Bundle Trust Board (Open Session) 28 September 2023

Agenda attachments

ITEM 0 Trust Board Open Agenda 28 September 2023
ITEM 0 Trust Board Open Agenda 28 September 2023 welsh copy

0 09:30 - OPENING ITEMS

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

2 Declarations of Interest
Declarations of Interest

3 Minutes of Previous Meeting: 27 July 2023
Item 3 - Minutes of meeting - 27 July 2023
ITEM 3 Trust Board Minutes Open 27 July 2023 - v2

4 Action Log and Matters Arising
ITEM 4 Trust Board Public CURENT Action and Decisions Log
ITEM 4.1 Penthrox Board update

5 09:35 - Chair's Report

6 09:45 - Chief Executive's Report
ITEM 6 CEO Rport to Trust Board September 2023

7 10:00 - Questions from Members of the Public

8 10:10 - Staff Story

9 10:40 - Progress on Actions to Mitigate Avoidable Patient Harm
ITEM 9 Realtime Mitigations for Avoidable Patient Harm
ITEM 9.1 Reducing Patient Harm Action Plan

10 11:00 - Risk Management and Board Assurance Framework
ITEM 10 Executive Summary Risk Management Report Trust Board 280923

10.1 11:10 - COMFORT BREAK - 15 Minutes

11 11:25 - Integrated Medium Term Plan 2023-2026 - Update
ITEM 11 Executive Summary - IMTP 2023-26 Q1Q2 Delivery and Assurance

12 11:40 - Financial Performance Month 5
Note;
Items 12.2 and 12.4 (Finance Worksheets) have been circulated separately by e mail.
ITEM 12 Finance Report Month 5 23-24 - TB 28 Sept 2023
ITEM 12.1 Month 4 2023-24 - Welsh Ambulance Services NHS Trust - Monitoring Return
ITEM 12.3 Month 5 2023-24 - Welsh Ambulance Services NHS Trust - Monitoring Return

13 11:50 - Monthly Integrated Performance Report
ITEM 13 MIQPR SBAR TB July August 2023
ITEM 13.1 Annex 1 MIQPR TB July August 2023

14 12:05 - Amendments to Standing Orders and Standing Financial Instructions
ITEM 14 TB SBAR Standing Orders Review July 2023
ITEM 14.1 Annex 1 - Standing Orders Main Document v.6 draft for approval
ITEM 14.2 Annex 2 - Standing Orders - Schedule 2.1 Standing Financial Instructions v.6 for approval 280923
ITEM 14.3 Annex 3 - Standing Orders Schedule 1 Scheme of Reservation & D'gation v.6 for approval 280923
ITEM 14.4 Final - Summary EqIA Form - SO Amendments - Sept 2023

15.1 Quest Committee
- Safeguarding Annual Report
- IPC Annual Report
15.2 People and Culture Committee
- Welsh Language Annual Report
15.3 Finance and Performance Committee
- Sustainability Report 2022/23
15.4. Academic Partnership Committee
- Research and Innovation Annual Report
15.5. Audit Committee
ITEM 15.1 Quest Committee Highlight Report August 2023
ITEM 15.1a Welsh Ambulance Services NHS Trust Safeguarding Annual Report 22-23 -

Annex

ITEM 15.1b Infection, Prevention & Control Annual Report - Appendix 1
ITEM 15.2 People and Culture Committee Highlight Report August 2023
ITEM 15.2.1 Welsh Language Standards Annual Report 2022-23 for Approval
ITEM 15.2.2 Adroddiad Blynyddol Safonau'r Gymraeg 2022-23
ITEM 15.3 Finance and Performance Committee Highlight Report September 2023 (2)
ITEM 15.3.1 Annual Sustainability Report 2022-23 for Approval
ITEM 15.4 Academic Partnerships Committee Report August 2023
ITEM 15.4.1 WAST Research & Innovation Annual Report 2022 - 2023
ITEM 15.5 Audit Committee Highlight Report September 2023

15.1 12:45 - 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 Governance Report

ITEM 16 Governance Report

17 Minutes of Board Committees

17.1 Academic Partnership Committee – 25 April 2023
17.2 People and Culture Committee – 9 May 2023
17.3 Quest Committee – 11 May 2023
17.4 Finance and Performance Committee – 17 July 2023
17.5 Audit Committee – 25 July 2023

ITEM 17.1 2023-04-25-Open Minutes-Academic Partnerships Committee
ITEM 17.2 2023-05-09-Open Minutes-People and Culture Committee
ITEM 17.3 2023-05-11-Open Minutes-QuEST Committee
ITEM 17.4 2023-07-17-Open Minutes-Finance and Performance Committee
ITEM 17.5 2023-07-25-Open Minutes-Audit Committee

18 NHS Wales Joint Committee Update Reports

18.1 Chair's EASC Summary - 18 July 2023
18.2 Welsh Health Specialised Services Committee Briefing - 18 July 2023
18.3 Shared Services Partnership Committee - 20 July 2023
18.4 Welsh Health Specialised Services Committee Extraordinary Briefing - 1 August 2023

ITEM 18 Joint Committee Update Report
ITEM 18.1 Chair's EASC Summary from 18 July 2023
ITEM 18.2 JC Briefing (Public) 18 July 2023
ITEM 18.3 SSPC Assurance Report 20 July 2023
ITEM 18.4 JC Briefing Extraordinay (Public) Meeting 1 August 2023

18.1 12:50 - CLOSING ITEMS

19 Any Other Business

20 Date and time of next meeting -Thursday 23 November 2023 at 09:30 in Cardiff MRD

21 Exclusion of the press and members of the public.

22 Acronyms

ITEM 22 Acronyms

MEETING OF THE TRUST BOARD

Held in Open Session on Thursday 28 September 2023 from 09.30 to 12:55

Meeting held in Cardiff MRD, Merton House, Croescadarn Close, Pontprennau, Cardiff, CF23 8HF and Via Zoom

AGENDA

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome, apologies, and confirmation of quorum	Information	Colin Dennis	Verbal	5 Mins
2.	Declarations of Interest	Information	Colin Dennis	Verbal	
3.	Minutes of Previous Meeting: 27 July 2023	Approval	Colin Dennis	Paper	
4.	Action Log and Matters Arising	Review	Colin Dennis	Verbal	
5.	Chair's Report	Information	Colin Dennis	Verbal	10 Mins
6.	Chief Executive's Report	Information	Jason Killens	Paper	15 Mins
7.	Questions from Members of the Public	Information	Estelle Hitchon	Verbal	10 Mins
STAFF/PATIENT EXPERIENCE					
8.	Staff Story: Bethan Jones	Discussion	Liam Williams	Verbal	30 Mins
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
9.	Progress on Actions to Mitigate Avoidable Patient Harm	Assurance	Jason Killens	Paper	20 Mins
10.	Risk Management and Board Assurance Framework	Assurance	Trish Mills	Paper	10 Mins
COMFORT BREAK – 15 Minutes					
11.	Integrated Medium-Term Plan 2023-2026 – Update	Assurance	Rachel Marsh	Paper	15 Mins

No.	Agenda Item	Purpose	Lead	Format	Time
12.	Financial Performance Month 5	Assurance	Chris Turley	Paper	10 Mins
13.	Monthly Integrated Quality and Performance Report	Assurance	Rachel Marsh	Paper	15 Mins
14.	Amendments to Standing Orders and Standing Financial Instructions	Approval	Trish Mills	Paper	5 Mins
15.	Board Committee Reports				
	15.1. Quest Committee - Safeguarding Annual Report - IPC Annual Report	Assurance	Bethan Evans	Paper	5 Mins
	15.2. People and Culture Committee - Welsh Language Annual Report	Assurance Approval	Paul Hollard Melfyn Hughes	Paper Paper	10 Mins
	15.3. Finance and Performance Committee - Sustainability Report 2022/23	Assurance Approval	Joga Singh Chris Turley	Paper	10 Mins
	15.4. Academic Partnership Committee - Research and Innovation Annual Report	Assurance	Hannah Rowan	Paper	5 Mins
	15.5. Audit Committee	Assurance	Martin Turner	Paper	5 Mins
CONSENT ITEMS **The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.**					
16.	Governance Report	Information	Trish Mills	Paper	5 Mins
17.	Minutes of Board Committees 17.1 Academic Partnership Committee – 25 April 2023 17.2 People and Culture Committee – 9 May 2023	Information	Colin Dennis	Paper	

No.	Agenda Item	Purpose	Lead	Format	Time
	17.3 Quest Committee – 11 May 2023 17.4 Finance and Performance Committee – 17 July 2023 17.5 Audit Committee – 25 July 2023				
18.	NHS Wales Joint Committee Update Reports: 18.1 Chair's EASC Summary - 18 July 2023 18.2 Welsh Health Specialised Services Committee Briefing - 18 July 2023 18.3 Shared Services Partnership Committee - 20 July 2023 18.4 Welsh Health Specialised Services Committee Extraordinary Briefing - 1 August 2023	Information	Colin Dennis	Paper	
CLOSING ITEMS					
19.	Any Other Business	Discussion	Colin Dennis	Verbal	5 Mins
20.	Date and time of next meeting – Thursday 23 November 2023 at 09:30 in Cardiff MRD	Information	Colin Dennis	Verbal	
21.	Exclusion of the press and members of the public. To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).	Resolution	Colin Dennis	Verbal	
22.	Acronyms	Information	Colin Dennis	Paper	

Lead Presenters

Name of Lead	Position of Lead
Colin Dennis	Chair of the Board
Bethan Evans	Non-Executive Director; Chair of Quality, Patient Experience and Safety Committee
Paul Hollard	Non-Executive Director; Chair of People and Culture Committee
Melfyn Hughes	Welsh Language Services Manager
Ceri Jackson	Non-Executive Director, Chair of Charity Committee
Jason Killens	Chief Executive Officer
Angela Lewis	Director of People and Culture
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Hannah Rowan	Non-Executive Director; Chair of the Academic Partnerships Committee
Joga Singh	Non-Executive Director; Chair of Finance and Performance Committee
Chris Turley	Executive Director of Finance and Corporate Resources
Martin Turner	Non-Executive Director; Chair of Audit Committee
Liam Williams	Executive Director of Quality and Nursing

CYFARFOD BWRDD YR YMDDIRIEDOLAETH

Cynhaliwyd mewn Sesiwn Agored ddydd Iau 28 Medi 2023 o 9.30am tan 12.50pm

Cynhaliwyd y cyfarfod yn MRD Caerdydd, Tŷ Merton, Clos Croescadarn, Pontprennau, Caerdydd, CF23 8HF a thrwy Zoom

AGENDA

Rhif	Eitem yr Agenda	Diben	Yn arwain	Fformat	Amser
EITEMAU AGORIADOL					
1.	Croeso gan y Cadeirydd, ymddiheuriadau a chadarnhau cworwm	Gwybodaeth	Colin Dennis	Llafar	5 Mun
2.	Datganiadau o fuddiant	Gwybodaeth	Colin Dennis	Llafar	
3.	Cofnodion o'r cyfarfod blaenorol: 27 Mehefin 2023	Cymderadwyaeth	Colin Dennis	Papur	
4.	Log gweithredu a materion sy'n codi	Adolygu	Colin Dennis	Llafar	
5.	Adroddiad y Cadeirydd	Gwybodaeth	Colin Dennis	Llafar	10 Mun
6.	Adroddiad y Prif Weithredwr	Gwybodaeth	Jason Killens	Papur	15 Mun
7.	Cwestiynau gan aelodau'r cyhoedd	Gwybodaeth	Estelle Hitchon	Llafar	10 Mun
PROFIAD STAFF/CLEIFION					
8.	Stori cleifion – I'w gadarnhau	Trafodaeth	Liam Williams	I'w gadarnhau	30 Mun
EITEMAU AR GYFER CYMERADWYAETH, SICRWYDD A THRAFOD					
9.	Cynnydd ar gamau i liniaru niwed y gellir ei osgoi i gleifion	Sicrwydd	Jason Killens	Papur	20 Mun
10.	Fframwaith Rheoli Risg a Sicrwydd y Bwrdd	Sicrwydd	Trish Mills	Papur	10 Mun
SEIBIANT – 15 munud					

Rhif	Eitem yr Agenda	Diben	Yn arwain	Fformat	Amser
11.	Cynllun Tymor Canolig Integredig 2023-2026 – Diweddariad	Sicrwydd	Rachel Marsh	Papur	15 Mun
12.	Perfformiad Ariannol mis 5 [canlyniad posibl o arbedion system GIG Cymru]	Sicrwydd	Chris Turley	Papur	10 Mun
13.	Adroddiad Misol Integredig Ansawdd a Pherfformiad	Sicrwydd	Rachel Marsh	Papur	15 Mun
14.	Diwygiadau i Reolau Sefydlog a Chyfarwyddiadau Ariannol Sefydlog	Cymeradwyaeth /	Trish Mills	Papur	5 Mun
15.	Adroddiadau Pwyllgor y Bwrdd				
	15.1. Pwyllgor Ymchwil - Adroddiad Diogelu Blynyddol - Adroddiad Comisiwn Cynllunio Seilwaith Blynyddol	Sicrwydd	Bethan Evans	Papur	5 Mun
	15.2. Pwyllgor Pobl a Diwylliant - Adroddiad Blynyddol y Gymraeg	Sicrwydd Cymeradwyaeth	Paul Hollard Melfyn Hughes	Papur Papur	10 Mun
	15.3. Pwyllgor Cyllid a Pherfformiad - Adroddiad Cynaliadwyedd 2022/23	Sicrwydd Cymeradwyaeth	Joga Singh Chris Turley	Papur	10 Mun
	15.4. Pwyllgor Partneriaeth Academaidd	Sicrwydd /	Hannah Rowan	Papur	5 Mun
EITEMAU CYDSYNIAD **Mae'r eitemau canlynol er gwybodaeth yn unig. Os bydd aelod yn dymuno trafod unrhyw un o'r eitemau hyn, gofynnir iddynt roi gwybod i'r Cadeirydd fel y gellir dyrannu amser i wneud hynny.**					
16.	Adroddiad Llywodraethu	Gwybodaeth	Trish Mills	Papur	

Rhif	Eitem yr Agenda	Diben	Yn arwain	Fformat	Amser
17.	Cofnodion Pwyllgorau'r Bwrdd 17.1 Pwyllgor Archwilio 17.2 Pwyllgor Ymchwil 17.3 Pwyllgor Pobl a Diwylliant 17.4 Pwyllgor Cyllid a Pherfformiad 17.5 Pwyllgor Partneriaeth Academaidd	Gwybodaeth	Colin Dennis	Papur	5 Mun
18.	Adroddiadau Diweddariad Cyd-bwyllgor GIG Cymru	Gwybodaeth	Colin Dennis	Papur	
EITEMAU CAU					
19.	Unrhyw fater arall	Trafodaeth	Colin Dennis	Llafar	5 Mun
20.	Dyddiad ac amser y cyfarfod nesaf – dydd Iau 23 Tachwedd am 9.30am yn MRD Caerdydd	Gwybodaeth	Colin Dennis	Llafar	
21.	Eithrio'r wasg ac aelodau'r cyhoedd. Gwahodd y wasg a'r cyhoedd i adael y cyfarfod oherwydd natur gyfrinachol y busnes sydd ar fin cael ei drafod (yn unol ag Adran 1(2) o Ddeddf Cyrff Cyhoeddus (Derbyn i Gyfarfodydd) 1960)	Penderfyniad	Colin Dennis	Llafar	
22.	Acronymau	Gwybodaeth	Colin Dennis	Papur	

Prif Gyflwynwyr

Enw'r arweinydd	Swydd yr arweinydd
Colin Dennis	Cadeirydd y Bwrdd
Bethan Evans	Cyfarwyddwr Anweithredol, Cadeirydd y Pwyllgor Ansawdd, Profiad y Claf a Diogelwch
Paul Hollard	Cyfarwyddwr Anweithredol; Cadeirydd y Pwyllgor Pobl a Diwylliant
Melfyn Hughes	Rheolwr y Gymraeg
Ceri Jackson	Cyfarwyddwr Anweithredol, Cadeirydd y Pwyllgor Elusen
Jason Killens	Prif Swyddog Gweithredol
Angela Lewis	Cyfarwyddwr Pobl a Diwylliant
Rachel Marsh	Cyfarwyddwr Gweithredol Strategaeth, Cynllunio a Pherfformiad
Trish Mills	Ysgrifennydd y Bwrdd

Joga Singh	Cyfarwyddwr Anweithredol, Cadeirydd y Pwyllgor Cyllid a Pherfformiad
Chris Turley	Cyfarwyddwr Gweithredol Cyllid ac Adnoddau Corfforaethol
Martin Turner	Cyfarwyddwr Anweithredol; Cadeirydd y Pwyllgor Archwilio

UNCONFIRMED MINUTES OF THE OPEN MEETING OF THE WELSH AMBULANCE SERVICES NHS TRUST BOARD, HELD on THURSDAY 27 JULY 2023 MEETING HELD IN CARDIFF AMBULANCE STATION, and VIA ZOOM

Meeting started at 09:30

PRESENT:

Colin Dennis	Non-Executive Director and Chair of the Board
Jason Killens	Chief Executive
Lee Brooks	Executive Director of Operations
Professor Kevin Davies	Non-Executive Director and Vice Chair of the Board
Bethan Evans	Non-Executive Director
Estelle Hitchon	Director of Partnerships and Engagement
Paul Hollard	Non-Executive Director
Ceri Jackson	Non-Executive Director (Via Zoom)
Angela Lewis	Director of People and Culture
Dr Brendan Lloyd	Executive Director of Medical and Clinical Services
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Hugh Parry	Trade Union Partner
Hannah Rowan	Non-Executive Director (Via Zoom)
Joga Singh	Non-Executive Director
Leanne Smith	Interim Director of Digital Services
Andy Swinburn	Director of Paramedicine
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner
Martin Turner	Non-Executive Director
Liam Williams	Executive Director of Quality and Nursing

Attendees

Navin Kalia	Deputy Director of Finance and Corporate Resources
Steve Owen	Corporate Governance Officer (Via Zoom)
Alex Payne	Corporate Governance Manager
Erin Pollard	Audit Wales (Item 64/23 only)

58/23 WELCOME AND APOLOGIES FOR ABSENCE

Welcome and apologies

The Chair welcomed all to the meeting, particularly Navin Kalia the Deputy Director of Finance and Corporate Resources, and noted there were no apologies.

Declarations of interest

The Board noted that all declarations of interest were formally recorded on the Trust's declarations of interest register.

RESOLVED: That the declarations of interest on the register were formally recorded.

59/23 PROCEDURAL MATTERS

The Chair reiterated that the Board meeting was part of the overall scrutiny and assurance process with much of the detailed work undertaken in the committees, that met prior to the Trust Board, and that Committee AAA highlight reports, which featured later in the agenda, together with committee minutes, all added to the overall assurance and scrutiny process. He added that all Committee meetings had been quorate and well attended.

Minutes: The Minutes of the Board meetings held on 25 May 2023 were presented and confirmed as a correct record.

Action Log: The Board received the action log:

Action number 133/22. Update on cultural measures. An update on this featured under Item 14 on the agenda. Action Closed.

Action number 41/23. Chris Turley advised the Board that an update would be provided at a future Board Development Day which would demonstrate the improvements to the Trust Estate over the last few years. Action Closed.

RESOLVED: That

(1) the Minutes of the meeting held on 25 May 2023 were confirmed as a correct record; and

(2) the update on the action log was noted.

60/23 CHAIR'S REPORT AND UPDATE

The Chair updated the Board on a recent Board Development session where the focus had included strategy development and the People and Culture plan.

RESOLVED: The update was noted.

61/23 CHIEF EXECUTIVE'S UPDATE

In presenting his report, Jason Killens drew the Board's attention to the following:

1. South East Fleet Workshop. Work had progressed well, and the building work was almost complete. This has now meant that Blackweir workshop was no longer occupied, with staff moving to the new facility.

2. Delivery of the 2022/23 Fleet Programme. Jason Killens outlined the current position and asked for a note of thanks to be recorded for the Fleet Team involved in implementing the programme and enabling its readiness; particularly as the mix of vehicles has changed over the last few years.

3. Members were updated on the development of a new role within the Trust, Emergency Medical Technician 3 (EMT) on a permanent basis. This would enable EMT grade 2 to progress to EMT 3 on a Band 5. This role would receive additional training giving them to opportunity to manage patients in the Community differently. It was anticipated, following further liaison with Trade Union partners, that the EMT 3 role will be implemented shortly.

4. The Trust continues to implement ways to improve Clinical Leadership within the 111 Wales service. Part of this is the implementation and delivery of the Clinical Supervision Module.

5. In developing the Trust's commitment to build a safe environment for staff, several initiatives including the Sexual Safety Charter, International Women's Day and the Allyship programme were underway.

6. Jason referred to the Wish Ambulance in which staff in the Trust gave up their time to organise and take part in journeys for patients who were at the end of their life. He asked that the Board recognise the excellent work of the staff, who give up their own time, to enable those journeys to take place.

Comments:

Regarding the additional duties of Trust staff in Health Boards and the notice from WAST to end this. Members were disappointed that not all Health Board had responded to the Executive Director of Operations letter regarding issues raised. Lee Brooks outlined details of a meeting he had attended with his peer group across the Health Boards. During this and other meetings, the rationale for the Trust's position on cessation of the additional duties was set out. Having allowed time for reflection, he felt more comfortable that colleagues across the Health Boards have acknowledged that these additional duties were not part of the Trust's role. Work continued with Health Boards to aid the transition from the cessation of additional duties whilst they enhance their pathways.

Jason Killens commented that high-level dialogue continued with one particular Health Board to consider ways to loosen the bottleneck at the ED, either by defraying activity in the Community or conveying patients somewhere else: thus not creating the problem at the Emergency Department (ED) in the first place.

The Board noted all the positives within the report and were pleased to see that a Welsh Language translator had been appointed and that work on the Welsh Language Strategy was moving forward.

Members also noted the increase of patient experience returns through the Trust's Civica Experience Platform. Liam Williams added that the Quality, Patient Experience and Safety Committee would be kept updated on this feedback going forward.

The Chair asked that an update report on the use of Analgesia by volunteers be presented to the Board at the next meeting. It was agreed that Andy Swinburn would provide this.

The Board sought confirmation that the vacancies in the Clinical Support Desk (CSD) had been filled. Lee Brooks advised that in respect of the CSD there were still vacancies, but it was envisaged full establishment would be met before Winter.

RESOLVED: That the update was noted.

62/23 QUESTIONS FROM MEMBERS OF THE PUBLIC

The Board were advised that at this time no questions had been received. Estelle Hitchon informed the Board that the Communications Team were actively monitoring for any live questions during the meeting.

63/23 STAFF STORY

Liam Williams introduced the story which was an experience being shared through a video by Theresa Stevens, an EMT, which focused on supporting a dementia patient and the impact of all involved. Prior to the story he asked the Board to

consider the role of our staff and the use of technical equipment, namely a tablet: Reminiscence Therapy Interactive Activities (RITA). It was recognised that Theresa was a RITA champion.

The Board listened to Theresa who had recorded a video setting out details of a recent experience she had involving a patient with dementia.

Theresa and a colleague received a call to attend to a patient at their property as a doctor referral from Singleton hospital, for social needs. The information they had was that the patient was an 83-year-old male.

On arrival at the property, they noticed that the front door was slightly open and on approaching the door, were hit by an awful smell. Theresa opened the door and called out to the patient; he was lying on a broken bed, and he had a catheter in place which was full of dark urine. The patient was half naked and covered in excrement. It became increasingly obvious that the patient was living in extremely squalid and neglected conditions.

The patient asked Theresa to leave his property claiming that he did not require any help. He kept asking for his wife but realised she had died some time ago, and for Theresa and her colleague to leave.

Theresa advised the patient that she was there as the Doctor had requested ambulance assistance. On hearing this the patient responded positively and agreed to be taken to hospital.

On the way to hospital Theresa interacted with the patient through RITA, showing him videos and pictures of Ballroom dancing, as this was an activity he enjoyed with his wife. He was very talkative and described details of his life he shared with his wife.

On arrival at Singleton hospital, Theresa and her colleague took him to the ward and assisted him to a bed. Before Theresa left, the patient thanked her for taking the time to talk to him about his wife.

Theresa explained this incident was very sad and distressing, adding that the use of RITA had assisted the patient to reminisce of good times gone by.

Comments:

Liam Williams reassured the Board that Theresa was being supported from within her own team and with the dementia care lead. The Board recognised the impact this had on Theresa and were pleased to learn that the relevant support was being provided.

Kevin Davies added that sadly this was not an isolated case and prompted that this was a real reason to properly resource and develop virtual wards, noting that with the proper support the patient may have been able to be supported in the Community.

Liam Williams added that work on virtual wards was ongoing, and from a Trust perspective there was ambition in Health Boards to progress this.

Details of the outcome of the patient was not known, but Liam Williams advised that he had been assured by the relevant Executive Director of Nursing that the right steps were being taken to care for the patient.

Liam Williams reiterated that regrettably these situations do occur, adding that both patient and staff stories are used extensively as case studies within the Trust. He was aware that more could be done externally going forward. Furthermore, the use of the RITA tablet on this occasion has proved invaluable.

The Board queried whether there was a formal reporting framework in these circumstances to report to other organisations, given this was not an isolated case. Liam Williams explained the processes in place which the Trust carried out in respect of vulnerable adults and the safeguarding route, followed with alerts being raised to the appropriate organisation as required.

Members were keen to understand how effective the RITA initiative was and whether there were any other similar initiatives that could make a difference to patients. Liam Williams reiterated that Theresa was a RITA champion. He advised that the RITA tablets have also been used to support patients in similar circumstances and those not necessarily living with dementia whilst waiting in ambulances outside the ED. There is comprehensive dementia training for staff and several online training modules where staff can access further information.

Brendan Lloyd added that incidents of this nature were happening all too frequently. In terms of this case, notwithstanding the impact on the crew attending, it went very smoothly because it was a situation where the GP had already arranged admission. This patient was unlikely to return to his place of residence and may become a patient who is medically fit to be discharged from hospital but unable to return home / to the community. He advised the Board that one of the considerations of the Trust's Clinical Strategy was accommodation / care of patients in the most appropriate setting.

Jason Killens extended his thanks on behalf of the Board to Theresa and her crewmate with the compassionate care they showed for this patient. He added that the compassion and kindness shown was typical for all staff who encountered similar incidents daily.

The Chair reiterated the Board's recognition of the compassion shown and asked that the letter of thanks to Theresa included the fact the Board were fully engaged and noted the clear benefits of RITA.

RESOLVED: That the staff experience was noted.

64/23 TRUST BOARD ANNUAL REPORT AND ACCOUNTS 2022-23

Annual Accounts

Chris Turley introduced the presentation, which was given by Navin Kalia - recognising that it had recently been reviewed by the Audit Committee - who drew the Board's attention to the following key points:

1. The draft accounts had been formally submitted to Audit Wales on 5 May 2023 with all statutory financial duties being met.

2. A retained surplus for the year of £0.062m had been achieved; effectively a break-even position with total income of £296.092m and Net expenditure of £296.030m.

3. The breakdown of income from patient care activities was £283.2m consisting of: Emergency Ambulance Services Committee, £230m, Local Health Boards, £17m, Welsh Government, £34m and income from other Trusts, £2m. The total increase from the previous year was £21.6m.

4. In terms of expenditure, pay costs were £204m and Non-pay and other costs came to £92m. The main differences for the previous year were an increase of £14.6m in pay and a net increase of £5.4m in Non-pay expenditure.

5. With respect to the Balance Sheet, the Net Book Value as of 31 March 2023 was £99m. Debtors had increased by £1.4m, with borrowings increasing by £10m.

6. Capital Investment funds of £28.795m was expended thereby utilising 100% of the Trust's Capital Expenditure Limit (CEL).

7. Achieved Public Sector Payments Policy (PSPP) of 97.4% within 30 days against the 95% target.

8. Personal Injury Benefit Scheme (PIBS), the income of £2.5m reflected as other income instead of Welsh Government (WG) income.

9. Employee Costs – 6.3% pension support from WG was reflected in Employer Pension Contribution line instead of Salaries and wages line in the note. The figures were £8.4m and £7.8m for 2022/23 and 2021/22 respectively.

10. The Audit opinion resulted in an unqualified audit opinion and the accounts showed a true and fair view of the state of affairs of WAST as of 31 March 2023 and of its surplus for the year then ended.

11. The Accounts, following today's approval will be submitted to Welsh Government by 31 July 2023.

Annual Report

The report was presented by Trish Mills who indicated the report consisted of two parts, the Performance Report, and the Accountability Report. The Performance Report contained details of how the Trust had performed during the last year. The Accountability Report detailed the key accountability requirements and how the Trust managed its risks and the Governance Statement. It also included the Corporate Governance Report, the Remuneration and Staff Report and the Parliamentary Accountability and Audit Report. The Board were further advised that the Trust's final Letter of Representation, provided by management to Audit Wales, was also contained with the suite of reports.

The Board were reminded of the various reviews the report had undertaken at both management and Committee level prior to its presentation at Board for approval. The report had also been reviewed and commented on by Audit Wales and WG.

Members were advised that the translation of the report into Welsh was in process and would be ready for the AGM on 27 September 2023.

Comments:

Martin Turner, Chair of the Audit Committee, commented that whilst the Trust had met its financial target, there was still an underlying concern that the Trust continued to use non-recurring savings to do so.

Erin Pollard from Audit Wales thanked the Finance team for their assistance and help in the production of the Accounts.

Jason Killens commented there was sufficient assurance to be able to sign the documents later based on the fact the Trust had met its statutory duties and asked that a note of thanks be recorded for all the teams involved.

RESOLVED: The Board

(1) The Trust's Annual Report and Annual Accounts for 2022/23 were adopted and approved by the Trust Board; and

(2) The Trust's Letter of Representation was accepted and approved.

65/23 PROGRESS ON ACTIONS TO MITIGATE AVOIDABLE PATIENT HARM

The Chair explained that this report was received by the Board for them to be updated on the progress the Trust was making in completing the actions to mitigate real-time avoidable patient harm.

Jason Killens presented the report as read and drew the Board's attention to the following key points:

1. Whilst good progress has been made on the actions that the Trust can control, the extreme system pressure continues. In June 2023, over 18,000 hours were lost to hospital handover equivalent to 21% of the Trust's conveying capacity. This was a reduction from the 37% in December 2022, but was still extreme.

2. 13 of the 32 actions within the Trust's control have been completed with eight shown as being on target, five off target, five substantially off target and one that has been stopped. He added that several of the actions relied on other partners across the system to enable delivery.

3. The Board were updated on the changes to how the Trust uses it resources to respond to calls; this has proven to show a better use of the resources available with a reduction in 'multiple attendance ratio.'

4. Members were updated on Immediate Release Directions in which it was noted good progress and compliance with patients in the Amber category was being made against most Health Boards. In terms of patients in the Red category, during the last two weeks, most Health Boards did not reject and Red Release Directions.

Comments:

The Board held a discussion in which they recognised the improvements being made but noted there was still further work. Considering that the whole system was under pressure Members queried whether there were any outward signs of further improvement going forward. Lee Brooks explained there were signs of improvement; the numbers of hours lost due to handover delays was decreasing each month with 23,000 hours in May to 18,000 in June, and it was likely that the figures for July would be like June's. Reduction in lost hours was being seen in most Health Board areas, and also a reduction in the extremely long delays.

Lee Brooks added that the position with the Red Immediate Release Directions had significantly improved, but there were still some disparities amongst Health Boards.

He outlined the process the Trust used to capture data surrounding these directions, adding that it was shared on a weekly basis with Health Board counterparts. The analysis of this data included a review all declined Reds, and importantly whether the applications for immediate release were being treated on a consistent basis. Furthermore, a 10% dip sample on the Amber category was taken and passed on to Health Board colleagues.

In terms of six Welsh Government goals, it was questioned if there was any update. Rachel Marsh updated the Board on a recent meeting she had attended where each Health Board updated Welsh Government on their progress with the six-goal programme, which overall, was positive. Further updates will be provided at future Board meetings.

In respect of the issue of Same Day Emergency Care (SDEC), Jason Killens explained there was a nationally agreed referral protocol both for front line staff and Clinical Support Desk (CSD) Staff. He added the number of patients the Trust could send was minimal and have raised this issue consistently with WG, EASC and Health Boards. Direct referral to SDEC and other appropriate pathways would help in the flow of patients through the ED.

The Board considered this point in further detail, following a concern from a Member that clinical leadership should be more robust, with clinical leaders making effective change. Liam Williams assured the Board that the level of attention across al Health Boards and the intervention by senior managers and clinicians was having an impact.

An update was sought on current Advance Paramedic Practitioner (APP) training (22 staff), their deployment, and an update on how their impact was being captured to support any future bids for APP courses. Andy Swinburn confirmed that their training was complete, and a future bid had been successful. In terms of their deployment, the Trust was testing out various deployment models to ascertain how greater productivity could be gained. Several elements were still being tested, and going forward, will consider methods of capturing this data.

RESOLVED: The Board

(1) NOTED the report; and

(2) CONSIDERED whether there were any further actions available to the Trust to mitigate patient harm.

66/23 RISK MANAGEMENT AND CORPORATE RISK REGISTER

Trish Mills presented the report indicating there were 17 principal risks listed on the Corporate Risk Register (CRR).

The principal risks were updated as of 6th July 2023 and the high rated risks have been reviewed during this reporting period in line with the agreed schedule. The Board were reminded that focus had been given to the risk ratings and the mitigating actions identified and taken to ensure risks achieved their target score.

The Trust's highest scoring 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) both continue to be rated at a score of 25. Both these risks were constantly reviewed, and it was felt too early for any change in risk score to be considered.

The two other higher rated risks Risk 160 (high absence rates impacting on patient safety, staff wellbeing and the Trust's ability to provide a safe and effective service) and risk 201 (damage to the Trust's reputation following a loss of stakeholder confidence) were currently rated at 20. Whilst there have been improvements in sickness absence it was decided by the People and Culture Committee to maintain the current score with a further review to be conducted at its next meeting.

Two risks had increased in score, 424 (Prioritisation or Availability of Resources to Deliver the Trust's IMTP) from 12 to 16, and risk 163 (Maintaining Effective & Strong Trade Union Partnerships) from 12 to 16.

There were two risks which were set for closure, 557 (Potential impact on services because of Industrial Action) and 245 (Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations). Both risks had reached their target score and will be taken off the CRR.

In terms of those risks which have remained static, details of the rationale of any movement were contained in the report.

Comments:

In respect of risk 424 (Prioritisation or Availability of Resources to Deliver the Trust's IMTP) the Board sought clarity on the impact to patients of any savings, and where this was being captured. Rachel Marsh explained that the larger savings schemes which were likely to have an impact on the quality of the service, for example overtime, were being considered.

Navin Kalia further explained that as part of the Financial Sustainability Programme the impact on quality was highlighted using Quality Impact Assessments (QIA). Also, prior to considering new savings schemes a Quality Impact Assessment would be

carried out on each scheme. Liam Williams explained that QIA guidance had recently been re-issued; enabling a more robust process.

RESOLVED: The Board: considered and discussed the contents of the report and:

(1) Noted the review of each high rated principal risk including ratings and mitigating actions;

(2) Noted the increase in score of Risk 424 from 12 to 16;

(3) Noted the increase in score of Risk 163 from 12 to 16;

(4) Noted the closure of Risk 245 from the Corporate Risk Register;

(5) Noted the closure of Risk 557 from the Corporate Risk Register; and

(6) Noted the update on the Risk Management Transformation Programme.

67/23 INTEGRATED MEDIUM TERM PLAN (IMTP) 2023 – 2026 FY23/24 DELIVERY & ASSURANCE ARRANGEMENTS (INCORPORATING POST IMPLEMENTATION REVIEW)

Rachel Marsh presented the report and drew out the following points:

1. Following Trust Board approval on 30 March 2023, the Trust IMTP for 2023-26 was submitted to Welsh Government on 31 March 2023. Formal feedback and approval, including any Accountability Conditions, was awaited.

2. Members noted that the delivery risk around Salus remained Red and had been raised for escalation by the Salus Programme Senior Responsible Owner.

RESOLVED: That the Board;

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

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

68/23 FINANCIAL PERFORMANCE MONTH 3

Navin Kalia presented the report noting it had been presented to the Finance and Performance Committee earlier in the month. In terms of highlights, he drew the Board's attention to the following:

1. Month 3 financial position was a relatively break-even one of a deficit of £33k.

2. At this stage of the financial year, the forecast was to break-even for 2023/24.

3. Capital expenditure was expected to be fully achieved in the current year.

4. Funding for the £6m 100 front line Whole Time Equivalents funded non recurringly in and appointed to in 2022/23 was fully assumed. Negotiations with Commissioners was ongoing.

5. A fully identified £6m savings plan, albeit with risks to delivery, should see the Trust balance by 31 March 2024.

RESOLVED: The Board;

(1) Noted and gained assurance in relation to the Month 3 revenue financial position and performance of the Trust as at 30th June 2023;

(2) Noted the update in relation to the Financial Sustainability Programme and progress in relation to residual savings to be identified;

(3) Noted the capital programme for 2023/24, and;

(4) Noted the Month 2 and Month 3 Welsh Government monitoring return submissions included within Appendices 1 – 4 (as required by WG).

69/23 MONTHLY INTEGRATED QUALITY AND PERFORMANCE REPORT (MIQPR) AND KEY METRICS 2023/24

Rachel Marsh presented the report as read and in terms of highlights from the report, the following was brought to the Board's attention:

1. 111 call answering was improving, with the call abandonment target of 5% being achieved in June and 59.2% of calls being answered with 60 seconds.

2. Sickness absence, this was now below 8% against the expected target rate of 6%.

Key metrics

Rachel Marsh explained that each year a review of Board level metrics was undertaken. A presentation was provided to Finance and Performance Committee in May 2023 setting out some proposed changes. These were discussed further at EMT, at a Board development meeting in June 2023, and again at Finance & Performance Committee this month. As a result of these discussions several changes have been made and the final set of metrics was set out in Appendix 2 of the report. A total of 43 metrics were proposed, which was a slight increase on those which have been reported this year.

Comments:

Kevin Davies, who had Chaired the Finance and Performance Committee meeting, supported and endorsed the proposed changes adding that a note of thanks was to be recorded for Hugh Bennett, Judith Bryce, and Jason Fernard for their respective presentations at that Committee.

Andy Swinburn highlighted the increase of Return to Spontaneous Circulation (ROSC) rates (22%), the highest recorded by the Trust, which directly aligned with the roll out of the Cymru High Acuity Response Unit (CHARU).

The Board sought clarity regarding the funding for 198 call handlers and whether this was the agreed number. Rachel Marsh explained that recruitment continued to secure this number, however there were still vacancies.

Lee Brooks gave an overview of the challenges over the next few weeks. He asked the Board to exercise caution when looking at the Unit Hours Production (UHP) percentage reporting between Emergency Ambulances (EA) and CHARU. At this stage there was a period of transition which may show an under resource of EA and an over resource of CHARU production.

Whilst some improvements have been seen in staff abstractions throughout July, it is expected that there will be an increase in August when staff annual leave is maximised. He was optimistic there would be further improvement in September, with more resources joining the Trust.

Rachel Marsh added that the Trust was looking at a new metric whereby the totality of the hours produced against what the Trust was commissioned to do, was in development.

RESOLVED: The Board considered the May/June 2023 Integrated Quality and Performance Report and actions being taken and approved the new metrics for 2023/24.

70/23 STANDARDS OF BUSINESS CONDUCT POLICY

Trish Mills advised the Board that following a limited assurance internal audit on standards of business conduct, it was recommended that a revised policy be developed.

The Audit Committee was provided with an update on the progress of management actions on the limited assurance internal audit. All audit recommendations have been addressed with one management response being extended to April 2024, and one due in August.

Members noted that the revised policy had followed a robust governance process adding that it had been reviewed by the Trust's Policy Group, and in partnership with Trade Union Partners.

A communications plan, following Board approval of the policy, will begin with the initial announcement on Siren of the revised policy and include regular announcements throughout the year, particularly at festive and religious holidays when issues with gifts is most prevalent.

The Board were given assurance that all the issues detailed in the limited assurance report have been addressed.

RESOLVED: The Standards of Business Conduct Policy was approved.

71/23 GOVERNANCE REPORT

The Board was asked to approve the affixing of the Trust's seal to a licence for alterations for unit 3 Phoenix Park, Telford Street, Newport NP19 0LW, and to note the use of the Trust Seal entry number 0239 for fence installation at the Cardiff Make Ready Depot.

RESOLVED: The Board approved the affixing of the seal to a licence for alterations for unit 3 Phoenix Park, Telford Street, Newport. NP19 0LW and noted the use of the seal for fence installation at the Cardiff Make Ready Depot.

72/23 BOARD COMMITTEE REPORTS

The following Committee highlight reports were received noting that updates had been provided earlier in the agenda.

Finance and Performance Committee – July 2023
Kevin Davies, chaired the last Committee meeting and updated the Board on several points from the report as below:

1. An update on policies was received.
2. Emergency Preparedness, Resilience and Response

Audit Committee (Verbal) – July 2023

Martin Turner advised that the main focus was on the Accounts and Annual report. A note of thanks was recorded for the teams involved in producing the report.

Trish Mills informed the Board that the Head of Internal Audit's Annual report and opinion was attached to the Committee highlight report for noting.

Remuneration Committee – July 2023

Jason Killens updated the Board on the meeting held on 26 July 2023 which considered changes to the senior leadership in the clinical services directorate as a result of the retirement of Dr Brendan Lloyd on 31 December 2023. It was further noted that the Director of Paramedicine would become an Executive Director with full voting rights on the Board on 1 January 2024. Details of ongoing recruitment to replace Dr Brendan Lloyd was also given.

RESOLVED: The Board received the above Committee Highlight Reports and received assurance that each of the Committees had fulfilled their Terms of Reference, and that matters of concern had been escalated in line with the Alert, Advise, Assure framework of reporting

73/23 MINUTES OF COMMITTEES

The minutes of the Finance and Performance Committee dated 15 May 2023 were received.

The following NHS Wales Joint Committee update reports were received:

1. Welsh Health Specialised Services Committee Joint Committee Meeting Briefing – 16 May 2023.
2. Emergency Ambulance Services Committee meeting – 16 May 2023.
3. NHS Wales Shared Services Partnership Committee meeting – 18 May 2023

RESOLVED: That the above minutes and update reports were received.

74/23 ANY OTHER BUSINESS

None

75/23 EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC – 27 July 2023

Members of the Press and Public were invited to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).

RESOLVED: The Board would meet in private on 27 July 2023.

Date of next Open meeting: 28 September 2023

Meeting closed at 12:06

ACTION LOG

WELSH AMBULANCE SERVICES NHS TRUST BOARD - FOLLOWING NOVEMBER MEETING

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
61/23	27 July 2023	CEO Update	To provide an update report on the use of analgesia by volunteers	Andy Swinburn	28 September 2023	Update for 28 September 2023 See Attached ITEM 4.1 - propose for completion	Complete
63/23	27 July 2023	Staff Story	The Chair reiterated the Board's recognition of the compassion shown and asked that the letter of thanks to Theresa included the fact the Board were fully engaged and noted the clear benefits of RITA.	Trish Mills	28 September 2023	Update for 28 September 2023 Letter sent	Complete

PENTHROX TRUST BOARD UPDATE – ACTION LOG NO. 61/23

The Penthrox training package went live nationally on the 18th April 2023. Each health board area went live once 50% of staff within the area had completed the training package. The health board areas and the Hazardous Area Response Team (HART) went live in May 2023.

HB area/ Team	Staff trained as of 06/05/2023	Go live date	Staff trained as of 31/08/2023
Swansea Bay (SB)	76%	03/05/2023	87%
Powys	94%	03/05/2023	99%
Cwm Taf	74%	03/05/2023	82%
Hywel Dda	78%	03/05/2023	86%
Cardiff & Vale	82%	04/05/2023	89%
Betsi Cadwaladr	79%	05/05/2023	89%
Aneurin Bevan	71%	10/05/2023	80%
HART	91%	03/05/2023	100%
CFRs	49%	15/05/2023	99%

From go live date to the 31st August 2023, Penthrox was administered on 1,749 occasions by Emergency Medical Services (EMS) staff and Community First Responders (CFRs). The clinical leads continue to work with teams to improve the compliance rates and reduce any variances across Wales.

	May 2023	June 2023	July 2023	August 2023
EMS	**369**	**425**	**403**	**435**
Advance Paramedic Practitioner (APP)	6	15	13	24
Senior Paramedic (SP)	3	6	4	5
Cymru High Acuity Response Unit (CHARU)	30	29	28	35
Paramedic	260	299	271	280
Emergency Medical Technician 1 (EMT1)	60	59	76	63
Emergency Medical Technician 2 (EMT2)	17	32	17	25
Emergency Medical Technician 3 (EMT3)	2	6	0	2
Ambulance Care Assistant 2 (ACA2)	12	13	19	29
CFR	**0**	**3**	**0**	**6**

*Data source: ePCR (CFR ePCR rollout commenced the 31st July 2023 and is due to be completed 30th September 2023)

During this time 106 patients were administered a second dose of Penthrox (2 occasions by a CFR). A further 2 patients were administered a third dose of Penthrox (by a Paramedic). A pilot clinical audit to measure the administration and effectiveness of Penthrox in line with the training and protocol has commenced. Following analysis, the full audit is scheduled to commence in November 2023 with a view to completing it for the Clinical Intelligence and Assurance Group approval in January 2024.

Administration by HB area (May 2023 – August 2023)

Swansea Bay	Powys	Cwm Taf	Hywel Dda	Cardiff & Vale	Betsi	Aneurin Bevan
223	108	198	256	207	454	303

Staff Feedback	
EMTs	*'We attended a patient who had fallen of his scrambler and was on the side of the mountain. The patient had sustained a knee injury and was unable to straighten his leg due to the pain. I administered Penthrox which had the desired effect and enabled the patient to straighten his leg and assist us in mobilising him in to a waiting Land Rover to extricate him from the mountain side. We were a double EMT crew so, prior to the introduction of Penthrox, would have required paramedic back up to deliver adequate analgesia for this patient.'*

	'Attended a patient in his late 50's who had been knocked off his motorbike by oncoming traffic. The patient's foot had de-gloved and the patient was in an awful lot of pain. When we arrived at scene an off duty paramedic was assisting the patient but was unable to get an IV cannula line in to the patient and didn't have access to Entonox. I was able to offer the patient Penthrox which took the edge off the pain immediately. I have never seen anything like it. The patient was more relaxed which enabled the off duty paramedic to get an IV cannula line into the patient.'
CFRs	*'I have used it and have only positive things to say about it!'* *'The last time i used it was on a coast path, where a lady had fallen and suffered a badly broken ankle. On arrival, her pain score was 10+, but within 5 minutes of receiving Penthrox, her pain score was a 5 and then 15 minutes later, was a 2.'* *'It's a great addition to our CFR toolkit and is only going to benefit the patients.'*

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

CHIEF EXECUTIVE REPORT: 28 SEPTEMBER 2023

MEETING	Trust Board
DATE	28 September 2023
EXECUTIVE	Jason Killens, Chief Executive
AUTHOR	Jason Killens, Chief Executive
CONTACT	Jason.Killens@wales.nhs.uk

EXECUTIVE SUMMARY

This report is presented to the Trust Board to provide awareness of the Chief Executive's activities and key service issues since the last Trust Board meeting held on 27th July 2023. It is intended that this report will provide a useful briefing on current issues and is structured by directorate function.

RECOMMENDATION

That Trust Board note the contents of this report.

KEY ISSUES/IMPLICATIONS

This report is for information only to ensure Trust Board are aware of the Chief Executive's activities and key service issues.

REPORT APPROVAL ROUTE

The Trust Board meeting held on 28 September 2023.

REPORT APPENDICES

An SBAR is attached.

REPORT CHECKLIST

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

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

Annex 1

SITUATION

1. This report provides an update to the Trust Board on recent key activities, matters of interest and material issues since my last report dated 27 July 2023.

BACKGROUND

2. This report is presented to the Trust Board to provide awareness of the Chief Executive's activities and key service issues. It is intended that this report will provide a useful briefing on current issues and is structured by directorate function.

ASSESSMENT

CHIEF EXECUTIVE

3. Since the last Trust Board meeting, examples of items of note include:

- Attending frequent meetings with key stakeholders such as NHS Wales CEOs, the Director General of NHS Wales, Blue Light Service Leaders, Trade Union Partners, Commissioners, AACE, EASC and senior elected representatives.
- I attended the first of two Volunteer Conferences at Venue Cymru on Saturday 9th September. The second will take place on 14th October at the Guildhall, Swansea. These are the first such Volunteer Conferences since the pandemic to celebrate the important contribution made by our volunteers and share the planned improvements to better support our Volunteer Care Drivers and Community First Responders.
- I undertook a ride out on an Emergency Ambulance in Cardiff at the end of July. It was very insightful to listen and learn more about the challenges faced by our EMS clinicians.
- I undertook an interview with BBC Wales about the steps we are taking as a result of the findings of our sexual safety survey and the subsequent organisational journey to ensure our people our safe and our Culture is transformed.
- Executive Leadership colleagues had two away days to further develop the Insights profiling and further develop the plans for the implementation of the Trust's long term strategy.
- I was delighted to present Commendations to five members of staff at Olcha Comprehensive School in Swansea to recognise their fantastic life saving CPR and quick thinking which successfully resulted in a ROSC following a pupil suffering a cardiac arrest. I am pleased to report that the pupil has made a complete recovery and returned to school.
- My COVID-19 Module 2B statement has been completed and submitted to the Covid Inquiry. Work continues on my statement in respect of Module 3.
- I met with the North Wales Conservative MP Group to provide a briefing on the Trust performance and future plans.

- On 24 September 2023 I was pleased to release a short video internally and via our social media channels charting some of the major achievements and changes that have taken place at WAST in the five years I have now been Chief Executive. The video also makes mention of some of the key challenges whilst looking ahead to the next five year to 2028.

OPERATIONS DIRECTORATE

Manchester Arena Inquiry Report (MAI)

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

Volunteering

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

Continued System Pressures

6. Delayed handover of care at Emergency Departments across Wales remains a significant challenge in being able to provide a safe level of care. 33,081 hours were lost in April 2023, 20,397 in May 2023, 18,543 in June 2023, and 19,118 in July 2023. The impacts of the pressures are regularly discussed by the Executive Team, Committees and Trust Board.

Red performance and Amber response

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

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

9. Reduced overtime allocation due to the Financial Savings Plan requirement has resulted in reduced UHP.

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

Delivering on Financial Savings Plan

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

Capacity Management Plan (CMP)

12. Following the introduction of the CMP to manage eligibility within Ambulance Care, the team have reviewed and implemented changes to improve the management of activity. This allows Ambulance Care to ensure eligible users are prioritised above ineligible patients. This also enables Ambulance Care to maintain a focus on financial stability throughout the year. The changes were supported by the Delivery Assurance Group and work continues to improve the NEPTS application of the Eligibility Criteria.

Vehicles Development

13. The delivery and operational commencement of the new MAN B class Ambulances had been delayed but since delivery of vehicles last month the Trust has been able to fit the relevant communication and other equipment and they are ready for service. A training plan will be devised and a roll out programme for Barry and Bassaleg Stations will be implemented before an evaluation of the new vehicles performance is undertaken to inform any future developments and procurement.

ECNS Accreditation

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

EMSC Culture Programme

15. The EMSC Culture Programme has commenced with meetings chaired by the Director of People and Culture. Senior leaders in the EMSC team have met with Trade Union Partners to discuss culture, behaviours, and concerns to design an action plan for improvement. As part of this work a Staff Experience agenda item has been added to the EMSC Quality Meeting which will be Chaired by the Service Manager for Operations Quality from 23 September 2023. This forum gives a platform for EMS Coordination staff to share their experiences of working in EMSC with the Senior Leadership Team. The Group has heard powerful presentations from the Carmarthen EMSC Culture Champion and a North Wales 999 Call Handler and it is hoped to have a representative from Vantage Point House at the next meeting in later this month.

DIGITAL SERVICES

Mobile Data Vehicle Solution

16. As part of the Operational Communications Programme, and following on from the Control Room Solution project which was deployed in April, the next milestone involves implementing a new Mobile Data Vehicle Solution (MDVS) across the fleet. This includes replacement of the mobile data terminals (MDT) on vehicles, and introduction of a new National Mobilisation Application (NMA).

17. At the last Trust Board, we noted that the pilot had successfully gone live with 3 vehicles in the North, and was generating great learnings. The pilot is now expanding into Central and South Wales with 3 more vehicles already online, and an additional 6 vehicles expected to undergo installation in Cardiff during September.

18. A new version of the NMA is being tested within WAST which is the first version to include an application for NEPTS as well as for EMS. This application allows separate volume controls for voiced navigation information, as well as allowing each Trust to define how acronyms should be voiced, improving understanding and efficiency of communications between control rooms and field staff and enabling WAST to improve the pronunciation of Welsh words.

19. A training workstream is also underway, with MDVS training materials for EMS already having been published on the Learning Launchpad for operations. This content includes videos produced by the Ambulance Radio Programme highlighting the reason and need for change. The materials also demonstrate how the system works, and links to ESR for self-declaration of the competency, offering visibility to managers.

Digital Reporting

20. The Digital Team have recently developed two new monitoring reports. The first, which presents key metrics on the Trust's information governance and information security, will be presented to QUEST on a quarterly basis offering oversight and assurance of regulatory compliance areas, any breaches, and progress towards improvement plans (particular in relation to our Information Governance Toolkit submission and the Network and Information Systems (NIS) regulation requirements). The second report looks inwardly at progress of the Digital Strategy (as published in 2020) and key measures of Digital systems, infrastructure, and service quality. This overview will be presented to Finance & Performance Committee for scrutiny on a bi-monthly basis.

DOS Data Improvements

21. The Directory of Services (DOS) has recently received an upgrade, whereby two new external data feeds for Pharmacy Information Services have been merged into the DOS back-end, providing hourly updated intel of live services for five pharmacy services (Common Ailment Service, Emergency Medicines Supply, Emergency Contraception, Independent Prescribing, and Sore Throat Test & Treat). The key benefits of this development for WAST service delivery are:

- More accurate patient-facing information on the NHS Wales 111 website, reducing the need for the public to ring 111 for services.
- More accurate signposting from within 111 for key / highly utilised pharmacy services.
- Reduction in call backs to the NHS 111 Wales service due to lack of provision (e.g. incorrect opening times).
- More accurate signposting to GP Out-of-Hours, with the email inclusion.
- An improved patient experience.

STRATEGY, PLANNING AND PERFORMANCE

Strategy, Planning and Transformation

22. The Planning and Transformation Teams have been developing planning and project frameworks which align to the Trust's Quality and Performance Management Framework organisational requirements. Strategic Transformation Board has signed off a Planning Framework which sets out how the Trust will develop plans throughout the planning cycle at directorate level and through the Integrated Medium Term Plan (IMTP) development. A timeline for developing the next IMTP is underway with the first collaborative planning sessions scheduled to take place in October 2023 and sessions with the Board planned throughout quarters 3 and 4. To inform our internal and external plans, working with Health Boards and other partners, the team has also developed a framework for Gathering Intelligence,

Sharing Information and Influencing the System which sets out how and where intelligence can be sought on system wide operational and strategic change and where that needs to be directed across the organisation to help us play our part in influencing system wide change. The Assistant Director of Planning & Transformation (ADOP) is also engaged with the NHS Wales ADOPs network in reviewing strategic service changes across Wales to inform Directors of Planning about the opportunities for collaboration and regionalisation.

23. A key issue for Health Boards is the current financial sustainability issues, and the Assistant Director of Planning worked with Operational Senior teams on additional savings proposals which have been submitted to Welsh Government, undertaking Quality Impact Assessments and Integrated Equality Impact Assessments to ascertain the impact of the proposals. Health Boards have paused some of the projects that we have been working with them on, particularly in North Wales. However, key workstreams continue in the South East with full WAST engagement, particularly regional ophthalmology, orthopaedics and diagnostics as well as changes to pathways such as Critical Care in Cwm Taf Morgannwg, for which WAST may be required to change some patient transport arrangements. The team also continues to engage with Health Boards through the Integrated Commissioning Action Plan meetings and Six Goals meetings. Our engagement with the Six Goals programme has increased as the Director of Planning now sits on the national programme board and other colleagues across WAST attend six goal programme groups nationally and at health board level, reporting into WAST's Integrated Strategic Planning Group and onward to STB where required.

24. The development of a Project Path Framework and associated templates to support IMTP delivery is underway. In addition to the development of the framework, the team is in the process of building and testing the Verto 365 project management platform. This platform will standardise the way that projects are delivered and controlled, by replacing local project control tools held in various formats including MS Excel, MS Word and MS PowerPoint making assurance reporting more efficient and reducing the risk of duplication. The current IMTP delivery structures are being reviewed to identify any opportunities to streamline and/or improve alignment with the organisation's transformation journey in light of the need to be a more efficient organisation. A paper on IMTP delivery assurance is included in the papers for Trust Board and has been reviewed by Finance and Performance Committee.

25. The Strategy Team have continued to support discussions with Board members and the Executive Team to review the organisation's Long Term Strategy 'Delivering Excellence'. Opportunities have been identified to further strengthen the strategy and future vision of the organisation, with a requirement to develop a longer term internal delivery plan up to 2030. Work is continuing to prepare an internal communications briefing to further promote and embed the Trusts' recently agreed Purpose Statement. The team are also supporting a review being conducted by Internal Audit into the 'arrangements to support the development of the Trust's strategic ambitions.

26. Further work has been undertaken with PWC to strengthen the Strategic Case for Change to support our EMS transformation plans with the final version to be ready by mid September (at the time of writing). Preparatory work is underway to undertake a focussed internal communications campaign to support our EMS Transformation Plans, commencing in October. Work is also underway to refine the Engagement Delivery Plan in readiness for Phase 1 engagement with key system leaders and influencers in Q3. The Strategy Team continue to support a range of key transformation work streams, this has included supporting Phases 1 & 2 of the 'APP Flooding' test of change initiatives conducted in June & August, and preparatory work for Phase 3 planned for the end of September.

Commissioning & Performance

27. The Commissioning & Performance Team continues to service the multiple commissioning interfaces (111 & EASC), Welsh Government accountability mechanisms (IQPD and JET) and its own Board/Committee performance accountability mechanisms. The national review of commissioning has concluded with the recommendation of a new national commissioning function coming into force on 1 April 2024. This is viewed as a positive step for the Trust, both in terms of its strategic ambitions and potential streamlining of reporting. The Monthly Integrated Quality & Performance Report has also been formally reviewed in the first half of the year, with the indicators being updated to further align to the Trust's strategic ambitions and areas of focus, for example, sexual safety.

28. The Team continues to support the Trust with strategic and tactical forecasting and modelling information. Recent work includes the rebasing of UCS, a new EMS strategic demand & capacity review (expected to conclude in November 2023), financial savings impact modelling and winter forecasting and modelling. Developmental work is also being undertaken on improving the accuracy of the two simulation software models used, through improved data feeds and automated feeds. A 111 re-roster project (effectively a demand & capacity review) of 111 call handlers is imminent, subject to final agreement on its funding by 111 Commissioners.

29. The Team is also continuing to support the Trust on operationalising changes identified through commissioning, performance, forecasting and modelling. Examples include the EMS Operational Transformation Programme (CHARUs, EMS Co-ordinational Reconfiguration) and tactical EMS workforce planning.

FINANCE AND CORPORATE RESOURCES

Finance

30. Audit Wales concluded the year end audit in July. The 2022/23 Annual Report and Accounts was signed off on 25 July and 27 July 2023 by the Audit Committee and

Trust Board respectively, while the unqualified audit opinion was signed off on 28 July 2023 by the Auditor General for Wales. The Annual Report and Accounts and other associated returns were submitted to the Welsh Government via Audit Wales by the deadline of 31 July 2023. The approved 2022/23 Annual Report and Accounts was presented to the AGM on 27 September 2023.

31. The Finance Team continues to play a key role in helping the organisation to work through and deliver the significant £6m savings plan required for the 2023/24 financial year. Themes and schemes to aid delivery have been fully identified and focus is on delivery over the remainder of 2023/24. The Finance Team continues to support the Financial Sustainability Programme (FSP) and the identification of schemes/themes for this and future financial years.

32. Work will begin over the next few months to build the financial plan for next and future financial years to support the emerging IMTP cycle for 2024/25 and beyond. Work is progressing well on evaluating the use of automation along with progressing the development of the Patient Level Information Costing system (PLICs), both the financial and activity data has been uploaded into the system, and the process of quality checking, reconciling and reviewing data has commenced to ensure consistency and the data accuracy. The team are now meeting weekly with the supplier to ensure any issues can be resolved to expedite the process. This will be a key underpinning element of the continuing progress on our VBHC agenda.

Capital & Estates

33. **South East Fleet Workshop** - The project is on course to be completed by the end of September 2023, with the Commissioning Team already in occupation and the Fleet Team in the process of relocating. Decommissioning plans for Blackwood and Blackweir are being progressed, with an intention that the Blackweir site will be decommissioned through late September/October. Consideration will be given to the Blackwood site to explore the potential to improve capacity for Operational Teams, however, it should be noted that funding has not yet been identified.

34. **Dolgellau** – Discussions are ongoing between NWSSP and the landlord regarding the lease. A business case has been developed for consideration by Executive Leadership Team. In support of the planning application process, a drop-in public engagement session was held on 30th August 2023 and this feedback will be collated in support of the process. Costs and timescales are challenging, and the scope of works has been identified to align with the available cost envelope.

35. **Ruthin** – Full planning permission has been granted, and the tender scoring and procurement process is underway. It is anticipated that work will commence on the construction of an extension to the fire station which will house a Social Deployment Point during October 2023. It is hoped that the project will be completed before the end of the financial year.

36. **Monmouth** – Options continue to be developed in collaboration with South Wales Fire & Rescue Service and Gwent Police. Early design proposals and spatial requirements have been agreed by each organisation and cost plans have been prepared. Initial cost proposals have been received by the Trust and these will be scrutinised in more detail. Early indications are that the total investment required for this project would be significantly more than the costs estimated for an independent Trust project.

37. **Swansea** – Land options in the area remain limited, and engagement is continuing with NWSSP Estates. A preferred site within Fforestfach is being explored following discussion at the Project Board and heads of terms are being sought. A resource schedule will be developed which will support the funding required for the initial stages for inclusion in a BJC to Welsh Government.

38. **Decarbonisation/Estates Funding Advisory Board (EFAB)** – The EFAB Project Team is meeting on a regular basis to manage the project through its 2 year timeframe. Tender specifications are complete for the North Wales projects, with work ongoing to finalise the specifications for the South Wales projects.

39. **Newport Ambulance Station** – this project has been established with the development of a Project Initiation Document, Terms of Reference and site searches. Meetings with Operational colleagues have been held at 2 potential locations and feedback provided to the Capital Project Team. This work has been overtaken in recent months by more urgent works required at Bassaleg and Cwmbran.

40. **Bassaleg** – Work has been completed at Bassaleg to demolish the mortuary and develop the car parking space, to provide greater external capacity at the station. Challenges within the station footprint capacity continue, and it is hoped that colleagues moving to Phoenix Park will reduce numbers at the station. At the moment additional funding has not been identified for further improvement works on the site.

41. **Cwmbran** – This is a leasehold site which the Trust has had since 1998. Due to a significant increase in the rental costs under a 'section 25 notice', WAST has served notice to the landlord to vacate the site. Staff based in Cwmbran Ambulance Station will move to Beacon House in October 2023. Some minor enhancements will be made to support the additional staff moving to the Beacon House station.

42. **Llangunnor** – this project was prioritised for progression in 2023/24 with an anticipated completion date in 2024/25. Therefore, project management and capital delivery resource has been identified and work will start in on the project. A meeting was held with Dyfed Powys Police and colleagues from the Design Team on 15th September to further scope the requirements and begin the design work. The first deliverable will be to produce the plans for agreement and start work on the development of a business case.

43. **North Wales CCC Estate** – A North Wales CCC Project Board will be established and it is anticipated that project management resource will be provided by the Strategic Planning and Performance Team. A project manager and capital delivery manager resource will be identified to oversee the estates element.

44. **Reinforced Autoclaved Aerated Concrete (RAAC) -** In line with other NHS Wales organisations, the Trust conducted a detailed independent inspection of all potentially effected sites built up to 1990 and it was confirmed that RAAC was not present within the estate. In addition, further detail has been sought for buildings where WAST colleagues share estate with Fire and Rescue Services.

45. As a result of a subsequent request by NWSSP Shared Estates Services to increase the scope of the RAAC surveys for buildings built prior to 1995, further work was undertaken on the estate built up to 2000, including a number of surveys, and it was confirmed that RAAC was not present.

Fleet

46. The delivery of the Vehicle Replacement Project from 2021/22 was complicated by many global supply factors, however, it is almost complete with the majority of the remaining 17 Renault Masters being converted into a mixture of double wheel chair accessible vehicles and stretcher bearing vehicles. All stretcher bearing vehicles will be equipped with bariatric capability equipment to provide greater flexibility when planning and allocating workloads. The majority of the vehicles are in service with the remaining going through the commissioning process.

47. The following provides the current position of the 2022/23 fleet replacement programme:

- The 50 Mercedes Sprinter Emergency Ambulances were completed on target and are in service pan Wales. These were the first to be powered by the smaller more fuel efficient engine and an improved automatic gearbox. The vehicles have been well received by staff who have provided positive feedback.
- There are still delays in the delivery of the 15 Ford Transit Customs ordered in April 2022, with just 4 vehicles being delivered to the nominated convertor. The remaining 11 vehicles had their build dates delayed to September.
- Twenty of the 22 Renault Masters ordered at the say time as the Fords have been delivered to our nominated convertor. The conversion of the first 11 to a stretcher bearing variant is well underway and the remainder will be converted into double wheelchair accessible vehicles.

48. The 2023/24 Fleet BJC which contained further potential for decarbonisation and EV initiatives was approved by the Trust Board in November 2022 and submitted to Welsh Government. The amount of funding made available by Welsh Government was significantly less than requested which resulted in a detailed review process and a decision was made to prioritise the procurement of 41 Emergency Ambulance

chassis. These went into production last month and deliveries to the nominated converter has begun.

CLINICAL DIRECTORATE

RAPID2 Trial

49. RAPID2 is a randomised controlled trial involving four UK ambulance services and partner hospitals. The aim of the study is to test the safety, clinical and cost effectiveness of paramedics providing a fascia iliaca compartment block (FICB) as pain relief to patients with suspected hip fracture in the prehospital environment. Duncan Robertson (Assistant Director of Clinical Development) is acting as the Trust's Principal Investigator and Charlotte Evans, Clinical Research & Innovation Officer, is facilitating the required paramedic training. To date the Trust has recruited 25 paramedics who have completed training Stages 1 & 2 with 16 booked onto Stage 3 (Theatre Placements).

Corpuls Defibrillator and ePCR Update

50. The next software development kit (SDK) update for the Corpuls defibrillators used by the Trust will see the defibrillators being able to integrate with the Trust's electronic patient care record (ePCR), enabling clinicians to link patient electrocardiogram data to the patient's ePCR and transfer patient observations directly into the ePCR. This much anticipated SDK will not only help to integrate essential information into the ePCRs but will also improve the efficiency of patient care by enabling sharing of the data with healthcare professionals in the hospital setting. Likewise, it will automate the input of data into the Corpuls mission file ensuring Corpuls mission files are identifiable. The roll out of the SDK started this month with the Cardiff and Vale area already completed. When all Corpuls are updated the ePCR software update will be activated.

Clinical Support Desk & Advanced Paramedic Practitioner Test of Change

51. The second Test of Change day was carried out on 22 August as a Plan-Do-Study-Act (PDSA) exercise, with APPs supporting in the CSD, responding to filtered patient calls aligned to their skill set. This is preparatory work in support of the strategic transformation of the Trust and focussing on optimising care for patients and delivering care in the community where possible. The third Test of Change day is being planned for 5 October with evaluation and lessons learned feedback from the previous cycles being incorporated.

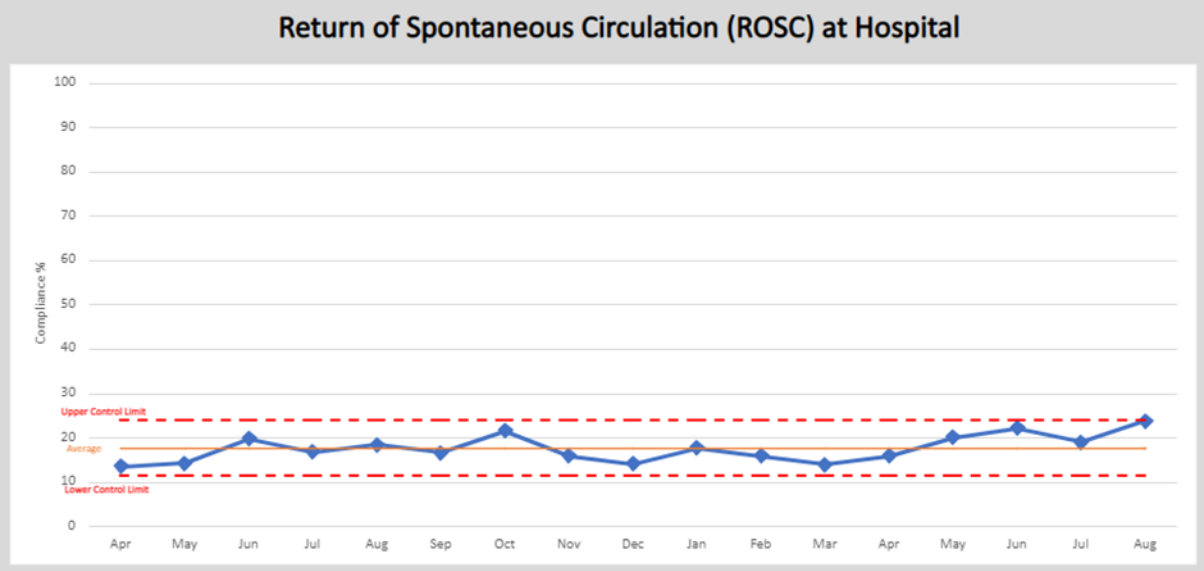
HSJ Awards

52. The Trust's Macmillan and End of Life Care Project Team, led by Clinical Lead, End of Life Care Ed O'Brian and Project Manager, Andeep Chohan, have been shortlisted for the final of their category at the HSJ Awards. In addition, alongside Swansea Bay

University Health Board, the team are finalists in the Provider Collaboration of the Year Award for the excellent and innovative work that has been done with the Rotational Palliative Care Paramedics model. Congratulations to all on reaching the final and best of luck to the team for the Awards in November.

Increased ROSC Reporting

53. Despite the challenges facing Red performance in the current climate, there has been a further increase in the reporting of Return of Spontaneous Circulation (ROSC) since the introduction of changes in the area of clinical/operational delivery within the Trust. This includes, amongst other factors, clinical decision making and clinical leadership through the Cymru High Acuity Response Unity (CHARU) and the Senior Paramedic roles. We have also seen improvements in community resilience with an increased number of Public Access Defibrillators (now totalling 8,000) and people who have registered with 'The Circuit' to become guardians of the defibrillators.



PEOPLE AND CULTURE DIRECTORATE

Culture

54. The first phase of the Strategic Equality Objectives consultation and engagement has been completed. Feedback from the survey and PECI Team engagement has been analysed by the People and Culture Team and Non-Executive leads for EDI and has been discussed at Executive Leadership Team. Four key themes have emerged which will be used to shape the draft objectives.

55. In line with our commitment to build an inclusive culture for all of our people and ensure a sense of belonging, Active Bystander and Allyship training continues to be rolled out, with further sessions scheduled throughout the autumn. Since the launch of the training in May 2023, 141 members of staff have attended the full day training in person. The next batch of training sessions will now be delivered remotely to allow

accessibility for all staff members across Wales. This includes a further 10 sessions (200 spaces) until the end of January, with over 50% of those already booked. The EDI team have developed a detailed feedback form to evaluate the training which staff are asked to complete at the end of each session. Feedback is used to update the training programme content and to inform future training sessions.

56. Linked to our objective to amplify employee voices, a review of Staff Networks is underway with a view to establish a new Staff Disability Network. The LGBTQ+ Staff Network continues to thrive with members attending the AACE LGBTQ+ 2 day conference in Manchester and several PRIDE events across Wales.

57. The Culture Champion network is flourishing as it continues to expand its reach. The current focus of the Champions remains on embedding WAST 'Be Our Best' behaviours. As a result, inspiring success stories and positive experiences are being shared across Team WAST and some Culture Champions are actively working with their team to show how the behaviours can effectively be applied to daily work.

58. "Compassionate Practices For All" was launched in November 2022 and is linked to the wider NHS focus on "Just Culture" and creating the right conditions for all staff to feel confident to speak up when things go wrong. Recognising the impact of conduct issues on all parties, we have committed to improving how we undertake employee investigations, ensuring we prioritise the wellbeing of all those involved in investigations and disciplinaries.

59. A total of 125 staff have attended a training session on compassionate practices and we have utilised feedback from the training sessions to inform our high level Action Plan. Working closely with our Trade Union Partners, we are focusing on increasing support and improving timeframes associated with employee relations cases. We continue to roll out training for our managers and trade union partners, with further sessions held in September and planned for October. We are also reviewing our current employee relations data, to establish our baseline and understand the current position. We will use this assessment to inform our actions and identify trends. As we move this work forward, we are planning to review our disciplinary documentation, ensuring it is clear, supportive, and fit for purpose, together with designing some bitesize training to support managers in undertaking elements of the disciplinary process. Our aim is to support our people and ensure that harm to individuals is minimised.

60. Building on the theme of "Just Culture", The Organisational Development Team is working towards the upcoming launch of the Freedom to Speak Up process, scheduled for October. This process represents a significant milestone in our commitment to creating a safe and transparent work environment and aligns with the recent publication of the All Wales Speaking Up Safely Framework. It will provide all colleagues with an additional safe channel to voice their concerns, knowing that their feedback will be treated confidentially if they wish, without fear of retribution.

We believe that fostering open communication and trust is crucial for developing a positive and inclusive culture.

61. Our proactive media exclusive with BBC Wales provided an online news piece and TV coverage to share the organisational journey of sexual safety, learning so far, different interventions used and how we are continually evaluating the impact of our approach. This transparency has enabled collaborative work to commence with external partners and has provoked discussion and elevated internal engagement for us to build upon.

Capacity

62. As per our commitment to enhance the experience of all of our people, two National Volunteer Conferences were scheduled for September and October to recognise the important contribution that volunteers make to the organisation. A key focus of this will be an offer of support to our existing volunteers to help with their health and wellbeing. Members of the People and Culture Team will attend both events to engage with attendees and to facilitate workshops and deliver sessions throughout the day.

63. A 'Moving on Interview' Process has been developed to replace the Exit Interview Policy and to provide more meaningful intelligence to ensure we understand why colleagues are leaving WAST and to help identify reasons and target our retention plans appropriately. The process includes the completion of an electronic questionnaire via MS Forms, with questions that have been designed to encourage the employee to candidly share their experience on key themes and factors including role insights, training and development, workplace relationships, well-being, diversity, and inclusion. Individuals are then given the opportunity to have a meaningful conversation with their line manager or the People Services Team. The approach is currently being trialled in 111, Powys EMS and Hywel Dda EMS to test its effectiveness before an evaluation exercise.

Capability

64. A new advisory service for staff undertaking EQIAs has been introduced with advice provided on 16 projects and policies to date. The next step in improving EQIA mechanisms within WAST includes reviewing the EQIA policy and templates. Discussions have also taken place with the Board Secretary to align EQIA to other impact assessments and plans are in place to develop new guidance for staff.

65. Additional Learning and Development Managers (LDMs) have completed Practical Obstetric Multi-Professional Training (PROMPT) and the team has assisted in the delivery of community PROMPT to midwives and other WAST colleagues. In August, the first five LDMs also successfully completed the CHARU development course and will be involved in future delivery.

66. In response to locally identified training needs, bespoke training sessions have been delivered by the Education and Development team at locality level, specifically around cord compression transfers, safe use of stretchers and thrombolysis. We have continued to assist colleagues back into operational duties through the Return-to-Work programme and we developed new training videos which have been added to the Learning Launchpad for colleagues to reference to maintain their skills and knowledge.

67. Colleagues involved with facilitating education and training within 111 and CSD have been able to undertake a training session (three facilitated pan Wales) to aid their progress with the Level 4 Certificate in Education and Training qualification. We also hosted the third Aortic Dissection webinar for EMS colleagues which was facilitated by Dr Graham Cooper and his colleagues at the Aortic Dissection Charitable Trust.

68. Following a recent Leadership Symposium where the Insights psychometric tool was used to discover more about leadership and working style, the OD team is now collaborating with managers to explore ways this tool can be used with their teams to provide them with valuable insights, enhancing their communication and decision-making capabilities and fostering a culture of self-awareness and continuous improvement. Understanding more about our self and others, and our personal impact is an important part of building a positive relationships at TEAM WAST. We will be building on this work for the forthcoming, autumn event.

QUALITY SAFETY AND PATIENT EXPERIENCE DIRECTORATE

Quality Improvement - SBRI Phase 2 Approval/Progression

69. Having evaluated Phase 1, the Small Business Research Institute (SBRI) led challenge to industry for 'innovative solutions to support the Welsh Ambulance Services NHS Trust (WAST) manage more patients safely at home and to avoid conveyance to the Emergency Department (ED)' has successfully progressed to Phase 2.

70. Advanced discussions with Health Board Leads have since received considerable support for project collaboration and formal approval mechanisms have commenced for the Luscii remote monitoring solution. Given the necessary dependence on external services (radiology and radiography assets), the project board agreed for Fujifilm mobile diagnostics to be Health Board led. Subsequent engagement with Cwm Taf Morgannwg University Health Board has proven positive, with an agreement in principle for them to lead. Further work aligning Connected Support Cymru workstreams continues at pace.

Patient Experience & Community Involvement (PECI)

71. The Bevan Commission is currently exploring how to create a sustainable model for future health and care in Wales. Work will commence this autumn with a first draft of a report expected at the end of November. Activity on gathering insight and understanding from the public using a survey and a series of seven 'town hall' style workshops is planned with surveys being completed by end of October and Workshops by the end of November 2023. The PECI team will attend the workshops and ensure wide dissemination of the survey to the public through its public networks.

Infection Prevention & Control (IPC)

72. As we move into Autumn and Winter there will be an increase in respiratory and Covid-19 infections, with a particular focus on new variants circulating in the UK. These are potentially concerning and a timely reminder that good, intelligent, and instinctive use of transmission-based IPC precautions are imperative to keeping our patients and staff safe. Covid-19 and Influenza vaccine boosters will be available for staff and the public via the Health Boards in Wales, and we are actively encouraging our colleagues to receive them.

73. Following the COVID-19 Pandemic guideline, the Trust published refreshed IPC Guidance on 25 August 2023 confirming how and when personal protection measures should be adopted, with a particular focus on ensuring the protection of those most at risk from infection due to frailty and underlying health conditions.

Health and Safety Internal Audit Report

74. Audit Wales reported on their Health and Safety Audit reviewing the Trust's structures and arrangements for complying with Health & Safety legislation. The audit follows significant investment by the Trust in a transformation programme for the Health and Safety function across the organisation. It was positive to receive a 'Reasonable Assurance' opinion for all six key objectives included in the audit and areas for additional assurance, such as a refreshed Health and Safety Policy, had mitigating plans in place for timely delivery.

PARTNERSHIPS AND ENGAGEMENT

75. August was dominated by a BBC Wales story about sexism and sexual harassment at the Welsh Ambulance Service, which had been in the planning for several months with Health Correspondent Jenny Rees and People Services colleagues. Key to this pro-active media approach was colleagues with lived experience, to whom we are grateful for their courage and honesty on this sensitive issue. Feedback from staff and stakeholders suggests that while it was a bold move reputationally, it was an important step in addressing the issue.

76. ITV Wales Sharp End has been filming with an Advanced Paramedic Practitioner in North Wales for an upcoming episode about how the public access NHS services,

and the Chief Executive also recorded a number of podcasts about our ambitions to transform the way we deliver services. A paramedic with skin cancer urging others to recognise the signs and symptoms was also among our top-performing news stories over the summer.

77. The BBC One series Critical Incident aired an episode about the assault of a Barry paramedic, whose subsequent panic attacks left her unable to work. An evaluation of the #WithUsNotAgainstUs campaign, launched by WAST in May 2021 to try and reduce assaults on emergency workers in Wales, has begun in earnest. We also collaborated with blue light partners in North Wales on a new campaign to educate road users on what to do when emergency service vehicles approach.

78. Preparations for the annual WAST Awards in October have been gathering pace. More than 350 nominations have been received across a dozen categories ahead of the first in-person WAST Awards since 2019.

79. There remains significant political and stakeholder interest in a wide range of issues, including performance. As part of the mitigation of reputational risk, extensive stakeholder engagement briefing, media relations work, patient experience and internal communication and engagement continue. The Director of Partnerships and Engagement and wider Executive Team discuss matters of reputation on a regular basis and the Trust's approach to stakeholder engagement is regularly reviewed in this context.

80. Work is also underway to refine the Trust's approach to engagement in respect of its transformational journey, with the Directors of Partnership and Engagement and Strategy, Planning and Performance and their teams working closely together on this, with a view to a short internal focus on this in October prior to staff roadshows in November.

81. Opportunities have been explored with the Gwent RPB on funding for an enhanced falls service across the Aneurin Bevan UHB area, which has met with agreement in principle. Further work is needed to consolidate both service and funding commitments.

CORPORATE GOVERNANCE

82. The eight year tenure of the Trust's Vice Chair, Professor Kevin Davies, ended on 31 December 2022. Appointments of the Chair, Vice Chair and Non-Executive Directors are made by the Welsh Government and campaigns are run and managed by the Public Appointments Unit. Following a campaign for the Vice Chair position that closed in October 2022 an appointment was not made by Welsh Government and Kevin's tenure was extended, with a recent further extension to 1 December 2023. Our thanks goes to Kevin for his continued support of the Trust. The Trust is in discussion with Welsh Government and the Public Appointments Unit regarding a further campaign for the post.

83. As part of the work in the development of a Welsh Language Workforce Plan, engagement work has commenced with the National Centre for Learning Welsh regarding Welsh language confidence sessions for Trust staff who would like to increase their confidence in speaking Welsh with our service users. On 11th August our Welsh Language Services Manager, Melfyn Hughes and Richard Lewis, a CFR volunteer from the Pwllheli area, attended this year's National Eisteddfod at Boduan, Gwynedd where WAST had an exhibition stand as part of BCUHB's exhibition tent. This was a valuable opportunity to engage with our service users and the WAST stand also received a special visit from Eluned Morgan, Minister for Health and Social Services. The Trust's new Welsh Language Translator, Kate Evans, started work for the Trust on 30th August 2023. Over the coming months a WAST translation service will be developed and a managed approach will be taken in introducing Trust service areas to the new translation service.

84. The Trust's preparation for its participation in Covid-19 Public Inquiry continues with the gathering of evidence in response to Rule 9 requests from the Inquiry Team. The second preliminary hearing for module 3 will take place on 27th September 2023 with a public hearing anticipated in 2024.

85. A recent effectiveness review of the Executive Management Team resulted in amended terms of reference, a revised and focused approach to the agenda and a change of name to the Executive Leadership Team (ELT). The Assistant Directors Leadership Team will shortly undergo a similar effectiveness review.

86. The cycles of business for the Board Committees and timeline documents to support good governance are being presented to Directorates at their monthly meetings. This enables report writers to understand the methodology used in developing the cycles and the rationale for reporting during the year. This, coupled with the timelines for agenda setting, commissioning and submission of papers also enables Directorates to scope their work plan for the year to ensure reports manage their way through the appropriate governance structures.

87. A prioritisation of policies past their review date is the next step in the policy improvement programme with the Audit Committee reviewing these at their meeting on 14 September. The Policy Group has developed a programme of work which includes a refresh of the Policy on Policies with this work being monitored by the Executive Leadership Team and Audit Committee.

88. The Risk Management Framework includes the policy, procedure, guidance and platform, as well as the transition to a more strategic Board Assurance Framework (BAF) as key elements of the programme. Marinela Stoicheci, Risk Officer, joined the Risk Team this month and her expertise will enable us to focus on charity risks and directorate risks to further strengthen the excellent risk culture that is developing in the Trust.

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

ACTIONS TO MITIGATE REALTIME AVOIDABLE PATIENT HARM IN THE CONTEXT OF EXTREME AND SUSTAINED PRESSURE ACROSS URGENT AND EMERGENCY CARE
- PROGRESS UPDATE -

MEETING	Trust Board
DATE	28th September 2023
EXECUTIVE	Jason Killens, Chief Executive
AUTHOR	Jason Killens, Chief Executive
CONTACT	Jason.Killens@wales.nhs.uk

EXECUTIVE SUMMARY

1. At its July 2022 meeting Trust Board received and discussed a report relating to avoidable harm. The report identified: -

   "Sustained and extreme pressure across the Welsh NHS urgent and emergency care system has negatively impacted patient flow through all hospital sites. This pressure has led to a substantial growth in emergency ambulance handover lost hours.

   The workplace experience for our people has been under considerable stress leading to pressure on overall attendance rates which has reduced the number of hours we are able to produce.

   These and a range of other factors have meant that response times have deteriorated significantly. Delays in community response and those associated with a delayed transfer from the ambulance on arrival at the emergency department to a suitable hospital bed have led to a growing number of cases of avoidable harm or death to patients."

2. The report identified 32 actions, 26 for the Trust and six system stakeholder actions. This is the eighth iteration of the report and identifies progress against these actions.

