
 - Darparu gohebiaeth Gymraeg i staff drwy gyfrwng y Gymraeg heb i staff orfod gofyn amdani.
 - Darparu unrhyw gyfathrebiad am y weithdrefn hon trwy gyfrwng y Gymraeg heb i staff orfod gofyn am gyfathrebiadau gennym trwy gyfrwng y Gymraeg.
 - Darparu gwasanaeth ffôn trwy gyfrwng y Gymraeg sy'n gyfartal â'r gwasanaeth Saesneg a ddarparwn.
 - Sicrhau bod yr holl ddogfennau a ffurflenni sy'n ymwneud â'r weithdrefn hon a chyflwyno'r weithdrefn ar gael yn Gymraeg heb oedi.
 - Sicrhau bod gwybodaeth am y weithdrefn hon ar gael ar ein tudalennau mewnwyd a thudalennau gwe a'u bod ar gael i Staff y GIG.
 - Bydd unrhyw bostiadau cyfryngau cymdeithasol sy'n ymwneud â'r weithdrefn hon ar gael yn Gymraeg ar yr un pryd ag y bydd postiadau cyfrwng Saesneg ar gael.

5. Amcanion

Amcanion y weithdrefn hon yw sicrhau'r canlynol:

- Proses deg ar gyfer adennill gordaliadau tra'n caniatáu ystyried amgylchiadau ariannol personol y rhai sydd wedi cael eu gordalu.
- Dylai adennill y gordaliad fod yn fforddiadwy ac yn gynaliadwy.
- Mae cyfrifoldebau'r rhai a all fod yn rhan o'r broses wedi'u hegluro yn Atodiad A.
- Eglurir y rhesymau posibl dros ordaliadau yn Atodiad B.
- Gostyngiad mewn achosion o ordaliadau trwy ddefnyddio gwybodaeth a geir yn y weithdrefn hon i addysgu a gwella.

6. Cwmpas

Bydd y weithdrefn hon yn berthnasol i gyflogeion, cyn-gyflogeion, gweithwyr a chyn-weithwyr Sefydliadau GIG Cymru. Mae'n cwmpasu systemau llaw ac electronig a ddefnyddir ar draws GIG Cymru.

Pan fo Sefydliadau'r GIG wedi cyflwyno cyfleuster Hunanwasanaeth i Reolwyr (MSS) yn y Cofnod Staff Electronig (ESR), dylai'r Rheolwr Llinell ddefnyddio MSS i ddiweddarau aseiniadau cyflogeion. Os na chaiff y cyfleuster MSS ei gyflwyno'n llawn, dylid rhoi gwybodaeth i Wasanaethau'r Gyflogres gan ddefnyddio'r ffurflenni/Hysbysiad Symud Staff (SMA) sydd ar gael o dan "Dogfennau Defnyddiol" ar dudalen mewnwyd y Sefydliad trwy'r ddolen isod.

Mae'r ddolen hefyd yn cynnwys manylion cyswllt gwasanaethau'r gyflogres: [Gwasanaethau'r Gyflogres \(sharepoint.com\)](#).

7. Proses Adennill Gordaliad

Adferiad Awtomatig

Efallai y bydd amgylchiadau pan ellid adennill gordaliadau yn awtomatig o daliadau cyflog yn y dyfodol.

Dim ond os yw'r canlynol yn berthnasol y bydd hyn yn digwydd:

- Roedd y gordaliad o ganlyniad i gyflwyno hysbysiad o newidiadau yn hwyr h.y. newid oriau, terfynu cyflogaeth, salwch, absenoldeb arall, neu bensiwn **a**
- Bod y newid neu derfynu cyflogaeth wedi cael ei weithredu llai na mis cyn i Wasanaethau'r Gyflogres gael hysbysiad **a**
- Ni fydd y didyniad yn gyfystyr â gostyngiad o fwy na 30% yn y cyflog misol gros.

Os bodlonir yr holl feini prawf hyn, bydd y cyflog a ordalwyd yn cael ei adennill yn awtomatig dros gyfnod o 3 mis ar y mwyaf. Bydd gordaliadau cyflog misol gros o 0-10% yn cael eu hadennill dros fis, 10-20% dros 2 fis ac 20-30% dros 3 mis.

Os bydd didyniad awtomatig yn digwydd, bydd Gwasanaethau'r Gyflogres yn hysbysu'r unigolyn cyn y diwrnod cyflog drwy anfon **Llythyr Addasiad Cyflog** (Atodiad C). Bydd y llythyr yn rhoi manylion am y symiau a fwriedir eu hadennill bob mis. Bwriad hyn yw darparu opsiwn adennill sy'n fforddiadwy a chynaliadwy. Mae offer i'ch helpu i weithio allan beth sy'n fforddiadwy i'w gweld yn Atodiad D.

Os nad yw'r amserlen arfaethedig ar gyfer adennill y gordaliad yn fforddiadwy, gellir cysylltu â Gwasanaethau Cyflogres PCGC drwy'r manylion cyswllt a ddarperir yn y llythyr. Os na ellir cytuno i adennill y gordaliad dros y cyfnod o 3 mis, bydd y gordaliad yn cael ei gyfeirio at Dîm Gordaliadau Cymru Gyfan i symud ymlaen â'r weithdrefn adennill safonol a amlinellir isod.

Os bydd yr unigolyn yn terfynu ei gyflogaeth cyn i'r gordaliad gael ei ad-dalu'n llawn, bydd gwasanaethau'r gyflogres yn cysylltu â'r unigolyn gyda'r bwriad o adennill y swm sy'n weddill o'r cyflog terfynol.

Proses Adennill Safonol

Pan fo gordaliad yn swm o arian mwy a/neu wedi digwydd dros gyfnod hwy o amser, ac felly nid yw'r meini prawf ar gyfer adennill yn awtomatig yn cael eu bodloni, bydd y broses adennill safonol yn cael ei dilyn fel a ganlyn.

Mae hyn hefyd wedi'i nodi mewn siart llif yn Atodiad E.

1. Bydd gwasanaethau'r gyflogres yn anfon **Llythyr Gordaliad 1** (Atodiad F) at yr unigolyn sydd wedi'i ordalu cyn gynted ag y daw'n ymwybodol o ordaliad posibl. Bydd y llythyr yn rhoi hysbysiad bod gordaliad posibl wedi digwydd, yn manylu ar y rheswm dros y gordaliad a amheuir a'r cyfnod y mae'n berthnasol iddo (os yw'n hysbys). Bydd yn cyfeirio at y llythyr dilynol (**Llythyr Gordaliad 2** – Atodiad G) a anfonir gyda chyfrifiad manwl o'r gordaliad unwaith y caiff ei gadarnhau.
2. Bydd gwasanaethau'r gyflogres yn anfon e-bost gyda llythyr ynghlwm at Reolwr Llinell yr unigolyn i roi gwybod iddo am y gordaliad posibl (Atodiad H). Gall hyn gynnwys dolen MS

Forms i roi manylion neu resymau dros pam a sut y gallai'r gordaliad fod wedi digwydd a dolen fideo yn esbonio sut i leihau gordaliadau yn y dyfodol.

3. Unwaith y bydd y gordaliad wedi'i gyfrifo, bydd Gwasanaethau'r Gyflogres yn anfon **Llythyr Gordaliad 2** at yr unigolyn a'i Reolwr Llinell yn manylu ar gyfrifo'r gordaliad (Atodiad G). Bydd Adran Gyllid y Sefydliad dan sylw yn cael copi o'r llythyr hwn.

(a) Os yw'r unigolyn yn parhau yn ei swydd o fewn y Sefydliad:

Bydd **Llythyr Gordaliad 2** yn dangos cyfrifiad y gordaliad a'r gwerth llawn. Bydd y llythyr yn egluro y bydd rhaid adennill y gordaliad yn llawn a sut y gellir gwneud hynny.

Ein nod yw adennill unrhyw ordaliadau dros yr un amserlen â'r gordaliad e.e. os cawsoch eich gordalu am 3 mis, dylid adennill y gordaliad dros 3 mis. Mae opsiwn hefyd i ad-dalu'r gordaliad fel cyfandaliad neu i drafod trefniant adennill misol mwy fforddiadwy.

Bydd angen i'r Cyfarwyddwr Cyllid a/neu Gyfarwyddwr y Gweithlu/Pobl ar gyfer y Sefydliad neu eu dirprwyon enwebedig gytuno i unrhyw geisiadau i adennill y gordaliad dros gyfnod o dros 12 mis. Bydd unrhyw geisiadau yn cael eu hadolygu gan ystyried sut a phryd y digwyddodd y gordaliad ac amgylchiadau ariannol yr unigolyn.

Gellir hefyd ystyried opsiynau eraill megis ymgymryd ag oriau ychwanegol i ad-dalu'r symiau sy'n ddyledus.

Dylid adennill gordaliadau drwy gyflog oni bai eich bod yn dewis ad-dalu'n llawn ar wahân neu'n cytuno i drefnu archeb sefydlog.