3. 14 actions are rated blue (complete), 6 actions have been rated Green (on target), eight are Amber (off target), 3 are Red (substantially off target) and one Grey (stopped). Of the three substantially off target actions, all are actions for the wider system (minutes per handover reduction, four hour back stop and Same Day Emergency Care).

4. Whilst good progress has been made on the actions that the Trust can control, the extreme system pressure continues. As a result, the likelihood is that the levels of avoidable harm will continue. The Trust estimates that for the 3-month period June 2023 to August 2023;

    - 1.512 patients could have come to severe harm as a result of being held on an ambulance for longer than an hour outside an ED;
    - 26,636 patients will not have received a response due to the operation of the Clinical Safety Plan or through the patient cancelling the ambulance;
    - There were 49 severe cases of avoidable harm, including death, referred to health boards under the Joint Investigation Framework.

5. All of the hard-won efficiencies and investment (re-rostering, increased consult & close, additional front line ambulance staff) by the Trust are still being offset by the levels of extreme handover.

6. In August 2023, over 19,000 hours were lost to hospital handover equivalent to 23% of the Trust's conveying capacity. This is a reduction from the 37% in December 2022, but is still extreme. However, Cardiff & Vale Health Board is particularly noticeable for its handover hours improvement trend. The historical pattern is for lost hours to increase over the winter period, and given current levels, this could mean 25,000 hours lost in December 2023. This remains a main focus for the Health Boards with a target of 12,000 hours lost by the end of Q3.

7. Intelligence indicates that commissioners are challenging why improved handover has not led to improved performance. Performance has improved since the low of December 2022, but as handover hours have improved there are fewer patient cancellations and less Clinical Safety Plan "unable to sends", which means more patients are seen, which means improved patient safety. The Trust has recently agreed to collaborate on a paper with the Chief Ambulance Services Commissioner (CASC) and his team to explain how the emergency ambulance care pathway will operate when there are extreme levels of handover.

8. The Association of Ambulance Chief Executives (AACE) has recently published a paper: "Taking Stock: assessing patient handover delays a decade after "zero tolerance". The paper identifies a "staggering" rise in handover delays over the last decade and that there is "no room for complacency". As part of the on-going Emergency Medical Services (EMS) Demand & Capacity Review, Operational Research in Health (ORH) identified Wales as a "huge outlier" with regard to hospital delays.

RECOMMENDATIONS

Trust Board is asked to:

- **NOTE the report and the progress the Trust is making on "WAST Actions".**
- **CONSIDER whether there are any further actions available to the Trust to mitigate patient harm.**

KEY ISSUES/IMPLICATIONS

As outlined in the Executive Summary above.

REPORT APPROVAL ROUTE

Date	**Meeting**
18 September 2023	**Executive Director of SP&P Sign Off**
18 September 2023	**CEO Sign Off**
28 September 2023	**Trust Board**

REPORT APPENDICES

Appendix 1 – Action Plan Progress Update Status

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. Sustained and extreme pressure across the Welsh NHS urgent and emergency care system is negatively impacting on patient flow leading to avoidable patient harm and death. This report provides a progress update on actions to mitigate this patient harm that the Trust has put in place.

BACKGROUND

2. The 28 July 2022 Trust Board received the first iteration of a report and actions to mitigate real time avoidable patient harm. This report provides an update to the end of August 2023.

3. There were 32 actions set out in the plan, 26 of which are for the Trust and six for system stakeholders.

ASSESSMENT

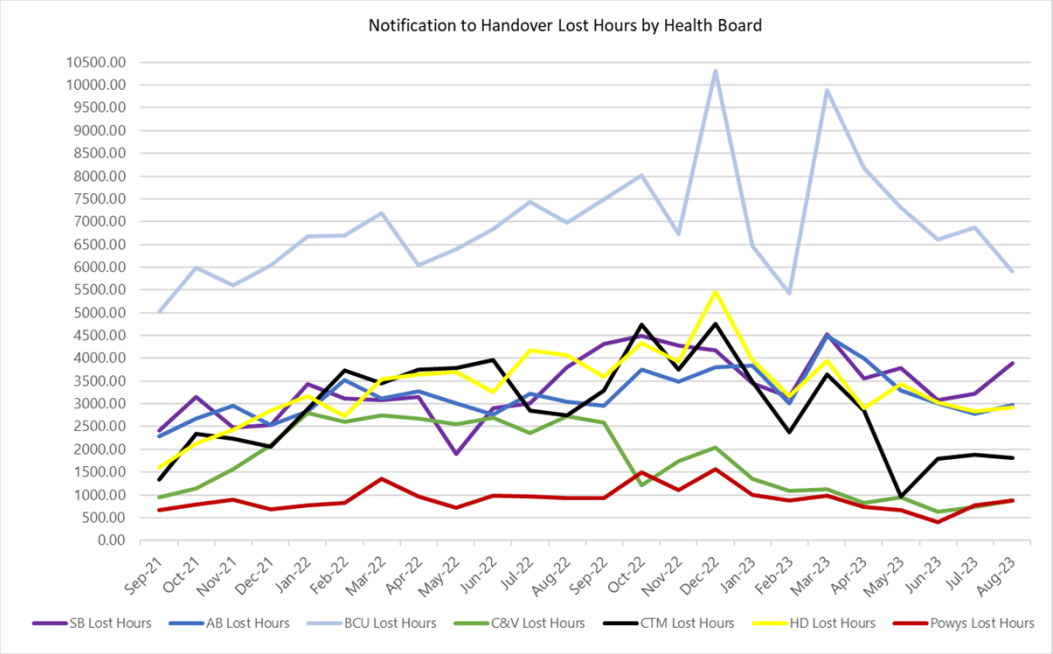
4. Appendix 1 contains the action plan with a narrative update on each action. Of the 32 actions:

    - 3 are red (significantly off target);
    - 8 are amber (off target);
    - 6 are green (on target);
    - 1 is grey (stopped); and
    - 14 are blue (complete).

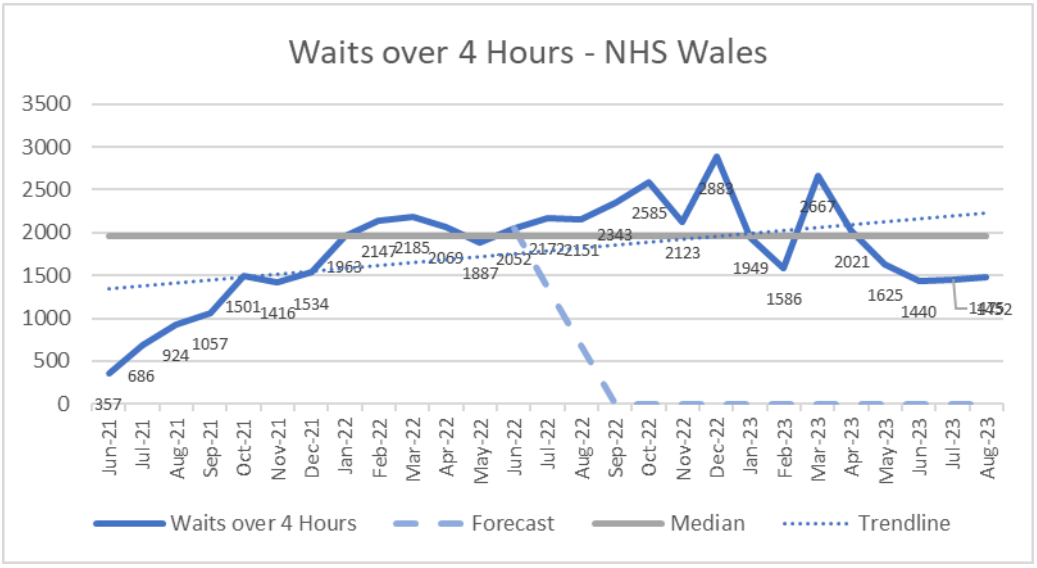
5. The number of actions has increased from 26 to 32 to reflect the additional actions currently being undertaken on red improvement.

6. The red (significantly off target) actions are:-

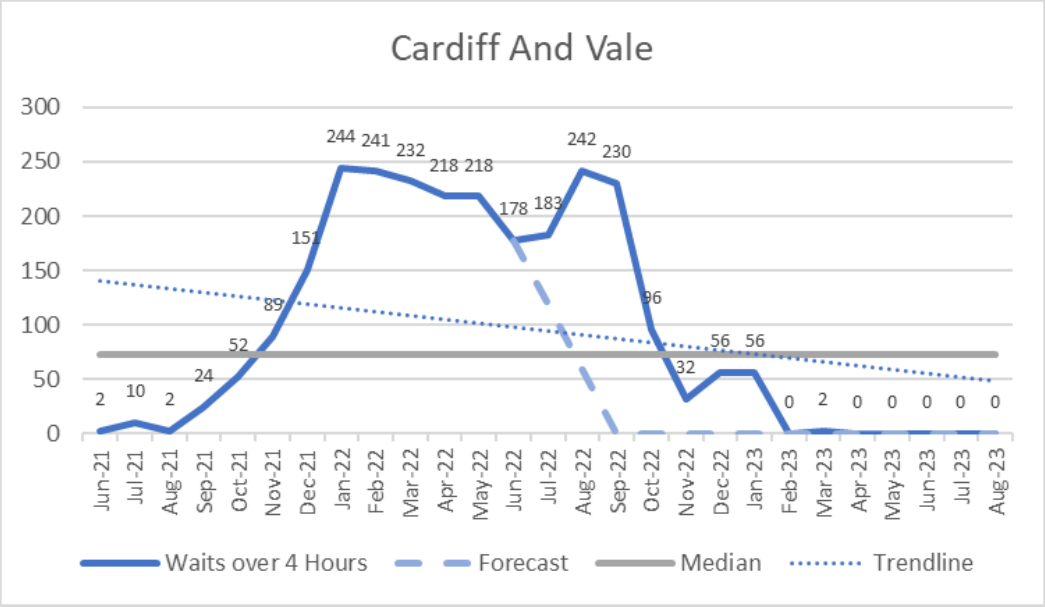
- **Reduction in emergency department handover lost hours:** The average lost minutes per arrival in August 2023 was 76 minutes (EASC target is 42 minutes). Handover lost hour levels are reducing slightly with August 2023's handover lost hours at 19,233, 21% below the same period last year. Whilst an improvement, the Trust lost 23% of its conveying capacity to handover in August 2023. Handover levels remain extreme and are three times higher than those used for the modelling for the roster review.



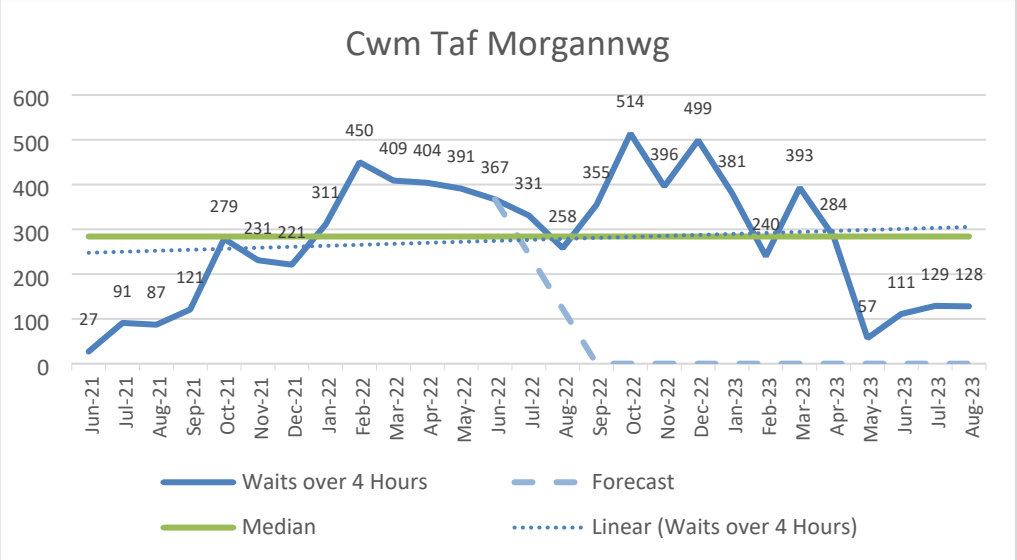
- **Eradication of handover waits of > 4 hours**: there were 1,475 patient handovers in August 2023 which were over 4 hours. The target was originally to have zero by September 2022. The expectation now is that these will be eradicated by end of 2023/24. Given the current levels of handover and the move towards winter there is a real risk that this will not be achieved.



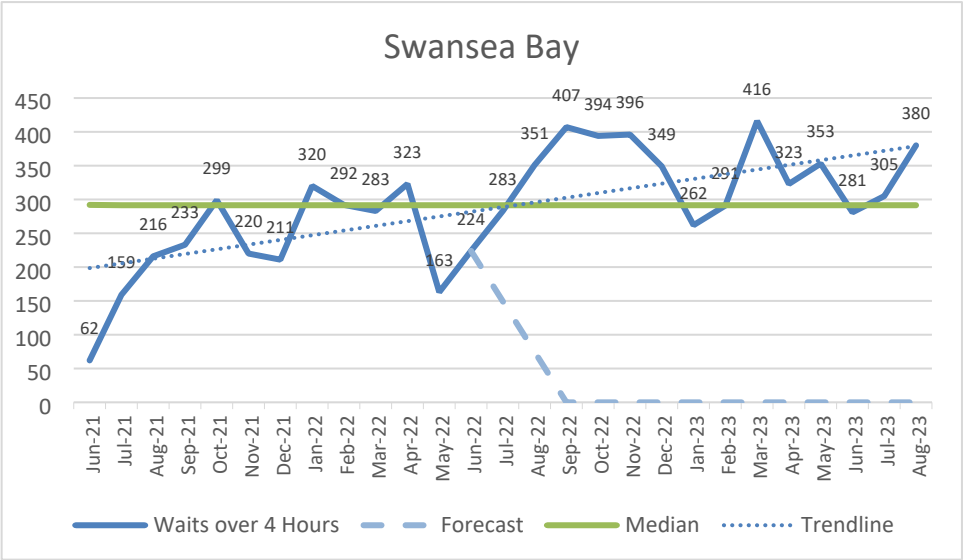
Cardiff & Vale UHB has demonstrated material improvement and is an outlier when compared to other health boards.



Cwm Taf Morgannwg has also demonstrated material improvement.

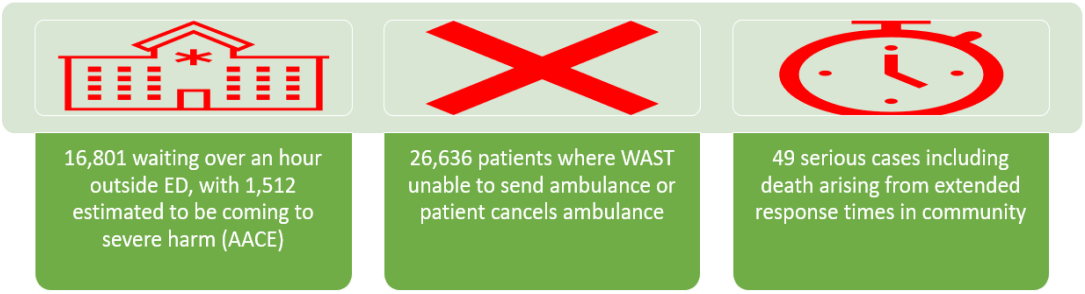


Swansea Bay is an area of concern.

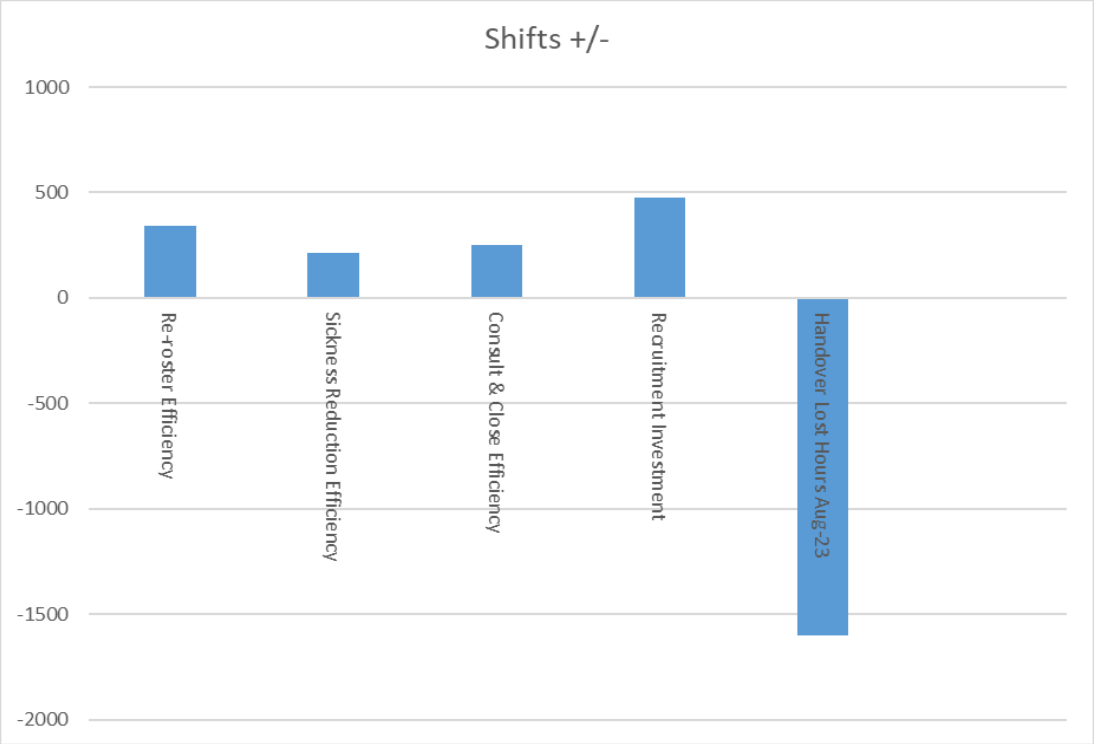


- **Implementation of Same Day Emergency Care (SDEC) services in each Health Board**: the Trust has provided Welsh Government with information which indicates that SDEC referrals account for less than 1% of the Trust's verified EMS demand. The modelling indicates 4% of the Trust's verified EMS demand, using the acceptance criteria and opening times used in the modelling, could go into SDECs. The Trust reported to Welsh Government at its April 2023 Integrated Quality, Performance & Delivery meeting that in March 2023 0.14% of the Trust's demand went to SDECs. It was 0.32% in August 2023.

7. The Trust continues to provide Welsh Government's Joint Executive Team (JET) with estimates of patient harm for the period. The visual below attempts to show the 3 areas of harm, updated with data for the last three months to the end of August 2023.



9. To contextualise the impact of lost hours to handover the graph below shows the positive impact of the improvements WAST has made compared with the effect of lost capacity at hospital.



8. The Trust will have put an equivalent of 1,282 EA/UCS 12 hour shifts back into the system in 2022/23 through efficiencies and investment: re-roster (343), sickness reduction (214), consult & close (249) and +100 FTE recruitment (476), but the Trust lost 1,603 EA/UCS 12 hour shifts to hospital handover in August 2023, which offsets all of the investment and efficiencies.

9. The health boards have all been required to develop handover reduction action plans, which are monitored at their Integrated Quality and Delivery meetings by Welsh Government. This is also discussed at the Integrated Commissioning Action Plan (ICAP) meetings which are held monthly between the CASC, WAST and each health board.

10. The Trust continues to work on actions within its own control, including:

- The Trust achieved a Consult & Close rate of 12.9% in August against a target of 17%, which is lower than that achieved towards the end of the last financial year. A corrective action plan is in place.
- It has been confirmed that the Trust will receive non-recurring funding again in 2023/24 for the +100 front line ambulance staff recruited last year.
- The Trust has a coherent and comprehensive work programme for management attendance, a 2022-23 IMTP interim trajectory ambition of 8% and a final 2023/24 IMTP trajectory of 6% (March 2024). The Trust achieved 8.23% in July 2023.

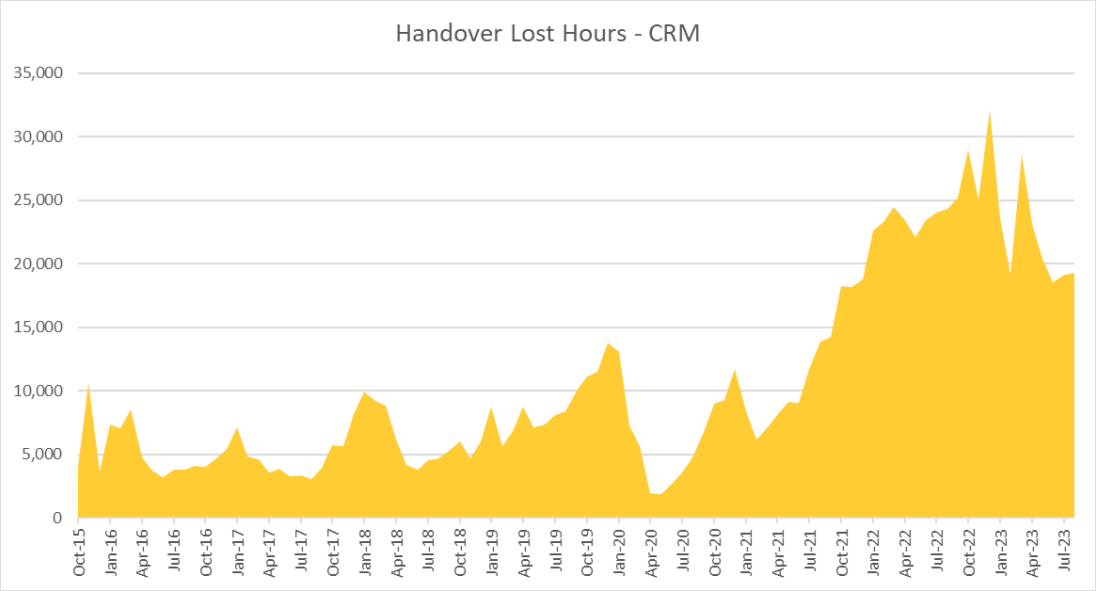
11. Through the last year, the Trust has continued to consider and review other actions which might have the potential to mitigate risk, and this is seen in the

detailed action plan. Other areas of focus have been the development of the Connected Support Cymru model, continued review of ePCR data to identify more appropriate responses for callers, engagement with system leaders at all levels on the WAST offer, growing evidence of the effectiveness of alternative models through, for example the APP tests of change, work with AB in particular to put the level 2 falls service on a more sustainable footing as well as pilot a mental health car.

12. As outlined in the previous report to Trust Board, in the light of the continued pressures, patient (community and ED handover) waiting times are likely to remain under significant stress. The delays in community response and those associated with a delayed transfer from the ambulance on arrival at the emergency department to a suitable hospital bed are likely to lead to a continuing number of cases of avoidable harm or death to patients. This situation will also continue to be one which is likely to have an adverse effect on our people.

13. The Trust is receiving some degree of challenge from health boards regarding handover reduction and a perceived view that performance is not improving. The CASC and the Trust have agreed to collaborate on a paper that explains the relationship between handover and performance for health boards, in particular, that as handover hours reduce, previously unmet patient demand (cancellations and unable to sends) will start to be met, which is good from a patient safety perspective, but means performance will not improve in the way that health boards anticipate.

14. AACE published a paper on 14 September 2023: "Taking Stock: assessing patient handover delays a decade after "zero tolerance". The paper identifies the "staggering" rise in handover delays over the last decade. The following graph shows in the increase in Wales since the start of the clinical response model (CRM in October 2015):-



15. The paper states there is "no room for complacency", but does acknowledge there is "increased awareness" of handover which is a "positive change". It also highlights the reductions that have been seen this year, but that these reductions are a "short term trend" that need to be sustained and that the spotlight on hospitals that have achieved handover reduction continue to offer valuable insight how improvement can be achieved.

16. Finally, handover continues to be discussed at the highest levels with the CASC, health board CEOs, the Director General and the Minister in a number of regular fora. Director peer groups are also regularly updated. The expectation from the Minister through the six goals programme priorities, is for no 4 hour delays to be seen by the end of 2023/24 and the EASC IMTP sets an expectation of a reduction in total hours lost to 12,000 by the end of Q3.

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
WAST ACTIONS				
1.	With respect to Red and Amber 1 immediate release directions: 1. Devise escalation protocol in the event of rejection 2. Share weekly highlight data with Judith Paget and CEOs showing those directions made, accepted and rejected	Lee Brooks Rachel Marsh	• The Trusts actions are complete. • Improvements have been made on adherence to the red release in particular. • There were 541 requests made to health board EDs for immediate release of Red or Amber 1 calls in August 2023, significantly less than the 1,234 requested in December 2022. In the Red category 125 were accepted and released, four were not. In the Amber 1 category, 140 were released, but 272 were not.	31 July 2022
2.	Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation i.e. +100 FTEs.	Angie Lewis	• Strong focus from Executives with detailed updates to EMT every two weeks. • Year-end position was +85 FTEs, with a vacancy factor of just 1% • Further non recurrent funding has been secured for 23/24	End of Q3 and into Q4 Complete
3.	Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Andy Swinburn	• Whilst no additional funding has been secured, the EMT has agreed to offer places to all APPs completing their education, funded from a reduction in technician posts 1/2s i.e. internal movement.	Q4 2023/24
4.	Improve internal efficiency – roster review, providing performance gain equivalent of 72 WTE	Rachel Marsh	• The roster review has concluded with all the roster lines that are funded live. • The evaluation report is delayed due to internal capacity, however, all the modelling (ORH and Optima) indicated improved performance from this project.	Q3 Complete

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
5.	Improve internal efficiency – improve attendance in line with agreed trajectory	Lee Brooks Catherine Goodwin	• Improvement trajectory agreed as part of IMTP 22/23 that returns us to pre pandemic sickness' rates over the lifetime of the IMTP • Comprehensive action plan established • Sickness is on a downward trend with the Trust achieving its interim (31 March 2023) IMTP target. In July 2023, sickness absence was 8.23%, an increase on the previous month's (seasonality). • The Trust will continue its focus through the Managing Attendance Programme into 2023/24, with a wider focus on abstractions as well. Abstractions have come down, currently at 35% (July 2023), with a pre-pandemic benchmark of 30%,	6% by 31 March 2024
6.	Improve internal efficiency – post production lost hours (PPLH) (6792 hours unavailable for all reasons in June 2022)	Lee Brooks	• Work has been completed in relation to the actions within the Trust's gift in terms of areas where it can reduce PPLH. Some small improvements seen in those area. PPLH hours are now expected to remain broadly similar.	End of Q2
7.	Maximise the opportunity from Consult & Close for 999 calls – stretch to 15% and beyond	Lee Brooks Andy Swinburn	• The Trust achieved an average of 14.5% for quarter four, therefore achieved. • The IMTP 2023/24 ambition to move this up to 17% within existing resource constraints i.e. by delivering more efficiencies, by quarter four 2023/24. • This action was closed, based on the above commentary, however, the 2023/24 ambition of 17% is looking less likely based on August 2023's performance of 12.9% • A corrective action plan is in place	Dec-22 Delivered. Re-opened Sep-23
8.	Senior system influencing	Jason Killens Colin Dennis	• CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant for settings. • Continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm.	Ongoing
9.	24/7 operational oversight by ODU with dynamic CSP review and system escalation as required	Lee Brooks	• Specific actions complete - BAU	BAU Complete

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
10.	Weekly REAP review by senior Operations Directorate team with assessment of action compliance	Lee Brooks	• Ongoing BAU action that works well.	On going
11.	Recruitment and deployment of new CFRs	Lee Brooks	• Target for +100 CFR volunteers by 31 March 2023. • Year-end figure +76 CFRs. Target exceeded in April 2023.	Q4 Complete
12.	Sharing of potential case of serious avoidable harm/death with HBs for investigation when response delay associated with ED congestion is the primary cause	Wendy Herbert	• Twice weekly SCIF to identify potential cases • New joint investigation framework in place.	Complete BAU
13.	Evidence submission to Senedd Health and Social Care Committee	Jason Killens	• Report published in June 2022 • Our evidence appears in the report from paragraph 57 through to 65.	Q2 - Complete
14.	National 111 awareness campaign	Estelle Hitchon	• The national awareness campaign was undertaken as planned and ended in March 2023. An evaluation will be provided to the 111 Board.	Complete
15.	Emergency Department cohorting	Lee Brooks	• Evaluation of cohorting has been completed and as a result, there has been an agreement to terminate these arrangements in Morriston and GUH	Stopped.
16.	Third party additional capacity	Lee Brooks	• Contracted third party UCS equivalent capacity deployed where available and funded by commissioners • Four vehicles a day 7 days a week secured for winter period	Q3 and Q4 21/22 Live Complete
17.	Transition Plan	Jason Killens	• Action complete, but the Trust will continue to undertake strategic and technical workforce planning in support of the Trust's ambition	Complete Funding for

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
			e.g. inverting the triangle etc.	+100 not recurrent at this time.
18.	Overnight falls service extension	Wendy Herbert	• Night Car Scheme extension agreed to 31 March 2024 (2 regional resources) • Nighttime falls assistance 64% Utilisation (Apr 2023 -Jun 2023) • Nighttime July 2023 – September (14th) 2023 utilisation further improved, currently 67% • Continued daytime utilisation improvement: July -August 58%. September currently achieving the utilisation target of 60%. • Falls level 1 and 2 impact evaluation report completed -and presented to Clinical Quality Governance Group (CQGG) Jan 2023. Completed . • Optima modelling underway to examine optimal resourcing level. The has been delayed due to prioritisation of Executive requests. Subject to further Executive request, plan to pick this up in second half of September.	30 June
19.	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?	Jason Killens	• 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.	Q1 23/24
20.	Consideration of additional WAST	Lee Brooks	• Action relates to winter 2022/23. • WAST will not operate a winter plan this year, but Welsh	Q3 Complete.

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
	schemes to support overall risk mitigation through winter		Government have asked for mitigations around the 111 service, in particular, communications, the website and clinical support.	Summer modelling. No Summer Plan.
21.	Full roll out of CHARU	Andy Swinburn	• Current position (August 2023 Strategic Transformation Board) against the 153.1 FTEs, required for full roll out, is 97 staff in post and 11.5 Senior Paramedic contribution, with vacancies at 44.5.	May-23
22.	Virtual Ward now Connected Support Cymru	Liam Williams	• Currently identifying a 42.3% EA avoidance rate, through SJAC CWR pilot (due to cease 31/10/23). Additionally, proportion of clinically appropriate upgrades/clinical escalation identified (data analysis underway). • Previous issues with SJAC rota (roster gaps) now remedied. • Funding also obtained to support the capacity to recruit volunteers (600 in total in 2 years). Potential CFR teams for the pilot have been identified; role profile drafted and awaiting approval. Development of kit bags is underway, but procurement will be needed before further on-boarding (rate limiting). JD for the B4 training position is complete and is being reviewed by job evaluation. • SBRI Phase 2 commenced; 12 month delivery phase over 12 months (phase 2a (Sept-October) – process design & project scope; phase 2b – delivery) • Business case development concluding (due at project board 21 Sept 23). Identified cost pressures include project management, Integrated Care staffing, Clinical specialist engagement requirements, further commissioning of SJAC resources.	Apr-23 subject to funding

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
23.	Red screening		• Red review for protocol six breathing difficulties, currently undertaken when CSD UHP is over 100%. • The ability to sustain the Red review may work against increasing the consult & close rate. • The Trust has written to the CASC with regard to workforce additionality in 2023/24 which could include a further expanded CSD to support the screening of calls. Any further funding considered unlikely within the context of the financial pressures being experienced by NHS Wales. • Related actions on automation, review and training. • Screening being undertaken within existing resource, with exception of when at high levels of the Clinical Safety Plan and/or when a lot of welfare screening being done. • The Trust needs to formally model the balance between screening and Paramedics in the Clinical Support Desk being focused on consult & close.	Live
24.	Response Logic		• The change in dispatch logic for Red incidents (aimed at improving the 65% 8 minute performance and improving patient safety) went live on 19 June 2023. • Operations SOT are monitoring the resource attendance ratios and the Director of Paramedicine is updating EMT each month, which have moved now to analysing the performance impact.	Live
25.	Red modelling		• Modelling estimates that a seven percentage point gain could be achieved for Red performance, based on full roll of CHARU, Red screening and handover reduction to 15,000 hours. • Further modelling bringing together all the changes that have occurred in 2023 currently being undertaken, including further future efficiencies, e.g. handover reduction, abstraction reduction etc. (completed).	Complete

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
26.	Further 2023/24 workforce additionality	Rachel Marsh	• Detailed workforce planning has been undertaken for 2023/24 and what further front line workforce additionality the Trust could develop, if funding is made available. • No further funding available at this time. • Internal movements agreed by EMT to support offers to the 22 APPs "tipping out" of university now, plus EMT3 open grade and supporting the Paramedic/APP pipeline.	Complete Information Supplied
SYSTEM STAKEHOLDER ACTIONS				
27.	NHS Wales reduces emergency department handover lost hours by 25% Note: the target is -25% minute per arrival from the October 2021 baseline. The National Collaborative Commissioning Unit have calculated this target as 42 minutes per arrival.	HB CEOs	• Commitment made at EASC in October 2021. • August 2023's handover lost hours were 19,233, 21% below the same period last year, which is a clear improvement. • Whilst a clear improvement the Trust lost 23% of its conveying capacity to handover in August 2023. • Handover levels remain extreme and are three times higher than those used for the modelling for the roster review. • The average lost minutes per arrival in August 2023 was 76 minutes (EASC target, see opposite is 42 minutes).	Sep-22, revised to end of 2023/24
28.	NHS Wales eradicates all emergency department handover delays in excess of 4 hours	HB CEOs	• There were 1,475 +4 hour patient handovers in August 2023. • The target was originally to have 0 by September 2022. • Expectation now that these will be eradicated by end of 2023/24. • Given the current levels of handover and the move towards winter this is looking less likely.	Sep-22, revised to end of 2023/24
29.	Alternative capacity equivalent to 1,000 beds	HB CEOs	• 678 additional beds delivered, a significant achievement, but short of the target of 1,000. (last year action)	Q3

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
30.	Implement nationwide approach to emergency department 'Fit 2 Sit'	CMO/CNO	• Some Challenges placed in the system from health boards in a number of areas. Limited progress has been made.	Further progress dependent on NCCU and health boards.
31.	Implementation of Same Day Emergency Care (SDEC) services in each Health Board	NHS Wales	• The Trust has provided Welsh Government with information which indicates that SDEC referrals account for less than 1% of the Trust's verified EMS demand. • The modelling indicates 4% of the Trust's verified EMS demand, using the acceptance criteria and opening times used in the modelling, could go into SDECs. • The Trust reported to Welsh Government at its April 2023 Integrated Quality, Performance & Delivery meeting that in March 2023 0.14% of the Trust's demand went to SDECs. It was 0.32% in August 2023. • Welsh Government have asked the Trust to supply a regular data feed on SDEC activity to so they can challenge health boards. This is currently being organised.	Q4 22/23
32.	National Six Goals programme for Urgent and Emergency Care	NHS Wales	• 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 Andy Swinburn and on the overarching Programme Board by the Executive Director Strategy, Planning & Performance • The Trust also now has presence on all of the individual Goal Boards	Ongoing

AGENDA ITEM No	**10**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Trust Board
DATE	28th September 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk, Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks.

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 Board 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 framework in Annex 2.

4. The principal risks are updated as at 1st September 2023 and each of the risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3. Focus has been given to ratings, controls, assurances, gaps and the mitigating actions identified and taken to ensure risks achieve their target score.

5. Updates made in respect of actions, controls and assurances are highlighted in blue on the BAF. Whilst there has been no material change to the risk ratings during this period, the Risk report submitted at the July 2023 Board meeting included a rationale for each of the risk ratings which is particularly important where ratings have remained static or increased. Notwithstanding, the detailed review, discussion and challenge that takes place with the Executive Leadership Team (ELT) and Assistant Director Leadership Team (ADLT) on these risks on a monthly basis.

6. This executive summary draws together the broader discussions across the senior leadership teams and the Committees on the higher rated risks and signposts the Board accordingly. Additionally, the Risk Owners have an opportunity to further add to this narrative and detail of any assurances or escalations during the meeting and

Committee Chairs will also contribute to this as appropriate, drawing from the Alert, Advise, Assure reports (AAA).

7. **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) both continue to be rated 25:

    7.1. The Quality, Patient Experience and Safety Committee (QUEST) reviewed both risks at its meeting in August 2023 with the theme of these risks arising throughout the agenda items discussed at this meeting and are part of the escalation section of this report and are escalated in the QUEST AAA report for this meeting.
    7.2. These risks continue to be presented at the Finance & Performance Committee (FPC) and the People & Culture Committee (PCC) meetings to ensure all perspectives and elements of these risks are considered and reviewed.
    7.3. As has been previously reported, all current mitigating actions within WAST's control have been completed or superseded in relation to Risk 223 and remain on the BAF for review; that does not mean that the Trust is not continually seeking additional actions to mitigate this risk and most of these actions are articulated in the avoidable harm paper that the Board receive at each meeting.
    7.4. The Executive Director of Quality & Nursing and Executive Director of Operations reported to Committees on the depth of review that is undertaken on these risks during the reporting cycle. Consideration has been given as to whether the scores and mitigations could be stratified by Health Board and the potential differentiation of risk across each of these areas as opposed to an all Wales Risk, and this continues.
    7.5. Whilst both risks remain static at the highest score of 25, it is anticipated that this will be the case for the foreseeable future as long as the Trust is in a position where it is highly likely to have an incidence of premature death or avoidable harm as a result of being unable to respond in a way that it would wish to. The score is not based on the volume of cases of catastrophic harm, it is based on any one individual that experiences avoidable harm. The quality dimension of each of these risks will always be a challenging one to reduce whilst patients and the Trust are experiencing delays in the way in which they currently are.
    7.6. The Chief Executive's report sets out participation in, and discussion at, regular stakeholder meetings with NHS Wales CEOs, the Director General of NHS Wales, Commissioners and EASC where stakeholder actions related to these risks.

8. **Risk 160** (high absence rates impacting on patient safety, staff wellbeing and the Trust's ability to provide a safe and effective service) is rated 20.

    8.1. The ELT continue to review the sickness absence management programme and discussed the mitigations and rating of this risk in August 2023. The PCC discussed sickness rates and this risk at its August meeting both in the performance report and a standalone absence management presentation to gain assurance on the

mitigations in place and actions planned. The risk score remains static; however, good progress is being made to reduce sickness absence and a further review of the score and mitigations will be undertaken ahead of the December 2023 Board meeting.

9. **Risk 201** (damage to the Trust's reputation following a loss of stakeholder confidence) is currently rated 20:

9.1. The current risk score remains at 20 given that many of the mitigations are outside the Trust's control. The PCC will receive a partnerships and engagement bi-annual report at the next meeting in November 2023 which will include a discussion on the engagement delivery framework and a deep dive on this risk taking account of the expanded remit with the Regional Partnership Boards.
9.2. The reputation audit will be the subject of a future Board development discussion.

RECOMMENDATION: Members are asked to consider and discuss the contents of the report and:

(1) Receive assurance on the review and attention to the principal risks, their review at ELT and at relevant Committees,
(2) Note the ratings and mitigating actions for each principal risk.
(3) Note that there have been no material changes to the risks or scores during this period.
(4) Note the update on the Risk Management Transformation Programme.

KEY ISSUES/IMPLICATIONS
The key issues and implications are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
Each of the Principal Risks have been or are due to be considered by the following Committees, as relevant to their remit, during the forthcoming reporting period: ADLT (14 August 2023) EMT (30 August 2023) Finance & Performance Committee (18 September 2023) Charity Committee (9 October 2023) Quality, Safety & Patient Experience (31 October 2023) People & Culture Committee (16 November 2023)

REPORT ANNEXES
SBAR report. Annex 1 - Summary table describing the Trust's Principal 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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The purpose of the report is to provide assurance in respect of the management of the Trust's principal risks, an overview of the current risk management framework with particular focus on assurance to Committees and the Board, and an update regarding the risk programme within the Integrated Medium Term Plan (IMTP) 2023-26.

2. A summary of the Trust's 15 principal risks on the corporate risk register as at 1st September 2023 is detailed in Annex 1; each of these risks have been fully and formally reviewed in accordance with the review schedule.

BACKGROUND

3. Risks are allocated to appropriate Directors to drive the reviews and actions to mitigate the Trust's principal risks. In addition to directorate reviews there are formal risk review discussions with the Assistant Directors Leadership Team (ADLT) and the Executive Management Team (EMT) in relation to risk escalation, changes in ratings, and any new risks for inclusion on the CRR.

4. This report highlights the focus that is maintained on management of these risks, not only as a result of risk discussions in the various but also as a result of broader attention to planned mitigations across the system.

ASSESSMENT

5. The summary of the 15 principal risks is set out in Annex 1 with the full risk detail including controls, assurances, gaps and mitigating actions contained within the Board Assurance Framework (BAF) in Annex 2.

6. The Executive Leadership Team (ELT) has approved the Principal Risk activity described in this paper and considered the full review of each risk undertaken throughout September 2023 by Risk Owners and the Assistant Directors Leadership Team (ADLT).

Principal Risks

7. Each of the risks have been reviewed during this reporting period in line with the agreed review schedule detailed at Annex 3. Focus has been given to each of the risk ratings and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the regular review of controls, assurances, and any gaps.

8. Specifically, The Trust's highest rated Risks 223 and 224, scoring 25, remain unchanged despite a series of mitigating actions being in place. These risks continue to be closely monitored by management, Board Committees, and at the Trust Board meetings.

9. All current mitigating actions within WAST's control have been completed or superseded in relation to Risk 223. Work has been undertaken by the Operations Senior Leadership Team in relation to regional modelling and a breakdown of risk scores by Health Board. This will be included in the risk report and BAF for the December 2023 Trust Board. Additionally, the Board continues to receive an update against the Avoidable Harm paper and action plan at each meeting and updates are included against the mitigations for this risk.

10. Several updates have been made to the controls and assurances in relation to Risk 224 during this period and these are highlighted on the BAF to address gaps in assurance.

11. The ELT discussed additional mitigating actions that will be included against Risk 163 during the next review and acknowledged that a review is required in relation to Risk 424 considering the current financial climate.

12. A full review of Risk 199 is scheduled in the coming weeks and a potential reduction in score will be considered given the demonstrable work that has been undertaken across the Trust in relation to the Working Safely Programme and Health & Safety.

<u>Development of New Principal Risks</u>

13. Work continues to consider and develop potential new Risks for inclusion on the CRR in the following areas:

    a. Capacity to handle volume of complex concerns and requests i.e. Putting Things Right Team.
    b. Decarbonisation programme.
    c. Salus (IIS, CAS, Symptom Checkers, Website, Clinical Workforce training and funding).
    d. Covid-19 Inquiry risks
    e. Volunteer Fundraising Risk (for the Charity)

<u>Risk Management Transformation Programme</u>

14. The Risk Management Transformation Programme has been designed to further strengthen and positively impact the development of the Trust's future strategic ambition which is highlighted in our 2023-26 IMTP as one of the fundamentals of a quality driven, clinically led, value focussed organisation.

15. Areas of focus for the risk management improvement programme plan during 2023 are to deliver a risk management framework as a key enabler of our long-term strategy and decision making. This will be achieved by further developing the risk management framework, transitioning to a strategic BAF that reflects more closely the Trust's strategic objectives against its long-term strategy – Delivering Excellence: Vision 2030. This is in addition to designing and delivering a programme of training and education on both the risk management framework and the BAF.

16. This programme is overseen by the Audit Committee.

RECOMMENDED

17. Members are asked to consider and discuss the contents of the report and:
    a) Receive assurance on the review and attention to the principal risks, their review at ELT and at relevant Committees,
    b) Note the ratings and mitigating actions for each principal risk.
    c) Note that there have been no material changes to the risks or scores during this period.
    d) Note the update on the Risk Management Transformation Programme.

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Director of Operations	**25 (5x5)** →
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Director of Quality & Nursing	**25 (5x5)** →
160 PCC	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	**IF** there are high levels of absence **THEN** there is a risk that there is a reduced resource capacity **RESULTING IN** an inability to deliver services which adversely impacts on quality, safety and patient/staff experience	Director of Workforce & Organisational Development	**20 (5x4)** →
201 PCC	Damage to Trust reputation following a loss of stakeholder confidence	**IF** the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations **THEN** there is a risk of a loss of stakeholder confidence in the Trust	Director of Partnerships & Engagement	**20 (4x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		RESULTING IN damage to reputation and increased external scrutiny		
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) **THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Director of Finance & Corporate Resources	**16 (4x4)** →
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	**IF** the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained **THEN** there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised	Director of Workforce & Organisational Development	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		RESULTING IN a negative impact on colleague experience and/or services to patients.		
424 FPC	Prioritisation or Availability of Resources to Deliver the Trust's IMTP	**IF** resources are not forthcoming within the funding envelope available to WAST (link to risk 139) **THEN** there is a risk that there is insufficient capacity to deliver the IMTP **RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing	Director of Strategy Planning and Performance	**16 (4x4)** →
458 FPC	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	**IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis **THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients. **RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory	Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		obligations causing reputational damage.		
199 PCC	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	**IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance **THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments **RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation	Director of Quality & Nursing	**15 (3x5)** →
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**15 (3x5)** →
543 FPC	Major disruptive incident resulting in a loss of critical IT systems	**IF** there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems	Director of Digital Services	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		THEN there is a risk of a loss of critical IT systems **RESULTING IN** a partial or total interruption in WAST's effective ability to deliver essential services		
558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	**IF** significant internal and external system pressures continue **THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST **RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm	Director of Workforce & Organisational Development	**15 (3x5)** →
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.	Director of Operations	**15 (3x5)** →
100 FPC	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	**IF** WAST fails to persuade EASC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes	Director of Strategy Planning & Performance	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		within the IMTP not being delivered		
283 FPC	Failure to implement the EMS Operational Transformation Programme	**IF** there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme **THEN** there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters **RESULTING IN** potential patient harm, deterioration in staff wellbeing and reputational damage	Director of Strategy Planning & Performance	**12 (3x4)** 

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	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.	ɔcal 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	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Annex 3 - Frequency of Risk Review

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

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

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

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

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

Risk Commentary Q2 2023/24

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

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

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

a) Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E)
b) Consideration of additional WAST schemes to support risk mitigation through winter (I)
c) NHS Wales educes emergency department handover lost hours by 25% (E)
d) NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E)
e) Alterative capacity equivalent to 1000 beds (E)
f) Implement nationwide approach to emergency department 'Fit 2 Sit' (E)
g) Implementation of Same Day Emergency Care services in each Health Board (E)
h) National Six Goals programme for Urgent and Emergency Car (E)

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Regional Escalation Protocol	1. Daily conference calls to agree RE levels in conjunction with Health Boards
2. Immediate release protocol	2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)
3. Resource Escalation Action Plan (REAP)	3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure.
4. 24/7 Operational Delivery Unit (ODU)	4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
5. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans	5. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
6. Limited Alternative Care Pathways in place	6. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
7. Consult and Close (previously Hear and Treat)	7. Monitoring CSD rates through AQIs. Consult and Close volumes form part of EMS CCC weekly reports to SLT. Regular reporting of incident volumes to Operational Review Groups. Summary level information about Consult and Close volumes, targets, trends and recontact rates reported to TB and sub-committees. Metrics relating to Ambulance Quality Indicators (AQI) published on a quarterly basis by EASC. Bi-monthly EASC Provider reports. Consult and Close performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information

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

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

	Management Internal Audit report February 2022 (External Assurance). Consult and Close rate has increased from 12% to circa 15% March 2023.
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	8. Qlik sense APP dashboard monitors performance and provides assurance that APPs are flowing patients into alternatives to emergency department. Qlik sense is a national report and can drill down into regional, local and individual performance as required. APP Navigation – Test of Change Framework (Swansea Bay & Hywel Dda). Review of despatch criteria for APPs. EMT have agreed to offer contracts to the 22 APPs who are about to complete their Masters programme. This will take our APP headcount to 88.7FTE. An investment proposal has been submitted to Welsh Government AHP in primary and community care pot. I think that there is low expectation that the bid will be successful. We are currently workforce planning to increase our APP headcount by 40 per year.
9. Clinical Safety Plan	9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group
10. Recruitment and deployment of CFRs	10. Volunteers are another resource for response, Volunteer
11. ETA scripting	11. The ETA Dashboard is a tactic that was signed off by EMT – there is a dashboard that supports scripting analysed by comparing with real time data
12. Clinical Contact Centre (CCC) emergency rule	12. CCC Emergency Rule is policy that has been signed off by Execs.
13. National Risk Huddle	13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
14.	14.
15. Summer/Winter initiatives	15. Monitoring through SLT and STB
16. CHARU implementation	16. Monitored via the EMS project Board
17. National Transfer & Discharge Model	17.
18. Conveyance Reduction	18. This is part of the weekly performance review and aligned to Care Closer to Home Programme
19. Access to Same Day Emergency Care (SDEC) for paramedic referrals	19. This forms part of the handover improvement plans in place with Health Boards, however assurance is limited given that the acceptance of paramedic referrals is low (less than 1%) and inconsistent.
20. Mental Health Practitioners in cars	20.
21. Roll out of ECNS	21. Reported through QuEST
22. Clinical Model and clinical review of code sets	22. Reported through QuEST
23. Remote Clinical Support Strategy	23. Strategic Transformation Board – IMTP deliverable
24. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	24. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)
25. Information sharing	25. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
26. Completed EMS Roster Review	26. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner
27. Work underway to reduce the number of multiple attendances dispatched to red calls	27. This will increase vehicle availability generally across the Trust

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

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

28. Transfer of Care	28. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief
29. New 2023 EMS Demand and Capacity (roster) review	29. **To commence in order to ensure we continue to match capacity and demand to our best ability**
30. Connected Support Cymru – an innovative approach to supporting patients to remain at home with clinically appropriate support mechanisms, thus avoiding admission to hospital where appropriate.	30. **Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform and a Community Welfare Responder model to enhance community resilience.**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards
2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow	
3. Covid capacity streaming	
4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding	
5. Local delivery units mirroring WAST ODU	
6. Handover delays link to risk 224	
7.	
8. During industrial action days, Health Boards demonstrated compliance with reducing handover delays in order to maximise WAST resources. Despite a reduced volume of conveyance as a result of the industrial action, there is however a demonstration that reduced handover delays are achievable, and this therefore warrants a triangulation of data.	
9. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 6 months there is a low confidence in attaining this.	
10. Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration	
11.	
12. Handover Improvement Plans agreed between WAST and Health Boards	12. Handover Improvement Plans have been replaced by Integrated Commissioning Action Plans (ICAPS) and are subject to review with EASC; However, it is noted that previous plans did not demonstrate sufficient improvement in reducing handover delays
18. National Transfer & Discharge Model	18. National Transfer & Discharge model is yet to be determined. A task and finish has been established to progress this piece of work
21. Mental Health Practitioners	21. Mental Health Practitioners – not yet implemented but part of the Care Closer to Home workstream
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:

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

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

1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters	Assistant Director of Operations EMS	Complete	Majority of EMS rosters complete and implemented
4. Transition arrangements post pandemic	Executive Pandemic Team / Assistant Director of Strategic Planning (BCRT Chair)	Complete 30/08/22	Transition complete
5. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of People & Culture	**30.07.23 Checkpoint**	Offers to 22 in July 2023. 13.33 FTE uplift. Continue to seek opportunities for funding APPs to improve service delivery.
6. Maximise the opportunity from Consult and Close – stretch to 15% and beyond (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, Integrated Care	31.03.23 Complete	Work undertaken to map influences and progress towards each. Current % of Consult and Close increased from 12% to 15% at March 2023.
7. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support	Complete	System in place and ongoing.
8. Weekly REAP review by senior Operations Directorate team with assessment of action compliance (I) Source: Action Plan presented to Trust Board 28/07/22]	Director of Operations / Operations Senior Leadership Team	Complete	In place and ongoing - Weekly Performance Meetings occur every Tuesday lunchtime to review performance, etc. and determine REAP level.
9. Recruitment and deployment of new CFRs (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support / National Volunteer Manager	Complete 21.03.23	Additional CFR Trainers and Operations Assistants appointed to support recruitment and training of new CFRs. Volunteer Management Team, supported by the Volunteer Steering Group, now embarking on volunteer recruitment programme and increasing public engagement to raise awareness about volunteering opportunities available within WAST. Volunteer team has recruited and trained 173 additional volunteers between November and March 2023.
10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]		Superseded	
11. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	Ended March 2023	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	03/08/2023	TREND	25 (5x5)
		Date of Next Review:	11/09/2023	➡	

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

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

IMTP Deliverable Numbers: 7,9, 10, 11, 12, 13, 14, 15, 16, 23, 24, 25, 26, 33, 35

EXECUTIVE OWNER	Director of Quality & Nursing	**ASSURANCE COMMITTEE**	Quality, Safety and Patient Experience Committee

Risk Commentary Q1 2023/24

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

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

Improvement actions led by Welsh Government and system partners include:

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

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

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	03/08/2023	TREND	25 (5x5)
		Date of Next Review:	11/09/2023		

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

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

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

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		Date of Next Review:	11/09/2023	➡	

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

16. Implementation of Duty of Quality, Duty of Candour and new Quality Standards requirements in April 2023.	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of July 2023 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candour Implementation Group and is actively engaged in developing resources.
	External Sources of Assurance Management (1st Line of Assurance)
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures.	1.
2.	2. Implementation of the revised Joint Investigation process remains in pilot stage with good engagement seen by system partners. A number of overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has **25** overdue nationally reportable incident investigations. **Shared system learning from the Joint Investigation Framework is currently limited.**
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales*.	3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. In **June 2023**, **18,000** hours were lost with **1,440 +4 hour** delayed patient handovers.
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*.	4. Strengthening of patient safety reports and audit processes as e PCR system embeds.
5.	5.
6. Variation pan Wales / England as position not implemented across all emergency departments*.	6.
7.	7.
8. Variation pan Wales / England as position not implemented across all emergency departments*.	8. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.
9. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	9.
10.	10.
11. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	11.
12.	12.
13. Transition to ePCR impacting on data temporarily	13.
14. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas*.	14. HIW approve and sign off WAST elements of recommendations.
15.	15.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators

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Inherent	5	5	25
Current	5	5	25
Target	3	2	6

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

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Inherent	5	5	25
Current	5	5	25
Target	3	2	6

8. Organisational change process of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	• Q3 2023/24	• Informal consultation phase commenced May 2023.
9. Connect with All Wales Tissue Viability Network to explore strengthening the current investigations into harm from pressure damage across the whole patient pathway.	Assistant Director Quality & Nursing	• Q2 2023/24	• Meeting planned August 2023 with the Chair of the TVN Network.
10. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	CEO	• Q4 2023/24	• Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital; access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Expected outcomes in 2023/24.
11. Internal Audit to undertake a review of Serious Adverse Incidents & Joint Investigation Framework	**Executive Director of Quality & Nursing**	• **Q3 2023/24**	• **Terms of reference drafted.**
Completed Actions	**Action Owner**	**When /Milestone**	**Progress Notes:**
1. HIW Improvement Plan / Workshop – WAST inputs / influencing improvements. Response and improvement actions to Healthcare Inspectorate Wales Inspection report (2021) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' which links to Fundamentals of Care.	Assistant Director of Quality & Nursing	Completed	
2. Representation at the Right care, right place, first time Six Goals for Urgent and Emergency Care Delivery Boards and Clinical Advisory Board.	Chief Executive Officer	Completed	• Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales • WAST will be represented on the Clinical Reference Group by Andy Swinburn with first meeting now held. • The Trust recently reported to EASC that is has further updated how it maps into six goals programmes. The programme structure nationally is being embedded and the Trust now has presence on goals 2, 5 & 6 at delivery board level and on the clinical advisory board.
3. Participation in the CASC led workshop to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019.	Executive Director of Quality & Nursing	Completed	• Revised joint investigation approach agreed and now formalised.
4. Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation	Director of People & Culture	Completed	• Strong focus from Executives with detailed updates to EMT every two weeks. • Year-end position is +85 FTEs, with a vacancy factor of just 1%, rather than the often used 5%, which would produce a figure of -88 FTEs rather than the estimated - 15 FTEs. • Further non recurrent funding has been secured for 2023/24
5. Transition Plan	Chief Executive Officer	Completed	• Action complete, but the Trust will continue to undertake strategic and technical workforce planning in support of the Trust's ambition e.g. inverting the triangle etc.
6. Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	Completed	• Winter ended. Focus now on forecasting and modelling for the summer, but Trust not aiming to produce specific Summer Plan (the Trust did during the pandemic linked to travel restrictions). • The Trust needs to determine whether there is value in producing a specific winter plan, particularly, within the context of the financial constraints NHS Wales is not operating in.
7. National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	Completed	• The national awareness campaign was undertaken as planned and ended in March 2023. An evaluation will be provided to the 111 Board.

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	13/08/2023	TREND	20 (5x4)
		Date of Next Review:	13/09/2023	➡	

IF there are high levels of absence e.g. sickness and alternative duties	THEN there is a risk that there is reduced resource capacity	RESULTING IN an inability to deliver services which adversely impacts on quality, safety and patient/staff experience

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	5	4	20
Target	3	4	12

IMTP Deliverable Numbers: 1,5, 9, 10, 12, 17, 18, 19, 20, 26, 34

EXECUTIVE OWNER	Director of People & Culture	ASSURANCE COMMITTEE	People and Culture Committee

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Managing Attendance at Work Policy/Procedures in place	1. (a) Policy reviews to ensure policies and procedures are fit for purpose (b) Audits by People Services on sickness
2. Respect and Resolution Policy- recognising issues at work may contribute to sick absence	2. Policy reviews to ensure policies and procedures are fit for purpose in line with agreed time frames and contribute to All Wales forum on this policy
3. Raising Concerns Policy- recognising issues at work may contribute to sick absence	3. Policy reviews to ensure policies and procedures are fit for purpose in line with agreed time frames
4. Health and Wellbeing Strategy – key document that outlines commitment to wellbeing and supportive culture	4. Regular reference to strategy to ensure themes are addressed and linked to wider people and culture plan
5. Operational Workforce Recruitment Plans- provide evidence of sufficient resources and identify any gaps or potential areas of increased workload pressure	5. Local plans link to the wider organisational workforce plan and provide intelligence regarding any particular pinch points in terms of resources
6. Roster Review & Implementation- to support demand and capacity which can have an impact on absence levels	6. Roster Review for EMS completed. Review in 111 underway
7. Return to Work interviews are undertaken - **Sharepoint Sway document** ensuring accurate reporting of reason for absence and identifying any additional support required	7. Process regularly reviewed and managers provided with relevant training and coaching on process and importance of carrying out return to work interviews promptly
8. Training on all aspects of Managing Attendance – ensures focus is high and understanding of why this is important is maintained	8. Regular bitesize training provided for managers, adapted to reflect feedback and to ensure all aspects of managing attendance is understood
9. Directors receives monthly email with setting out ESR sickness data- ensures ownership and awareness	9. Monthly reporting provided with opportunity for discussion with relevant people services lead and Director
10. Operational managers receive daily sickness absence data via GRS- ensures ownership and awareness	10. Provided daily, with opportunity for discussion with relevant people services lead and operational managers
11. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme- providing professional support	11. Monthly reporting on services provided, volume of referrals and timeframes for accessing support.
12. WAST Keep Talking (mental health portal) additional measures to offer support	12. Quarterly reporting on numbers accessing and regular promotion of service.
13. Suicide first aiders- additional layer of support	13. Quarterly reporting of numbers of trained suicide first aiders and numbers who have accessed.
14. TRiM- additional layer of support	14. Quarterly reporting on access to TRiM and promotion of service
15. Peer Support network- additional level of support	15. Promotion of network and support provided
16. Coaching and mentoring framework- additional level of support	16. Promotion of network and support provided
17. Staff surveys- assess levels of engagement and wellbeing	17. New **HIVE** survey tool will provide data on overall engagement and wellbeing
18. Stress risk assessments- identify measures that can be taken to address issues	18. Reference to the assessments during attendance management line manager training and to the TUS
19. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC	19. Sickness forms part of Workforce Scorecard to People & Culture Committee
20. External agency support e.g. St John Ambulance, Fire and Rescue- if needed at times of increased pressure	20. Standard procedures in place to access additional resource capacity
21. Monthly reviews of colleagues on Alternative duties	21. Action plans arising from meetings with colleagues implemented through monthly diarised meetings
22. Manager guidance on managing Alternative duties	22. Evidence of managers guidance in place and referenced in attendance management training
23. Fortnightly report on absence to EMT and report to every meeting of People & Culture Committee	23. Minuted meetings and action logs for EMT & People & Culture Committee
24. Sickness audits for localities- provides additional level of detail	24. Audits carried out and actions taken forward
25. Additional support for areas with higher than average absence – emphasis is on understanding reasons and developing action plans	25. Dedicated meetings taking place and support from people services for areas with absence with local plans in place to address specific issues
26. Review of top 100 cases -carried out on a monthly basis	26. Provides a focus on cases with a clear focus on support and making sure there are plans attached to each case.

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	13/08/2023	TREND	20 (5x4)
		Date of Next Review:	13/09/2023	➡	

IF	THEN	RESULTING IN
there are high levels of absence e.g. sickness and alternative duties	there is a risk that there is reduced resource capacity	an inability to deliver services which adversely impacts on quality, safety and patient/staff experience

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	5	4	20
Target	3	4	12

27. Deep dives on specific issues and reasons for absence	27. Enables wider consideration of additional measures that may be adopted and identifies themes and keeps focus on absence management eg – mental health and causes
28 2023 10 point action plan shared with EMT for assurance and RAG rated to track progress quarter	28. **Offers assurance to EMT on the activities and measures in place.**
	External Management (2nd Line of Assurance)
	1a. All Wales review of All Wales Attendance at Work Policy
	Independent Assurance (3rd Line of Assurance)
	1b. Internal Audits scheduled through Shared Services Partnership (controls 1 - 24)
	2. Audit Wales – Taking Care of the Carers report in October 2021 (controls 1 - 24)
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. (a) Consistency and Application in Managing Attendance at Work Policy	1. There are other factors that impact on sickness which can't be controlled
9 and 10 It is not known what is undertaken with respect to the data covered in assurances 9 and 10 once it is received	9, 10 and 19 Absence data is not updated in a timely manner into ESR by managers
1 – 22 Education and communication with managers about resources available and how to implement it e.g. stress risk assessments	
	External Gaps in Assurance None identified at the present moment

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Implementation of Improving Attendance project	Deputy Director of People & Culture	31.09.23 Completed 2022/23	Underway and ongoing, 2022/23 actions complete or embedded as BAU. May data 7.6%. Trajectory continues to be positive. 10 point plan for 2023/24 agreed by EMT and being implemented.
2. Implementation of Behaviours Refresh Plan	Assistant Director – Inclusion, Culture and Wellbeing	31.10.22 Extended to 31.05.23 CLOSED	Underway and ongoing. Captured in the IMTP for the service. Impacted by IA. New approach adopted from April 2023 to focus on a new behaviour every 6 weeks and continue conversations. Directly linked to people and culture plan. Closed
3. Long term sickness absence deep dive	Deputy Director of People & Culture	31.07.23 **Extend to 31.01.24 based on new plan for 2023/24**	Underway and ongoing. Downward trajectory in levels of long term absence- proposed that this is extended until 31/12/23 to enable more detailed work of reasons, measures being implemented and impact.
4. Develop guidance for line managers to support addressing challenging conversations and change	Deputy Director of People & Culture	31.07.22 Complete	Training produced and rolled out. Now BAU
5. Roll out platform for raising concerns (in relation to Freedom to Speak Up Arrangements)	Freedom to Speak Up Arrangements Task & Finish Group Ownership moving to DWOD	Extended from 31.07.22 to 31.03.23. Extended to 31.05.23 **Extended to 31.08.23**	Extended date in terms of project plans and impact of Industrial Action. 21.3 The task and finish group has completed its work and the project is now going to be handed to DWOD as SRO for the work. 21.06 soft launch of the platform in August with official launch in September in line with Practice Ethically behaviour.

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	13/08/2023	TREND	20 (5x4)
		Date of Next Review:	13/09/2023	➡	

IF	THEN	RESULTING IN
there are high levels of absence e.g. sickness and alternative duties	there is a risk that there is reduced resource capacity	an inability to deliver services which adversely impacts on quality, safety and patient/staff experience

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	5	4	20
Target	3	4	12

			03/08/23 - Soft launch commenced 1 August 2023, full launch moved to October as it is freedom to speak up month.
6. Strengthen Freedom to Speak Up Arrangements policy and advice	Assistant Director of Inclusion, Culture and Wellbeing	**31.05.23 Extended to 31/08/23**	Deadline extended to coincide with launch of new platform, although Guardians are in place and weekly review meetings taking place. They are receiving the highly confidential Datix and concerns raised through networks and attendance at ER monthly review from July. SharePoint page constructed and comms plan being finalised following refresher demos to key stakeholders. Behaviours reinforced via culture champions group, rotating through behaviours, currently broaden our understanding. Head of Culture and OD in post from August to further this work. **03/08/23 - Share point page published, comms plan in place.** **complete**
7. Create a Manager and Staff training plan for Freedom to Speak Up Arrangements	Assistant Director Inclusion, Culture and Wellbeing	**31.05.23 extended to 30/9/23**	Ongoing – extended until 30/9/23 to enable soft launch with feedback and policy and advice to be shared. Training plan will be produced with an emphasis on making the platform and use of freedom to speak up as simple and accessible as possible. SharePoint page constructed and comms plan being finalised following refresher demos to key stakeholders. Head of Culture and OD in post from August to further this work. **03/08/23 - Training plan identified**
8. Accountability meetings with senior ops managers	Deputy Director of People & Culture	30.09.22 Complete and ongoing BAU	Underway, conversations re sickness absence well established and continuing
9. Attendance Management training for managers	Deputy Director of People & Culture	31.12.22 Complete and BAU	Underway and ongoing – now BAU 1.11.22
10. PADR review including wellness questions	Assistant Director – Inclusion, Culture and Wellbeing	Complete	Complete. New PADR distributed October 22.
11. Restart the Health and Wellbeing Steering Group	Assistant Director – Inclusion, Culture and Wellbeing	Complete **Aug 23 - Paused**	Complete – group started 17.10.22 and will meet quarterly. **03/08/23 - Paused until key vacant posts, i.e. Head of Workplace Wellbeing and OH Manager, are filled**
12. Review of top 100 cases by the team on a monthly basis	Deputy Director of People & Culture	Commenced and ongoing – review 30.06.23 BAU	Underway and now BAU
13. Actions identified from the Managing Attendance Audit	Deputy Director, People and Culture	Commenced and ongoing. Completion 31.12.23	Delivery of the actions underway and partially complete. All will be completed by 31.12.2023.

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence	Date of Review:	09/08/2023	TREND	20 (4x5)
		Date of Next Review:	09/09/2023	➡	

IF the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations	THEN there is a risk of a loss of stakeholder confidence in the Trust	RESULTING IN damage to reputation and increased external scrutiny

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

IMTP Deliverable Numbers: 2,18, 26, 34, 38

EXECUTIVE OWNER	Director of Partnerships and Engagement	ASSURANCE COMMITTEE	People and Culture Committee

Risk Commentary Q4 2022/23

a) The risk score remains constant at 20 (highly likely and catastrophic). The organisation's reputational risk is one which is long-standing and entrenched. After initial improvements in risk rating some years ago, the impact of the pandemic, long standing performance and morale issues (including the impact of extended handover delays at hospitals), the impact of recent industrial action and the levels of patient harm which are being documented all result in limited opportunity to de-escalate the risk. Significant efforts are being made to address all of these factors. However, to date, the issues which contribute to reputation continue to be problematic and, therefore, militate against de-escalation of the risk for the foreseeable future. As part of the mitigation, extensive stakeholder engagement briefing, media relations work, patient experience and internal communication and engagement continue, but are not sufficient to outweigh the impact of the core issues which affect reputation. The lead Director and wider Executive Team discuss matters of reputation on a regular basis and the Trust's approach to stakeholder engagement is regularly reviewed in this context.

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Regular engagement with senior stakeholders e.g. Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders	1. Agendas, minutes and documents of engagement events
2. Challenging of media reports to ensure accuracy	2. Programme of daily media engagement
3. Media liaison to ensure relationships developed with key media stakeholders	3. Programme of daily media engagement
4. Engagement Framework approved by the Board July 2022	4. Issues of reputation monitored at EMT via weekly Forward Look item – minuted meetings and action logs.
5. Engagement Framework Delivery Plan approved by the Board January 2023	5. The Director of Partnerships and the Head of Strategy are working closely with colleagues from PWC to inform further detail regarding future engagement including stakeholder analysis, case for change etc. Routine stakeholder and staff engagement continues, including the recent round of Executive roadshows and WAST Live.
6. Engagement governance and reporting structures are in place	6. Relevant information which impacts on reputation is reported and scrutinised via all internal committees e.g. EMT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs. Outcome of recent reputation audit to be reported through EMT in April and onward, as a minimum, to PCC.
7. Escalation procedure for issues to the Board	7. Minuted meetings, action logs and Board papers

GAPS IN CONTROLS	GAPS IN ASSURANCE
1.	1.
2.	2.
3.	3.
4.	4.
5. The delivery plan is in abeyance pending outcome of the work underway by PWC in relation to the Trust's strategic ambitions.	5.
6.	6.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Submit refreshed Board Engagement Framework to Trust Board for approval	Director of Partnerships & Engagement	26.05.22 Complete	Approved July 2022
2. Roll out of the Engagement Framework Delivery Plan	Director of Partnerships & Engagement	Paused	Pending outcome of PWC work
3. Board oversight, scrutiny and challenge of performance, concerns, quality	CEO / Executive Management Team	Ongoing	
4. Monitoring internal Quality and Performance of Trust and raising system issues	Executive Management Team, Finance and Performance Committee	Ongoing	

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence	Date of Review:	09/08/2023	TREND	20 (4x5)
		Date of Next Review:	09/09/2023	➡	

IF the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations	THEN there is a risk of a loss of stakeholder confidence in the Trust	RESULTING IN damage to reputation and increased external scrutiny

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

	Quality, Safety and Patient Experience Committee, People and Culture Committee, Audit Committee		
5. Engaging with internal and external stakeholders to develop confidence	CEO & Director of Partnerships & Engagement	Ongoing BAU	Regular engagement continued with staff, TU partners and a range of external stakeholders such as AMs, MPs, Local Authorities etc. BAU.
6. Monitoring external factors that may affect the Trust	CEO & Director of Partnerships & Engagement	Ongoing BAU	
7. Llais (the new Citizens Voice Body attending October 2023 Board Development	Director of Partnerships & Engagement	October 2023	
8. Reputation Audit deep dive on findings to be presented at Board Development	Director of Partnerships & Engagement	October 2023	

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

IF the Trust does:	**THEN** there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	**RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage

- not achieve financial breakeven and/or
- does not meet the planning framework requirements and/or
- does not work within the EFL and/or
- fails to meet the 95% PSPP target and/or
- does not receive an agreement with commissioners on funding (linked to 458)

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

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

EXECUTIVE OWNER	Executive Director of Finance and Corporate Resources	**ASSURANCE COMMITTEE**	Finance and Performance Committee

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at F&P and a report is submitted bi-monthly to Trust Board
2. Financial policies and procedures in place	2.
3. Budget management meetings	3. Diarised dates for budget management meetings
4. Regular financial reporting to ADLT, EFG, EMT, FPC and Trust Board in place	4. Diarised dates for EFG and FPC and monthly reports
5. Welsh government reporting	5.
6. Monthly review of savings targets	6. ADLT monthly review
7. Regular review monitoring and challenge via WAST and CASC quality and delivery meeting with commissioners.	7.
8. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads.	8. Diarised dates for ICMB meetings with regular monthly report
9. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications	9. Regular PSPP communications (Trust wide) on Siren
10. Forecasting of revenue and capital budgets	10. (a) Monthly monitoring returns to ADLT, EFG, EMT and FPC (b) Reliance on available intelligence to inform future forecasting.
11. Business cases and benefits realisation (both revenue and capital)	11. Business cases – scrutiny and approval at senior management team which are submitted to ADLT, EMT, FPC prior to Trust Board for approval as appropriate according to value.
	External Assurances Management (1st Line of Assurance)
	5. Monthly Monitoring Returns to Welsh Government
	7. EASC management meetings. Monthly meetings with EASC and DAG for NEPTS.
	8. Bi-monthly Capital CRL meetings with Trust and WG capital leads
	9. Regular P2P meetings diarised (bi-monthly)
	10. Monthly monitoring returns into Welsh Government
	Independent Assurances (3rd Line of Assurance)
	1-10 Internal audit reviews covering
	1-10 External audit reviews

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Lack of formalised service contracts between Commissioner and WAST as a commissioned body	None identified.

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

IF the Trust does:	**THEN** there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	**RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage
• not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)		

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

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

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	03/08/2023	TREND	16 (4x4)
		Date of Next Review:	03/09/2023	➡	

IF the response to tensions and challenges in the relationships with TU partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained	**THEN** there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised	**RESULTING IN** a negative impact on colleague experience and/or services to patients		Likelihood	Consequence	Score
			Inherent	5	3	15
			Current	4	4	16
			Target	4	3	12

IMTP Deliverable Numbers: 2, 4, 6, 11, 20, 34

EXECUTIVE OWNER	Director of People & Culture	**ASSURANCE COMMITTEE**	People & Culture Committee

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Agreed (Refreshed) TU Facilities Agreement developed in partnership	1. Agreed document which states governance arrangements and the criteria for time off for TU activity etc.
2. Go Together Go Far (GTGF) statement and CEO/TU Partners statement	2. Both parties refer to the documents and are signed up/committed to it
3. IPA Workshops	3. Meetings completed with participation from TUs and senior managers. Attendance lists are available
4. Trade Union representation at Trust Board, Committees	4. Committee or Board ask TU representative for feedback or whether they have been consulted. Big issues items progress as planned as a result of TU partner buy in
5. Monthly Informal Lead TU representatives and Chief Executive meetings	5. Diarised meetings
6. Staff representative management in Task & Finish Groups	6. Good attendance and commitment is observed at the meetings. TU partners listed as members in terms of reference
7. WASPT re-established post stand down of cell structure post pandemic	7. Diarised meetings with a formal agenda. Any business needed to be discussed is included in the agenda. Good attendance and commitment observed at meetings.
8. Local Co-Op Forums, and informal monthly meetings between TUs and Senior Operations Team	8. Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings
9. Quarterly Report on TU activity to People and Culture Committee	9. Report at every P& C committee meeting regarding activities TUPs involved with which is noted. Whenever Partnerships are discussed, the value of these is formally minuted in the Board and Committee minutes
10. Structures below WASPT to be signed off at next WASPT meeting in June 2023	10.
	External - Not applicable

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Need to move back to business-as-usual footing	None identified
2. Facility to manage situations where there is a failure to agree, to avoid grievance and disputes from occurring	

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Develop an action plan from the recommendations of the ACAS report	Deputy Director of People & Culture	Completed 12/01/23	Action Plan for delivery created and shared with TU Secretary for feedback from TUPs
2. Agree the ToR for refreshed Partnership Forum meeting and move back to a business-as-usual footing	Deputy Director of People & Culture	Completed 12/01/23	WASPT re-established. Third meeting scheduled T&F group undertaking work on the engagement model below WASPT through SLT and SOT is in progress with TU engagement. TU cell stood down.
3. Proposed externally facilitated mediation session(s) building on the IPA workshops and specifically to address the thorny issue of what happens when we fail to agree	Deputy Director of People & Culture	Completed 12/01/23	Rearranged date 24.08.22 due to COVID in ACAS facilitators. First ACAS sessions delivered in June. Joint ACAS session with TUPs and Senior Team delivered on 24.08.22. Awaiting report from ACAS advised they are finalising by 23.09 and will forward week of 26th Sept. Draft plan in development to capture actions from the meeting. Actions from the ACAS recommendations will be added on receipt. Report received in October. Action plan developed and shared with TUs. Implementation underway
4. Minutes of formal Partnership Forum should be reported to PCC or Board in future (return to BAU).	Deputy Director of People & Culture	Completed 12/01/23	WASPT feeding into PCC

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships			Date of Review:	03/08/2023	TREND	16 (4x4)
				Date of Next Review:	03/09/2023	→	

IF the response to tensions and challenges in the relationships with TU partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained	THEN there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised	RESULTING IN a negative impact on colleague experience and/or services to patients		Likelihood	Consequence	Score
			Inherent	5	3	15
			Current	4	4	16
			Target	4	3	12

5. Establish formal meeting structures below WASPT	Deputy Director of People & Culture	30.06.2023 Completed	Structure agreed with TUs. Sign off at next WASPT meeting. Highlight reports to be shared at WASPT. Completed structures for Local Partnership Forums and SOT/ SLT for operations and Partnership Meeting for Corporate Services agreed, ToR for SOT /SLT and LFP agreed.
6. Refresh of engagement programme post Industrial Action and establish work	Deputy Director of People & Culture	30/08/23	

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

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

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

IMTP Deliverable Numbers: 5,9,10, 17, 28

EXECUTIVE OWNER	Director of Strategy, Planning & Performance	**ASSURANCE COMMITTEE**	Strategic Transformation Board and Finance and Performance Committee

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Prioritisation of IMTP deliverables	1. Prioritisation detailed in IMTP and reviewed and agreed at Strategic Transformation Board
2. Financial policy and procedures	2.
3. Governance and reporting structures e.g. Strategic Transformation Board (STB)	3. IMTP sets out delivery structures and meeting minutes are available
4. Assurance meetings with Welsh Government and Commissioners	4. Agendas, minutes and slide decks available
5. Transformation Support Office (TSO) which supports the major delivery programmes	5. Paper on TSO to Strategic Transformation Board
6. Project and programme management framework	6. PowerPoint pack detailing PPM
7. Regular engagement with key stakeholders	7. Stakeholder Engagement Framework
8. Financial Sustainability Programme – savings and income work streams	8. FSP programme highlight reports
	Independent Assurance (3rd Line of Assurance) 2. Subject to Internal Audit
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Project and programme management (PPM) framework to be reviewed	1. PPM needs to be reviewed and approved through STB
~~2.~~	2. Benefits have not been fully linked to benefits realisation
3. Lack of a commercial contractual relationship with Commissioners (link to risk 458)	

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

Risk ID 458	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding of recurrent costs of commissioning services to deliver the IMTP and/or any additional services	Date of Review:	08/08/2023	TREND	16 (4x4)
		Date of Next Review:	08/09/2023	➡	

				Likelihood	Consequence	Score
IF sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis.	**THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients.	**RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage	**Inherent**	3	4	12
			Current	4	4	16
			Target	2	4	8

IMTP Deliverable Numbers: 2, 12, 16, 18, 23, 24, 25, 26, 28,30, 34, 37, 38

EXECUTIVE OWNER	Director of Finance and Corporate Resources	**ASSURANCE COMMITTEE**	Finance and Performance Committee

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at F&P and a report is submitted bimonthly to Trust Board
2. Financial policies and procedures in place	2.
3. Setting and agreement of recurrent resources	3.
4. Budget management meetings	4. Diarised dates for budget management meetings. If an area is in financial deficit, the meeting would be at least once a month. If the area is in balance or surplus, the meeting would be quarterly.
5. Budget holder training	5. Diarised dates for budget holder training
6. Annual Financial Plan	6. Submission to Trust Board in March annually
7. Regular financial reporting to EFG & FPC in place	7. Diarised dates for EFG and FPC with full financial reports
8. Regular engagement with commissioners of Trust's services	**External** **Management (1st Line of Assurance)** 1. Accountability Officer letter to Welsh Government 3 and 8 EASC management meetings. Monthly meetings with EASC and DAG meetings for NEPTS. Meetings are diarised. 9. Monthly monitoring returns
9. Welsh Government reporting on a monthly basis	**Independent Assurance (3rd Line of Assurance)** 2. Internal Audit reviews of financial policies & procedures as part of their audit plan
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Lack of clarity regarding EASC/Welsh Government commitments with respect to recurrent funding	1. Dialogue with EASC and DAG does not always result in recurrent arrangements (outside of WAST control)

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. A formal approach to service change to be developed providing secure recurrent funding with commissioners.	Executive Management Team	31.12.23	Update: 22/23 Recurrent & non-recurrent Finances have been agreed as part of year end agreement of balances. Issue currently around the 100 WTE £6m funding and negotiations continue. **Recent letter from Commissioners indicates funding will be forthcoming however with conditions.**
5. Develop a Value Based Healthcare system approach with commissioners. This would mean that funding would flow more seamlessly between organisations and would go some way to mitigating the risk of not receiving recurrent funding.	Deputy Director of Finance	31.12.23	Update: Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	04/08/2023	TREND	15 (3x5)
		Date of Next Review:	04/09/2023	➡	

IF	THEN	RESULTING IN
there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation

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

IMTP Deliverable Numbers: 1, 7, 9, 12, 16, 17, 24, 25, 26, 33, 35, 38

EXECUTIVE OWNER	Director of Quality and Nursing	ASSURANCE COMMITTEE	People and Culture Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1 Systematic review and assessment of Health and Safety arrangements and Governance (All NHS Wales Health & Safety Management System - HSMS).	1. Assessment criteria set for health and safety management system (HSMS) All Wales system). HSMS approved at ADLT in 2022. ADLT members sponsorship for all 11 management principles.
1. Health & Safety Governance and reporting arrangements – National Health, Safety and Welfare Committee. Reporting into People and Culture Committee. (PCC)	2. Trusts Legislative Compliance Register in place **and assessment approved by SOT and ADLT in April 23. Position landed as 1.98/3 providing a Moderate level of Assurance.** Monthly, Quarterly and Annual H&S performance reports to ADLT and H&S National Health, Safety and Welfare Committee. Quarterly performance reports to ADLT, EMT and PCC **- commencing presentation at SOT in Q2 23.** Reports published on H&S webpage. H&S climate cultural survey developed to determine perception of Trust position against Bradley Curve.
2. Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, - Regulation 7 'Health and Safety Assistance'.	3. H&S Policy approved in 2018. Following landing of business case, Policy reviewed and **substantial consultation process completed in Q2 23. Policy expected to go to EMT for approval in Q2 -Q3 23.** Violence and Aggression Policy in place. Risk Assessment Procedure, Display Screen Equipment Procedure, Workplace Premise Audits Inspection Procedure in place. Control of Substances Hazardous to Health (COSHH), New and Expectant Mothers Risk Assessment Procedure approved at ADLT in February 2023. Lifting Operations Lifting Equipment / Provision and Use of Workplace Equipment (PUWER) combined Procedure in draft with an expectation of commencing the approval process approval during Q2-Q3 2023. Lone Worker Procedure ongoing - expectation of second draft Q2-**Q3** 2023. Trust wide Hazard register in place. Reviewed by ADLT in Q1 2023 and **approved by SOT and ADLT in April 23 Q1 2023.**
3. Health & Safety Policy and Corporate level Procedures.	4. H&S Policy approved in 2018. Following landing of business case, Policy review underway Q4 2022-Q1 2023. Violence and Aggression Policy, Risk Assessment Procedure, Display Screen Equipment Procedure, Workplace Premise Audits inspection Procedure in place. Control of Substances Hazardous to Health (COSHH), New and Expectant Mothers Risk Assessment Procedure approved at ADLT in February 2023. Dangerous Substances Explosive Atmospheres (DSEAR) Procedure, Lifting Operations Lifting Equipment / Provision and Use of Workplace Equipment (PUWER) combined Procedure in draft with an expectation of commencing the approval process approval during Q1 2023. Lone Worker Procedure ongoing - expectation of second draft Q1 2023. Trust wide Hazard register framework in place. Reviewed by ADLT in Q1 2023 with expectation of approval Q1 2023.
4. Mandatory Health and Safety training for all staff on ESR. Induction training in place for all new operational staff.	5. Quarterly statistics provided by ESR support team and incorporated into Health and Safety Quarterly Performance reports. Induction training compliance held on ESR
5. 2 year rolling programme of scheduled H&S premise audits.	6. Inspections are being undertaken in line with schedule. Live action.
6. Risk assessments (including local risk assessments, Covid 19, Workplace Risk Assessments, risk assessments covering EMS and NEPTs activities, operations risk assessments).	7. Workplace risk assessments are undertaken by local management teams, reviewed by H&S team and previously monitored by BCRT. These are being monitored by local operations mangers. Other operational risk assessments and SOPs are held on dedicated Share-point sections. Performance metrics in place **and monitored via SOT and Quarterly Performance Reports.**
7. Working Safely Strategic Programme Board (STB) to provide oversight of the Working Safely Action plan. Dynamic Delivery Action Group to continue to undertake actions on the Working Safely Action Plan.	8. Working Safely Action Plan has been agreed and this is being held to account by Strategic Transformation Board. Deliverables are being monitored through the Dynamic Delivery Group meeting. Terms of reference for Dynamic Delivery Group are approved. **Live action.**

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	04/08/2023	TREND	15 (3x5)
		Date of Next Review:	04/09/2023	➡	

IF	THEN	RESULTING IN
there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation

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

8. Rolling programme of IOSH Managing Safely- for Managers- scheduled training programme in place.	9. Attendance and competency figures provided in a quarterly **04** to ADLT, National Health, Safety and Welfare Committee and People and Culture Committee.
9. IOSH Leading Safely for Directors and Senior Managers training in place.	10. Attendance and figures provided in monthly report to ADLT. Personal safety commitments are to be monitored on a quarterly basis **following discussions to be held with Board Secretary, Executive Director for Quality and Safety and Head of Health & Safety in Q2-3 2023.**
10. Board Development Day covering Health & Safety Management and Culture Awareness training undertaken in April 2022.	11. Diarised meeting.
11. Health and Safety Management System recognised document approval routes for health and safety documentation.	12. Approved and minuted at ADLT meeting in 2022. **HSMS document approval process to be reviewed to include SOT approval Q2 2023.**
12. IOSH Leading Safely training delivered to majority of Board and Executive Team on 26 July 2022.	13. Compliance metrics held on H&S team database.
13. IOSH Leading Safely additional sessions for new Board /EMT members and ADLT to be scheduled for 2023.	14.
14. Leading Safely, Safety Positive conversations training to be delivered to Board and EMT to be rescheduled from June 2023.	15. **Discussions scheduled with Board Secretary and Head of H&S in August 23 on options for delivery.**
15.	16. Internal Audit to be undertaken in Q1-**Q2** 23/24 (controls 1– 10). **Audit position landed as 'Reasonable' level of assurance.** **(External Independent Assurance (3rd Line of Assurance)**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1.	**1.** Baseline audit for HSMS not to be commenced till Q**3** 2023 (***being addressed in Action 1)***
2. Subgroups of National H&S and Welfare Committee currently under review. **(being addressed in Action 2)**	2. H&S Climate Cultural survey to be rolled out once political pressures (IA) reduce**.** Expectation of roll out **Q3-Q4** 2023/24 (***being addressed in Action 3)***
3.	3.
4. The Health and Safety Policy and some procedures are due to be reviewed by the end of Q4 2022 in Q1 2022 (***being addressed in Action 4***)	4. (a) Review of H&S Policy has been undertaken, **and substantial consultation process ceased in August 23. Policy to be presented at EMT in Q2-Q3 20203 for approval before commencing to PCC for final approval.** (***being addressed in Action 4)*** (b) Workforce Transformational change has influenced some content within H&S policy (***being addressed in Action 4)***
5. Poor uptake in statutory and mandatory H&S training ***(being addressed as part of Actions 5)***	5.
6.	6. Two-year Schedule for H&S inspections and visits commenced September 2022. Compliance metrics, themes and trends are to be included within Monthly and Quarterly and Annual Performance Reports. ***(being addressed as part of Actions 6)***
7.	7. (a) Current copies of risk assessments and SOPs are not available at all stations. ***(being addressed as part of Actions 7)*** (b) Lack of clarification over many SOPs are required until HSMS baseline audit has been completed. ***(being addressed as part of Actions 7)***
8. Operational pressures and Industrial Action on service impacting on Working Safely Programme delivery **(being addressed in Action 8)**	8.
9. Staff availability to attend training ***(being addressed in Action 5)***	9. Work ongoing to determine how many Managers require IOSH Manging Safely. ***(being addressed in Action 9).*** A H&S Training needs analysis has been developed and incorporated into the H&S Policy.
10. Effective learning from events to be documented ***(being addressed in Action 8)***	10. Currently there is no structured monitoring process in place to ensure attendance on the IOSH Leading Safely course. ***(being addressed in Action 5)***
11.	11.
12.	12.

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	04/08/2023	TREND	15 (3x5)
		Date of Next Review:	04/09/2023	➡	

IF	THEN	RESULTING IN
IF there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	THEN there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	RESULTING IN death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation

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

13.	13.
14.	14.
15.	15.
16.	16.
17.	17.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Meetings to be scheduled to undertake baseline assessment and feedback to EMT.	Head of Health and Safety	Q2-Q3 2023	
2. Meetings to be held with TU partners and AD/Head of H&S to agree arrangements for sub-groups.	Head of Health and Safety	**Q1 2023**	ToR Developed and presented at National HSW Committee in Q2 2022. Further discussions requested a Charter arrangement. Draft Charter developed and presented in National HSW committee in Q3 2022. Further discussions requested by TU partners. Following discussions held with OD in April 2023 to provide consideration of integrating subgroups into WASTP, 23.06.23- H&S to be incorporated into WASTP sub-groups LPF.
3. Assessment to be undertaken in Q1 2023 of political pressure to determine viability of conducting culture survey	Head of Health and Safety	Q2-Q3 2023	Political pressures still present. Survey to be rolled out once eased. Watching brief.
4. **Revised** H&S Policy **to achieve ratification**	Head of Health and Safety	**Q1 2023**	Initial meeting held in December 2022 first draft to be presented at Policy Group Meeting in January 2023 for comments from key stakeholders. Challenges with attendance due to IA. Expectation of draft Policy being presented at Policy Group to propose full consultation in May 2023. Policy presented at Policy Group in June 23 and commences substantial consultation process on 30.06.23. **Policy expected to be presented to EMT for approval in Q2-3 2023.**
5. IT solution being investigated to collate data from inspections to enable trending and monitoring of actions generated	Deputy Head of Health and Safety	Q4 2023	The audit proforma has been migrated onto MS Forms to allow for improved data collection. Meeting held with I.T. provider in Q4 2022 provide consideration for the development of utilisation of Power B.I systems. Ongoing.
6. H&S advisors will liaise with local management teams to identify risk assessments and SOP's in place and ensure visibility on SharePoint	Deputy Head of Health and safety	Q2-Q3 2023	Ongoing action. Assessment against the HSMS Principle 3- Compliance Assurance will assist in determining what RA/SOPS are required. **Live action.**
7. Priority Elements of Working Safely Action Plan to be identified and programme schedule presented to STB to ensure sufficient support from Operational Teams. Migrate into Annual Health and Safety Improvement Plan.	Head of Health and Safety	Q2 2023	Priority actions for 2023-24 identified as Culture, Manual Handling, Violence and Aggression, Incident investigation training. 05.04.23 Development of Health and Safety Improvement Plan **developed Q1 2023 and monitored via Monthly H&S team meetings.**.
8. Review of number of line managers within the Trust to put in place a suitable schedule to roll out appropriate H&S training as determined within the training needs analysis within the H&S Policy.	Deputy Head of Health and Safety	Q2 2023	Interim schedule in place to address known line managers. Further work required with other Directorates to allow for performance metrics to be generated.
Completed Actions	**Action Owner**	**When /Milestone**	**Progress Notes:**
1. Delivery of the Working Safely Action Plan (WSAP) (Priority top 25)	Head of Health & Safety	31.09.22 **Partially completed.** Long term action.	Pump and Prime phase commenced 01.09.21. Closure report for PPP presented to EMT during Q3 2022/23. Working Safely Programme to continue being monitored by STB. Four priorities determined for 2023/24- Violence & Aggression, Culture, Manual Handling and Incident Investigation.
2. IOSH Leading Safely training to be delivered to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22 **Partially completed.**	Training delivered to Board and Executive team on 26.07.22. IA and operational pressures impacted on availability to attend during Q4 2022.Further sessions to be scheduled for Q1 2023/4- Q2 2023/24 for new members.

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	04/08/2023	TREND	15 (3x5)
		Date of Next Review:	04/09/2023	➡	

IF there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance	THEN there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments	RESULTING IN death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation

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

3. WAST Leading Safely Behavioural Audit training to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22 Scheduled	Initially scheduled for BDD - February 2023. Rescheduled to June 2023. **Discussions to be held with Board Secretary and Head of H&S in August 23 around alternative delivery style of training.**
4. H&S team workforce review (accompanying Business Case forms part of this) (this forms part of WSAP)	Head of Health & Safety	31.03.22 Completed	Completed- Workforce review fully implemented 03.10.22
5. Culture survey to all members of staff (forms part of WSAP)	Head of Health & Safety	30.09.22 **Partially completed**	Survey developed and to be presented at National H&S Committee on 02.11.22 and SOT in December for feedback. Decision made during Q3 2022/23 to postpone survey unit political pressures ease. Expectation of roll out Q4 2023-Q1 2023/24. Political unease impacted on the roll out of the survey roll out. Expectation that survey will be rolled out during Q1-Q2 2023/4
6. A compliance register that describes the requirements of the various Health & Safety legislation that the Trust needs to comply with (part of WSAP)	Deputy Head of H&S	30.06.22 Completed	Compliance Register framework developed, **and assessment approved as providing a moderate level of assurance Q1 2022.**
7. An initial assessment will provide assurance on how we are complying with the legislation.	Deputy Head of H&S	**Partially completed.** Assurance - 01.06.22 Rolling programme of assessments – 31.12.22	Assessments undertaken. Some outstanding estates assessments scheduled January 2023. Compliance register presented to ADLT members on 04.04.23. **Further legislation in relation to V&A , Road Safety Traffic Act and the and Civil Contingencies Act to be added and assessed Q3-Q4 2023.**
8. Quarterly report on training compliance to be presented to ADLT for actioning within respective Directorates	Head of Health and Safety	Q3 2022 - Complete	Report is a standard section of Quarterly H&S Performance report to ADLT

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

IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	THEN there is a risk of a significant information security incident	RESULTING IN a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

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

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

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Appropriate policy and procedures in place for Information/Cyber Security	1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
2. Trust Business Continuity Procedure and Incident Response Plan	2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
3. IT Disaster Recovery Plan	3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
4. Relevant expertise in Trust with respect to information security	4. Staff undertake relevant training courses e.g. CISSP to increase knowledge and expertise
5. Data Protection Officer in post	5. In job description of Head of ICT
6. Cyber and information security training and awareness	6. Training statistics are available on ESR and from Phish threat module
7. Mandatory Information Governance training which includes GDPR	7. Training statistics reported on by Information Governance department
8. ICT tests and monitoring on networks & servers	8. Any issues would be identified and flagged and actioned
9. Information Governance framework	9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
10. Internal and NHS Wales governance reporting structures in place	10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.
11. Checks undertaken on inactive user accounts	11. Software in place to run check on inactive accounts as and when
12. Business Continuity exercises	12. Annual schedule of testing
13. Operational ICT controls e.g. penetration testing, firewalls, patching	13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when. **04/08/23 – Exploring procurement of additional penetration tests with the aim of annual testing of all critical systems.**
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
	External Independent Assurance NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Not all information security procedures are documented	1. No regular Cyber/Info Security KPIs are reported to senior management committees. **04/08/23 – Monthly KPI reports now being generated routinely and fed into the Digital Leadership Group. Needs to transfer to assurance – no longer gap?**
2. Lack of understanding and compliance with policy and procedures by all staff members	2. Cyber awareness campaigns could be undertaken more regularly e.g. bi-monthly. **04/08/23 – Latest campaign commenced 01/08/23 to raise staff awareness. Needs to transfer to assurance – no longer gap?**
3. No organisational information security management system in place	

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

IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	THEN there is a risk of a significant information security incident	RESULTING IN a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

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

4. IT Disaster Recovery Plan does not include a cyber response
5. Departments do not communicate in a timely manner with Digital Services around putting in new processes, new projects and procurement and this has a cyber security, information governance and resource impact

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

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

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

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

IMTP Deliverable Numbers: TBC

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

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

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

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences	Date of Review:	03/08/2023	TREND	15 (3x5)
		Date of Next Review:	03/09/2023	→	

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of a significant deterioration in staff health and wellbeing within WAST	increased sickness levels, staff burnout, poor staff and patient experience and patient harm

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

IMTP Deliverable Numbers: TBC

EXECUTIVE OWNER	Director of People & Culture	ASSURANCE COMMITTEE	People & Culture Committee

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Health and wellbeing strategy in place and shared across the Trust.	1. Review undertaken of the Health and Wellbeing Strategy by Assistant Director annually.
2. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme	2. Regular review meetings with all external providers to ensure they meet requirements of the SLA contracts. Regular management information received so that trends can be monitored.
3. Self-referrals or managerial referrals to Occupational Health	3. Regular reports submitted by Occupational Health team to WOD Business Meetings for monitoring.
4. Wellbeing support and training for line managers	4. Diarised meetings, webinars and workshops in place through a rolling programme.
5. Development of range of wellbeing resources for staff and line manager	5. Tools are available on WAST intranet. Occupational Health and Wellbeing teams visit stations, A&E , CCCs and other locations regularly where operational staff are based to promote the occupational health and wellbeing offer.
6. Peer support network forum	6. Agendas and minutes of meetings produced for each meeting.
7. WAST Keep Talking (mental health portal) and Sway on the Intranet	7. Available on intranet for staff to access easily.
8. TRiM	8. TRiM Coordinator has regular dialogue with TRiM managers and practitioners. Project plan and training schedule in place.
9. Coaching and mentoring framework	9. Information on intranet on Learning launch pad available to all staff.
10. Acting on results of staff surveys relating to staff experience	10. Each Directorate has developed their own action plan to address staff surveys.
11. HSE stress risk assessments	11. Undertaken by managers and advice is provided on how to use them by Occupational Health team.
12. KPIs are reported monthly to WOD regarding Occupational Health and Wellbeing activity	12. Received at WOD Business Meetings monthly.
13. Wellbeing drop-in sessions for CCC and 111 staff	13. Diarised sessions in place as part of the programme.
14. Fast track physiotherapy	14. Regular review meetings with physiotherapy provider and monthly monitoring information received at WOD Business meetings.
15. Specialist trauma counselling service	15. Same as 15.
16. Regular psycho-educational sessions with managers and staff	16. Diarised sessions
17. Compassionate leadership training sessions	17. Same as 17 in place as part of the programme.
18. Chaplaincy programme	18. Training plan and minutes of meetings produced quarterly for the Wellbeing Team – to be reviewed.
19. Occupational Health team inclusion in sickness and absence meetings	19. Diarised meetings in place.
20. Procure a pulse survey tool to benchmark how colleagues are feeling and get feedback on the employee experience	20. **HIVE due to go live in September 2023.**
	External - Independent Assurance - Audit Wales – Taking Care of the Carers report in October 2021

GAPS IN CONTROLS	GAPS IN ASSURANCE
	4. Reporting on wellbeing training take up
11. Need to increase the education and communication with managers about stress risk assessments. Presentation developed and shared with people services. Delivery dates being agreed in conjunction with Health and Safety.	Lack of awareness about staff wellbeing services
	Effects of REAP 4 affecting the ability of staff to engage with staff health and wellbeing services. Important to recognise the consistent reports of the impact of culture on wellbeing.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences	Date of Review:	03/08/2023	TREND	15 (3x5)
		Date of Next Review:	03/09/2023	➡	

IF	THEN	RESULTING IN
significant internal and external system pressures continue	there is a risk of a significant deterioration in staff health and wellbeing within WAST	increased sickness levels, staff burnout, poor staff and patient experience and patient harm

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

1. Restart the Health and Wellbeing Steering Group (link to risk 160)	Assistant Director Inclusion, Culture and Wellbeing	Completed **03.08.23 Group paused due to two key vacancies.**	First meeting was on 17/10/2022. This however does not yet bring down the score of the risk as the Steering Group meeting was to re-establish a way forward. Next meeting to be scheduled within 2 months. **03/08/23 - Head of workplace Wellbeing due to be in post in October and OH Manager about to go to advert. No capacity within the team to restart the group.**
2. Increase the education and communication with managers about stress risk assessments	Head of Health & Safety	Completed	This is part of the IOSH Managing Safety Training BAU. OH to undertake workshops with CCC managers – dates to be confirmed this week.
3. Deliver the employee engagement tool into WAST	Deputy Director of People and Culture	**30.09.23**	Software has been procured. Planning for rollout is underway. First survey delivery in July 2023. **03/08/23 - Working on the timing of launch based on the rollout of the Freedom to Speak up platform.**

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

				Likelihood	Consequence	Score
IF a major incident or mass casualty incident is declared	**THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients due to vehicles not being released from hospital sites	**RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004	**Inherent**	4	5	20
			Current	3	5	15
			Target	2	5	10

IMTP Deliverable Numbers: TBC

EXECUTIVE OWNER	Director of Operations	**ASSURANCE COMMITTEE**	Finance & Performance Committee

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

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

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

Risk ID 100	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	04/08/2023	TREND	12 (3x4)
		Date of Next Review:	03/11/2023	➡	

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

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

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

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

CONTROLS	ASSURANCES
	Internal & External Management (1st Line of Assurance)
1. EASC/WAST Forward Plan for EMS and NEPTS in place and monitored at EASC meetings	1. Minutes of meetings and a standard agenda item
2. EASC and its 2 sub-committees established as a forum to discuss WAST's strategy	2. Minutes of meetings and a standard agenda item
3. Weekly catch up between CASC/CEO	3. Meetings are diarised every week
4. Collaboration between EASC and WAST on specific projects e.g. Amber Review, EMS Operational Transformation Programme, Ambulance Care Programme	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
5. Monthly CASC Quality and Delivery Meeting established	5. Formal meeting with agendas, minutes and action logs available.
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced	6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholders fortnightly
7. Programme structure has been established for 'inverting the triangles' including EASC	7. It exists and has had its first meeting
	External Management (1st Line of Assurance) 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. EASC meetings focus largely on EMS and cursory note of NEPTS	**1. NEPTS is covered in the WAST Provider Report to EASC.**
2. Governance coordination between NCCU and WAST to be improved.	2. Identified need for a governance meeting between NCCU and WAST to manage the overall commissioner/provider interface. Actioned but has lapsed due to capacity and resourcing in NCCU team. HB to reboot.
3. WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	**3. Ministerial direction on handover reduction**
4. Funding does not flow in a manner to balance demand with capacity (outside of WAST's control)	**4. Strategic demand and capacity review being undertaken with output due to be reported to EASC in Jan-24.**

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

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

IF	THEN	RESULTING IN		Likelihood	Consequence	Score
there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme	there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters	potential patient harm, deterioration in staff wellbeing and reputational damage	**Inherent**	4	4	16
			Current	3	4	12
			Target	2	4	8

IMTP Deliverable Numbers: 3, 7, 17, 18, 19, 20, 27

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Implementation Programme Board in place – meetings held every 3 weeks with the DASC and TU reps on the membership	1. Minutes and papers of Implementation Programme Board
2. Executive sponsor and Senior Responsible Owner (SRO) for programme in place	2. Project Initiation Document (PID) detailing structure and minutes of Implementation Programme Board
3. Programme Manager and Programme support office in place (for delivery of the programme)	3. Same as 2
4. Programme risk register	4. Highlight reports showing key risks reported to STB every 6 weeks
5. Assurance meetings held with Strategic Transformation Board (STB) every 6 weeks and with CEO every 3 weeks	5. Highlight reports presented to STB every 6 weeks
6. Programme budget in place (including additional £3m funding for 22/23)	6. Programme budget monitoring report is provided to the Implementation Programme Board – every 6 weeks and letter received from CASC on £3m funding for 22/23
7. Programme documentation and reporting is in place to Programme Board every 3 weeks and STB receives highlight report	7. PID and Programme Plan Summary kept up to date**.** PID is presented to the STB if there is a significant change in the programme deliverables. Programme Plan Summary reported to the Implementation Programme Board every 3 weeks.
8. Regular engagement with the Commissioner and Trade Unions and representation	8. Commissioner and TU participation at the Implementation Programme Board
9. Management of external stakeholder and political concerns	9. Communications and Engagement Plan sets out WAST's arrangements for engagement with stakeholders
10. Secured specialist consultancy to support decision making	10. Reports and contractual compliance
	External **Management (1st Line of Assurance)**
	a. Deputy Ambulance Services Commissioner sits on the Implementation Programme Board
	b. Emergency Ambulance Service Committee Management Group receives a highlight report every two months
	c. EASC receives an update every 2 months on the programme as part of the WAST Provider Report

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

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

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

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

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

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

AGENDA ITEM No	**11**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

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

MEETING	Trust Board
DATE	28th September 2023
EXECUTIVE	Rachel Marsh - Executive Director of Strategy, Planning and Performance
AUTHOR	Alexander Crawford - Assistant Director of Planning and Transformation Heather Holden – Head of Transformation
CONTACT	Heather.holden@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this paper is to provide the Board with the progress and delivery of actions in the IMTP 2023/26. A full delivery and assurance report has been reviewed at Finance & Performance Committee, alongside a detailed assurance report in relation to the 'Inverting the Triangle' Programme.

RECOMMENDED: That the Board Notes the overall delivery of the IMTP detailed in this paper.

KEY ISSUES/IMPLICATIONS

Following Trust Board approval on 30 March 2023, the WAST IMTP for 2023-26 was submitted to Welsh Government on 31 March 2023. The Minister scrutinised plans during the summer recess and has confirmed approval of WAST's IMTP on 12th September 2023. Approval is subject to a number of accountability conditions which we are awaiting from the Chief Executive of NHS Wales. Since the submission of our IMTP the financial planning within NHS Wales has shifted and WAST has undertaken some work on choices for further savings opportunities alongside our IMTP committed savings plan. We are awaiting feedback on the proposals put forward to assess the impact on our current IMTP delivery.

Finance & Performance Committee received a full delivery and assurance report which included a written update from each of the IMTP Delivery Programmes:

- EMS Operations Programme
- Ambulance Care Programme

- Gateway to Care Programme
- Clinical Transformation Programme
- Financial Sustainability Workstreams

These programmes provide a written assurance report quarterly to Strategic Transformation Board (STB), including progress against agreed milestones. The Committee also received a further update on the discrete work being undertaken around our EMS Transformation Programme (currently referred to in the IMTP as 'Inverting the Triangle'). This is a crucial time for this programme of work as we undertake a mid-point review of our long term strategy and think forward to how we engage on solutions to the challenges highlighted through the 'Inverting the Triangles' work. We are also considering how we evolve the language we use to describe our strategic transformation agenda so that it is meaningful to stakeholders across Wales.

The assurance report to Finance & Performance Committee also included updates by exception on the IMTP Enabling Programmes:

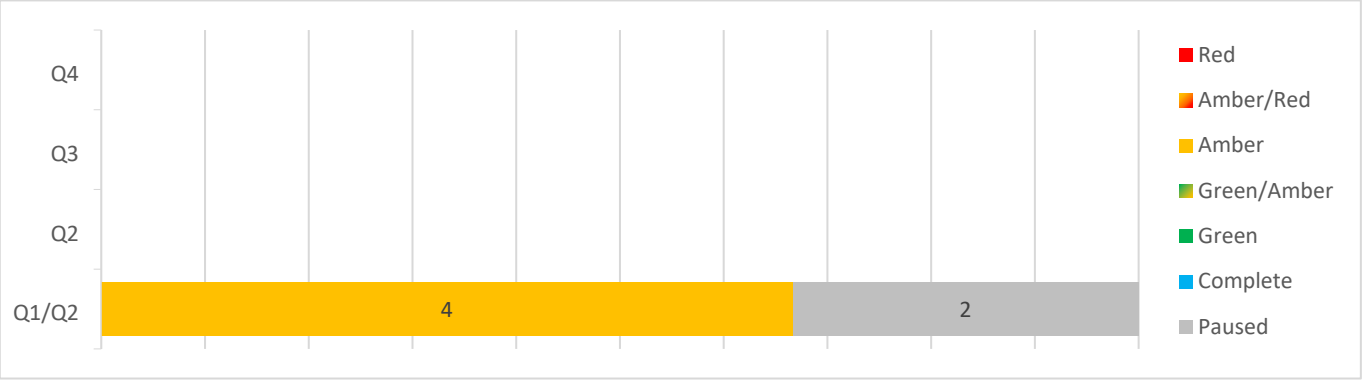
- People and Culture
- Digital
- Infrastructure
- Fundamentals (including Quality Safety & Patient Experience, and Corporate Governance)

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

IMTP Delivery Programmes

EMS Operations Programme

Overall RAG Status: AMBER



4 Amber, 2 Paused:

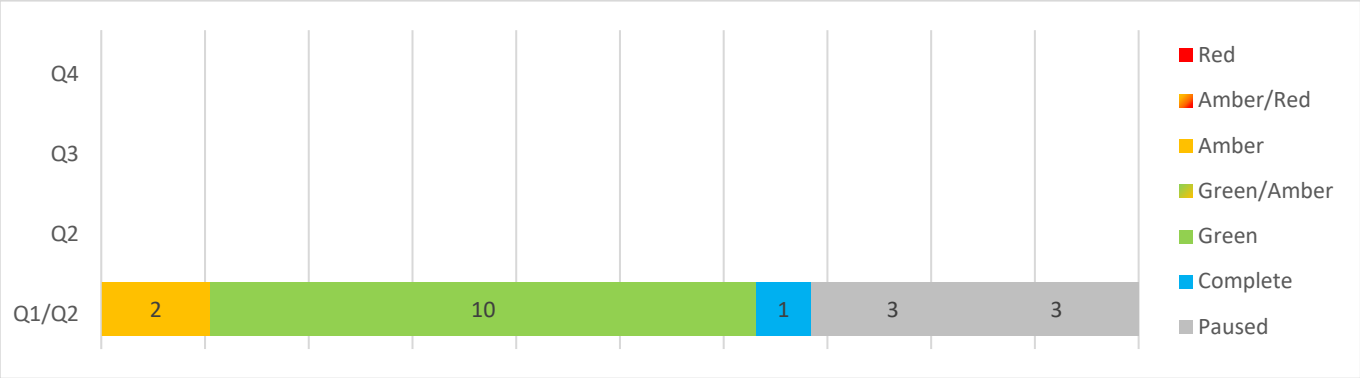
- The EMS Response Roster Review completed implementation last year, but the project evaluation remains outstanding due to limited planning team capacity and has therefore been identified as Amber.
- Work is ongoing in terms of how we amend rosters in the light of decisions on resource prioritisation, for example, as a result of decisions to offer APPs who have finished their

training a permanent APP role. This is complex work that is ongoing and is taking slightly longer than originally planned.

- The EMS Control Reconfiguration Project has experienced slippage across all three workstreams, with both Boundary Changes and the CCC Roster Review paused for a variety of reasons.
- CHARU work is also rated Amber as there continues to be a gap of 44 against the original target of 153 WTE in post. Discussions are ongoing in relation to how this gap is filled, in the light of the national position on finances.

Ambulance Care Programme

Overall RAG Status: GREEN

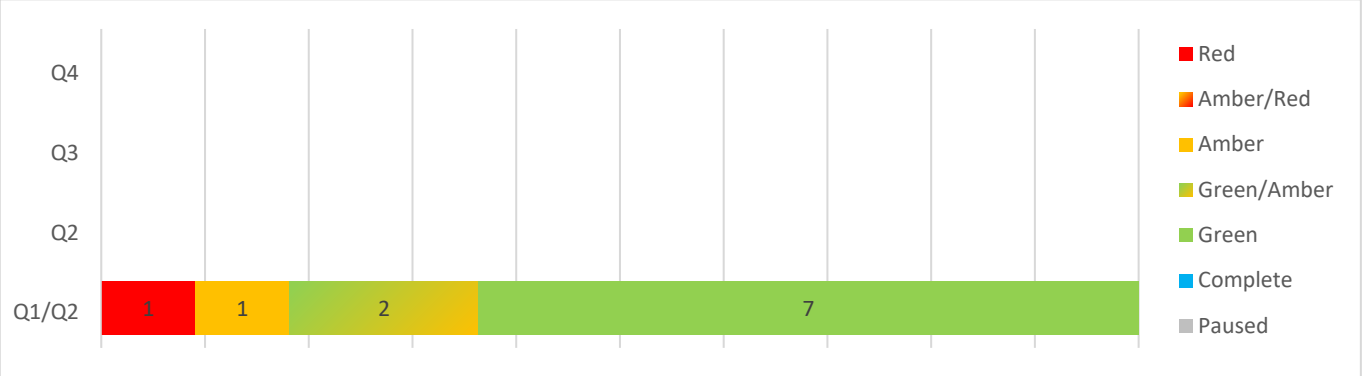


2 Amber, 10 Green, 1 Complete, 3 Paused, 3 Not Started:

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

Gateway to Care Programme

Overall RAG Status: GREEN/AMBER

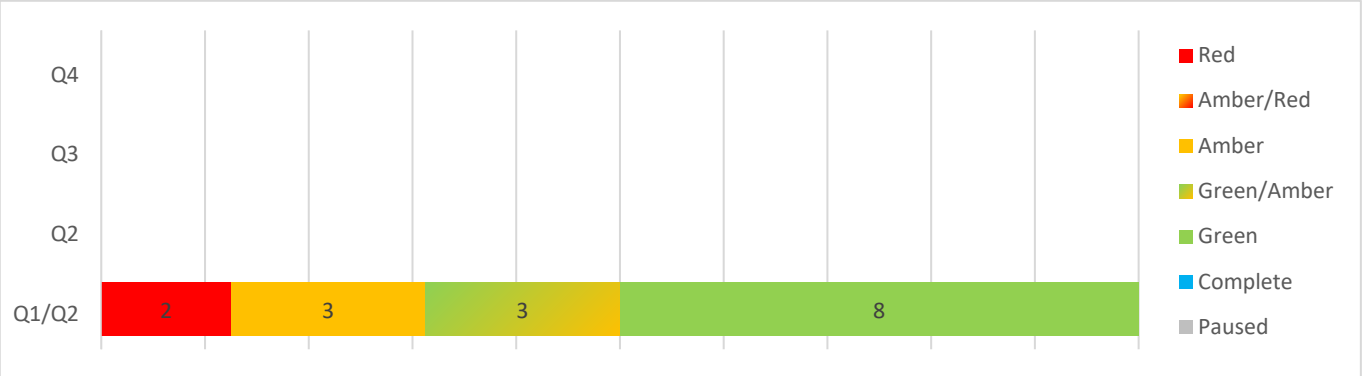


1 Red, 1 Amber, 2 Green/Amber, 7 Green:

- **Delivery risk around SALUS remains Red;** User Acceptance Testing (UAT) was due to conclude on w/e 07/08, however, due to the missed delivery of CMM Prescribing module into the UAT environment in Jul-23, there is a risk to the delivery of the full solution in November. Train the trainer was due to commence on 31/07 but has been paused whilst the issues around CMM are resolved.
- Improvements to the 111.Wales website are Amber as work depends on funding availability and discussions with the 111-commissioning team continue.
- Implementation of text and email functionality in ECNS continues to be pursued with the Supplier (Green/Amber). A range of options have been presented and testing will now be arranged.
- The 111 re-roster is Green/Amber as the establishment of the project group has been delayed due to procurement framework discussions, however this continues to progress. Of note, this deliverable is being led by the commissioner, with WAST heavily engaged.

Clinical Transformation Programme

Overall RAG Status: AMBER



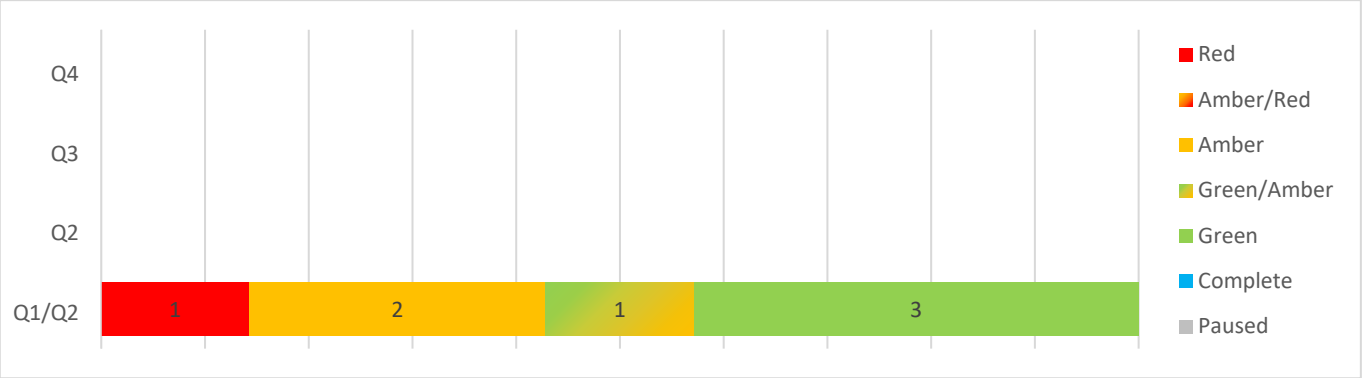
2 Red, 3 Amber, 3 Green/Amber, 8 Green:

- **Development of the WAST Principles of Advanced Practice and the Independent Prescribing Programme remain Red** and are anticipated to remain so until the lack of Trainee Advanced Paramedic Practitioner (TAPP) and APP supervisory support is resolved, linked to available funding.
- The BCU breathing and chest pain pathway pilot is currently Amber as BCU are considering PTAS/SICAT provision given the challenging financial context.

- Expansion of L1 Falls and Frailty commissioning arrangements are being explored to address gaps in dedicated provision in Anglesey and Gwyneth and regional night-time provision.
- The SBRI 10-week feasibility is now complete. Phase 2 evaluations were received from both LUSCII (wearable technology) and Fujifilm (mobile x-ray) and the status was Amber at the time of reporting. However, scoring and evaluations are now complete with a recommendation through EMT to progress to Phase 2 with the Luscii solution, but to suspend collaboration with Fujifilm due to requirement for Health Board leadership.

Financial Sustainability Programme

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



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

- The Income Generation workstream continues to explore how the organisation could develop a **Commercial and Efficiency Mindset by scoping the potential for a dedicated structure for oversight and delivery of commercial opportunities.This work is currently Red**, and flagged as a risk due to the viability of proposals coming through. Commercial training to be explored and an STB workshop was held on 18th September to focus on the next steps for income generation. This yielded good discussion with further work to be undertaken to explore the structures needed to support a commercial entity learning from way that other ambulance services have developed their structures.
- NEPTS Tender and Quality Examplar initiatives are Amber as changes in the Ambulance Care structure have led to uncertainty over ownership to take this work forwards, to be resolved by the directorate and reported back to the Programme Board.
- An internal project lead has been identified to take forward Robotic Process Automation opportunities, however this is currently flagged as Green/Amber as consultation allocation to deliver the plan is still to be confirmed.
- Having completed the Administrative Review, a proposal on next steps and recommendations will be prepared and presented to ADLT and EMT for consideration. A Services Review is now in its planning phase to be rolled out during quarter 3 which will take an in-depth view of all WAST service lines (corporate and operational) to identify further opportunities for greater efficiency.

IMTP Enabling Programmes (by exception only)

People & Culture

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

CULTURE

Develop and articulate our target culture: GREEN/AMBER

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

Refresh TU partnership working arrangements: GREEN/AMBER

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

CAPACITY

Develop our employee offer: GREEN/AMBER

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

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

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

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

CAPABILITY

Promote personal responsibility: GREEN/AMBER

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

Digital

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

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

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

Fundamentals

These portfolios are monitored through a local Directorate Plan, with actions aligned to IMTP Objectives. Directorate Plans have been reviewed and updates provided by exception, with key quality issues being reported into QUEST.

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

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

IMTP Project Delivery

There are further risks to delivery emerging from the change in the NHS Wales financial landscape, as there will be limited availability of funding to resource some of our key ambitions. This remains a corporate risk (CRR424) with a recently updated risk score (16) in light of the shifting landscape with further mitigations considered. One further mitigation developing would be a more streamlined approach to project and programme delivery through an updated Project Path Framework.

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

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

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

REPORT APPROVAL ROUTE
Finance and Performance Committee 18th September 2023

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

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

Financial Performance as at Month 5 – 2023/24

MEETING	Trust Board
DATE	28th September 2023
EXECUTIVE	Chris Turley (Executive Director of Finance & Corporate Resources)
AUTHORS	Edward Roberts (Head of Financial Business Intelligence & Capital Planning)
CONTACT	Chris.Turley2@wales.nhs.uk

EXECUTIVE SUMMARY

This paper presents to the Board the Financial Performance Report of the 2023/24 financial year, the reported position as at Month 5 (August 2023). This builds on a detailed presentation provided to, and discussion at, Finance & Performance Committee (FPC) on 18th September 2023.

The Board is asked to review, comment, note and receive assurance on the financial position and 2023/24 outlook and forecast of the Trust, noting the risks to in-year delivery in doing so.

KEY ISSUES/IMPLICATIONS

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

- The Trust is reporting a small revenue surplus (£0.027m) for month 5 2023/24;
- 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 2023/24 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 £3.115m have been achieved in month 5 against a target of £2.696m;
- Public Sector Payment Policy is on track with performance, against a target of 95%, of 96.9% for the number, and 99.2% of the value of non NHS invoices paid within 30 days.

RECOMMENDED that the Board:

(1) Notes and gains assurance in relation to the Month 5 revenue financial position and performance of the Trust as at 31st August 2023;
(2) Notes the capital programme update for 2023/24, and;
(3) Notes the Month 4 and Month 5 Welsh Government monitoring return submissions included within Appendices 1 – 4 (as required by WG).

REPORT APPROVAL ROUTE
• EFG – 13th September 2023 – Initial presentation on draft M05 position • FPC – 18th September 2023 – Finance Presentation • ELT – 20th September 2023

REPORT APPENDICES
Appendices 1 – 4 *– Monitoring return submitted to Welsh Government for months 4 and 5 – as required by WG*

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 NHS TRUST

TRUST BOARD

FINANCIAL PERFORMANCE AS AT MONTH 5 2023/24

INTRODUCTION

1. This report provides the Board with a summary of the revenue financial performance of the Trust as at 31st August 2023 (Month 5 2023/24), along with a brief update on the 2023/24 capital programme. This builds on a detailed presentation and discussion held at the Finance & Performance Committee (FPC) meeting held on 18th September 2023.

BACKGROUND

2. The key points to note in relation to the **delivery of the Statutory Financial Targets for month 5 2023/24** (1st April 2023 – 31st August 2023) are that:

   - The cumulative revenue financial position reported is a small **underspend against budget of £0.027m,** based on some key assumptions consistent with that within the IMTP financial plan and the Board approved budget for 2023/24. The underlying year-end forecast for 2023/24 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 £3.115m have been achieved against a target of £2.696m;

   - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 96.9% for the number, and 99.2% of the value** of non-NHS invoices paid within 30 days.

3. Whilst broadly balanced for the financial year, which is encouraging given the financial challenges the organisation is facing, it is key to also note the following assumptions that have been made in reporting this current position:

   - That funding for the c£5.7m 100 front line WTEs funded and appointed to in 2022/23 is fully assumed. Without this, we would potentially be c£2.5m overspent already after five months. Discussions have continued with CASC and WG colleagues to secure the required clarity of the sources of this funding, building on previous correspondence received that supported the financial planning assumption of this funding being made available to the Trust in year.

FPC received a more detailed update on this, including what is currently able to be confirmed from the CASC and what continues to be sought from WG / monies available from the national 6 Goals for Urgent and Emergency Care funding. This update also reconfirmed how this assumed £5.7m had been treated in delegated budgets for the year and how this is currently driving some of the year to date reported financial positions, including at a Directorate level. It also described the impact through the rest of the financial year of a number of scenarios, based on potentially only elements of this funding now being available in year, and how the Trust would seek to manage this should this be the case, in order to remain as close to a balanced financial position by year end as possible. Given the discretionary and more controllable nature of the spend, this inevitably directly impacts on the level of overtime, in particular in relation to front line EMS staff, that may be able to be afforded through the rest of the financial year, with obvious corresponding impacts on staffing resource and capacity levels.

Fully funding this additionality up to the previously planned levels will however allow for the maximum affordable level of additional overtime to be offered, including that generated from any reported underspend in the Operational Directorate year to date, driven in part by vacancies in the additional 100 WTEs previously recruited or elsewhere in the Directorate, and which are currently not been offset with some additional overtime until the certainty over this £5.7m funding is fully received.

Based on the most recent discussions and agreement with the CASC it is now assumed that:

- a £2.485m reserve, representing funding that was received by the Trust from EASC in 2022/23 but only committed non recurringly, will now be required to be offset against the costs of the 100 WTEs;
- an additional £1m will be available non recurrently from EASC in 2023/24, and
- a further £2m continues to be sought from the 6 Goals programme.

The impact and required timing of confirmation of this final £2m towards the spend currently being incurred by the Trust, and what additional measures the Trust would have to take in year should this not be available have also been clearly conveyed back to commissioners.

- Specifically in terms of the forecast balanced position at year end, this also continues to assume the full delivery of the required £6m savings plan for 2023/24. The position (or forecast) however does not take into account the impact of any further savings or reduction in income that may be required following the recent exercise across NHS Wales given the wider in year

financial position. A response to that submitted for this is, at the time of writing, awaited from WG.

4. In terms of the annual savings requirement, and that delivered to date, this is summarised in the following table. As we progress through the financial year, much more detailed monitoring and updates of the full savings programme will be provided to Strategic Transformation Board (via FSP updates), Finance & Performance Committee and Board.

Savings Performance by Theme 23-24				
Reporting Month	**5**			
	Annual Plan £000	**Year To Date**		
		Plan £000	**Actual £000**	**Variance £000**
Workforce Efficiencies & Transformation	615	230	419	189
Management of Non Operational Vacancies	2600	1370	1422	52
Digital	220	133	171	38
Estates	134	55	54	-1
Fleet	142	45	0	-45
Income	1175	484	502	18
Local Schemes (non pay)	614	274	442	168
Procurement Efficiencies	500	105	105	0
Totals	**6,000**	**2,696**	**3,115**	**419**

5. 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 5 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. However, as Board members will be aware, we do currently hold a greater number (and value) of financial risk as we progress through the 2023/24 financial year, the main outstanding one of which has already been described above.

REVENUE FINANCIAL PERFORMANCE – MONTH 05 2023/24

6. The table below presents an overview of the financial position for the period 1st April 2023 to 31st August 2023.

Revenue Financial Position for the period 1st April - 31st August				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-296,755	-122,828	-122,919	-90
Expenditure				
Pay	213,801	90,277	89,324	-953
Non-pay	60,330	23,203	24,335	1,131
Total pay & non-pay expenditure	274,130	113,480	113,659	178
Depreciation & Impairments / interest payable & receivable	22,625	9,348	9,233	-115
Total	0	0	-27	-27

Treatment of Covid-19 spend

7. Due to the Covid-19 pandemic, and that which had been indicated by WG that will continue to be supported by additional funding in 2023/24, the Trust has recorded additional unavoidable spend up to Month 5 totalling **£0.045m** relating to PPE costs.

8. A summary of the Covid-19 revenue costs reported in the Month 5 financial position is shown in the table below:

Covid-19 Revenue Costs	YTD £'000	FYF £'000
Total Pay	0	0
Total Non Pay	45	200
Non Delivery of Savings	0	0
Expenditure Reductions	0	0
NET COVID	**45**	**200**

Income

9. Reported Income against the initial budget set to Month 5 shows an overachievement of **£0.090m**.

10. As above, within this we are assuming income will be fully provided by WG for the reported Covid costs.

Pay Costs

11. Overall, the total pay variance at Month 5 is an underspend of **£0.953m**.

Non-pay Costs

12. The overall non-pay position at Month 5 is an overspend of **£1.016m**.

Savings

13. As above, the 2023/24 financial plan identifies that a minimum of **£6.000m** of savings, cost avoidance and cost containment measures are required to achieve financial balance in 2023/24. This is a significant increase from that which has been able to be achieved in the recent past, and especially over the last couple of years.

14. As at Month 5 for the financial year 2023/24 the Trust achieved total savings of **£3.115m** against a target of **£2.696m**.

Financial Performance by Directorate

15. Whilst there is a small surplus reported at Month 5 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, given we are early in the financial year, but they will be continued to be closely monitored.

Financial Performance Month 05 2023-24 (August 2023)					
	Aug-2023				
	Annual Budget	Cumulative Budget	Cumulative Actual	Cumulative Variance	Cum. Variance
	£000	£000	£000	£000	%
Chief Executive Directorate	1,855	802	849	47	5.9%
Corporate Governance	511	240	232	-8	-3.1%
Partnerships & Engagement Directorate	585	239	232	-8	-3.2%
Operations Directorate	189,147	77,598	76,850	-748	-1.0%
Finance and Corporate Resources Directorate	33,744	13,981	14,334	353	2.5%
Planning and Performance Directorate	2,429	966	963	-3	-0.3%
Quality, Safety and Patient Experience Directorate	5,898	2,410	2,311	-98	-4.1%
Digital Directorate	12,881	5,074	4,974	-99	-2.0%
People and Culture Directorate	4,555	1,856	1,973	117	6.3%
Trust Reserves	4,761	174	599	425	244.6%
Trust Income	-259,748	-104,574	-104,574	-0	0.0%
Medical & Clinical Services Directorate	3,383	1,235	1,230	-5	-0.4%
Overall Trust Position	0	0	-27	-27	

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

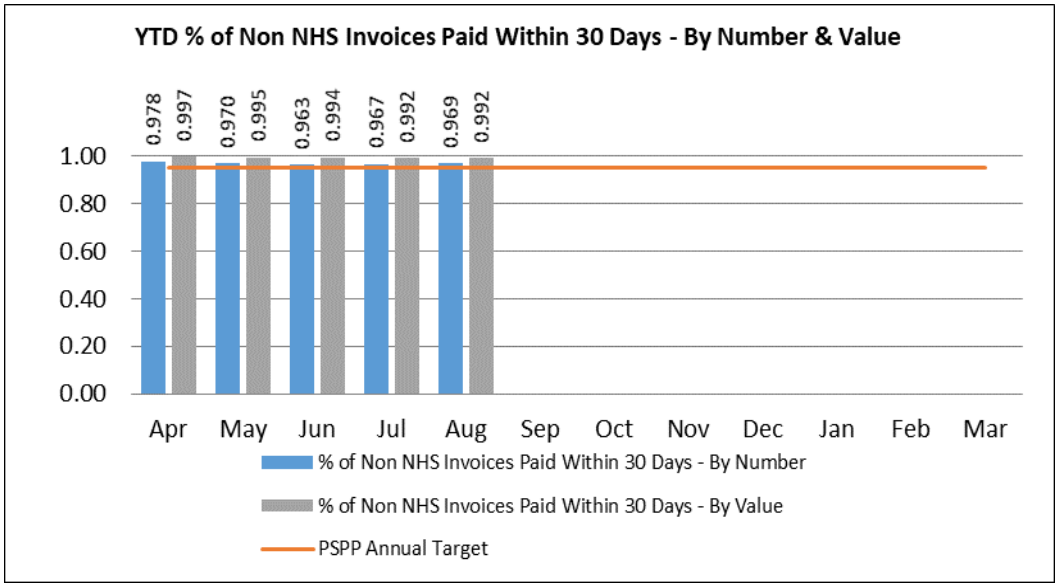
- Operations directorate now reported as underspending by £748k mostly around pay vacancies and saving controls. As already described, clarity on the outstanding funding issues underpinning the delegated budget driving in large part this current reported position, will allow for the impact of these vacancies to be offset through additional variable pay spend through the second half of the financial year;

- Reserves overspend is in part due to the impact of salary sacrifice schemes where the benefits are realised in directorate positions and pension payments;

- People and Culture is overspent due to an underachievement of Income from stretched savings target and non-pay pressures;

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

17. Public Sector Payment Policy (PSPP) compliance up to Month 5 was **96.9%** against the **95%** WG target set for non-NHS invoices by number and **99.2%** by value.



2023-24 CAPITAL PROGRAMME

18. At Month 5, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2022/23 is **£32.184m**. This includes **£27.863m** of All Wales Approved schemes and **£4.321m** for Discretionary schemes.

19. Whilst the above values are now fully committed, to M5, the Trust has expended **£2.170m** against the current All Wales capital scheme full year budget of

£27.863m (as detailed below), and **£2.247m** against the discretionary budget of **£4.321m,** also as per the table below**.**

	Actual £'000	Plan £'000
All Wales Capital Programme: Schemes:		
ESMCP – Control Room Solution	399	801
111 Project Costs	150	13,200
MDVS	714	1,791
Ambulance Replacement Programme 23-24	123	8,732
Ambulance Replacement Programme 22-23	777	2,389
EFAB - Infrastructure	2	381
EFAB - Decarbonisation	5	569
Sub Total	**2,170**	**27,863**
Discretionary:		
I.T.	505	975
Equipment	265	915
Statutory Compliance	0	0
Estates	1,477	1,903
Other	0	180
Unallocated Discretionary Capital	0	348
Sub Total	**2,247**	**4,321**
Total	**4,417**	**32,184**
Less NBV reinvested		
Total Funding from WG	**4,417**	**32,184**

20. Expectation remains, as per previous years, the capital plan will be fully spent by the end of the financial year, subject to any adjustments to the Trust's CEL.

RISKS AND ASSUMPTIONS

21. As part of the WG reporting 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 these 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.

22. There are however 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 and included as such in the accompanying returns provided to WG. The main ones are described below, along where possible with an indicative value currently placed on these risks, as required by WG as well as the current assessed level of risk.

23. As already described, the Trust is still seeking final clarity on the total funding sources for the 100 WTE, at the reporting date, the position assumes this funding in full. For the purposes of the WG returns, this is included at the rounded amount of **£6.000m** (considered low risk given, purely from a financial perspective the mitigations available), therefore once confirmation is received, this will almost half the total risk value currently stated within the returns.

24. Given the significantly larger saving target that has been required this financial year, to cover increasing cost pressures the Trust had included a number of risks around both the identified savings and the remaining non-identified savings, at Month 1 this stood at c£3.500m, following the Trust being able to finalise the schemes this has now been reduced to **£0.700m** (low risk), a further £0.100m reduction from Month 4 and as we move through the financial year the aim will be to reduce the risk down once savings are achieved and plans crystalise.

25. There are a number of risks that have materialised in relation to the current financial climate, these include a risk associated with energy and vehicle fuel prices, whilst we have seen a decrease in these, they still remain volatile therefore a low risk has been included, this has however been reduced in month to **£0.700m**. Also included in line with the current financial climate is a risk associated with non-pay inflation, whilst budgets have been set on the latest intelligence, there remains a risk associated with inflation going higher than original predictions, this has been reduced in month to **£1.100m** based on current intelligence.

26. Given the pressures the Trust feels every winter, the Trust has included a figure of **£1.000m** to cover any unfunded winter pressures; this has been deemed as a low risk, based on support provided from Commissioners over recent years.

27. A low-level risk is included re PIBS (Permanent Injury Benefit Scheme) now revised in line with the latest estimate of **£1.222m**. Matched funding for this highly volatile area is provided by WG on an annual basis, arranged between Jillian Gill and Jackie Salmon (WG).

28. A low-level risk is included of **£0.900m** in relation to pay award funding, given the current uncertainty around the pay deal for 2023/24. We are still awaiting clarification of this funding, as there is a significant difference between the calculated value and the actual amount paid.

29. On top of the above, as per all discussions and guidance received, it is also continued to be assumed that the impact of IFRS16 will be fully funded by WG.

30. As noted above, whilst there are therefore no current individually assessed high financial risks as we enter the financial year, the number and total value of financial risk described within these returns is clearly greater than in recent financial years,

which in itself raises the level of risk in relation to the continuing delivery of our statutory financial duties. 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 withing the IMTP, this will likely be a challenging financial year, despite the initial continued good financial performance in M05. 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 & Performance and Quality Committees.

Appendix 1
Attached

Appendix 2
Sent by e mail

Appendix 3
Attached

Appendix 4
Sent by e mail

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services 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 August 2023

Your ref:

Dear Claire,

Re: JULY 2023 (MONTH 4 2023/24) MONITORING RETURN

Please find attached the Monitoring Returns for the Welsh Ambulance Services NHS Trust for July 2023.

All automatic validation rules incorporated in the reporting template have been successfully passed.

In line with our submitted IMTP, our opening budgets and financial plan for the year reflect 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 2023.

The Trust's performance against financial targets for Month 4 2023/24 is as follows: -

1. **Actual Year to Date 23/24 (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 for 2023/24 being that the 2022/23 funding is, where applicable, fully recurrent, and the 2023/24 funding will include: -

- The nationally made available 1.5% uplift for core cost growth, which excludes any funding to meet the 2022/23 and 2023/24 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 the previous IMTP and Annual Plan, along with funding for other nationally delivered projects. In particular it is key to note that this assumes that, as supported by the CASC and the EASC IMTP, just under £6m of funding in 2023/24, for 100 WTEs front line staff initially funded non recurringly and appointed to during the second half of 2022/23.

It should be noted that as per the IMTP the income and corresponding pay cost in our opening plan did not include any allowances for the 2023/24 pay awards or any one-off allowances now agreed by WG. It is assumed that the actual costs incurred for each pay award which includes the 1.5% consolidated paid in May 2023, recovery payment paid in June 2023 and the 5% award paid in July 2023 will be funded in full by WG and this is reflected in this return.

The resulting reported performance at Month 4 as per Table B is therefore a very small over-spend against budget of **£0.015m**. The main funding and expenditure / savings assumptions within this reported position needs to be recognized, however.

The reported total pay variance against plan as at Month 4 is an underspend of £0.474m.

The non-pay position at Month 4 is a reported overspend of £0.516m.

Income at Month 4 shows an overachievement of £0.027m. However, as noted above, there is one income stream contained within our IMTP, supported as such by the CASC and which is therefore currently assumed within the M04 reported financial position, and for which whilst the Trust has again recently received further confirmation, however we are still awaiting more details around the drawdown mechanism. This is the funding for the additional 100 WTEs front line staff appointed in 2022/23 and if this was not funded the Trust's month 4 position would be showing a much larger deficit, in the region of £2m and the full year forecast would potentially be up to c£6m deficit. It is however not expected that such values will materialise, with the required draw down of the confirmed available funding now needing to be agreed as soon as possible.

The Trust can confirm that an invoice has now been raised in month 5 in relation to the recovery payment **(Action Point 3.2),** however as discussed elsewhere in this letter the Trust still has a shortfall in funding in regards to the payment received for the 1.5% for 2022/23 and hence a potential shortfall for 2023/24 if based on the 2022/23 values. To be clear again though, the current and forecast financial position of the Trust assumes all actuals costs associated with the various tranches of pay awards will be funded in full.

2. Movement (Table A)

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

Due to the annual leave within the team and the tight turn around time of the Month 4 return unfortunately it hasn't been possible to arrange a discussion around the changes to the table, however if the revisions within the latest submission do not address the issues, please contact Edward Roberts to discuss in more detail. **(Action Point 3.1)**

3. Risk (Table A2)

The financial risks reported in Table A2 continue to be assessed on a monthly basis, and these have again been reduced from the risks stated within the Month 3 return and 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 appraised of such risks and any mitigating actions.

There remains 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. The number and values of these in itself represents much higher overall financial risk at this stage of the financial year.

The Trust is constantly monitoring the risks, looking for opportunities and ways to mitigate the risks.

Given the significantly larger saving target that has been required this financial year, to cover increasing cost pressures the Trust had included a number of risks around both the identified savings and the remaining non-identified savings, at Month 1 this stood at c£3.500m, following the Trust being able to finalize the schemes this has now been reduced to £0.800m, a further £0.200m reduction from Month 3 and as we move through the financial year the aim will be to reduce the risk down, once savings are achieved and plans crystalize. The level of unidentified savings requirement is however now **fully identified**, which is clearly positive at this stage of the year.

As detailed above the Trust is still seeking to confirm the drawdown mechanism for the agreed funding for the 100 WTE **(Action Point 3.3)** permanently employed in 2022/23, funding for the Trust for 2023/24 for which was confirmed in the letter from Nick Wood's letter to Stephen Harrhy dated 10th May 2023. As such, our present position assumes this funding in full, but until fully received this is included at the full amount of £6.000m, albeit at what should now be a very low risk and therefore once confirmation is received, this will almost half the total risk value currently stated.

There are a number of risks that have materialized in relation to the current financial climate, these include a risk associated with energy and 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, this has however been reduced in month to £0.800m. Also included in line with the current financial climate is a risk associated with non-pay inflation, whilst budgets have been set on the latest intelligence, there remains a risk associated with inflation going higher than original predictions, this has been reduced in month to £1.300m based on current intelligence.

Given the pressures the Trust feels every winter, the Trust has included a figure of £1.000m to cover any unfunded winter pressures; this has been deemed as a low risk, based on support provided from Commissioners over recent years.

A low-level risk is included re PIBS (Permanent Injury Benefit Scheme) now revised in line with the latest estimate of £1.222m. Matched funding for this highly volatile area is provided by WG on an annual basis, arranged between Jillian Gill and Jackie Salmon. **(WAST Action Point W4.1 for WG to resolve)**

Given the current uncertainty around the pay deal for 2023/24, as per our email from Jason Collins to Gwen Kohler on the 5th April and then the subsequent follow up email from Navin Kalia to Matthew Denham-Jones on the 7th June we are still awaiting clarification of this funding, as there is a significant difference between the calculated value and the actual amount paid in relation to the 1.5% consolidated pay award deal and funding in regards to the payment received for the 1.5% for 2022/23 and hence a potential shortfall for 2023/24 if based on the 2022/23 values. **(WAST Action Point W4.2 for WG to resolve)**

As noted above, whilst there are therefore no current individually assessed high financial risks, the number and total value of the financial risks described within these returns is clearly greater than in recent financial years, which in itself raises the level of risk in relation to the continuing delivery of our statutory financial duties. 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 withing the IMTP, this will likely be a challenging financial year, despite the initially reported good financial performance in M04, 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 has also recently been increased, alongside a more detailed review of this risk on the Trust's Corporate Risk Register.

Work is currently on going following the Minsters letter requesting a solution to the financial pressures across the NHS Wales system, to reduce the current forecasted deficit, *"organisations who have submitted balanced plans are also requested to provide options to go further and improve the positions laid out in their plans."* The WAST Board will be submitting our proposed additional savings ideas in line with the deadline.

4. Monthly Profiles (Table B)

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

The reason behind the Month 3 non-pay being £0.400m less than the forecast position is based on a number of different factors include the expenditure in month 3 being lower than originally forecasted at the outset of the financial year, in relation to slow down in fuel expenditure and other non-pay areas, however this is then being offset by intelligence around other non-pay costs (e.g. Fleet maintenance linked to the reduced Capital funding) increasing in the latter months of the financial year. (**Action Point 3.4)**

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

Agency costs for Month 4 totalled £0.059m. The current percentage of agency costs against the total pay figure is 0.3%, this is to cover vacancies, in a number of areas across the Trust which the Trust is having difficulties recruiting

into, however it is hoped that some of these agency staff will be replaced by permanent staff in the near future **(Action Point 3.5).**

6. COVID-19 (Table B3)

Table B3 has been completed in accordance with the guidance and information provided in the required table. Anticipated spend and hence income assumptions will be reviewed at Month 5 and updated accordingly.

7. Saving Plans (Table C, C1, C2, C3 & C4)

For Month 4 the Trust is reporting planned savings (including Income generation) of £2.233m and actual savings of £2.529m.

As requested we can confirm that all the savings are based on confirmed savings plans and these have now been updated in line with the latest internal intelligence.

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

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

The Trust will be engaging with colleagues across NHS Wales to eliminate any variance within reported values elsewhere, which is always likely at the outset of the financial year as financial plans are fully aligned.

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

At Month 4 there are 7 invoices over 17 weeks, however the Trust has received assurance that these are to be paid. **(Action Point 3.6**) There are also 10 invoices over 11 weeks which the Trust is actively chasing and working with the other bodies to ensure payment.

10. 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	12	15	15	17	15	15	15	15	15	15	15	15	179
Other Non NHS Income	214	231	186	64	200	200	200	200	200	200	200	200	2,295
Pensions Agency	0	0	0	0	0	0	0	0	0	0	0	0	0
Vat Refund	164	1,078	0	397	1,180	350	350	350	350	350	350	350	5,269
Risk Pool Refund	108	0	41	0	0	0	0	0	0	0	0	0	149
Total	498	1,324	242	478	1,395	565	565	565	565	565	565	565	7,892

11. Public Sector Payment Compliance (Table H)

This table has been completed in accordance with the guidance. The Trust will endeavour to ensure that NHS invoices along with Non-NHS invoices are paid within targets moving through 2023/24.

Up to quarter 1 the cumulative percentage of Non-NHS invoices paid within 30 days by number was 96.3% against a target of 95%. This table will again be updated for quarter 2 in September.

12. Capital (Tables I, J and K)

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

At month 4, works are ongoing with Programme managers to establish updated cash flows that reflect the profiles of approved projects now for this financial year, however at present schemes are progressing well, and more detailed updates will be provided as the financial year progresses.

13. 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 4 Financial Monitoring Return will be presented to the Finance and Performance Committee on 18th September 2023.

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, Director of Finance & Corporate Resources and Jason Killens, Chief Executive.

14. 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

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services 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

13th September 2023

Your ref:

Dear Claire,

Re: AUGUST 2023 (MONTH 5 2023/24) MONITORING RETURN

Please find attached the Monitoring Returns for the Welsh Ambulance Services NHS Trust for August 2023.

All automatic validation rules incorporated in the reporting template have been successfully passed.

In line with our submitted IMTP, our opening budgets and financial plan for the year reflect 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 2023.

The Trust's performance against financial targets for Month 5 2023/24 is as follows: -

1. **Actual Year to Date 23/24 (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 for 2023/24 being that the 2022/23 funding is, where applicable, fully recurrent, and the 2023/24 funding will include: -

- The nationally made available 1.5% uplift for core cost growth, which excludes any funding to meet the 2022/23 and 2023/24 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 the previous IMTP and Annual Plan, along with funding for other nationally delivered projects. In particular it is key to note that this assumes that, as supported by the CASC and the EASC IMTP, just under £6m of funding in 2023/24, for 100 WTEs front line staff initially funded non recurringly and appointed to during the second half of 2022/23. Discussions on finalising the funding routes and resulting budget impacts (if any) with the CASC are now drawing to a conclusion, to hopefully ensure clarity on this through the rest of the financial year.

It should be noted that as per the IMTP the income and corresponding pay cost in our opening plan did not include any allowances for the 2023/24 pay awards or any one-off allowances now agreed by WG. It is assumed that the actual costs incurred for each pay award which includes the 1.5% consolidated paid in May 2023, recovery payment paid in June 2023 and the 5% award paid in July 2023 will be funded in full by WG and this is reflected in this return.

The resulting reported performance at Month 5 as per Table B is therefore a very small under-spend against budget of **£0.027m**. The main funding and expenditure / savings assumptions within this reported position needs to be recognized, however.

The reported total pay variance against plan as at Month 5 is an underspend of £0.953m.

The non-pay position at Month 5 is a reported overspend of £1.016m.

Income at Month 5 shows an overachievement of £0.090m. However, as noted above, there is one income stream contained within our IMTP, supported as such by the CASC and which is therefore currently assumed within the M05 reported financial position, and for which whilst the Trust has again recently received further confirmation, however we are still awaiting more details around the drawdown mechanism. This is the funding for the additional 100 WTEs front line staff appointed in 2022/23 and if this was not funded the Trust's month 5 position would be showing a deficit, in the region of £2.5m and the full year forecast would potentially be up to c£6m deficit. It is however not expected that such values will materialise, as above discussions to conclude the required draw down of the confirmed available funding now hopefully drawing to a conclusion.

As discussed elsewhere in this letter the Trust still has a shortfall in funding in regards to the payment received for the 1.5% for 2022/23 and hence a potential shortfall for 2023/24 if based on the 2022/23 values. To be clear again though, the current and forecast financial position of the Trust assumes all actuals costs associated with the various tranches of pay awards will be funded in full, it would be helpful for the Trust to reduce the uncertainty around this funding if you were able to confirm this assumption in writing? **(WAST Action Point W4.2 for WG to resolve)**

2. Movement (Table A)

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

3. Risk (Table A2)

The financial risks reported in Table A2 continue to be assessed on a monthly basis, and these have again been reduced from the risks stated within the Month 4 return and 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 appraised of such risks and any mitigating actions.

There remains 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. The number and values of these in itself represents much higher overall financial risk at this stage of the financial year.

The Trust is constantly monitoring the risks, looking for opportunities and ways to mitigate the risks.

Given the significantly larger saving target that has been required this financial year, to cover increasing cost pressures the Trust had included a number of risks around both the identified savings and the remaining non-identified savings, at Month 1 this stood at c£3.500m, following the Trust being able to finalize the schemes this has now been reduced to £0.700m, a further £0.100m reduction from Month 4 and as we move through the financial year the aim will be to reduce the risk down, once savings are achieved and plans crystalize. The level of unidentified savings requirement is however now **fully identified**, which is clearly positive at this stage of the year.

As detailed above the Trust is still seeking to finalise the drawdown mechanism for the agreed funding for the 100 WTE permanently employed in 2022/23, funding for the Trust for 2023/24 for which was confirmed in the letter from Nick Wood's letter to Stephen Harrhy dated 10th May 2023. As such, our present position assumes this funding in full, but until fully received this is included at the full amount of £6.000m, albeit at what should now be a very low risk and therefore once full confirmation is received, this will almost half the total risk value currently stated.

There are a number of risks that have materialised in relation to the current financial climate, these include a risk associated with energy and 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, this has however been reduced in month to £0.700m. Also included in line with the current financial climate is a risk associated with non-pay inflation, whilst budgets have been set on the latest intelligence, there remains a risk associated with inflation going higher than original predictions, this has been reduced in month to £1.100m based on current intelligence.

Given the pressures the Trust feels every winter, the Trust has included a figure of £1.000m to cover any unfunded winter pressures; this has been deemed as a low risk, based on support provided from Commissioners over recent years.

A low-level risk is included re PIBS (Permanent Injury Benefit Scheme) now revised in line with the latest estimate of £1.222m. Matched funding for this highly volatile area is provided by WG on an annual basis, arranged between Jillian Gill and Jackie Salmon. As requested last month it would be helpful if WG could respond in relation to this point **(WAST Action Point W4.1 for WG to resolve)**

Given the current uncertainty around the pay deal for 2023/24, as per our email from Jason Collins to Gwen Kohler on the 5th April and then the subsequent follow up email from Navin Kalia to Matthew Denham-Jones on the 7th June we are still awaiting clarification of this funding, as there is a significant difference between the calculated value and the actual amount paid in relation to the 1.5% consolidated pay award deal and funding in regards to the payment received for the 1.5% for 2022/23 and hence a potential shortfall for 2023/24 if based on the 2022/23 values. Again, this is becoming an area of concern in which a response would be greatly apricated in writing **(WAST Action Point W4.2 for WG to resolve)**

As noted above, whilst there are therefore no current individually assessed high financial risks, the number and total value of the financial risks described within these returns is clearly greater than in recent financial years, which in itself raises the level of risk in relation to the continuing delivery of our statutory financial duties. 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 withing the IMTP, this will likely be a challenging financial year, despite the initially reported good financial performance in M05, 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 has also recently been increased, alongside a more detailed review of this risk on the Trust's Corporate Risk Register.

4. Monthly Profiles (Table B)

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

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

Agency costs for Month 5 totalled £0.051m. The current percentage of agency costs against the total pay figure is 0.3%, this is to cover vacancies, in a number of areas across the Trust which the Trust is having difficulties recruiting into, however it is hoped that some of these agency staff will be replaced by permanent staff in the near future.

6. COVID-19 (Table B3)

Table B3 has been completed in accordance with the guidance and information provided in the required table. Anticipated spend and hence income assumptions were reviewed and reduced at Month 5, it is now assumed that the funding the Trust require from WG for the additional PPE requirements will be £0.200m.

7. Saving Plans (Table C, C1, C2, C3 & C4)

For Month 5 the Trust is reporting planned savings (including Income generation) of £2.696m and actual savings of £3.115m.

As requested, we can confirm that all the savings are based on confirmed savings plans and these have now been updated in line with the latest internal intelligence.

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

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

As stated above it is acknowledged that the c£6.000m is owing to WAST and is shown both in the EACS and WAST figure on Table D what is yet to be established is the mechanism and timing of the payment for this, therefore at this point it is prudent to continue to flag this as a risk until at which time these funds flow to WAST. **(Action Point 4.1)**

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

At Month 5 there are no invoices over 11 weeks. **(Action Point 3.6)**

10. Cash flow (Table G)

The cash flow has been completed in accordance with the guidance, the Trust can confirm that the figures in Table G and table K are now consistent **(Action Point 4.2)**

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	12	15	15	17	16	15	15	15	15	15	15	15	180
Other Non NHS Income	214	231	186	64	59	200	200	200	200	200	200	200	2,154
Pensions Agency	0	0	0	0	0	0	0	0	0	0	0	0	0
Vat Refund	164	1,078	0	397	858	1,033	450	450	450	450	450	450	6,230
Risk Pool Refund	108	0	41	0	0	0	0	0	0	0	0	0	149
Total	498	1,324	242	478	933	1,248	665	665	665	665	665	665	8,713

11. Public Sector Payment Compliance (Table H)

This table has been completed in accordance with the guidance. The Trust will endeavour to ensure that NHS invoices along with Non-NHS invoices are paid within targets moving through 2023/24.

Up to quarter 1 the cumulative percentage of Non-NHS invoices paid within 30 days by number was 96.3% against a target of 95%. This table will again be updated for quarter 2 in next month's return.

12. Capital (Tables I, J and K)

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

At month 5, works are ongoing with Programme managers to establish updated cash flows that reflect the profiles of approved projects now for this financial year, however at present schemes are progressing well, and more detailed updates will be provided as the financial year progresses.

13. 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 5 Financial Monitoring Return will be presented to the Trust Board on 28th September 2023.

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, Director of Finance & Corporate Resources and Jason Killens, Chief Executive.

14. 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	**13**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – July/August 2023

MEETING	Trust Board
DATE	28th September 2023
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning & Performance Mark Thomas – Commissioning & Performance Manager
CONTACT	Hugh.bennett2@wales.nhs.uk Mark.Thomas12@wales.nhs.uk

EXECUTIVE SUMMARY

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

The indicators used at this high-level show an increase of system pressure, in particular, with increasing handover lost hours and therefore worsening quality and performance for the Emergency Medical Service (EMS). 111 is showing continuous improvement throughout 2023 with abandonment rates and call answer times achieving the best performance since February 2022.

Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance has been stable, but with demand increasing to pre-Covid levels, performance has dipped slightly over the past two months. Overall, the picture remains one in which the Trust can demonstrate clear improvement over things it controls, but a more mixed picture where there are system dependencies e.g. handover lost hours.

RECOMMENDATION: The Board is asked to consider the July/August 2023 Integrated Quality and Performance Report and actions being taken and determine whether:

(1) The report provides sufficient assurance.
(2) Whether further information, scrutiny or assurance is required, or
(3) Further remedial actions are to be undertaken through Executives.

REPORT APPROVAL ROUTE	
Date	**Meeting**
27 September-23	**Executive Management Team**
28 September-23	**Trust Board**

REPORT APPENDICES
Appendix 1 – Top Indicator Dashboard **Appendix 2 – Review of Board Level Metrics Appendix 2 Metrics Review FPC July 2023**

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

SITUATION

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

BACKGROUND

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

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

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

4. As previously agreed, the metrics which form part of this committee/Board report will be updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (Integrated Medium-Term Plan - IMTP) and strategies. A revised set were recently agreed, which are now being built into the report on an iterative basis.

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, having been challenging across the winter, but have now been on target for the past eight months. However, the 95th percentile did worsen in August 2023 to 31 seconds, from 10 seconds in July 2023.

7. **111 call answering is improving,** with the call abandonment target of 5% being achieved in August (3.2%) and 65.9% of calls being answered within 60 seconds, although this still remains significantly off target (95%). Negotiations with commissioners have indicated that funding is available for 198 call handlers and recruitment has been underway to secure this number, but there remain a number of vacancies. It has recently been agreed to recruit another cohort in November, with the aim of getting closer to the 198 level. Further work is required to reduce capacity lost through sickness absence (particular

improvement now being seen in call handlers), aligning capacity with demand and improving the efficient use of resource. A priority is now re-rostering 111, which is dependent on commissioners initiating the procurement process (third party identified, now subject to funding considerations).

8. **111 Clinical response:** the Trust continues to see achievement of the clinical call back time target for the highest priority 111 calls (P1CT – 99.2%) , and pleasingly, other priorities of calls (P2 and P3) also achieved the 90% performance target in August 2023, with the respective figures being 93.8% and 93.2%. This improvement has been driven by more efficient working practices and the alignment of capacity to demand. The numbers of clinicians are now broadly at agreed establishment levels (recently agreed as 100 WTE).

9. **Ambulance Response** (safety / patient experience): the Red 8-minute response performance for August 2023 was 50.4%, a slight drop when compared to July 2023, and below the 65% target. The Amber 1 median was 1 hour 14 minutes (ideal 18 minutes) and the Amber 1 95th percentile was 5 hours 33 minutes. These long response times have a direct impact on outcomes for many patients. Actions within the Trust's control include:

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

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

   Demand Management
   - The increase in Clinical Support Desk capacity has meant that the Trust has been able to increase its consult and close rate, however, it has declined in recent months, achieving 12.9% in Augst 2023, with an increased ambition of 17% in 2023/24 (quarter 4). Action plans are in place within the service, but there are some risks emerging in terms of delivery.

   Red Improvement Actions
   - The full roll out of the Cymru High Acuity Response Units (CHARUs). Recruitment and training is being undertaken at pace with the aim to fully

populate the CHARU rosters keys (153 full time equivalents), with a current vacancy level of c44 FTEs.

- Red review. This is being undertaken within additional resource, when possible, but ideally, as previously modelled, would require additional FTEs.
- A more efficient response logic, which went live on 19 June 2023, is reducing the number of multiple attendances to certain categories of red call, releasing resource to respond to other calls.

10. One of the key factors in relation to response times is the capacity lost to **handover outside Emergency Departments**. 19,233 hours were lost during August 2023, an increase compared to the 19,118 hours lost in July 2023 and the second monthly increase in a row. These levels remain so extreme that all the actions within the Trust's control cannot mitigate or offset this level of loss. There has been a noticeable improvement in Cardiff & Vale's handover lost hours linked to an organisational focus, with other health boards reporting that they are seeking to learn lessons. The improved handover levels in Cardiff & Vale has particularly manifested itself in Amber 2 and Amber 1 performance. Pan Wales Immediate Release figures for August 2023 were: Red 125 accepted and 4 declined; and Amber 1, 140 accepted and 272 declined.

11. Modelling has indicated that red performance could improve by 7% to around 58% as a result of the CHARU implementation, red logic changes and a reduction to 15,000 lost hours. Further modelling has recently been undertaken around financial savings, with further seasonal modelling now being undertaken for winter.

12. **Ambulance Care (formally NEPTS) (Patient Experience)**: Oncology performance achieved the 70% target in August 2023 (71.9%). Renal performance also increased to 74.9%, although Discharge journey performance declined slightly to 79% (target 90%). Overall demand for the service continues to increase, and in June 2023 demand was at levels not seen since 2019. The Trust has a comprehensive Ambulance Care Transformation Programme in place, which includes delivering a range of efficiencies and improvements, for example: improved procurement through the plurality model, aligning clinic patient ready times to ambulance availability, re-rostering (NET Centre and NEPTS transport) and addressing oncology performance.

13. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported one NRI to the NHS Executive in August 2023, a decrease of three from the four reported in July 2023; and 23 serious patient safety incidents were referred to health boards under the Joint Investigation Framework, which has now been adopted NHS Wales wide. In July 2023 complaint response times increased to 49%, although still did not meet the 75% target with cases remaining complex. Reviews of lower graded concerns are being undertaken to ensure proportionate investigations are undertaken. The Trust has put more capacity into the Putting

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

14. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 76.6% in August 2023, a slight deterioration from the 78.8% seen in July 2023 and remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system. The return to spontaneous circulation (ROSC) rate increased to 23.8% in August 2023 compared to 19.2% in July 2023.

Our People (workforce resourcing, experience, and safety)

15. **Hours Produced**: The Trust produced 113,830 Ambulance Response unit hours in August 2023, a decrease from the 117,737 produced in July 2023. Emergency ambulance unit hours production (UHP) was 87% in August 2023, thus failing to achieve the 95% target. CHARU UHP also decreased slightly to 128% (note this is of the commissioned level, not full roll out). Key to the number of hours produced are roster abstractions, which remain above benchmark, but are reducing i.e. improving.

16. **Response Abstractions:** EMS abstraction levels increased to 37.46% in August 2023, the third month in a row to see an increase and remains above the 30% benchmark. An initial deep dive meeting has been held, with further work planned. EMS Response sickness abstractions stood at 10.01% in August 2023 (benchmark 5.99%).

17. **Trust sickness absence:** the Trust's overall sickness percentage was 8.23% in July 2023, a deterioration from the 7.51% recorded in June 2023. Actions within the IMTP concentrate on staff well-being with an aim to start to reduce this level.

18. **Staff training and PADRs:** PADR rates did not achieve the 85% target in August 2023 (70.61%), while compliance for Statutory and Mandatory training also declined slightly to 75.78%.

Finance and Value

19. **Financial Balance**: The reported outturn performance at Month 4 is a deficit of £15k, with a forecast to the yearend of breakeven.

Partnerships/ System Contribution

20. **Shift left:** much of Trust's work relates to working with health boards and other partners to provide the right care closer to home and reducing the number of patients who need to be conveyed to hospital. Good progress has been made through the year in increasing **consult and close** rates after 999 calls; and the Trust achieved 12.9% in August 2023, a drop from the 14% seen in July 2023 and below the Trust's 2023/24 IMTP ambition of 17%.

21. In August 2023, 9,847 patients cancelled their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 208 callers. A formal programme to take forward "inverting the triangle" has been established. The Trust has proceeded with growing the numbers of APPs in training. The current focus is on developing a "strategic case for change" and a stakeholder engagement process.

Summary

22. The indicators used at this high-level highlight an increase of system pressure, in particular, handover lost hours, and therefore worsening quality and performance for the Emergency Medical Service (EMS) during the early part of 2023/24. 111 is continuing to show improvement with abandonment rates and call answer times achieving the best performance since February 2022. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance has been stable, with performance improving last month following a slight dip over the previous two months. Overall, the picture remains one in which the Trust can demonstrate clear improvement over some things it controls, but a more mixed picture where there are system dependencies e.g. handover lost hours.

Welsh Ambulance Services NHS Trust

Monthly Integrated Quality & Performance Report

July/August 2023

Annex 1 – Top Indicator Dashboard

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

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

by Commissioning & Performance Department

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2023/24	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	2 Year Trend	RAG
Timeliness Indicators															
NHS111 Call Handling Abandonment Rates	< 5%	11.2%	14.8%	13.6%	49.5%	16.0%	14.9%	15.4%	11.8%	7.9%	3.8%	4.1%	3.2%		G
111 Clinical Triage Call Back Time (P1)	90%	97.9%	98.3%	97.2%	94.9%	99.0%	99.3%	98.5%	98.9%	98.9%	99.3%	99.2%	99.2%		G
999 Call Answer Times 95th Percentile	95% in 00:00:06	00:52	01:03	01:11	01:34	00:03	00:03	00:06	00:03	00:03	00:15	00:10	00:31		A
NEPTS Call Answering	Improvement Trend	05:36	03:22	03:32	02:38	01:47	02:08	01:08	01:43	01:18	00:46	01:03	02:08		A
999 Red Response within 8 minutes	65%	50.0%	48.0%	48.0%	39.5%	48.9%	50.9%	47.5%	53.0%	54.4%	54.6%	52.6%	50.4%		R
999 Amber 1 Median	00:18	01:30	01:42	01:34	03:30	00:50	00:55	01:35	00:59	00:55	00:55	01:07	01:14		R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	70.5%	71.3%	72.4%	71.7%	76.6%	75.5%	73.4%	76.5%	69.9%	68.7%	69.6%	71.9%		G
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	88.0%	85.0%	90.0%	90.0%	90.0%	78.5%	82.7%	82.2%	83.0%	78.0%	84.0%	79.0%		R
Clinical Outcomes / Quality Indicators															
Return of Spontaneous Circulation (ROSC)	Improvement Trend	-	-	15.9%	14.2%	17.8%	15.9%	14.0%	16.0%	20.7%	22.3%	19.2%	23.8%		A
Stroke Patients with Appropriate Care	95%	79.1%	78.2%	80.2%	79.4%	76.2%	76.6%	72.2%	80.1%	74.5%	74.6%	78.8%	76.6%		R
Acute Coronary Syndrome Patients with Appropriate Care	95%	51.0%	44.0%	51.3%	37.9%	49.4%	42.1%	46.3%	38.3%	47.5%	34.8%	32.5%	43.4%		R
National Reportable Incidents reports (NRI)	Reduction Trend	7	8	2	0	5	12	3	8	8	8	4	1		A
Can't Send & Cancelled by Patient Volumes	Reduction Trend	10,605	11,482	10,087	13,556	7,086	6,938	10,124	7,687	8,091	8,015	8,604	10,017		R
Concerns Response within 30 Days	75%	28%	28%	24%	27.0%	21.0%	24.0%	33.0%	35.0%	29.0%	43.0%	49.0%	47.0%		R
Our People															
Capacity															
Hours Produced for Emergency Ambulances	95-100%	96%	90%	92%	91%	97%	95%	95%	98%	96%	93%	90%	87%		R

Top Monthly Indicators	Target 2023/24	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	2 Year Trend	RAG
Health & Well-being															
Sickness Absence *(all staff)*	6.0%	8.68%	9.48%	8.77%	10.65%	8.92%	8.06%	8.33%	8.04%	7.76%	7.51%	8.23%	N/A		A
Mental Health Absence Rates	Reduction Trend	2.30%	2.30%	2.44%	2.41%	2.36%	2.04%	2.12%	2.08%	2.24%	2.08%	2.25%	N/A		A
Staff Turnover Rate	Reduction Trend	11.35%	11.11%	10.70%	10.64%	10.69%	10.86%	10.38%	10.28%	9.89%	9.79%	9.58%	9.48%		G
Statutory & Mandatory Training	>85%	85.60%	85.58%	85.40%	84.63%	76.51%	60.10%	65.05%	75.55%	76.32%	77.53%	77.98%	75.78%		R
PADR/Medical Appraisal	>85%	78.75%	80.49%	80.75%	87.89%	79.12%	78.71%	72.10%	73.0%	72.0%	73.1%	73.3%	70.6%		R
Number of Shift Overruns	Reduction Trend	3,786	3,901	3,758	3,799	3,720	3,431	4,064	3,839	4,087	2,053	4,035	4,005		R
Inclusion & Engagement / Culture															
NHS111 % of Total Calls Answered in Welsh	TBD	0.37%	0.30%	0.35%	0.03%	0.48%	0.28%	0.31%	0.44%	0.59%	0.74%	0.78%	0.92%		TBD
NEPTS % of Total Calls Answered in Welsh	TBD	0.7%	1.2%	1.3%	0.8%	0.7%	0.9%	1.1%	1.4%	1.8%	1.7%	1.5%	1.5%		TBD
Value															
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A		G
EMS Utilisation Metric (All Vehicles)	Improvement Trend	61.8%	62.6%	61.2%	64.6%	56.0%	56.6%	61.4%	58.8%	56.3%	55.3%	55.9%	57.1%		A
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.43	2.46	2.48	2.38	2.23	2.32	2.28	2.39	2.45	2.43	2.40	2.42		A
NEPTS on the Day Cancellations	Reduction Trend	19.9%	19.7%	18.3%	23.2%	19.4%	20.4%	21.6%	18.3%	17.8%	18.7%	18.6%	19.2%		A
Partnerships / System Contribution															
Inverting the Traingle															
Successful Consult & Close Outcome	17.0%	12.2%	12.8%	12.6%	14.6%	14.9%	14.2%	13.8%	14.7%	14.1%	13.9%	14.0%	12.9%		R
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Improvement Trend	11.14%	10.65%	11.04%	11.18%	10.72%	10.05%	11.11%	10.70%	11.80%	11.70%	10.90%	10.95%		A
Number of Handover Lost Hours	15,000	25,174	28,038	25,020	32,098	23,525	19,110	28,620	23,082	20,392	18,548	19,118	19,233		R
NHS111															
NHS111 Dental Calls	-	5,913	6,051	5,829	4,657	6,063	5,746	6,668	6,723	6,865	6,515	7,573	7,603		TBD
Consult & Close Volumes by NHS111	Increasing Trend	1,180	1,287	1,196	1,338	811	949	956	985	1,015	1,031	1,058	986		A

In-Month RAG Indicates =

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

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

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

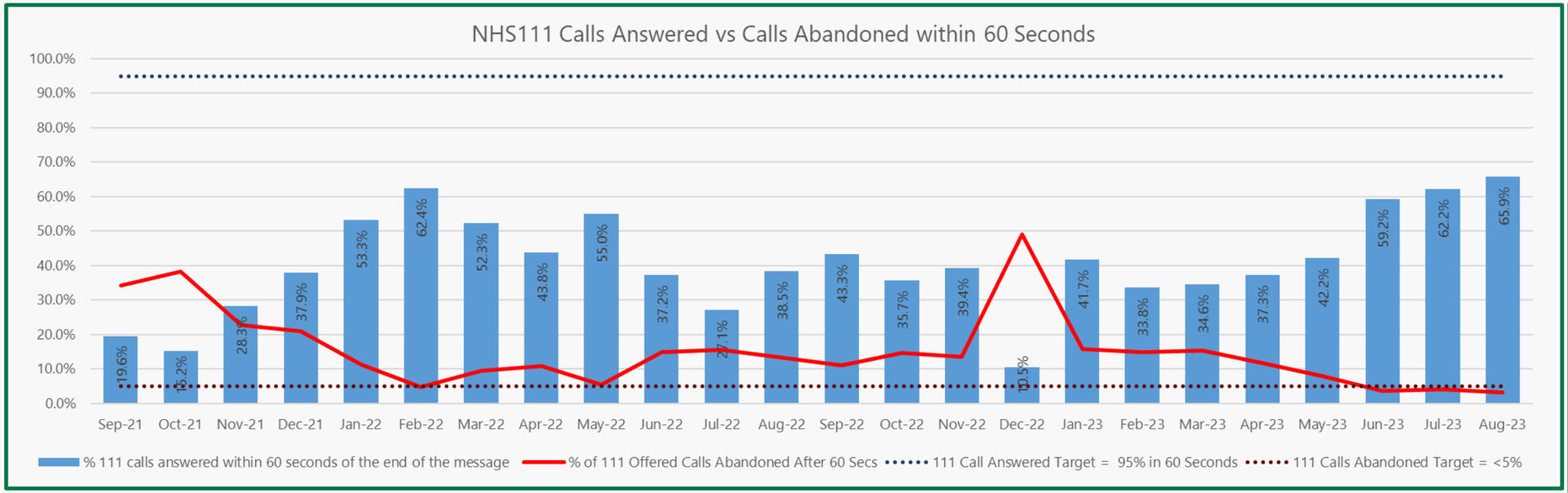
TBD: Status cannot be calculated (To Be Determined)

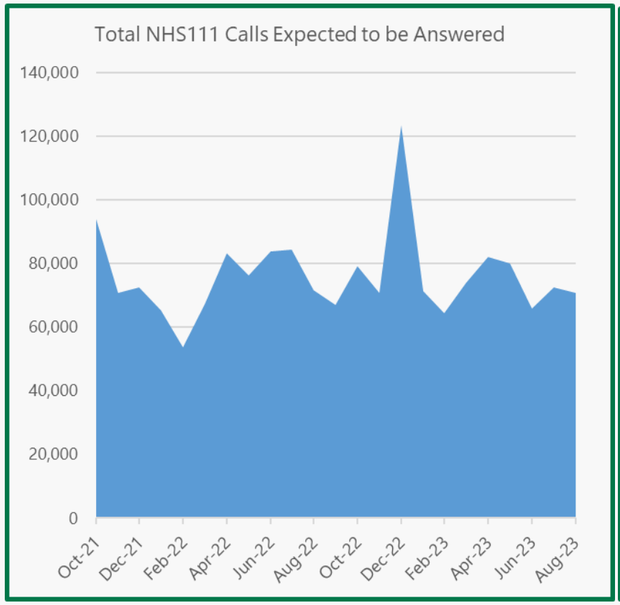
Our Patients: Quality, Patient Safety & Experience
111 Call Answering/Abandoned Performance Indicators
Influencing Factors – Demand and Call Handling Hours Produced

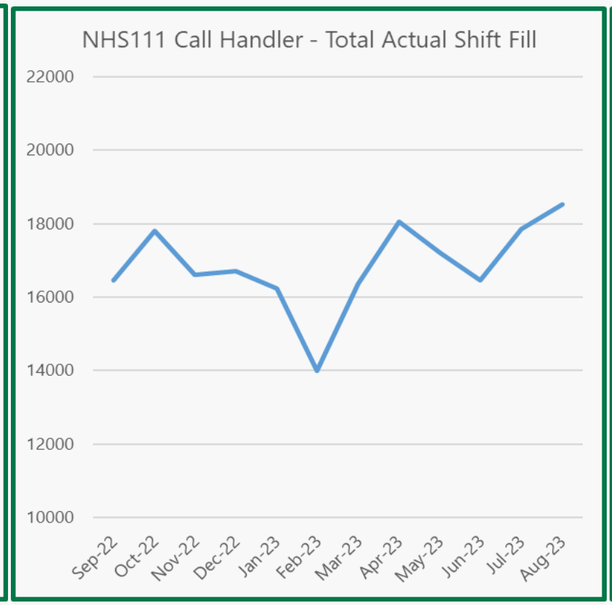
(Responsible Officer: Lee Brooks)

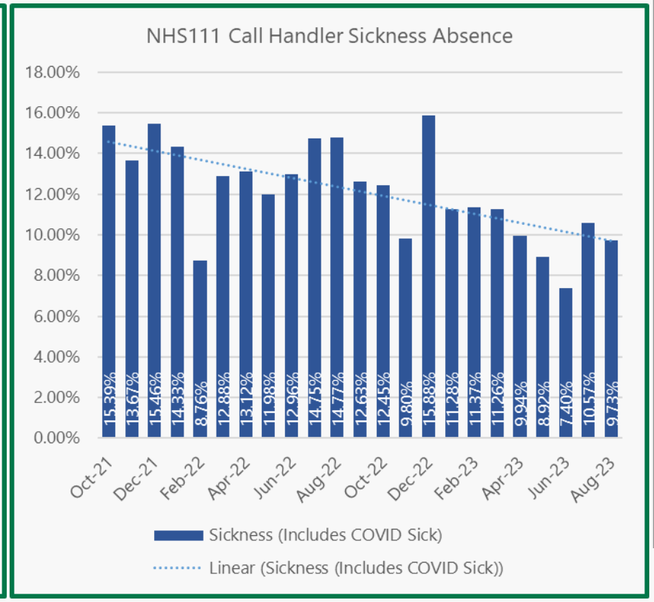
Abandonment Rate G

FPC









Analysis

111 call abandonment is a key patient safety indicator for the service. August 2023 saw an **abandonment rate of 3.2%,** an improvement compared to the 4.1% figure seen in July 2023, and remaining below the 5% target. It is also the lowest monthly figure recorded during the 2-year recording period.