Bydd Llythyr Gordaliad 2 yn nodi y bydd anfoneb yn cael ei hanfon yn fuan, a bydd yr anfoneb yn cynnwys gwybodaeth am yr unigolyn y gallwch gysylltu ag ef i gytuno i adennill y gordaliad.

Bydd Adran Gyllid eich Sefydliad yn cael copi o'r llythyr hwn er mwyn gallu anfon anfoneb. Bydd yr adran gyllid yn cadarnhau eich bod yn gyflogai neu'n weithiwr ar hyn y bryd a bod modd adennill arian drwy ddiyniadau cyflog.

Mae copi o'r ffurflen gais i drefnu didyniad cyflog wedi'i chynnwys yn Atodiad I.

Mae offer i'ch helpu i weithio allan beth sy'n fforddiadwy i'w gweld yn Atodiad D.

(b) Os nad yw'r unigolyn yn gweithio i'r Sefydliad mwyach:

Bydd Llythyr Gordaliad 2 yn dangos cyfrifiad y gordaliad a'r gwerth llawn. Bydd y llythyr yn egluro y bydd rhaid adennill y gordaliad yn llawn a sut y gellir gwneud hynny.

Bydd y llythyr yn nodi y bydd anfoneb yn cael ei hanfon yn fuan, a bydd yr anfoneb yn cynnwys gwybodaeth ynglŷn â'r unigolyn y gallwch gysylltu ag ef i gytuno i adennill y gordaliad.

Bydd Adran Gyllid eich Sefydliad yn cael copi o'r llythyr hwn er mwyn gallu anfon anfoneb. Gan nad yw'r unigolyn bellach yn gyflogai neu'n weithiwr i'r Sefydliad, nid yw adennill drwy gyflog yn bosibl. Gellir gwneud taliadau drwy Archeb Sefydlog, Trosglwyddiad Banc, Siec neu Gerdyn Debyd/Credyd (pan fo gan y sefydliad y cyfleuster hwn).

Ein nod yw adennill unrhyw ordaliadau dros yr un amserlen â'r gordaliad e.e. os cawsoch eich gordalu am 3 mis, dylid adennill y gordaliad dros 3 mis. Mae opsiwn hefyd i ad-dalu'r gordaliad fel cyfandaliad neu i drafod trefniant adennill misol mwy fforddiadwy.

Efallai y bydd cyfnodau adennill hirach yn bosibl, ond bydd angen i'r Cyfarwyddwr Cyllid a/neu Gyfarwyddwr y Gweithlu/Pobl ar gyfer y Sefydliad hwnnw neu eu dirprwyon enwebedig eu cymeradwyo.

Mae offer i'ch helpu i weithio allan beth sy'n fforddiadwy i'w gweld yn Atodiad D.

Mae'r Adran Gyllid yn cadw'r hawl i drosglwyddo gweithdrefnau casglu dyledion ymlaen i asiantaeth casglu dyledion unwaith y bydd gweithdrefnau lleol y Sefydliad ac ymdrechion i gasglu'r ddyled sy'n weddill wedi'u dihysbyddu.

Atal Twyll

Efallai y bydd adegau pan fydd angen i'r Gwasanaeth Atal Twyll asesu gordaliad.

Gofynnir am asesiad lefel uchel cychwynnol gan y Gwasanaeth Atal Twyll, dim ond os bodlonir **pob un o'r tri** maen prawf isod sy'n nodi y gallai fod tystiolaeth i awgrymu y gallai twyll fod wedi digwydd:

1. Nid yw'r unigolyn wedi hysbysu'r Sefydliad/Rheolwr Llinell/Gwasanaethau'r Gyflogres am y gordaliad; **ac**
2. Mae'r gordaliad wedi digwydd dros gyfnod o fwy na 3 mis; **ac**
3. Amcangyfrifir bod gwerth y gordaliad yn fwy na £5,000

Os bodlonir y tri maen prawf uchod, bydd gwasanaethau'r gyflogres yn anfon hysbysiad at y tîm Atal Twyll Lleol perthnasol gan ddefnyddio'r ffurflen adolygu yn Atodiad J.

Bydd y tîm Atal Twyll lleol yn gwneud asesiad cychwynnol ac yn rhoi gwybod o fewn 5 diwrnod gwaith os oes angen ymchwiliad, neu os gall y broses o adennill y gordaliad barhau trwy'r drefn adennill arferol. Os na cheir ymateb gan y tîm Atal Twyll Lleol o fewn 5 diwrnod gwaith, bydd gwasanaethau'r gyflogres yn gofyn am gadarnhad terfynol i barhau i adennill y gordaliad yn unol â'r weithdrefn hon ac fel y dangosir yn Atodiad E.

Mae unrhyw ordaliadau o dan asesiad cychwynnol gan dimau Atal Twyll Lleol wedi'u cynnwys o dan adran Atal Twyll y dangosfwrdd gordaliadau. Mae gan uwch gydweithwyr Gweithlu/Pobl a Chyllid o fewn Sefydliadau fynediad at y dangosfwrdd hwn i fonitro asesiadau sy'n cael eu cynnal.

Os bydd y Gwasanaethau Atal Twyll yn nodi bod angen ymchwiliad pellach, bydd gwasanaethau'r gyflogres yn gohirio adennill y gordaliad hyd nes y ceir cyngor pellach gan y tîm Atal Twyll Lleol.

Cyn i ymchwiliadau pellach ddechrau, bydd y tîm Atal Twyll Lleol yn dilyn trefn leol y Sefydliad ar gyfer hysbysu Cyfarwyddwr y Gweithlu/Pobl a/neu'r Cyfarwyddwr Cyllid am fanylion yr achos. Gall hyn gynnwys cael unrhyw gytundeb i gynnal ymchwiliad pellach os oes angen yn lleol gan y sefydliad. Os bydd unrhyw anghytundeb lleol ar y camau gweithredu cywir, bydd y tîm Atal Twyll Lleol yn ceisio cyngor gan Wasanaeth Atal Twyll cenedlaethol GIG Cymru.

Er mwyn sicrhau nad yw unrhyw ymchwiliadau troseddol posibl yn cael eu peryglu, mae'n bwysig nad oes unrhyw gysylltiad yn cael ei wneud â'r unigolyn sydd wedi cael gordaliad nes bod y tîm Atal Twyll Lleol wedi cadarnhau nad oes angen ymchwilio i'r mater ymhellach.

8. Datrys Anghydfod

Pan fo unigolyn yn gwrthod cydsynio i adennill y gordaliad a phan fo trafodaethau wedi dod i ben, dylid cyfeirio'r gordaliad at y Cyfarwyddwr Gweithlu/Pobl a/neu'r Cyfarwyddwr Cyllid neu eu dirprwyon enwebedig yn y Sefydliad gyda'r nod o ddod i gytundeb ar gyfer adennill y gordaliad, gan ystyried amgylchiadau personol yr unigolyn.

Dylid trefnu cyfarfod rhwng yr unigolyn sydd wedi cael gordaliad a Chyfarwyddwr y Gweithlu/Pobl a/neu'r Cyfarwyddwr Cyllid neu eu dirprwyon. Mae gan yr unigolyn yr hawl i ddod â chynrychiolydd Undeb Llafur neu gydweithiwr yn y gweithle gydag ef i'r cyfarfod.

Gellir gofyn hefyd i aelodau o'r tîm Cyllid neu'r Gwasanaethau'r Gyflogres ynghyd â'r Rheolwr Llinell neu'r Deiliad Cyllideb ddod i'r cyfarfod hwn os byddai hynny'n ddefnyddiol. Mae'n bosibl y bydd angen i'r Cyfarwyddwr Cyllid neu ddeiliad cyllideb awdurdodedig arall gymeradwyo canlyniad arfaethedig y cyfarfod os nad ydynt yn bresennol yn y cyfarfod.

Os yw unigolyn yn teimlo ei fod wedi cael ei drin yn annheg, fe'i hanogir i ddefnyddio'r polisi Parch a Datrys. Ni ddylid cymryd unrhyw gamau pellach i adennill y gordaliad yn ystod unrhyw broses datrys anghydfod gan gynnwys cwynion o dan y broses Parch a Datrys.

Os ydych wedi terfynu eich cyflogaeth gyda GIG Cymru ac wedi methu dod i gytundeb, efallai y gallwch gael cymorth drwy:

[Acas | Making working life better for everyone in Britain](#) (Saesneg yn unig) neu [Gwaith - Hafan \(citizensadvice.org.uk/cymraeg/\)](https://www.citizensadvice.org.uk/cymraeg/)

Neu eich Undeb Llafur os ydych yn dal yn aelod (os ydych yn talu trwy eich cyflog, gallwch newid i dalu trwy Ddebyd Uniongyrchol i gynnal eich aelodaeth).

Mae'n bwysig cofio bod gan Sefydliadau'r GIG hawl gyfreithiol i adennill unrhyw ordaliad. Mae Sefydliadau'r GIG yn cadw'r hawl i ddefnyddio asiantaeth casglu dyledion pe bai angen.