The percentage of 111 calls answered within 60 seconds of the end of the message also increased again in August 2023 to 65.9%, the sixth consecutive month in which an improvement has been seen.

Total capacity measured through call handler shift fill increased in August to 18,523 hours, which is above the 12-month average.

Remedial Plans and Actions

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

- Agreement has been reached with commissioners that 198 WTE call handlers will be funded in 2023/24. The Trust is currently 21.25 FTE short of establishment. The Trust is aiming to address this in quarter three.
- Work continues on sickness absence in line with the Trust's managing absence work programme with an IMTP aim to get organisational sickness down to 6%
- A roster review in three parts is due to start, in collaboration with the 111 commissioners to review rosters and ensure that capacity is aligned to demand, and to try and even out performance through the week. Currently out to tender.
- Work also continues in reviewing the use of the Clinical Advice Line which is available to call handlers who want some clinical advice whilst on call with the patient. The call handler has to wait for a clinician to answer the call and therefore call times are related to clinician availability.

Expected Performance Trajectory

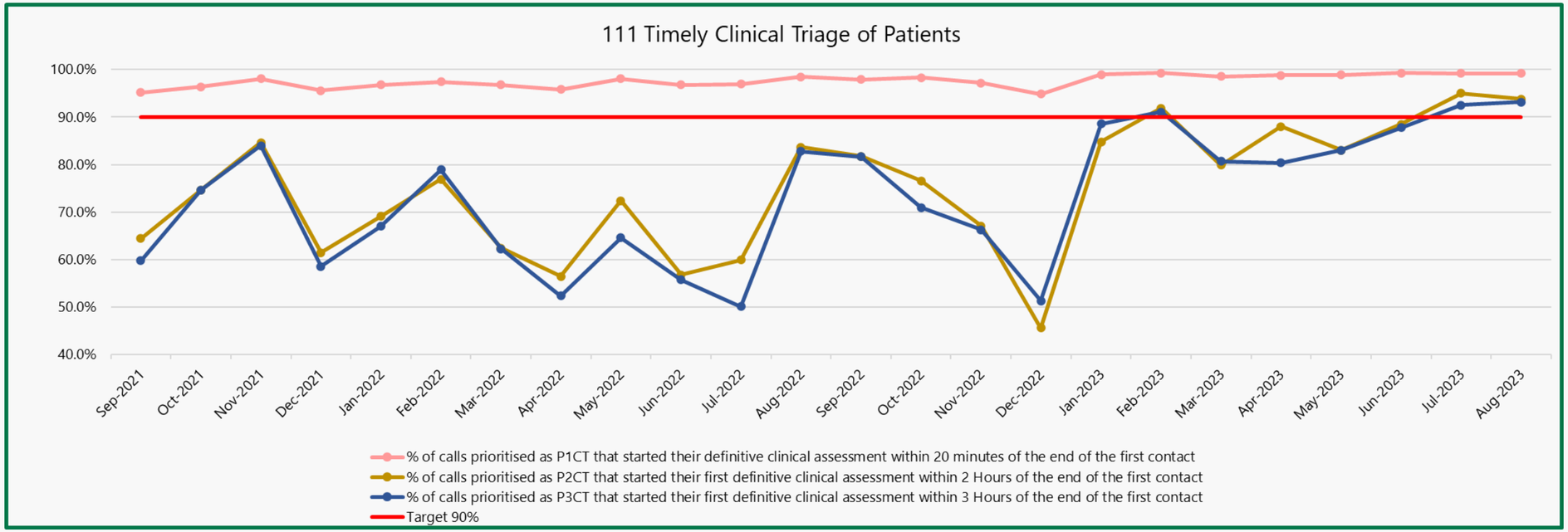
As call handler numbers reduce through the SALUS implementation phase and additional abstractions for SALUS training are accommodated performance is expected to deteriorate month on month until Q4. Agreed further action to address this.

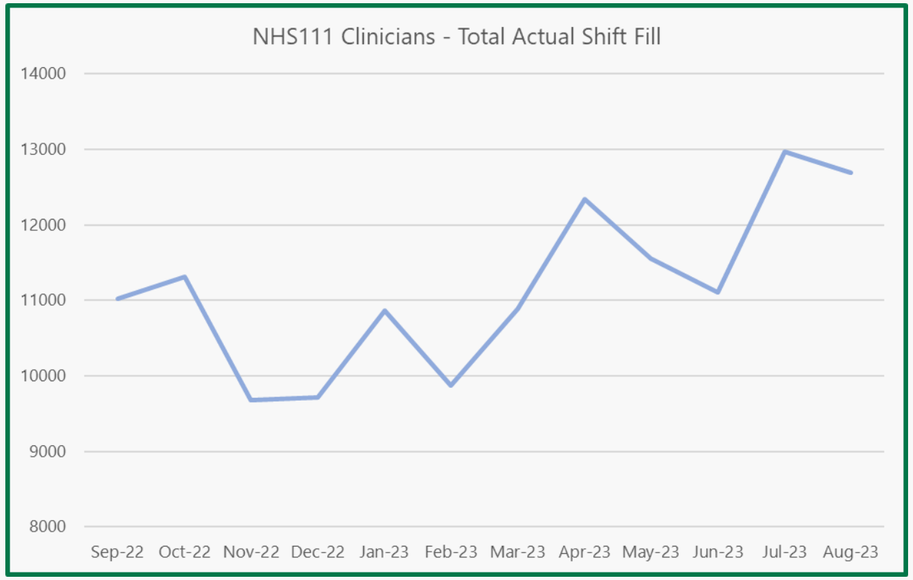
Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators

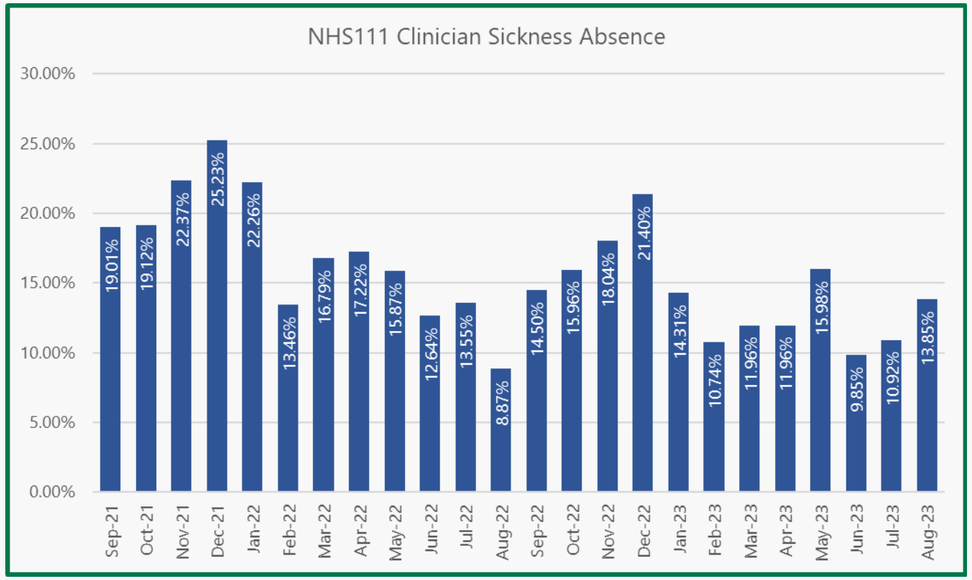
(Responsible Officer: Lee Brooks)

P1CT G FPC

Influencing Factors – Demand and Clinical Hours Produced







Analysis

The highest priority calls, P1CT, continues to achieve the 90% target (99.2%).

For lower category calls P2CT decreased slightly to 93.8% in August 2023 when compared to 95% in July 2023, while P3CT increased to 93.2% in August 2023 compared to 92.5% in July 2023.

Clinical staff capacity decreased to 12,687 hours during August 2023, a drop of 280 when compared to July 2023. Clinician sickness absence increased to 13.85% in August 2023, up from the 10.92% reported in July 2023.

Remedial Plans and Actions

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

Expected Performance Trajectory

Clinical performance, whilst much improved, is expected to decline due to attrition and abstractions arising as a result of SALUS. Further demand & capacity work to determine the correct number of clinicians with the correct level of abstractions is also an area of future development.

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

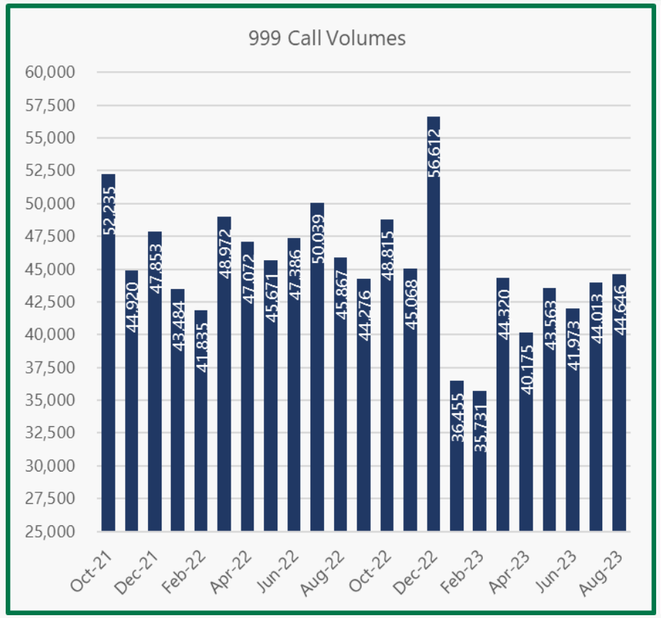
(Responsible Officer: Lee Brooks)

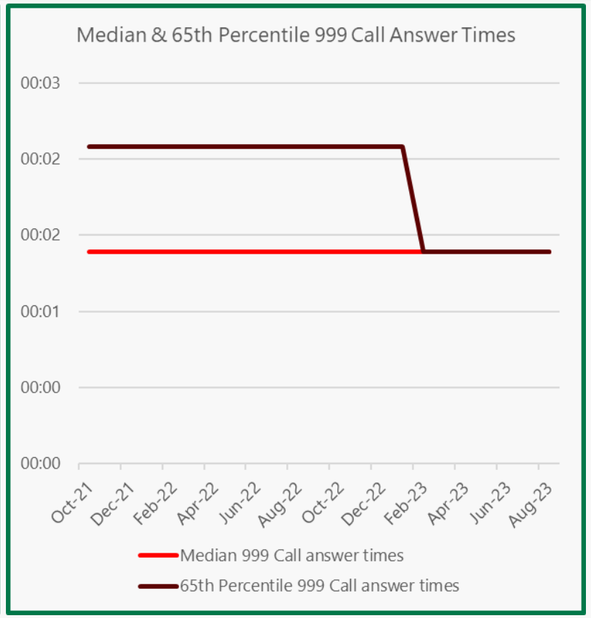
G

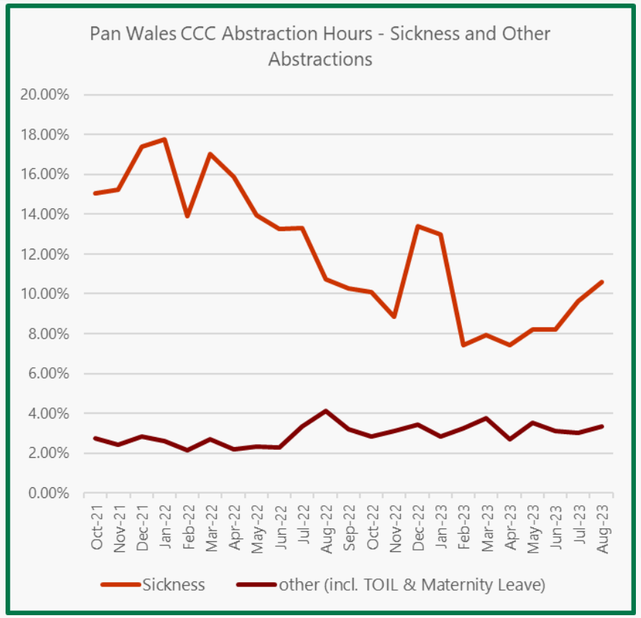
FPC

CI

Influencing Factors – Demand and Hours Produced







Analysis

The 95th percentile 999 call answering performance increased to 31 seconds in August 2023, up from 10 seconds in July 2023 and above the 6 second target.

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

The Trust received 44,646 emergency 999 calls in August 2023, a slight increase from the 44,013 calls received during July 2023.

Overall sickness abstractions within the CCC have risen over the past three months, after being on a downward trajectory till April 2023 rising to 10.59% in August 2023. This means they have been above the 8% target for the past 4 months.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

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

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

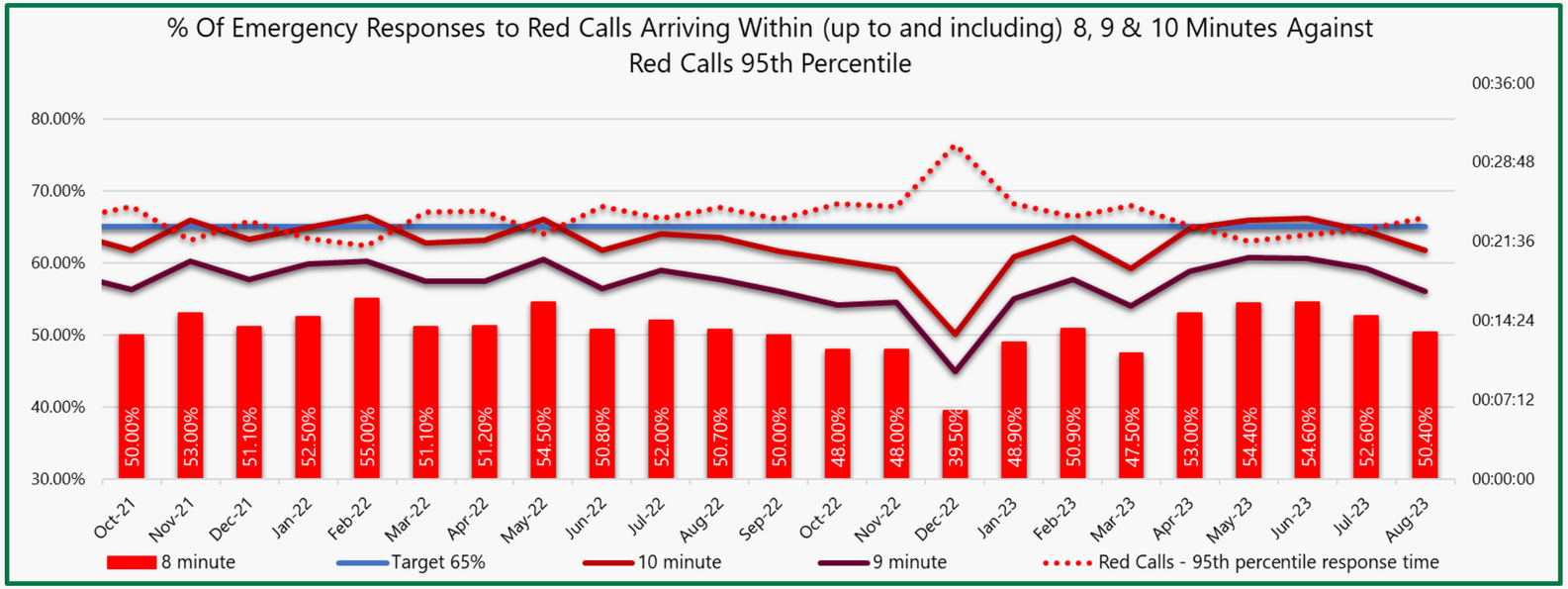
65% R

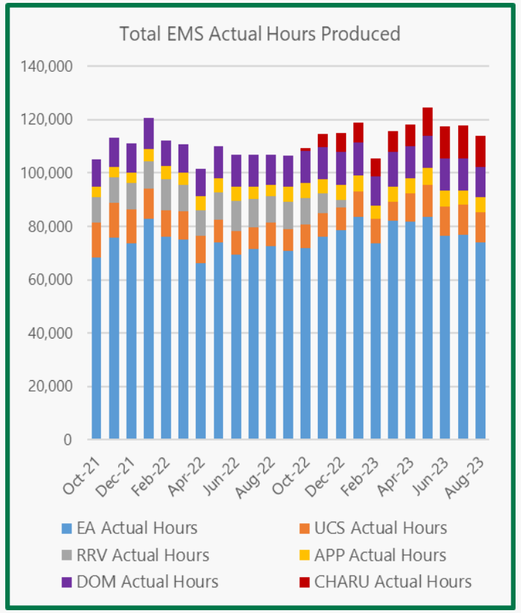
95% R

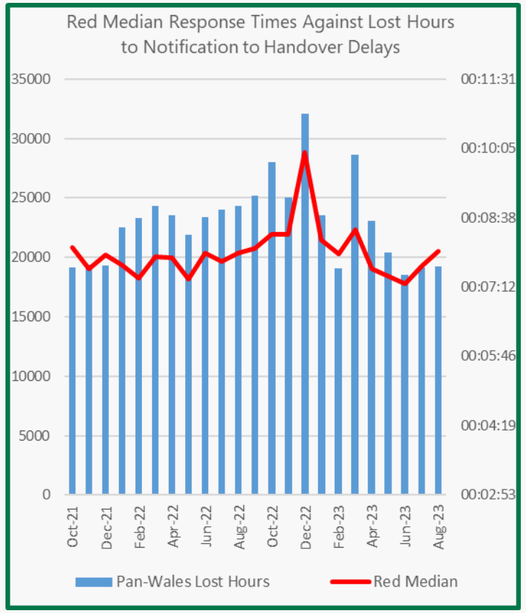
QUEST

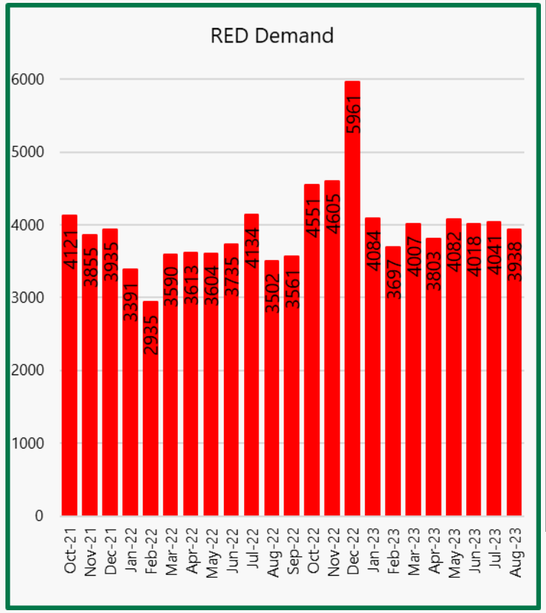
FPC

CI









Analysis

Red performance declined slightly in August 2023, with Red 8-minute performance decreasing to 50.40% and continues to remain below the 65% target. Although there was variation, none of the seven health boards achieved this target. Red 10-minute performance was 61.8% for August 2023, down from 64.4% in July 2023.

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

Red demand has generally been increasing over the past two years, reaching a peak in December 2022. Demand has remained consistent since that spike but remains slightly higher than the same period last year.

Hours produced to 113,830 hours in August, although this still remains slightly above the 2-year monthly average.

The lower centre graph demonstrates the correlation between overall Red performance and hospital handover lost hours. Lost hours are now lower than their peak in December, but August 2023 saw an increase to 19,233 lost hours compared to a figure of 19,118 in July 2023. This was the second month in a row that has seen an increase, following 3 months of decline, meaning these levels continue to remain significantly above where they need to be.

Remedial Plans and Actions

The main improvement actions are:

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

Expected Performance Trajectory

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

*NB: Data correct at time of abstraction

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

(Responsible Officer: Lee Brooks)

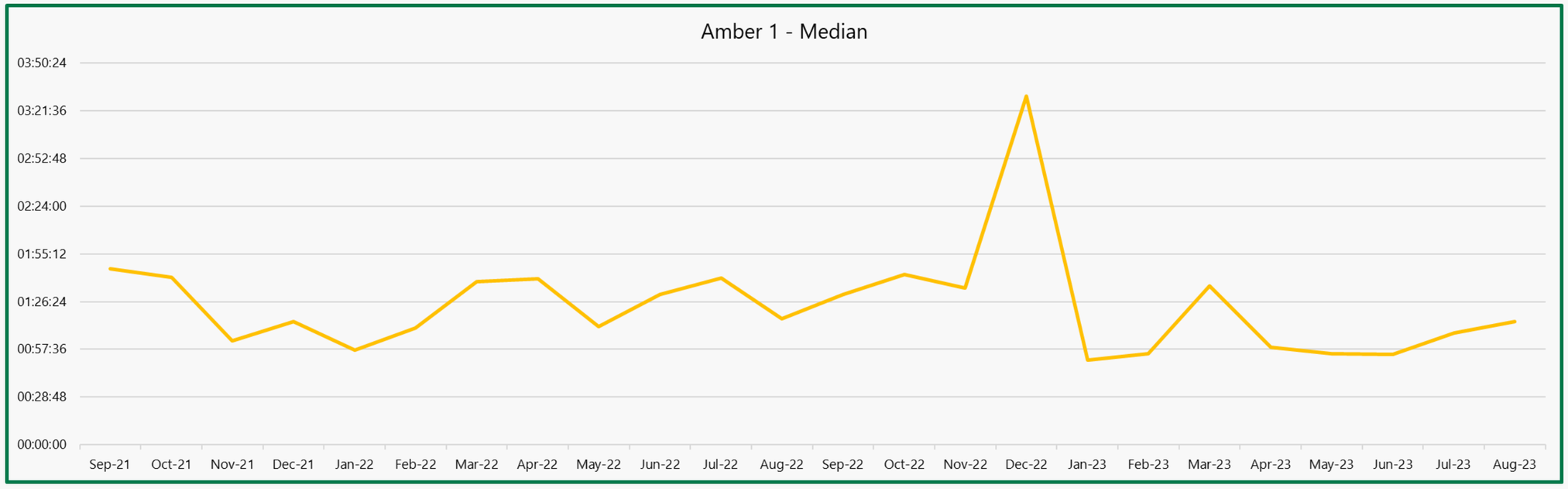
R

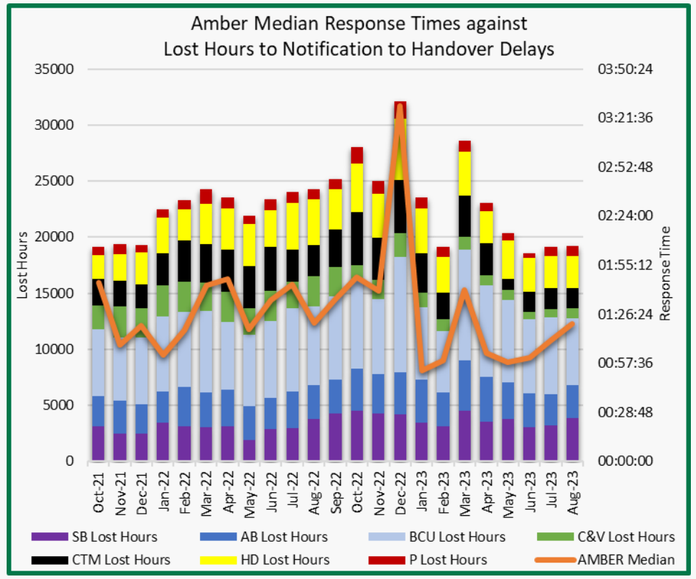
FPC

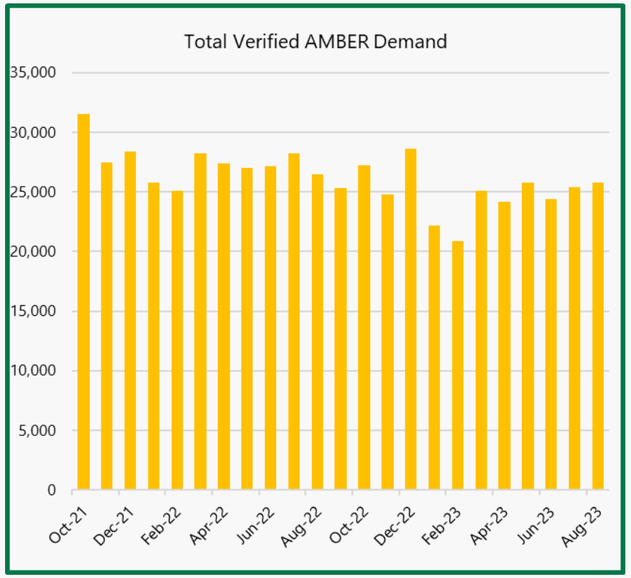
CI

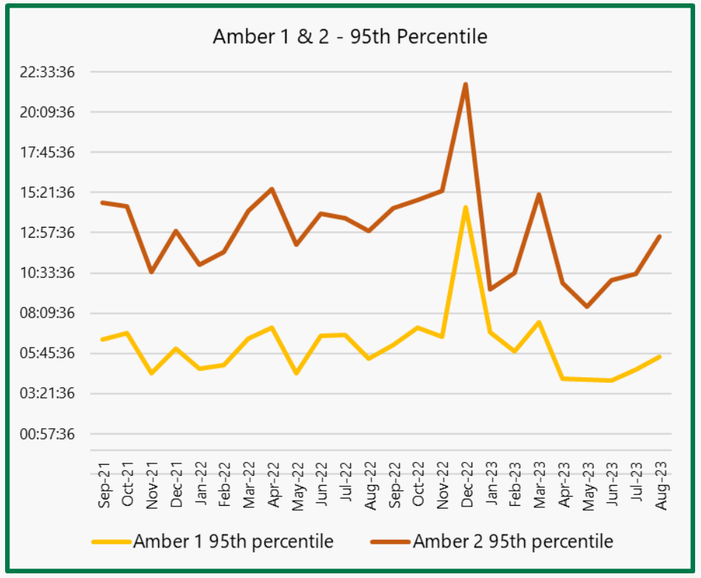
QUEST

Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

Amber 1 median performance declined during August 2023 to 1 hour 14 minutes, from the 1 hour 7 minutes recorded in July 2023. The ideal Amber 1 median response time is 18 minutes. The 95th percentile also rose to 5 hours and 33 minutes.

There were still some long patient waits in August 2023, with 1,475 patients (all categories, not just Amber) waiting over 4 hours, a slight increase from the 1,452 recorded in July 2023.

Amber demand increased in August 2023 to 25,807 verified incidents.

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

Remedial Plans and Actions

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

Expected Performance Trajectory

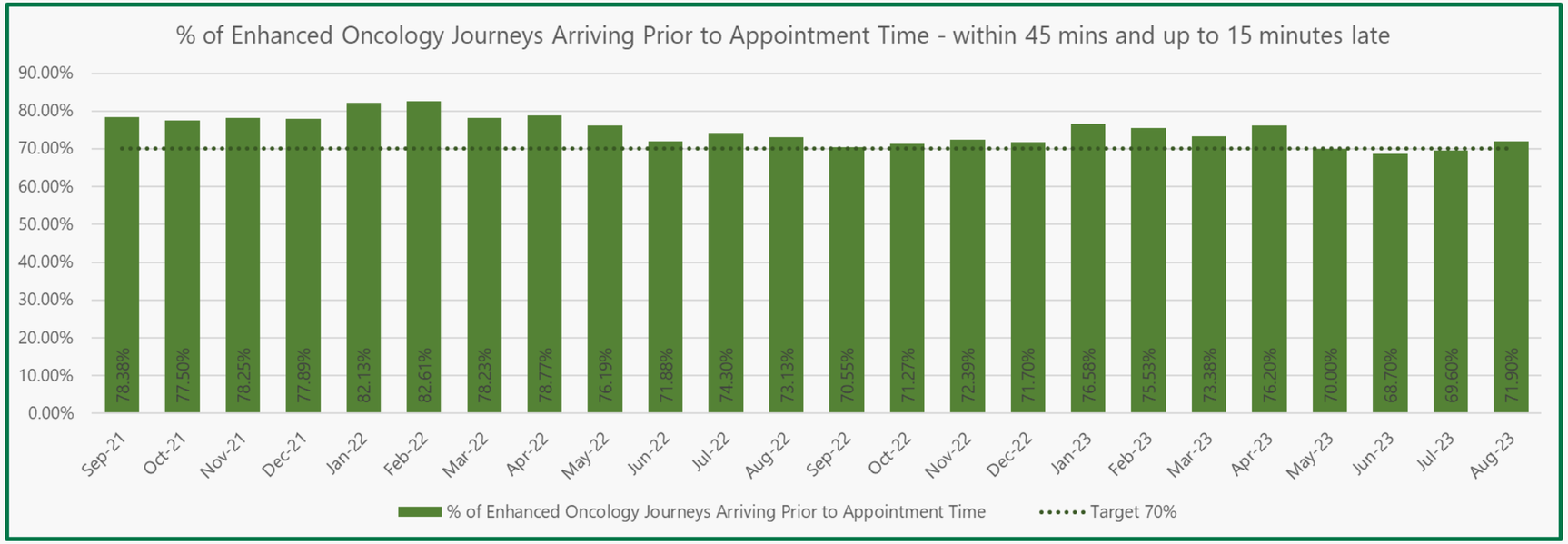
The EMS Operational Transformation Programme is the Trust's key strategic response to Amber. As per the commentary on Red performance delivering these benchmarks is dependent on a range of investments and system efficiencies, not all of which are within the Trust's control.

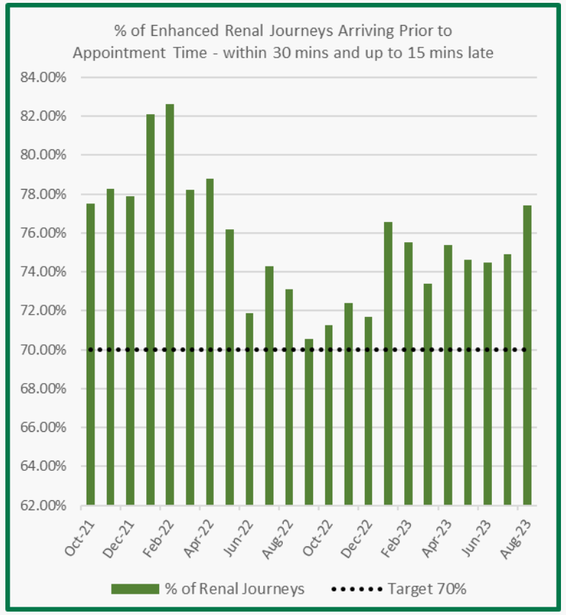
Our Patients: Quality, Safety & Patient Experience
Ambulance Care Indicators

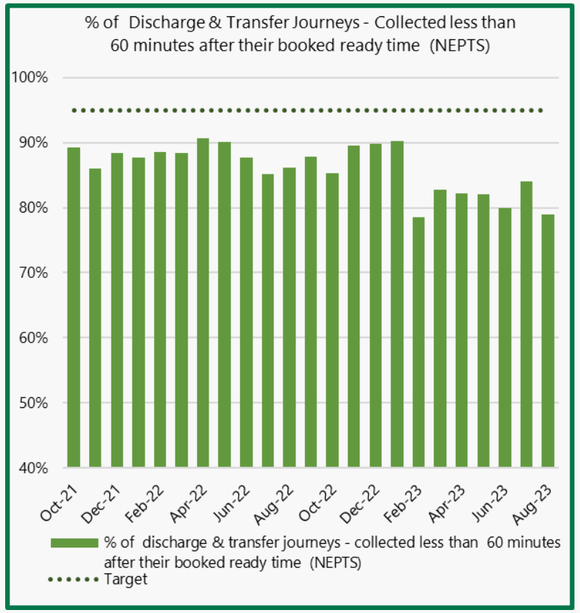
(Responsible Officer: Lee Brooks)

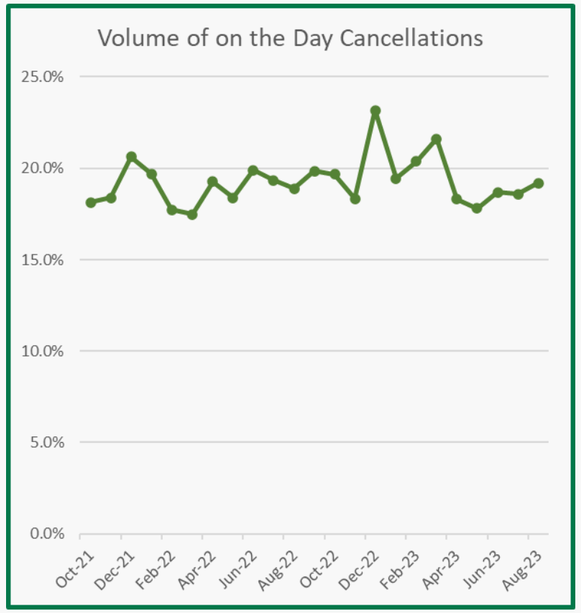
Oncology G | D&T R | FPC | CI

Patient Experience









Analysis

Ambulance Care (NEPTS element) performance improved slightly during August 2023. 71.9% of enhanced oncology journeys arrived within 45 minutes prior and up to 15 minutes late to their appointment time, up from 69.6% in July 2023, and achieving the 70% target. Enhanced Renal journeys also saw improvement, from 74.9% in July 2023 to 77.4% in August 2023.

79% of discharge & transfer journeys were collected within 60 minutes of their booked ready time, a decrease compared to July 2023 (84%), and below the 95% target.

Same day cancellations increased slightly from 18.6% in July 2023 to 19.2% in August 2023.

Overall demand has continued to increase as the planned care system continues to reset. In particular:-

- Completed journeys for Patients requiring Ambulance Transport – Non T1 & C3 mobility (exc. Discharge & Transfer) are at or in excess of levels seen prior to the pandemic.
- Oncology journeys in particular have increased significantly since April 2023 and in June 2023 were at levels not seen since 2019.
- There has been a notable increase in requests for discharges from the ED. This correlates with EMS no longer facilitating these requests.

Remedial Plans and Actions

- D&C Project: roster review of NEPTS transport paused as part of IMTP prioritisation exercise.
- Transfer and Discharge Service: work is in progress with regards to the modelling (initial results received, almost complete).
- The service has implemented a performance standard implementation plan to support the roll out of the new parameters. This plan is focused on ensuring the entire team are aware of the standards and their role in delivering them.
- Updated NEPTS performance parameters went live in April 2023, these will separate out on the day and advance booked journeys. At present most bookings are made on the day, which makes it difficult to respond to within the times allowed. A focus on pre-planned discharge should support work being completed by working groups 5&6 of the 6 goals programme board.

Expected Performance Trajectory

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

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

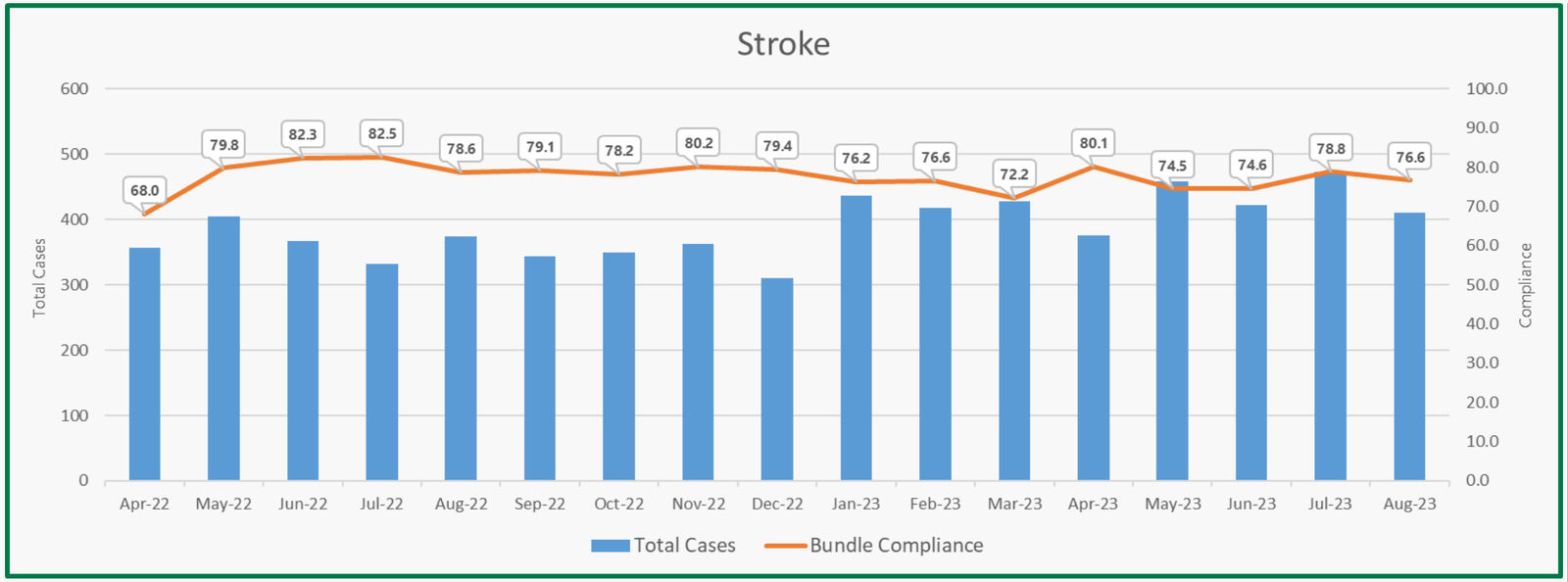
(Responsible Officer: Andy Swinburn)

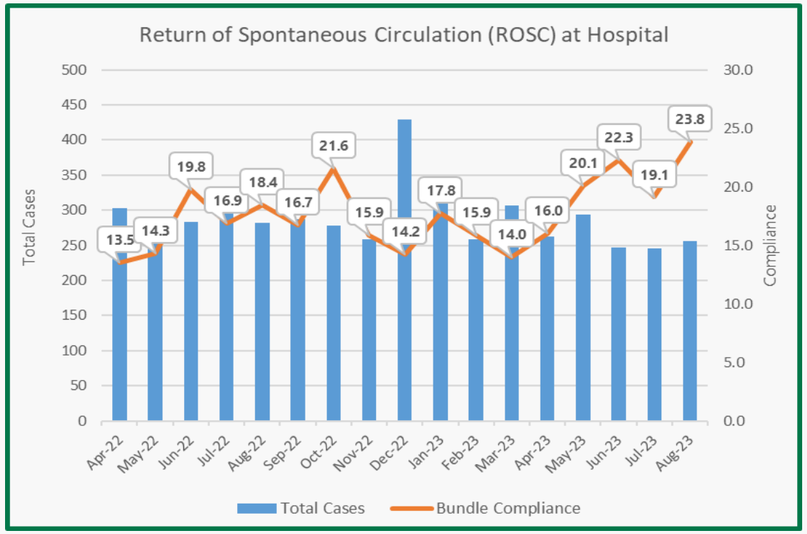
Stroke/Hip Fracture/Hypoglycaemic
R

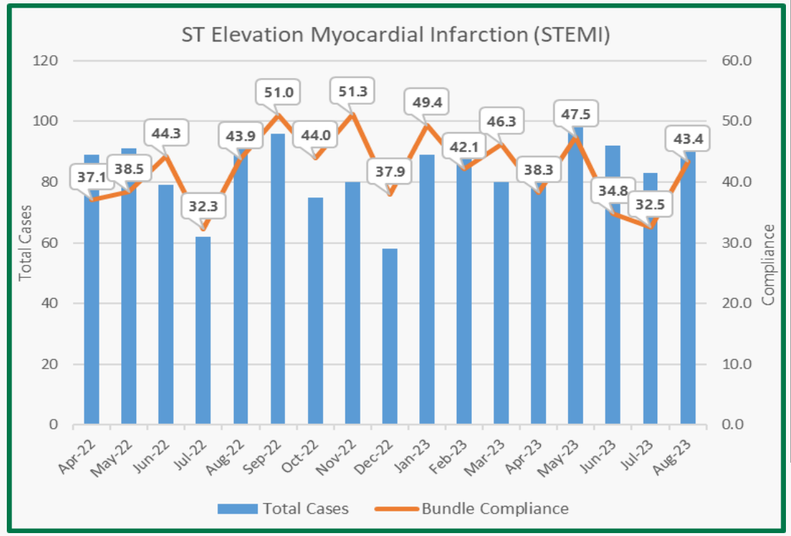
Self-Assessment: Strength of Internal Control: Moderate

QUEST

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







Analysis

The percentage of suspected stroke patients receiving an appropriate stroke care bundle in August 2023 was 76.6%. This was a slight deterioration from the 78.8% recorded in July 2023 and remains below the 95% performance target. This was against a total case number of 410 during the month of August.

The ROSC rate improved to 23.8% in August 2023 from 19.2% in July 2023, and is the highest figure recorded over the past two years.

The STEMI rate also improved to 43.4% in August 2023 compared to 32.5% in July 2023, this at the same time as total cases also increased.

Work on reporting a new clinical indicator relating to call to door times for STEMI and Stroke continues and is planned to be included next month.

Remedial Plans and Actions

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

In relation to the new clinical indicator, further review is ongoing to ensure data points are correct and in line with other national reporting systems.

The Trust's introduction of the Cymru High Acuity Response Unit (CHARU) model, based on improved clinical leadership and enhanced training, will further improve outcomes for patients and is our main response to the need to improve ROSC rates. This has been in place since October 2022 in some areas, but vacancies do remain, and work is also required in terms of utilisation of this resource type, which is lower than expected.

Expected Performance Trajectory

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

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

(Responsible Officer: Liam Williams)

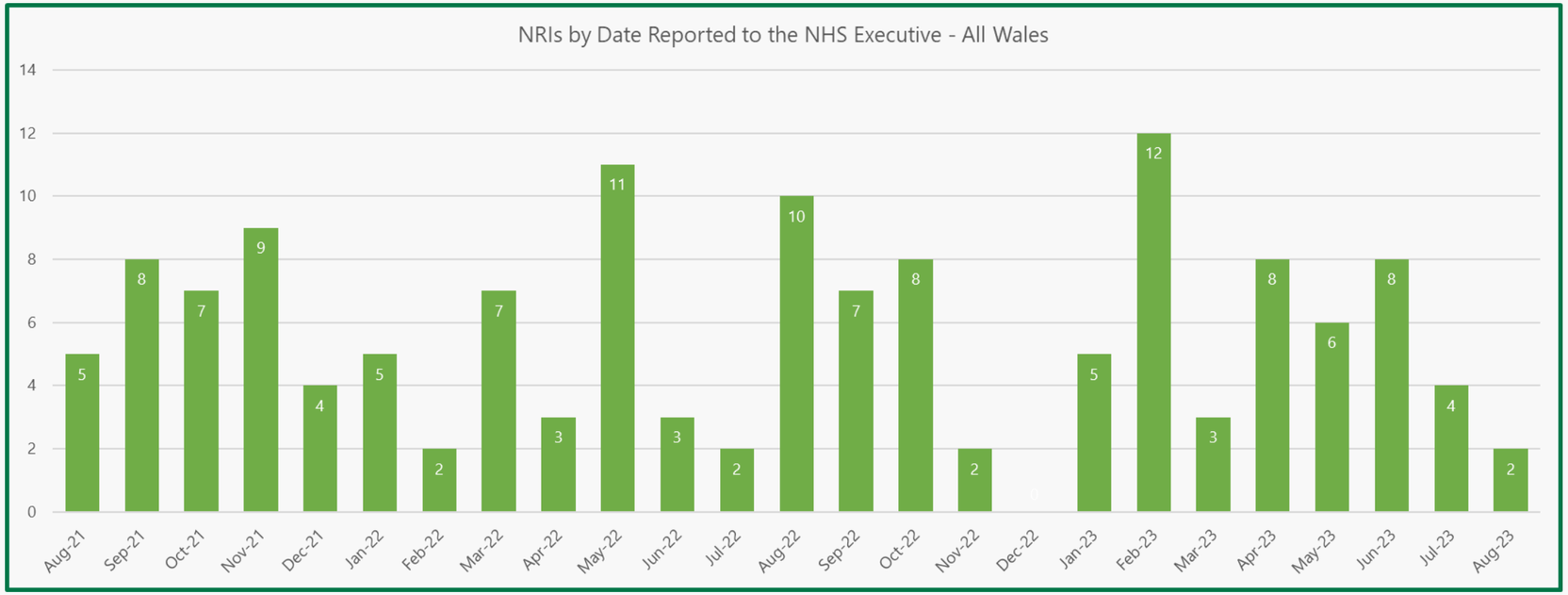
NRI. A

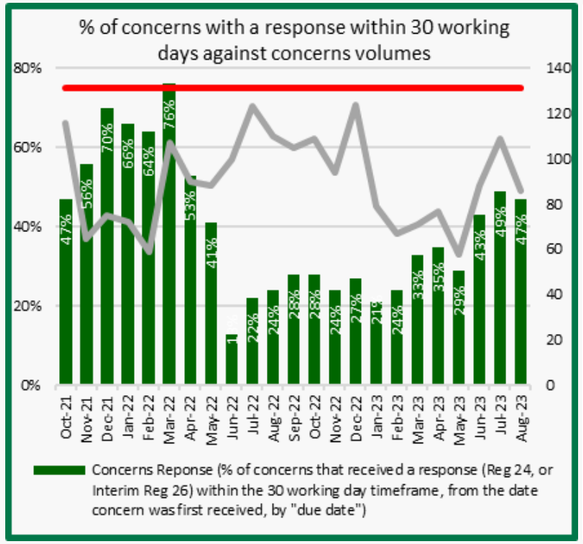
Self-Assessment: Strength of Internal Control: Moderate

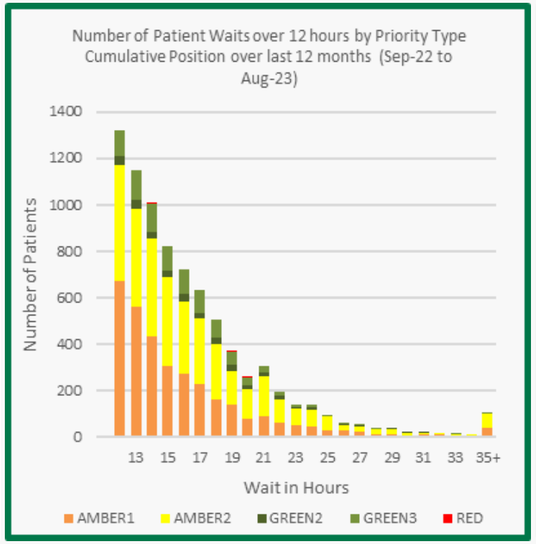
QUEST

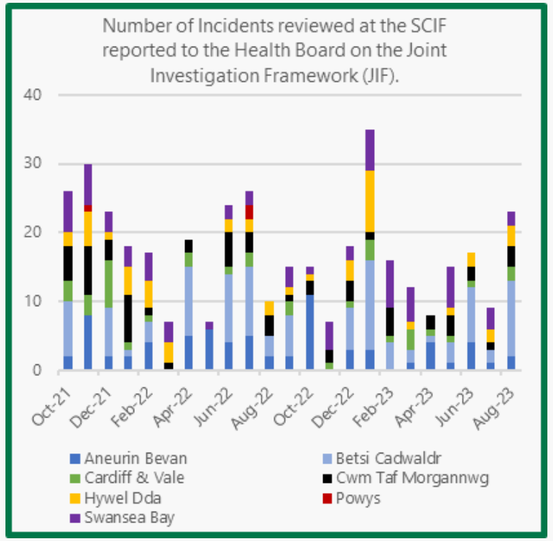
Health & Care Standard
Health - Safe Care / Timely Care

Responses Indicators









Analysis

The percentage of responses to concerns in August 2023 is 47% against a 75% target (30-day response) which is a slightly reduced position. Several factors continue to affect the Trust's ability to respond to concerns, including, overall increased demand, a rise in the number of inquests, continuing volumes of Nationally Reportable Incident's (NRIs) and timely response to requests for information from key parties. The number of total concerns has slightly decreased with 86 complaints being received in August 2023. These complaints are frequently complex with our concerns administrators frequently taking lengthy calls from distressed patients or family members for up to one hour per call. From April 2023 the 2-day acknowledgment (77% compliance August 2023) measure for complaints has been revised to a 5-day acknowledgement measure (100% compliance August 2023). This is to bring the Putting Things Right Regulations in line with Duty of Candour. The 2-day measure will continue to be monitored internally due to the fragile position currently. Seven Serious Case Incident Forums (SCIF) were held during the month and thirty-three cases were discussed. Following discussion two serious patient safety incidents were reported to the NHS Wales Executive (Delivery Unit) and twenty-three cases were referred to Health Boards for investigation under the Joint Investigation Framework. The Trust received no referrals from Health Boards under the Joint Investigation Framework during the period. Learning from the Joint Investigation Framework process remains limited whilst the process embeds.

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

Themes relating to serious patient safety incidents reported to the NHS Wales Executive (Delivery Unit) as Nationally Reportable Incidents (NRIs) include delayed community response times and call categorisation, predominately ineffective breathing which is being discussed at national ambulance forums as a consistent theme.

In August 23, 554 patients waited over 12 hours for an ambulance response, which is an increase on the 425 reported in July. 53 compliments were received from patients and/or their families in August 2023.

Remedial Plans and Actions

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

Delayed community response (Risk 223) and handover of care delays at hospitals (Risk 224) are the two highest rated risks on the Trust's Corporate Risk Register (both rated 25) and include detailed mitigations and current actions, both are considered at Board sub-committee level and at Trust Board. The Joint Investigation Framework is now formally in place across NHS Wales and is referenced in the recently published NHS Wales National Policy on Patient Safety Incident Reporting & Management (May 2023) which was approved by the Clinical Quality Governance Group in June 2023.

Immediate improvement actions following the Serious Case Incident Forum (SCIF) include education and training for individual staff, updates to operating procedures and circulation of bulletins to share learning and provide updates. The key strategic action is the EMS Operational Transformation Programme.

Expected Performance Trajectory

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

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

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

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

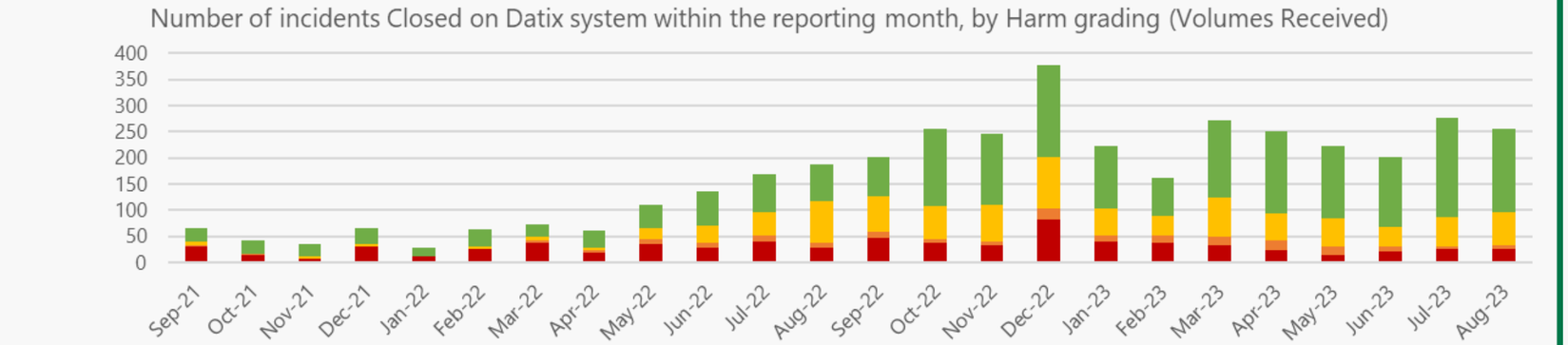
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care



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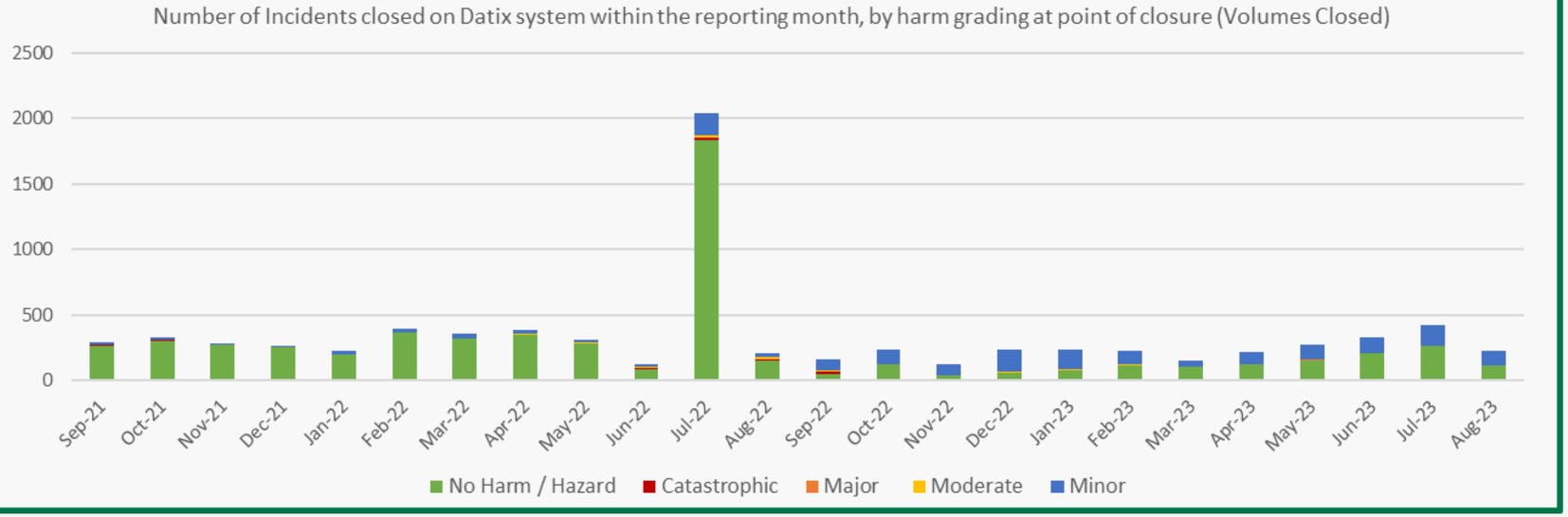
Minor	24	24	22	30	15	33	23	33	44	66	71	71	75	146	136	175	119	74	147	159	137	132	189	160
Moderate	8	2	5	5	1	3	7	5	22	32	46	79	67	64	70	99	52	38	74	50	53	37	58	63
Severe	1	2	0	0	0	1	6	3	9	9	10	10	12	8	7	21	12	14	17	18	17	10	4	7
Catastrophic	32	14	8	30	12	26	37	20	36	29	41	28	48	37	34	82	40	37	33	25	15	22	26	26



Analysis

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

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

- No harm or hazard – 73
- Minor harm – 160
- Moderate harm - 63
- Severe Outcomes - 7
- Catastrophic - 26

(*NB: Volumes received).

The bottom graph highlights the 229 Incidents that were closed on the Datix system in August 2023. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident).

Remedial Plans and Actions

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

Early informal engagement on the structure of the Putting Things Right team has begun ahead of the formal organisational change process planned for quarter 3 2023/24 which will consider our local and national priorities and resources to meet the needs of our patients and families.

The Trust is represented at national networks including Duty of Candour, Complaints, Ombudsman, Learning, Mortality, Claims, Redress and Datix Cymru development groups as resources allow. Work is progressing in respect of the development of dashboards to inform reporting and oversight internally with Health Informatics and through the national Wels Risk Pool Once for Wales team (Datix Cymru).

Expected Performance Trajectory

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

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

Data source: Datix

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

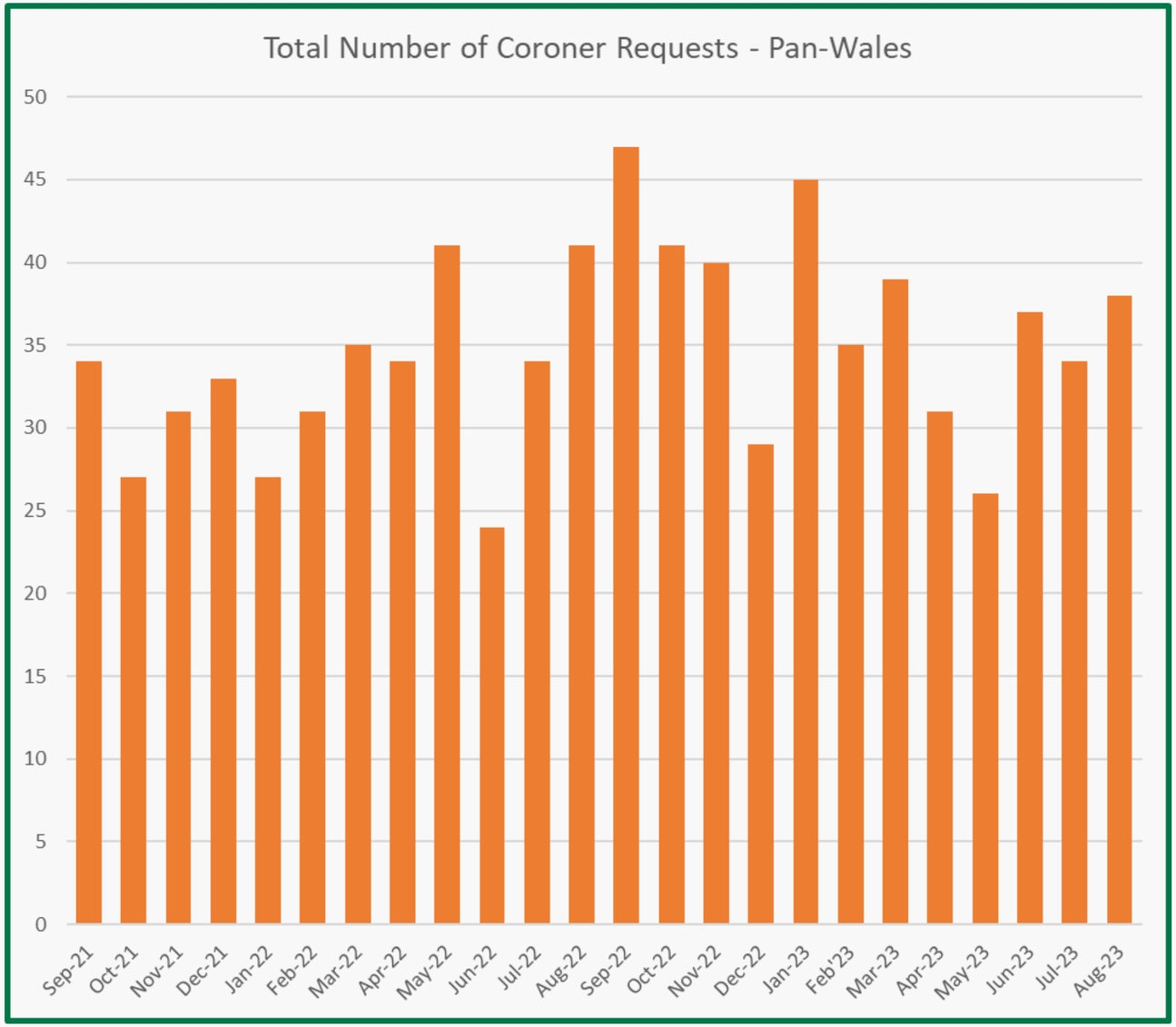
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



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

Analysis

Coroners: The number of in month request continues to be higher than pre pandemic. This increased number of approaches is now the norm, rather than the exception. The complexity remains high, with multiple statements per approach. The Trust is moving the cases from the Datix web system (legacy) to the new Datix Cymru system. This will affect how we record our data and what we will be able to report on, as we come in line with an all-Wales format. August historically sees a slowdown in inquests being booked. September will see an increase in cases where the Trust are an IP. At the end of August 2023 there were 548 claims open; these relate to Personal Injury (72 Claims); Personal Injury - Road Traffic Accidents (62 Claims), Clinical negligence (138 claims); Road Traffic Accident (253 claims) and Damage to Property (23 claims).

Ombudsman: There are currently 10 open Ombudsman cases in August 2023. Due to staff absences no actions have been taken regarding Ombudsman cases this month but will be recorded next month.

Mortality Review: The Trust continues to participate in Health Board led mortality reviews as appropriate, with attendance from the patient safety team and clinical colleagues as available. Data and information is also provided by the Trust as required to the Medical Examiner Service to inform their reviews of deaths in acute care. To date the Trust have received over 570 requests for information or feedback from the Medical Examiner Service with themes and trends so far including timeliness in response to patients in the community, handover of care delays and patients on the end-of-life care pathway being conveyed to acute care. The All-Wales Mortality Review Group at which WAST has representation has recently commissioned 'A Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) All-Wales Thematic Review' selecting cases covering January 2022 to January 2023. This review encompasses all Health Boards, and the final report will be provided by October 2023.

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

Remedial Plans and Actions

Coroners: Cases continue to be registered and distributed and the Team has had to introduce a new process surrounding the notification of summons to inquest. This has affected the timeliness of our case registration and distribution. The number of cases where staff are giving evidence for continuity purposes has reduced and the number where staff are giving evidence as the Trust is an IP has increased significantly, representing a quarter of all open cases. This also has a significant impact on the capacity of the Team, as these cases require considerably more management.

Ombudsmen: *All cases are recorded and monitored on the Datix system.*

Mortality Review: The Trust is in the process of developing the internal mechanisms in order to facilitate mortality reviews under the new approach and our internal framework has been approved at the Clinical Quality Governance Group and an internal mortality group (learning from deaths) is being established, closely aligning to the Serious Case Incident Forum.

Representation and contribution by the Trust at the All-Wales Mortality Working Group will continue and a task and finish group has been established to review the process for contacting families following their meetings with the Medical Examiners. Additionally, the Trust are engaged in the meetings lead by the Once for Wales Datix Cymru team who are developing the Datix Cymru Mortality Module currently.

Expected Performance Trajectory

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

Ombudsmen: Learning has been placed in a Patient Safety Newsletter, for sharing pan-Wales.

Mortality Review: Whilst the multiple benefits of the ME process are recognised there will undoubtedly be significant resource implications for the Trust, particularly as the process expands to every non-coronial death in NHS Wales in September 2023 and the Health Boards (who are at different levels of maturity regarding mortality reviews) start to develop and embed their processes. It is recognised that some cases will have already been reviewed via Putting Things Right processes internally through the Serious Case Incident Forum.

Data source: Datix

Mortality Reviews Data source: Internal Web Application

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

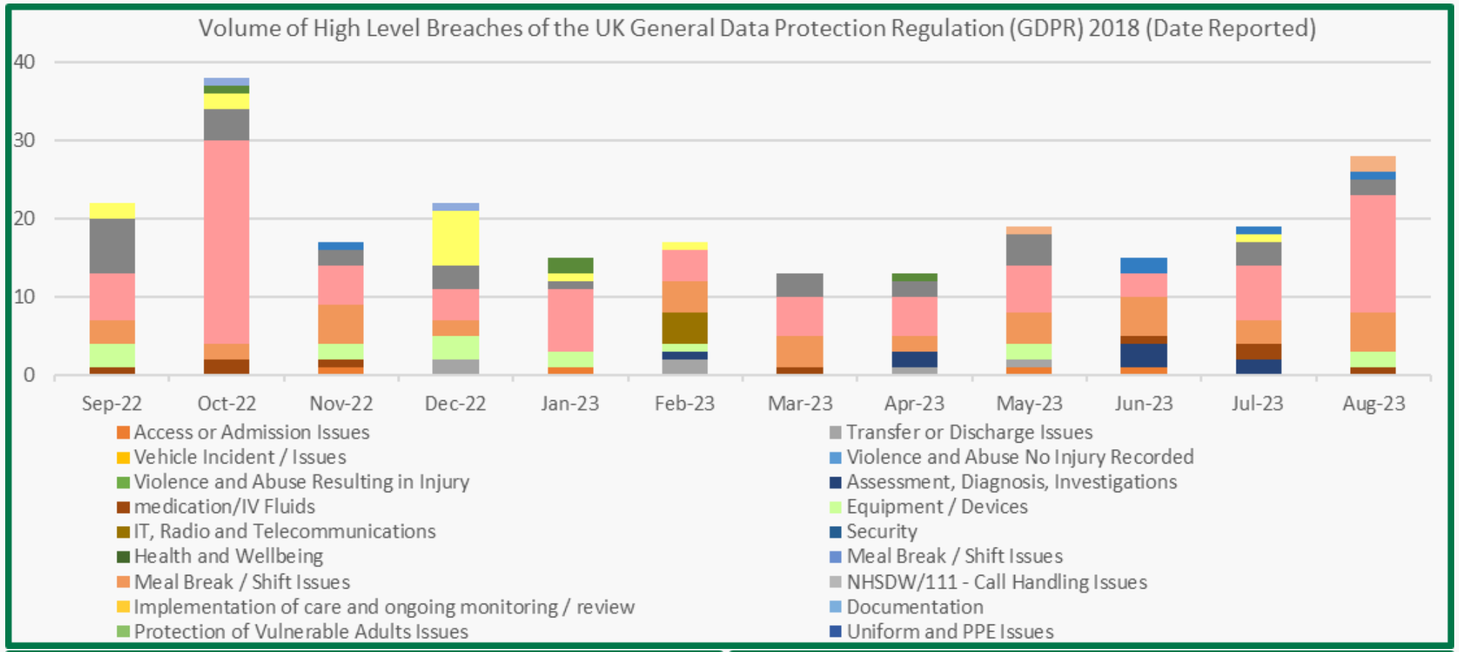
(Responsible Officer: Liam Williams)

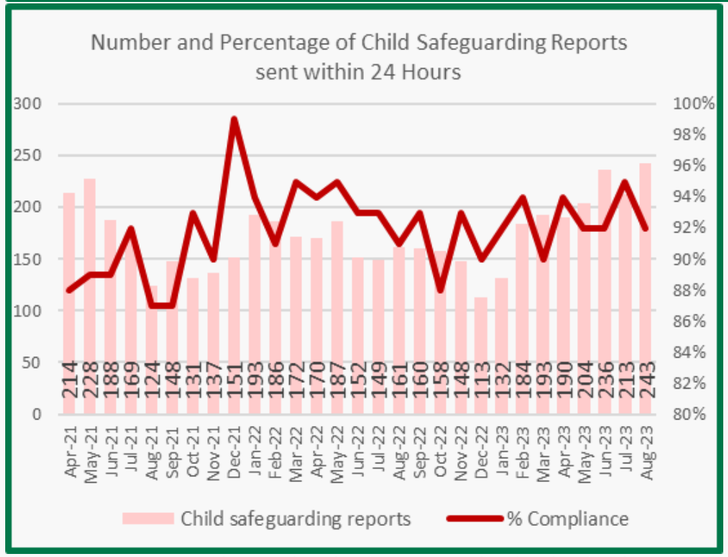
Self-Assessment: Strength of Internal Control: Strong

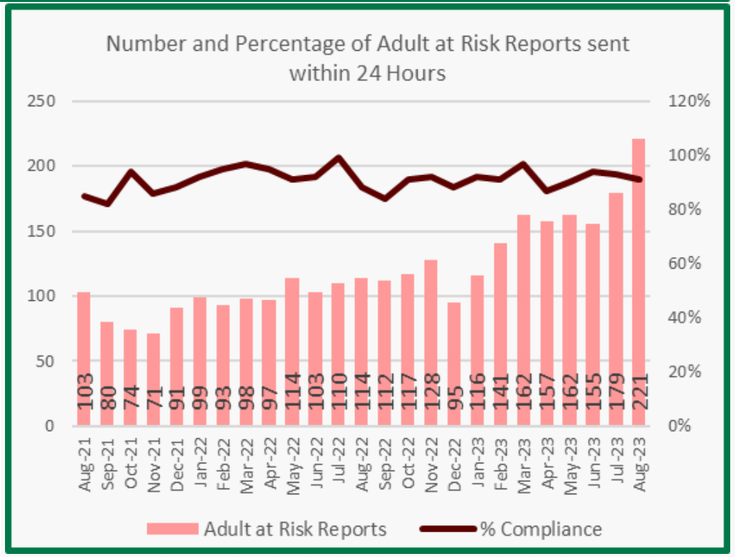
QUEST

Health & Care Standard
Health – Safe Care

Safeguarding Data source: Doc Works







Analysis

Safeguarding: In August 2023 staff completed a total of 221 Adult at Risk Reports, 91% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 487 referrals were received and processed to the local authority during this reporting period. There have been 243 Child Safeguarding Reports in August 2023, 92% of these were processed within 24 hours.

Data Governance: In August 2023 there were 28 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 28 breaches, 5 related to information governance/confidentiality, 15 records/information, 2 Information Technology, 1 behaviour/aggression, 2 equipment, 2 infrastructure and 1 medication/IV/fluids.

Public Engagement: During August 2023, the Patient Experience and Community Involvement Team attended 26 community engagement opportunities, engaging with approximately 2,036 people. This month our engagement has incorporated several school visits as part of the Food Fun Wales programme, engaging with young people attending schools across Cardiff in areas of higher social deprivation. We also attended the Pembrokeshire Agricultural Show, engaging with a large number of people from farming and rural communities. This month we have also engaged with the Bevam Commision, supporting them with their upcoming 'Big Conversation', talking to the people of Wales about the future of how Health & Social Care is delivered across Wales. We have also supported other Teams across WAST with their engagement requirements, supporting the Estates Team for example with an engagement event about a proposed new ambulance station in Dolgellau. At engagement events throughout the month, we continued to use engagement opportunities to listen to people's experiences of using our services and to recruit people to join our People & Community Network. During August we also continued to promote our Patient Experience Surveys (PREMS), asking people to provide feedback about their interactions with our services. Engagement and survey outcomes remain largely consistent and tell us that people continue to be concerned that help will not be available when they need it and that people have experienced delays after calling 999, but that people are happy with the care they eventually receive. 111 callers have told us that they experienced long waits for their calls to be answered and reported long waits for call backs. NEPTS users told us that overall, they continue to be happy with the transport they receive but experience long delays when making their initial telephone booking.

Remedial Plans and Actions

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

Data Governance: During the reporting period, of the 28-information governance related incidents reported on Datix, 0 incidents were deemed to meet the risk threshold for reporting to the Information Commissioner's Office (ICO) so far. The IG Team will continue to review and provide advice on reported incidents where applicable.

Public Engagement: Community involvement and engagement with patients/public forms an integral part of the Trust's ambition to 'invert the triangle' and deliver value-based healthcare evaluated against service users' experiences and health outcomes. The work delivered by the PECI Team is supporting the Trust's principles of providing the highest quality of care and service user experience as a driver for change and delivering services which meet the differing needs of communities we serve without prejudice or discrimination. The PECI Team will continue to engage in an ongoing dialogue with the public on what they think are important developments the Trust could make to improve services they receive. Our learning disability work has continued to take a particular focus this month as we prepare to present our work to date in this area to the Welsh Government Ministerial Advisory Group on Learning Disabilities.

Expected Performance Trajectory

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

Data Governance: The submission for the FY22-23 IG Toolkit closed on 30th June 2023. The outcome scoring report for this submission still waiting to be received. The new submission for FY23-24 has already opened and population of the evidence has commenced.

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

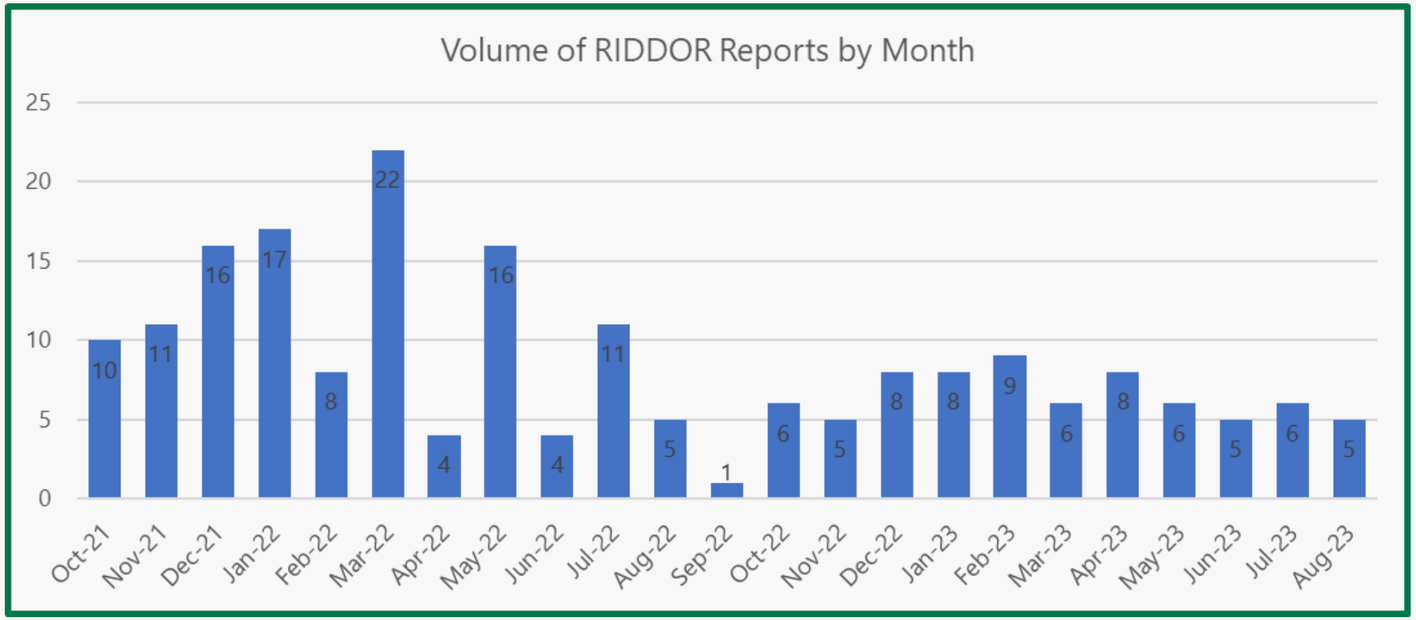
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

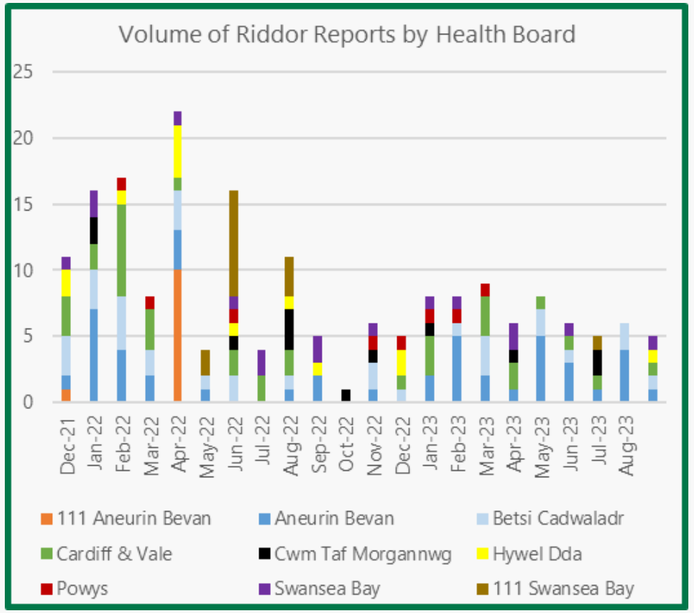
(Responsible Officer: Liam Williams)

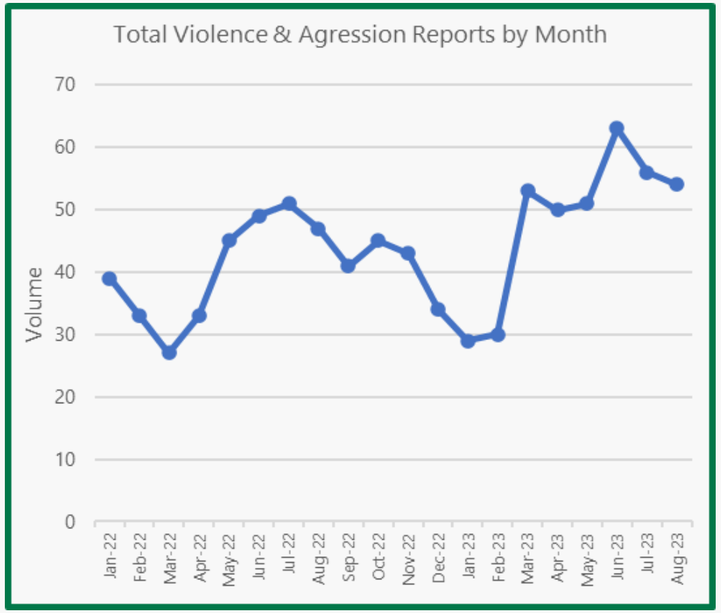
Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care







Analysis

RIDDOR: There were 5 incidents requiring reporting under RIDDOR during August due to staff being absent from work for over 7 days as a result of their injury.

1 incident of note was an injury due to a failure of a stretcher pole whilst pulling a stretcher toward a tail lift. The failure mode of the stretcher pole is under investigation

80% of the incidents reported were notified to the HSE within the reporting required time frames.

One report did not meet the reporting time frame due to delay in information being provided to the Safety Team.

Health and Safety team will continue to work with Incident Handlers to ensure reports are submitted within the required timescales.

Violence and Aggression: A total of 54 incidents have been reported of V&A in August.

7 Physical Assaults on staff were reported during the month with incidents of verbal abuse amounting to 4.

Aneurin Bevan & Betsi Cadwaladr remain the highest reporting areas with a total of 27 incidents

3 incidents were reported as Severe in harm, one noted being asked to attend a property where the patient was recorded as having a knife but there was no Police back up.

Remedial Plans and Actions

RIDDOR: The use of multiple individuals to lift patients presents a particular hazard in regard to manual handling injuries and a trust wide continues to be investigated.

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

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

The Case Manager continues to actively support staff who are involved cases being heard at Court to ensure they are (25 live cases).

Expected Performance Trajectory

RIDDOR: The reporting of incidents of vehicle fume has started to increase and is expected to rise s we approach the winter period. Risk assessments have been completed and mitigation measure are being put in place in Emergency departments across Wales

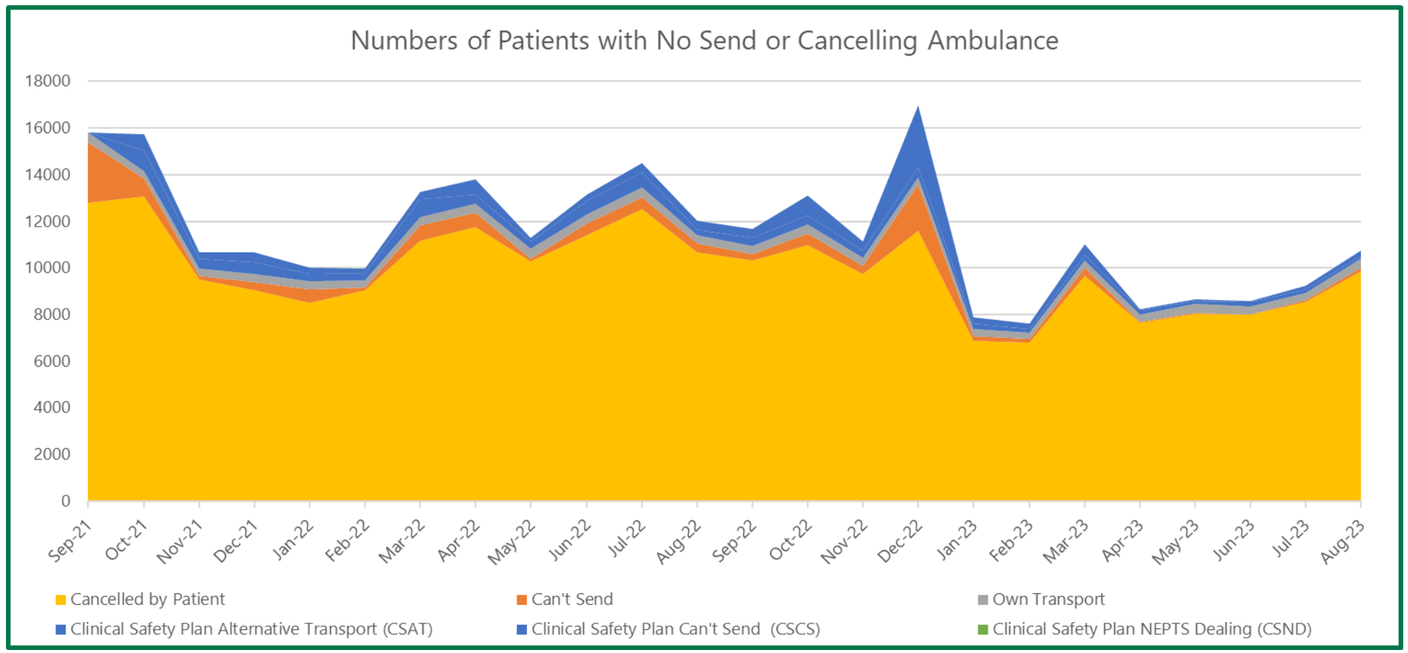
Violence and Aggression: Toolbox talks, raising awareness of case management continue to take place across the Region by the Case Manager & V&A Manager to support staff and raise awareness, it is planned to establish regular interaction with staff directly affected by incidents of V&A. With the aim of improving the help and support available to staff.

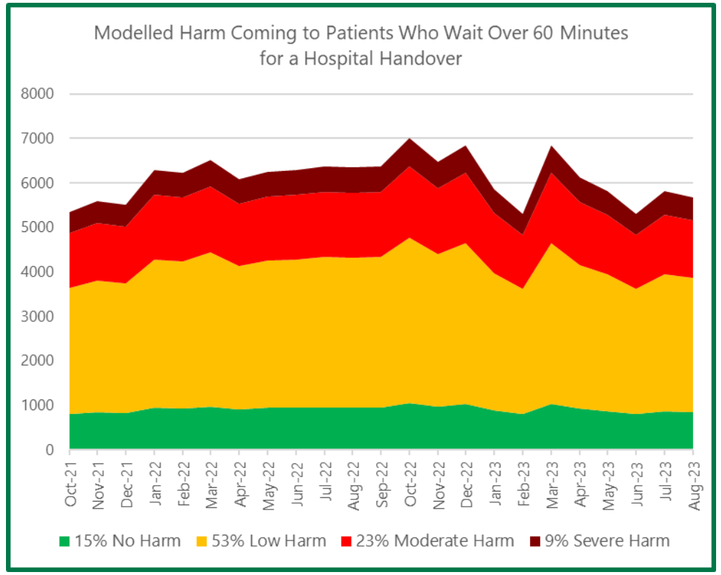
**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

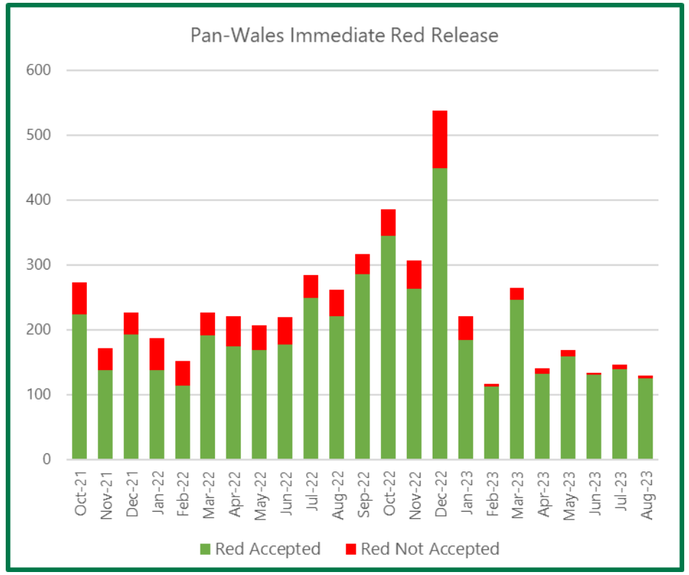
Data source: Datix

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

(Responsible Officer: Andy Swinburn) TBD FPC







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

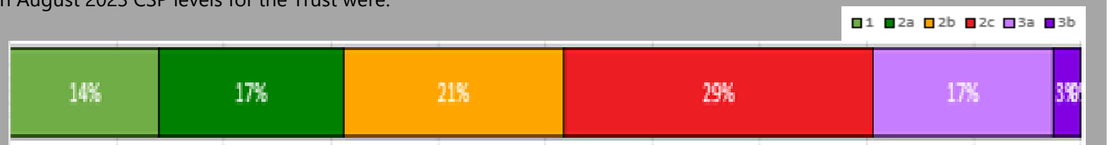
Analysis

In August 2023, 138 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 208 were stopped as a result of CSP 'Can't Send' options. In addition, 9,847 ambulances were cancelled by patients (including patients refusing treatment at scene) and 364 patients made their way to hospital using their own transport.

There were 541 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in August 2023. Of these 125 were accepted and released in the Red category, with 4 not being accepted. Further to this, 140 ambulances were released to respond to Amber 1 calls, but 272 were not.

The graph in the bottom left shows that in August 2023 of the 5,676 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% (851 patients) would experience no harm, 53% (3,008 patients) would experience low harm, 23% (1,305 patients) would experience moderate harm and 9% (511 patients) would experience severe harm.

In August 2023 CSP levels for the Trust were:



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

Remedial Plans and Actions

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

Expected Performance Trajectory

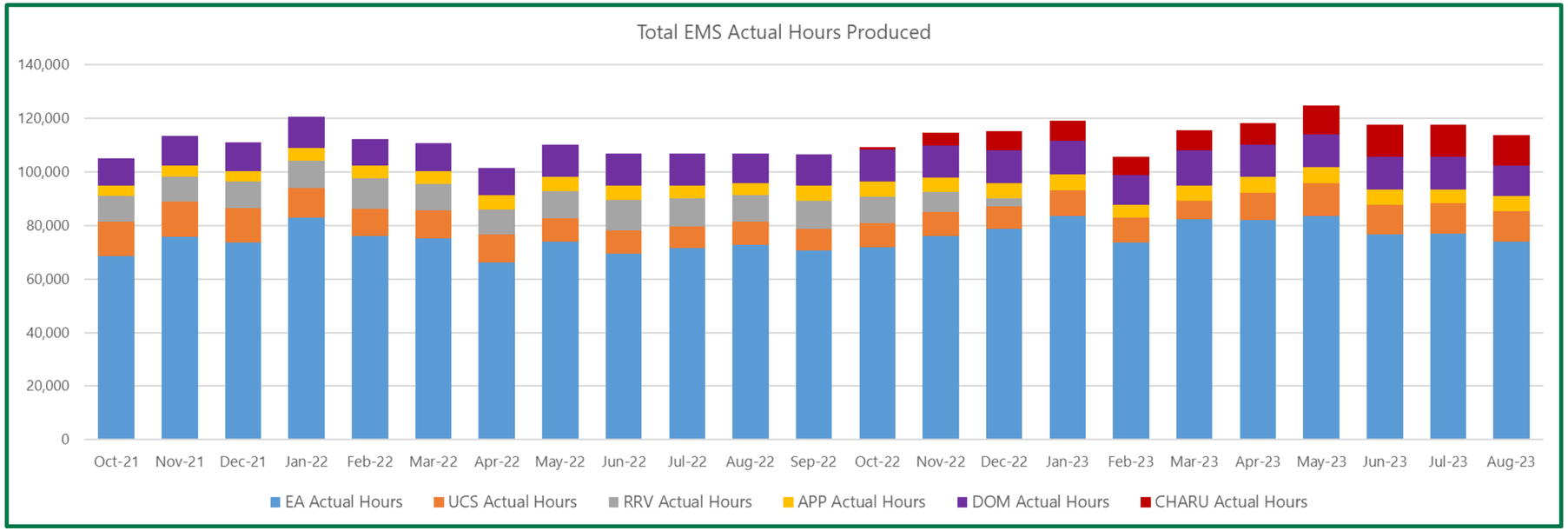
The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trusts ability to respond to demand. Seasonal pressures impact the Trust and planning is being used to prepare for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

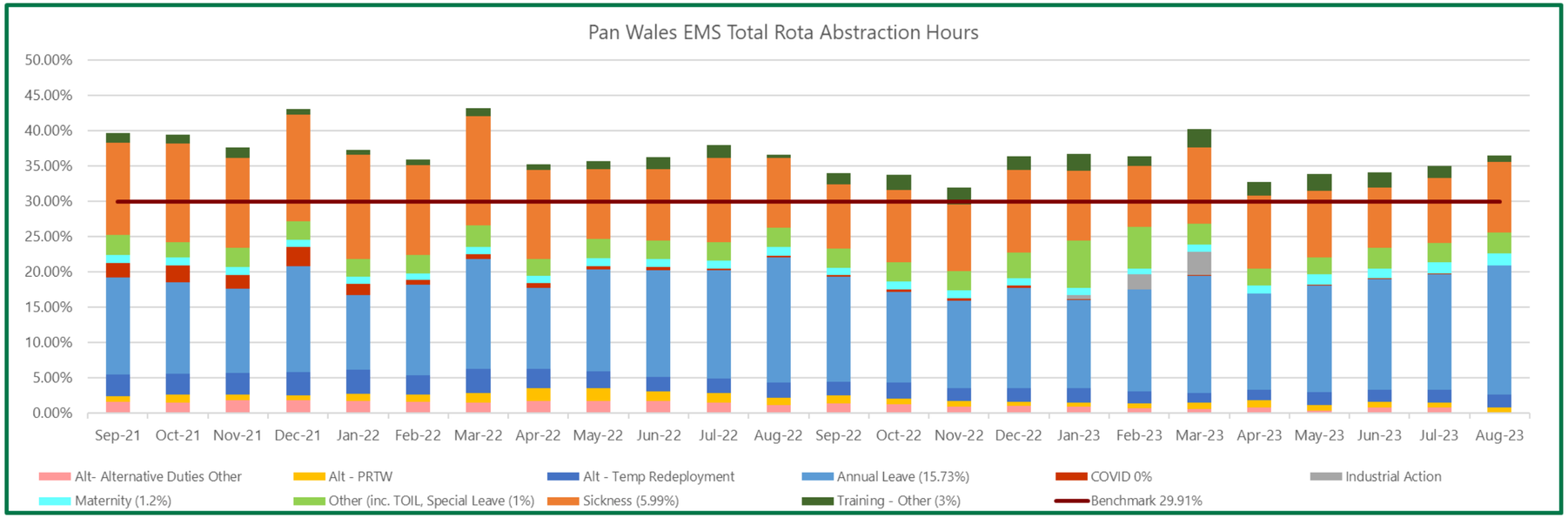
Our People
Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions
G	R

CI PCC FPC





Analysis

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced. In August 2023, total EMS abstractions (excluding Induction Training) stood at 37.46%. This was an increase on the 34.89% recorded in July 2023. This percentage continues to remain above the 30% benchmark figure set in the Demand & Capacity Review. The highest proportion of abstractions was due to annual leave at 18.32% followed by sickness at 10.01%. This figure for sickness abstractions for August 2023 was an increase when compared to the same month last year (9.87%).

Emergency Ambulance Unit Hours Production (UHP) was 87% in August 2023 (73,849) Actual Hours). CHARU UHP achieved 128% (11,406 Actual Hours) compared to 139% in July 2023 (this is the commissioned level not the modelled level). The total hours produced is a key metric for patient safety. The Trust produced 113,830 hours in August 2023, which is a reduction from the 117,737 hours produced in July 2023.

Remedial Plans and Actions

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

The Trust had a budgeted establishment of 1,761 FTEs for 2022-23. This is unchanged for 2023/24.

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

Expected Performance Trajectory

UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to EMT.

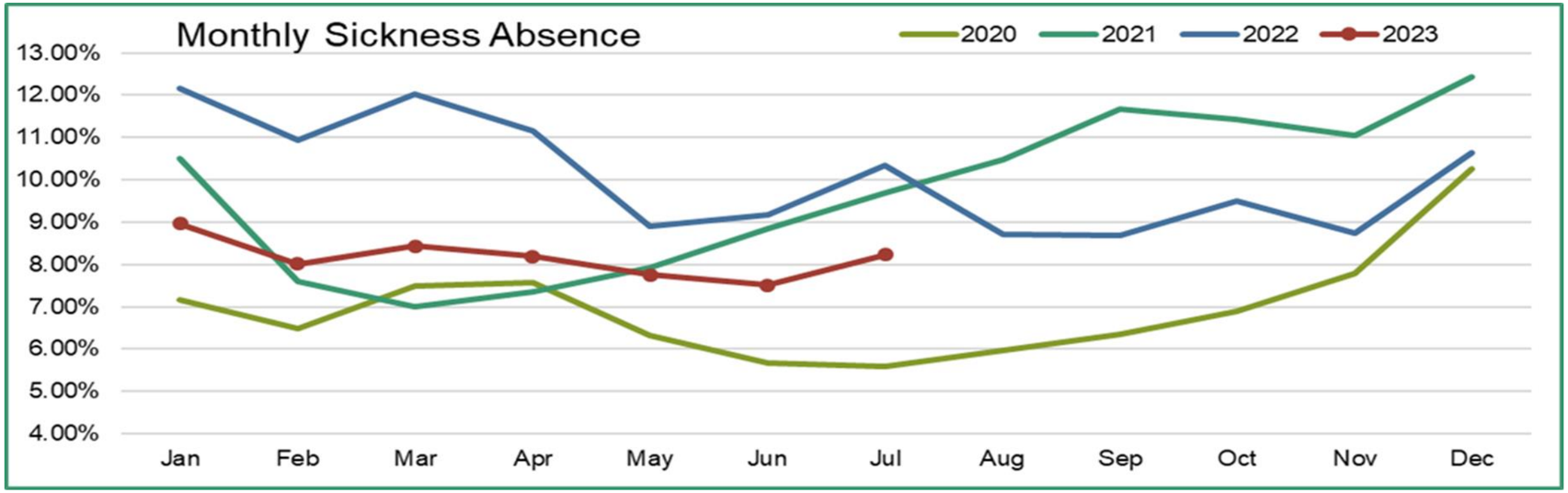
Our People
Capacity - Sickness Absence Indicators

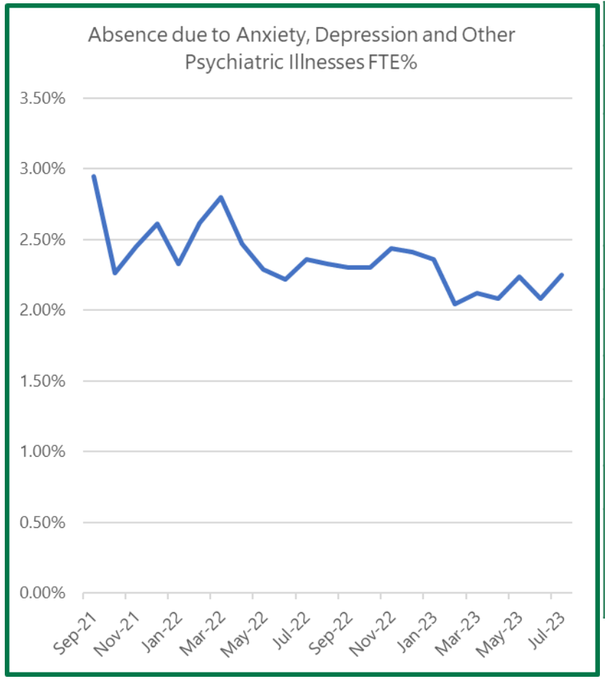
(Responsible Officer: Angela Lewis)

G

CI

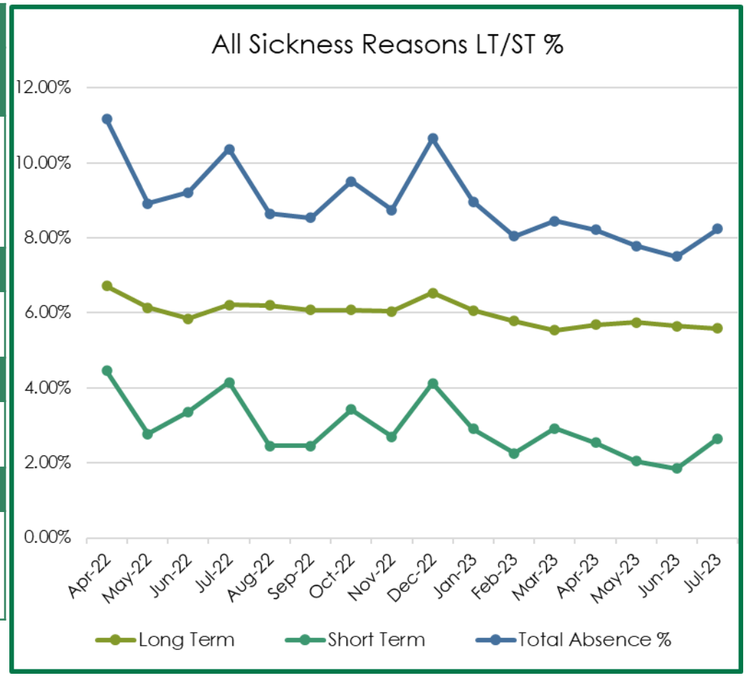
NB: Sickness data will always be reported one month in arrears.





Average working days lost per FTE (Annual)	
19.64 days	
Single month Absence %	
8.23%	
Long Term	**Short Term**
5.59%	2.65%
Mental Health	**Other MSK**
(S10 Stress/Anxiety)	(excluding Back)
2.25%	1.24%

July 2023



Analysis

There was a rise in sickness absence in July 2023, increasing from 7.51% in June 2023 to 8.23% in July 2023. Short-term absence increased slightly from 2.08% in June 2023 to 2.25% in July 2023, while long-term absence, remained the same at 5.59%.

Indicative figures for August 2023 show an increase in short term absence to 3.19% and long-term absence to 5.91%.

The highest reason for short term absence in July & August was Gastrointestinal issues, with Anxiety/ Stress/ Depression and Cold/ Cough/ Flu as the next highest reasons. Covid related short term absences remained high in July 2023 (17 absences) and August (18 absences). Headache, Musculoskeletal and Chest/ respiratory account for the next highest levels.

Physiotherapy: 27 referrals were received in July 2023; this was 15 less than in June 2023.

Remedial Plans and Actions

- MAAW training and bitesize training sessions continue to be scheduled on a bi-monthly (MAAW) and monthly basis (Bitesize sessions).
- In line with the Improving Attendance Action Plan, the People Services Advisors have undertaken audits on short term absence occurrences within the Operations Directorate.
  - The findings of the audit displayed common themes across all areas within the Operational Directorate, including missing paperwork, no return-to-work meeting and inappropriate discretion applied.
  - Audits for all Directorates, will be undertaken on a monthly basis over the next 6 months and the People Services Team will provide targeted support to line managers on reasonable adjustments and the appropriate use of discretion in areas identified as hot spots.

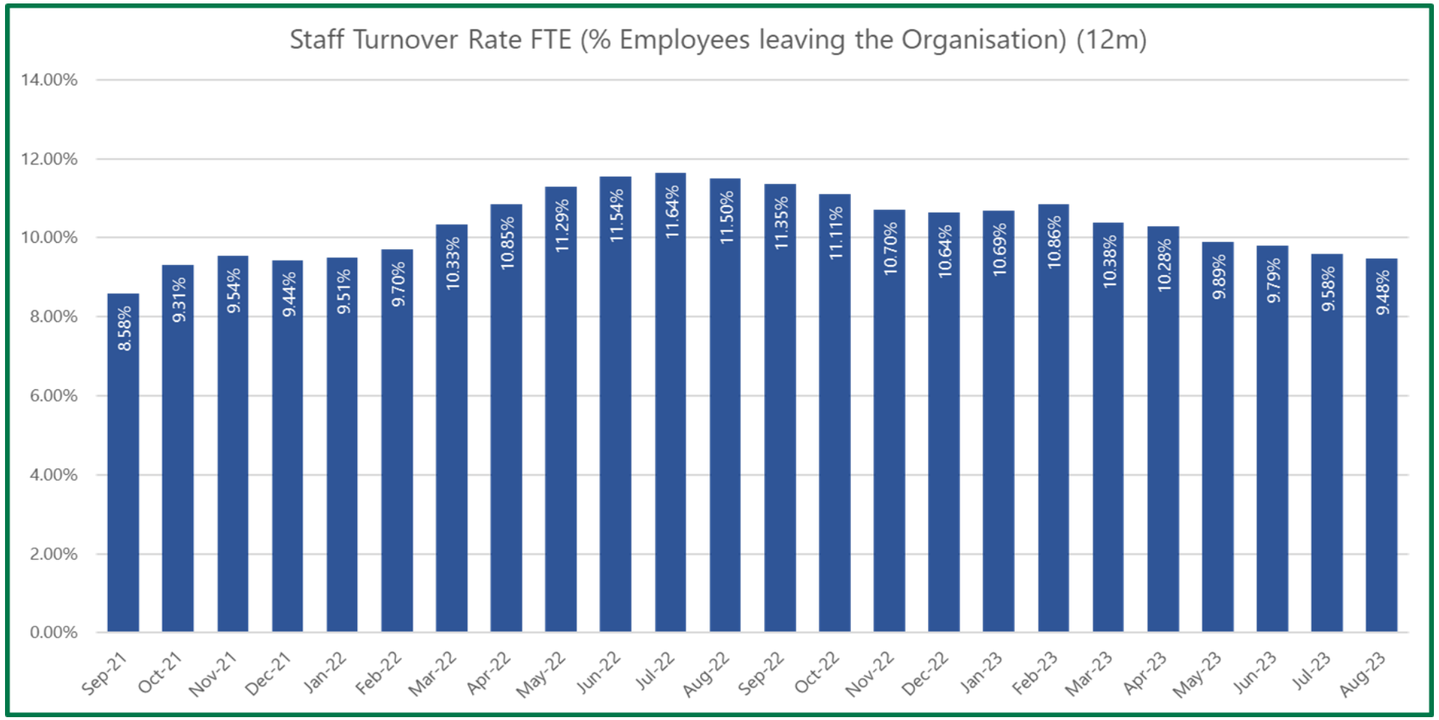
Expected Performance Trajectory

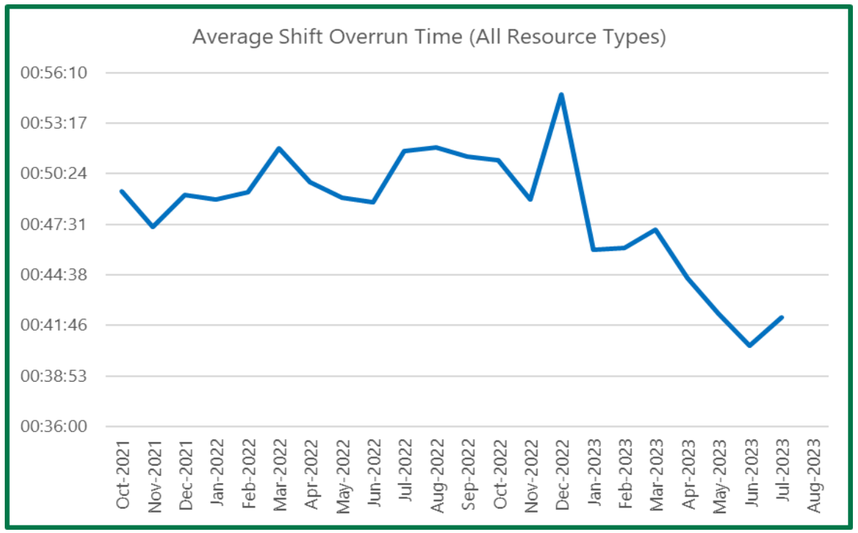
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but that there remain risks to delivery.

Our People
Capacity - Turnover

(Responsible Officer: Angela Lewis)

A





Aug-23 Org L4	FTE by Post
020 Ambulance Care L4 (NX10)	896.33
020 Emergency Medical Services L4 (DX04)	1,777.57
020 Integrated Care L4 (DX03)	444.21
020 National Operations & Support L4 (DX02)	133.5
020 Resourcing & EMS Coordination L4 (DX05)	346.34
Grand Total	**3,597.95**
Ambulance Response	**1513.79**
020 Ambulance Care L4 (NX10) ACA2/Team Leaders	**269.03**

Analysis

Staff turnover rates in August 2023 were 9.48%. Rates have gradually been declining since they peaked in July 2022, with the current monthly rate being the lowest reported since December 2021. Staff leave the Trust for a variety of reasons including promotions, relocations, culture and due to the pressures of NHS working.

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

Shift overrun average times have been steadily decreasing between the peak of 54 minutes 55 seconds in December 2022 and June 2023, when they reached a two year low of 40 minutes 36 seconds. However, the past two months have seen small increases in shift overruns, with the average figure for August 2023 standing at 43 minutes and 6 seconds.

The Integrated Technical Planning Group are receiving monthly workforce data, and this is being integrated into a Power BI platform to enable the reader to more easily interpret the FTE table opposite.

Remedial Plans and Actions

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

The WAST Voices Network held its first Advocate meeting in March 2023 and activity continues relating to themes of misogyny and sexual safety within the organisation. Reverse mentoring relationships have been established and the impact of these will be measured after 2 sessions of Senior Leaders hearing from lived experience of these issues.

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

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

WAST Outdoors initiatives being trialled.

Expected Performance Trajectory

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

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

Our People
Culture - Staff Vaccination Indicators

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

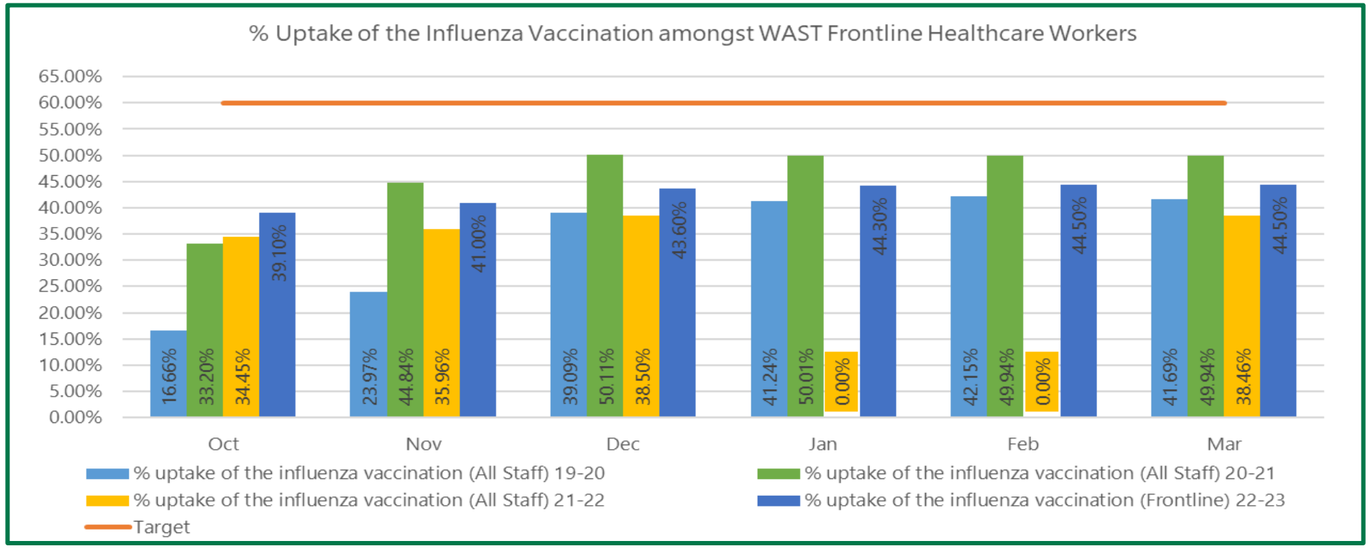
Flu R

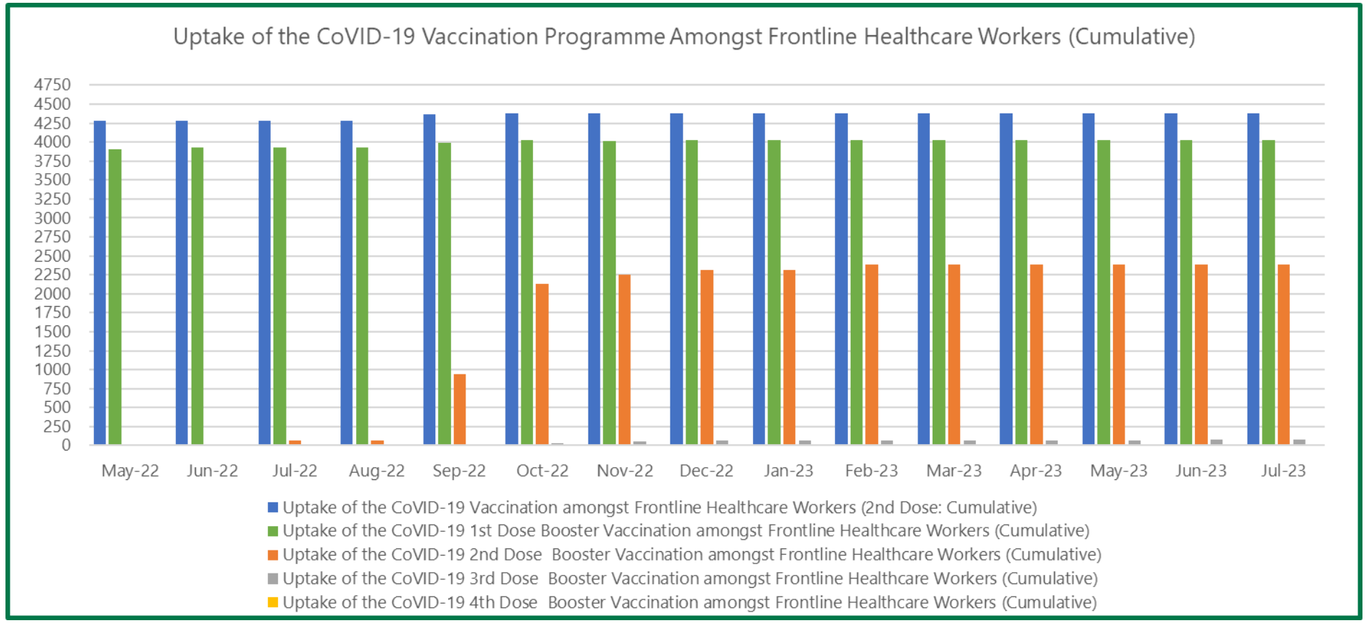
PCC

CI

Health & Care Standard - Health (PPI)

NB: Flu – Next reporting schedule is October 2023





Analysis

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

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

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

Remedial Plans and Actions

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

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

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

Expected Performance Trajectory

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

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

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

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

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

Our People
Capability - PADR and Training Rates Indicators

(Responsible Officer: Angela Lewis)

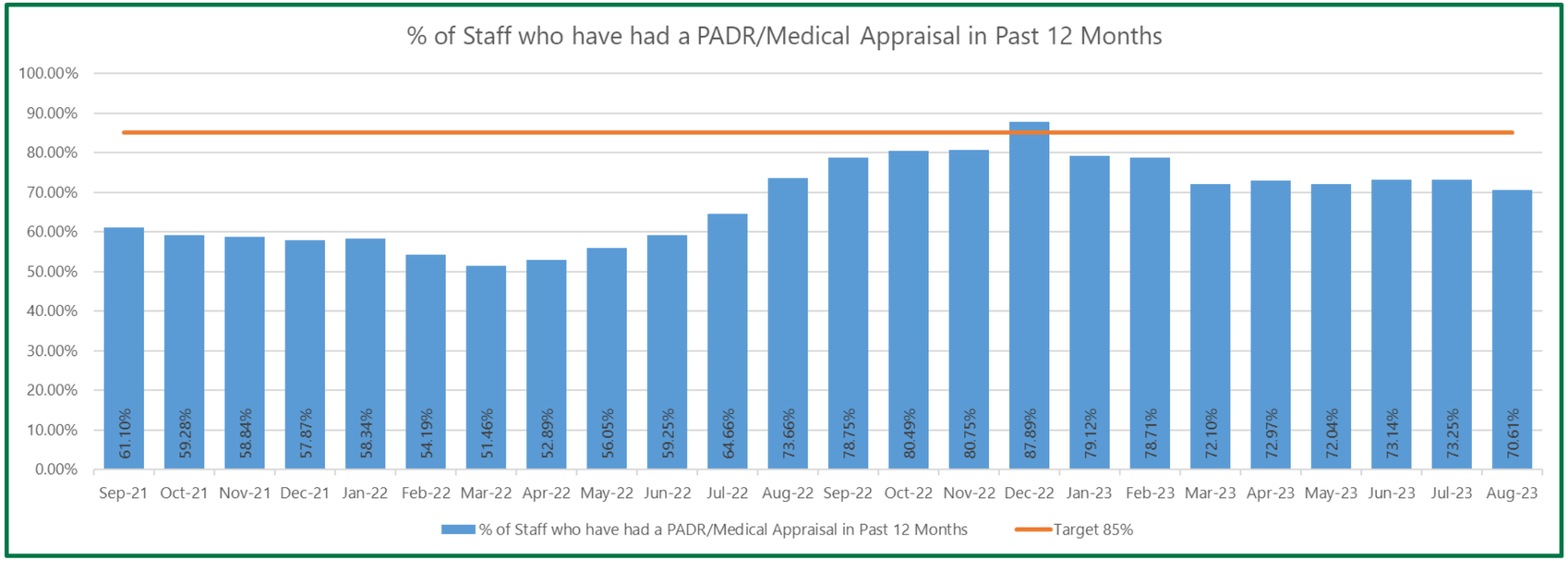
A

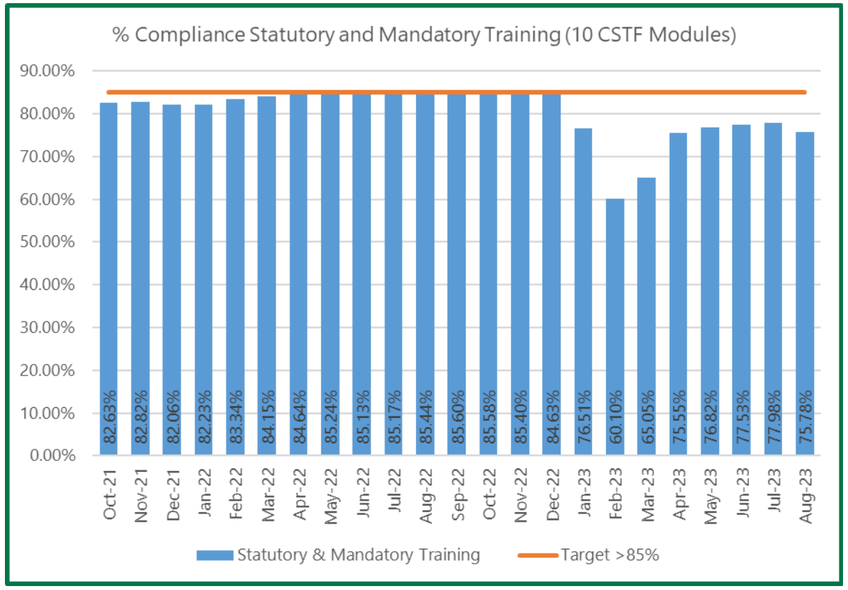
Self-Assessment: Strength of Internal Control: Strong

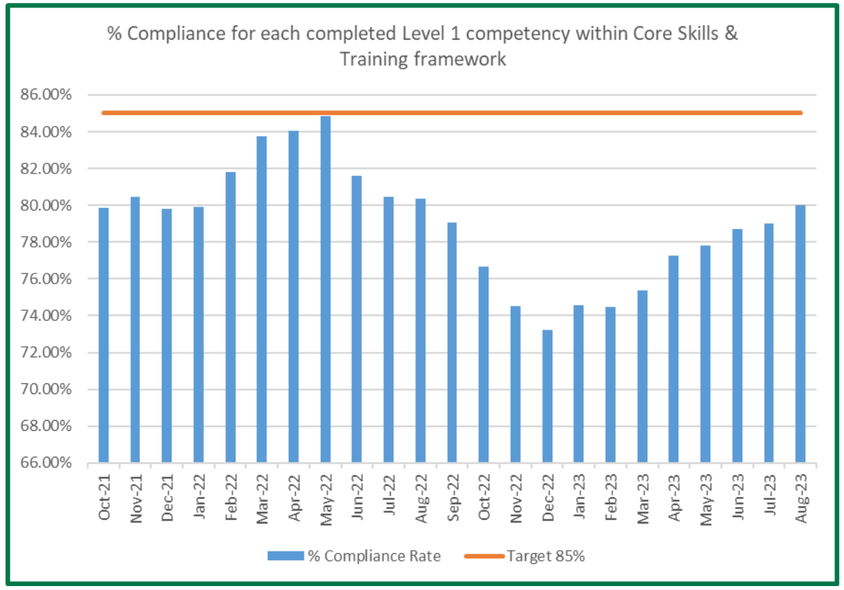
CI

PCC

Health & Care Standard
Health – Staff & Resources







Analysis

PADR rates for August 2023 decreased when compared to the previous month to 70.61% and remain below the 85% target. Over the reporting period this target has only been achieved once, in December 2022, although current rates are significantly higher than during the same period last year.

In July 2023 Statutory & Mandatory Training rates reported a combined compliance of 75.78%; with Safeguarding Adults (92.45%), Dementia Awareness (92.12%) and Violence Against Women, Domestic Abuse & Sexual Violence (85.72%) all achieving the 85% target. Moving & Handling (78.97%), Fire Safety (76.96%), Equality & Diversity (78.00%), Information Governance (71.27%), and Paul Ridd (55.40%) all remain below this target. The Paul Ridd course is new and is the reason for a reduction in overall compliance.

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

Remedial Plans and Actions

Throughout August the Workforce Education and Development team opened and have been assisting colleagues in using the self-service booking system for the 2023/24 Mandatory In-Service Training (MIST) annual refresher programme. As of the end of August, 685 members of staff fromACA1, ACA2, EMT and Paramedic roles have booked their face-to-face day. MIST 2023/24 commenced on the 4th of September; sufficient MIST sessions will be provided to enable all those requiring a place to secure one. MIST provision is planned to be closed mid Q3, subject to Operational pressures and demand. Communications via Yammer and Siren are in place to make people aware of dates/how to book on. Progress toward 100% compliance is tracked and communicated throughout the MIST 'window' via a combination of update reports and presentations detailing performance and gain assurance that under-performance will be addressed locally. For road-based colleagues who attend MIST sessions, the opportunity will be taken to encourage individuals to complete any E-learning statutory or mandatory areas they are not compliant with.

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

The ESR statistics at the end of July are as follows, 67.4% of operational colleagues had completed their Tail Lift Refresher Training, 55.4% if all colleagues had completed their Paul Ridd Learning Disability Awareness Training, and 43.7% of all colleagues have completed their Welsh Language Awareness.

Expected Performance Trajectory

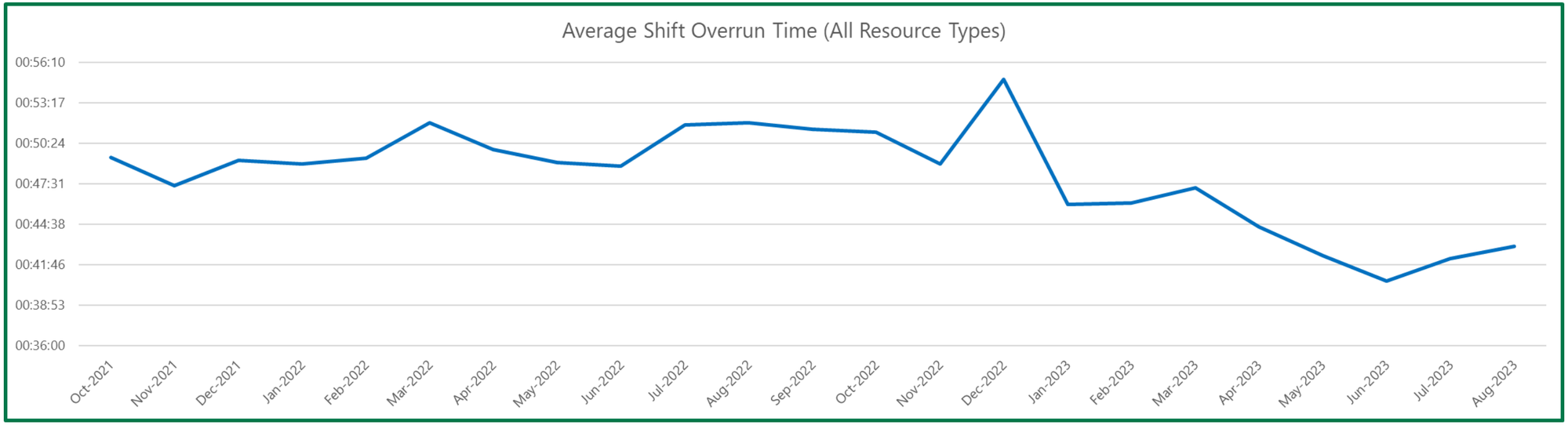
Performance is improving as compliance has risen in relation to Paul Ridd

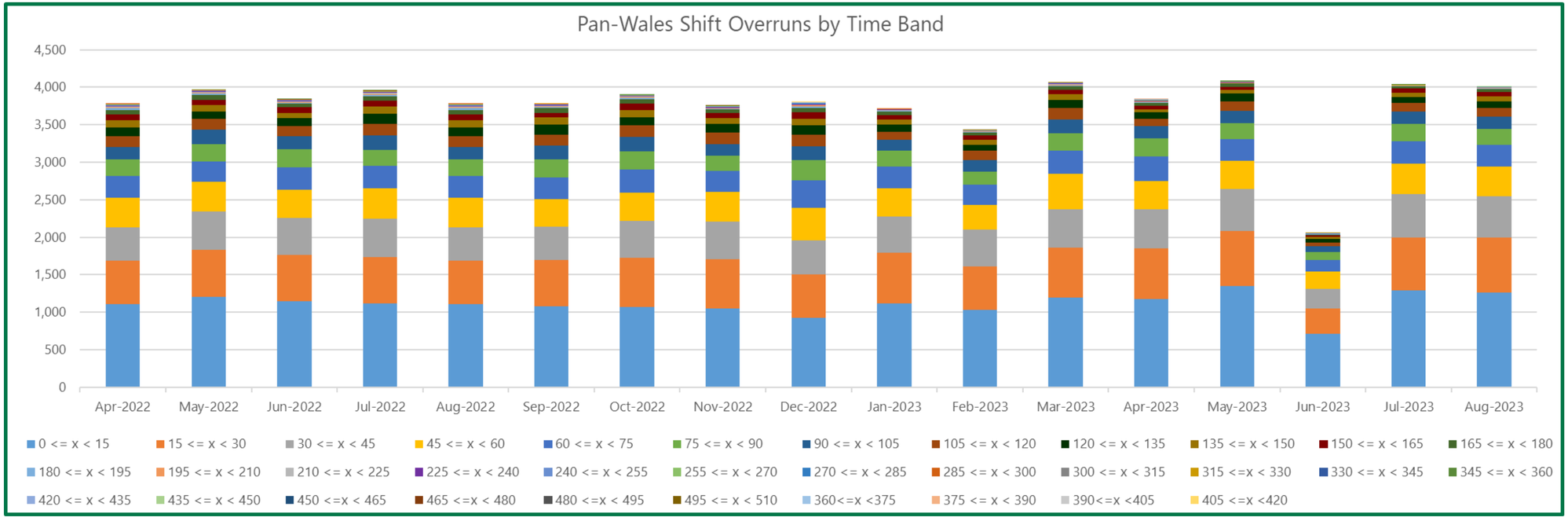
Data source: ESR

Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

CI





Analysis

The average shift overrun (for all resource types) in August 2023 was 43 minutes and 6 seconds, an increase when compared to the previous month (42 minutes and 12 seconds).

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 70.3% of the total. 21.3% fall within the 61 to 120-minute category, 7.2% in the 121 to 180-minute category, 0.8% in the 181 to 240-minute category and 0.4% in the 241 minutes and over category.

Remedial Plans and Actions

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

Expected Performance Trajectory

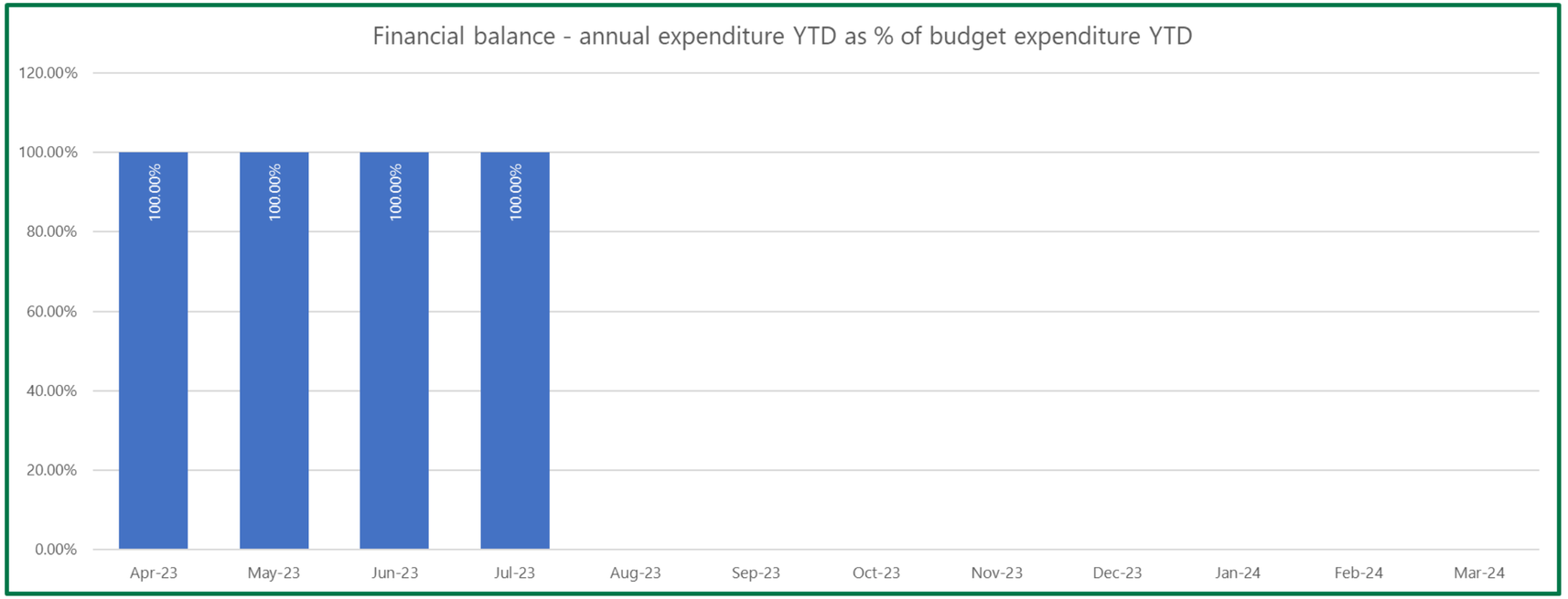
A new People and Culture Plan is due to be launched in the coming months along with an accompanying enabling framework that covers People and Culture Directorate Plans that focus on our people.

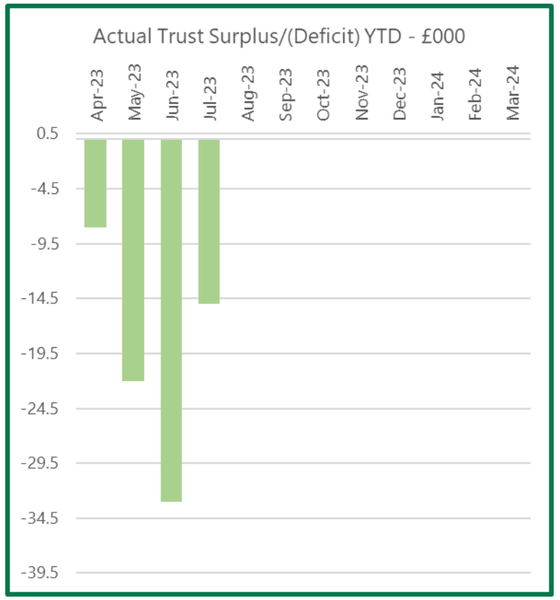
Finance, Resources and Value
Value - Finance Indicators

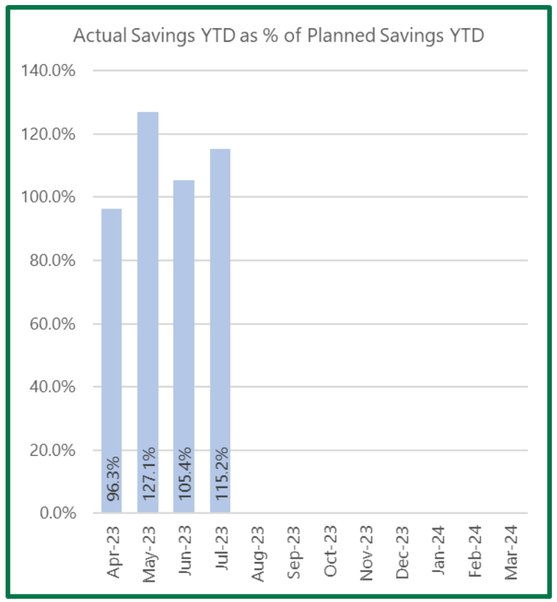
(Responsible Officer: Chris Turley)

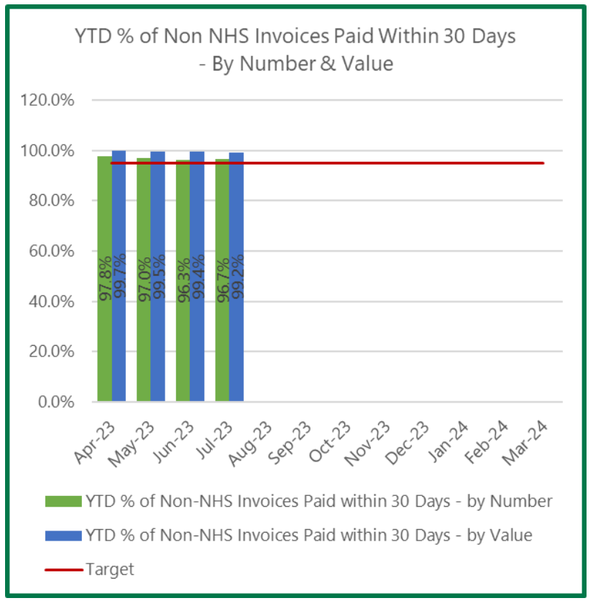
G

FPC









Analysis

The reported outturn performance at Month 4 is a deficit of £15k, with a forecast to the year end of breakeven.

For Month 4 the Trust is reporting planned savings of £1.834m and actual savings of £2.113m.

The Trust's cumulative performance against PSPP as at Month 4 is 96.7% against a target of 95%.

At Month 4 the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit.

Remedial Plans and Actions

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

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

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

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

Expected Performance Trajectory

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

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

(Responsible Officer: Lee Brooks)

Utilisation
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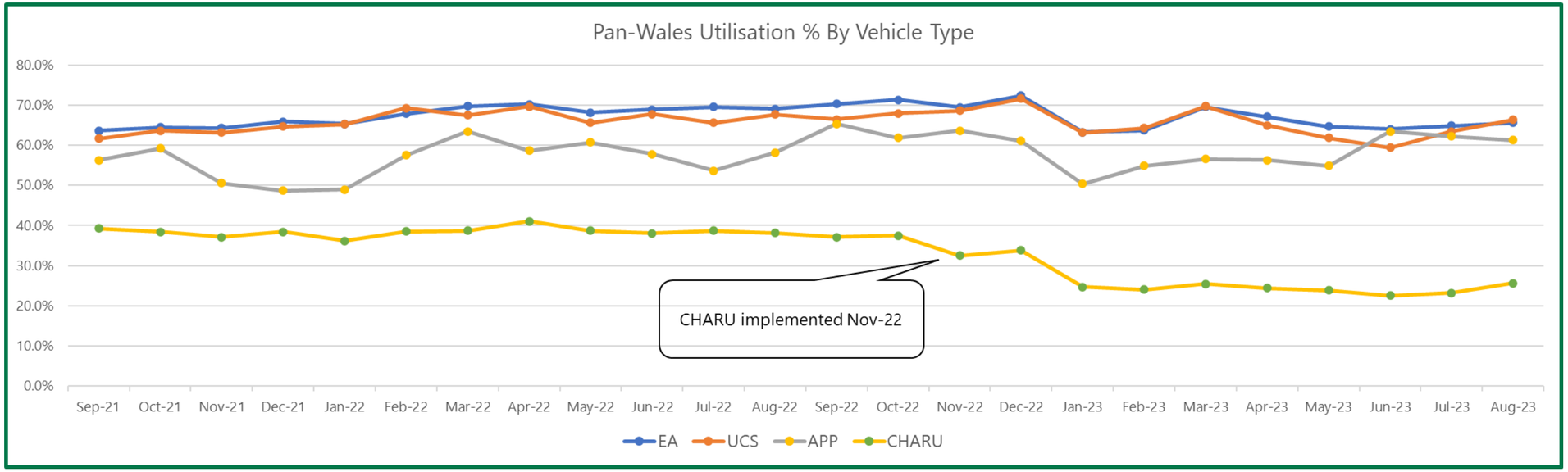

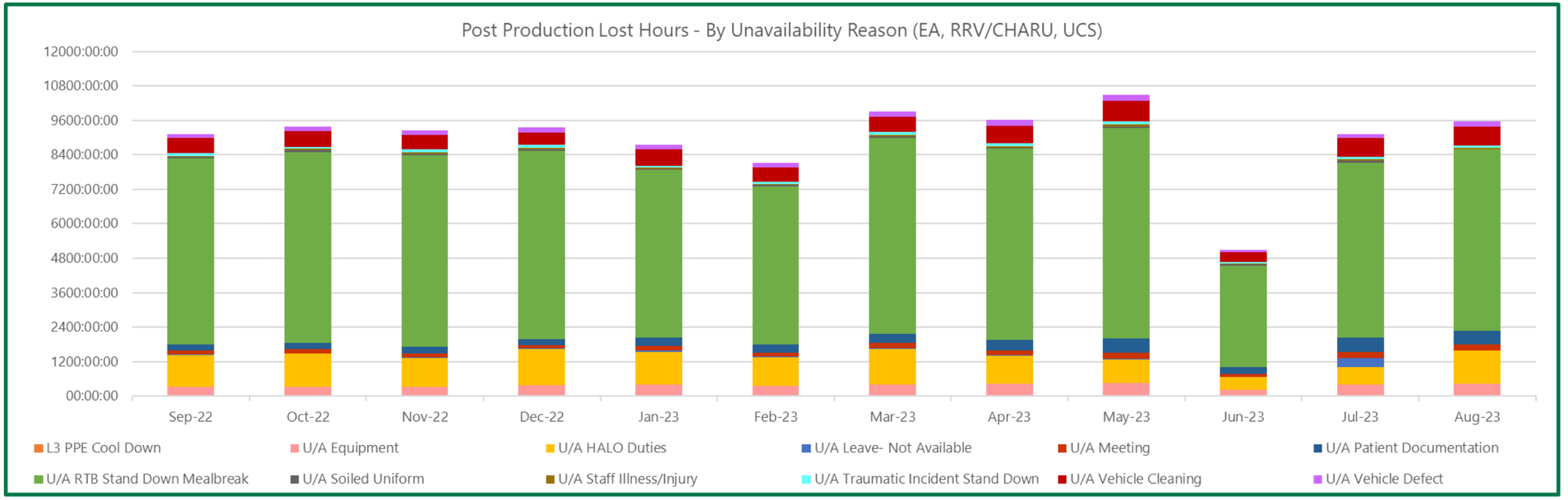

Analysis

Pan Wales Utilisation metrics in August 2023 was 57.1% for all vehicles types, a slight increase from 55.9% in July 2023. UCS achieved the highest rate during the month at 66.4% while EA was at 65.6%. Both have seen a generally stable trend over the past two years. The optimal utilisation rate for EAs needs to lower so that they are free to respond to incoming calls.

There were 9,648 post-production lost hours (PPLH) across EA, RRV/CHARU, APP & UCS vehicles in August 2023; which is an increase compared to July 2023 (8,813). The low figure in June 2023 is due to no data being available between the 14th and 26th June following the CCM update. Unfortunately, it is unlikely that this data will be recoverable and therefore the June figure will remain low.

PPLH are due to numerous factors, as outlined in the bar chart, which demonstrates they remained relatively consistent since May 2022 (the month a retrospective fix was undertaken for the under-reporting of U/A RTB Stand Down Meal-break code).

Remedial Plans and Actions

The Trust will not be able to eliminate PPLH, however, efficiency options continue to be worked through, and PPLH are monitored and scrutinised closely, forming part of the weekly performance meeting.

Expected Performance Trajectory

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

Finance, Resources and Value
Resource and Value Indicators

(Responsible Officer: Chris Turley)

Decarbonisation

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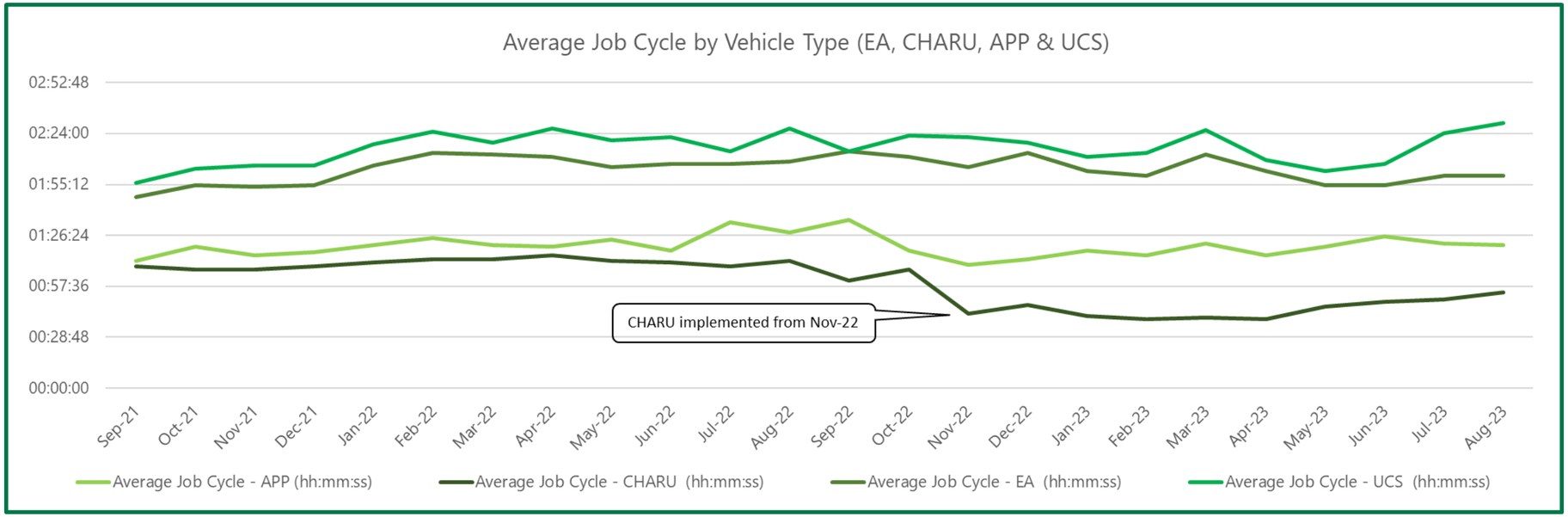

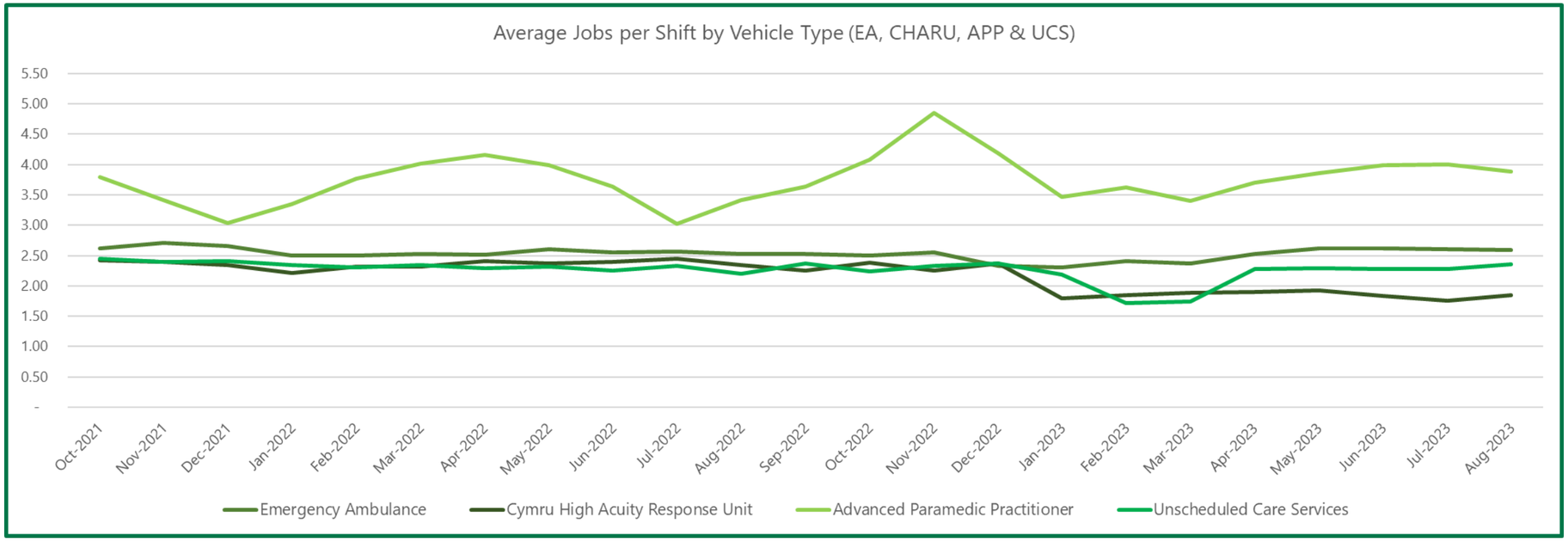

Value – Job Cycle and Volume

Analysis

As demonstrated in the top graph, the average job cycle in August 2023 remained static at 2 hours for EA increased for UCS and CHARU and decreased for APP. UCS crews saw their average increase to 2 hours 30 minutes, CHARUs increased from 49 minutes to 54 minutes while APP reduced from 1 hour 22 to 1 hour 21.

Overall average jobs per shift was 2.42 in August 2023, a slight increase from the 2.40 recorded in July 2023. APPs attended on average 3.88 jobs per shift, EAs 2.59 jobs per shift, UCS crews 2.36 jobs per shift and CHARU's 1.85 jobs per shift.

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

Remedial Plans and Actions

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

Expected Performance Trajectory

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

**NB: Average jobs per shift only includes data where the full shift worked is less than 20 hours.*

Total shift hours currently includes the meal break for the shift. Total shift hours also includes Postproduction Lost Hours

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

(Responsible Officer: Lee Brooks)

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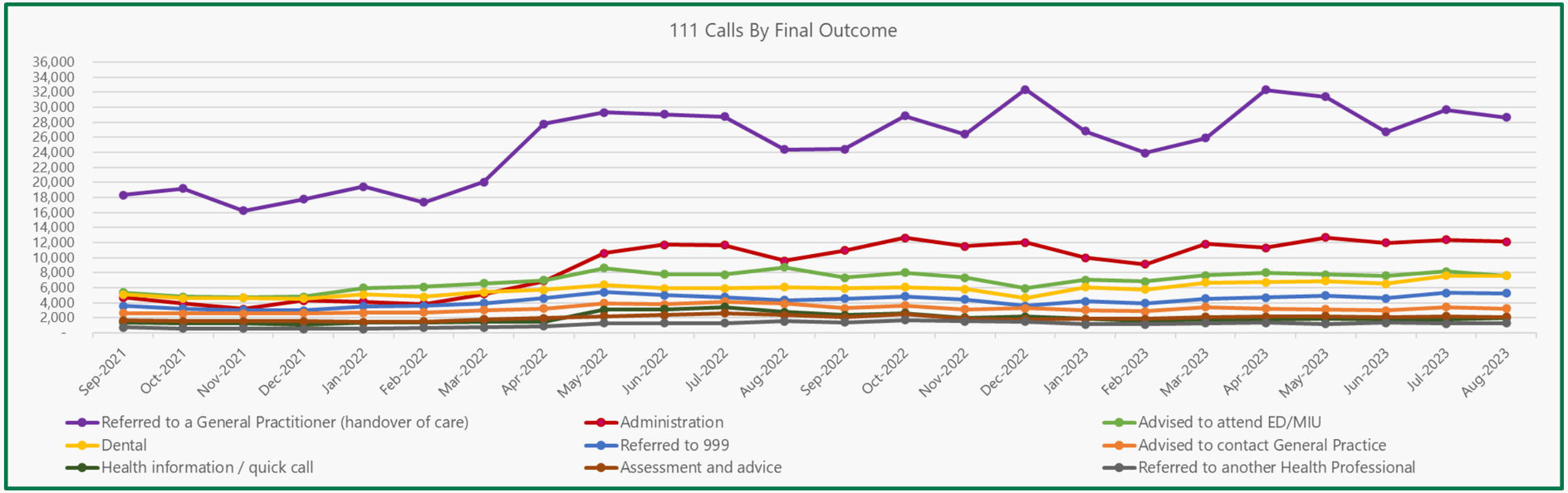
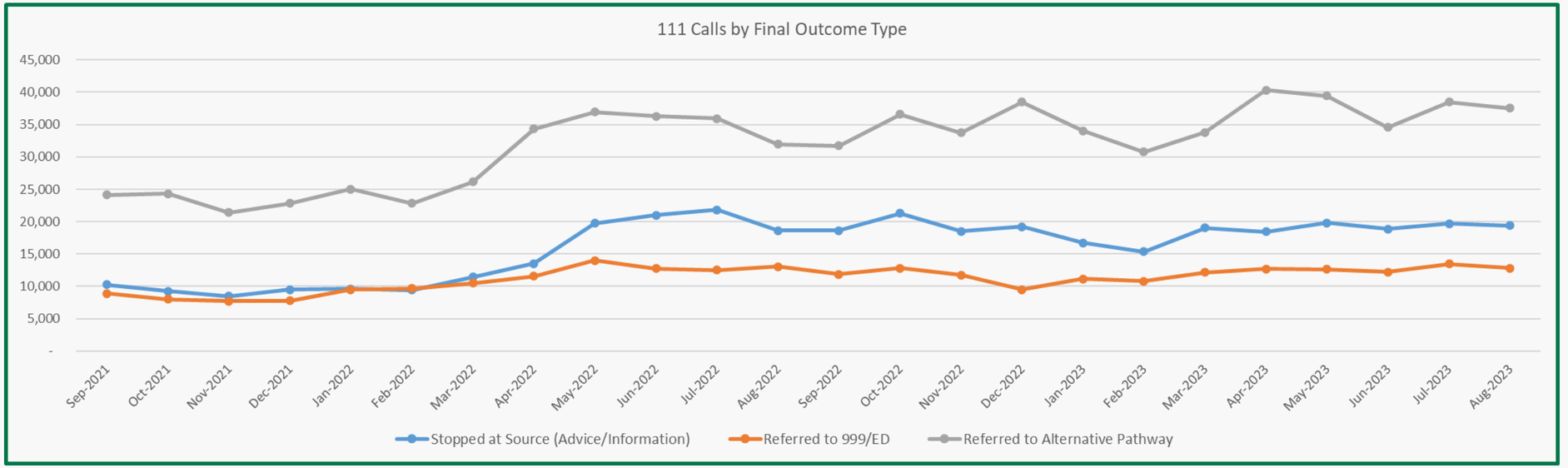
Influencing Factors – Demand and Clinical Hours Produced





Analysis

69,799 calls were received into the 9 categories displayed in the graph opposite during August 2023, a decrease compared to the 71,646 received during July 2023. This was above the average volume of calls seen over the past 12 months (66,540).

In August 2023, calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 41% of all calls.

As the bottom graphs highlights, in August 2023, 19,414 calls into 111 were provided with information or advice, with no onward referral.

Remedial Plans and Actions

There is currently a 111 Measures Task and Finish group. This is a collaborative meeting between WAST its commissioners and DCHW. The focus is the development of a Nationally reportable 111 data set. Similar to what is currently in place for ASIs. Part of this work involves looking at the reporting of disposition final outcomes.

Expected Performance Trajectory

The Trust currently have a target to consult and close 17% of calls and are ambitious in aims to increase the proportion of activity resolved at step 2. The IMTP aspiration is to advance this to 20% but will require further investment of FTEs within the Clinical Support Desk (CSD).

Partnerships / System Contribution
Consult & Close Indicators

(Responsible Officer: Lee Brooks)

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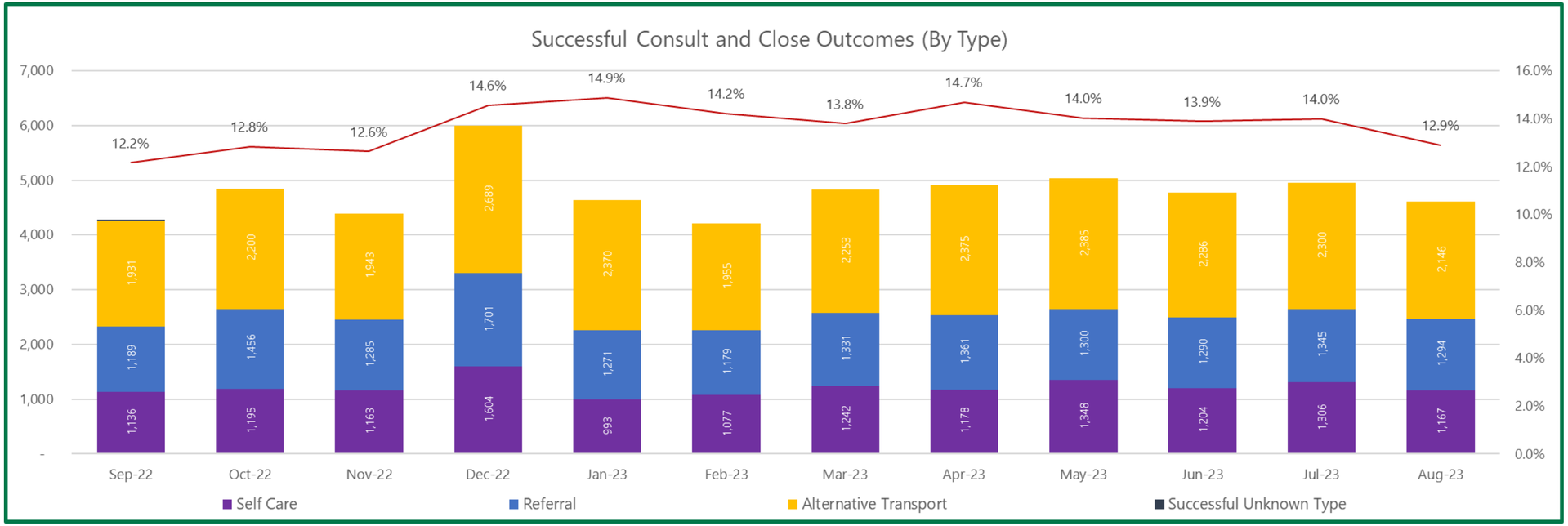

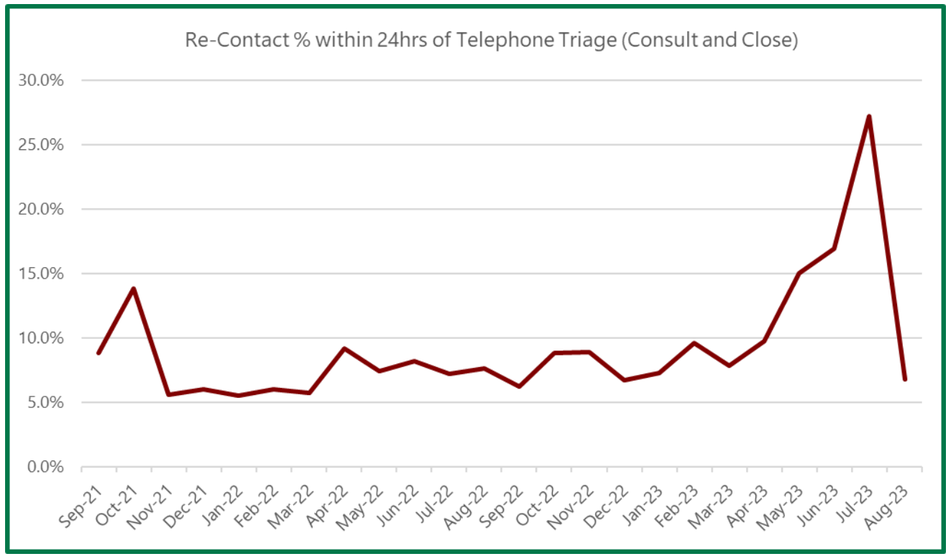

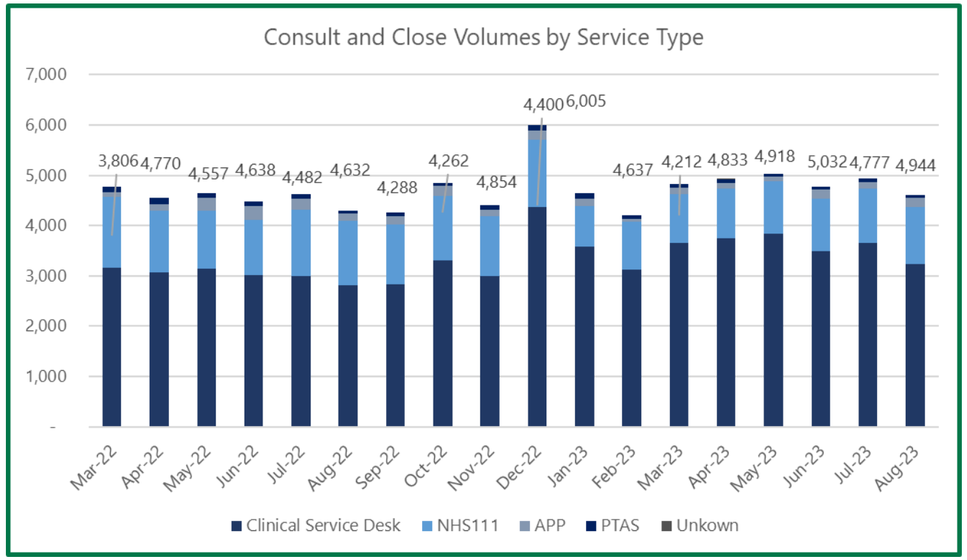

Analysis

Consult and Close, with contributions from Clinical Support Desk (CSD) (9%), NHS111 (3.2%), WAST APP (0.5%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.2%) achieved 12.9% in August 2023. This was a decrease on the 14.0% seen during July 2023 and remained short of the new 17% target. In August 2023, the number of 999 calls resulting in a Consult and Close outcome was 4,604, down from 4,944 in July 2023.

Of the calls successfully closed in August 2023, 1,167 patients received an outcome of self-care; 1,294 patients were referred to other services (including to Minor Injury Units and SDEC) and 2,146 were advised to seek alternative transport services in order to acquire treatment.

Re-contact rates in August 2023 were 6.8%, a significant decrease compared to the 27.2% seen in July 2023, and the 16.3% in June 2023.

Remedial Plans and Actions

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

Expected Performance Trajectory

The Trust currently have a target to consult and close 17% of calls. The IMTP aspiration is to advance this to 20% but will require further investment of FTEs in the Clinical Support Desk (CSD).

Partnerships / System Contribution
Conveyance to ED Indicators

(Responsible Officer: Andy Swinburn)

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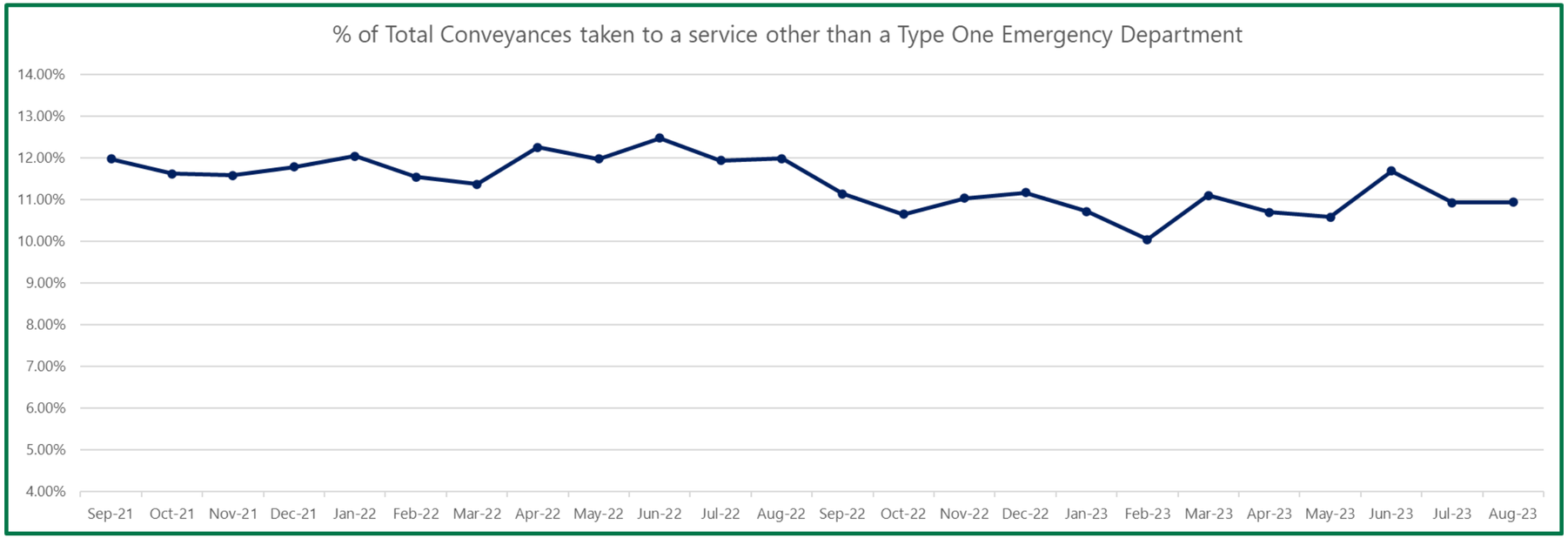
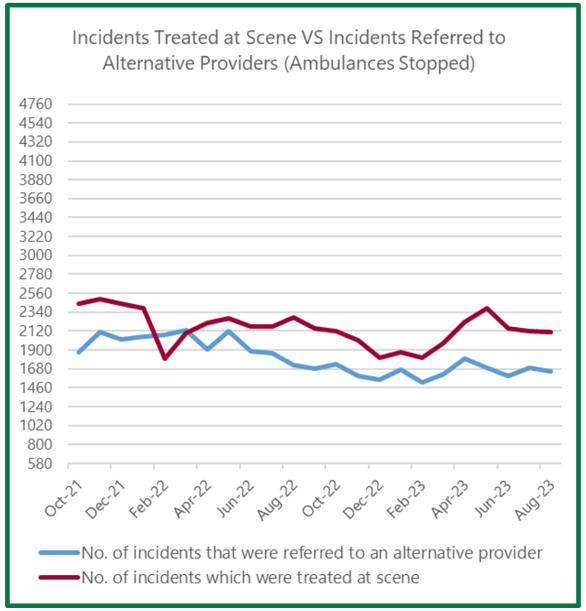
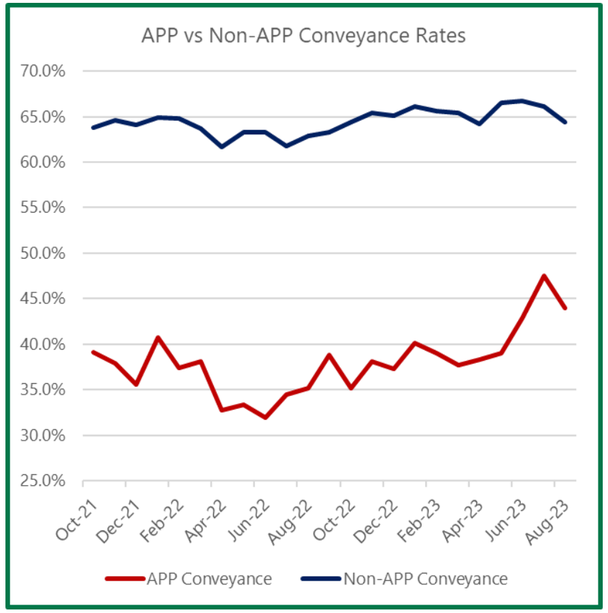
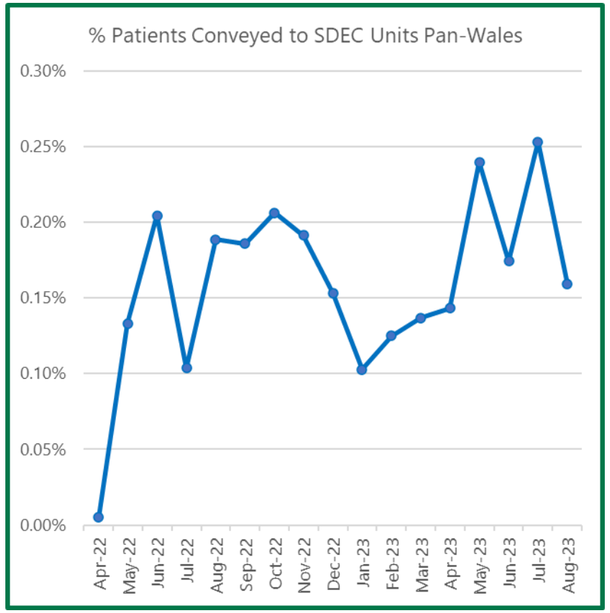
Ministerial Measure









Analysis

In August 2023 10.95% of patients (1,623) were conveyed to a service other than a Type One ED, while 36.84% of patients were conveyed to a major ED.

The combined number of incidents treated at scene or referred to alternate providers decreased slightly, from 3,784 in July 2023 to 3,752 in August 2023.

Although APP conveyance rates decreased during August 2023, there has been a general increase in rates in recent months due to increased levels of CSP, which result in patients choosing to transport themselves to the ED, with only patients who do not have this ability (usually sicker) receiving a response.

Remedial Plans and Actions

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

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

Expected Performance Trajectory

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

Partnerships / System Contribution Handover Indicators

(Responsible Officer: Health Boards)

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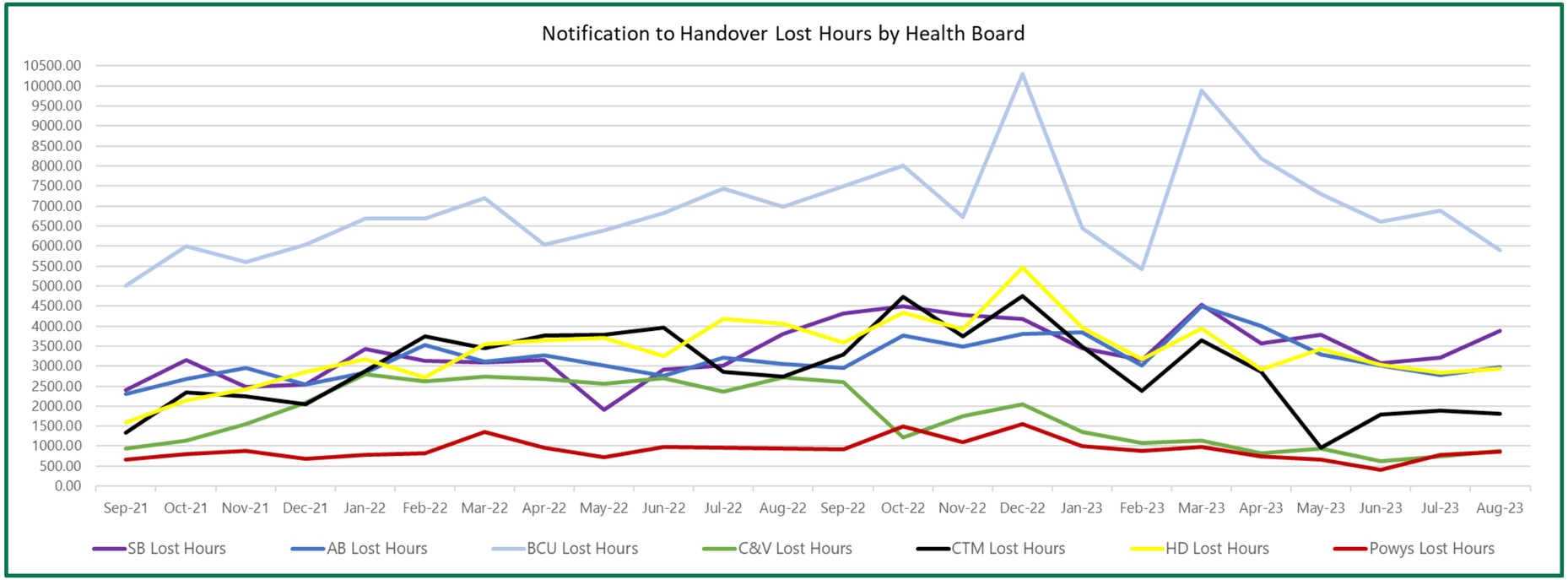

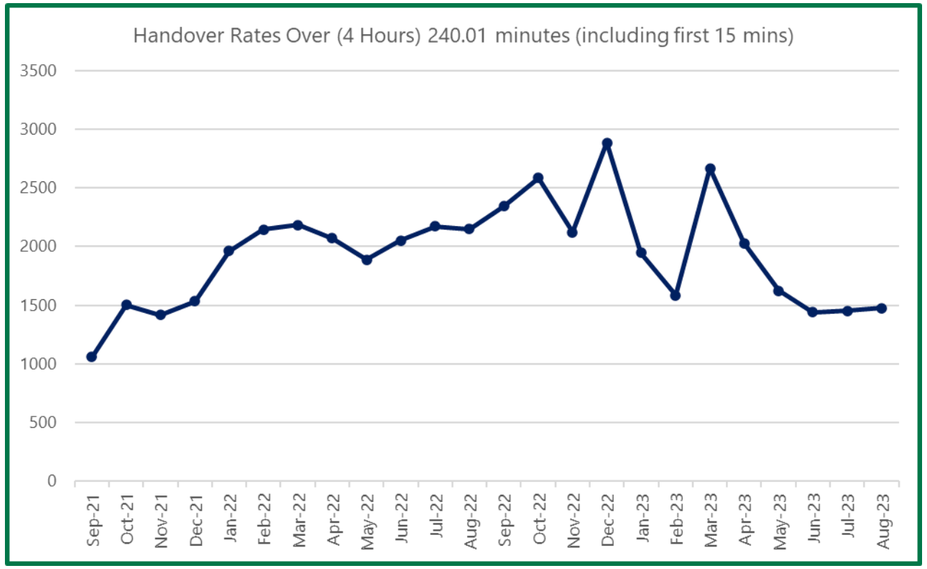

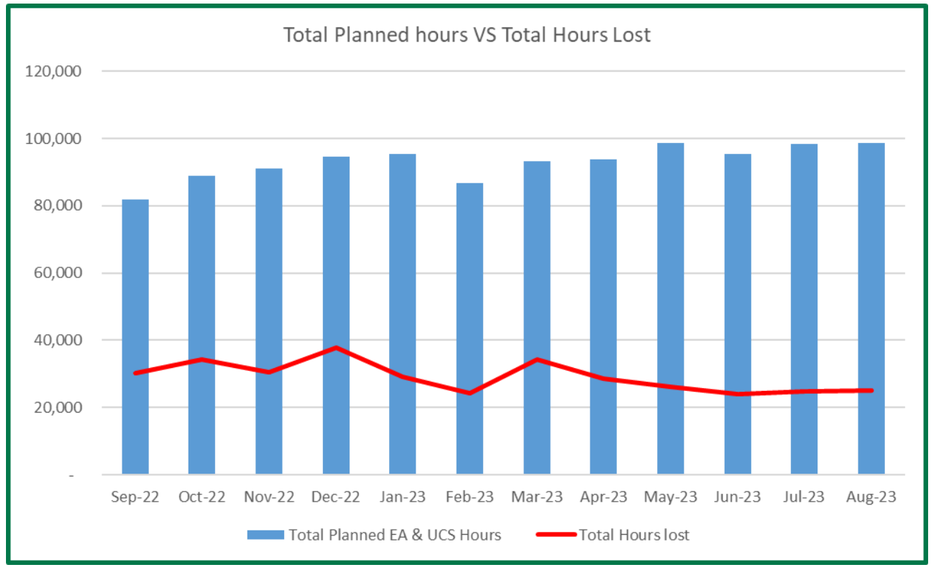

Analysis

282,851 hours were lost to Notification to Handover, i.e., hospital handover delays, over the last 12 months (Sep-22 to Aug-23), compared to 256,801 over the same timeframe the previous year. 19,233 hours were lost in August 2023, an increase from the 19,118 lost in July 2023. This is the second month in a row the figure has increased, following a significant decline between march and June 2023.