9. Hyfforddiant ac Ymwybyddiaeth

Dylai Sefydliadau'r GIG sicrhau bod cyflogeion neu weithwyr a rheolwyr yn ymwybodol o'r weithdrefn hon ar ddechrau eu cyflogaeth. Dylai copi o'r weithdrefn fod ar gael ar safle mewnruyd y sefydliad GIG a dylid cyfeirio ato mewn unrhyw hyfforddiant ymsefydlu a/neu hyfforddiant i reolwyr newydd.

Gellir lleihau gordaliadau os bydd pawb yn gwneud eu rhan. Gall rheolwyr ofyn am arweiniad ynghylch sut i sicrhau bod gwybodaeth am gyflogaeth yn cael ei diweddarau'n brydlon ac yn gywir gan gynnwys gweithwyr newydd, newidiadau i gyflogaeth, terfyniadau cyflogaeth, ac absenoldebau cyflogai neu weithiwr pe bai angen.

Gall oedi cyn cyflwyno dogfennaeth gyflogres neu ddiweddariadau Hunanwasanaeth i Reolwyr achosi anghyfleustra a phryder sylweddol i staff, yn ogystal â gwaith gweinyddol ychwanegol diangen i Wasanaethau'r Gyflogres PCGC. Gall hefyd arwain at gymhlethdodau i'r rhai yr effeithir arnynt o ran materion treth a chredyd cynhwysol.

Amlinellir rolau a chyfrifoldebau pob parti y manylir arnynt yn y weithdrefn hon yn Atodiad A.

10. Llywodraethu Gwybodaeth

Bydd unrhyw ddata personol a ddefnyddir wrth gymhwyso'r weithdrefn hon yn cael eu prosesu yn unol â Rheoliad Cyffredinol ar Ddiogelu Data'r DU (UK GDPR) a fframweithiau a pholisïau strategol rheoli cofnodion perthnasol.

ATODIAD A

Gellir crynhoi cyfrifoldebau allweddol o ran y broses gordaliadau fel a ganlyn:

Bydd gwasanaethau'r gyflogres Partneriaeth Cydwasanaethau GIG Cymru (PCGC) yn:

-

- Talu staff yn gywir ac ar amser yn unol â data cyflogai/gweithiwr a gedwir ar y Cofnod Staff Electronig (ESR) ar adeg rhedeg y gyflogres.
- Sicrhau fod slip cyflog manwl ar gael i'r cyflogai/gweithiwr. Slip cyflog electronig fydd hwn pan fo MyESR (Hunanwasanaeth i Weithwyr) yn cael ei ddefnyddio.
- Hysbysu staff perthnasol ynghylch dyddiadau cau ar gyfer cyflwyno Gwaith Papur Electronig er enghraifft staff newydd, newidiadau, terfyniadau cyflogaeth, a data tâl amrywiol [Gwasanaethau'r Gyflogres \(sharepoint.com\)](https://sharepoint.com).
- Cywiro gwallau a nodwyd.
- Cynnal asesiad o ordaliadau yn erbyn y meini prawf i gadarnhau a oes angen adolygiad gan y Gwasanaeth Atal Twyll Lleol
- Cywiro unrhyw ordaliad a nodwyd yn unol â'r weithdrefn hon ar gyfer adennill gordaliadau cyflog. Bydd hyn yn cynnwys ysgrifennu at y cyflogai/cyn-gyflogai/gweithiwr/cyn-weithwr, gan roi esboniad manwl o'r gordaliad.
- Hysbysu'r Rheolwr Llinell bod gordaliad wedi digwydd a rhoi dolen MS Forms iddo gwblhau adroddiad gordaliad. Bydd yr adroddiad yn gofyn am fanylion ynghylch pam mae'r gordaliad wedi digwydd a pha gamau adferol a gymerwyd i atal hynny rhag digwydd eto.
- Cadw cofrestr o ordaliadau i'w rhannu'n fisol/bob deufis gyda chynrychiolwyr enwebedig o bob Sefydliad. Bydd PCGC yn rhoi gwybod i'r Sefydliad GIG am ordaliadau, y rhesymau drostynt ac os yw'r rheolwr yn methu â chydymffurfio â phrosesau a gweithdrefnau sy'n ymwneud â data cyflogaion/gweithwyr dro ar ôl tro.
- Adolygu'r gofrestr o ordaliadau gyda Sefydliadau'r GIG yng nghyfarfodydd rheolaidd Rheoli Cysylltiadau Cwsmeriaid y Gyflogres
- Cydgysylltu â chynrychiolwyr undebau llafur lleol lle bo'n briodol.
- Tynnu arian o gyflog y cyflogai/gweithiwr yn unol â'r cyfnod adennill y cytunwyd arno lle bo'n briodol.
- Wrth derfynu cyflogaeth, didynnu unrhyw ordaliadau sy'n weddill, gwyliau blynyddol gormodol, gan gynnwys trefniadau aberthu cyflog o'r cyflog terfynol lle bo modd.
- Delio â materion gordaliad gyda thosturi a dealltwriaeth, gan gofio nad yw'r cyflogai/gweithiwr ar fai yn y mwyafrif helaeth o achosion.

- Sicrhau fod cyn-gyflogeion/cyn-weithwyr yn gallu cyrchu eu slipiau cyflog, P60s a P45s trwy Ddangosfwrdd Ymadawyr am gyfnod cyfyngedig ar ôl terfynu cyflogaeth.
- Cysylltu â CThEF a/neu Bensiynau'r GIG os yw gordaliad yn debygol o effeithio ar dreth neu bensiwn.
- Gweithredu'r weithdrefn hon drwy gyfrwng y Gymraeg yn unol â Safonau'r Gymraeg.

Cyfrifoldeb y Cyflogai/Cyn-gyflogai/Gweithiwr/Cyn-weithiwr:-

Rhaid i gyflogeion/cyn-weithwyr/gweithwyr/cyn-weithwyr:

- Gwirio tâl sylfaenol, oriau contract a thaliadau rheolaidd eraill sydd wedi'u cynnwys yn eu slip cyflog i sicrhau eu bod yn unol â'u contract.
- Lle bo hynny'n berthnasol, ac yn bosibl, gwirio fod oriau amrywiol yn gywir ar systemau e-amserlennu cyn i restrau dyletswyddau gael eu cwblhau.
- Codi unrhyw ymholiadau ynghylch slipiau cyflog gyda'u Rheolwr Llinell yn y lle cyntaf. Gall hyn fod mewn perthynas â chyflog contract anghywir, oriau, taliadau rheolaidd, cael oriau amrywiol ar gam neu gael unrhyw arian annisgwyl.
- Gofyn am eglurhad gan Wasanaethau'r Gyflogres os na all eu Rheolwr Llinell ddatrys unrhyw ymholiadau ar eu slip cyflog.
- Rhoi gwybod i Wasanaethau'r Gyflogres ar unwaith os canfyddir gordaliad fel y gellir dechrau'r broses adennill. Gall unrhyw gyflogai, cyn-gyflogai, gweithiwr neu gyn-weithiwr sy'n methu'n fwrriadol neu o wirfodd â rhoi gwybod i Wasanaethau'r Gyflogres am ordaliad gael ei gyfeirio at y tîm Atal Twyll Lleol ac, os oes angen, yr Heddlu.
- Cytuno ar delerau adennill a sicrhau bod unrhyw ordaliadau yn cael eu hadennill yn llawn.
- Bod yn ymwybodol o ddyddiadau terfynol y gyflogres i wybod pryd i ddisgwyl yn rhesymol am daliadau teithio, hawliadau cynhaliaeth, sifftiau ar systemau e-amserlennu neu elfennau tâl amrywiol.
- Cyflwyno hawliadau treuliau a hawliadau oriau ychwanegol a weithiwyd i'w talu o fewn 3 mis. Sylwch na fydd unrhyw hawliadau sy'n hŷn na 3 mis yn cael eu prosesu i'w talu oni bai bod amgylchiadau'n atal cyflwyno'r hawliad mewn pryd.
- Sicrhau bod y sefydliad GIG yn ymwybodol o unrhyw newid cyfeiriad a manylion cyswllt trwy'u diweddarau ar MyESR (Hunanwasanaeth Gweithwyr).
- Cael cymorth a chynghor gan gynrychiolwyr Undebau Llafur lle bo'n berthnasol.