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

- Morriston Hospital (SBUHB) at 4,081 lost hours
- Wrexham Maelor Hospital (BCUHB) at 2,582 lost hours
- The Grange University Hospital (ABUHB) at 2,748 lost hours
- Ysbyty Glan Clwyd Hospital (BCUHB) at 1,540 lost hours

Notification to handover lost hours averaged 620 hours per day during August 2023 compared to 617 hours a day in July 2023.

In August 2023, the Trust could have responded to approximately 6,059 more patients if handovers were reduced, which highlights the impact the numbers are still having on service.

Remedial Plans and Actions

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

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

Expected Performance Trajectory

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

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

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

Definition of Indicators

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

AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**3**

STANDING ORDERS, SCHEME OF RESERVATION & DELEGATION OF POWERS, AND STANDING FINANCIAL INSTRUCTIONS

MEETING	Trust Board
DATE	28 September 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Trust's Standing Orders require an annual review to ensure they remain accurate and current. The Standing Orders (SOs) includes the Scheme of Reservation and Delegation of Powers (SoRD), and the Standing Financial Instructions (SFIs).

2. The Trust Board approved changes to Schedule 3 of the SOs in May 2023 following the updating of the terms of reference by all Board Committees. At that time non-material changes were also approved to the SoRD with respect to Directors' titles.

3. A review of the Model SOs and SFIs took place in July 2023 by Welsh Government. The amendments made are reflected in the SBAR.

4. The Audit Committee reviewed the amendments at their meeting on 14 September and recommend the changes to the Board for approval.

RECOMMENDATION

5. The Trust Board is requested to approve the amendments to the Standing Orders, Scheme of Reservation and Delegation of Powers and Standing Financial Instructions.

KEY ISSUES/IMPLICATIONS

6. The Model SO have incorporated the change from Community Health Councils to the Citizen Voice Body (Llais) and reflect the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
7. The requirement for the Trust to publish Board papers has been changed from ten to seven days.
8. The SO now include the role of the Vice Chair and the additional voting Director introduced in 2022.

REPORT APPROVAL ROUTE
6 September 2023 – Executive Leadership Team 14 September 2023 – Audit Committee

REPORT APPENDICES
Annex 1 – Marked up Standing Orders Annex 2 – Scheme of Reservation and Delegation of Powers Annex 3 – Standing Financial Instructions Annex 4 – Summary EqIA

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	N/A	Financial Implications	Y
Environmental/Sustainability	N/A	Legal Implications	Y
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

SITUATION

1. The Trust's Standing Orders must be kept under annual review to ensure they remain accurate and current. The Standing Orders (SOs) includes the Scheme of Reservation and Delegation of Powers (SoRD), and the Standing Financial Instructions (SFIs).

BACKGROUND

2. The Standing Orders underwent extensive review by the Audit Committee in December 2021 and the Trust Board in January 2022, including a wholesale review of the SFIs and Tables A and B of the SoRD.

3. The Trust Board approved changes to Schedule 3 of the SO in May 2023 following the updating of the terms of reference by all Board Committees. At that time non-material changes were also approved to the SoRD with respect to titles for Directors.

4. Welsh Government updated the Model SO and SFI in July 2023.

ASSESSMENT

<u>Standing Orders</u>

5. A marked-up version of the changes to the SOs is attached at Annex 1. The changes primarily reflect the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 including the introduction of the duty of quality and duty of candour, and the change from the Community Health Councils to the Citizens Voice Body (Llais). The Committee will note that there is regular engagement with Llais both from the executive team and the Patient Experience and Community Involvement Team. Llais also has a standing invitation to the QUEST and Board meetings.

6. Section 1.1.1 notes the formal introduction of the Vice Chair position and the additional voting director, reflecting the Board membership as 'the Chair, Vice Chair, six non-executive directors and six executive directors'.

7. Whilst the SOs note that WAST is not, at present, subject to the Wellbeing of Future Generations (Wales) Act 2015, it notes the commitment to achieving the wellbeing goals and sustainable development principles, which are reflected in our IMTP. It is anticipated that WAST will shortly come within the purview of the Act.

8. Paragraph 7.1.3 has been removed as it was not part of the model SOs and Board meetings are now live streamed and recordings maintained on the Trust website. A WAST policy is in development on meeting etiquette which will include a policy position and guidance on the recording and retention of meeting recordings.

9. Paragraph 7.4.3 has been amended to provide that Board members shall be sent an agenda and a complete set of supporting papers at least seven calendar days (was previously ten) before a formal Board meeting.

Scheme of Reservation and Delegation of Powers

10. The marked up changes to the SoRD appear at Annex 2 and the Committee will note the changes are non-material.

Standing Financial Instructions

11. The marked up amended SFIs appear at Annex 3. These have also had non-material changes given the extensive review they underwent in 2022.

12. The SOs require that the Trust undertakes an impact assessment on changes to the documents. We have received confirmation that a full Equality Impact Assessment (EqIA) is not necessary for these types of statutory requirements at a national government level, however a summary EqIA is attached at Annex 4.

13. The Audit Committee reviewed the amendments to the SOs, SoRD and SFIs at their meeting on 14 September and recommend the changes to the Board for approval.

RECOMMENDATION: The Trust Board is requested to approve the amendments to the Standing Orders, Scheme of Reservation and Delegation of Powers and Standing Financial Instructions.

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

Welsh Ambulance Services NHS Trust

STANDING ORDERS

For approval by Trust Board
28 September 2023

Adopted from the Model Standing Orders, Schedule of Reservation and Delegation of Powers, and Standing Financial Instructions issued by Welsh Government in July 2023

Date approved:	**28 September 2023**
Approved by:	**Trust Board**
Review date:	**Annual**
Version:	**6**

Foreword

These Model Standing Orders are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. National Health Service Trusts ("NHS Trusts") in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs Trusts must ensure they are made in accordance with directions as may be issued by Welsh Ministers.

They are designed to translate the statutory requirements set out in the National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024) as amended into day to day operating practice, and, together with the adoption of a Schedule of decisions reserved to the Board of directors; a Scheme of decisions to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Trust.

These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Trust's Board Secretary will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the Trust.

Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

Contents

SCHEDULES

The following Schedules which support the Standing Orders are held separately to this main Standing Orders Document. These are:

Schedule 1:	**Scheme of Reservation and Delegation of Powers**
Schedule 2:	**Key Guidance Instructions and Other Related Documents**
Schedule 2.1:	**Model Standing Financial Instructions**
Schedule 3:	**Board Committees Terms of Reference**
Schedule 4:	**Advisory Group Terms of Reference**

Section A – Introduction

Statutory framework

i) Welsh Ambulance Services National Health Service Trust ("the Trust") is a statutory body that came into existence on 1st April 1998 under the **Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998 (S.I. 1998/678)**, "the Establishment Order".

ii) The principal place of business of the Trust is Beacon House, William Brown Close, Cwmbran NP44 3AB~~Vantage Point House, Ty Coch Way, Cwmbran, NP44 7HF~~.

iii) All business shall be conducted in the name of Welsh Ambulance Services National Health Service Trust, and all funds received in trust shall be held in the name of the Trust as a corporate Trustee.

iv) NHS Trusts are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how NHS Trusts are governed and their functions.

v) **The National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024)**, as amended ("the Membership Regulations") set out the membership and procedural arrangements of the Trust.

vi) Sections 18 and 19 of and Schedule 3 to the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on NHS Trusts and to give directions about how they exercise those functions. NHS Trusts must act in accordance with those directions. The NHS Trust's main statutory functions

are set out in their Establishment Order but additional functions may also be contained in other legislation, such as the NHS (Wales) Act 2006.

vii) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (**the 2020 Act) makes provision for:

- Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality);
- Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour);
- The creation of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and
- The appointment of statutory vice-chairs for NHS Trusts.

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

NHS Trusts will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023

~~vii)~~viii) The Well-being of Future Generations (Wales) Act 2015 also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

~~viii)~~ix) In exercising their powers NHS Trusts must be clear about the statutory basis for exercising such powers.

~~ix)~~x) In addition to directions the Welsh Ministers may from time to time issue guidance which NHS Trusts must take into account when exercising any function.

~~x)~~xi) NHS Trusts work closely with the seven Local Health Boards (LHBs) in Wales. The chief executive of the Trust is an associate member of the following joint-committees of the LHBs:

- The Welsh Health Specialised Services Committee, and
- The Emergency Ambulance Service Committee.

~~xi)~~xii) **The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee ("WHSSC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097)** which make provision for the constitution and membership of the WHSSC including its procedures and administrative arrangements.

~~xii)~~xiii) **The Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8 (W.08))** as amended by the **Emergency Ambulance Services (Wales) Amendment Directions 2016 (2016/8 (W.8))** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance services and for the purpose of jointly exercising those functions will establish the Emergency Ambulance Services Committee ("EASC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014/566)** which make provision for the constitution and membership of the EASC including its procedures and administrative arrangements.

~~xiii)~~xiv) **The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012) (as amended) require the Trust to establish a Shared Services Committee and prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and

Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

~~xiv)~~xv) **The National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014.**

~~xv)~~xvi) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trust and, for the purposes of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

~~xvi)~~xvii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

~~xvii)~~xviii) The Welsh Language (Wales) Measure 2011 makes provision with regard to the development of standards of conduct relating to the Welsh Language. These standards replace the requirement for a Welsh Language Scheme previously provided for Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of NHS Trusts. The Trust will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

~~xviii)~~xix) Paragraph 18 of Schedule 3 to the NHS (Wales) Act 2006 provides

for NHS Trusts to enter into arrangements for the carrying out, on such terms as considered appropriate, of any of its functions jointly with any Strategic Health Authority, Local Health Board or other NHS Trust, or any other body or individual.

~~xix)~~xx) NHS Trusts are also bound by any other statutes and legal provisions which govern the way they do business. The powers of NHS Trusts established under statute shall be exercised by NHS Trusts meeting in public session, except as otherwise provided by these SOs.

NHS framework

~~xx)~~xxi) In addition to the statutory requirements set out above, NHS Trusts must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.

~~xxi)~~xxii) Adoption of the principles will better equip NHS Trusts to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

~~xxii)~~xxiii) The overarching NHS governance and accountability framework incorporates these SOs; the Scheme of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the ~~*'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework~~Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/

~~xxiii)~~xxiv) The Welsh Ministers, reflecting their constitutional obligations, and legal duties under the **Well-being of Future Generations (Wales) Act 2015 (2015/2)**, have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

The Welsh Ambulance Service NHS Trust is not, at present, considered a public body under the Act but is committed to achieving the Well-being Goals and the sustainable development principle.

~~xxiv)~~xxv) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual, which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of NHS Trust business are also issued electronically, usually under cover of a Welsh Health Circular.

NHS Trust framework

~~xxv)~~xxvi) Schedule 2 provides details of the key documents that, together with these SOs, make up the NHS Trust's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

~~xxvi)~~xxvii) NHS Trusts will from time to time agree and approve policy statements which apply to the Trust's Board of directors and/or all or specific groups of staff employed by the Welsh Ambulance Services National Health Service Trust and others. The decisions to approve these policies will be recorded and, where appropriate, will also be considered to be an integral part of the Trust's SOs and SFIs. *Details of the Trust's key policy statements are also included in Schedule 2.*

~~xxvii)~~xxviii) NHS Trusts shall ensure that an official is designated to undertake the role of the Board Secretary (the role of which is set out in paragraph xxxv) below).

~~xxviii)~~xxix) For the purposes of these SOs, the Trust Board of directors shall collectively to be known as "the Board" or "Board members"; the executive and non-executive directors shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance (hereafter referred to as Director of Finance and Corporate Resources) – SO 1.1.2 refers.

Applying Standing Orders

~~xxix)~~xxx) The SOs of NHS Trusts (together with SFIs and the Values and Standards of Behaviour Framework) will, as far as they are applicable, also apply to meetings of any formal Committees established by the Trust, including any sub-Committees and Advisory Groups. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs.*

~~xxx)~~xxxi) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and Trust officers have a duty to report any non-compliance to the Board Secretary as soon as they are aware of any circumstance that has not previously been reported.

~~xxxi)~~xxxii) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

~~xxxii)~~xxxiii) Although these SOs are subject to regular, annual review by the NHS Trust, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 19 of the Membership Regulations and does not contravene a statutory

provision or direction made by the Welsh Ministers;

- The proposed variation or amendment has been considered and approved by the Audit Committee and is the subject of a formal report to the Board; and

- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

~~xxxiii)~~xxxiv) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the Trust shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Board Secretary and, where appropriate the Chief Executive or the Director of Finance and Corporate Resources (in the case of SFIs).

~~xxxiv)~~xxxv) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

The role of the Board Secretary

~~xxxv)~~xxxvi) The role of the Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within NHS Trusts, and is a key source of advice and support to the NHS Trust Chair and other Board members. Independent of the Board, the Board Secretary acts as the guardian of good governance within NHS Trusts. The Board Secretary is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of NHS Trust business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity,

and without prejudice or discrimination;

- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the NHS Trust compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers.

As advisor to the Board, the *Board Secretary's* role does not affect the specific responsibilities of Board members for governing the organisation. The Board Secretary is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

Further details on the role of the Board Secretary within the Welsh Ambulance Services NHS Trust, including details on how to contact them, is available at Welsh Ambulance Service NHS Trust - Trust Board (wales.nhs.uk).

Section B – Standing Orders

1. THE TRUST

1.0.1 The Trust's principal role is:

(a) to manage ambulance and associated transport services;

(b) to manage such other services (including communications and training) relating to the provision of care as can reasonably be carried out in conjunction with the management of ambulance and associated transport services from Ambulance Headquarters at:

(i) Beacon House, William Brown Close, Cwmbran NP44 3AB
~~(i)~~(ii) Vantage Point House, Ty Coch Way, Cwmbran, NP44 7HF
~~(ii)~~(iii) Ty Elwy, St Asaph Business Park, St Asaph, LL17 0LJ,
~~(iii)~~(iv) Matrix One, Northern Boulevard, Swansea, SA6 8RE,

(c) to own the premises associated with the provision of the services in paragraphs (a) and (b);

(d) to perform the functions of the National Contact Point in Wales for the purposes of Directive 2011/24/EU as set out in regulations 3 to 6 of the National Health Service (Cross-Border Healthcare) Regulations 2013; and

(e) to provide—

(i) information about health conditions and availability of health services; and

(ii) remote access health advisory, triage and referral services,

for the purposes of the health service in Wales.

1.0.2 The Trust was established by, and its functions are contained in, the **Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998** (S.I. 1998/678), as amended. The Trust must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.

1.0.3 To fulfil this role, the Trust will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Trust

1.1.1 The membership of the Trust shall comprise the Chair, Vice Chair, six~~7~~ non-executive directors and ~~5~~six executive directors.

1.1.2 For the purposes of these SOs, the Trust Board of directors shall collectively to be known as "the Board" or "Board members"; the executive and non-executive directors (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively. The Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance and Corporate Resources. All such members shall have full voting rights.

1.1.3 The Minister for Health and Social Services shall appoint the Chair and non-officer members of the Trust.

1.1.4 The Trust will appoint a Committee whose members will be the Chair and non-executive directors of the Trust whose function will be to appoint the Chief Executive as a director of the Trust.

1.1.5 The Trust will appoint a Committee whose members will be the chair, the non-executive directors and the Chief Executive whose function will be to appoint the executive directors other than the Chief Executive.

Executive Directors

1.1.6 A total of ~~5~~six, appointed by the relevant committee, and consisting of the Chief Executive, the Director of Finance and Corporate Resources and ~~3~~four others. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to

officers.

Non-executive directors [to be known as Independent Members]

1.1.7 A total of six~~7~~ (excluding the Chair and Vice Chair) appointed by the Minister for Health and Social Services.

1.1.8 In addition to the eligibility, disqualification, suspension, and removal provisions contained within the Membership Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Use of the term 'Independent Members'

1.1.9 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:

- Chair
- Vice-Chair
- Non-Executive Directors

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the Trust is shared between more than one person because of their being appointed jointly to a post:

(i) Either or both persons may attend and take part in Board meetings;
(ii) If both are present at a meeting they shall cast one vote if they agree;
(iii) In the case of disagreement no vote shall be cast; and
(iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

1.3.1 The Chair and Independent Members appointed by the Minister for Health and Social Services shall be appointed as Trust members for a period specified by the Welsh Ministers, but for no longer than four~~4~~ years in any one term. These members can be reappointed. Time served need not be

consecutive and will still be counted towards the total period even where there is a break in the term.

1.3.2 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.3 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in the Membership Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.4 The Trust will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the Trust, its Board and responsibilities of individual members

Role

1.4.1 The principal role of the Trust is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the Trust's performance across all areas of activity.

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular

perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 NHS Trusts shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

1.4.5 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the Trust within the communities it serves.

1.4.6 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.7 The Chair shall work in close harmony with the Chief Executive and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.8 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed.

1.4.9 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the Trust. They are the appointed Accountable Officer for the Trust and shall be responsible for

meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.10 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the Trust, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF TRUST FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

(i) Schedule of matters reserved to the Board;
(ii) Scheme of delegation to committees and others; and
(iii) Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 The Trust retains full responsibility for any functions delegated to others to carry out on its behalf. Where Trusts and Local Health Boards have a joint duty the Trust remains fully responsible for its part, and shall agree the governance and assurance arrangements for the partnership, setting out respective responsibilities, ways of working, accountabilities and sources of assurance of the partner organisations.

2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

2.2 Delegation of Board functions

2.2.1 The Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2 (i), to Committees and others, setting any conditions and restrictions it considers necessary and in accordance with any directions or regulations given by the Welsh Ministers. These functions may be carried out:

(i) By a Committee, sub-Committee or officer of the Trust (or of another Trust); or
(ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
(iii) With one or more bodies including local authorities through a sub-Committee.]

2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees or sub-Committees which it has formally constituted.

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 NHS Trust Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term "Committee"

3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee

- Sub-Committee

unless otherwise stated.

3.2 Sub-Committees

3.2.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.3 Committees established by the Trust

3.3.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance (as appropriate);
- Charitable Funds;
- Remuneration and Terms of Service; and
- Mental Health Act requirements (as appropriate).

3.3.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity;
- Maximise cohesion and integration across all aspects of governance and assurance.

3.3.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;

- Meeting arrangements;
- Relationships and accountabilities with others (including the Board**,** its Committees and any Advisory Groups);
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.3.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.3.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the Trust Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the Trust.

3.3.6 Executive Directors or other Trust officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated Trust officers shall, however, be in attendance at such Committees, as appropriate.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.3.7 Substitution arrangements – Should any Non-Executive Director on the Board be unable to attend a meeting of a Committee the member may consider appointing a substitute member to attend the meeting in his/her place. The substitute member will assume upon appointment, full delegated responsibility on behalf of the substituted member and will be eligible to vote, as necessary on any matter before the Committee and will be counted as part of the quorum for that meeting. To instigate a substitution arrangement, the member of the Committee must notify the

Board Secretary before the day of the meeting that he/she is unable to attend and the name of the member who will attend as the substitute

3.4 Other Committees

3.4.1 The Board may also establish other Committees to help the Trust in the conduct of its business.

3.5 Confidentiality

3.5.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.6 Reporting activity to the Board

3.6.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261 (W.156)) ("the Shared Services Regulations") require the Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.

4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs, ~~and~~ Trusts and Special Health Authorities ~~-~~setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

5.0.1 The Trust may and where directed by the Welsh Ministers must, appoint Advisory Groups to the Trust to provide advice to the Board in the exercise of its functions.

5.0.2 *Details of the Trust's Advisory Groups, their membership and terms of reference are set out in Schedule 4.*

5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Advisory Groups established by the Trust

5.1.1 The Trust has established the following Advisory Group(s):

- Local Partnership Forum (known as the Welsh Ambulance Services Partnership Team – WASPT)

5.2 Terms of reference and operating arrangements

5.2.1 The Board must formally approve terms of reference and operating arrangements in respect of any Advisory Group it has established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the Board, its Committees and Advisory Groups) as well as other relevant local and national groups;
- Any budget and financial responsibility (where appropriate);
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.2.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements for the Trust's Advisory Groups are set out in Schedule 4.

5.2.3 The Board may determine that any Advisory Group it has set up should be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.3 Support to Advisory Groups

5.3.1 The Trust's Board Secretary, on behalf of the Chair, will ensure that Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the Trust Board and others;

- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see 5.7 and Schedule 4);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.4 Confidentiality

5.4.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.5 Advice and feedback

5.5.1 The Trust may specifically request advice and feedback from the Advisory Group(s) on any aspect of its business and they may also offer advice and feedback even if not specifically requested by the Trust. The Group(s) may provide advice to the Board:

- In written advice;
- In any other form specified by the Board

5.6 Reporting activity

5.6.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.6.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its

performance and that of any sub-groups it has established.

5.6.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.7 The Local Partnership Forum (LPF)

Role

5.7.1 The LPF's role is to provide a formal mechanism where the Trust, as employer, and trade unions/professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust - achieved through a regular and timely process of consultation, negotiation, and communication. In doing so, the LPF must effectively represent the views and interests of the Trust's workforce.

5.7.2 It is the forum where the Trust and staff organisations will engage with each other to inform, debate, and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.8 Relationship with the Board and others

5.8.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.8.2 The Board may determine that designated Board members or Trust staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Board members or Trust staff, subject to the agreement of the Trust Chair.

5.8.3 The Board shall determine the arrangements for any joint meetings between the Board and the LPF's staff representative members.

5.8.4 The Board's Chair shall put in place arrangements to meet with the LPF's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.8.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 4 for detailed Terms of Reference and Operating Arrangements.

6. WORKING IN PARTNERSHIP

6.0.1 The Trust shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the Trust through:

- The Trust's own structures and operating arrangements, e.g., Advisory Groups; and
- The involvement (at very local and community wide levels) in partnerships and community groups – such as Public Service Boards – of Board members and Trust officers with delegated authority to represent the Trust and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working---implications-for-health-boards-and-NHS-Trusts.pdf

6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance

with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6.1 ~~Community Health Councils (CHCs~~The Citizen Voice Body for Health and Social Care Wales (known as Llais)

6.1.1 ~~The **Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010** (S.I. 2010/288) and the **Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010** (S.I. 2010/289)~~ Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on Trusts in relation to the engagement and involvement of ~~CHCs~~ LLais in its operations.

6.1.2 The 2020 Act places a statutory duty on the Trust to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.1.3 The 2020 Act also places a statutory duty on the Trust to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. The Trust must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant)

~~6.1.2~~6.1.4 In discharging these duties, and given the all-Wales nature of the Trust's functions, the Board shall work constructively with the Board of ~~Community Health Councils in Wales~~Llais, to ensure that ~~CHCs~~ regional offices of Llais ~~across Wales~~ are involved, as appropriate, in:

- The planning of the provision of its healthcare services;

- The development and consideration of proposals for service changes and ~~in~~ the way in which those services are provided; and
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and
- Engaging, ~~and~~ formally consulting and working jointly with the Board of ~~Community Health Councils and CHCs~~ Llais ~~as appropriate~~ on any proposals for substantial development or change of the services it is responsible for in line with the Guidance on Changes to Health Services in Wales 2023.

The Guidance on Changes to Health Services can be found at https://www.gov.wales/guidance-changes-health-services

~~6.1.3~~6.1.5 The Board shall ensure that Llais~~each relevant CHC~~ is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

~~6.1.4~~6.1.6 The Board may determine that a designated ~~CHC~~ Llais ~~members~~ representative shall be invited to attend Board meetings.

~~6.1.5~~6.1.7 The Board ~~may make~~ shall ensure arrangements are in place for ~~to hold~~ regular meetings between Trust officers and representatives of Llais. ~~the Board of Community Health Councils and CHCs, as appropriate~~.

~~6.1.6~~6.1.8 The Board's Chair shall put in place arrangements to meet with the Chair or Deputy Chair and/or representatives of Llais~~Board of Community Health Councils Chair~~ on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

7.1.1 The Trust's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The Trust, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways,

including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested and required) and in electronic formats;
- Requesting that attendees notify the Trust of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the Trust's citizens and other stakeholders, including any views expressed formally to the Trust, e.g., through ~~CHCs~~Llais.

~~7.1.3 The Board at its meeting in March 2014 agreed to introduce audio recording of Board meetings with effect from 1 April 2014. The intention behind this proposal is for the Trust to be as open and transparent as possible about the way decisions are made, to use the recordings to write up the decision at the end of a debate and also for reference purposes should it be necessary to recall the precise wording of suggestions, advice and recommendations made at the meeting~~

7.2 Annual Plan of Board Business

7.2.1 The Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as

a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

7.2.2 The plan shall set out the arrangements in place to enable the Trust to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisation's website.

Annual General Meeting (AGM)

7.2.5 The Trust must hold an AGM in public no later than the 31 July each year. [Note : this will be no later than 30 September in 2023 to take account of the timetable for audit and laying of the Accounts by Audit Wales.] At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the Trust's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the Trust are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

7.2.6 The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts, and may also include presentation of other reports of interest to citizens and others.

7.2.7 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Board Secretary, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the Trust. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Board Secretary, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least ~~10~~ seven calendar days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 6.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On the Trust's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the Trust's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the Trust shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The Trust shall encourage attendance at its formal Board meetings by the public and members of the press as well as Trust officers or representatives from organisations who have an interest in Trust business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.

7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

> *That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).*

7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

7.5.4 The Board Secretary, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers

leave the meeting.

7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

7.5.7 The Board will decide what arrangements and terms and conditions it feels are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Trust, (whether directly or through the activities of bodies such as ~~CHC~~ Llais and the Trust's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

7.5.8 The Chair of the Trust will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and Vice-Chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Board Secretary. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

7.5.10 At least one-third of all Board members, at least one of whom is an

Executive Director and one is an Independent Members, must be present to allow any formal business to take place at a Board meeting.

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes.

Dealing with motions

7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Board Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

7.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined

that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

7.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e.., the substantive motion.

7.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

7.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.5.20 **Withdrawal of motion or amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

7.5.21 **Motion to rescind a resolution –** The Board may not consider a motion

to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted.

7.5.24 In determining every question at a meeting the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the Trust's citizens and stakeholders. Such views will usually be presented to the Board through the Chair*(s)* of the Trust's Advisory Group*(s)* and the ~~CHC~~ Llais representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for

absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the Trust's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulations 2018, and the Trust's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 All Board members together with members of any Committee or Advisory Group established by or on behalf of the Board and Trust officials must respect the confidentiality of all matters considered by the Trust in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework (including the Standards of Business Conduct Policy) or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

8.0.1 The Board must adopt a set of values and standards of behaviour for the Trust that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Trust, including Board members, Trust officers and others, as appropriate. The framework adopted by the Board framework will form part of these SOs.

8.1 Declaring and recording Board members' interests

8.1.1 ***Declaration of interests –*** It is a requirement that all Board members must declare any personal or business interests they may have which may affect,

or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework, the Standards of Business Conduct Policy, and their statutory duties under the Membership Regulations. Board members must notify the Chair and Board Secretary of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Board Secretary will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Board Secretary. However, the onus regarding declaration will reside with the individual Board member.

8.1.3 ***Register of interests –*** The Chief Executive, through the Board Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4 The register will be held by the Board Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Board Secretary will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

8.1.5 In line with the Board's commitment to openness and transparency, the Board Secretary must take reasonable steps to ensure that the citizens served by the Trust are made aware of, and have access to view the Trust's Register of Interests. This may include publication on the Trust's website.

8.1.6 ***Publication of declared interests in Annual Report –*** Board members' directorships of companies or positions in other organisations likely or

possibly seeking to do business with the NHS shall be published in the Trust's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Board Secretary, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the Trust and the NHS in Wales.

8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Board Secretary before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

(i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;

(ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;

(iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;

(iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.

8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Board Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

8.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Membership Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

8.2.9 ***Members with Professional Interests*** **-** During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as a Trust Board member and that of their

[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Board Secretary.

8.3 Dealing with officers' interests

8.3.1 The Board must ensure that the Board Secretary, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of Trust officers' interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how Interests are handled

8.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts[2], hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework (including the Standards of Business Conduct Policy) approved by the Board prohibits Board members and Trust officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or Trust officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Trust Board member or officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from

[2] The term gift refers also to any reward or benefit.

the Board Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Trust;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Trust; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

8.6 Sponsorship

8.6.1 In addition gifts and hospitality individuals and the organisation may also

receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the Values and Standards of Behaviour Framework (including the Standards of Business Conduct Policy) and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to Trust officers working within their Directorates.

8.7.2 Every Board member and Trust officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.

- **Hospitality:** Only significant hospitality offered or received should

be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

8.7.4 Board members and Trust officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- acceptance would further the aims of the Trust;
- the level of hospitality is reasonable in the circumstances;
- it has been openly offered; and,
- it could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

8.7.5 The Board Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Trust to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the adequacy of the Trust's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board or Committee of the Board.

9.02. Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1 Register of Sealing

[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

9.1.1 The Board Secretary shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal proceedings involving the Trust, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

9.3.1 The Common Seal of the Trust shall be kept securely by the Board Secretary.

10. GAINING ASSURANCE ON THE CONDUCT OF TRUST BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of Trust business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

10.0.3 Assurances in respect of services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the

Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the Trust.

10.0.4 Whilst the Trust is not a member of WHSSC or EASC the Chief Executive does attend the Committees as an Associate Member. Assurances in respect of the functions discharged by WHSSC and EASC shall achieved by the reports of the respective Joint Committee Chair, and reported back by the Chief Executive.

10.0.5 Arrangements for seeking and providing assurance is respect of any other services provided on behalf of or in association with the Trust shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.1 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

10.2.3 The Board shall use the information from this evaluation activity to inform:

- the ongoing development of its governance arrangements, including its structures and processes;
- its Board Development Programme, as part of an overall Organisation Development framework; and
- the Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

10.3 External Assurance

10.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the Trust's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the Trust implements any recommendations relevant to its business made by

the Welsh Government's Audit Committee, the Senedd Cymru/Welsh Parliament's Public Accounts Committee or other appropriate bodies.

10.3.4 The Trust shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of citizens and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their partners.

11.0.3 The Board shall also facilitate effective scrutiny of the Trust's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.0.4 The Board shall ensure that within the Trust, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12. REVIEW OF STANDING ORDERS

12.0.1 The Board Secretary shall arrange for ~~an~~ appropriate impact assessments to be carried out on a draft of these SOs prior to their formal adoption by the Board, the results of which shall be presented to the Board for consideration and action, as appropriate. The fact that an assessment has been carried out shall be noted in the SOs.

12.0.2 These SOs shall be reviewed annually by the Audit Committee, which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants:

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid 'put downs' of views or points made by colleagues
- Respect a colleague's point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No 'side-meetings' to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the LPF member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as 'staff organisations' within these Standing Orders

- British Medical Association (BMA)
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCN)
- UNISON
- UNITE
- GMB
- British Orthoptic Society
- Society of Radiographers
- British Dental Association
- Society of Chiropodists and Podiatrists
- Federation of Clinical Scientists
- Chartered Society of Physiotherapy (CSP)
- British Dietetic Association
- British Association of Occupational Therapists (BAOT)

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Schedule 2.1

STANDING FINANCIAL INSTRUCTIONS

This Schedule forms part of, and shall have effect as if incorporated in the NHS Trust Standing Orders (incorporated as Schedule 2.1 of SOs)

Foreword

These Model Standing Financial Instructions are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. NHS Trusts in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. Designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders (SOs), a Schedule of decisions reserved to the Board and a Scheme of delegations to officers and others, they provide the regulatory framework for the business conduct of the Trust.

These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Trust Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Executive Director of Finance and Corporate Resources will be able to provide further advice and guidance on any aspect of the Standing Financial Instructions. The Board Secretary will be able to provide further advice and guidance on the wider governance arrangements within the Trust. Further information on

governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/

Contents

WELSH AMBULANCE SERVICES NHS TRUST

1. INTRODUCTION

1.1 General

1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. NHS Trusts in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have effect as if incorporated in the Standing Orders (SOs) (incorporated as Schedule 2.1of SOs).

1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by **the Welsh Ambulance Services National Health Service Trust** "the Trust". They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Board and the Scheme of delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial control procedure notes. All financial procedures must be approved by the Executive Director of Finance and Corporate Resources and Audit Committee.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Board Secretary or Executive Director of Finance and Corporate Resources must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.2 Overriding Standing Financial Instructions

1.2.1 Full details of any non compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the Executive Director of Finance and Corporate Resources and the Board Secretary, who will ask the Audit Committee to formally consider the matter

and make proposals to the Board on any action to be taken. All Board members and Trust officers have a duty to report any non compliance to the Executive Director of Finance and Corporate Resources and Board Secretary as soon as they are aware of any circumstances that has not previously been reported.

1.2.2 **Ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

1.3 Financial provisions and obligations of NHS Trusts

1.3.1 The financial provisions and obligations for NHS Trusts are set out under Schedule 4 to the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the Trust meets its statutory obligation to perform its functions within the available financial resources.

1.3.2 The financial obligation as set out in paragraph 2 of Schedule 4 is as follows:

(1) Each NHS trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account.

(2) Each NHS trust must achieve such financial objectives as may from time to time be set by the Welsh Ministers with the consent of the Treasury and as are applicable to it.

(3) Any such objectives may be made applicable to NHS trusts generally, or to a particular NHS trust or to NHS trusts of a particular description.

2. RESPONSIBILITIES AND DELEGATION

2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

a) Formulating and approving the Medium Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium Term Plan (IMTP);

b) Requiring the submission and approval of balanced budgets within approved allocations/overall income;

c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability); and

d) Defining specific responsibilities placed on Board members and Trust officers, and Trust committees and Advisory Groups as indicated in the 'Scheme of delegation' document.

2.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of matters reserved to the Board' document. The Board, subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. This will be via powers and authority delegated to committees or sub-committees that the Trust has established or to an officer of the Trust in accordance with the 'Scheme of delegation' document adopted by the Trust.

2.2 The Chief Executive and Executive Director of Finance and Corporate Resources

2.2.1 The Chief Executive and Executive Director of Finance and Corporate Resources will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.2 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Welsh Government, for ensuring that the Board meets its obligation to perform its

functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that financial provisions, obligations and targets are met; and has overall responsibility for the Trust's system of internal control.

2.2.3 It is a duty of the Chief Executive to ensure that Board members and Trust officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

2.3 The Executive Director of Finance and Corporate Resources

2.3.1 The Executive Director of Finance and Corporate Resources is responsible for:

a) Implementing the Trust's financial policies and for co-coordinating any corrective action necessary to further these policies;

b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and

d) Without prejudice to any other functions of the Trust, and Board members and Trust officers, the duties of the Executive Director of Finance and Corporate Resources include:

(i) the provision of financial advice to other Board members and Trust officers, and to Trust committees and Advisory Groups,

(ii) the design, implementation and supervision of systems of internal financial control, and

(iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

2.3.2 The Executive Director of Finance and Corporate Resources is responsible for ensuring an ongoing training and communication programme is in place to

affect these SFIs.

2.4 Board members and Trust officers, and Trust Committees

2.4.1 All Board members and Trust officers, and Trust committees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy, efficiency and sustainability in the use of resources; and

d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.

2.4.2 For all Board members and Trust officers, and Trust committees who carry out a financial function, the form in which financial records are kept and the manner in which Trust Board members and officers, and Trust committees, Advisory Groups and employees discharge their duties must be to the satisfaction of the Executive Director of Finance and Corporate Resources .

2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit Committee

3.1.1 An independent Audit Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Board. In accordance with SOs the Board shall formally establish an Audit Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook.

~~http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Audit%20Committee%20Handbook%20%28June%202012%29.pdf~~
nwssp.nhs.wales/a-wp/governance-e-manual/governance-e-manual-documents/useful-documents/nhs-wales-audit-committee-handbook-june-2012/

3.2 Chief Executive

3.2.1 The Chief Executive is responsible for:

a) Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with the requirements of the Public Sector Internal Audit Standards.

- major internal financial control weaknesses discovered,
- progress on the implementation of Internal Audit recommendations,
- progress against plan over the previous year,
- a strategic audit plan covering the coming three years, and
- a detailed plan for the coming year.

3.2.2 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land or property owned or leased by the Trust;

c) Access at all reasonable times to Board members and officers;

d) The production of any cash, stores or other property of the Trust under a Board member or a Trust official's control; and

e) Explanations concerning any matter under investigation.

3.3 Internal Audit

3.3.1 The Accountable Officer Memorandum requires the Chief Executive to have an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. This framework is defined within an Internal Audit Charter that incorporates a definition of internal audit, a code of ethics and Public Sector Internal Audit Standards. Standing Order 10.1 details the relationship between the Head of Internal Audit and the Board. The role of the Audit Committee in relation to Internal Audit is set out within its Terms of Reference, incorporated in Schedule 3 of the SOs, and the NHS Wales Audit Committee Handbook.

3.4 External Audit

3.4.1 Pursuant to the Public Audit (Wales) Act 2004 (c. 23), the Auditor General for Wales (Auditor General) is the external auditor of the Trust. The Auditor General may nominate his representative to represent him within the Trust and to undertake the required audit work. The cost of the audit is paid for by the Trust. The Trust's Audit Committee must ensure that a cost-efficient external audit service is delivered. If there are any problems relating to the service provided, this should be raised with the Auditor General's representative and referred on to the Auditor General if the issue cannot be resolved.

3.4.2 The objectives of the external audit fall under three broad headings, to review and report on:

a) Whether the expenditure to which the financial statements relate has been incurred lawfully and in accordance with the authority that governs it;

b) The audited body's financial statements, and on its Annual Governance Statement and remuneration report [1];

c) Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

3.4.3 The Auditor General's representatives will prepare a risk-based annual audit plan, designed to deliver the Auditor General's objectives, for consideration by the Audit Committee. The annual plan will set out details of the work to be carried out, providing sufficient detail for the Audit Committee and other recipients to understand the purpose and scope of the defined work and their level of priority. The Audit Committee should review the annual plan and the associated fees, although in so doing it needs to recognise the statutory duties of the Auditor General. The annual audit plan should be kept under review to identify any amendment needed to reflect changing priorities and emerging audit needs. The Audit Committee should consider material changes to the annual audit plan.

3.4.4 The Auditor General's representative should be invited to attend every Audit Committee meeting. The cycle of approving and monitoring the progress of external audit plans and reports, culminating in the opinion on the annual

[1] The Healthcare Inspectorate Wales will review and report on the Annual Quality Statement.

report and accounts, is central to the core work of the Audit Committee.

3.4.5 The Auditor General's representatives will liaise with Internal Audit when developing the external audit plan. The Auditor General's representative will ensure that planned external audit work takes into account the work of Internal Audit to avoid duplication wherever possible and considers where Internal Audit work can be relied upon for opinion purposes.

3.4.6 The Auditor General and his representatives shall have a right of access to the Chair of the Audit Committee at any time.

3.4.7 The Government of Wales Act 2006 (GOWA) provides that the Auditor General has statutory rights of access to all documents and information, as set out in paragraph 3.2.2a of these SFIs, that relate to the exercise of many of his core functions, including his statutory audits of accounts, value for money examinations and improvement studies. The rights of access include access to confidential information; personal information as defined by the Data Protection Act 2018 and the UK General Data Protection Legislation; information subject to legal privilege; personal information and sensitive personal information that may otherwise be subject to protection under the European Convention of Human Rights; information held by third parties; and electronic files and IT systems. Paragraph 17 of Schedule 8 to GOWA operates to provide the Auditor General with a right of access to every document relating to the Trust that appears to him to be necessary for the discharge of any of these functions. Paragraph 17(3) of Schedule 8 also requires any person that the Auditor General thinks has information related to the discharge of his functions to give any assistance, information and explanation that he thinks necessary. It also requires such persons to attend before the Auditor General and to provide any facility that he and his representatives may reasonably require, such as audit accommodation and access to IT facilities. The rights apply not just to the Trust and its officers and staff, but also to, among others, suppliers to the Trust.

3.4.8 The Auditor General's independence in the exercise of his audit functions is protected by statute (section 8 of the Public Audit (Wales) Act 2013), and audit independence is required by professional and ethical standards. Accordingly, the Trust (including its Audit Committee) must be careful not to seek to fetter the Auditor General's discretion in the exercise of his functions. While the Trust may offer comments on the plans and outputs of the Auditor General, it must not seek to direct the Auditor General.

3.4.9 The Auditor General will issue a number of reports over the year, some of which are specified in the Auditor General's Code of Audit and Inspection

Practice and International Standards on Auditing. Other reports will depend on the contents of the audit plan.

The main mandatory reports are:

- Report to those charged with governance (incorporating the report required under ISA 260) that sets out the main issues arising from the audit of the financial statements and use of resources work
- Statutory report and opinion on the financial statements
- Annual audit report.

In addition to these reports, the Auditor General may prepare a report on a matter the Auditor General considers would be in the public interest to bring to the public's attention; or make a referral to the Welsh Ministers if significant breaches occur.

3.4.10 The Auditor General also has statutory powers to undertake Value for Money Examinations and Improvement Studies within the Trust and other public sector bodies. At the Trust he also undertakes a Structured Assessment to help him assess whether there are proper arrangements for securing economy, efficiency and effectiveness in the use of resources. The Auditor General will take account of audit work when planning and undertaking such examinations and studies. The Auditor General and his representatives have the same access rights in relation to these examinations and studies as they do in relation to annual audit work.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the Chief Executive and Executive Director of Finance and Corporate Resources shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by Directions to NHS bodies on Counter Fraud Measures 2005.

~~http://www.wales.nhs.uk/sitesplus/documents/1064/WHC%282005%2995%20%28Revised%29%20Directions%20to%20National%20Health%20Service%20bodies%20on%20Counter%20Fraud%20Measures%202005.pdf~~
https://nwssp.nhs.wales/a-wp/governance-e-manual/knowing-who-does-

what-why/supporting-good-governance/nhs-counter-fraud-service-wales/

3.5.3 The LCFS shall report to the Trust Executive Director of Finance and Corporate Resources and the LCFS must work with NHS Counter Fraud Authority (NHSCFA) and the NHS Counter Fraud Service Wales (CFSW) Team in accordance with the Directions to NHS bodies on Counter Fraud Measures 2005.

3.5.4 The LCFS will provide a written report to the Executive Director of Finance and Corporate Resources and Audit Committee, at least annually, on proactive and reactive counter fraud work within the Trust.

3.5.5 The Trust must participate in the annual National Fraud Initiative (NFI) led by Audit Wales and must provide the necessary data for the mandatory element of the NFI by the due dates. The Trust should participate in appropriate risk measurement or additional dataset matching exercise in order to support the detection of fraud across the whole public sector.

3.6 Security Management

3.6.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management.

3.6.2 The Chief Executive has overall responsibility for controlling and coordinating security.

4. FINANCIAL DUTIES

4.1 Legislation and Directions

4.1.1 The Trust has two statutory financial duties, to:

- First Duty - A breakeven duty, to ensure that its revenue is not less than sufficient to meet outgoings properly chargeable to revenue account in respect of each rolling three-year accounting period
- Second Duty - A duty to prepare a plan to secure compliance with the first duty and for that plan to be submitted to and approved by the Welsh Ministers

~~4.1.2~~ The first duty is provided for under paragraph 2(1) of Schedule 4 of the National Health Service (Wales) Act 2006, although this should be read in conjunction with 'Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts' which sets out the duty to break even over a three-year period. The second duty arises as a result of the Welsh Ministers' powers to set financial objectives for the Trust under paragraph 2(2) of Schedule 4 of the National Health Service (Wales) 2006 Act. The planning requirement, which by virtue of being set as a financial objective becomes a statutory financial duty, was previously set by the Welsh Ministers and has been retained by Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts. Further details of the WHC can be obtained from the HSSG Director of Finance' hywel.jones38@gov.wales~~A link to the relevant Welsh Health Circular is below.~~

~~5.1.2~~

~~6.1.2 http://www.wales.nhs.uk/sitesplus/documents/863/12b%29%20Statutory%20Duties%20of%20Welsh%20Health%20Boards.pdf~~

4.2 First Financial Duty – The Breakeven Duty

4.2.1 The Trust has a statutory duty to ensure that its revenue is not less than sufficient to meet outgoings properly chargeable to revenue account in respect of each rolling three-year accounting period, that is to breakeven over a 3-year rolling period.

4.2.2 Trusts must ensure their boards approve balanced revenue and capital plans before the start of each financial year.

4.2.3 The Executive Director of Finance and Corporate Resources of the Trust will:

a) Prior to the start of each financial year submit to the Board for approval a report showing the total funding received, assumed in-year funding and other adjustments and their proposed distribution to delegated budgets, including any sums to be held in reserve;

b) Ensure that any ring-fenced or non-discretionary funding are disbursed in accordance with Welsh Ministers' requirements;

c) Periodically review any assumed in-year funding to ensure that these are reasonable and realistic; and

d) Regularly update the Board on significant changes to the initial funding and the application of such funds.

4.2.4 The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that it meets its First Financial Duty.

4.3. Second Financial Duty – The Planning Duty

4.3.1 The Trust has a statutory duty to prepare a plan, the Integrated Medium Term Plan (IMTP), to secure compliance with the first duty, and for that plan to be submitted to and approved by the Welsh Ministers.

4.3.2 The Integrated Medium Term Plan must reflect longer-term planning and delivery objectives and should be continually reviewed based on latest Welsh Government policy and local priority requirements. The Integrated Medium Term Plan, produced and approved annually, will be 3 year rolling plans. In particular the Integrated Medium Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.
~~https://gov.wales/sites/default/files/publications/2019-09/nhs-wales-planning-framework-2020-23%20.pdf~~

4.3.3 The NHS Planning Framework directs Trusts to develop, approve and submit an Integrated Medium Term Plan (IMTP) for approval by Welsh Ministers. The plan must

- describe the context within which the Trust will deliver key policy directives from Welsh Government.
- demonstrate how the Health Board are
  - delivering their well-being objectives, including how the five ways of working have been applied
  - contributing to the seven Well-being Goals,

- establishing preventative approaches across all care and services
- demonstrate how the Trust will utilise its existing services and resources, and planned service changes, to deliver improvements in population health and clinical services, and at the same time demonstrate improvements to efficiency of services.
- demonstrate how the three-year rolling financial breakeven duty is to be achieved.

4.3.4 An Integrated Medium Term Plans should be based on a reasonable expectation of future income, service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium Term Plan (including a balanced Medium Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.

4.3.5 The Integrated Medium Term Plan will be the overarching planning document enveloping component plans and service delivery plans. The Integrated Medium Term Plan will incorporate the balanced Medium Term Financial Plan and will incorporate the Trusts response to delivering the

- NHS Planning Framework,
- Quality, governance and risk frameworks and plans, and
- Outcomes Framework

4.3.6 The Integrated Medium Term Plan will be developed in line with the NHS Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based;
- Details of major changes in activity, service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans; and
- Profiled activity, service, quality, workforce and financial schedules.
- Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures;

4.3.7 The Chief Executive has overall executive responsibility to develop and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan (IMTP).

4.3.8 The Board will:

a) Approve the Integrated Medium Term Plan prior to the beginning of the

financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Board approval the Plan will be submitted to Welsh Government prior to the beginning of the financial year of implementation.

b) Approve a balanced Medium Term Financial Plan as part of the Integrated Medium Term Plan, which meets all financial duties, probity and value for money requirements; and

c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the Trust plan is not in place or in balance.

4.3.9 The Board approved Integrated Medium Term Plan will be submitted to Welsh Government, for approval by the Minister, in line with the requirements set out in the NHS Planning Framework.

4.3.10 The finalised approved Integrated Medium Term Plan will form the basis of the Performance Agreement between the Trust and Welsh Government.

5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

5.1 Budget Setting

5.1.1 Prior to the start of the financial year the Executive Director of Finance and Corporate Resources will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

a) Be in accordance with the aims and objectives set out in the Board approved Integrated Medium Term Plan, and Medium Term Financial Plan, and focussed on delivery of safe patient centred quality services;

b) Be in line with Revenue, Capital, Commissioner, Activity, Service, Quality, Performance, and Workforce plans contained within the Board approved balanced IMTP;

c) Take account of approved business cases and associated revenue costs and funding;

d) Be produced following discussion with appropriate Directors and budget holders;

e) Be prepared within the limits of available funds;

f) Take account of ring-fenced or specified funding;

g) Include both financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents);

h) Be within the scope of activities and authority defined by the National Health Service (Wales) Act 2006, including pooled budget arrangements;

i) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and

j) Identify potential risks and opportunities.

5.2 Budgetary Delegation

5.2.1 The Chief Executive may delegate, via the Executive Director of Finance and Corporate Resources , the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition of:

a) The amount of the budget;
b) The purpose(s) of each budget heading;
c) Individual or committee responsibilities;
d) Arrangements during periods of absence;
e) Authority to exercise virement;
f) Achievement of planned levels of service; and
g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

5.2.2 The Chief Executive, Executive Director of Finance and Corporate Resources and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Executive Director of Finance and Corporate Resources .

5.2.5 All budget holders must provide information as required by the Executive Director of Finance and Corporate Resources to enable budgets to be compiled and managed appropriately.

5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.

5.2.7 The Executive Director of Finance and Corporate Resources has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.

5.3 Financial Management, Reporting and Budgetary Control

5.3.1 The Executive Director of Finance and Corporate Resources shall monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to Trust Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.

5.3.2 The Executive Director of Finance and Corporate Resources will devise and maintain systems of financial management performance reporting and budgetary control. These will include:

a) Regular financial reports, for revenue and capital, to the Board in a form approved by the Board containing sufficient information for the Board to:
- Understand the current and forecast financial position
- Evaluate risks and opportunities
- Use insight to make informed decisions
- Be consistent with other Board reports

As a minimum the reports will cover:
- Current and forecast year end position on statutory financial duties
- Actual income and expenditure to date compared to budget and showing trends and run rates
- Forecast year end positions
- A statement of assets and liabilities, including analysis of cash flow and movements in working capital.
- Explanations of material variances from plan
- Capital expenditure and projected outturn against plan
- Investigations and reporting of variances from financial, activity and workforce budgets.
- Details of corrective actions being taken, as advised by the relevant budget holder and the Chief Executive's and/or Executive Director of Finance and Corporate Resources ' view of whether such actions are sufficient to correct the situation;
- Statement of performance against savings targets
- Key workforce and other cost drivers
- Income and expenditure run rates, historic trends, extrapolation and explanations
- Clear assessment of risks and opportunities
- Provide a rounded and holistic view of financial and wider organisational performance.

b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible;

c) An accountability and escalation framework to be established for the organisation to formally address material budget variances

d) Investigation and reporting of variances from financial, activity and workforce budgets;

e) Monitoring of management action to correct variances;

f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will

- be held to account for managing services within the delegated budget
- investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation;

b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

5.3.5 The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans and SFI 9.1.

5.4 Capital Financial Management, Reporting and Budgetary Control

5.4.1 The general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans,

budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers.

5.5 Reporting to Welsh Government - Monitoring Returns

5.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales.

~~https://gov.wales/health-boards-and-trusts-financial-monitoring-guidance-2019-2020-whc-2019013~~

5.5.2 All monitoring returns must be supported by a detailed commentary signed by the Executive Director of Finance and Corporate Resources and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.

5.5.3 All information made available to the Welsh Ministers should also be made available to the Board. There must be consistency between the Medium Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly Board reports.

6. ANNUAL ACCOUNTS AND REPORTS

6.1 The Board must approve the Trust's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.

6.2 The Chair and Chief Executive have responsibility for signing the accounts on behalf of the Trust. The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the ~~Annual~~ Governance Statement ~~and the Annual Quality Statement~~.

6.3 The Executive Director of Finance and Corporate Resources , on behalf of the Trust, is responsible for ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers, as per Welsh Government's Manual for Accounts, and consistent with Financial Reporting Manual (FReM) and International Financial Reporting Standards.

6.4 The Trust's annual accounts must be audited by the Auditor General for Wales. The Trust's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.

6.5 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The annual report must also be sent to the Welsh Ministers. The Board Secretary will ensure that the Annual Report is prepared in line with the Welsh Government's Manual for Accounts. The Annual Report will include

- The Accountability Report containing:
  - Corporate Governance Report
  - Remuneration Report and Staff Report
  - Accountability and Audit Report

- The Performance Report, which must include:
  - An overview
  - A performance Analysis

7. BANKING ARRANGEMENTS

7.1 General

7.1.1 The Executive Director of Finance and Corporate Resources is responsible for managing the Trust's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Welsh Ministers. NHS Trusts are required to use the Government Banking Service (GBS) for its banking services.

7.1.2 The Board shall approve the banking arrangements.

7.2 Bank Accounts

7.2.1 The Executive Director of Finance and Corporate Resources is responsible for:

a) Establishing bank accounts and ensuring that the Government Banking Service is utilised for main Trust business transactions;

b) Establishing additional commercial accounts only exceptionally and where there is a clear rationale for not utilising the Government Banking Service;

c) Establishing separate bank accounts for the Trust's non-exchequer funds;

d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

e) Ensuring accounts are not overdrawn except in exceptional and planned situations.

f) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.

7.2.2 With the exception of Project Bank Accounts, all bank accounts should be held in the name of the Trust. No officer other than the Executive Director of

Finance and Corporate Resources shall open any account in the name of the Trust or for the purposes of furthering Trust activities.

7.2.3 Any Project Bank Account that is required may be held jointly in the name of the Trust and the relevant third party contractor.

7.3 Banking Procedures

7.3.1 The Executive Director of Finance and Corporate Resources will prepare detailed instructions on the operation of bank accounts, that ensure there are sound controls over the day-to-day operation of bank accounts, which must include:

a) The conditions under which each bank account is to be operated;

b) Those authorised to sign cheques or other orders drawn on the Trust's accounts.

c) Effective divisions of duty for employees working within the banking and treasury management function to minimise the risk of fraud and error.

d) Authorised signatories are identified with sufficient seniority, and in the case of e banking approvers, together with an appropriate payment approval hierarchy.

e) Procedures are in place for prompt banking of money received.

f) Ensure there are physical security arrangements in place for cheque stationery, e banking access devices and payment cards.

g) Cheques and payable orders are treated as controlled stationery with management responsibility given to a duly designated employee.

h) Frequent reconciliations are undertaken between cash books, bank statements and the general ledger so that all differences are fully understood and accounted appropriately.

i) Commercial bank accounts should only be used exceptionally where there is a sound rationale and demonstrates value for money. Commercial accounts should be procured through a tendering exercise and the outcome reported to the Audit Committee on behalf of the Board.

7.3.2 The Executive Director of Finance and Corporate Resources must advise the

Trust's bankers in writing of the conditions under which each account will be operated.

7.3.3 The Executive Director of Finance and Corporate Resources shall approve security procedures for any payable orders issued without a hand-written signature e.g. automatically printed. All Payable Orders shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

7.4 Review

7.4.1 The Executive Director of Finance and Corporate Resources will review banking arrangements of the Trust at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money. The results of the review should be reported to the Audit Committee.

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1 General

8.1.1 The Executive Director of Finance and Corporate Resources is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery, ensuring all cash related stationery treated as controlled stationery with management responsibility given to a duly designated employee;

c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

e) Ensuring effective control systems are in place for the use of payment cards,

f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.

8.1.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs (informal documents acknowledging debt).

8.1.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Executive Director of Finance and Corporate Resources .

8.1.4 The holders of safe/cash box combinations/keys shall not accept unofficial funds for depositing in their safe/cash box unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8.1.5 The opening of coin operated machines (including telephone, if applicable) and the counting and recording of takings shall be undertaken by two officers together, except as may be authorised in writing by the Executive Director of Finance and Corporate Resources and the coin box keys shall be held by a nominated officer.

8.1.6 During the absence (for example, on holiday) of the holder of a safe/cash box combination/key, the officer who acts in their place shall be subject to the same controls as the normal holder of the combination/key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

8.2 Petty Cash

8.2.1 The Executive Director of Finance and Corporate Resources will issue instructions restricting the use and value of petty cash purchases.

8.2.3 Petty cash use should be minimised and be subject to regular cash balance reviews in order to minimise cash levels held.

8.2.3 Petty cash should be operated under an imprest system and be subject to regular checks to ensure physical and book cash levels are consistent.

9. INCOME, FEES AND CHARGES

9.1 Income Generation and Participation in/Formation of Companies

9.1.1 The Trust shall only generate income for those goods and services that are approved by the Welsh Ministers. Any income generating activities must be complementary to the provision of NHS services and must be in accordance with the Welsh Ministers' policy and powers to raise money as set out in section 169 of the National Health Service (Wales) Act 2006 (c. 42).

9.1.2 The Trust can only form or participate in a company for income generation, improving health, healthcare care and health services, purposes with the consent and/or direction of Welsh Ministers. The Trust should obtain advice from Welsh Government officials prior to undertaking substantive work on formation or participation in any company.

9.2 Income Systems

9.2.1 The Executive Director of Finance and Corporate Resources is responsible for designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

9.2.2 The Executive Director of Finance and Corporate Resources is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

9.3 Fees and Charges

9.3.1 The Executive Director of Finance and Corporate Resources is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

9.3.2 All officers must inform the Executive Director of Finance and Corporate Resources promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.4 Income Due and Debt Recovery

9.4.1 Delegated budget holders and managers are responsible for informing the

Executive Director of Finance and Corporate Resources of any income due that arises from any contracts, service levels agreements, leases, activities such as private patients or other transactions.

9.4.2 Delegated budget holders and managers must inform the Executive Director of Finance and Corporate Resources when overpayment of salary or expenses have been made, in order that recovery can be made.

9.4.3 The Executive Director of Finance and Corporate Resources is responsible for recovering income due and for ensuring debt recovery procedures are in place to secure early payment and minimise bad debt risk on all outstanding debts.

9.4.4 Income not received should be dealt with in accordance with losses procedures.

9.4.5 Overpayments should be detected (or preferably prevented) and recovery initiated.

9.4.6 The Chief Executive and the Executive Director of Finance and Corporate Resources are responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.

10. NON PAY EXPENDITURE

10.1 Scheme of Delegation, Non Pay Expenditure Limits and Accountability

10.1.1. The Board must agree a Scheme of Delegation in line with that set out in its Standing Orders Scheme of Reservation and Delegation of Powers.

10.1.2. The Chief Executive will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the Trust's scheme of delegation.

10.1.3. The Chief Executive will set out in the operational scheme of delegation and authorisation:

- The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts; and
- The maximum level of each requisition and the system for authorisation above that level.

10.2 The Executive Director of Finance and Corporate Resources 's responsibilities

10.2.1 The Executive Director of Finance and Corporate Resources will:

a) Advise the Board regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs;

b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay expenditure;

c) Ensure systems are in place for the authorisation of all accounts and claims;

d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all amounts payable.

e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices.

f) Be responsible for ensuring compliance with the Public Sector Payment

policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs;

h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures

10.3 Duties of Budget Holders and Managers

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Executive Director of Finance and Corporate Resources , and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Executive Director of Finance and Corporate Resources in advance of both any commitment being made and NWSSP Procurement Services being engaged;

b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement;

c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;

d) goods have been duly received, examined and are in accordance with specification and order,

e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,

f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or Trust officers, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars,

(ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7.

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Executive Director of Finance and Corporate Resources on behalf of the Chief Executive;

h) All goods, services, or works are ordered on official orders

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

10.3.2 The Chief Executive and Executive Director of Finance and Corporate Resources shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the Trust's scheme of delegation.

10.4 Departures from SFI's

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. Trusts must consult with NWSSP Procurement Services, Executive Director of Finance and Corporate Resources and Board Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Trust's Scheme of Delegation.

10.5 Accounts Payable

10.5.1 NWSSP Finance, shall on behalf of the Trust, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable

10.6 Prepayments

10.6.1 Prepayment should be exceptional, and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
- It is the industry norm e.g. courses and conferences;
- In line with requirements of Managing Welsh Public Money
- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

a) The appropriate Executive Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) The Executive Director of Finance and Corporate Resources will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations 2015 where the contract is above a stipulated financial threshold); and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement the service is delivered by NWSSP Procurement Services.

11.1.2 Procurement staff are employed by NHS Wales Shared Services Partnership (NWSSP) and provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the Trust. Where the term Procurement staff or department is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of NWSSP Procurement Department, for example pharmacy and works who undertake procurement on a devolved basis.

11.2 Policies and procedures

11.2.1 NWSSP Procurement Services shall, on behalf of the Trust, maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes. The policies and procedures shall comply with these SFIs, Procurement Manual, and the Contract Notification Arrangements, included as **Schedule 1** of these SFIs.

11.2.2 The Chief Executive is ultimately responsible for ensuring that the Trust's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures

- Are kept up to date;
- Conform to statutory requirements and regulations;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Procurement Principles

11.3.1 The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the Trust to perform its functions, and furthermore embrace all building, equipment, consumables and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.3.2 The main legal and governing principles guiding public procurement and which are incorporated into these SFIs are:

- Transparency: public bodies should ensure that there is openness and clarity on procurement processes and how they are implemented;
- Non-discrimination: public bodies may not discriminate between suppliers or products on grounds of their origin;
- Equal treatment: suppliers should be treated fairly and without discrimination, including in particular equality of opportunity and access to information;
- Proportionality: requirements and conditions in the procurement should be reasonable in proportion to the object of procurement and measures taken should not go beyond what is necessary;
- Legality: public bodies must conform to European Community and other legal requirements;
- Integrity: there should be no corruption or collusion with suppliers or others;
- Effectiveness and efficiency: public bodies should meet the commercial, regulatory and socio-economic goals of government in a balanced manner appropriate to the procurement requirement;
- Efficiency: procurement processes should be carried out as cost effectively as possible and secure value for money.

11.4 Legislation Governing Public Procurement

11.4.1 There are a range of EU Directives which set out the EU legal framework for public procurement. These EU Directives have been implemented into UK law by statutory regulations which govern public sector procurement, the primary statutory regulations in Wales being 'The Public Contracts Regulations 2015 No. 102.' From 1 January 2021, all aspects of EU law in respect of the EU Directives relating to public procurement, except where expressly stated

otherwise by domestic legislation, will continue to govern public sector procurement, although further amendments or developments of EU related procurement law following this will not be incorporated into domestic law. The Welsh Government policy framework and the Wales Procurement Policy Statement (WPPS) also govern this area. One of the key objectives of governing legislation is to ensure public procurement markets are open and that there is free movement of supplies, services and works. Legislation, policy and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the Trust's SFIs.

11.4.2 The main Regulations (the Public Contracts Regulations 2015 No. 102) cover the whole field of procurement, including thresholds above which special and demanding procurement protocols and legal requirements apply. All Directors and their staff are responsible for seeing that those Regulations are understood and fully implemented. The protocols set out in the Regulations, and any Procurement Policy Notices, are the model upon which all formal procurement shall be based.

11.4.3 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the Trust and Procurement Services e.g. Engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.4.4 Other relevant legislation and policy include:

- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government's Code of Practice for Ethical Employment in Supply Chains.
- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government 'Towards zero waste: our waste strategy'
- The Welsh Government Policy Framework
- The Wales Procurement Policy Statement (WPPS)

11.5 Procurement Procedures

11.5.1 To ensure that the Trust is fully compliant with UK Procurement Regulations, EU Procurement Directives and Welsh Ministers' guidance and policy, the Trust shall, through NWSSP Procurement Services, ensure that it shall have procedures that set out:

a) Requirements and exceptions to formal competitive tendering requirements;
b) Tendering processes including post tender discussions;
c) Requirements and exceptions to obtaining quotations;
d) Evaluation and scoring methodologies
e) Approval of firms for providing goods and services.

11.5.2 All procurement procedures shall reflect the Welsh Ministers' guidance and the Trust's delegation arrangements and approval processes.

11.6 Procurement Consent and Notification

11.6.1 Paragraph 14(2) of Schedule 3 to the National Health Service (Wales) Act 2006 allows the Trust to:

- Acquire and dispose of property;
- Enter into contracts; and
- Accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the NHS trust or for any purpose relating to the health service).

11.6.2 **Schedule 1** details the requirement process for contract notification for Trusts.

Planning

11.7 Sustainable Procurement

11.7.4 To further nurture the Welsh economy, in support of social, environmental and economic regeneration, Trusts must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible. The principles of the Well-being of Future Generations (Wales) Act 2015 (WBFGA 2015) should be adopted at the earliest stage of planning. Procurement solutions must be developed embracing the five ways of working described within the Act and capture how they will deliver against the seven goals set out in the Act.

11.7.2 The WBFGA 2015 requires that bodies listed under the Act must operate in a manner that embraces sustainability. The Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with

people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

11.7.3 The 7 Wellbeing goals are:

- a prosperous Wales;
- a resilient Wales;
- a healthier Wales;
- a more equal Wales;
- a Wales of cohesive communities;
- a Wales of vibrant culture and thriving Welsh language; and
- a globally responsible Wales.

These goals have been put in place to improve the social, economic, environmental, and cultural well-being of Wales.

11.7.4 Public bodies need to make sure that when making their decisions they take into account the impact they could have on people living their lives in Wales in the future. The Act expects them to:

- work together better
- involve people reflecting the diversity of our communities
- look to the long term as well as focusing on now
- take action to try and stop problems getting worse - or even stop them happening in the first place.

11.7.5 The Trust is required to consider the Welsh Government Guidance on Ethical Procurement and the new Code of Practice on Ethical Employment in supply chains which commit public, private and third sector organisations to a set of actions that tackle illegal and unfair employment practices including blacklisting, modern slavery and living wage.

11.7.6 The Trust shall make use of the tools developed by Value Wales in implementing the principles of the WBFGA 2015. The Trust shall benchmark its performance against the WBFGA 2015. For all contracts over £25,000, the Trust shall take account of social, economic and environmental issues when making procurement decisions using the Sustainable Risk Assessment Template (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with Welsh Government commitments policy set out in the current WPPS and subsequent versions of this statement, the Trust shall ensure that it provides opportunities for these organisations to quote or tender for its business.

11.9 Planning Procurements

11.9.1 Trust must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks governing public procurement and the requirement of open competition.

11.9.2 Depending on the value of the procurement, a process of planning the procurement must be undertaken with the Procurement Services and appropriate representative from the service and other appropriate stakeholders. The purpose of a planning phase is to determine:

- the likely financial value of the procurement, , including whole life cost
- the likely 'route to market' which will consider the legislative and policy framework set out above.
- The availability of funding to be able to award a contract following a successful procurement process.
- That the procurement follows current legislative and policy frameworks including Value Based Procurement.

11.9.3 The procurement specification should factor in the 4 principles of prudent healthcare:

- Equal partners through co-production;
- Care for those with the greatest health need first;
- Do only what is needed; and
- Reduce inappropriate variation.

Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement**.**

11.9.4 Where free of charge services are made available to the Trust, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Trust does not unintentionally commit itself to a single provider or longer term commitment. Regular reports on free of charge services provided to the Trust should be submitted by Board Secretary to Audit Committee.

11.9.5 Trusts are required to participate in all-Wales collaborative planning activity

where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government and the opinions of NWSSP Procurement Services and NWSSP Legal and Risk prior to external opinion being sought where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Trust's approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales.

11.10.2 In the absence of an existing suitable procurement framework to source the required item, a competition must be run in accordance with the table below. Trust's must ensure the value of their requirement considers cumulative spend across the Trust for like requirements and opportunity for collaboration with other Trusts and Health Boards:

11.10.3 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

Competition Requirements

11.11 Procurement Thresholds

11.11.1 The following table summarises the minimum thresholds for quotes and competitive tendering arrangements. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of

an indeterminate duration) as set out below, and in EU Procurement Directives and UK Procurement Regulations.

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Minimum competition[1]	Form of Contract
<£5,000	Evidence of value for money has been achieved	Purchase Order
>£5,000 - <£25,000	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
>£25,000 – Prevailing OJEU threshold	Advertised open call for competition. Minimum of 4 tenders received if available.	Formal contract and Purchase Order
>OJEU threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route.	Formal contract and Purchase Order
Contracts above £1 million	Welsh Government approval required[2]	Formal contract and Purchase Order

[1] subject to the existence of suitable suppliers
[2] in accordance with the requirements set out in SO 11.6.

11.11.2 Advice from the Procurement Services must be sought for all requirements in excess of £5,000.

11.11.3 The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.4 Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000, must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 and require competition.

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- Required timescales are achievable
- Specifications are drafted which:
  - are fit for inclusion in competition documents;
  - are drafted in a manner encouraging innovation by the market;
  - are capable of being responded to and do not narrow competition;
  - deliver in line with legislative and policy frameworks;
  - include robust performance measures to effectively measure and manage supplier performance; and
  - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities.

11.12.3 Criteria for selecting suppliers and achieving an award recommendation must:

- be appropriately weighted in consideration of quality/price;
- consider cost of change where relevant;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life cost.

11.13 Single Quotation Application or Single Tender Application

11.13.1 In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met e.g. specific

equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all Wales competition/National strategy.

11.13.2 Procurement Services must be consulted prior to any such application being submitted for approval. The Executive Director of Finance and Corporate Resources must approve such applications up to £25,000, the Chief Executive or designated deputy, and Executive Director of Finance and Corporate Resources , are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

11.13.3 In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Executive Director of Finance and Corporate Resources , as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- Robust justification is provided;
- A value for money test has been undertaken;
- No bias towards a particular supplier;
- Future competitive processes are not adversely affected;
- No distortion of the market is intended;
- An acceptable level of assurance is available before presentation for approval in line with the Trust Scheme of Delegation; and
- An "or equivalent" test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Trust has already entered into an arrangement directly.

11.13.5 As SQA/ STAs are only used in exceptional circumstances, the Trust, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Executive Director of Finance and Corporate Resources or NWSSP Director of Procurement Services to

prevent recurrence by the Trust.

11.13.6 The Audit Committee may consider further steps to be appropriate, such as:

- Instruct a representative of the Trust to attend Audit Committee;
- Escalate to the Board;
- Request an internal Audit Review;
- Request further training; or
- Take internal disciplinary action.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. Procurement Manual details schedule of departures from SQA/STA where competition not possible.

11.13.8 For performance monitoring purposes, the NWSSP Procurement Service will retain a central register of all such activity including SQA/STA's not endorsed by Procurement or any exceptional matters.

11.14 Disposals

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g. Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Trust making use of any agreements covering the disposal of such items.

11.14.3 The Trust must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

11.15.1 The evaluation of competitions via quotation or tender, must be undertaken by a minimum of 2 evaluators from within the operational service of the Trust. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a competition must follow the Board's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract Management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder shall oversee and manage each contract on behalf of the Trust so as to ensure that these implicit obligations are met. This contract management will include:

- Retaining accurate records;
- Monitoring contract performance measures;
- Engaging suppliers to ensure performance delivery;
- Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- Permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by NWSSP Procurement Services.

11.16.3 Advice on best practice on Contract Management is available from NWSSP Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 Extending, modifying or varying the scope of an existing contract is possible,

if the provision to do so was included as an option in the original awarded contract, e.g. scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.2 If there is no such provision, the Public Contracts Regulations 2015 define such limitations.

11.17.3 The Public Contracts Regulations 2015 provide further constraints on this matter, under which modifications/variations/extensions are capped at 50% of the original award value.

11.17.4 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.5 If there was no provision to extend, further approvals are required from the Trust budget holder and the local Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.6 This ensures an appropriate identification and assessment of potential risks to the Trusts compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.7 The budget holder must seek advice from NWSSP Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

11.18 Requisitioning

11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. The budget holder will source those goods or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown

Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract, the budget manager shall request the NWSSP Procurement Services to undertake quotation / tendering exercises on their behalf in line with SFI 11.11 thresholds.

11.18.3 All orders for goods and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

11.19.1 The Trust will ensure compliance with the 'No Purchase Order, No Pay' policy, the All Wales policy introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official Orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

a) Be consecutively numbered;
b) State the Trust's terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the Trust by NWSSP Procurement Services.

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

12.1 Health Care Agreements

12.1.1 The Chief Executive is responsible for ensuring the Trust enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for its provision of health care services.

12.1.2 All Health Care Agreements should aim to implement the agreed priorities

contained within the Integrated Medium Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant quality, governance and risk frameworks and plans;
- The relevant national service framework (if any);
- The provision of reliable information on quality, volume and cost of service; and
- That the agreements are based on integrated care pathways.

12.1.3 All agreements must be in accordance with the functions conferred on the Trust by the Welsh Ministers.

12.2 Statutory provisions

The National Health Service (Wales) Act 2006 (c. 42) enables NHS Trusts to commission certain healthcare services. Section 7 sets out the definition of an NHS contract, being an arrangement under which one health service body arranges for the provision to it by another of goods or services which it reasonably requires for the purposes of its functions. It also provides a definition of a health service body.

12.3 Reports to Board on Health Care Agreements (HCAs)

12.3.1 The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all health care agreements. These reports will be linked to, and consistent with, other Board reports on quality and financial performance.

13. GRANT FUNDING

It is a matter for Trusts to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary. (Grants are defined as all non-procured payments to external bodies or individuals for activities which are linked to delivering policy objectives and statutory obligations. Payments are made to fund or reimburse expenditure on agreed items or functions in accordance with legally binding conditions.)

13.1 Legal Advice

13.1.1 Before the award of funding is made, legal advice where necessary must be sought to ensure that:

- The award does not breach the Trust's functions or its regularity of expenditure duty (that is, the activities for which the grant is made are within the scope of activities that the Trust has a legal remit to undertake);
- The activities would not be deemed to be normally subject to procurement legislation and policy; and
- A legally binding agreement is made with all delivery organisations.

See attached toolkit for grants v procurement:

Grant v Procurement.doc

13.2 Policies and procedures

13.2.1 The Trust shall maintain detailed policies and procedures for all aspects of grant funding. The policies and procedures shall comply with these SFIs, and where appropriate the Minister's Code of Practice to funding the third sector:

https://gov.wales/sites/default/files/publications/2019-01/third-sector-scheme-2014.pdf

13.2.2 The Chief Executive is ultimately responsible for ensuring that the Trust's grant procedures:

- Are kept up to date;
- Conform to statutory requirements;
- Adhere to guidance issued by the Welsh Ministers;

- Are consistent with the principles of sustainable development; and
- Are strictly followed by all Executive Directors, Independent Members and staff within the organisation.

13.2.3 The award of grant funding must comply with the policy and principles set out in the Procurement section of these SFIs and ensure that the award meets the requirements of regularity, propriety and value for money.

13.2.4 All grant guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

13.3 Corporate Principles underpinning Grants Management

13.3.1 While there is a need to make the financial arrangements for awarding funding as simple and streamlined as possible, Trusts should also ensure that taxpayers' money is spent appropriately and that it provides good value for money.

13.3.2 The overarching principles for managing public resources in Wales are set out in Managing Welsh Public Money. The document states that the award of funding should be made in accordance with the law and the requirements of propriety, regularity and value for money.

13.3.3 Regularity requires compliance with appropriate authorities, regulations and legislation. Propriety requires both public authorities and funded bodies to deliver appropriate standards of conduct, behaviour and corporate governance. In addition, the public expects official decisions to be made fairly and impartially with public money spent wisely and appropriately, delivering value for money and ensuring that best use is made of resources.

13.3.4 The **corporate principles** of grants management are:

- The development of grant management processes and procedures that are transparent, accountable, proportionate and consistent;
- The delivery of a high quality regulatory framework that responds to demands but does not place unnecessary administrative burdens on Trusts or funded bodies;
- A regulatory framework that will take into consideration the need for proportionality, balancing the need for governance with the burden of administration, thus striking an appropriate balance between accountability and simplicity;
- An effective grant management process to ensure funded bodies spend the funding efficiently, transparently and for the purpose intended, with a

view to maximising the impact and outcome from budgets;

- An appropriate evidence-based approach to underpin the design and development of all new funding programmes to ensure efficient and effective use of public funds, ensuring that the funding programme is the optimal solution and that funding is targeted where it is most needed and where it can have most impact;
- A consistent framework that will reinforce respect and effectiveness of the rules for both administrators and funded bodies; and
- Compliance of the grant funding with State aid requirements in accordance with the State aid rules.

13.4 Grant Procedures

13.4.1 It is vital that money is put to use in a way that delivers the maximum benefit to the people of Wales. Grants funding programmes need to be managed as efficiently and cost effectively as possible to make sure that every penny is spent appropriately and in an accountable manner. When establishing grant funding programmes, Trusts should ensure principles of good practice, available from a number of external sources, are considered and reflected in grant programmes. ~~Information on grants management is available on the Audit Wales website at:~~

~~https://www.audit.wales/good-practice/grants-management-miniguides~~

13.4.2 Trusts must agree a clear purpose for each grant and how it will measure the delivery organisation's success in delivering those purposes. It should also agree appropriate targets with the delivery organisation.

13.4.3 For grant programmes that span a number of financial years, the Trust is responsible for evaluating the programmes to ensure they are fit for purpose, are achieving required outcomes and continue to provide value for money.

13.4.4 Trusts are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. **They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.**

13.4.5 Trusts are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the organisation(s). These checks are important in order to identify any risks or issues that could expose the Trust to potential financial loss, fraud or

reputational damage. A proportionate level of due diligence should be carried out, both prior to the award of any grant funding and throughout the life of the award.

13.4.6 The Trust must enter into legally binding funding agreements with all delivery organisations. When developing funding agreements, the Trust should ensure principles of good practice, available from a number of external sources, are considered and reflected.

13.4.7 The Trust is responsible for ensuring that all third party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.

14. PAY EXPENDITURE

14.1 Remuneration and Terms of Service Committee

14.1.1 In accordance with SOs, the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility. This Standing Financial Instruction should be read in conjunction with Standing Order 3.4.

14.1.2 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.

14.1.3 The Board will, after due consideration and amendment, if appropriate, approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.

14.1.4 The Trust will remunerate the Chair, Chief Executive, Executive Directors and Independent Members of the Board in accordance with instructions issued by the Welsh Ministers. Welsh Ministers approval will be required in the exceptional event that remuneration needs to be above the maximum of the salary band range, administratively this approval will be exercised by the Director General HSSG.

14.1.5 The Remuneration and Terms of Service Committee will consider cases of redundancy and Voluntary Early Release applications. The Remuneration and Terms of Service Committee will consider any novel employment and pay cases, such as compromise agreements and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered.

14.2 Funded Establishment

14.2.1 The workforce plans incorporated within the approved Integrated Medium Term Plan will form the funded establishment, i.e, the budget for all approved posts. (The financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents) as per SFI 5.1.1 g)

14.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.

14.3 Staff Appointments

14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.

14.3.2 No Board member or Trust official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.

14.4 Pay Rates and Terms and Conditions

14.4.1 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Ministerial directions on Agenda for Change and Medical and Dental pay, and any staff with pre-existing terms and conditions of service, following a TUPE transfer into employment or ad hoc salaried staff.

14.4.2 The Remuneration Committee will determine pay rates and conditions of services for board members, and other senior employees, in accordance with ministerial instructions.

14.5 Payroll

14.5.1 The Director of Workforce and Organisational Development has responsibility for securing an efficient, well-controlled payroll service from NHS Wales Shared Services Partnership that:

- pays the correct staff with the correct amount,
- all payments are supported by properly authorised documentation.

14.5.2 The Director of Workforce and Organisational Development has responsibility for:

a) The control framework and detailed procedures which are in place to:
   - To ensure all payments comply with HMRC, Pensions Agency and other

regulation in relation to the deduction and payment of tax, national insurance, pension or other payments,
- reduce the risk of fraud and error within the payroll function.

b) Specifying timetables for submission of properly authorised time records and other notifications;

c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;

d) Agreeing the timing and method of payment with the payroll service;

e) Authorising the release of payroll data where in accordance with the provisions of the applicable Data Protection Legislation (the Data Protection Act 2018 and the UK General Data Protection Legislation);

f) Verification and documentation of data;

g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

i) Security and confidentiality of payroll information;

j) Checks to be applied to completed payroll before and after payment; and

k) A system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

14.5.3 The Chief Executive is responsible for:

a) Ensuring that arrangements for a payroll service from NHS Wales Shared Services Partnership (NWSSP) is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and internal audit review procedures;

b) Ensuring a sound system of internal control and audit review of any internally provided payroll service; and

c) Maintenance and/or the authorisation of regular and independent

reconciliation of pay control accounts.

14.5.4 Appropriately nominated managers have delegated responsibility for:

a) Submitting time records and other notifications in accordance with agreed timetables;

b) Completing time records and other notifications in accordance with the Service Level Agreements; and

c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Executive Director of Finance and Corporate Resources .

14.6 Contracts of Employment

14.6.1 The Director of Workforce and Organisational Development must:

a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) Deal with variations to, or termination of, contracts of employment.

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Plan

15.1.1 Capital plans, and annual capital programmes, must be approved by the Board before the commencement of a financial year and should be in line with the objectives set out in the approved Integrated Medium Term Plan (IMTP) for the organisation. The capital plan and programmes must be delivered within Welsh Government capital external financing limit.

15.1.2 The Director of Planning (or nominated responsible director) will develop a capital plan, and detailed capital programme, for the organisation that sets out a detailed capital investment plan to support the objectives set out in the IMTP. The capital programme must be affordable and within the external financing limit, as set out by Welsh Government (WG) for the year, and the Trust must not exceed the external financing limit. There must be an approved revenue funding plan in place to support any revenue costs associated with the capital plan. Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.1.3 The Board must approve a three year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium Term Plan and Budgetary Control chapters of these SFI.

15.2 Capital Investment Decisions

15.2.1 Robust business case and capital investment appraisal must be undertaken prior to formal submission to Welsh Government, the level of detail within the appraisal commensurate with the value and risk of the investment. Capital investment decisions should be undertaken in line with Welsh Government requirements and guidance for the development of business cases as set out in:

- NHS Wales Infrastructure Investment Guidance (Welsh Health Circular WHC (2018) 043) **https://gov.wales/nhs-wales-infrastructure-investment-guidance**
- Better business cases: investment decision-making framework **https://gov.wales/better-business-cases-investment-decision-making-framework**

15.2.2 The Executive Director of Finance and Corporate Resources must provide a professional opinion on the financial elements of the business case. Capital

investment decisions will be taken by the organisation in line with the financial thresholds specified by Welsh Government and in the Trust's Scheme of Delegation.

15.3 Capital Projects

15.3.1 The Chief Executive shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received.

15.3.2 When capital investment decisions are taken and a Capital Programme is approved the project cannot be initiated until the authority to commit expenditure is formally delegated to a manager, in line with the organisation's Scheme of Delegation. The capital project must then be procured in line with normal procurement procedures or the Designed for Life or other approved procurement framework and in line with Welsh Government requirements and guidance and the applicable procurement legislation. Management control and financial reporting systems must be established to ensure that the project is:

- delivered on time;
- on budget; and
- within contractual obligations.

15.3.3 Project management controls and financial reporting systems must be established to ensure these objectives are met. Reporting requirements to Welsh Government will be set out in the approval letter provided post Ministerial approval.

15.3.4 Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.4 Capital Procedures and Responsibilities

15.4.1 The Chief Executive:

a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c) Shall ensure that any capital investment above the Welsh Ministers'

delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received;

d) Shall ensure that the three year Capital Plan, and detailed annual Capital Programme is adopted by the Board, as part of the IMTP, prior to the commencement of the financial year;

e) Shall ensure the availability of resources to finance all revenue consequences of the investment, including capital charges; and

f) Shall ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities.

15.4.2 For every capital expenditure proposal the Chief Executive shall ensure:

a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model;

b) That the Executive Director of Finance and Corporate Resources has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Trust personnel and external agencies in the process.

15.4.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.

15.4.4 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme.

15.4.5 The Chief Executive shall issue to the manager responsible for any scheme:

a) Specific authority to commit expenditure;

b) Authority to proceed to tender; and

c) Approval to accept a successful tender.

15.4.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the

Trust's SOs.

15.4.7 The Director of Planning and Executive Director of Finance and Corporate Resources shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the requirements and delegated limits for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered. The Executive Director of Finance and Corporate Resources shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.4.8 The Executive Director of Finance and Corporate Resources shall ensure, for each capital project over £2m, that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. The Executive Director of Finance and Corporate Resources should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.

15.5 Capital Financing with the Private Sector

15.5.1 The Trust must not enter into any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and 3rd Party Developments, without the consent of the Welsh Ministers.

15.6 Asset Registers

15.6.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Planning and Executive Director of Finance and Corporate Resources , concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically.

15.6.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance and to satisfy the financial disclosure requirements for the Annual Accounts.

15.6.3 Additions to the fixed asset register must be clearly identified to the operational or departmental manager or delegated budget holder and be

validated by reference to appropriate documentation to provide evidence of the financial value recorded, including:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) Lease agreements in respect of assets held under a finance lease and included on the Trust's balance sheet.

15.6.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Disposal receipts are to be treated in accordance with the Welsh Ministers' guidance and clearly set out in the over-arching business case.

15.6.5 The Executive Director of Finance and Corporate Resources shall apply accounting policies for fixed assets in line with Welsh Government guidance and accounting standards and values recorded in the asset register, including depreciation and revaluations. The Executive Director of Finance and Corporate Resources shall approve procedures for reconciling balances on fixed assets accounts in general ledgers against balances on fixed asset registers.

15.6.6 The value of each asset, and depreciation, shall be considered annually in accordance with valuation guidance and methods specified by the Welsh Ministers. Assets should be considered for early revaluation where there is the likelihood of impairment as a result in a change of valuation or asset life.

15.7 Security of Assets

15.7.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.7.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Executive Director of Finance and Corporate Resources . This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Regular verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.7.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Planning and Executive Director of Finance and Corporate Resources .

15.7.4 Whilst individual officers have a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior Trust officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.7.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and Trust officers in accordance with the procedure for reporting losses.

15.7.6 Where practical, assets should be marked as Trust property.

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) Kept to a minimum;
b) Subjected to annual stock take; and
c) Valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Executive Director of Finance and Corporate Resources for the systems of financial control, overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers/managers and stores managers/keepers, subject to such delegation being entered in a record available to the Executive Director of Finance and Corporate Resources . The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager; the control of any fuel oil and coal of a designated estates manager~~, including the control of vehicle fuel stocks by Fleet~~.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.

16.2.3 The Executive Director of Finance and Corporate Resources is responsible for developing financial control systems and procedures for the regulation and operation of the stores, to include the accounting arrangements including records for receipt, issues, and returns of goods to stores and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Executive Director of Finance and Corporate Resources and there shall be a physical check covering all items in store at least once a year.

16.2.5 Where a complete system of controlled stores is not justified, alternative stores arrangements shall require the approval of the Executive Director of Finance and Corporate Resources .

16.2.6 The designated officer/manager shall be responsible for a system approved by the Executive Director of Finance and Corporate Resources for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer/manager shall report to the Executive Director of Finance and Corporate Resources any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 17, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by an NHS supplies agency

16.3.1 For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Executive Director of Finance and Corporate Resources or authorised officer who shall satisfy himself that the goods have been received before accepting the recharge.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 Disposals and Condemnations

17.1.1 The Executive Director of Finance and Corporate Resources must prepare detailed procedures for the disposal of assets and goods, including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a Trust asset and goods, the head of department or authorised deputy will determine and advise the Executive Director of Finance and Corporate Resources of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable assets and goods shall be:

a) Condemned or otherwise disposed of by an officer, the Condemning Officer, authorised for that purpose by the Executive Director of Finance and Corporate Resources ;

b) Recorded by the Condemning Officer in a form approved by the Executive Director of Finance and Corporate Resources which will indicate whether the assets and good are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Executive Director of Finance and Corporate Resources .

17.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Executive Director of Finance and Corporate Resources who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

17.2.2 The Executive Director of Finance and Corporate Resources is responsible for ensuring procedural instructions on the recording of and accounting for losses

and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

17.2.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and/or the Executive Director of Finance and Corporate Resources or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Executive Director of Finance and Corporate Resources and/or the Chief Executive.

17.2.4 Where a criminal offence is suspected, the Executive Director of Finance and Corporate Resources must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Executive Director of Finance and Corporate Resources must inform the Local Counter Fraud Specialist (LCFS) and the CFS Wales Team in accordance with Directions issued by the Welsh Ministers on fraud and corruption.

17.2.5 The Executive Director of Finance and Corporate Resources or the LCFS must notify the Audit Committee, the Auditor General's representative and the fraud liaison officer within the Welsh Government's Health and Social Services Group Finance Directorate of all frauds.

17.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Executive Director of Finance and Corporate Resources must notify:

a) The Audit Committee on behalf of the Board, and

b) An Auditor General's representative.

17.2.7 The Executive Director of Finance and Corporate Resources shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

17.2.8 The Executive Director of Finance and Corporate Resources shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.).

17.2.9 The Audit Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in Schedule 3 of the SOs.

17.2.10 For any loss or special payments, the Executive Director of Finance and Corporate Resources should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

17.2.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Health and Social Services Group Executive Director of Finance and Corporate Resources .

17.2.12 All novel, contentious and repercussive cases must be referred to the Welsh Government's Health and Social Services Group Finance Directorate, irrespective of the delegated limit.

17.2.13 The Executive Director of Finance and Corporate Resources shall ensure all losses and special payments are reported to the Audit Committee at every meeting.

17.2.14 The Trust must obtain the Health and Social Services Group Director General's approval for special severance payments.

18. DIGITAL, DATA and TECHNOLOGY

18.1 Digital Data and Technology Strategy

18.1.1 The Board shall approve a Digital Data and Technology Strategy which sets out the development needs of the Trust for the medium term based on an appropriate assessment of risk. The Integrated Medium Term Plan shall include costed implementation plans of the strategy. The Board shall also ensure that a Director has responsibility for Digital Data and Technology .

18.1.2 The Trust shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that are made publicly available.

18.2 Responsibilities and duties of the responsible Director

18.2.1 The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of the Trust digital systems and data and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection and availability of the Trust's digital systems and data for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Network and Information Systems Regulations 2018, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018;

b) Ensure that, following risk assessment of threats, adequate (reasonable) controls exist over access to systems, data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) Ensure that an adequate management (audit) trail is maintained of access to digital systems and data and that such audit reviews as the Director may consider necessary to meet the organisational requirements under the Network and Information Systems Regulations 2018 are being carried out;

d) Shall ensure that policies, procedures and training arrangements are in place to ensure compliance with information governance law and the Network and Information Systems Regulations 2018; and

e) Shall ensure comprehensive incident reporting.

18.3 Responsibilities and duties of the Executive Director of Finance and Corporate Resources

18.3.1 The Executive Director of Finance and Corporate Resources shall need to ensure that new financial data and systems and amendments to current financial data and systems are developed in a controlled manner and thoroughly tested prior to implementation and business as usual phases. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation and business as usual phases.

18.4 Contracts for data and digital services with other health bodies or outside agencies

18.4.1 The responsible Director for Digital Data and Technology shall ensure that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for:

- the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and
- the availability of the service including the resilience required to maintain continuity of the service.

The contract should also ensure rights of access for audit purposes.

18.4.2 Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Informatics and Digital shall, to maintain the confidentiality, integrity and availability of the service provided, periodically seek assurances that adequate controls, based on risk assessment, are in operation.

18.5 Risk assurance

18.5.1 The responsible Director for Digital Data and Technology shall ensure that the risks to the Trust arising from the use of data, information and IT are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of

appropriate resilience plans, including both a business continuity and disaster recovery plan.

19. PATIENTS' PROPERTY

19.1 NHS Trust Responsibility

19.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of patients that lack capacity, or found in the possession of patients dead on arrival.

19.1.2 Where the Welsh Ministers' instructions require the opening of separate accounts for patient monies, these shall be opened and operated under arrangements agreed by the Executive Director of Finance and Corporate Resources .

19.1.3 In all cases where property, including cash and valuables, of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 (c. 32)), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

19.1.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19.1.5 Where patient property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.2 Responsibilities of the Chief Executive

19.2.1 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, that the Trust will not accept responsibility or liability for patient property brought onto health service premises, unless it is handed in for safe custody and a copy of an official patient property record is retained as a receipt, by:

a) Notices and information booklets;

b) Hospital admission documentation and property records; and

c) The oral advice of administrative and nursing staff responsible for admissions.

19.3 Responsibilities of the Executive Director of Finance and Corporate Resources

19.3.1 The Executive Director of Finance and Corporate Resources must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 Corporate Trustee

20.1.1 All business shall be conducted in the name of Welsh Ambulance Services National Health Service Trust Charity, and all funds received in trust shall be held in the name of the Trust as a corporate Trustee. SFI 20.2 defines the need for compliance with Charities Commission latest guidance and best practice.

20.1.2 The discharge of the Trust's corporate trustee responsibilities for funds held on trust are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

20.1.3 The Trust shall establish a Charity~~able Funds~~ Committee as set out in Standing Order 3.4 to ensure that each fund held on trust which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

20.2 Accountability to Charity Commission and the Welsh Ministers

20.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds and to the Welsh Ministers for exchequer funds.

20.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and Trust officers must take account of that guidance before taking action.

20.2.3 The Trust shall make appropriate arrangements for the Annual Accounts and audit of Funds held on Trust in accordance with Charity Commission requirements.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

20.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

20.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21. RETENTION OF RECORDS

21.1 Responsibilities of the Chief Executive

21.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018 and the Freedom of Information Act 2000 (c. 36).

21.1.2 The records held in archives shall be capable of retrieval by authorised persons.

21.1.3 Records held shall only be destroyed in accordance with the applicable data protection laws and at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed.

SCHEDULE 1

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Directors of Finance
Deputy Directors of Finance
Local Health Boards, NHS Trusts Wales & HEIW

Our Ref: SE&IG/

Date: 30 November, 2020

Dear All

RE: PROCESSES FOR LOCAL HEALTH BOARDS AND NHS TRUSTS CONTRACTS, AND INTERESTS IN PROPERTY EXCEEDING £0.5M

Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on Local Health Boards (LHBs) to obtain the consent of Welsh Ministers before:

- Acquiring and disposing of property;
- Entering into contracts; and
- Accepting gifts of property (including property to be held on trust).

Acquiring and disposing of property

WHC (2018) 043 NHS Wales Infrastructure Investment Guidance issued 22 October 2018 sets out at section 10.1:

LHBs and HEIW

Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and

disposal of leases, where consent does not form part of the business case process will be included in a Welsh Health Circular WHC(2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.

NHS Trusts

Whilst formal Ministerial consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above.

Guidance on disposals is contained in Section 11

WHC (2015) 031 issued 22 June 2015 clarified the approval process linked to the acquisition or disposal of a lease, where approval does not form part of a business case process. A lease being a property right requires the consent of the Welsh Ministers in accordance with paragraph 13(2) (a). The WHC set out for NHS Trusts and LHBs a notification and consent process mirroring the contract processes noted below.

Entering into contracts

Guidance was issued to NHS Wales bodies on 27th January 2017 in a letter to Directors of Finance issued jointly by the Deputy Directors of Finance and Capital Estates and Facilities. This letter now updates that guidance to reconfirm to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisitions or disposals of a lease or any interest in property are delegated to the Director General, Health and Social Services Group.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Minister for Health and Social Services on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly any issues relevant to the exercise of the Minister for Health and Social Service's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSSG prior to tendering for the contract;

- All eligible LHB and HEIW contracts >£1m in total to be submitted to the Director General HSSG for consent prior to award;
- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSSG for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

(i) Contracts of employment between LHBs and their staff;
(ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs;
(iii) Out of Hours contracts; and
(iv) All NHS contracts; that is where one health services body contracts with another health service body.

For non- capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

Kind regards,

Steve Elliot & Ian Gunney
Diprwy Cyfarwyddwr Cyllid - Deputy Executive Director of Finance and Corporate Resources
Dirprwy Gyfarwyddwr, Cyfalaf Ystadau a Cyfleusterau - Deputy Director Capital Estates & Facilities
Finance Directorate / Cyfarwyddiaeth Cyllid
Y Grwp Iechyd a Gwasanaethau/Health and Social Services Group

SCHEDULE 1

REVISED GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Directors of Finance
Deputy Directors of Finance
Local Health Boards, NHS Trusts Wales, HEIW and DHCW

Our Ref: SE&IG/

Date: 31 March, 2022

Dear All,

This letter supercedes the consent guidance issued in our joint letter on 30 November 2020.

RE: PROCESSES FOR LOCAL HEALTH BOARDS AND NHS TRUSTS CONTRACTS, AND INTERESTS IN PROPERTY EXCEEDING £0.5M

Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on Local Health Boards (LHBs) to obtain the consent of Welsh Ministers before:

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Acquiring and disposing of property

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Steve.elliot@gov.wales
Gwefan • website:
www.gov.wales

LHBs and HEIW

Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process will be included in a Welsh Health Circular WHC(2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.

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The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Minister for Health and Social Services on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

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- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.

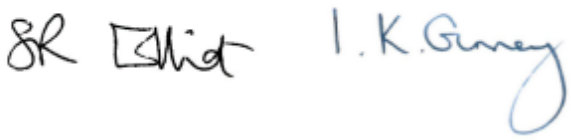
The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

(i) Contracts of employment between LHBs and their staff;
(ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs;
(iii) Out of Hours contracts; and
(iv) All NHS contracts; that is where one health services body contracts with another health service body.

Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Minister e.g. annual education and training commissioning do not require further Ministerial notification or consent.

For non- capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

Kind regards,



Steve Elliot & Ian Gunney
Cyfarwyddwr Cyllid dros dro - Interim Director of Finance
Dirprwy Gyfarwyddwr, Cyfalaf Ystadau a Cyfleusterau - Deputy Director Capital Estates & Facilities
Finance Directorate / Cyfarwyddiaeth Cyllid
Y Grwp Iechyd a Gwasanaethau/Health and Social Services Group

Schedule 1

SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Schedule forms part of, and shall have effect as if incorporated in the NHS Trust Standing Orders

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

(i) A Committee, e.g., Quality and Safety Committee;

(ii) A sub-Committee e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board; and

(iii) Officers of the Trust (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the Trust.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the Trust's Standing Orders.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***

- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***

- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***

- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***

- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***

- ***The Board may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles)
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Board Secretary

The Board Secretary will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of Trust functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Trust's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Board Secretary of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of control and other established procedures within the Trust.

SCHEDULE OF MATTERS RESERVED TO THE BOARD[1]

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
1	Board	General	The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs.
2	Board	General	The Board must determine any matter that will be reserved to the whole Board.
3	Board	General	Approve the Trust's Governance Framework
4	Board	Operating Arrangements	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the Trust; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	Board	Operating Arrangements	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements.
6	Audit Committee	Operating Arrangements	Formal consideration of report of Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.

[1] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or ~~Assembly~~ Welsh Government requirements.

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
7	Board	Operating Arrangements	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	Board	Operating Arrangements	Authorise use of the Trust's official seal.
9	Board	Operating Arrangements	Approve the Trust's Values and Standards of Behaviour framework.
10	Chair on behalf of Board/Joint Committee, Vice-Chair on behalf of Joint Committee Board if Chair is declaring interest	Organisation Structure and Staffing	Require, receive, and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee or Board Secretary
11	Board	Strategy Planning	Determine the Trust's strategic aims, objectives and priorities
12	Board	Strategy Planning	Approve the Trust's key strategies and programmes related to: ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
13	Board	Strategy Planning	Approve the Trust's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
14	Board	Strategy Planning	Approve the Trust's budget and financial framework (including overall distribution and unbudgeted expenditure)
15	Board	Operating Arrangements	Approve the Trust's framework and strategy for performance management.
16	Board	Strategy and Planning	Approve the Trust's framework and strategy for risk management and assurance.
17	Board	Operating Arrangements	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
18	Board	Operating Arrangements	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Trust, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE).
19	Board	Strategy and Planning	Approve the Trust's patient, public, staff, partnership and stakeholder engagement and co-production strategies.
20	Board	Operating Arrangements	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the Trust's aims, objectives and priorities.
21	Remuneration Committee. (For Chief Executive, Committee to consist of Chair and non-Officer Members. For all others officer members as above and to include Chief Executive)	Organisation Structure and Staffing	Appointment of the Chief Executive and Executive Directors (officer members of the Board)
22	Remuneration Committee	Organisation Structure and Staffing	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial instructions e.g. the Board Secretary.
23	Remuneration Committee	Organisation Structure and Staffing	Termination of appointment and suspension of officer members in accordance with the provisions of Regulations
24	Remuneration	Organisation Structure	Consider appraisal of officer members of the Board

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
	Committee	and Staffing	
25	Remuneration Committee	Organisation Structure and Staffing	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
26	Board	Organisation Structure and Staffing	Approve, [arrange the] review, and revise the Trust's top level organisation structure and corporate policies
27	Board	Organisation Structure and Staffing	Appoint, [arrange the] review, revise and dismiss Trust Committees directly accountable to the Board
28	Board	Organisation Structure and Staffing	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee or Group set up by the Board
29	Board	Organisation Structure and Staffing	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
30	Board	Organisation Structure and Staffing	Approve the standing orders and terms of reference and reporting arrangements of all Committees and groups established by the Board
31	Audit Committee	Operating Arrangements	Approve arrangements relating to the discharge of the Trust's responsibility as a bailee for patients' property
32	Board Except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	Operating Arrangements	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
33	Board	Operating Arrangements	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
	Except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers		
34	Board	Operating Arrangements	Approve proposals for action on litigation on behalf of the Trust
35	Board	Organisation Structure and Staffing	Approve the arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.
36	Board	Strategy and Planning	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
37	Board	Performance and Assurance	Approve the Trust's audit and assurance arrangements
38	Board	Performance and Assurance	Receive reports from the Trust's Executive on progress and performance in the delivery of the Trust's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate.
39	Board	Performance and Assurance	Receive reports from the Trusts Committees, groups and other internal sources on the Trust's performance and approve action required, including improvement plans, as appropriate
40	Board	Performance and Assurance	Receive reports on the Trust's performance produced by external regulators and inspectors (including, e.g., Audit Wales~~, HIW,~~ etc.) that raise significant issue or concerns impacting on the Trust's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Trust Committees (as appropriate)
41	Board	Performance and Assurance	Receive the annual opinion of the Trust's Chief Internal Auditor and approve action required, including improvement plans
42	Board	Performance and Assurance	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans

NO.	BOARD /COMMITTEE	AREA	DECISIONS RESERVED
43	Board	Performance and Assurance	Receive assurance regarding the Trust's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
44	Board	Reporting	Approve the Trust's Reporting Arrangements, including reports on activity and performance to citizens, partners and stakeholders and nationally to the Welsh Government where required.
45	Board	Reporting	Receive, approve and ensure the publication of Trust reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.
~~46~~	~~Board~~	~~Strategy and Planning~~	~~Ratify proposals for the acquisition, disposal or change of use of land and/or buildings. (see also Schedule 1 to SFIs)~~

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
1.	Chair		In accordance with statutory and Welsh Government requirements
2.	Vice Chair		In accordance with statutory and Welsh Government requirements
3.	Champion/ Nominated Lead		In accordance with statutory and Welsh Government requirements

DELEGATION OF POWERS TO COMMITTEES AND OTHERS[2]

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- The composition, terms of reference and reporting requirements in respect of any such Committees; and
- The governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Board has delegated a range of its powers to the following Committees and others:

- Audit Committee
- Quality Patient Experience and Safety Committee
- Remuneration Committee
- Finance and Performance Committee
- People and Culture
- Charity Committee
- Academic Partnerships Committee

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the Trust's Scheme of Delegation to Committees. The Committee terms of reference appear in Schedule 3 to these Standing Orders.

In the event the Chief Executive Officer is absent they will appoint a ~~the~~ Deputy Chief Executive Officer to take~~s~~ on full responsibility of the Chief Executive Officer. If the Deputy Chief Executive is the Director of Finance and Corporate Resources then the Director of Finance and Corporate Resources responsibilities is delegated to the Deputy Director of Finance.

[2] As defined in Standing Orders.

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, DIRECTORS AND OFFICERS

The Trust SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and Corporate Resources and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders.

These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the Trust's Scheme of Delegation to Officers.

Table A – Delegated Matters

Note for Table A, where a delegation is made to more than one post holder:

- '/' signifies that either post holder may act individually, or they may act jointly.
- 'and' signifies they must act jointly

Delegated Matter	Responsible Officer/Committee	Delegated To
1. Audit arrangements		
1.1. Ensure that there is an adequate provision of internal and external audit services	Audit Committee	Board Secretary
1.2. Implement recommendations	Chief Executive	Relevant Director
1.3. Ensure the financial accounts of the Trust are audited annually	Chief Executive	Executive Director of Finance and Corporate Resources
2. Authorisation of new drugs	Chief Executive	Medical Director and Director of Paramedicine
3. Bank/OPG Accounts/Cash (Excluding Charitable Funds (Funds Held on Trust Accounts))	Chief Executive	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
Refer to SFIs for banking arrangements		
4. Capital investment (Refer to SFIs)		
4.1. Programme		
(a) Preparation of Capital Investment for submission to Board	Chief Executive	Executive Director of Finance & Corporate Resources and Director of Strategy, Planning & Performance
(b) Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Chief Executive	Executive Director of Finance & Corporate Resources
(c) Variation to capital programme (up to delegated limits)	Chief Executive	Executive Director of Finance & Corporate Resources and Director of Strategy, Planning & Performance
4.2. Leases – granting and termination of leases subject to the limits set out in Table B	Chief Executive	Executive Director of Finance & Corporate Resources
5. Clinical		
5.1. Clinical governance arrangements	Chief Executive	Medical Director, Executive Director of Quality & Nursing and Director of Paramedicine
5.2. Clinical leadership	Chief Executive	Medical Director, Executive Director of Quality & Nursing and Director of Paramedicine
5.3. Programmes of clinical education	Chief Executive	Executive Director of People and Culture with Executive Director of Quality & Nursing and Director of Paramedicine
5.4. Clinical staffing rotas	Chief Executive	Executive Director of Operations
5.5. Clinical trials and research projects (authorisation of) In accordance with JRCALC guidelines	Chief Executive	Director of Paramedicine unless specified as Medical Director
5.6. Responsible officer for medical revalidation	Chief Executive	Medical Director
5.7. Clinical Audit To ensure there is a programme in place	Chief Executive	Medical Director
6. Clinical Practice and Registration		

Delegated Matter	Responsible Officer/Committee	Delegated To
6.1. Compliance with statutory and regulatory arrangements relating to professional practice and/or breaches of clinical standards		
(a) Nursing	Chief Executive	Executive Director of Quality and Nursing
(b) Medical	Chief Executive	Medical Director
(c) Paramedicine and affiliated roles	Chief Executive	Director of Paramedicine
(d) Community First Responders	Chief Executive	Director of Paramedicine
7. Complaints/concerns (patients and relatives) – Putting Things Right/the NHS (Concerns, Complaints and Redress Arrangements (Wales)) Regs 2011	Chief Executive	Executive Director of Quality & Nursing
8. Confidential information		
8.1. Monitoring of the Trust's compliance with the Caldicott report on protecting patient confidentiality in the NHS	Chief Executive	Executive Director of Quality and Nursing
8.2. Freedom of Information Act compliance code	Chief Executive	Board Secretary
9. Data Protection Act and General Data Protection Regulations		
9.1. Monitoring of Trust's compliance	Chief Executive	Director of Digital Services
9.2. Senior Information Risk Owner (SIRO)	Chief Executive	Director of Digital Services
10. Declarations of interest		
10.1. Maintaining a register	Chief Executive	Board Secretary
11. Disposal and condemnations		
11.1. Items obsolete, redundant, irreparable or cannot be repaired cost effectively	Chief Executive	Executive Director of Finance & Corporate Resources
11.2. Develop arrangements for the sale of assets	Chief Executive	Executive Director of Finance & Corporate Resources
11.3. Disposal of protected property (as defined in the terms of authorisation)	Chief Executive	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
12. Environmental Regulations		
12.1. Monitoring of compliance and ensuring compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Executive Director of Finance and Corporate Resources
13. External Borrowing		
13.1. Advise Trust Board of the requirements to repay / draw down Public Dividend Capital	Executive Director of Finance & Corporate Resources	Deputy Director of Finance and Corporate Resources
13.2. Approve a list of employees authorised to make short term borrowings on behalf of the Trust	Trust Board	Chief Executive and Executive Director of Finance & Corporate Resources
13.3. Application for draw down of Public Dividend Capital, overdrafts, and other forms of external borrowing	Chief Executive	Executive Director of Finance & Corporate Resources
14. Financial Planning/Budgetary Responsibility		
14.1. Develop and submit to Trust Board a financial plan in accordance with priorities and objectives as set out in the IMTP	Chief Executive	Executive Director of Finance & Corporate Resources
14.2. Budgetary responsibility	Chief Executive	Executive Director of Finance & Corporate Resources
14.3. Prior to the start of the financial year, prepare and submit to Trust Board for approval balanced budgets that delivers the financial plan as contained within the IMTP	Chief Executive	Executive Director of Finance & Corporate Resources
14.4. Monitoring and report to Trust Board on performance against the financial plan	Chief Executive	Executive Director of Finance & Corporate Resources
14.5. Devise and maintain systems of budgetary control	Chief Executive	Executive Director of Finance & Corporate Resources
14.6. Monitor performance against budget	Chief Executive	Executive Director of Finance & Corporate Resources
14.7. Delegate budgets to budget holders	Chief Executive	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
14.8. Ensure adequate training is delivered to budget holders to facilitate their management of allocated budget	Chief Executive	Executive Director of Finance & Corporate Resources
14.9. Submit in accordance with the independent regulators' requirements for financial monitoring returns	Chief Executive	Executive Director of Finance & Corporate Resources
14.10. Identify and implement cost improvements and income generating activities in line with the business plan	Chief Executive	All budget holders
14.11. Preparation of		
(a) Annual accounts	Executive Director of Finance & Corporate Resources	Deputy Director of Finance and Corporate Resources
(b) Annual report	Chief Executive	Board Secretary
14.12. Budget Responsibilities. Ensure that:		
(a) No overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board	Chief Executive and Executive Director of Finance & Corporate Resources	Deputy Director of Finance and Corporate Resources
(b) Approved budget is not used for any other than specified purpose subject to rules of virement	Chief Executive and Executive Director of Finance & Corporate Resources	Deputy Director of Finance and Corporate Resources
(c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and workforce establishment	Chief Executive and Executive Director of Finance & Corporate Resources	Deputy Director of Finance and Corporate Resources
14.13. Authorisation of Virement The Chief Executive, Executive Director of Finance & Corporate Resources and delegated budget holders must not exceed the	Chief Executive	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
budgetary total or virement limits set by the Board.		
Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement		
15. Financial Procedures and Systems Development and maintenance of systems and procedures	Chief Executive	Executive Director of Finance & Corporate Resources
16. Fire Precautions Ensure that the Fire Precautions and prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact.	Chief Executive	Executive Director of Finance & Corporate Resources
17. Fixed Assets		
17.1. Maintenance of asset register including asset identification and monitoring	Chief Executive	Executive Director of Finance & Corporate Resources
17.2. Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with CONCODE and ESTATECODE.	Chief Executive	Executive Director of Finance & Corporate Resources
17.3. Calculate and pay capital charges in accordance with the requirements of the Independent Regulator	Chief Executive	Executive Director of Finance & Corporate Resources
17.4. Responsibility for security of Trust's assets including notifying discrepancies to the Executive Director of Finance and Corporate Services, and reporting losses in accordance with Trust's procedures	Chief Executive	All Staff
18. Fraud (see also 26 and 36) Monitor and ensure compliance with Welsh Government Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Chief Executive	Executive Director of Finance & Corporate Resources
19. Funds Held on Trust Charitable Funds Charitable Funds held are managed and scrutinised appropriately	Charitable Funds Committee	Executive Director of Finance & Corporate Resources

Delegated Matter	Responsible Officer/Committee	Delegated To
20. Gifts and Hospitality		
20.1. Maintaining the gifts and hospitality register	Chief Executive	Board Secretary
20.2. Process for declaring gifts and hospitality	Chief Executive	Board Secretary
21. Health and Safety Monitor and ensure statutory compliance with all legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Executive Director of Quality & Nursing
22. Infectious Diseases and Notifiable Outbreaks	Chief Executive	Executive Director of Quality & Nursing
23. Integrated Medium Term Plan (IMTP)		
23.1. Develop and present to Trust Board for approval an IMTP that sets out the Trust Strategies and objectives and meets Welsh Government requirement	Chief Executive	Executive Director of Strategy, Planning & Performance
24. IT Systems		
24.1. Ensuring integrity of system e.g. security, privacy, accuracy, completeness and storage	Chief Executive	Director of Digital Services
24.2. Maintain & replacement of i) business critical systems ii) All other systems	Chief Executive	Director of Digital Services
24.3. Disaster recovery systems	Chief Executive	Director of Digital Services
24.4. Developing Business Critical Systems in accordance with the Trust's IM&T Strategy	Chief Executive	Director of Digital Services
24.5. Developing new systems to ensure they are developed in a controlled manner and thoroughly tested	Chief Executive	Director of Digital Services
24.6. Seeking third party assurances regarding Business Critical Systems operated externally	Chief Executive	Director of Digital Services
25. Losses, Write Offs and Compensation		

Delegated Matter	Responsible Officer/Committee	Delegated To
25.1. Prepare procedures for recording accounting and reporting to Audit Committee for losses and special payments, including clinical negligence and personal injury claims	Chief Executive	Executive Director of Finance & Corporate Resources
25.2. Ex-gratia payments	Chief Executive	Executive Director of Finance & Corporate Resources and relevant Director
26. Patients' Property (in conjunction with financial advice) Ensuring patients and guardians are informed about patients' monies and property procedures	Chief Executive	Executive Director of Operations
27. Patient Services Agreements Negotiation, agreement, and monitoring of external non-clinical patient transport contracts	Chief Executive	Executive Director of Finance & Corporate Resources/Executive Director of Operations
28. Procuring Goods and Services		
28.1. Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Table B	Chief Executive	Executive Director of Finance & Corporate Resources
28.2. Obtain the best value for money when requisitioning goods/services	Chief Executive	Executive Director of Finance & Corporate Resources
28.3. Prompt payment to suppliers (pspp)	Chief Executive	Executive Director of Finance & Corporate Resources
28.4. Financial limits for ordering/requisitioning goods and services Refer to Table B for delegated limits	Chief Executive	Executive Director of Finance & Corporate Resources
29. Quotation, Tendering and Contract Procedures		
29.1. Services:		
(a) Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Executive Director of Finance & Corporate Resources
(b) Nominate officers to oversee and manage the contract on behalf of the Trust	Chief Executive	Heads of Department

Delegated Matter	Responsible Officer/Committee	Delegated To
29.2. Competitive Tenders:		
(a) Authorisation Limits Refer to Table B for delegated limits	Chief Executive	Executive Director of Finance & Corporate Resources
(b) Maintain a register to show each set of competitive tender invitations despatched	Chief Executive	Executive Director of Finance & Corporate Resources
(c) Receipt and custody of tenders prior to opening	Chief Executive	Executive Director of Finance & Corporate Resources
(d) Opening tenders	Chief Executive	Executive Director of Finance & Corporate Resources
(e) Decide if late tenders should be considered	Chief Executive	Executive Director of Finance & Corporate Resources/Board Secretary
(f) Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote	Chief Executive	Executive Director of Finance & Corporate Resources
29.3. Quotations Refer to Table B for delegated limits	Chief Executive	Executive Director of Finance & Corporate Resources
29.4. Waiving the requirement to request		
(a) Tenders – subject to Standing Orders (reporting to the Board) Refer to Table B for delegated limits	Chief Executive	Executive Director of Finance & Corporate Resources
(b) Quotes – subject to Standing Orders	Chief Executive	Executive Director of Finance & Corporate Resources
30. Reporting of Non-Urgent Incidents to the Police	Chief Executive	Relevant Director
31. Risk Management		
31.1. Ensuring the Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Board Secretary
31.2. Developing systems for the management and reporting of risks and incidents	Chief Executive	Board Secretary (risk) and Executive Director of Quality & Nursing (incidents)
32. Seal	Chief Executive	Board Secretary

Delegated Matter	Responsible Officer/Committee	Delegated To
The keeping of a register of seal and safekeeping of the seal		
33. Signing of Documents		
33.1. Legal Proceedings/Advice		
(a) Engage Trust's solicitors/legal advisor	Chief Executive	Relevant Director or Board Secretary
(b) Documents connected with legal proceedings[3]	Chief Executive	Relevant Director or Board Secretary
33.2. Documents which are required to be executed as a Deed[4]	Chief Executive	Relevant Director and Board Secretary
33.3. Other Agreements not required to be executed as a Deed	Chief Executive	Relevant Director
33.4. Lease Agreements[5]	Chief Executive	Director of Finance and Corporate Resources and Board Secretary
34. Security Management Provide an oversight and assurance within the context of security management within NHS Wales; working in conjunction with the following leads on specific functional areas of security management:		
34.1. Finance, fraud etc.	Chief Executive	Director of Finance & Corporate Resources
34.2. Estates, premises security etc.	Chief Executive	Director of Finance and Corporate Resources
34.3. ICT	Chief Executive	Director of Digital Services
34.4. Information/data security/records management	Chief Executive	Director of Digital Services
34.5. Violence and aggression	Chief Executive	Director of People and Culture
34.6. Patient Confidentiality	Chief Executive	Caldicott Guardian (Executive Director of Quality and Nursing)
35. Setting of Fees and Charges (Income)		
35.1. Income generation	Chief Executive	Executive Director of Finance & Corporate Resources

3 May include but not be limited to consent orders, defences, and settlement agreements)

4 Where the Trust Seal is required on a Deed, it must be affixed to the document in the presence of the Chair or Vice Chair (or an Independent Member authorised by them in writing where they are unavailable) and the Chief Executive (or an Executive Director nominated by them where they are unavailable)

5 Copies of all leases are to be kept once signed by the Estates Manager for property related leases and by the Board Secretary for all other leases/contracts

Delegated Matter	Responsible Officer/Committee	Delegated To
35.2. Non-patient care income (e.g., research)	Chief Executive	Executive Director of Finance & Corporate Resources
36. Stores and Receipt of Goods		
36.1. Responsibility for systems of control over stores and receipt of goods, issues and returns	Chief Executive	Relevant Director
36.2. Stocktaking arrangements	Executive Director of Finance & Corporate Resources	Deputy Director of Finance and Corporate Resources
36.3. Responsibility for controls of pharmaceutical supplies	Medical Director	Heads of Department as appropriate
37. Workforce and Pay		
37.1. Nomination of officers to enter into staff contracts of employment	Chief Executive	Director of People and Culture
37.2. Develop Workforce policies and strategies for approval by the Board including but not limited to training and industrial relations	Chief Executive	Director of People and Culture
37.3. Renewal of Fixed Term Contract	Chief Executive	Director of People and Culture
37.4. The granting of additional increments to staff upon initial appointment within the parameters of existing agreements	Chief Executive	Director of People and Culture
37.5. Establishments		
(a) Additional staff to the agreed establishment with specifically allocated finance	Chief Executive	Executive Director of Finance & Corporate Resources/ Director of People and Culture
(b) Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	Executive Director of Finance & Corporate Resources/ Director of People and Culture
(c) Self-financing changes to the establishment	Chief Executive	Relevant Director
(d) Self-financing changes to an establishment which involves movement between pay and other types of expenditure	Chief Executive	Executive Director of Finance & Corporate Resources
37.6. Pay	Chief Executive	Director of People and Culture

Delegated Matter	Responsible Officer/Committee	Delegated To
Preparation of proposals for the Trust Board for the setting of remuneration and conditions of service for those staff not covered by Agenda for Change		
37.7. Annual Leave		
(a) Approval of annual leave	Chief Executive	Relevant Directors
(b) Annual leave - approval of carry forward up to maximum of 5 days (and pro rata for part time staff)	Chief Executive	Relevant Directors
(c) Annual leave – approval of carry forward over 5 days (and pro rata for part time staff) (to occur in exceptional circumstances only)	Chief Executive	Director of People and Culture/ Executive Director of Finance & Corporate Resources
37.8. Special Leave To be applied in accordance with Trust Policy. Departure from policy will be as follows:		
(a) Compassionate leave	Chief Executive	Director of People and Culture
(b) Special leave arrangements for domestic/personal/family reasons: • Paternity leave • Carers leave • Adoption leave	Chief Executive	Director of People and Culture
(c) Special leave – this includes: • Jury service • Armed services • School governor To be applied in accordance with Trust Policy	Chief Executive	Director of People and Culture
(d) Leave without pay	Chief Executive	Director of People and Culture
(e) Time off in lieu	Executive Director of People and Culture	Line/Departmental Manager

Delegated Matter	Responsible Officer/Committee	Delegated To
(f) Maternity leave – paid and unpaid	Executive Director of People and Culture	Automatic approval within approved guidance
37.9. Sick Leave		
(a) Extension of sick leave on pay due to: • Delays in process • Exceptional circumstances	Chief Executive	Director of People and Culture
(b) Return to work part-time on full pay to assist recovery	Chief Executive	Heads of Department/Heads of Service in conjunction with WOD Business Partners
37.10. Study Leave	Chief Executive	Director of People and Culture
37.11. Removal expenses, excess rent and house purchases in accordance with Table B	Chief Executive	Director of People and Culture
37.12. Authorised – car users leased car	Chief Executive	Executive Director of Finance & Corporate Resources
37.13. Approval of secondary employment (also subject to a declaration of interest)	Chief Executive	Director of People and Culture
37.14. Putting proposal to Remuneration Committee in respect of Redundancy/ Severance/ VERS/ Settlement Payments within Trust limits and, where necessary, subject to WG approval	Chief Executive	Director of People and Culture/ Executive Director of Finance & Corporate Resources
37.15. Disciplinary procedures (excluding Executive Directors)	Chief Executive	To be applied in accordance with the Trust's disciplinary procedure
37.16. Booking of bank staff		
(a) Nursing	Chief Executive	Executive Director of Quality & Nursing
(b) Clinical (excluding nursing)	Chief Executive	Medical Director/Executive Director of Operations/Director of Paramedicine
(c) Other	Chief Executive	Relevant Director
37.17. Booking of agency and locum staff		
(a) Nursing	Chief Executive	Executive Director of Operations

Delegated Matter	Responsible Officer/Committee	Delegated To
(b) Medical	Chief Executive	Medical Director
(c) Paramedicine and affiliated roles	Chief Executive	Executive Director of Operations
(d) Other	Chief Executive	Relevant Director

Table B – Delegated Financial Limits

NB Thresholds are inclusive of VAT irrespective of recovery arrangements with the exception of procurement thresholds which are provided net of VAT.

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
1. LOSSES										
1.1. Losses of Cash due to:										
(a) Theft, fraud, arson, sabotage, neglect of duty or gross carelessness	50,000	Over 50,000[8]	50,000	10,000						See Annex 1 to Chapter 6 of Welsh Govt Manual for Accounts (WGMFA)
(b) Overpayment of salaries, wages, fees & allowances	50,000	Over 50,000[8]	50,000	10,000						See Annex 1 to Chapter 6 of WGMFA
(c) Other causes, including un-vouched or completely vouched payments, overpayments other than those included under 1b; physical losses of cash and cash equivalents e.g. postage stamps due to fire (other than arson), accident and similar cause	50,000	Over 50,000[8]	50,000	10,000						See Annex 1 to Chapter 6 of WGMFA
1.2. Fruitless Payments, including abandoned capital schemes	250,000	Over 250,000[8]	250,000				100,000	50,000	10,000	A "fruitless payment" is a payment for which liability ought not to have been incurred, or where the demand for the goods and service in question could have been cancelled in time to avoid liability. See further info at annex 1 to Chapter 6 of WGMFA

6 NHS Wales health bodies do not have unlimited powers to make special payments or to write-off losses. They must obtain the written approval of the Welsh Government H&SSG Finance Director before writing-off a loss or making, or undertaking to make, any special payment that exceeds their delegated limit. The limits are listed in this column.
7 These notes are intended to guide the reader. They must be read in conjunction with the SO/SoRD/SFIs and those related to losses and special payments with respect to the Welsh Government Manual of Accounts
8 Does not negate the need for WG Approval which is also required

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
1.3. Bad Debts and Claims Abandoned										See Annex 1 to Chapter 6 of WGMFA
(a) Private patients	50,000	Over 50,000[8]	50,000	10,000						
(b) Overseas visitors	50,000	Over 50,000[8]	50,000	10,000						
(c) Causes other than (a) and (b) above	50,000	Over 50,000[8]	50,000	10,000						
1.4. Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:										
(a) Culpable causes, e.g., theft, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	50,000	Over 50,000[8]	50,000	10,000						
(b) Other causes	50,000	Over 50,000[8]	50,000	10,000						May include losses by fire (other than arson); losses by weather damage or by accident beyond the control of any responsible person; losses due to deterioration. See Annex 1 to Chapter 6 of WGMFA for further info
2. SPECIAL PAYMENTS										
2.1. Compensation payments under legal obligation	N/A	Board to be made aware of payment over 25K	Over 100,000	100,000	25,000	25,000				Payments fall into this category only if a clear liability exists as a result of a Court Order or a legally binding arbitration award. This category can include compensation for injuries to persons, damage to property and unfair dismissal. Payments into court, and out of court settlements, are not payments made under legal obligation.

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
2.2. Extra contractual payments to contractors	50,000	Over 50,000[8]	50,000	10,000						An extra contractual payment is one which, although not legally due under the original contract or subsequent amendments, appears to be an obligation which the Courts may uphold. Such an obligation will usually be attributable to action or inaction by a health body in relation to the contract. See Annex 2 to Chapter 6 of WGMFA for further info
2.3. Ex gratia payment										Ex gratia payments are payments which a health body is not obliged to make or for which there is no statutory cover or legal liability. An example is a payment to compensate for financial loss resulting from an act or failure of the body or its servants which does not give rise to a legal liability or the payment of compensation claims or damages. See Annex 2 to Chapter 6 of WGMFA for further info
(a) To patients and staff for loss of personal effects	50,000	Over 50,000[8]	50,000	10,000	10,000					
(b) For clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payment has been applied	1,000,000	Over 500,000[8]	500,000			100,000		50,000	10,000	Delegations are inclusive of plaintiff's costs. Many clinical negligence and personal injury cases are settled out of Court and are, therefore, classified as ex gratia payments. Provided the relevant guidance has been followed and appropriate legal advice has been obtained, in cases involving negligence the delegated limits are much higher than those which apply to other ex gratia payments

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
(c) For personal injury claims where legal advice obtained and relevant guidance has been applied	1,000,000	Over 500,000[8]	500,000			100,000		50,000	10,000	Delegations are inclusive of plaintiff's costs. Many clinical negligence and personal injury cases are settled out of Court and are, therefore, classified as ex gratia payments. Provided the relevant guidance has been followed and appropriate legal advice has been obtained, in cases involving negligence the delegated limits are much higher than those which apply to other ex gratia payments
(d) Other clinical negligence and personal injury claims including Putting Things Right arrangements	50,000	Over 50,000[8]	50,000			10,000				
(e) Other[9] Except cases for maladministration where there was no financial loss by claimant	50,000	RemCom Over 50,000[8]	50,000		10,000					Other ex-gratia payments include: Voluntary Early Release Scheme payments which must be approved by RemCom regardless of value (SoR 25). Special severance payments when staff leave public service employment should be exceptional. They are usually novel contentious and potentially repercussive and **ALL must be referred to WG for approval, even if they are within delegated limits** which must be approved by RemCom regardless of value (SoR 25) Settlements on termination of employment. Most payments to staff on termination of their employment will be contractual, but ex gratia payments will sometimes arise (for example to settle a claim against the health body for breach

9 ALL special severance payments (novel, contentious and potentially repercussive) of whatever value must be referred to WG for approval, even if they are within delegated limits

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
										of contract). Only payments made in excess of that which is paid under contractual obligation should be recorded as ex-gratia in the losses and special payments register. *These payments may be made by Chief Executive (up to £50K) and Executive Director of Workforce and OD (up to £10K) and reported to the next RemCom. They are also included in the report to AC on losses and special payments.
(f) Maladministration where there was no financial loss by claimant	N/A	Over 50,000	50,000	10,000						In most cases of maladministration there is unlikely to be any legal obligation to pay compensation, and any payment would, as a result, be ex gratia. Such payments may arise: • as a result of a recommendation by the Public Services Ombudsman Wales (PSOW). • in cases, not involving the PSOW, where NHS Wales health bodies consider that the effect of official failure may justify a payment
(g) Patient referrals outside UK and EEA guidelines	N/A	Over 50,000	50,000	10,000						
2.4. Extra statutory and extra regulatory Payments	N/A	Over 50,000	50,000	10,000						These are payments considered to be within the broad intention of a statute or statutory regulation but which go beyond a strict interpretation of its terms. In some cases WG will advise to classify the payments as extra statutory. In all other cases WG must be informed and will advise whether the payments may be treated as extra statutory See Annex 2 of WGMOA for more info.

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
3. REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENT										
3.1. Agency staff and private providers	N/A	Over 500,000	500,000	200,000	200,000	200,000	200,000	50,000 (100,000 for Assistant Director of Operations, Ambulance Care for private providers only)	10,000	Any agency staff, including medical locums. No other managers can authorise use of agency staff.
3.2. Building and engineering works (non-capital)	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	
3.3. Call off orders (annual value)	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	High cost medical consumables, provisions, routine supplies, excluding locums or agency staff
3.4. Capital expenditure (subject to annual programme being approved by Trust Board)	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	The Board to approve cases outside discretionary allowances. Capital programme agreed annually by Board.
3.5. Information Technology	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Major IT systems, software purchase, PC and printer purchase, networking, computer consumables. Includes software or hardware maintenance contracts
3.6. Management consultants (including professional services)	N/A	Over 200,000	200,000	10,000	10,000	10,000	10,000			
3.7. Periodic payments (invoice value)	N/A	Over 500,000	500,000 *750,000 for utilities/ fuel	100,000 *750,000 for utilities/ fuel	100,000	100,000	100,000	50,000	10,000	*In relation to Gas, Electricity, Council tax, Telephone, Water and Fleet Fuel invoices, due to the high level of expenditure on a recurring basis, payments up to a value not exceeding £750,000 can be authorised by the Director of Finance or the Chief

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
										Executive. For the provision of clarity, payments of PIBS (Personal Injury Benefit Scheme) invoices do not require authorisation on the basis that these quarterly payments are a reimbursement of pension payments made that have already been authorised.
3.8. Removal expenses	N/A	N/A			8,000					Allowance of £6,000 per relevant staff member
3.9. Services (including maintenance contracts) over lifetime of contract	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Routine maintenance contracts, clinical services (e.g. MRI), legal services, audit, clinical waste etc.
3.10. All other requisitions	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	
4. QUOTATIONS AND TENDERS										
4.1. Authorisation of tenders and competitive quotations	N/A	Over 500,000	500,000	100,000	100,000	100,000	100,000	50,000	10,000	Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by these staff to the value of the contract. The Chair of the Trust in this instance will have the same limit as that for the CEO. Quotations- a minimum of 3 written quotations for goods/services must be sought where the anticipated value is likely to be above £5,000. Competitive Tenders- a minimum of 3 written competitive tenders for goods/services must be sought where the anticipated value is likely to be above £25,000.

Category	Welsh Govt Delegated Limit - Approval Required[6]	Trust Board	Chief Executive	Exec Director Finance & Corporate Resources	Exec Director Workforce & OD	Exec Director Quality and Nursing	Exec Directors / Directors	Heads of service/ Heads of Dept/ Board Secretary	Budget Holders	Notes[7]
										Tenders for Supplies and Services above the limit set EU Procurement matters for works above set limits must be sought in compliance with EC Directives (Updated Jan 2008) (OJEU Regulations) as appropriate. **All Tenders and Quotations must be sought, registered, and opened via the SSP**. These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes. Exceptions and Instances where formal tendering need not be applied will require authorisation in the form of a request to waive SFIs (pre numbered document from SSP) and authorisation in advance from the Director of Finance or Deputy Director of Finance (or in their absence the Board Secretary)
5. VIREMENT	N/A	Over 100,000	100,000	25,000						Trust must still meet financial targets and the total Trust budget must remain underspent
6. LEASE AGREEMENTS	**	Over 500,000	500,000	100,000 (with Board Secretary)						**See Schedule 1 to SFIs Copies of all leases are to be kept once signed by the Estates Manager for property related leases and by the Board Secretary for all other leases/contracts

Category	Welsh Govt Delegated Limit - Approval Required	Board of Trustees/ Trust Board	Charitable Funds Committee	Bids Panel	Bursary Panel					Notes
7. CHARITABLE FUNDS	N/A	N/A	Over 50,000	50,000	N/A					

Unless otherwise stated, sub-delegations to others are permitted. It is for individual Directors to ensure that a system of sub-delegations are in place for their respective directorates.

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs. Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

SUMMARY EQUALITY IMPACT ASSESSMENT: –

Organisation:	Welsh Ambulance Service NHS Trust

Proposal Sponsored by:	**Name:**	Trish Mills
	Title:	Board Secretary
	Department:	Corporate Governance Team

Policy Title:	Standing Orders Scheme of Reservation & Delegation of Powers Standing Financial Instructions – 2023 Review

Brief Aims and Objectives of Policy:	The Standing Orders, Scheme of Reservation & Delegation of Powers (SoRD) and the Standing Financial Instructions (SFIs), are the Trust's governing documents. They require review every year to ensure that they remain accurate and current. The changes to the documents proposed for approval by the Trust Board in September 2023 are high-level (as a thorough review was undertaken in 2021). The primary changes are: - 1) The Model Standing Orders (issued by the Welsh Government) incorporating the change from Community Health Councils to the Citizen Voice Body (Llais), and they reflect the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020;

	2) The requirement for the Trust to publish Board papers has been changed from ten days prior to the meeting to seven days, and; 3) The Standing Orders now include the role of the Vice-Chair and the additional voting Director, which was introduced in 2022.

Was the decision reached to proceed to full Equality Impact Assessment?	~~Yes~~	**No**
	Please state reason why: Advice from the Head of Inclusion and Engagement was that a full EqIA was not required due to the nature of the documents; they are fundamentally Model Standing Orders and Standing Financial Instructions which the Trust is required to adopt. The changes that have been proposed to the documents for approval by the Trust Board are minimal and are primarily changes prescribed by the Welsh Government.	
If no, are there any issues to be addressed?		
	No	

Is the Policy Lawful?	**Yes**	~~No~~

Will the Policy be adopted?	**Yes**	~~No~~
	If no, please record the reason and any further action required:	

Are monitoring arrangements in place?	**Yes**	**No**
	Please give details: The Trust's governing documents require review annually, and this activity is programmed into the Corporate Governance Directorate's annual programme of work. The Board Secretary is responsible is responsible for ensuring that this review is completed on behalf of the Trust Board.	

Who is the Lead Officer?	**Name:**	Trish Mills
	Title:	Board Secretary
	Department:	Corporate Governance Directorate
Review Date of Policy:	Spring 2024	

Signature of all parties:	**Name**	**Title**	**Signature**
	Trish Mils	Board Secretary	n/a
	Kat Cobley	Head of Inclusion & Engagement	n/a
	Alex Payne	Corporate Governance Manager	n/a

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO BOARD

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

Trust Board Meeting Date	28 September 2023
Committee Meeting Date	10 August 2023
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. With handover delays at 19,118 hours in July they are still far in excess of what is acceptable and so remain in this alert section. These delays, coupled with many patients waiting in excess of four hours outside Emergency Departments, **continue to present patient safety risks and extended waits in the community.** The Committee is aware of the actions being taken by WAST to mitigate harm and of the escalations and actions in the system. Progress against these actions is a focus at each public Trust Board meeting, however, the number of amber immediate release direction refusals, and a high number of concerns raised, and incidents linked to timeliness of response demonstrates the continued need for more pace to address the issue at a system and strategic level. Members will continue to challenge on any further actions that can be put in place by the Trust and its influence on system partner actions and, raise the Trust's ongoing concerns in their respective forums.

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

ADVISE

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

3. The Committee **heard from Beth Hews**, Palliative Care Paramedic about her experience attending a patient with metastatic bowel cancer who had been referred to Specialist Palliative Care Team (SPCT) for pain management. Through the intervention of the SPCT they were able to keep this patient in her own home rather than have her taken to hospital by ambulance, providing a holistic plan which enabled her to die with dignity and in comfort. Current statistics suggest around 85% of patients seen by the SPCT Paramedics remain in their own care setting, thereby avoiding a likely 999 call and hospital admission. The Committee thanked Beth for sharing her story, the rest of the SPCT for their excellent work, and Ed O'Brien, Clinical Lead Palliative and End of Life Care for giving the Committee a broader context on the work of the SPCT. The Committee will keep this area on it radar to watch progress and take the opportunity to promote this area of our practice at a national level.

4. The Committee received the quarterly **Operational Update** as a standing agenda item. The development of the Non-Emergency Patient Transport Service (NEPTS) dashboard was noted, as was its focus on a range of measures including patient experience.

5. The **Infection Prevention and Control (IPC) Annual Report for 2022/23** was presented to the Committee and is attached at Annex 1 for the Board's attention. The report includes the transition from the Covid-19 Pandemic response to business as usual and notes how the Trust supported outbreaks of Monkeypox and invasive Group A Streptococcus. The Committee noted and were assured the Trust is actively driving towards a consistent IPC culture, one in which high standards of patient care and staff safety are maintained. Bethan Evans, IPC Board Champion and Chair of the Committee commended the team and recognised there has been significant and sustained improvement in this area.

6. The **Safeguarding Annual Report for 2022/23** was presented to the Committee and is attached at Annex 2 for the Board's attention. The report provides assurance on safeguarding activities, engagement, and collaborative working with our partner agencies; as well as the necessary assurances that the statutory duties under the relevant safeguarding legislation and guidance are being fulfilled. Safeguarding metrics are reviewed regularly by the Committee via the Monthly Integrated Quality and Performance Report. Paul Hollard, Safeguarding Board Champion, commended the team and the compassionate way they approach their work in what are often very difficult circumstances.

7. An update was provided on the **Health Inspectorate Wales (HIW) Review: Patient Safety, Privacy, Dignity and Experience whilst waiting in ambulances during delayed handover (2021)**. There was an expectation from HIW that the recommendations made would be considered at a system level and an Emergency Ambulance Services Committee (EASC) task and finish group was established to respond to the review. The Trust's particular management actions are reported to that group and HIW have concluded that sufficient assurance has been received in response to the findings identified within the review report for the Trust for the stage one review. A stage two review will be initiated by HIW in the coming weeks.

8. An update was received on progress against recommendations raised from the **HIW Emergency Services Clinical Contact Centre EMSCCC Patient Safety Review**. The principal objective of the 2019/20 review was to assess how patients are managed by EMS Coordination (EMSCCC) encompassing the period from the time the call is received through to an operational response arriving with the patient. A secondary objective was consideration of how staff working in EMSCC are resourced and supported. There are two actions outstanding which the Committee were assured were progressing.

9. The **National Policy on Patient Safety Incident Reporting and Management** was approved.

10. Members' **reflections** on the meeting included:

- The introduction of a review of the agenda and timings with the Chair closer to the meeting. This will enable the Chair to review placement and timing of items;
- Helpfully, areas of greatest focus and where strong assurance was required were placed higher in the agenda which enabled appropriate critique and discussion to confirm assurance, however, more time could be given to some items to enable members to drill down further on performance.
- Good succinct discussion; and
- The desire to reduce the volume of papers, recognising however the Committee has a substantial remit. The Board's risk appetite as to the level of assurance required could be reviewed.

ASSURE

(Detail here any areas of assurance the Committee has received)

11. The Health and Care (Quality and Engagement) (Wales) Act 2020 and hence the **duty of quality and duty of candour** came into force on 1 April 2023. Work is progressing regarding 'Always On' reporting with the development of a scalable digital dashboard specification based on the Quality Standards 2023 reflective of strategic, tactical, and operational quality requirements. A technical specification template is being designed by key stakeholders to ensure compliance and consistent approach to data quality standards for current and future quality measures. A set of Performance and Quality Standards are currently being developed for the duty of candour to to collect data and information consistently at a local and national level and create a dashboard. Progress on the Welsh Government milestones was said to be amber/green with two key outstanding areas being the 'Always-On' reporting and the ability to resource the requirements arising from the duty of candour'. It was recognised that there was a need to continue to 'hold the tone' of the duty of quality and duty of candour and that the new quality leads will play a pinnacle role in this.

12. The Committee receives assurance reporting by way of the **Monthly Integrated Performance Report** (MIQPR) for June/July and the **Q1 Putting Things Right Report**. The organisational learning from clinical reviews were set out in the latter report. The Trust Board will note the escalation in the alert section regarding continued handover delays. The Committee noted:

- Continued achievement of the clinical call back time target for the highest priority 111Wales

calls, while the priority 2 and 3 call back times also achieved the 90% performance target in July.

- The myriad of factors that influence the red 8 minute response were discussed given the slight improvement in terms of system pressure and handover delays not equating to improvement in red response. The primary influencers of demand, capacity and lost capacity remain a focus which the Committee will monitor.
- A new five-day acknowledgement for concerns has been introduced but due to the fragile position the two-day target will be retained internally until compliance is sustained. Improved processes in the EMS Co-ordination and Resourcing Centre have seen a timelier response and there has been some improvement in the 30-day response to concerns, however it remains some off target at 43% for June against a target of 75%. The overwhelming theme through most concerns remains timeliness to responding to calls in the community. Themes are also emerging in respect of Ambulance Care regarding cancellation of transport.
- The Committee raised an alert following their last meeting as to effect of the backlog and volume of concerns on the teams dealing with them. The Executive Management Team will review a proposed organisational change process to support these teams before the next Committee meeting and will update members thereafter.
- A continuing number of incidents are being reviewed at the Serious Case Incident Forum (SCIF) and Joint Investigations passed to Health Boards.
- An increase in the number of road traffic incident and personal injury claims with the latter increasing in complexity and value.
- There is a continued upward trend in Coroner's requests for information. The Trust received two Regulation 28 Reports during this period, both of which relate to delays in responding to patients in the community, including a case were the patient was also significantly delayed outside of the hospital on arrival.
- Changes in the Operations Directorate have started to see a positive impact on outstanding coroner statements.

13. A **deep dive on red rural performance** was presented following a request by the Committee at the last meeting. The Committee noted that performance consistently tracks below pan-Wales performance and below the 65% target. By contrast however, Amber 1 performance is consistently better than more urban areas. Members recognised that whilst red rural performance remains an issue, actions are being taken to address this. The Committee was assured there was focus on this including demand led rosters, rosters that are recruited to and efficient use of that resource (in particular, handover lost hours, but also internal efficiencies like abstractions and mobilisation times). The forthcoming EMS demand and capacity review explicitly includes rurality in its terms of reference. The People and Culture Committee will look at the effect of rurality on abstractions, recruitment and retention.

14. A **focus on clinical indicators** was agreed at the last effectiveness review and the first report was presented at this meeting. The current clinical indicators and ambulance service indicators are the care bundles and individual metrics for STEMI (ST-elevation myocardial infarction), stroke, #NOF (fractured neck of femur) and hypoglycemia, as well as the ROSC (return of spontaneous circulation) at hospital indicator. Clinical indicators in development are call to door time for STEMI and stroke. Others in consideration include older fallers, paediatric trauma/pain management, and advanced paramedic practitioner (condition specific compliance). The Committee was reminded of the journey from paper record to digital pens to the now electronic patient clinical record (ePCR)

and the improvements that has made to the capture of data. Exploration of ways in which artificial intelligence and machine learning can improve compliance are being developed. The Committee noted continued improvement in ROSC rates at 22.2% in June whereas previously they have been in the sub-10%. This is an area which CHARU is targeting in terms of providing better outcomes for the most seriously ill patients.

15. The **Clinical audit plan update** was received with no escalations. Nine actions were open and on track, with one action off target but progressing.

16. The Committee reviewed the position, plans and proposed reporting for **Information Security and Information Governance** which is an area that was expanded in its remit in 2022. The comprehensive report provided an overview of information governance in terms of accountability, assurance and compliance and the Committee agreed a set of metrics. The Committee noted:

    - The annual Welsh Information Governance Toolkit compliance assessment for 2023/23 demonstrates the Trust did not meet the minimum expectations for some areas including policies and procedures. Whilst the information security policy is in the latter stages of review currently, there are other policies and guidance that require updating and development for data protection, freedom of information and environmental information requests. Training and awareness standards are also not meeting minimum expectations. The improvement plan to address these areas will be reviewed by the Information Governance Steering Group and Executive Management Team.
    - An internal audit of records management and requests is underway and will come to the next meeting. A reasonable assurance rated internal audit was received recently on cyber security and reviewed by the Finance and Performance Committee who has cyber security in their remit.
    - There were 172 responses to requests under the Freedom of Information Act in 2022/23 and metrics are being developed to provide trend analysis.

    Metrics were agreed for ongoing reporting and assurance on information governance and information security. Ceri Jackson, Digital Board Champion welcomed the dashboard.

17. An update was received on a revised process for the **Audit tracker** which will be before the Audit Committee for approval on 14 September. The Committee's attention was drawn to historical overdue audits which were the subject on discussion with Internal Audit following this meeting. The Committee also noted the upcoming internal audit reviews within the remit of this committee for the remainder of 2023/24.

18. The limited assurance **Pain Management internal audit** was presented to this meeting following it's discussion at the Audit Committee on 25 July. The Committee reviewed the recommendations and actions, welcoming the tight timeframes within which these would be closed given the limited nature of the audit.

19. The **Committee's priorities for 2023/24** (implementation of the quality strategy, and the duty of quality and duty of candour) are progressing well. The Committee also reviewed its progress against its cycle of business.

RISKS

Risks Discussed: There are two corporate risks assigned to the Committee which are rated as high risks with no changes to scores since the last review. **Risk 223:** the Trust's inability to reach patients in the community causing patient harm and death and **risk 224:** significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service are both rated at 25. The theme of these risks arose throughout the agenda items discussed at this meeting and are part of the escalation section of this report. The Executive Director of Operations and the Executive Director of Quality and Nursing updated the Committee that these risks had been reviewed this week and reiterated the need for the scores to remain at 25. A comparison had been done of risk 223 from the time it was first developed at a score of 20, through its escalation to 25 and at the current time on Health Board data and there was nothing in that analysis to support a reduction in the score for any Health Board area.

New Risks Identified: Challenges and risks in achieving, maintaining and assurance compliance of data protection were drawn out in the Information Governance and Information Security paper.

The papers for this meeting can be found by following this link to the Committee page on our website.

COMMITTEE AGENDA FOR MEETING		
Feedback from Chair on escalations from Committee to Board in March	Operations Directorate Quarterly Report for Q1	Patient (staff) experience
Monthly Integrated Quality Performance Report	Putting Things Right Report Q1	Spotlight on Clinical Indicators
Duty of Quality and Duty of Candour Implementation	Information Governance Report	Risk Management and BAF
Internal Audit Tracker update and Pain Management Internal Audit	HIW report updates: Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover and EMS CCC patient safety review	Annual Infection Prevention and Control Report
Annual Safeguarding Report	Clinical Audit Plan Update	Policy Report and National Policy on Patient Safety and Incident Reporting and Management
Committee priorities update and monitoring report for cycles of business	Groundhog Day 2: An opportunity for cultural change in complaint handling	

COMMITTEE ATTENDANCE				
NAME	**11 MAY 2023**	**10 AUGUST 2023**	**9 NOVEMBER 2023**	**8 FEBRUARY 2024**
Bethan Evans				
Kevin Davies				
Paul Hollard				
Ceri Jackson				
Liam Williams				
Andy Swinburn		Duncan Robertson		
Lee Brooks	Steve Clinton			
Leanne Smith	Jon Hopkins			
Rachel Marsh				

Trish Mills				
Mark Marsden				
Hugh Parry				
Ian James				

	Attended
	Deputy attended
	Apologies received
	No longer member

Welsh Ambulance Services NHS Trust

Safeguarding Annual Report 2022-2023

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

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Introduction

The Welsh Ambulance Services NHS Trust's (WAST) success in safeguarding is driven by an effective organisational culture; one with values and behaviours which foster professional curiosity, encourages scrutiny and supports the actions required to protect those at risk of abuse or in need of care and support.

The safeguarding annual report provides the Trust Board with the necessary assurances that the organisation is compliant with statutory duties under the Social Services and Well-being (Wales) Act 2014, the Violence Against Women Domestic Abuse and Sexual Violence (Wales) Act 2015, the Children Act 2004, and the Wales Safeguarding Procedures.

It provides an overview on how the Trust has performed over this reporting period in relation to safeguarding people in our care. Priority is given within the report to evidence the significant increase in safeguarding activity within the organisation, to celebrate the success and achievements of the dedicated Safeguarding Team as well as sharing the good practice of WAST colleagues; our improved safeguarding systems and processes and how we have learned from our experiences.

The Executive Director of Quality & Nursing is the executive lead for safeguarding within WAST. The Head of Safeguarding has responsibility as Named Professional for Safeguarding Children as well as Adults at Risk. This role ensures the Trust's compliance with Statutory Legislation and Guidance above. The Head of Safeguarding takes the organisational strategic lead on all safeguarding related matters.

The Safeguarding Team works collaboratively with senior managers and colleagues within WAST to promote an unequivocal safeguarding culture, both articulated and lived at each level in the organisation. External partnership working is also integral to the team's role, WAST contribution to the work of our partner agencies will be highlighted in this report.

1. Safeguarding People

Safeguarding People within this report for 2022-2023 relates to the Welsh Ambulance Services NHS Trust's Safeguarding activity.
The Safeguarding Team's priority is to ensure that WAST colleagues provide safe and effective care which protects people at risk of abuse and neglect as well as those in need of care and support. This involves reporting concerns appropriately to the relevant agencies and utilising appropriate pathways which further support victims of domestic abuse and sexual violence following contact with our service.

Reporting Rates

The number of reports submitted by WAST has continually increased since the initial launch of Doc Works in 2019. This reporting period illustrates a 20% increase as shown in Table 1. This data provides a further breakdown of the report types submitted over the last three reporting periods. The figures demonstrate the increase relates mainly to concerns for adults, the Safeguarding Team plan to scrutinise the disparity between adult and child reporting rates.

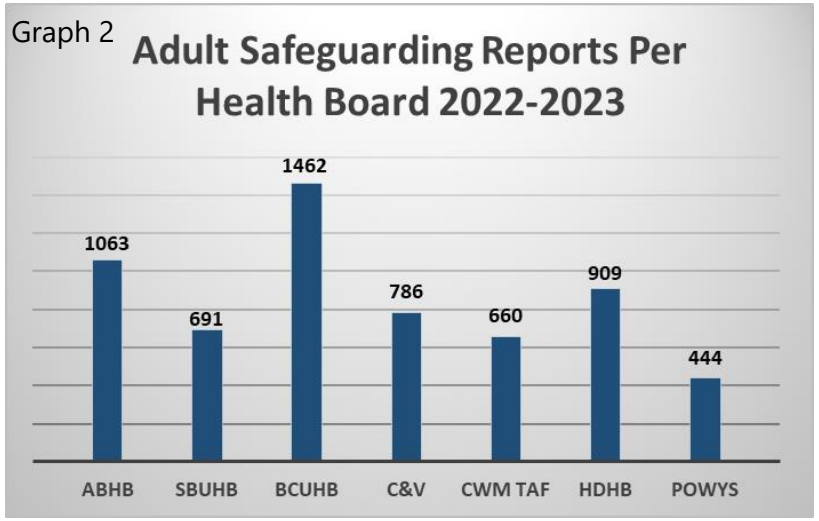
Table 1

Report Type	2020/21	2021/22	2022/23
Child at Risk	1,461	1,303	1,138
Child in Need	754	853	775
Adult at Risk	1,149	1,106	1,419
Adult social care need	3,291	3,785	4,605
Total	**6,655**	**7,047**	**7,937**

The following graphs illustrate the number of reports made per health board:

Graph 1

Graph 2

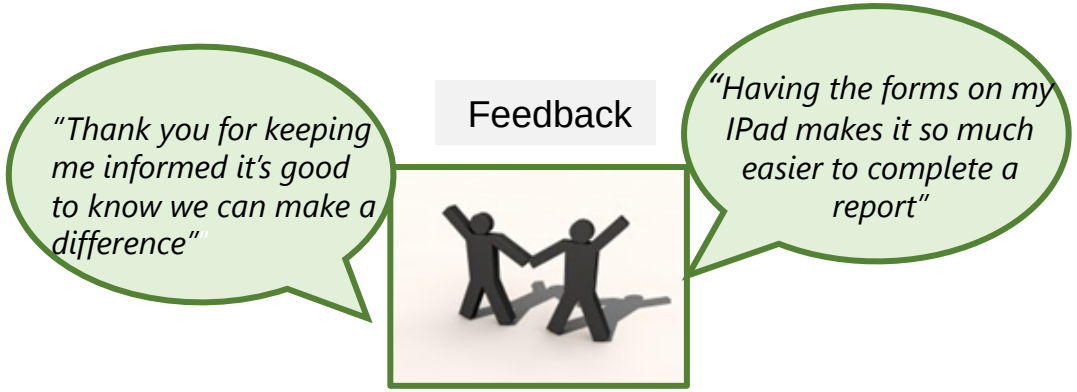


In addition to the reports made to Local Authorities within Wales, WAST colleagues also reported 12 concerns for children and 9 for Adults to the other relevant Authorities in the UK.

WAST Safeguarding Reports

The Safeguarding team has continued to progress WAST colleagues' skills and understanding of the Safeguarding thresholds met, to ensure that the reports made to Social Services are appropriate and in accordance with the required standard. The digital mechanism for submitting WAST safeguarding reports has been promoted throughout the Trust since the initial launch of DocWorks in 2019. This initiative has received recognition both internally and externally in the wider safeguarding arena.

To celebrate NHS Wales Safeguarding Network's 10th Anniversary, the National team hosted the *"NHS Wales Safeguarding Together: Then, Now, Next Conference"* in March 2023. Safeguarding teams across the Principality were asked to submit an abstract for a poster presentation that were exhibited on the day. WAST Safeguarding Team is pleased to report that our application was successful and our poster presentation *"Revolutionising safeguarding reporting"* will promote the innovative safeguarding work taking place within our organisation.



The Safeguarding team also received a commendation at the Cardiff and Vale Safeguarding Board's annual awards ceremony for the development of the DocWorks reporting process in November 2022.

WAST Pathway to Protect Victims and Survivors of Domestic Abuse

The Social Services and Wellbeing (Wales) Act 2014, the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, along with key guidance within 10,000 Safer Lives – Domestic Abuse Project and NICE (2014); recommended an improved multi-agency service delivery with integrated care pathways for identifying, referring and providing interventions to support people who experience forms of domestic abuse and sexual violence. WAST Safeguarding team initiated an appropriate pathway for facilitating contact with the specialist services of the Live Fear Free helpline with support from both the helpline manager and the projects and innovations manager from Welsh Womens Aid. The pathway has now been digitalised for WAST iPad users and provides an additional mechanism for front line colleagues to support victims and survivors who may have suffered from these issues.

Live Fear Free Helpline

Live Fear Free Helpline
Llinell Gymorth Byw Heb Ofn
0808 80 10 800

"In my capacity as the Live Fear Free Helpline Manager, I liaise closely with the Safeguarding Team in partnership to offer support to victims of domestic abuse and sexual violence.

I have found WAST to be passionate about making a difference to the lives of vulnerable people such as those who experience domestic and sexual abuse. The Safeguarding Team has worked tirelessly to ensure that the pathway is as robust as possible and that the patient's welfare is at the heart of the process.

I can truly say that it has been a pleasure, the Teams positivity and optimism are infectious and have made developing our partnership an extremely enjoyable experience. The pathway has been set up and developed to be a successful project that supports survivors of abuse at the earliest possible stage.

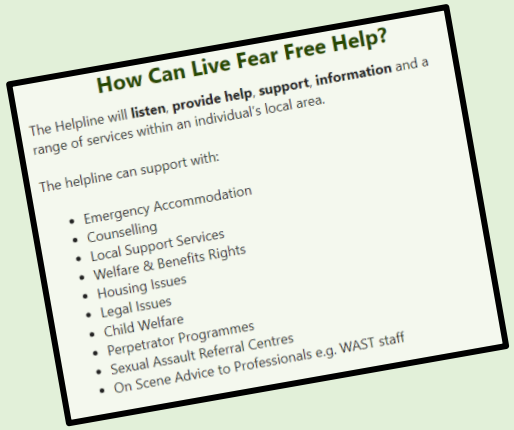
Because of the excellent and ongoing success of the pathway, we are looking to further develop additional resources. In summing up, the Safeguarding Team has been a lynchpin in ensuring the success of a most valuable partnership. It is thanks to their determination and 'can do' attitude, that we have been able to make the pathway so successful and, ultimately, offer support, safety and vital information to some of the most vulnerable people in Wales".

Ann Williams, Live Fear Free Helpline Manager

Live Fear Free Pathway

- Free 24/7 helpline for anyone in Wales who is experiencing Domestic Abuse or Sexual Violence.
- WAST have a bespoke pathway in place.
- **18/11/2021 – 31/03/2022 = 8**
- **01/04/2022 – 31/03/2023 = 41**
- These figures cannot capture the contacts where WAST colleagues provide service users with the helpline number.
- Helpline is available to all WAST colleagues and volunteers for specialist advice and support.
- Colleagues are reminded that an adult or child at Risk report may also be required.

41 digital reports to **Live Fear Free** this year



How Can Live Fear Free Help?

The Helpline will **listen**, **provide help**, **support**, **information** and a range of services within an individual's local area.

The helpline can support with:

- Emergency Accommodation
- Counselling
- Local Support Services
- Welfare & Benefits Rights
- Housing Issues
- Legal Issues
- Child Welfare
- Perpetrator Programmes
- Sexual Assault Referral Centres
- On Scene Advice to Professionals e.g. WAST staff

Who Do Live Fear Free Support?

Individuals who:

- Need to talk about current or past experiences of **abuse**
- Feel **frightened** and/or **controlled** by a partner or ex-partner
- Are being **stalked** or **harassed** and doesn't know what to do
- Feel **unsafe**, **pressurised** or frightened
- Have been, or is feeling at risk of being **forced into a marriage** against their will
- **Need to leave** an abusive relationship and needs access to safe, **emergency accommodation** anywhere across Wales
- Are thinking of **leaving the sex industry** and needs help and support
- Are being accused by a family or the wider community of bringing '**shame**' or '**dishonour**' on individuals, the family or wider community
- Have been given money, drugs, gifts or somewhere to stay and are then **pressured into having sex** or doing things they don't want to do
- Feel **isolated**, **frightened** and **would like to talk** about their concerns and explore what options are available

Fire Risk Pathway

Gwasanaeth Tân ac Achub Canolbarth a Gorllewin Cymru
Mid and West Wales Fire and Rescue Service

Gwasanaeth Tân ac Achub De Cymru
South Wales Fire and Rescue Service

Gwasanaeth Tân ac Achub Fire and Rescue Service

150 Fire Risk Referrals
Shared with our Fire & Rescue Services Partners (FRS)

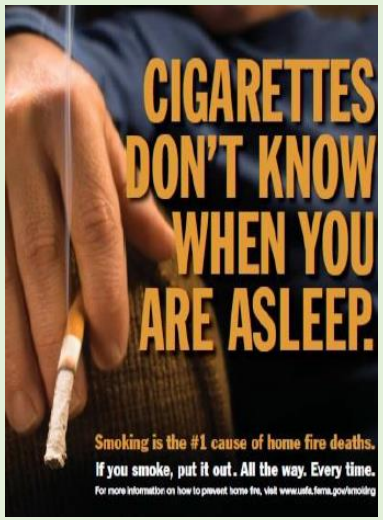


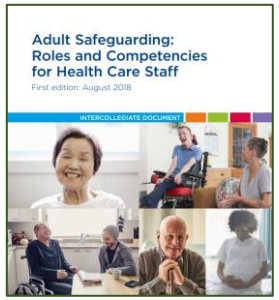
Table 2

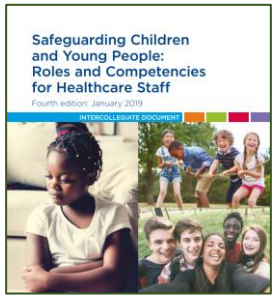
	North Wales FRS	Mid & West Wales FRS	South Wales FRS	Total
18/11/21 – 31/03/22	15	12	11	**38**
01/04/22 – 31/03/23	33	29	93	**155**

- Significant increase in the submission of fire risk referrals this year, evidenced in Table 2
- The referral process allows WAST colleagues request that the local FRS get in contact to **offer support** or conduct a **home safety check**
- Colleagues complete a referral on Docworks and it is e-mailed directly to the relevant FRS
- Streamlined and time-efficient collaborative referral process to protect some of the most vulnerable of our communities in Wales

2. Education and Training

The Trust's annual training plan continues to support statutory safeguarding requirements. Working in partnership with our dedicated training teams across WAST to establish a robust training program for all aspects of safeguarding.





Level 2 Safeguarding Training

The Safeguarding Team continue to provide face to face or virtual sessions to all CCC, ACA, EMS and NHS111 colleagues across the Trust. We delivered 54 induction sessions in the last reporting year providing assurances to the Trust that staff are trained commensurate to their roles as designated within the Inter Collegiate Documents for Adults and Children.

Level 2 compliance

WAST has achieved 86% compliance for child safeguarding and 92% for adult safeguarding training during this reporting period.

NHS111 CPD

The Team also developed their first recorded session which was accessed by over 280 Clinicians, Call Takers, Dental Nurses and Health Information Advisers.

The video explored emerging safeguarding themes such as Contextual Safeguarding and embedded learning from Adult and Child Practice Reviews such as **Professional Curiosity** and **Disguised Compliance.**

Quotes from staff on themes they took from the session

MIST Training

During this reporting period the team also worked collaboratively with the National Ambulance Training College (NATC), integrating safeguarding concerns into clinical scenarios as part of the Mandatory In Service Training. This provided an opportunity to deliver safeguarding in a particularly meaningful and realistic format. We were able to further embed learning from APR's, CPR's and DHR's. The Live Fear Free and Fire Service Pathways were also promoted during these sessions.

The sessions were well received and recommendations were made for this to continue in future MIST training.

"This is a good idea, every scenario could have this incorporated, it is easier to remember than reading in a textbook".

"This was an excellent addition- safeguarding discussions have carried on throughout the day"

In addition, 466 WAST staff have accessed the MCA training via WAST Learning Zone

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

This section of the Safeguarding Annual report outlines the VAWDASV National Training Framework Training Plan for the Welsh Ambulance Service NHS Trust (WAST). Under Section 15 of the VAWDASV (Wales) Act 2015, WAST "*is required to incorporate training for Groups 1, 2, 3 and 6 into their existing learning and development framework and submit to the Welsh Ministers their own training plan, training needs analysis and annual plan based on this*".
The Plan for WAST will be reviewed and updated in April 2023 and subsequently be included in an Annual NTF Report to Welsh Government in May 2023.

Llywodraeth Cymru
Welsh Government

Group 1 of the National Training Framework (NTF)

Table 3 illustrates the number of colleagues who have completed Group 1 training has been determined by the WAST Online Learning Management and training department records which are recorded on WAST electronic staff records (Target 100% compliance).

Table 3

Total per Group	Total completed	% compliance
4,383	3,719	85%

Group 2 of the National Training Framework (NTF)

Group 2 training under the NTF focusses on "Ask and Act"- a principles based approach of targeted enquiry.

The objective of this is to enable practitioners to "Ask" potential victims and survivors when concerns relating to VAWDASV are identified; and "Act" so that suffering and harm is prevented or reduced.

Learner Feedback

3. Partnership Working

The Safeguarding Team sits within the Quality, Safety and Patient Experience Directorate to carry out a necessary corporate function as well as supporting the specific work of the Directorate. Our commitment to delivering high quality care in safeguarding has been clearly demonstrated by achievements highlighted in previous reporting periods. Effective, compassionate leadership, courageous management and innovation have been integral to our success.

The Safeguarding Team achieve our safeguarding objectives by effectively working together with a wide range of services and professionals, ensuring good outcomes for people who have contact with our service.

This requires the Safeguarding Team to establish strong relationships with all departments in our organisation as well as within the wider safeguarding arena across Wales.

Our achievements obtained through improved knowledge, skills and attitudes as well as the promotion of our engagement with safeguarding multiagency activity has fortified our working relationships both at an operational and strategic level.

The Wider Safeguarding Arena

National Ambulance Safeguarding Advisory Group (NASAG)

The purpose of this group is to promote a consistent approach to safeguarding across the UK ambulance services. To connect, support and guide the safeguarding practice of its practitioners across the UK.
The Head of Safeguarding for WAST was Vice Chair of this group during this reporting period.
WAST Safeguarding Team contribute to the work of the group and participate in an annual benchmarking exercise to assess and analyse safeguarding activity as well as to identify areas of improvement.

Social Care Wales

In June 2022 Social Care Wales launched the **National Safeguarding Training Standards Consultation**.

The aim of the standard is to provide a framework for organisations to provide training which is commensurate with their role and responsibilities .
A Senior Professional from the Safeguarding Team was part of the task and finish group for this consultation.
The task and finish group ensured that the standards aligned with the Intercollegiate Document 2018.

Public Health Wales Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

The aim of the PRUDiC process is to ensure that the response is safe, consistent, sensitive and supportive to all concerned. It promotes uniformity across Wales in the multi-agency response to unexpected child deaths.

WAST plays a significant role in the PRUDiC process from the initial alert to Police through to attendance at the phase 1 multi-agency meeting.

The Safeguarding Team contributed to the review of this procedure in February 2023.

Welsh Government Single Unified Safeguarding Review (SUSR)

Following the findings from a thematic review of adult and domestic homicide reviews conducted in Wales in 2018. Welsh Government initiated work relating to the SUSR consultation.

The aim was to establish a more efficient review process to improve the governance arrangements of reviews and share learning across Wales via a safeguarding repository.

WAST Safeguarding Team took an active role in the work of the task and finish groups across Wales.

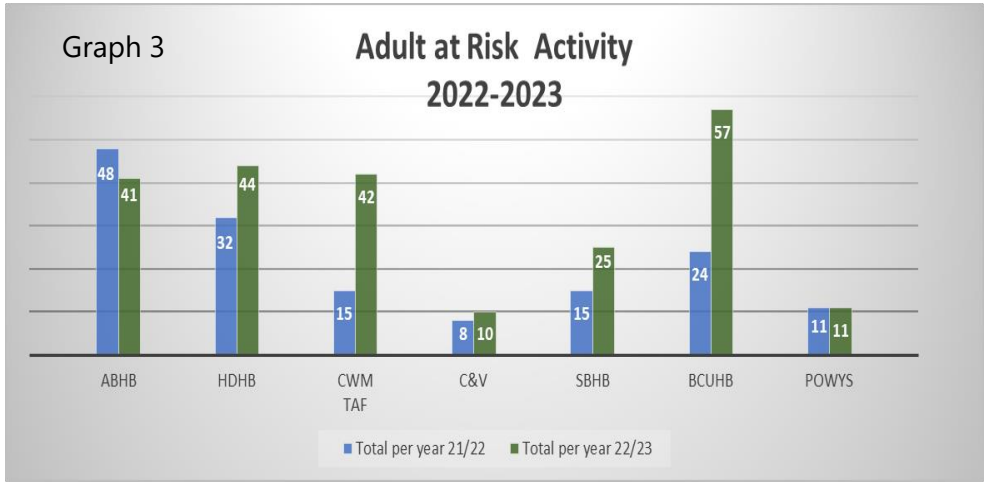
Protecting Adults at Risk

Following a report, social services have a duty to make enquiries under s126 of the Social Services and Wellbeing (Wales) Act 2014. As a recognised "relevant partner" of the Local Authority WAST has a legislative responsibility to participate in any enquiries or strategy meetings/discussions that may be undertaken.