Rheolwyr Llinell:

Rhaid i Reolwyr Llinell roi gwybod i Wasanaethau'r Gyflogres am unrhyw newidiadau sy'n effeithio ar gyflogau cyn gynted ag y dânt yn ymwybodol ohonynt ac mae eu cyfrifoldebau'n cynnwys:

- Cwblhau'r hysbysiadau o newidiadau cyflogai a'u cyflwyno i Wasanaethau'r Gyflogres cyn i gyflogeion/gweithwyr ddechrau eu swydd/oriau/lleoliad newydd.
- Cwblhau'r broses terfynu cyflogaeth ar yr adeg y mae'r cyflogai/gweithwyr yn ymddiswyddo.
- Ar gyfer cyflogeion/gweithwyr sy'n rhan o gynllun Pensiwn y GIG - yn unol â Pholisi Ymddeol Sefydliadau'r GIG rhaid llenwi ffurflen terfynu o leiaf 4 mis cyn terfynu.
- I ddatrys unrhyw ymholiadau cychwynnol a dderbyniwyd gan gyflogeion/gweithwyr ynghylch oriau amrywiol a delir yn ystod y mis neu dderbyn taliadau annisgwyl, gan eu cynghori bod yn rhaid iddynt hysbysu Gwasanaethau'r Gyflogres am unrhyw ordaliadau a amheuir.
- I agor a chau absenoldeb salwch cyflogai/gweithiwr ar eu cofnod ESR ar y pwynt hysbysu.
- Rhoi gwybod i Wasanaethau'r Gyflogres am unrhyw absenoldeb di-dâl.
- Cyflwyno hysbysiad awdurdodedig o Absenoldeb Mamolaeth/Tadolaeth/Mabwysiadu/Seibiant Gyrfa. Rhaid llenwi ffurflenni cais am daliad o dan y polisiau hyn a'u cyflwyno i Wasanaethau'r Gyflogres cyn y dyddiad y mae'r cyflogai/gweithiwr yn dechrau'r cyfnod o absenoldeb.
- Gwirio manylion contract cyflogai/gweithiwr trwy'r cyfleuster Hunanwasanaeth i Reolwyr a chyllidebau misol a hysbysu Gwasanaethau'r Gyflogres ar unwaith pan fo manylion cytundebol cyflogai/gweithiwr yn anghywir.
- Sicrhau bod rotâu cyflogai/gweithiwr (lle bo'n berthnasol) yn gywir yn unol â systemau E-amserlennu. Dylid tynnu sylw Timau E-Systemau Sefydliadol at anghysondebau ar unwaith.
- Sicrhau bod llyfrau gwaith cyflogres (lle bo'n berthnasol) yn cael eu cwblhau'n gywir yn unol â phatrwm gwaith y gweithwyr/cyflogeion.
- Cefnogi unigolion sydd wedi cael gordaliad.

Bydd Adran y Gweithlu/Pobl yn:-

- Gweithredu fel cyswllt rhwng gwasanaethau'r gyflogres PCGC, y Rheolwr Llinell, y tîm Cyllid a'r cyflogai/gweithiwr lle bo angen.
- Sicrhau bod rheolwyr yn ymwybodol o'u gofynion i gyflwyno data cyflogres gan gynnwys hysbysiadau newid cyflogai/gweithiwr, hysbysiadau terfynu a data e-restru yn unol â therfynau amser cyhoeddedig ar gyfer cyflwyno'r gyflogres.

- Sicrhau bod rheolwyr yn ymwybodol o'r potensial ar gyfer gordaliadau a'u gofyniad i sicrhau bod achosion o'r fath yn cael eu cadw mor isel â phosibl.
- Sicrhau bod rheolwyr yn ymwybodol o'r Weithdrefn Adennill Gordaliadau trwy ei chynnwys ar raglenni ymsefydlu a hyfforddi Rheolwyr.
- Adolygu data gordaliadau yn rheolaidd i nodi themâu allweddol ac unrhyw feysydd lle mae gordaliadau'n digwydd yn rheolaidd gan ddod ag ef i sylw'r Rheolwyr priodol i'w uwchgyfeirio.
- Ar y cyd ag Uwch staff Cyllid, adolygu unrhyw geisiadau caledi mewn perthynas â chyfnodau adennill estynedig a chytuno arnynt ar y cyd.
- Sicrhau bod unigolion sy'n destun i'r broses gordalu yn cael eu trin yn deg ac yn dosturiol.

Bydd Timau Cyllid/Cyfrifon Derbyniadwy yn: -

- Gyfrifol am ddsbarthu anfonebau i unigolion i adennill gordaliadau.
- Cytuno ar delerau adennill yn unol â'r weithdrefn hon.
- Datblygu gweithdrefnau casglu dyledion pan na fydd modd adennill gordaliadau.

Bydd Timau Atal Twyll Lleol yn:-

- Cynnal asesiad cychwynnol o unrhyw ordaliadau a gyfeiriwyd atynt gan Wasanaethau Cyflogres PCGC sy'n bodloni'r tri maen prawf atgyfeirio
- Ymateb i unrhyw gyfeiriadau o fewn 5 diwrnod gwaith a chadarnhau i Wasanaethau'r Gyflogres p'un a all camau adennill arferol ddechrau neu a oes angen ymchwiliad pellach.

ATODIAD B

Rhesymau dros Ordaliadau

Mae'n bwysig bod yr holl wybodaeth sy'n ymwneud â phenodiadau, newidiadau a therfyniadau yn cael ei chwblhau'n brydlon ac yn gywir gan y Rheolwr Llinell. Rhaid cyflwyno Ffurflenni/Hysbysiadau Symud Staff (SMA) i Wasanaethau Cyflogres PCGC neu ddiweddarau'r manylion ar ESR trwy'r cyfleuster Hunanwasanaeth i Reolwyr (MSS) yn syth ar ôl iddynt gael eu cytuno.

Noder:

- Bydd cyflogeion neu weithwyr yn parhau i gael eu talu yn unol â'r manylion a gedwir ar ESR hyd nes y bydd gwasanaethau'r gyflogres yn cael eu cyfarwyddo i wneud fel arall (h.y. trwy ffurflen newid neu ffurflen terfynu cyflogaeth)
- Er mwyn i newidiadau gael eu hadlewyrchu yn y cyflog misol nesaf, rhaid rhoi gwybod am unrhyw newidiadau i Wasanaethau'r Gyflogres erbyn diwrnod olaf y mis cyfredol (h.y. mae'n rhaid hysbysu gwasanaethau'r gyflogres am newidiadau i'w hadlewyrchu yng nghyflog mis Ebrill erbyn 31 Mawrth).
- mae taliadau cyflog misol yn cwmpasu'r cyfnod hyd at ddiwedd y mis ac nid at y dyddiad talu yn unig.
- Os bydd cyflogai neu weithiwr yn hunan-ddatgan gordaliad cyflog, gyda'i gytundeb yn ysgrifenedig, bydd Gwasanaethau'r Gyflogres yn ceisio atal yr elfen berthnasol o'u cyflog a ordalwyd er mwyn atal unrhyw ordaliadau pellach rhag digwydd tra ymchwilir i'r mater ac y gofynnir am ddogfennaeth berthnasol.

Mae atal gordaliad rhag digwydd yn hollbwysig.

Rhaid i Sefydliadau GIG Cymru sicrhau bod rheolwyr yn cadw at bolisïau a gweithdrefnau sy'n lleihau'r posibilrwydd o ordaliadau.

Y rhesymau mwyaf cyffredin dros ordaliadau yw: -

- Hysbysiad Terfynu Hwyr – Rhaid gweithredu ffurflen terfynu, Hysbysiad Symud Staff neu ddiweddariad drwy'r cyfleuster Hunanwasanaeth i Reolwyr cyn gynted ag y bydd yn hysbys bod cyflogai neu weithiwr yn gadael ei swydd, h.y. ar ôl ymddiswyddiad, diwedd contract neu ar ôl iddo gael ei ddiswyddo.
Rhaid ystyried a yw'r cyflogai neu'r gweithiwr wedi cymryd y swm cywir o wyliau blynyddol. Os yw'r unigolyn wedi cymryd mwy o wyliau nag y mae wedi'i gronni, gall naill ai weithio oriau ychwanegol i ad-dalu'r amser, neu ad-dalu'r arian. Os oes gwyliau blynyddol yn ddyledus i'r unigolyn, efallai y gall gymryd y gwyliau oddi ar y cyfnod rhybudd neu gellir ei dalu yn lle hynny os oes angen.
Mae'n bwysig bod y ffurflen terfynu cyflogaeth yn cael ei chyflwyno i Wasanaethau Cyflogres PCGC cyn gynted â phosibl rhag ofn y bydd angen tynnu swm o'r taliad cyflog terfynol.
- Diweddarau oriau cytundebol cyflogai neu weithiwr yn hwyr neu'n anghywir - cyn gynted ag y cytunir ar yr oriau newydd, dylid trosglwyddo'r wybodaeth drwy'r cyfleuster

Hunanwasanaeth i Reolwyr neu ffurflen newid cyflogai. Dylai hyn fod cyn y dyddiad y mae'r cyflogai neu'r gweithiwr yn dechrau gweithio'r oriau newydd.

- Diweddaru absenoldeb cyflogai neu weithiwr (salwch, mamolaeth, absenoldeb di-dâl ac ati) yn hwyr neu'n anghywir – dylid rhoi gwybod am absenoldebau drwy'r cyfleuster Hunanwasanaeth i Reolwyr ar ESR neu gyflwyno ffurflenni i'r gyflogres cyn gynted â phosibl a'u monitro am hyd yr absenoleb. Rhaid i reolwyr sicrhau bod yr absenoldeb yn cael ei gau cyn gynted ag y bydd yr unigolyn yn adrodd ei fod yn ffit i weithio. Bydd Gwasanaethau'r Gyflogres (ar ran Sefydliadau'r GIG) yn talu 'tâl salwch cyfartalog' yn seiliedig ar gyfnodau absenoldeb salwch agored. Os na chaiff yr absenoldeb ei gau, gall hyn arwain at wallau.
- Adroddiadau hwyr neu anghywir am dâl ychwanegol, goramser, ar alwad, dyddiad dechrau, cyflog, bandio ac ati – dylai'r rheolwr neu'r goruchwyliwr gyflwyno gwybodaeth, newidiadau neu dâl amrywiol yn brydlon a chyda digon o amser iddynt gael eu prosesu gan Wasanaethau'r Gyflogres.
- Gwallau system - er nad yw'r gwallau hyn yn digwydd yn aml, unwaith y darganfyddir gwall yn y system, dylid cymryd camau cyn gynted â phosibl er mwyn lleihau taliadau anghywir. Gall y rhain gynnwys ESR, E-amserlenni ac E-Dreuliau.

Pan fo Sefydliadau'r GIG wedi cyflwyno cyfleuster Hunanwasanaeth i Reolwyr (MSS) yn y Cofnod Staff Electronig (ESR), dylai'r Rheolwr Llinell ddefnyddio MSS i ddiweddaru aseiniadau cyflogeion. Os na chaiff y cyfleuster MSS ei gyflwyno'n llawn, dylid rhoi gwybodaeth i Wasanaethau'r Gyflogres gan ddefnyddio'r ffurflenni/Hysbysiad Symud Staff (SMA) sydd ar gael o dan "Dogfennau Defnyddiol" ar dudalen mewnrwyd y Sefydliad trwy'r ddolen isod.

Mae'r ddolen hon hefyd yn rhoi manylion cyswllt Gwasanaethau'r Gyflogres: [Gwasanaethau'r Gyflogres \(sharepoint.com\)](https://sharepoint.com)

Bydd Gwasanaethau Cyflogres PCGC yn ymdrechu i gadw gwallau i'r isafswm posibl, ond gall gwallau dynol ddigwydd oherwydd cyfrifo anghywir neu gamddehongli gwybodaeth.



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ATODIAD C – LLYTHYR ADDASIAD CYFLOG

Tim Gordaliadau Cymru Gyfan PCGC
Gwasanaethau Cyflogres NWSSP
4ydd Llawr
Tŷ'r Cwmniau
Ffordd y Goron
Caerdydd
CF14 3UB

Preifat a Chyfrinachol

Enw
Cyfeiriad 1
Cyfeiriad 2
Cyfeiriad 3
Cod Post

Ein Cyf: VPD/Rhif Aseiniad/Cyfenw
Ffôn: 02921 500100

E-bost:

Dyddiad:

PARTHED: Gordaliad Cyflog

Annwyl

Rydym yn ysgrifennu atoch i roi gwybod i chi ein bod wedi darganfod gordaliad o'ch cyflog, pensiwn a/neu dreuliau.

Y swm a ordalwyd yw **£XXX** a ddigwyddodd oherwydd bod gwybodaeth wedi'i chyflwyno'n hwyr i Wasanaethau Cyflogres PCGC yn ymwneud â newid i'ch cyflog a ddylai fod wedi'i wneud o fewn y mis diwethaf.

Mae Gweithdrefn Cymru Gyfan ar gyfer Adennill Gordaliadau yn dosbarthu gordaliad fel 'Addasiad i Gyflog' ac yn caniatáu adennill awtomatig o ordaliadau tâl gros o hyd at 30% o gyflog, gyda 0-10% yn adferadwy mewn un mis, 10-20% dros ddau fis a 20-30% dros dri mis. Roedd eich gordaliad yn **X%** o'ch cyflog felly bydd yn cael ei adennill dros X mis.

Os hoffech ragor o fanylion am y gordaliad neu os ydych yn teimlo nad yw'r adennill awtomatig arfaethedig yn fforddiadwy, cysylltwch â ni ar 02921 500100 gan ddyfynnu'r rhif cyfeirnod uchod. Mae'r tîm yn hapus i helpu a chefnogi gweithwyr a rheolwyr.

Os hoffech ragor o wybodaeth am sut yr ymdrinnir ag adennill gordaliadau, darllenwch Weithdrefn Cymru Gyfan ar gyfer Adennill Gordaliadau sydd i'w gweld ar ddolen gwefan sharepoint Gwasanaethau Cyflogres Partneriaeth Cydwasaethau GIG Cymru [Gwasanaethau Cyflogres \(sharepoint.com\)](https://sharepoint.com).

Mae'r Weithdrefn hefyd yn cynnwys teclyn cyllidebu i'ch helpu i gyfrifo'r hyn y gallwch fforddio ei dalu yn Atodiad D. Os ydych yn cael eich hun mewn caledi ariannol, efallai y bydd help neu gyngor ar ddyledion ar gael gan ein Hundeb Llafur. Gallwch hefyd wirio a allech fod yn gymwys i gael unrhyw fudd-daliadau drwy Mynd i'r Afael ag Ansicrwydd Ariannol Gyda'n Gilydd|Trowch atom Ni. Cyngor ar ddyledion o ffynonellau ag enw da:- Mynnwch gyngor ar ddyledion am ddim GOV.UK (www.gov.uk).

Yn gywir,

Insert OP Team Leader Name

Tim Gordaliadau Cymru Gyfan
Gwasanaethau Cyflogaeth y Bartneriaeth Cydwasaethau

ATODIAD D – TEMPLED INCWM A GWARIANT



Appendix%20D%20 -
%20Income%20and

[Teclynnau a chyfrifianellau | Helpwr Arian](#)

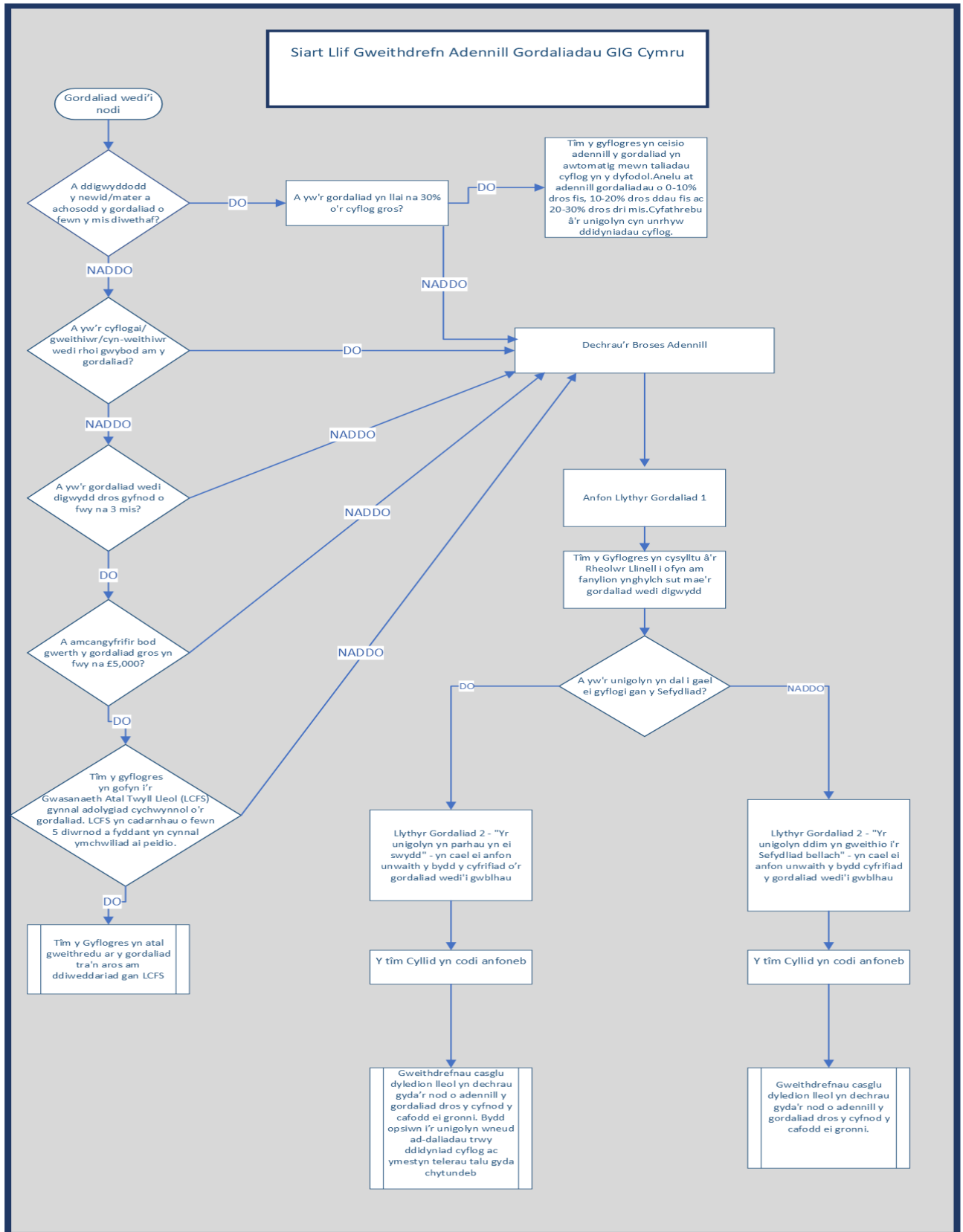
Os byddwch yn wynebu caledi ariannol, efallai y bydd cymorth neu gyngor ar ddyledion ar gael gan eich Undeb Llafur.

Gallwch hefyd wirio a allech fod yn gymwys am unrhyw fudd-daliadau yma:

[Tackling Financial Insecurity Together | Turn2us \(Saesneg yn unig\)](#)

Cyngor ar ddyledion o ffynonellau ag enw da:- [Cael cyngor ar ddyledion am ddim GOV.UK \(www.gov.uk\)](#).

ATODIAD E – DIAGRAM O'R BROSES GORDALIADAU





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ATODIAD F – LLYTHYR GORDALIAD 1

**Tîm Gordaliadau Cymru Gyfan PCGC
Gwasanaethau Cyflogres PCGC
4ydd Llawr
Tŷ'r Cwmniau
Ffordd y Goron
Caerdydd
CF14 3UB**

Preifat a Chyfrinachol

Enw
Cyfeiriad 1
Cyfeiriad 2
Cyfeiriad 3
Cod Post

Ein Cyf: VPD/Rhif Aseiniad/Cyfenw
Ffôn: 029 21 500055

E-bost: NWSSP.AllWalesoverpayments@wales.nhs.uk

Dyddiad:

PARTHED: Hysbysiad o Ordaliad Cyflog Posibl

Annwyl

Rydym yn ysgrifennu atoch i roi gwybod i chi ein bod wedi darganfod gwall posibl a allai fod wedi arwain at ordaliad o'ch cyflog/pensiwn a/neu dreuliau.

Roedd y gwall posibl o ganlyniad i *****Insert reason here*****.

Mae tîm y gyflogres yn ymchwilio i hyn ar hyn o bryd a byddant mewn cysylltiad yn fuan i gadarnhau'r gordaliad, i ddangos cyfrifiad manwl o'r swm a rhoi manylion ar sut y gellir adennill hwn.

Rydym hefyd wedi cysylltu â'ch rheolwr i'w hysbysu o'r gordaliad posibl fel y gall ddarparu unrhyw wybodaeth ychwanegol a allai helpu i egluro cyfrifiad y gordaliad.

Nid oes angen i chi wneud unrhyw beth ar hyn o bryd, ond os hoffech gysylltu â'r **tîm Gordaliadau, gallwch gysylltu â nhw ar 02921 500055 gan ddyfynnu'r cyfeirnod uchod [VPD/Rhif Aseiniad/Cyfenw]**. Mae'r tîm yn hapus i helpu a chefnogi gweithwyr a rheolwyr.

Byddwch yn ymwybodol, hyd nes bod y cyfrifiadau wedi'u cwblhau, ni fydd Gwasanaethau Cyflogres PCGC yn gallu rhoi unrhyw ffigurau gordaliad i chi. Felly, a fydddech cystal â chaniatáu amser i'r rhain gael eu cwblhau cyn cysylltu â ni. Gall gymryd hyd at 14 diwrnod o ddyddiad y llythyr hwn.

Os hoffech ragor o wybodaeth am sut yr ymdrinnir ag adennill gordaliadau, darllenwch Weithdrefn Cymru Gyfan ar gyfer Adennill Gordaliadau sydd i'w gweld ar ddolen gwefan SharePoint Gwasanaethau Cyflogres PCGC [Gwasanaethau Cyflogres \(sharepoint.com\)](https://sharepoint.com). Gallwch gael cymorth a chyngor gan gynrychiolwyr Undebau Llafur lle bo'n berthnasol.

Yn gywir,

Rhowch Enw Arweinydd Tîm OP
Tîm Gordaliadau Cymru Gyfan



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Gwasanaethau Cyflogaeth PCGC



Gwasanaethau Cyflogres PCGC
4ydd Llawr
Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB

ATODIAD G - LLYTHYR GORDALIAD 2

Unigolyn yn parhau yn ei swydd

Preifat a Chyfrinachol

Ein Cyf: VPD/Aseiniad/Cyfenw
Adran: Gwasanaethau Cyflogres PCGC ar gyfer Gordaliadau Cymru Gyfan
Ffôn: 029 21 500055
E-bost: NWSSP.AllWalesoverpayments@wales.nhs.uk

Dyddiad:

PARTHED: Gordaliad Cyflog

Annwyl

Yn dilyn ein llythyr blaenorol dyddiedig ** [nodwch y dyddiad] ** gallwn nawr roi mwy o fanylion am eich gordaliad. Derbyniwch ein hymddiheuriadau diffuant am y gordaliad hwn ac unrhyw ofid neu anghyfleustra y gallai ei achosi i chi.

Mae'r gordaliad wedi'i gyfrifo fel a ganlyn: -

Cyfnod y Gordaliad:

Rheswm dros y Gordaliad:

Gordaliad Gros:	£
Llai	
Pensiwn:	£
Talu wrth Ennill:	£
Cyfraniadau Yswiriant Gwladol:	£
Benthyciad Myfyriwr:	£
Gordaliad Net sy'n Ddyledus:	£

Bydd anfoneb yn cael ei hanfon atoch yn uniongyrchol gan Adran Gyllid eich sefydliad blaenorol er mwyn dechrau adennill y gordaliad hwn.

Os bydd gennych unrhyw ymholiadau ynglŷn â sut i dalu, bydd manylion cyswllt yr Adran Gyllid yn cael eu dangos ar yr anfoneb. Gan nad ydych bellach yn gyflogedig gan eich Sefydliad blaenorol, yr opsiynau i ad-dalu fydd naill ai trwy drosglwyddiad banc, archeb sefydlog, siec neu gerdyn debyd/credyd os yw'r cyfleuster ar gael o fewn y Sefydliad.

Gallwch drefnu opsiwn adennill misol fforddiadwy neu ddewis ad-dalu'r swm yn llawn mewn un taliad. Yn ddelfrydol, dylid adennill y gordaliad dros yr un cyfnod ag y digwyddodd y gordaliad. Os hoffech drafod amserlen adennill wahanol, cysylltwch â'r Adran Gyllid.

Os oes gennych unrhyw ymholiadau ynglŷn â chyfrifo'r gordaliad, mae croeso i chi gysylltu â Tîm Gordaliadau Cymru Gyfan PCGC drwy e-bostio NWSSP.AllWalesOverpayments@wales.nhs.uk, neu gysylltu â nhw ar **02921 500055 gan ddyfynnu'r rhif cyfeirnod uchod [VPD/rhif aseiniad/Cyfenw]**. Mae'r tîm yn hapus i helpu a chefnogi gweithwyr a rheolwyr.

Rydym yn deall bod gordaliadau yn anffodus ac y gallent achosi pryder, felly ein nod yw ateb pob ymholiad yn gyflym i leihau unrhyw ofid neu ansicrwydd.



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Ffordd y Goron
Caerdydd
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Bydd gordaliadau yn cael eu hadennill yn unol â Gweithdrefn Cymru Gyfan ar gyfer Adennill Gordaliadau, y gellir darparu copi ohoni os gofynnir amdano.

Mae'r Weithdrefn hefyd yn cynnwys offeryn cyllidebu i'ch helpu i weithio allan yr hyn y gallwch fforddio ei dalu yn Atodiad H. Gallwch hefyd gael cymorth a chyngor gan gynrychiolwyr Undebau Llafur lle bo'n berthnasol.

Yn gywir

Rhowch Enw Arweinydd Tîm OP
Tîm Gordaliadau Cymru Gyfan
Gwasanaethau Cyflogaeth PCGC



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Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB

Unigolyn nad yw'n gweithio i'r Sefydliad mwyach

Preifat a Chyfrinachol

Ein Cyf: VPD/Aseiniad/Cyfenw
Adran: Gwasanaethau Cyflogres PCGC ar gyfer Gordaliadau Cymru Gyfan
Ffôn: 029 21 500055
E-bost: NWSSP.AllWalesoverpayments@wales.nhs.uk

Dyddiad:

PARTHED: Gordaliad Cyflog

Annwyl

Yn dilyn ein llythyr blaenorol dyddiedig ** [nodwch y dyddiad] ** gallwn nawr roi mwy o fanylion am eich gordaliad.

Derbyniwch ein hymddiheuriadau diffuant am y gordaliad hwn ac unrhyw ofid neu anghyfleustra y gallai ei achosi i chi.

Mae'r gordaliad wedi'i gyfrifo fel a ganlyn: -

Cyfnod y Gordaliad:

Rheswm dros y Gordaliad:

Gordaliad Gros: £

Llai

Pensiwn: £

Talu wrth Ennill: £

Cyfraniadau Yswiriant Gwladol: £

Benthyciad Myfyriwr: £

Gordaliad Net sy'n Ddyledus: £

Bydd anfoneb yn cael ei hanfon atoch yn uniongyrchol gan Adran Gyllid eich sefydliad er mwyn dechrau adennill y gordaliad hwn. Os bydd gennych unrhyw ymholiadau ynglŷn â sut i dalu, bydd manylion cyswllt yr Adran Gyllid yn cael eu dangos ar yr anfoneb. Gan eich bod yn dal yn gyflogedig gan eich Sefydliad, mae'n bosibl adennill y gordaliad trwy ddiwydiadau cyflog misol.

Gallwch drefnu opsiwn adennill misol fforddiadwy neu ddewis ad-dalu'r swm yn llawn mewn un taliad. Yn ddelfrydol, dylid adennill y gordaliad dros yr un cyfnod ag y digwyddodd y gordaliad. Os hoffech drafod amserlen adennill wahanol, cysylltwch â'r Adran Gyllid.

Os oes gennych unrhyw ymholiadau ynglŷn â chyfrifo'r gordaliad, mae croeso i chi gysylltu â Thîm Gordaliadau Cymru Gyfan PCGC drwy e-bostio NWSSP.AllWalesOverpayments@wales.nhs.uk, neu gysylltu â nhw ar **02921 500055 gan ddyfynnu'r rhif cyfeirnod uchod [VPD/rhif aseiniad/Cyfenw]**. Mae'r tîm yn hapus i helpu a chefnogi gweithwyr a rheolwyr.

Rydym yn deall bod gordaliadau yn anffodus ac y gallent achosi pryder, felly ein nod yw ateb pob ymholiad yn gyflym i leihau unrhyw ofid neu ansicrwydd.

Bydd gordaliadau'n cael eu hadennill yn unol â Gweithdrefn Cymru Gyfan ar gyfer Adennill Gordaliadau sydd i'w gweld ar wefan SharePoint Gwasanaethau Cyflogres PCGC: [Gwasanaethau Cyflogres \(sharepoint.com\)](https://sharepoint.com). Mae'r Weithdrefn hefyd yn cynnwys offeryn cyllidebu i'ch helpu i gyfrifo'r hyn y gallwch fforddio ei dalu yn Atodiad D. Os ydych yn canfod eich hun mewn caledi ariannol, efallai y bydd help neu gyngor ar ddyledion ar gael gan ein Hundeb Llafur. Gallwch hefyd wirio a allech fod yn gymwys i gael unrhyw fudd-daliadau drwy Tackling Financial Insecurity Together|Turn to Us. Cyngor ar ddyledion o ffynonellau ag enw da:- Cael cyngor ar ddyledion am ddim GOV.UK (www.gov.uk).

Yn gywir

Rhowch Enw Arweinydd Tîm OP



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Mae Gwasanaethau Cyflogaeth yn is-adran o fewn Partneriaeth Cydwasaethau GIG Cymru
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**Gwasanaethau Cyflogres PCGC
4ydd Llawr
Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB**

Tîm Gordaliadau Cymru Gyfan
Gwasanaethau Cyflogaeth PCGC



**Gwasanaethau Cyflogres PCGC ar gyfer Gordaliadau Cymru Gyfan
4^{ydd} Llawr**

**Tŷ'r Cwmnïau
Ffordd y Goron
Caerdydd
CF14 3UB**

ATODIAD H – LLYTHYR Y RHEOLWR LLINELL

Preifat a Chyfrinachol

Ein Cyf: VPD/Aseiniad/Cyfenw
Adran: Gwasanaethau Cyflogres PCGC ar gyfer Gordaliadau Cymru Gyfan
Ffôn: 029 21 500055
E-bost: NWSSP.AllWalesOverpayments@wales.nhs.uk

Dyddiad:

PARTHED: Gordaliad Cyflog

Annwyl Reolwr

Rydym yn ysgrifennu atoch i roi gwybod bod gordaliad cyflog posibl wedi digwydd ar gyfer aelod o staff yr ydych yn rheolwr llinell arno.

Nodir manylion y gordaliad cyflog posibl isod:

Enw:

Rhif Aseiniad:

Cyfnod y Gordaliad:

Rheswm dros y Gordaliad:

Y Camau Nesaf...

Unwaith y bydd y gordaliad wedi'i wirio a'i brosesu yn ESR, byddwch chi a'r gweithiwr yn derbyn llythyr pellach a fydd yn cadarnhau'r gordaliad ac yn dangos cyfrifiad manwl o'r swm. Gall gymryd hyd at 14 diwrnod o ddyddiad y llythyr hwn.

Yna bydd y gweithiwr yn cael anfoneb gan Dîm Cyllid eich Sefydliad gyda chyfarwyddiadau ar sut y gellir adennill y gordaliad.

Fel rheolwr yr unigolyn sydd wedi cael gordaliad, a fyddech cystal â thrafod y gordaliad gydag ef a sicrhau ei fod yn deall bod angen ad-dalu'r arian a ordalwyd a bod yn rhaid adennill pob gordaliad ni waeth pwy sydd ar fai.

Bydd angen gwneud y gweithiwr yn ymwybodol fod gan y Sefydliad yr hawl i gyflogi asiantaeth casglu dyledion neu gymryd camau cyfreithiol er mwyn adennill y ddyled os na fydd yn ad-dalu'r gordaliad.

Byddwch yn gefnogol i'ch gweithiwr os gwelwch yn dda a thynnwch ei sylw at yr offer yn Atodiad D y Weithdrefn a grybwyllir isod os oes angen help arno i weld beth sy'n fforddiadwy.

I gael manylion llawn am sut y caiff y gordaliad ei drin, cyfeiriwch at Weithdrefn Cymru Gyfan ar gyfer Adennill Gordaliadau Cyflogres sydd i'w gweld ar wefan SharePoint Gwasanaethau Cyflogres PCGC: [Gwasanaethau Cyflogres \(sharepoint.com\)](https://www.sharepoint.com)

Anfonir ffurflen hysbysu Gordaliad atoch hefyd i'w chwblhau'n electronig. Bydd yr wybodaeth a gesglir yn cefnogi eich Sefydliad i fonitro gordaliadau, deall sut y digwyddodd a pha fesurau sydd wedi'u rhoi ar waith i osgoi gordaliadau yn y dyfodol.

Os oes unrhyw gwestiynau am y gordaliad, cysylltwch â'r **Tim Gordaliadau ar 02921 500055 gan ddyfynnu'r cyfeirnod uchod [JEC/assignment]**. Mae'r tîm yno i helpu a chefnogi gweithwyr a rheolwyr.

Yr eiddoch yn gywir,

Rhowch Enw Arweinydd Tîm OP
Tîm Gordaliadau Cymru Gyfan
Gwasanaethau Cyflogaeth PCGC

ATODIAD I – DIDYNNU GORDALIAD CYFLOG

Didyniad yn uniongyrchol o Daliad Cyflog – Ffurflen Awdurdodi

Enw:	
Rhif Aseiniad:	
Bwrdd Iechyd/Ymddiriedolaeth/Awdurdod Iechyd Arbennig (SHA):	
Adran:	

Rwy'n awdurdodi Gwasanaethau Cyflogres Partneriaeth Cydwasanaethau GIG Cymru i ddidynnu'r swm o £ _____ yn uniongyrchol o'm Cyflog bob mis.

Deallaf y bydd hwn yn cael ei ddidynnu fel taliad NET ac y bydd y didyniad hwn yn parhau hyd nes y bydd y gordaliad o £ _____ wedi ei ad-dalu'n llawn.

Rhoddaf fy nghydsyniad llawn ar gyfer y didyniad hwn.

Os daw fy nghyflogaeth i ben, cytunaf y byddaf yn cysylltu â'r Adran Gyllid i drafod opsiynau i naill ai adennill gweddill y gordaliad o'm tâl terfynol neu gytuno ar sut y caiff y balans sy'n weddill ei dalu.

Llofnod _____

Ysgrifennwch eich enw mewn priflythrennau _____

Dyddiad: _____

Ar ôl ei gwblhau, anfonwch e-bost at [\[Sefydliadau i nodi cyfeiriad e-bost eu tîm cyfrifon derbyniadwy\]](#).

Timau Cyllid i nodi bod adennill y gordaliad yn cael ei wneud mewn rhandaliadau trwy ddidyniadau cyflog ac yna anfon y ffurflen awdurdodi didyniad hwn ymlaen at:

NWSSP.AllWalesOverpayments@wales.nhs.uker mwyn i Wasanaethau'r Gyflogres weithredu

ATODIAD J – ASESIAD CYCHWYNNOL ATAL TWYLL - GWYBODAETH ANGENRHEIDIOL

Enw'r Unigolyn		
Grŵp Tâl / Rhif Tâl		
Sefydliad y GIG		
Teitl y Swydd		
Gradd Cyflog / Oriau	Gradd	Oriau
Llawnamser/ Rhan-amser		
Gweithle / Lleoliad		
Gwerth y Gordaliad Atodwch manylion y Broses Ordaliadau	Gros	Net
Cyfnod y Gordaliad	Dyddiad o	Dyddiad i
Rheswm dros y Gordaliad		
Enw cyswllt a manylion yr Adran / Rheolwr		
Manylion cyswllt Gwasanaethau'r Gyflogres		
Manylion cyswllt Gordaliad Cyflog		
Cadarnhewch pa wiriadau sydd wedi'u gwneud i wirio a yw'r unigolyn wedi cysylltu â Gwasanaethau'r Gyflogres		Gwiriadau wedi'u gwneud gan: Dyddiad:
MANYLION PELLACH AM YR UNIGOLYN:		
Cyfeiriad		
Dyddiad Geni		
Rhif Yswiriant Gwladol		
Manylion cyfrif banc		
Cwblhawyd y ffurflen gan:	Dyddiad:	
<p>Ychwanegwch unrhyw fanylion pellach a allai fod o gymorth i'r Tîm Atal Twyll Lleol gyda'u hadolygiad:</p> <p>Peidiwch â chysylltu ag unigolion heb ymgynghori â'ch tîm Gwasanaeth Atal Twyll Lleol.</p> <p>Rhowch wybod am unrhyw gyswllt pellach rhyngoch chi a'r unigolyn i'r tîm Atal Twyll Lleol ar unwaith.</p>		



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AGENDA ITEM No	16
OPEN or CLOSED	Open
No of ANNEXES	1

Committee Priorities and Cycle Monitoring Report

MEETING	Finance and Performance Committee
DATE	19 November 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



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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



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COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING FOR 2024/25

SITUATION

- 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

- 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.
- 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.
- 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.
- 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

- The Committee priorities, and progress against them is as follows:

Priority	Progress
<p><u>PRIORITY HAS BEEN FULFILLED</u></p> <ul style="list-style-type: none"> The development and approval of the Digital Plan. 	<p><u>2024/25 Progress</u></p> <ul style="list-style-type: none"> 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.

2023/24 Progress

- 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).



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<ul style="list-style-type: none"> • Oversight of the potential commercialisation streams in the Financial Sustainability Programme. 	<ul style="list-style-type: none"> • At the September 2024 meeting of the Committee an update was given on the development of a Head of Commercial role, whose responsibilities will include developing a commercial strategy for the Trust. It was noted that there has been some slippage in the recruitment for this role. • 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 (on the Committee Cycle of Business). • It is noted that no report was programmed for the July 2024 meeting; a related update was included in the Finance presentation. The update at the May 2024 meeting noted that commercialisation workstream will be progressed later in 2024/25.
<ul style="list-style-type: none"> • Focus on the new elements of its terms of reference relating to Information Governance and Information Security. 	<ul style="list-style-type: none"> • 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 Data Quality Internal Audit Report will be received by the Committee in November 2024. • 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; Nov 24: update on capital programme for 24/25 taken to closed.
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 9]	ELT	Ad Hoc							EDSPP	Endorsement	
IMTP for following year	STB/ELT/Board	Annually							EDSPP	Endorsement	Nov 24: ESPP sought inclusion of 25/28 IMTP on the agenda.
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; implementation being overseen by the ARAC.
ESTATES AND FLEET											
Estates Condition and Backlog Maintenance Update [EPFMS Data/Repo TBC]		Annually							EDOF	Assurance	This was added in as a future requirement (following initial receipt in September 2024) by CorGov.
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 (Closed)	Capital M'ment Board	Annual BJC see notes					→		EDOF	Approval/Endorsement	Nov 24 Update: Item deferred and to be rec'd in early 2025 (in closed session); position agreed w/WG.
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	July 24: IRP rec'd in July instead of September 24 (and not required to take again this year).
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	<p>IA raised need to be explicit and define intended timescales for delivery of digital strategy phases. Digital strategic outline case September 2022; focus on baseline and business usual in November 2022; SOP and resourcing September 2022 (in IMTP); digital governance</p> <p>Digital reporting presented to Sept 23 meeting and will be presented bi-monthly. Includes data and analytics status, ICT systems status, service provision and quality, summary of IMTP contributions, spotlight item, and people</p> <p>FPC = reporting on technology & process related metrics i.e. where Digital Directorate is responsible</p> <p>oE.g. Provision of training, provision of exercises / campaigns, infrastructure, physical barriers etc.</p> <p>oThis would include near misses related to software, suppliers, network, technology.</p>
2	Value Based Healthcare	<p>VBH is part of the financial sustainability programme and deliverables for IMTP 23-26 set out. Includes PLICS, PROMS and PREMS. Could be part of IMTP reporting generally, but propose a bi-annual update.</p>
3	Commissioning	<p>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.</p>
4	MIQPR	<p>FPC is primary Committee for review of performance across all four quadrants of the MIQPR.</p> <p>The Committee will commission deep dives or refer such deep dives to other Committees</p>
5	Emergency Preparedness	<p>The Trust is classed as a category one responder under the Civil Contingencies Act (2004) and as a result there is a legislative obligation for us to address 6 key responsibilities, which are</p> <ul style="list-style-type: none"> - 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 <p>CCA Part one devolved to Wales.</p> <p>WAST is a category 1 responder under the Civil Contingencies Act (2004) and Regulations (2005). Category 1 responders are required to maintain plans for preventing emergencies; reducing, controlling or mitigating the effects of emergencies in both the response and recovery phases, and has a duty to ensure business continuity plans are in place. Trust is working towards ISO22301 accreditation.</p> <p>Internal Audit on Major Incidents - September 2022 AC - raised F&P review of incident response plan when reviewed next.</p> <p>Incident Response Plan Report: WG report accompanied by assurance that Incident Response Plan (IRP) in place and approved by ELT. SBAR includes detail of staff training in place, compliance levels, and resourcing for assurance; list of plans that underpin IRP are in date and regularly reviewed. IRP provides guidance and support to commanders on a range of incidents. Moved from July to November as that is the date of review</p> <p>Business Continuity Annual Report: SBAR to include compliance with CCA 2004 if not included in WG annual report and compliance under policy; list of plans that underpin BCP are in date and regularly reviewed; staff training in place, compliance levels and resourcing for assurance if not included in IRP report above; exercises carried out and planned; learning from incidents/exercises/debriefs.</p>
6	Demand and Capacity	<p>May 2023 paper to FPC foreshadowed the development of a demand and capacity framework (as per EASC commissioning intentions) however there are current capacity issues</p>
7	Decarbonisation	<p>WAST Decarbonisation Action Plan (DAP) supports delivery of the national NHS Wales Decarbonisation Strategic Delivery Plan. IMTP sets out DAP details. Every second year IMTP must include copy of DAP and update - next 24-27.</p> <p>Decarbonisation reporting to WG as follows, however the reporting to FPC will draw from these reports and may or may not append them:</p> <p>(a) WG Public Sector Carbon Report (annual 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.</p> <p>(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 compiled by Jo Williams who takes the report through FPC. Looks like there may be a move for an annual qualitative report for 23/24 aligned to IMTP timetables.</p> <p>(c) 4 x Decarbonisation Coordination Reporting (DCR). This is reporting on our decarbonisation action plan (DAP) this is a new requirement where we will need to report updates to our DAP via NWSSP who collate and send to WG as a whole of NHS update. This report is being agreed by the Decarbonisation project Board. There are discussions relating to the need of any further governance routes - this is new.</p> <p>(d) Sustainability Report contained in the Performance Report if the data is available. Amalgamation of quantitative and qualitative reports. Otherwise it is a separate report with a reference to the report being on the publication section of the website. This developed from the data provided in the Quantitative Report above.</p>
8	Fire safety reporting	<p>Updated in January 2024 following compliance report to Committee. Report will be annual report from 24/25 (timing TBC) with exception reporting outside of that where appropriate.</p>
9	Service or Directorate Plans	<p>Committee with related remit to gain assurance on alignment of specific plans to Delivering Excellence. FPC to maintain overall view of aligned strategies. Suggest this is by way of an organogram showing the various plans aligned to the long term strategy and their revision dates</p>
10	Information Governance	<p>Information Governance (IG) is a framework for managing information processes and procedures in accordance with the law and associated standards. It describes the approach within which accountability, standards, policies and procedures are developed, implemented and maintained to ensure that all types of information used in the Trust are sourced, stored and used appropriately, legally, and securely.</p> <p>The Information Governance Steering Group oversees the Information Governance and Security strategy, policies, systems, processes and practices across the Trust and provides assurance that the organisation is compliant, and managing any risk to compliance. The strategic management of Information Governance forms part of the Digital Directorate under the leadership of the Director of Digital Services who holds the position of Senior Information Risk Owner (SIRO). Includes FOI (targeted percentage); Subject Access Request and Access to Health Records Requests (targeted percentage); Police Requests (no regulatory target). Data security and protection incidents: must notify ICO of personal data breaches within 72 hours.</p> <p>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).</p> <p>The Welsh IG Toolkit for NHS is an assessment tool that allows organisations to measure their performance against agreed national information governance and data security standards and legislation. All organisation that have access to NHS patient data and systems must use the toolkit to demonstrate compliance with DPA 2018; expected data security standards for health and social care for processing personal data; and readiness to access secure health and digital methods of information sharing such as NHS Email, Welsh healthcare records and systems and local information sharing solutions and agreements. The Trust is required to demonstrate whether it complies with each of the 225 evidence items with each item weighted and a level of compliance generated (foundation stage; satisfactory stage; competent stage). IGSG monitors the toolkit improvement plan. Information Commissioner's Office (ICO) monitors compliance with key legislation (DPA 2018, UK GDPR and FOIA).</p>