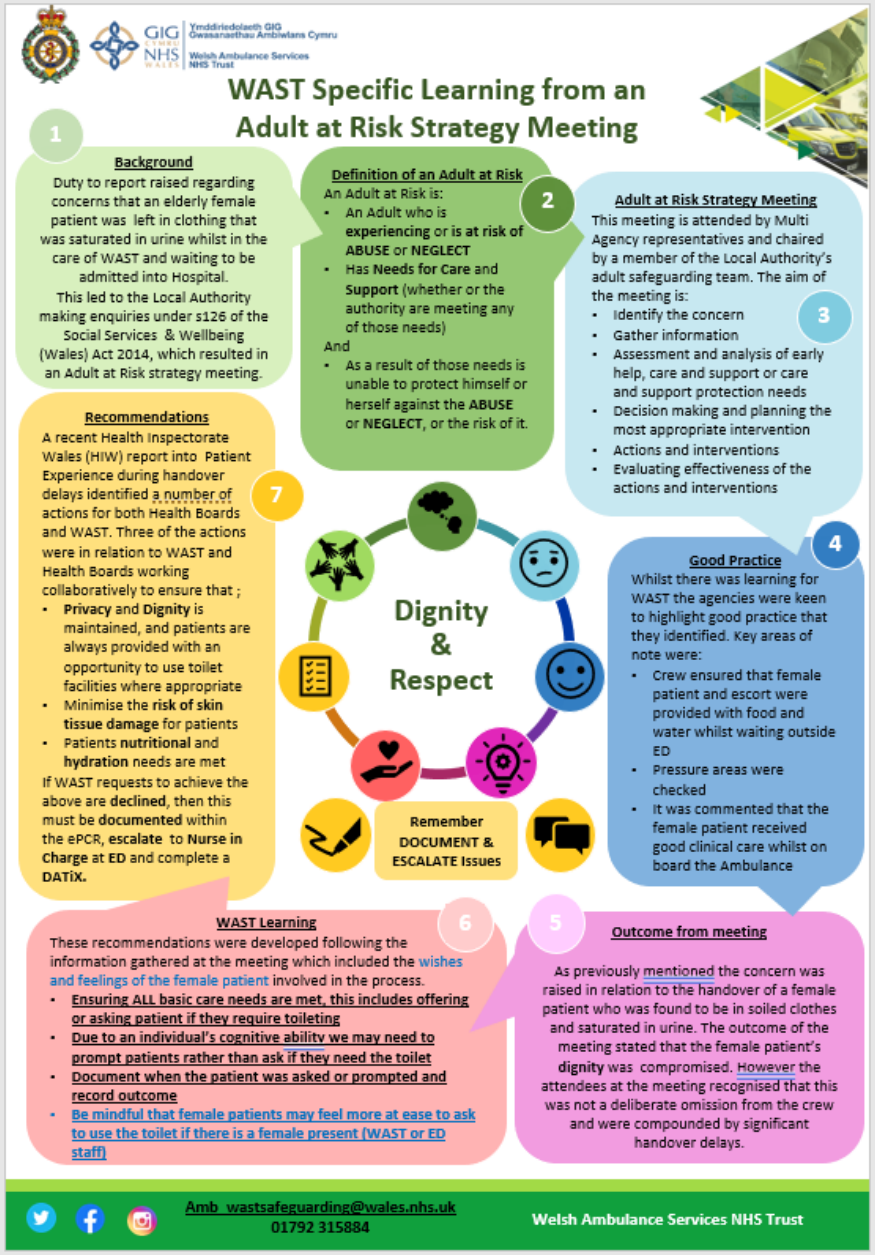
The aim of the process is to focus on the needs of the vulnerable person and allow agencies to appropriately share information, identify risks and take specific action.

The Safeguarding Team may need to access a variety of WAST systems and work collectively with many directorates within WAST to gather the appropriate information to support the process.

This activity has increased during this reporting period, demonstrated in Graph 3.



The 7-minute briefing relates to specific learning for WAST as a result of s126 Adult at Risk enquiries in one area of Wales. Whilst the concerns were raised in one Local Authority area, the Team used the opportunity to share the learning internally and externally (to Health Board colleagues) pan-Wales.



Regional Safeguarding Board's Activity

The amount of activity generated by our duty to cooperate with Adult/Child Practice Reviews and Domestic Homicide Reviews has continued to progress during this reporting period. The Head of Safeguarding and Senior Professionals have ensured strategic engagement at the board level, whilst panel membership on reviews has regained momentum as anticipated following the impact of the Covid-19 pandemic.

The following tables demonstrates WAST's engagement with APR, CPR, and DHR processes:

Adult Practice Reviews		
2020/2021	2021/2022	2022/2023
2	3	4

Table 4

Child Practice Reviews		
2020/2021	2021/2022	2022/2023
3	5	5

Table 5

Domestic Homicide Reviews		
2020/2021	2021/2022	2022/2023
0	4	6

Table 6

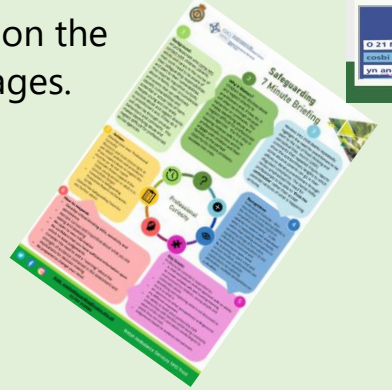
Learning from Reviews

Learning Events are an integral part of the review process as the information gathered from attending practitioners within this forum will often identify key learning themes and help shape the published report and action plan. The Safeguarding Team has continued to support WAST staff required to attend these events during 2022-23.

"I really appreciated the support provided by the safeguarding team during the review process. I have gained valuable insight into the events leading up to time we attended the call"

The Safeguarding Team also has responsibility for sharing the learning generated from the review process across the organisation.

This is achieved through a variety of different methods such as 7-minute briefings, Newsletters, or inclusion of relevant themes into training packages and on the safeguarding SharePoint pages.



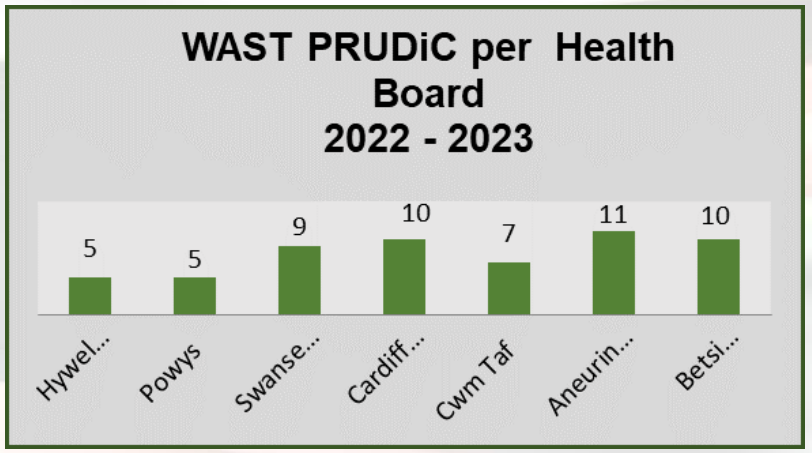
Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

The aim of the PRUDiC is to ensure that the response is safe, consistent and sensitive to those concerned, and that there is uniformity across Wales in the multi-agency response to unexpected child deaths.

During this reporting period WAST has contributed to **57** information and planning meetings held under the PRUDiC process.

The graphs and chart below highlight WAST data relating to unexpected child deaths during 2022-2023. This includes the numbers of PRUDiC incidents per WAST Health Board, monthly occurrence and also age range.

Graph 4



Graph 5

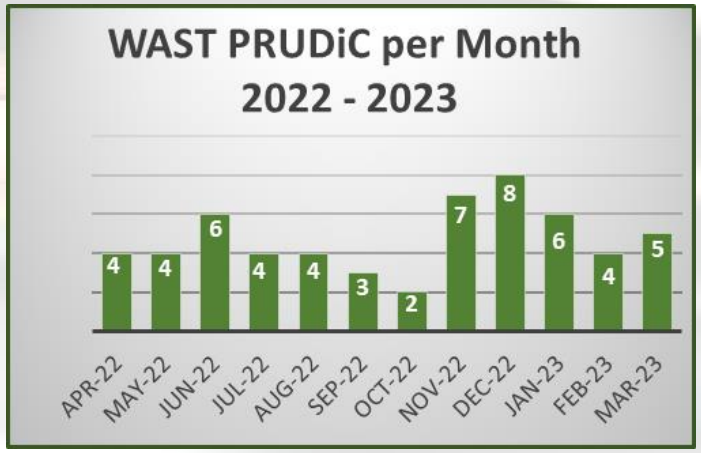
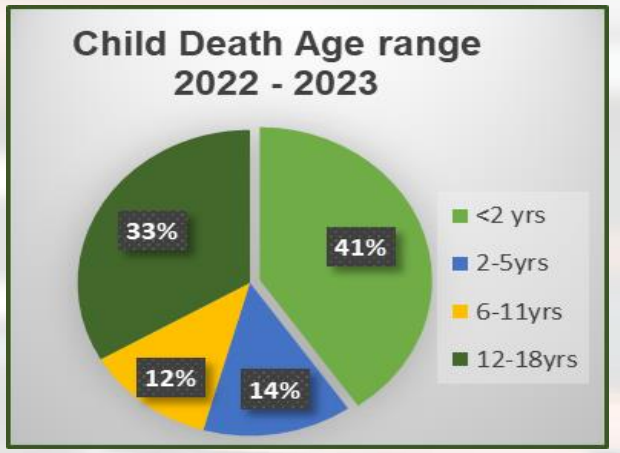


Chart 1



The highest percentage age range was for the under 2 years of age **(41%)** this includes babies found unresponsive and 12-18yrs **(33%)** which included death by suicide. These age ranges for such tragic events are consistent with previous annual figures.

The highest number of child deaths were seen during the winter months. It is worthy to note that cases of Streptococcus A related mortality figures increased during the winter months nationally. This was likely to be as a result of children being more isolated during the pandemic and resuming social interactions. This also impacted on NHS111 Wales service who reported one of the busiest weekends ever with huge numbers of calls from worried parents and carers (PHW, 2023).

Themes and trends are collated by the Public Health Wales child death review panel who provide annual reports from a national perspective. Data collated is then used to promote good practices which reduce harm. As a team we have also identified themes of unsafe sleep practices that may have contributed to a child's death. Learning resources are being considered to support staff across the organisation.

WAST Additional Partnership Working

The CMET group work in partnership to formulate a multi-agency, multi-disciplinary response to issues where there are contextual safeguarding concerns of exploitation, serious youth violence and other forms of extra familial harm to children.

WAST Safeguarding Team contribute to the work of various regions across Wales by participating in the development and delivery of safeguarding training to external partner agencies.

Child Protection Plans
Specific information is shared relating to the safeguarding arrangements in place for families with children who may have contact with our service. **12** child protection plans were placed on our alert system in 22/23.

Protecting the unborn - Specific information is shared and a pre-warning given to practitioners the aim of which is to give responding crews prior information on the existence of an agreed plan of care or safeguarding requirement. **65** midwifery alerts actioned by WAST in 22/23

Thematic Reviews – WAST Safeguarding Team engage with the thematic reviews instigated by the PHW child death review panel. The information obtained from each review is then utilised to formulate National health or safety campaigns to help protect the public.

Annual Partnership Reports – WAST Safeguarding Team contribute to the Partnership Reports to all Boards across Wales as requested. This ensures wider understanding of the safeguarding activity and experiences of our organisation.

Childline offers a unique service to help young people in the UK**.** WAST Safeguarding Team works with Childline when we have provided care for a child who has contacted them.

Partnership Working in Practice

GOOD NEWS STORY

WAST Safeguarding Team were invited to a section 126 strategy discussion for an adult at risk. This adult was bed bound living at home being cared for by family members and there were neglect concerns. These concerns included poor personal hygiene, family smoking in enclosed environment with burns to the bedding, inappropriate manual handling and not acting on medical advice.

The result of the discussions were the application to the courts to remove this adult at risk from the property.

Removal arrangements were a multi-organisational task with Police, Social Services and WAST NEPTS in attendance.

This adult was successfully removed from the property and taken to a care home where within hours they were cleaned, sat up in bed eating fish and chips for the first time in years.

Diolch yn Fawr

This story demonstrates the value of identification, reporting and the sharing of information with Local Authorities that is seen, heard and experienced during our contacts with services users to ensure the protection of vulnerable adults and children and promote positive outcomes.

"The crew were commended on their professionalism, the way they made the lady feel at ease during what could have been a traumatic conveyance for she had not left the house in years and they treated her in a very respectful and dignified way".

Local Authority, Central and West Region

Thank you to all WAST colleagues involved in safeguarding this adult at risk.

4. Quality Improvement

The Safeguarding team's approach to quality and quality improvement for this reporting period has been to focus on achieving the requirements set within the Safeguarding work plan 2022/23. This aims to achieve our targets within the WAST Quality Strategy (2021-24) and prioritises our contribution in delivering the Integrated Medium Term Plan; as well as to identify any actual or potential risks to deliverables during this reporting period and beyond.

WAST is required to report on the Safeguarding position of the organisation both internally and externally. The Safeguarding work plan provides the focus for improving quality as part of the organisation's internal strategy but also incorporates the requirements included in standards and outcomes set by external reporting mechanisms. The Safeguarding work plan & assurance framework is mapped to the Health & Care Standards (2015) specifically standard 2.7; safeguarding children and adults at risk. Safeguarding sits within the Quality Theme: Safe Care and Prudent Healthcare. The outcome of which is to ensure *our service users are protected from harm and protect themselves from harm.*

The principles of Prudent Healthcare are considered throughout, recognising continued progress is always required to integrate the principles into our safeguarding operational framework.

The following table illustrates the priority areas for achieving this by focussing on the key deliverables specified within the Safeguarding work plan for 2022/23. *(Ref kd19 IMTP 4 CR 1-6)*

Safe Care and Prudent Healthcare			
Safeguarding Reporting Process	**Training and Education**	**Policy and Procedure**	**National Collaboration**

Progress 2022/23

Safeguarding Reporting Process
- DocWorks and TerraPace ePCR interface implemented.

Training
- Safeguarding Training level 2 delivered as required. (86% for Level 2 Safeguarding Children and 92% for Adult Safeguarding training).
- Recorded sessions created and launched for NHS 111 CPD
- MIST sessions launched and well received

Policies and Procedures
- Required review and updates ongoing

National Collaboration
- Significant increase during this reporting period.

“Putting things right” and improving the quality of service we provide

The Safeguarding Team within WAST is fully committed to supporting the Trust’s legislative responsibility regarding Duty of Candour. Therefore, we fully embrace “Putting Things Right” as a process for highlighting, investigating and learning from concerns.

A close and collaborative working relationship exists between the Safeguarding and Patient Safety Teams. This ensures an effective interface in the considerations of concerns, adverse incidents and the safeguarding issues highlighted within them. Our working together ensures that any incidents that involve adult or child safeguarding issues are responded to correctly.

The aim is to provide a supportive framework for people to highlight issues. Support is offered by the Team for all staff involved to learn from adverse incidents raised within WAST that have an element of safeguarding attached to them.

Safeguarding regularly attend the WAST Serious Case Incident Forum (SCIF). This ensures all aspects are addressed internally and externally with our partner agencies.

Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix (SMM) is a self- assessment tool developed and managed by the National Safeguarding Service for Public Health Wales. It addresses the interdependent strands regarding Safeguarding, service quality improvement, compliance against agreed standards as well as learning from incidents and reviews.

The focus of the SMM is then for each Organisation to develop improvement plans which support a consistent approach to Safeguarding across Wales. Members from WAST Safeguarding team participate in the peer review process with 9 other NHS organisations. Utilising a facilitated approach Organisations were able to consider and discuss individual self-assessment improvement plans in a collaborative and transparent system of learning.

WAST improvement plan forms part of the Safeguarding priorities set for 2022-2023 and beyond.

Ongoing DocWorks Projects

Dementia Concern Referral

A new bespoke referral pathway to Dementia Connect (part of Alzheimer's Society) for any dementia related concern (confusion, memory loss or issues with communication or daily routine). Carers who may need additional support can also be referred.

Live Fear Free Referrals

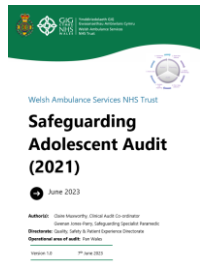
Following the success of the digital referral pathway for colleagues who use iPads, the pathway will soon be fully digitalised.
Colleagues in NHS 111 Wales and CSD will soon be able to complete digital referrals to Live Fear Free.

PREVENT

Digitalising the 'All Wales PREVENT Partners Referral' form to enable WAST colleagues to share information where they have radicalisation concerns.

Safeguarding Adolescent Audit

- Missed opportunities to safeguard identified during a Domestic Homicide Review and while completing searches for a Local Authority
- 11–17-year-olds who self-harm, overdose, have suicidal thought or die by suicide
- Looked at all 111 and 999 incidents which met criteria between 1st October 2020 and 31st December 2020
- 386 total incidences audited and 109 excluded as they did not match the inclusion criteria
- It was checked whether a safeguarding report was submitted for all 277 incidents which met inclusion criteria
- Audit Report will be finalised, any learning will be shared during 2023/2024


Welsh Ambulance Services NHS Trust
Safeguarding Adolescent Audit (2021)
June 2023

5. Support, Advice and Guidance

The Safeguarding Team within WAST appreciates that working to ensure good outcomes for children and adults at risk, and also victims of domestic abuse/sexual violence can be demanding and distressing work.

Supporting colleagues requires a collaborative approach which facilitates the promotion of good standards and ensures confident and competent practitioners who are able to make sound professional judgements.

Feedback

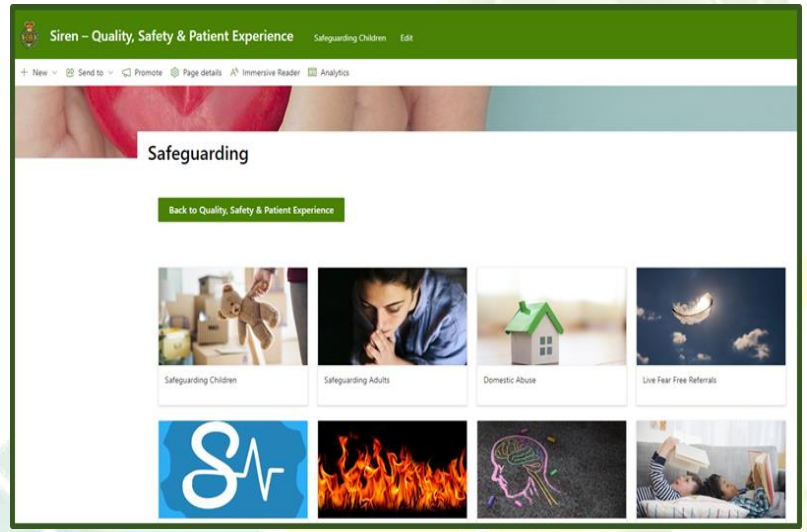
Local Authority

Obtaining feedback from social services in relation to safeguarding reports has been improved since the digitalised DocWorks process. The feedback received facilitates WAST practitioners learning to improve future practice.

"Following your report for this gentleman. He has consented to support and all referrals have been completed. Many thanks for highlighting his circumstances, the case will now be closed to Adult Safeguarding"

What do we offer

- Safeguarding Advice
- Bespoke 1:1 training
- Safeguarding/Restorative Supervision
- Shadowing Experience
- Central Resources
- 7 minute briefings



Safeguarding SharePoint Page

Modernised & Updated

Building the Team

"I worked as a Paramedic within the Welsh Ambulance Service NHS Trust for 5 years prior to joining the Safeguarding Team.

The transition from a face to face clinical role to a non-clinical role within the team took a little time for me to adjust. I've settled in more now and have found that my previous experience; understanding of the demands faced by crews for both clinical and safeguarding situations, has proved invaluable.

My new team has been very supportive and given me plenty of opportunities to shadow experienced members whilst developing my safeguarding knowledge, skills and understanding of the specialists' role.

I am aligned with the WAST safeguarding activity in the SE Region and will often work from various ambulance stations in that area. This gives me a great opportunity to engage with colleagues and support with any safeguarding queries, DocWorks issues or MIST sessions"

Charlotte Wilcockson
Safeguarding Specialist

Safeguarding Resources

Building the Team

"My background is in Paediatric Nursing within the acute and community setting as well as working on the Clinical Support Desk within WAST in more recent years.

I joined the Safeguarding Team in 2020. Since becoming a safeguarding specialist, I have experienced continued support and guidance from the team.

This has provided me with the opportunity to improve my IT skills and drive forward the development of safeguarding resources".

This work has included:

- Revamping the child safeguarding SharePoint page
- Creation of 7 minute briefings on Contextual Safeguarding, Cannabis & Parenting and Professional Curiosity.
- Modernising the VAWDASV Group 2

Jane Rees
Safeguarding Specialist

Conclusion

In conclusion the Safeguarding Annual report reflects the significant contribution which the Trust, Safeguarding Team and WAST colleagues have made in ensuring people are safeguarded from harm. There is much to celebrate in the achievements highlighted throughout the report.

The Safeguarding Team's collaborative partnership working continues to be significant. This contributes to the assurance that the Trust is fulfilling all of its safeguarding responsibilities. Our achievements obtained through improved knowledge, skills, attitudes and systems have promoted WAST's ability to utilise professional curiosity and act on the safeguarding concerns identified. The team's proactive engagement with safeguarding multiagency activity has strengthened our working relationships and reputation; both internally and externally with our partner agencies.

Safeguarding within WAST is dedicated to providing continual advice, guidance and support to colleagues at all levels. This is reflected in our daily activity; providing 'on scene' and retrospective safeguarding advice. In view of this important element of the team's role within WAST, work has commenced to capture this engagement data for 2023/24. Positive feedback has been received on the provision of safeguarding supervision, additional support sessions held for operational practitioners and the opportunity for shadowing experience to learn from a dedicated specialist team.

The work streams commenced during this reporting period provide focus for the team to continue to progress in 2023-24.

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Moving Forward 2023/2024

Building on the Safeguarding Team achievements during 2022-23 the following priorities have been identified for future progress.

- **To continue to progress DocWorks capabilities**
- **To continue to promote WAST Safeguarding National Collaboration**
- **To continue to update safeguarding training and methods of delivery**
- **To ensure the resilience and required resources for the WAST Safeguarding Team**

Infection Prevention and Control
Final Internal Audit Report

January 2023

Welsh Ambulance Services NHS Trust

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

Review reference:	WAST-2223-03
Report status:	Final
Fieldwork commencement:	7th September 2022
Fieldwork completion:	25th October 2022
Draft report issued:	2nd November 2022 & 5th December 2022
Debrief meeting:	4th November & 10th November 2022
Management response received:	4th January 2023
Final report issued:	5th January 2023
Auditors:	Osian Lloyd, Head of Internal Audit Jonathan Jones, Audit Manager
Executive sign-off:	Liam Williams, Executive Director of Quality & Nursing
Distribution:	Jonathan Turnbull-Ross, Assistant Director of Quality Governance, Louise Colson, Head of Infection Prevention and Control
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

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

Executive Summary

Purpose

To assess adherence to organisational policies and the Standards for Health Services in Wales and consider progress to implement recommendations raised in the 2019/20 'limited' assurance Cleaning Standards report.

Overview

We have issued reasonable assurance on this area. The matters which require management attention include:

- IPC audits are not yet underway with audit tools yet to be finalised.
- Continued issues in operation and membership of the IPC Strategic group.
- Clarity required for ongoing performance monitoring and reporting arrangements.
- Arrangements for formal monitoring of the IPC Action Plan are unclear.
- Inconsistencies identified in roles and responsibilities within draft policies and procedures.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 Cleaning Standards 2019/20

Assurance summary[1]

Assurance objectives		Assurance
1	Policies and procedures	Reasonable
2	Trust structure and responsibilities	Reasonable
3	IPC Programme	Limited
4	Guidance and training	Reasonable
5	Mechanisms for assurance	Limited
6	Performance and oversight	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	IPC Policies and related procedures	1	Design	Medium
2	IPC Strategic Group operation	2	Operation	Medium
3	Roles and responsibilities	1, 2	Design	Medium
4	IPC Work Plan content, monitoring and approval	3	Operation	Medium
5	'Onclick' Resources	4	Operation	Low
6	Trust IPC assurance mechanisms	5	Design	High
7	Performance reporting	4, 6	Operation	Medium

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

1. Introduction

1.1 The Welsh Ambulance Services NHS Trust ('the Trust') is committed to a zero tolerance of preventable healthcare associated infections (HCAI's). The Trust aims to work in partnership with all staff, service users and key stakeholders, to reduce the risk of transfer of community acquired infections in the pre-hospital care environment to secondary care and wider community environments.

1.2 The Infection Prevention and Control Annual Report 2021 – 2022, presented to the Trust's Quality, Patient Experience and Safety (QUEST) Committee in August 2022, outlined that the Infection Prevention and Control (IPC) team has necessarily had a COVID-19 focus in the past two years. The report outlined that the team was now looking to return to a business-as-usual approach, whilst retaining the improvements and IPC related behaviours gained through experience of the pandemic.

1.3 The Annual Report also provided a summary of IPC team priorities to be taken forward in 2022/23, including review of the Trust IPC Policy and a number of standard operating procedures, guidance and standards documents, alongside recommencing IPC audits which were suspended during the pandemic.

1.4 This review will also consider progress made to implement recommendations raised in the 2019/20 '*limited*' assurance Cleaning Standards report.

1.5 The risks considered during the review were as follows:

i. Patient or staff harm where infection prevention and control guidance and practice are not aligned to national standards.
ii. Financial loss or reputational damage to the Trust as a result of poor performance.

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	2	0	3
Operating Effectiveness	0	3	1	4
Total	1	5	1	7

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

Audit objective 1: The Trust has an infection prevention and control policy that provides clear direction, aligns with national standards, and is supported by appropriate operational policies and procedures.

2.3 The Trust has an overarching Infection Prevention and Control policy: '*Infection Prevention & Control Policy: Elimination of Healthcare Associated Infections'* ('the policy'), which was due for review in May 2021. Updates were made in September 2022, by the Head of Infection Prevention and Control (IPC), to align it with the Association of Ambulance Chief Executives (AACE) model national IPC policy. At the time of fieldwork closing the policy was to be submitted to the October 2022 meeting of the Trust Policy Review Group.

2.4 Whilst incorporating content from the AACE national policy, the Trust needs to ensure there remains alignment to the Welsh Government standards (*Code of Practice for the Prevention and Control of Healthcare Associated Infections*). We were also informed that the policy would retain guidance on Personal Protective Equipment provided by the Health and Safety Executive (HSE) that featured in previous revisions.

2.5 Review of the draft policy has identified a number of key revisions and updates. These include revised scope, aim and objectives and, in particular, reference to the previous IPC improvement plan has been replaced with a commitment to the prevention and control of infection and to set the strategic direction for IPC initiatives.

2.6 The draft revised policy expands on roles and responsibilities, including the addition of the Trust Board, Head of IPC and wider IPC team. Roles and responsibilities for managers and staff have also been refreshed and it provides further clarity on the need to ensure all staff and contractors receive sufficient training, information and supervision, with responsibility for developing training content assigned to the IPC team.

2.7 There is also outline of IPC audit arrangements, with audit subjects including vehicles, premises, equipment, clinical waste, sharps, linen and reference to 'local ownership of IPC standards by local management teams.' These are to be undertaken in line with the Trust's IPC audit programme. We discuss IPC audit arrangements in more detail at 2.46.

2.8 The overarching policy is supported by subject specific policies, standard operating procedures (SOPs) and guidance documents, although we note not all of these are owned or maintained by the IPC team. Following the move from Covid-19 response to business as usual in July 2022, there is currently a focus on updating those which have passed their review date, or those previously paused due to the pandemic.

2.9 At the time of fieldwork there were seven documents which were at various stages of draft or pending approval, these included the *Premises and Vehicle Cleanliness Policy*, *Safe Clean Care (IPC Handbook)*, *Key Standards for Environmental*

Cleanliness, and SOPs for hand hygiene, management of linen, mobile device decontamination and invasive procedures.

2.10 The *Premises and Vehicle Cleanliness* policy will be presented to the Trust Policy Review Group in October 2022. It contains detail on cleaning of premises, and outline of staff, management and reporting responsibilities. However, the cleaning instructions will require updating in line with the *Key Standards for Environmental Cleanliness* document which remains in draft, and monitoring arrangements detailed do not mention vehicles currently. We also note the Operations Directorate has issued a *Vehicle Decontamination* SOP, which provides instruction on vehicle cleaning for those which do not have access to regular cleaning at Trust Make Ready Depots (MRD). There is variation in cleaning instructions between these documents, the SOP also lacks detail on audit or other assurance arrangements. **See MA1 & MA3**

2.11 Throughout the pandemic the IPC team has produced a number of updates to Covid-19/PPE guidance documents, to ensure they remained in line with nationally issued guidance. Updates reflected changes in PPE, risk assessments, action cards and isolation/distancing requirements. In line with the movement from transition to business as usual, the team are now developing the next iteration of the IPC handbook: '*Safe Clean Care'*. The handbook combines content from a number of individual SOPs and national guidance, comments provided at the September IPC Strategic group, whilst positive, highlighted the requirement to ensure alignment and consistency. **See MA1**

2.12 There has also been focus on emerging risks with the co-production by IPC Team and Operations Directorate of an *Outbreak Management* SOP. This features trigger action cards for escalation, local management team processes, terms of reference and standard meeting agendas. Additionally, guidance has been issued for PPE and IPC management of Monkeypox.

Conclusion:

2.13 The Trust's IPC Policy has been updated, subject to formal review and approval, and aligns to national practice. A number of policies, SOPs and guidance documents are being reviewed, and the team has continued to address pandemic and other risk areas. However, there are a number of key documents remain in draft with inconsistencies that need to be addressed to ensure alignment. We assign this objective **reasonable** assurance.

Audit objective 2: The Trust has a clear infection prevention and control structure, and Operational and Executive responsibilities are clearly outlined.

2.14 The Trust established a pandemic structure in 2020, which transitioned through response and recovery to a return to business as usual in 2022. The IPC team engaged and contributed to a number of groups within the structure, particularly the Quality, Safety and Wellbeing Advisory and the Business Continuity and Recovery Cells.

2.15 During the pandemic, the IPC Team engaged with the cell structure established across the Trust, including the Quality, Safety and Wellbeing Cell, Health and Safety Advisory Cell, Clinical Advisory Cell, Trade Union Partnership Cell, and Senior Pandemic Team meetings. Example documents were provided supporting IPC team attendance and the sharing of guidance, training compliance, number and locations of positive Covid-19 tests and Covid outbreak team incident reports.

2.16 As the pandemic structure was stood down on 20th July 2022, the Chair of the Business Continuity and Recovery Team (BCRT) produced an SBAR to set out the governance arrangements proposed for those areas which had been included within the remit of the BCRT, and previous Senior Pandemic and Executive Pandemic teams. IPC features within this, with reference to the IPC Strategic Group for development of guidance, and the Clinical Quality Governance Group (CQGG) as the approving forum.

2.17 The IPC Strategic Group met infrequently during the pandemic period, as would be expected with the need to focus on Covid-19 response. The Terms of Reference (ToR) is in the process of being revisited and has been shared with the Executive Management Team (EMT) and the IPC Strategic group for review. The membership of the Group needs to be confirmed before the revised version can be finalised.

2.18 We reviewed agendas, papers and minutes for the three IPC Strategic meetings held in 2022 (January, April and September 2022), and compared these to the contents of the group's ToR and monitoring requirements in line with the updated IPC policy. Acknowledging that only the September meeting would have been held under a business-as-usual heading, the review suggests there are gaps in its operation. All three meetings were quorate.

2.19 The group's ToR includes a requirement '*to provide assurance on performance and the implementation of work programmes*'. However, it has not received the IPC work plan which was developed in 2021. The group is to provide a '*senior cross directorate forum*', but as noted above Senior Operations membership has not been confirmed. There is also a requirement to '*receive and disseminate information pertinent to IPC, monitoring and measuring performance at local, regional and Trust wide levels.*' Whilst the group has met only once since the return to business as usual, our review of meeting agendas does highlight limited performance information being presented. It is important that the Trust take the opportunity to address this for future meetings. **See MA2 & MA7**.

2.20 The IPC Strategic group attendance has included members from Estates, Fleet, and the Make Ready Depot Lead. However, review of agendas indicate that papers and reports are only produced by the IPC team, which suggests there could be more emphasis placed on membership responsibilities and contribution to support the group's operation. **See MA2**

2.21 We also reviewed the group's minutes and action logs, to identify if actions are identified, tracked, and monitored appropriately. Whilst there have been longstanding actions held within the action log, we observed the September meeting and can confirm each action was subject to discussion and review.

However, we do note that the most recent minutes for that meeting did not include specific capture of actions, and so consideration should be given to correct this for future meetings.

2.22 Operating alongside the pandemic cell structure, the CQGG was responsible for non-Covid related business. Review of CQGG minutes identified that it has received the IPC Annual Report 2021/22, circulation of and subsequent approval of Monkeypox guidance at an extraordinary meeting of the group in June 2022. We note the CQGG has also approved updates for a number of SOPs and SBARs, which suggest that there is a clear route for discussion and approval of IPC documents.

2.23 Our recent review of Respiratory Protective Equipment (RPE) included positive reflection of the RPE and Fit Testing SOPs, noting clear outline of both Executive, and operational roles and responsibilities. In particular we noted the IPC team responsibilities for designing policy and process documentation, and as subject experts ensuring these complied with required legislation. This also included consideration of the ability of the Trust to deliver the systems within resources available, while retaining responsibility for implementation through the Operations Directorate. As noted above, the team are progressing and prioritising a number of draft SOPs, and four of these were shared at the September meeting of the IPC Strategic Group for review.

2.24 We compared the outline of roles and responsibilities within those four draft SOPs, and the *'Key Standards for Environmental Cleanliness'* which was also submitted for comment at that meeting. Whilst acknowledging they are still in draft, we note variation in how responsibilities are outlined and so there is opportunity to consider further standardisation in format and terminology to support the good practice identified in our earlier review. **See MA3**

Conclusion:

2.25 There is a clear structure to support IPC within the Trust, with evidence of its use, including across a number of pandemic cells, to discuss and approve SOPs and guidance documents. In the return to business as usual it is important to improve the operation of the IPC Strategic group and its membership. We have also highlighted further opportunities to clarify roles and responsibilities. We assign this objective **reasonable** assurance.

Audit objective 3: A programme is in place to direct and deliver infection prevention and control improvements across the Trust.

2.26 We understand from discussion with the Head of IPC that a post pandemic IPC workplan was requested to support the delivery of the 2021-2024 IMTP, and were informed that this was approved through the Trust Pandemic structure.

2.27 The 2021 IMTP included reference to developing and implementing a sustainable health and safety transformation plan incorporating health and safety and infection prevention and control. The 2022-25 IMTP highlights key areas for

recovery, including how IPC measures continue to apply in a post-pandemic phase, and ensuring the lessons learnt and systems put in place during Covid-19 continue within business as usual.

2.28 The IPC work plan includes that the 2021 IMTP deliverable will be progressed through an IPC action plan, but the document has not been updated to capture the same link to the more recent IMTP.

2.29 The work plan is comprised of 10 IPC team deliverables, each with supporting actions, responsible officer, priority, status, and target implementation dates. There is also a column for progress updates and an outline of specific risks to delivery which are RAG rated.

2.30 In reviewing the priority areas we considered the deliverables listed above, the requirements of the updated IPC policy, and the priorities listed within the IPC Annual Report 2021-22. Overall, we note there is good coverage, although we did identify omissions. For example, the IPC Annual Report includes reference to actions to address audit recommendations, which is not reflected within the IPC work plan. Additionally, we note the plan does not include actions related to the sustainability of Fit Testing, which is currently a risk held by the team and highlighted as a major focus of team capacity. We also note the plan does not include the work to be undertaken in developing training in line with the HEIW national IPC training framework. **See MA4**

2.31 We also reviewed the work plan to consider if it demonstrated consideration of resource requirements, noting that at present it does not with all actions assigned to the Head of IPC. The work plan currently lists two of the ten actions as complete, and whilst a further six have target dates listed for November or December 2022, these include actions yet to be started (Action 10 – Safe Clean Care Campaign), reliant on external support (Action 6 – Audit tools/programme) and progressing of documents out for comment which will likely require approval outside of the group (Action 4 – SOPs, Action 5 IPC Standards). **See MA4**

2.32 Review of the IPC plan confirmed that each action has received at least one status review, with the majority having 2-3 narrative progress updates between June 2021 to September 2022. We have noted that priorities within the work plan have been discussed at the various cells within the pandemic structure, although we note this has been ad-hoc rather than on a regularly scheduled basis.

2.33 The work plan was initially shared at the IPC Strategic group in July 2021, and we are informed the priorities within the plan was also shared within presentations to the Clinical Advisory and Trade Union Partnership Cells. The plan has not returned to the IPC Strategic group or shared at the CQGG, which will have impacted on their ability to review and monitor progress across the priority areas. The QUEST committee terms of reference were revised this year to include '*Review the annual infection prevention and control plan and monitor its implementation*'. However, the IPC work plan has not been shared at that forum.

2.34 We also recognise that the work plan was intended to address post pandemic priorities, but that there has also been a need to tackle other pressing issues,

such as the Fit testing and subsequent quality assurance programme, which has impacted the team's capacity to achieve this.

2.35 Additional resource has been secured for the IPC team, including substantive appointments of a Senior and Assistant IPC Practitioner(s) and shared administrative resource with the Health and Safety team. This has primarily been directed to support the establishment of Fit testers and quality assurance arrangements. The majority of quality assurance assessments were undertaken in November and December 2021 and the Trust is committed to a 12-month review of QA Fit Testers by the accredited IPC team members.

Conclusion:

2.36 The Trust has an established IPC work plan which contains priorities linked to the IMTP and IPC policy. The work plan was shared at the IPC Strategic group but has not returned for further monitoring. It has not been presented to the CQGG, or QUEST committee, and we note there are delays in delivery of identified actions. We have outlined areas that could strengthen the plan content and monitoring. We assign this objective **limited** assurance.

Audit objective 4: There is awareness of infection prevention and control guidance and staff have undertaken appropriate training.

2.37 Outside of the statutory and mandatory IPC training requirements, the Trust has commissioned a supplementary suite of online training materials through the provider '*Onclick*'. The additional modules are available to all staff and volunteers through the Trust Learning Zone site and whilst completion is optional, it is recognised as contributing to Continuous Professional Development (CPD).

2.38 Guidance on the access and use of both statutory and mandatory training and the onclick modules is available through the IPC SharePoint site, under its training and education page.

2.39 Subject areas covered within the online modules include *transmission of infectious diseases*, *evolution of a pandemic*, *day in the life on the frontline*, *PPE Part A, Powered Respiratory Hood Part A*, and *vehicle cleaning, sharps and waste management*.

2.40 We reviewed the *vehicle cleaning, sharps and waste management* module. The module also refers to additional resources such as legislation, policies, and key documents, although we noted instances where the use of links directed the user to incorrect versions and the omission of the *Vehicle Decontamination* SOP. **See MA5**

2.41 Health Education Improvement Wales, at the request of Welsh Government, have developed a national framework for IPC Training. The framework outlines expectation across four levels, ranging from entry level: '*introductory awareness*' to Level 4: '*specialist knowledge understanding and application*'. The IPC team are working with the Trust's Training college to map the levels across staffing groups and specialised roles, and we were provided with an initial training needs

analysis. Further work is being undertaken to develop competency booklets to support these requirements. **See MA5**

2.42 Training compliance rates for statutory and mandatory IPC training and the Onclick modules were included within the IPC Annual Report 2021/22. Whilst this information is not currently reported to the IPC Strategic group, this has been identified as an area to address and capture in reporting going forward. At the time of fieldwork current performance is as below, noting the national target for IPC Level 1 and 2 is 85%:

Training Course	May 2022	October 2022
IPC Level 1	88.23%	75.63%
IPC Level 2	48.51%	45.46%
Onclick – EMS	72.73%	75.50%
Onclick - NEPTS	79.20%	72.34%

2.43 Review of QUEST and People and Culture Committee papers identified that they are provided with an overall combined training compliance figure, rather than a breakdown of performance for each subject area which was previously captured within a Quarterly Assurance Report. We understand that the report is currently under review. **See MA7**

2.44 The IPC team are actively supporting face to face training, and in observing the IPC Strategic group meeting in September it was clear that the team have good working relationships with the Learning and Development team. An action was agreed at that meeting to support the development of 'behavioural IPC champions' and to develop resources to highlight the risks of transmissibility within contact centres.

2.45 There is also awareness raising through the use of Quality & Nursing Directorate notices which are distributed throughout the Trust. We identified a number have been issued this year, including to promote awareness of infectious diseases, cleaning guidance, and fit test expiry dates.

Conclusion:

2.46 The Trust provides additional training and guidance materials to support staff, but links to key documents do require updating. Training compliance figures have been reported to QUEST, but we are unable to identify ongoing monitoring or reporting of these where focus is required to improve IPC Level 2 compliance. The team has undertaken an initial training needs analysis against the national framework, with further actions with the Learning and Development team planned. We assign the objective **reasonable** assurance.

Audit objective 5: Mechanisms in place to ensure compliance with Trust policies and procedures are appropriate.

2.47 Our previous review of Cleaning Standards, which was issued at the beginning of the pandemic in 2020, highlighted the need to develop more effective audit

methods to monitor compliance. The IPC Annual Report 2021/22 outlined that no audits were undertaken for 2021/22 due to the need to focus team resource and capacity on the pandemic response and any emerging variants of concern. The report included that a Trust IPC audit programme would be reintroduced in 2022-23 which would include:

- Corpro mask use, filter and maintenance logs and ESR Records;
- Versaflo usage, filter and maintenance logs;
- Peripheral cannulation and ANTT Compliance;
- On Click and eLearning compliance;
- Premise and Vehicle Cleaning;
- Hand Hygiene and Bare Below the elbow.

2.48 Discussion with the Head of IPC confirmed that at present the audit programme has not commenced, as there was a need to develop appropriate audit tools which utilised current software applications. The team does not have this capability and so both internal and external assistance had been sought. **See MA6**

2.49 The revised IPC policy references a number of additional subject areas which should feature within audit programmes, including staff competency at point of care, storage of medical consumables and equipment, handling and disposal of clinical waste and sharps, management and handling of linen, antimicrobial supply and administration, and local ownership of IPC standards by local management teams. In the previous iteration of the IPC policy some of the above were included but assigned to the Operations and Medical Directorates to undertake. **See MA6**

2.50 For the full benefit of the IPC audit programme, it would also require all subject areas having established criteria to be audited against. At the time of fieldwork, the *Premises and Vehicle Cleanliness* policy, *Key Standards for Environmental Cleaning*, and *Hand Hygiene and bare below the elbows* SOP were at draft stage.

2.51 With IPC audits not in operation, we queried if there were alternative mechanisms for assurance across key areas of premises and vehicles. Since our previous internal audit review of Cleaning Standards in 2019/20, and in response to the pandemic, the Trust has secured cleaning services for all Trust premises. Additionally, we note the health and safety team have undertaken a programme of Covid-19 risk assessments, which include elements of IPC, across Trust premises in 2021.

2.52 Vehicle arrangements have also been strengthened following the opening in 2022 of an additional Make Ready Depot (MRD) in Cardiff. The Trust has an ambition to increase the number of such facilities, to expand this model and approach across Wales. The MRD sites provide dedicated cleaning across three levels, which range from surface clean, a six weekly deep clean, and ad-hoc cleaning where contamination has occurred. As was the case at the time of our previous review of Cleaning Standards, the majority of Trust vehicles are not cleaned at MRD sites,

and so there remains a need to demonstrate and provide assurance for those vehicles.

2.53 Our previous review of cleaning standards identified that Adenosine Triphosphate (ATP) swab testing was being considered as a method for assessing cleaning standard compliance. We are informed that MRDs had used ATP during the pandemic, and was particularly useful as a source of assurance for staff. However, in the return to business as usual the process is currently retained for quality assurance purposes only, with future use to be determined through review of policies and procedures which is currently underway. MRD reporting of activity has continued, but as our previous review identified there is no reporting which captures cleaning status for the entire Trust fleet.

2.54 Included within the IPC Annual Report 21/22 was detailed outline of IPC related datix reporting, which was broken down by theme and health board area. Whilst the report highlighted an increase in needlestick injuries within the Swansea Bay University Health Board area, and we note a consistent number of returns related to IPC policy or procedural issues, these have not resulted in further action. The team has recently introduced a weekly review of datix reports and began to collate responses and actions. The intention will then be to map themes and actions, which can be incorporated into the ongoing highlight and dashboard reporting. **See MA6**

Conclusion:

2.55 The Trust IPC audit programme requirements are outlined within the IPC policy and included within the IPC work plan. Following suspension due to pandemic pressures audits are yet to be restarted. The Trust has some mitigating measures around MRD vehicle cleaning and premise cleaning, however the previous development of ATP swab testing, which provided a method for assessing cleaning standard compliance, has not been implemented fully resulting in an absence of assurance reporting. We assign this objective **limited** assurance.

Audit objective 6: There is regular reporting on Trust performance with clear oversight arrangements to support escalation of risks and issues.

2.56 Prior to the return to business as usual, the route for oversight and reporting remained through the pandemic structure for Covid-19 related activity. Senior Pandemic Team agendas and papers demonstrate the heightened profile of IPC during this period. Covid related incidents, risk assessments and IPC/'on click' training summaries were presented to cells across the structure.

2.57 The IPC Team also provided quarterly highlight reports to both the Assistant Directors Leadership Team, and the Trust's National Health and Safety Committee. These provide a narrative outline of team progress and developments, and a summary of key areas in the alert/advise/assure/inform format. Review of report content, alongside the reporting within the pandemic structure, provides coverage against priorities contained within the IPC work plan,

although only at a high level for some these suggesting therefore more focused monitoring arrangements would be beneficial in the return to business as usual.

2.58 With the pandemic structure now stood down, we considered the arrangements in place to support ongoing monitoring and reporting of risks in the return to business as usual. The IPC Strategic group meets on a quarterly basis and is a subgroup of the CQGG. Its ToR includes that it will provide a highlight report to the CQGG following each meeting. The CQGG holds monthly meetings and in turn provides a 'Quality Highlight Report' summarising its key activities the QUEST Committee, which meets on a quarterly basis.

2.59 We reviewed CQGG papers and minutes for the period January 2022 and August 2022 to identify the frequency and content of reporting in place. In that period the CQGG received and approved a number of IPC SOPs and guidance documents, and the IPC Annual Report 2021-22. The Annual Report provides summary of training compliance, datix incidents, and overview of IPC risks, alongside outline of the team's priorities for 2022/23. We could not identify use of highlight reports from the IPC group to the CQGG, suggesting there is opportunity to enhance future reporting of current performance, or the key activities of the group. **See MA7**

2.60 Review of the Quality Highlight Report from CQGG to QUEST identified that information provided varied. For example, the report provided in May 2022 included outline of the group's purpose, but little on its activity. The second, provided in August 2022, contained further detail including approval of IPC SOP for *High Consequence Infectious Diseases,* and this indicates that the structure for discussion and approval outlined within objective two is in place.

2.61 The Quality Highlight Report did not however contain indicators on performance or detail on progress against the IPC work plan. Our previous review of Cleaning Standards in 2019/20 had identified that the previous Quarterly Quality Assurance Reports, presented at the CQGG predecessor group (the Quality Steering Group), included detail on IPC statutory and mandatory training compliance, datix incidents and cleanliness audits. This, in turn, was reported to the QUEST Committee. Discussion with the Assistant Director of Quality Governance outlined that the reporting requirements from CQGG to QUEST are being considered. The Audit Wales Review of Quality Governance issued in 2022 highlighted that whilst current reporting provides a '*good high-level summary, some of the quality focus and detail in the original Quality Assurance Report has been lost*.'. A highlight report aligned to key indicators is planned for November 2022 onwards. **See MA7**

2.62 The QUEST Committee provides a highlight report to Trust Board following each meeting. This is formatted around an alert (escalation), advise (developments, monitoring, approval), and assure format. We note that receipt of the IPC Annual report at the August QUEST Committee meeting was included within the subsequent report to Board under the assure heading. **See MA7**

2.63 There has been a number of IPC related risks that were included within the Trust's Corporate Risk Register during the pandemic which have been subsequently de-escalated. The IPC Annual Report 2021/22 includes outline of six individual risks

that the team closed during the year, relating to team structure, PPE, and lack of compliance with HSE regulations for Fit testing. The September IPC Strategic group received and discussed a risk opened in May 2022 relating to the sustainability of the Fit testing programme within the Trust, a challenge highlighted within our review of RPE earlier this year. The group agreed that the risk required organisational awareness and that it should be escalated.

Conclusion:

2.64 There is a clear reporting structure from the IPC Strategic Group to the CQGG and onwards to the QUEST Committee and Trust Board. During the pandemic, there has been use of the Trust's cell structure to escalate risks and monitor training levels. We've considered the initial arrangements supporting the return to business as usual, which has identified the need to enhance the flow of reporting, in line with Audit Wales recommendations. We assign this objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter arising 1: IPC Policies and related procedures (Design)	Impact
In returning to business as usual the IPC team are reviewing and updating policies, procedures, and guidance documents. This includes the overarching IPC policy, which has been updated, but is awaiting approval from the Trust Policy Group. A number of supporting policies and procedures were also in development or pending approval at the time of fieldwork. The *Premise and Vehicle Cleanliness* policy is in draft we reviewed its content noting: • The adapting of *Key Standards for Environmental Cleanliness* for use within the Trust is still to be completed and these will need to be incorporated within the above policy once finalised. • Monitoring arrangements within the policy include IPC audits, however under responsibilities Health and Safety Managers are listed as responsible for audit of the policies operation. • Reporting is to be to a Building Cleaning Group yet to be established and there is no mention of the role of the IPC Strategic group. • The document includes cleaning instructions on premise cleaning, but information on vehicle cleaning does not replicate content from the *Vehicle Decontamination SOP* which does provide vehicle cleaning instructions. The SOP contains no outline of audit or other assurance arrangements. Alongside the current policies and SOPs there will shortly be an updated IPC handbook. Discussion at the IPC Strategic group, and our own review of the draft document, notes that handbook duplicates content from a number of other documents and will require ongoing maintenance to ensure content remains current.	Potential risk of: • Policies and procedures do not provide comprehensive coverage of related areas. • Lack of clarity across responsibilities and ownership.

Recommendations	Priority
1.1 Once the overarching IPC policy is formally approved, the supporting policies/procedures/guidance documents should be reviewed and approved in a timely manner. 1.2 The Trust should clarify arrangements within the Premise and Vehicle Cleaning policy to ensure cleaning instructions, responsibilities and monitoring are comprehensive and align with other related documents.	Medium

1.3	The Trust should map IPC and related policies, responsibilities, ownership, monitoring and governance arrangements to support future review and development of policies and guidance.		
1.4	Consideration should be given to modifying the IPC handbook to direct users to relevant content, this could also contain the outcome of mapping recommended above.		
Management response		**Target Date**	**Responsible Officer**
1.1 – 1.3	The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	March 2023	Louise Colson, Head of IPC
1.4	Consideration will be given to modifying the IPC Handbook following the IPC 3P Project. The aim of this action is to ensure staff are able to navigate to relevant and important content, as and when required.	June 2023	Louise Colson, Head of IPC

Matter arising 2: IPC Strategic Group (Operation)	Impact
Our previous review of Cleaning Standards in 2019/20 identified that the IPC Strategic group was not operating effectively. Since then there has been review of the group's terms of reference, however membership is still to be finalised. The group has met a number of times during the pandemic, transition period, and once during business as usual. Review of group agendas, papers and minutes identified the following gaps against its terms of reference; • '*The purpose of the IPC Strategic Group is to provide strategic expertise, assurance on performance, and implementation of work programmes within the organisation of matters relating to IPC.'* - We note the group has not received, approved, or discussed the IPC work plan which was developed in 2021. • '*The Group will provide a senior cross-directorate forum, in which IPC matters will be considered to ensure successful operationalisation and positive implementation into Trust policies, procedures and practices.*' – There is currently no attendance from senior Operations management and membership from that group is yet to be confirmed. • '*Receive and disseminate information pertinent to IPC, monitoring and measuring performance at local, regional and Trust-wide levels;*' – The group received narrative updates on development of policies/plans and guidance, however currently there are no IPC audits underway and limited input from non-IPC members on their areas of responsibility. • '*Contribute to and influence prudent antimicrobial prescribing into routine practice*.' – We did not identify discussion of this subject area within minutes reviewed. The gaps identified above would also impact the achievement of objectives listed within the updated IPC Policy. Draft minutes circulated following the group's September meeting did not include use of an action column. There would be benefit in a consistent approach and format used to identify and capture actions raised within the meeting.	Potential risk of: • Trust IPC priorities not delivered. • Effectiveness of group operation impacted by gaps in membership and subject coverage.

Recommendations	Priority
2.1 The Terms of Reference for the IPC Strategic group, including membership, should be finalised, and submitted for approval from the CQGG. 2.2 The format and agenda of the IPC Strategic group should be reviewed to align with the IPC Work Plan priorities.	**Medium**

2.3	In undertaking the above the Trust should consider the information, monitoring, and reporting contributions from each which could contribute to the progressing of the IPC priorities within the work plan.		

Management response		Target Date	Responsible Officer
2.1	The Terms of Reference for the IPC Strategic group, including membership, will be finalised, and submitted for approval from the CQGG. Additionally, a revised Agenda and group work programme will be implemented.	March 2023	J Turnbull-Ross, Asst. Director
2.2 – 2.3	The Terms of Reference, group work programme/agenda will include routine monitoring of performance, and review of documentation in a timely manner. Management response 1.1 will inform the content of the group's monitoring requirements.	March 2023	J Turnbull-Ross, Asst. Director

Matter arising 3: Roles and Responsibilities (Design)	Impact
Our recent review of Respiratory Protective Equipment (RPE) included positive reflection of the RPE and Fit Testing SOPs which contained clear outline roles and responsibilities across both Executive and operational staff and management. We have also noted the alignment within the overarching IPC policy to the content held in the AACE national IPC policy which itself includes outline of roles and responsibilities. We compared the outline of roles and responsibilities within four draft SOPs, and the *Key Standards for Environmental Cleanliness* presented to the IPC Strategic group in September. Whilst acknowledging they are still under development there is variation in frequency and terminology. We noted; • The *Decontamination of Mobile Devices* and *Invasive Procedure* SOPs did not include reference to Executive Director responsibilities. The *Key Standards for Environmental Cleanliness* refer to the Director responsible for IPC rather than the Director of Nursing and Quality. • The *Invasive Procedure, Management of Linen*, and *Decontamination of Mobile Devices* SOPs, and the draft Key Standards do not have clear outline of the responsibilities of the IPC team. • The *Invasive Procedure, Management of Linen*, and the draft *Key Standards for Environmental Cleanliness* do not have managers responsibilities clearly outlined.	Potential risk of: • Inconsistent outline of roles and responsibilities.

Recommendations	Priority
3.1 The Trust should consider further standardisation of roles and responsibilities outlined across executives, managers and staff which can be included within the development of future SOP, policies, and guidance documents. This could be drawn from the content within the updated IPC policy.	Medium

Management response	Target Date	Responsible Officer
3.1 We accept the recommendation to standardise documentation formats. This action will be addressed through the IPC 3P Project (management response 1.1)	March 2023	Louise Colson, Head of IPC

Matter arising 4: IPC Work Plan, monitoring and approval (Operation)	Impact
The work plan is comprised of 10 IPC team deliverables each with supporting actions, responsible officer, priority, status, and target implementation date. There is also a column for progress updates and an outline of specific risks to delivery which are RAG rated. Our review noted priorities matched with the requirements of the updated IPC policy and priorities within the IPC Annual Report 2021/22. We noted some small gaps against ongoing delivery including, action to address NWSSP Audit and Assurance reports, inclusion of the Fit testing Quality Assurance programme, and action to address the HEIW national IPC training framework. Review of actions outlined that two of the ten actions are currently complete, with a further six contain target dates of November/December 2022 these include actions yet to be started (Action 10 – Safe Clean Care Campaign), reliant on external support (Action 6 – Audit tools/programme) and progressing of documents out for comment which will likely require approval outside of the group (Action 4 – SOPs, Action 5 IPC Standards). All actions within the IPC work plan are assigned to the Head of IPC. Additional resource secured for the team has been directed towards the establishment of a Fit tester programme, followed by the need to provide ongoing quality assurance. These actions are not included within the plan. The IPC work plan has not been shared at the CQGG or QUEST Committee.	Potential risk of: • IPC performance and delivery of priorities may not be adequately scrutinised.

Recommendations	Priority
4.1 The IPC Work Plan and content should be reviewed to ensure it contains both the Trusts overall IPC priorities but also those areas which have greatest impact on the IPC team capacity and resource. It should then be submitted for approval from the CQGG. 4.2 Resource requirements and target dates should be reviewed with changes in timescales or actions included at IPC Strategic group and CQGG meetings. 4.3 The ongoing delivery of the IPC work plan should be regularly monitored at the IPC Strategic group.	Medium

Management response	Target Date	Responsible Officer
4.1 The IPC Work Plan will be reviewed and submitted to CQGG for approval.	March 2023	Louise Colson, Head of IPC

4.2	We accept the recommendation, future workplans will detail requirements.	March 2023	Louise Colson, Head of IPC
4.3	The IPC Strategic Group's Terms or Reference, group agenda and work programme will include monitoring of deliverables against the IPC Work Programme	March 2023	Louise Colson, Head of IPC

Matter arising 5: 'Onclick' Training resources (Operation)	Impact
Outside of the statutory and mandatory IPC training requirements the Trust has commissioned a supplementary suite of online training materials through the provider 'Onclick'. Subject areas covered within the online modules include *transmission of infectious diseases*, *evolution of a pandemic*, *day in the life on the frontline*, *PPE Part A*, *Powered Respiratory Hood Part A*, and *vehicle cleaning, sharps and waste management*. The modules are also supported by links to additional resources such as legislation, policies, and key documents. Review of the vehicle cleaning, sharps and waste management module The IPC documents linked to within the module were to previous out of date versions; • All things IPC - Version 1.3, current version is 3.0 • A-Z of Common Disease – Version 1.3, current version is 8.2 it did not include the Vehicle Decontamination SOP which provides the Trust's approach to non MRD cleaning instructions.	Potential risk of: • Access and use of out-of-date guidance.

Recommendations	Priority
5.1 The Trust should ensure online resources contain up to date links and guidance.	Low

Management response	Target Date	Responsible Officer
5.1 Immediate action will be undertaken on those identified. The IPC 3P Project will systematically review documentation for outdated links/information.	January 2023	Louise Colson, Head of IPC

Matter arising 6: Trust IPC Assurance Mechanisms (Design)	Impact
Our previous review of Cleaning Standards in 2019/20 highlighted that vehicle and premise checks undertaken were 'subjective and therefore provide only limited assurance'. Alternative methods of audit, such as the use of ATP swab testing, which did provide some assurance on the effectiveness of cleaning methods, were being considered at that point but these have not been continued. As outlined within the IPC Annual Report 2021-22 IPC audits were paused as team resource and capacity was directed to support the Trust's pandemic response. The report included intention to reintroduce an audit programme in 2022/23, and we're informed the team has allocated dedicated time to undertake these, however the audit tools to support the programme are yet to be finalised. The previous IPC policy included outline of those responsible for IPC related audits, including those outside of the IPC team itself. Review of IPC Strategic group papers has identified no reporting of any checks made by alternative parties. With the *Key Standards for Environmental Cleanliness* still in draft there will also need to be clear circulation of these once finalised to ensure staff are aware of the criteria being measured against. The IPC team has recently established regular review arrangements for datix incidents to capture related actions and themes, at present this only relates to August and September 2022.	Potential risk of: • Lack of assurance on compliance with policies.

Recommendations	Priority
6.1 Whilst continuing to progress the updating of IPC audit tools the Trust should develop a prioritised schedule of audits which can be delivered by the IPC team for the remainder of 2022/23. This should be alongside finalising and communicating expected criteria and standards. 6.2 The Trust should consider longer term mechanisms for compliance which incorporate and map responsibilities of the wider IPC Strategic membership and include outline of compliance monitoring and reporting. 6.3 To support both of the above actions the IPC team should incorporate analysis of datix incidents for 2022/23 so that the targeting of audits is risk based.	**High**

Management response	Target Date	Responsible Officer

6.1	A prioritisation assessment will be undertaken to audit higher risk focus areas.	March 2023	Louise Colson, Head of IPC
6.2	IPC 3P Project will provide a comprehensive assessment of monitoring and audit arrangements. Additionally, responsibilities will be articulated through a RACI framework	June 2023	Louise Colson, Head of IPC
6.3	The recommendation is supported. An analysis of the data will be undertaken to determine priorities for the IPC Work Plan for 2023/24, including auditing.	March 2023	Louise Colson, Head of IPC

Matter arising 7: Performance Reporting (Operation)	Impact
The IPC Annual Report 2021-22 was provided to the Clinical Quality Governance Group (CQGG) in May 2022, Executive Management Team in June 2022, and presented to the QUEST Committee in August 2022. This provided a good summary of training compliance, datix incidents, and overview of IPC risks, alongside outline of the team's priorities for 2022/23. There has been use of the Trust pandemic cell structure to report Covid-19 incidents, IPC training compliance, and use of SBARs for risks across a number of cells and the Senior Pandemic Team. Review of CQGG minutes and papers confirms that the group receives and approves guidance and procedure documents from the IPC Strategic group on a regular basis. In the return to business-as-usual arrangements to support ongoing performance monitoring and escalation is not as clear with no highlight reports from the IPC Strategic group to CQGG identified within the period reviewed. Our previous review of Cleaning Standards identified that whilst there were opportunities to strengthen the monitoring at the IPC Strategic Group, there had been consistent reporting of key indicators such as statutory and mandatory training compliance, datix incidents and audit outcomes featured within the Quarterly Assurance Reports to the QUEST Committee. Audit Wales in their review of Quality Governance highlighted that whilst current reporting provides a *'good high-level summary, some of the quality focus and detail in the original Quality Assurance Report has been lost.'*	Potential risk of: • Gaps in performance reporting.

Recommendations	Priority
7.1 We support the review of key indicators to be reported from CCQG to the QUEST Committee. This review should also determine the key indicators to be reported and monitored at the IPC Strategic Group.	**Medium**

Management response	Target Date	Responsible Officer
7.1 A review of performance indicators will be undertaken for the IPC function. Routinely, these will be reported by exception to CQGG. Further consideration will be undertaken to ensure Board committee oversight of key IPC measures.	March 2023	Louise Colson, Head of IPC

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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PEOPLE AND CULTURE COMMITTEE
HIGHLIGHT REPORT TO BOARD

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

Trust Board Meeting Date	28 September 2023
Committee Meeting Date	17 August 2023
Chair	Paul Hollard

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. The Committee noted there are a considerable number of **policies past their review date** and that this issues had been escalated to the Audit Committee and the Board. The Committee was reassured that a policy improvement programme is underway and were informed that there had been a slight improvement since the issue was raised at the July Board meeting. This was due to policies making their way through the consultation and approval process and reclassification where appropriate of policies that were in fact procedures. The Audit Committee will oversee the improvement plans to ensure we have a robust policy framework.

ADVISE

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

2. Key progress was celebrated with the **Director of People and Culture** and the **Quarterly Operations Directorate updates.** The Committee is mindful that the challenging financial outlook for 2023/24 and additional savings WAST may be required to find will have an impact on our people. The Committee also noted:

   - Following the recent BBC Wales story on sexual safety and misogyny, feedback as a whole has been relatively positive with our people welcoming the proactive and sensitive approach to this difficult issue. There has been a slight increase in individuals coming forward which is welcomed in line with our Speaking up Safely programme. The Speaking up Safely platform has commenced with three Guardians identified for a soft launch in July and formal launch in September.

   - Rollout of the Allyship Programme continues with 120 colleagues completing this to date.

   - Members of the WAST LGBTQ+ Staff Network attended the AACE conference. Congratulations to Ashley Page, ACA2, who received a special recognition award for his work to improve equality and inclusion for LGBTQ+ communities in Wales. Congratulations also to Catherine Wynn-Lloyd who

won the 2023 Employers for Carers Award.

- Thirty-four colleagues have now completed the Foundation level change management course and 9 at practitioner level which provides a much wider cohort of staff with a good understanding of change management and how it impacts our people.

- A pilot accelerated newly qualified paramedic consolidated programme offers this cohort exposure to our newest services such as CSD, CHARU and APP rotations.

- There are some challenges with partnership working currently that management and Trade Union Representatives are working through as they get back into a rhythm following industrial action. All recognise that there is a period of healing during which engagement is sensitive however there is a good partnership working basis upon which to have those discussions. The breadth of discussions in the WASPT AAA bear this out.

3. The metrics proposed to measure the impact of the **People and Culture Plan** were presented under the Plan's headings of Culture, Capacity and Capability giving a holistic evaluation of the Plan's effectiveness in enhancing organisational culture, fostering a sense of belonging and optimizing the capabilities of our people. At paragraph 9 of this AAA the Board will note the deep dive into stress-related sickness absence. The Committee noted that addressing sickness absence, especially those incidences relating to mental health issues and stress, requires a comprehensive approach. Treating individual sources or causes of stress is likely to provide temporary relief but does not address the root of the problem. This is an example of a focus on organisational culture, we are investment in long-term solutions that create lasting, positive change. The metrics were approved and will be monitored by the Committee quarterly.

4. Aligned to the metrics above, a new report was presented that illustrates **cultural themes and trends**. Three broad areas featured including planned actions to address findings and the impact what will be seen from those actions related to:

   - Employee relations, including compassionate practices and respect and resolution;
   - Moving on Interviews; and
   - Managing Attendance at Work, building on the successful reduction in sickness absence over the last year

   The Committee agreed a few adjustments and this report will be considered on a bi-annual basis. A focused session will be held with Trade Union colleagues on their concerns regarding condensing of compassionate practices training.

5. An approach was endorsed to assess concerns over **skills development/skill fade of clinicians** due to handover delays and number of patients attended. This was communicated on picket lines during industrial action and whilst there is no clear clinical evidence of this, the work will enable the Trust to gain insight and intelligence on the impact handover delays have on clinical skills.

ASSURE

(Detail here any areas of assurance the Committee has received)

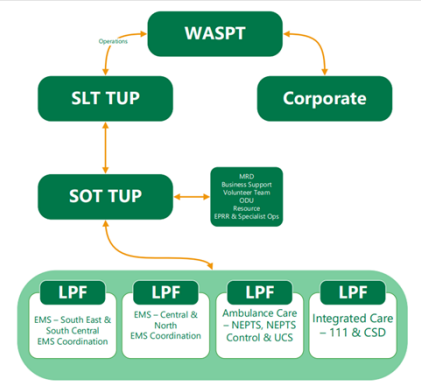
6. There was a welcomed focus on **volunteers** at this meeting including celebrating progress over the

first two years of the Volunteer Strategy, and an understanding the ways the Trust supports volunteers. The Volunteer Team in the Operations Directorate has expanded which has supported a strengthened voice of volunteers through the Volunteer Steering Group. The Chair of that Group also attends the Management Team meetings, WAST leadership symposiums and management training, allowing a more embedded relationship. Additionally, Community First Responders (CFRs) have increased by 224, with a total of 690 expected by the end of the 2023/24 financial year. This has meant more volunteers responding to incidents this year including to Red calls and thereby improving the mean response times for these calls. CFRs are closing 300-400 patient episodes of care on scene with support from the Clinical Support Desk. The Volunteer Car Service undertook 25,944 journeys this year including runs to Scotland and London. There are plans to grow that service from 98 to 200 by the end of the financial year.

Ian Cross, Volunteer Car Service Driver, joined the meeting. Ian has been volunteering for 40 years, more recently with his dog Buddy accompanying him, was recently awarded the British Empire Medal for services to WAST. Members heard of the regular runs Ian has in South Wales and his trips further afield to support patients to receive treatment. Improvements which could improve the experience of volunteers such as ease of access to PPE, in car communication methods and signage were discussed and the Committee will review progress on these at the November meeting. Members thanks Ian for his service and the comfort and support he and Buddy give to our patients and their families.

The five year **Volunteer Strategy** was launched in April 2021. Whilst delivery of strategic objectives for years 1 and 2 where somewhat impacted by the pandemic, in the last 18 months the volunteer scope and a governance framework have been developed with investment in all aspects of volunteering and enhanced inclusion of our volunteers into #TEAMWAST, including access to the 24/7 health support line and counsellors. Members heard of the extent of the successful schemes introduced for volunteers and commended the team for the exemplar work. The benefit of volunteers in the challenging financial climate was emphasized and the Committee welcomed a further focus on volunteers at the Trust's Annual General Meeting on 27 September where the full extent of the advances made will be showcased.

7. The **Welsh Ambulance Service Partnership Team (WASPT)** highlight report was received and the operational sub-structures that feed into WASPT were noted as set out below:



These forums will provide opportunities for resolution and escalation at a more local level, focusing WASPT on strategic issues.

8. The limited assurance **Trade Union Release Time Internal Audit** was received by the Committee and actions will be tracked in the audit tracker. The Director of People and Culture confirmed the outcome of audit was shared with Trade Union colleagues and realistic timeframes for management actions agreed.

9. The June/July 2023 **Monthly Integrated Quality and Performance Report** ("MIQPR") and the **Q1 Quarterly Workforce KPIs** shows that continued high handover delays remain a significant pressure on our people. The Committee noted:

   - **Shift overruns** have decreased as part of focused work under the IMTP, the WAST Annex and pilot programmes;

   - **Sickness absence** levels were reduced with June figures at 7.51%. There has been a slight increase in July, but it remains on a downward trajectory. Short term absence audits have commenced with the Operations Directorate and will be rolled out further over the next six months, with targeted support to line managers in response to the themes emerging. A **deep dive into absences** due to anxiety, stress, depression/other mental health illness (electronic staff record code S10) was presented. These account for 28.5% of all absences in June. It is clear that identifying a source of stress within this absence code is highly subjective however potential drivers include missed meal breaks, overruns and hand over delays, and Datix reporting would support this. Support at WAST for colleagues with stress related issues include a range of in person and online options ranging from occupational health and clinical psychology to REACT training.

   - **PADR** (Personal Annual Development Review) rates for June 2023 were 73.1%, an increase from 72.0% from the last meeting, however it did not achieve the 85% target. **Statutory and Mandatory Training** rates increased in June to 77.53% however it did not achieve the 85% target. The Committee noted that the Executive Management Team will have a focus on these metrics at a directorate level.

   - **Staff Turnover** has seen a positive decline from a peak of 11.64% in July 2022 to June's figure of 9.79%. Staff wellbeing offers continue to be promoted, together with the WAST Voices Network activity continuing.

   - There is an increasing number of **disciplinaries**. The Director of People and Culture will review and monitor themes and trends.

10. The **Health, Safety and Violence and Aggression Quarterly Report** was received with the Committee giving recognition to the improvements being made. The following was noted:

    - The number of violence and aggression incidents remains high at 168 for the quarter. Physical assaults on staff in this reporting period are 18 with incidents of verbal abuse amounting to 146. Collaborative working with AACE regarding violence and aggression training continues with the aim of improving the current training. Toolbox talks, raising awareness of case management support are taking place to support staff.

    - RIDDOR compliance has been sustained, with manual handling patients and violence and aggression highest reported by cause.

- Statutory health and safety, fire safety and manual handling training compliance continue to be below the Trust and Welsh Government standards. All staff are encouraged to bring their training levels up to Trust expectations.

- The reporting of incidents for diesel fumes exposure has continued to reduce into Q1. The Health and Safety Committee will be reviewing this in detail at their Autumn meeting with a report being presented to WASPT.

The reasonable assurance **Health and Safety Internal Audit** was received with the Auditors recognising the Trust's commitment to improving health and safety and the work undertaken to date.

11. The **Welsh** Language **Standards Annual Report 2022-23** was presented bilingually for the first time by the Welsh Language Manager, Melfyn Hughes which was welcomed. The report is attached at Annex 1 and will be presented to the Board at their September meeting. The Operations Directorate are reviewing the calls answered in Welsh to the 111 and NEPTS services at their weekly performance meeting and this metric will be monitored in the Committee metrics in the MIQPR. The Committee commended Melfyn for the extensive amount of work to promote and advance Welsh Language at the Trust in response to the Welsh Government's More than Just Words Action Plan.

12. An update was received on a revised process for the **Audit tracker** which will be before the Audit Committee for approval on 14 September. The Committee also noted the upcoming internal audit reviews within the remit of this committee for the remainder of 2023/24.

13. In private session the Committee reviewed progress on two **suspensions over four** months and three cases lodged with the **Employment Tribunal**. They were assured on actions in place to manage these cases.

14. The **Committee's priorities for 2023/24** are as follows and are progressing well:

    - Carry over the Committee priority to support the implementation and championing of the strategic equality objectives, including Welsh Language, to promote an inclusive organisation.

    - Development and implementation of the Speaking Up Safety Framework.

    - Development and Progress of the People and Culture Plan

The Committee also reviewed its progress against its cycle of business.

RISKS

Risks Discussed: The risks within the remit of this Committee were reviewed. The three highest risks for this Committee are set out below:

160 – high absence rates impacting on patient safety, staff wellbeing and the Trust's ability to provide a safe and effective service remains at a rating of 20 (5x4) as of July 2023. Despite positive movement in sickness rates, it was agreed that it was premature to reduce the score at this stage.

201 – damage to the Trust's reputation following a loss of stakeholder confidence remains at 20 (4x5).

This score has not changed. The bi-annual partnerships and engagement report will be discussed at the November meeting including a deep dive on this risk.

163 – maintaining effective and strong Trade Union partnerships increased in score from 12 (3x4) to 16 (4x4). Whilst the national pay dispute has ended for the majority of Trade Unions relationships with Trade Union Partners need to be approached sensitively. There are a range of issues that require engagement and partnership working, alongside the full implementation of all aspects of the WAST annex.

Updates were provided to risks **199** (failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with health and safety statutory legislation – score of 15). As noted above, the recent internal audit on health and safety received a reasonable assurance rating. Risk **558** (deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences) remains static at a score of 15.

Risk **557** – potential impact on services as a result of industrial action has been de-escalated and closed.

The Committee also reviewed risks 223 and 224 and agreed that the commentary box was useful to provide rationale for these high rated risks where the Trust's actions were unable to reduce them from 25.

New Risks Identified: No new risks identified at this meeting.

The papers for this meeting can be found by following this link to the Committee page on our website.

COMMITTEE AGENDA FOR MEETING		
Director of Workforce and Organisational Development Update	Operations Quarterly Report	Staff Story
Visible valuable volunteering	People and Culture Plan metrics	Welsh Language Standards Annual Report
Risk management and Board assurance framework	MIQPR	Workforce performance scorecard
Absence management	Cultural trends and themes	Staff development outline plan
WASPT AAA	TU release time internal audit	Policy report
Internal audit tracker	Health and Safety Update Health and safety internal audit	Committee priorities and cycle of business monitoring report

COMMITTEE ATTENDANCE				
Name	**9 MAY 2023**	**8 AUGUST 2023**	**16 NOVEMBER 2023**	**20 FEBRUARY 2024**
Paul Hollard				
Bethan Evans				
Joga Singh				
Hannah Rowan				
Angela Lewis	Liz Roberts			
Chris Turley				
Lee Brooks	Judith Bryce			
Estelle Hitchon				
Andy Swinburn				
Jonathan Turnbull-Ross	Liam Williams	Liam Williams		
Alex Crawford	Hugh Bennett			
Trish Mills				

Damon Turner				
Paul Seppman	Hugh Parry			
Ian James				
Tim Chalane				

	Attended
	Deputy attended
	Apologies received
	No longer member

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

WELSH AMBULANCE SERVICES NHS TRUST

WELSH LANGUAGE STANDARDS ANNUAL REPORT 2022-2023

This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg

Contents

Foreword

Croeso! Welcome!
As Chair and Chief Executive of the Welsh Ambulance Services NHS Trust, we are delighted to present our fourth report on implementing the Welsh Language Standards.

The Welsh Language (Wales) Measure 2011 sets out a legal framework which imposes a duty on the Welsh Ambulance Services NHS Trust, along with other public institutions, to comply with the Standards relating to the Welsh language and provides an opportunity to reinforce the requirements and to improve the quality and availability of services through the medium of Welsh.

There is a clear commitment from the Board in implementing the Standards and during 2022/23 we have continued to raise awareness of the requirements of the Standards by including Welsh language requirements in staff induction sessions together with promoting the online module 'Croeso Cymraeg Gwaith' which has been key to supporting staff who are at the beginning of their journey to learn Welsh.

Welsh Language Deliverables have been included in the Trust's Integrated Medium Term Plan (IMTP) 2023-26 that incorporates an action plan to implement the Welsh Government More Than Just Words strategy with a focus on an active offer of Welsh across our services. Progress against the IMTP is monitored by the Trust's Finance and Performance Committee, however the People and Culture Committee has specific oversight of Welsh language and has the promotion of the strategic equality objectives as one of its priorities for 2023/24.

This Annual Report sets out our compliance with the Standards and is supported by data for the reporting period 1 April 2022 to 31 March 2023. We recognise that we have made progress, but further improvements are planned to improve the provision of our Welsh language services. To achieve these improvements, we have been working closely with the Welsh Language Commissioner to establish solutions that meet our operational needs and ensure the rights of Welsh language speakers.

This report also reflects the positive impact of the Implementation of More than just words and the "Active Offer" principle, meaning the provision of a Welsh medium service without the service user having to request it.

Colin Dennis
Chair

Jason Killens
Chief Executive

1. Introduction

This is the fourth Annual Report of the Welsh Ambulance Services NHS Trust's work showcasing how the Welsh Language Standards have been implemented.

On 30 May 2019, the Trust moved from implementing its Welsh Language Scheme under the Welsh Language Act 1993 to implementing Welsh Language Standards as part of the Welsh Language (Wales) Measure 2011.

The Trust has continued to respond positively to the Welsh Language Standards as it provides an opportunity to reinforce and to improve the quality and availability of its services through the medium of Welsh.

2. About us

We are a team of over 4,000 people serving the 3.1 million people of Wales, along with the invaluable support of Community First Responders (CFRs), and volunteer car drivers who transport patients from their homes to hospital appointments and back again.

The 111 Call Centre provides thousands of patients a year with advice, support and signposting to the right services through our Consult and Close services. This includes the NHS 111 Wales Service, which provides 24/7 healthcare advice online and on the phone.

Our Non-Emergency Patient Transport Service (NEPTS) offers a dedicated call handling service dealing with over 1,000 calls a day nationally from eligible patients needing non-emergency ambulance transport. The NEPTS Service takes hundreds of thousands of patients to a place of care, or home, every year.

Our Emergency Call Handlers and Clinical Contact Centre staff deal with more than half a million calls every year, 24/7 and 365 days a year and we are at the frontline of service delivery, making sure that patients get the right advice and help.

3. Background to the Welsh Language Standards

Under the Welsh Language (Wales) Measure 2011, all public service organisations in Wales are required to comply with language duties, which ensure that the Welsh language is not treated less favourably than the English language. The duties encourage promotion of the Welsh language, the use of Welsh within internal administration and require that provision is made for the accessibility of Welsh to the public.

Section 44 of the 2011 measure permits the Welsh Language Commissioner to issue a compliance notice, requiring a body to comply with one or more standards specifically applicable to it. The Welsh Language Standards (No.7) Regulations 2018 were then introduced to the health sector organisations in Wales.

In accordance with section 44 of the 2011 measure, the purpose of the Welsh Language Standards is to provide:

- Clarity for organisations on the Welsh language
- Clarity for Welsh speakers on what services they can expect to receive in Welsh.
- Greater consistency in Welsh language services and improvement of quality for users

4. More than just words 2022-27 Action Plan

Welsh Government's **More than just words 2022-27 Action Plan** which was launched in August 2022 sets out how together Welsh Health and Social care services can drive forward progress under the overarching theme of culture and leadership and the following three themes:

- Theme 1 – Welsh language planning and policies including data.
- Theme 2 – Supporting and developing the Welsh language skills of the current and future workforce.
- Theme 3 - Sharing best practice and an enabling approach.

The Trust is committed in delivering the actions as set out in Action Plan so that the 'Active Offer' is an integral part of service quality and service delivery across the Trust.

5. Accountability and Support

5.1 Welsh Language Leads and Champions

Alongside the Trust's Welsh Language Services Manager, the Trust's Board Secretary, Trish Mills is the executive lead for the Welsh language who has been instrumental in championing the development of a new Welsh Language Framework that is included in the Trust IMTP and has been opening conversations in basic Welsh. In addition, the Trust Board has a Non-Executive Director, Bethan Evans who is the Board's Welsh Language Champion and has been involved in promoting the Welsh Language within the Trust to our staff and externally to our service users via the Trust's social media platforms.

Trish Mills
Board Secretary

Bethan Evans
Non-Executive Director

5.2 Welsh Language Advisory Group

The Welsh Ambulance Services NHS Trust has established a Welsh Language Advisory Group. This Group provides a mechanism for reviewing all aspects of the Welsh Language Standards and to ensure that a satisfactory service is maintained for all patients and members of the public who use the Trust's services.

5.3 Assistant Directors Leadership Team

The Trust's Assistant Directors Leadership Team (ADLT) are responsible for supporting the Trust's Executive Management Team on developing and delivering strategic plans and objectives, financial targets and compliance with legislation requirements, standards, and practices.

5.4 People and Culture Committee

The Trust's People and Culture Committee provides assurance to the Board of its leadership arrangements and monitors progress and seeks assurance that the Trust is discharging its statutory responsibilities in relation to the Welsh Language Standards.

5.5 Trust Board

The final part of the of the governance route of the Trust's Welsh Language Standards Annual Report following its approval route via the Trust's Welsh Language Advisory Group, ADLT, Executive Management Team and the People and Culture Committee will be for the Trust Board to review and discuss the progress made in complying with the Standards.

5.6 Complaints Procedure

Concerns received in relation to compliance with the Welsh Language Standards are received in a number of ways e.g., correspondence to the CEO. All complaints received will be investigated and response provided with any required corrective action. Issues relating to patient safety would be addressed under the Putting Things Right Regulations.

If a member of the public has a concern regarding a recent experience of using Trust services, they can register their concern in a number of ways using whichever is best suited to them: email the concerns team: Amb_PuttingThingsRight@wales.nhs.uk or complete an online form: Online Concerns Submission Form

6. Compliance with the Service Delivery Standards (Standards 1 – 77)

This set of standards identifies how the Trust is required to use the Welsh language in different situations so that Welsh speakers can have unhindered access to Welsh language services; for example, when sending correspondence, dealing with telephone calls, providing on-line or face-to-face services.

6.1 Correspondence (Standards 1 – 7)

The Trust has applied a consistent approach in relation to use of headed paper and email signatures and requires all staff to use the bilingual headed paper of the Trust. We have also actively encouraged all staff to include a message on email signatures noting that the individual 'welcomes correspondence in Welsh or English'.

6.2 Telephone Calls (Standards 8 – 20)

The Welsh Language Standards as imposed upon the Trust places no legal requirement to answer 999 calls in Welsh. Under The Welsh Language Standards (No. 7) Regulations 2018 Paragraph 35: Standards 8 to 10 and 13 to 16 do not apply to calls made to the 999 telephone number.

Callers to the 111 service and to the NEPTS service receive a bilingual greeting. When the Trust establishes telephone contact with a service user for the first time, the service user will be asked if they would prefer to receive future calls from the Trust in Welsh or English. That language preference will be noted and respected. Calls to 111 and NEPTS offer a language option for callers.

6.2.1 111 Service Review

During the financial year 2022/23 the 111 Service had significant performance challenges in relation to unprecedented winter demand. During these months the demand on the service at times challenged our technical and staffing capacity to answer the calls in a timely manner. This level of activity was beyond what was witnessed during the peak of the covid pandemic.

The Strep A outbreak in December, prolonged industrial action alongside an impacting National cyberattack over a 6 month period resulted in substantial impact on overall performance for the service.

This impact was seen in answer rate performance in both Welsh and English language calls.

NHS Wales 111 Service Welsh Language Call demand and answer rate 2022-2023

Welsh language demand	Total answered calls for 111	Welsh Calls Offered	Total calls answered in Welsh	% of calls answered in Welsh
01/04/22 – 31/03/23	**766,718**	**15,735**	**2,853**	**18.1%**
01/04/21 – 31/03/22	**680,161**	**15,341**	**6,949**	**45%**

* Orange figures/percentages represent the 2021/22 reporting period.

111 Service Improvements related to the Welsh Language

To address the performance of this standard the following is underway and planned for 2023/24.

1. Significant service and technical developments to improve overall answer rate performance.
2. Continued recruitment of Welsh speaking call handlers to the 111 service.
3. Welsh awareness training at start of employment.
4. Regular Welsh awareness training utilising the focused in-house training videos and materials.
5. Inclusion of a Welsh Language improvement plan within the 111 Service IMTP.

Additionally, Welsh language call answering for 111 and Non-Emergency Transport Patient Service is now a Board level key performance indicator in the Monthly Integrated Quality and Performance Report (MIQPR).

6.2.2 Non-Emergency Patient Transport Service (NEPTS)

All callers to our NEPTS Call Centre are welcomed with a bilingual greeting followed by our Integrated Voice Response (IVR) system allowing callers to select their preferred language being English or Welsh from this point. Depending on their selection all messages will be presented in their selected language.

Welsh callers are directed through the IVR to our Welsh Call takers. If our Welsh Call Takers are busy with other callers, the caller will be re-routed to the next available English or Welsh call taker to avoid unnecessary waiting time. It is important not only to provide a full Welsh call experience but to also ensure that no prolonged delays occurs if all our Welsh Call Takers are dealing with other calls.

Our Patient Needs Assessment is used to check the eligibility of each patient for ambulance transport and has been fully translated for use by our Welsh Call Takers to enhance the caller's experience.

NEPTS Welsh Language Call demand and answer rate 2022-2023

Welsh language demand	Total answered calls for NEPTS	Welsh Calls Offered	Total calls answered in Welsh	% of calls answered in Welsh
01/04/22 – 31/03/23	**200,864**	**1,878**	**1,856**	**98.8%**

*NET Centre call data has been included for this year's report as to align itself with the data set provided by the 111 Service. Going forward comparable data from previous year will be included.

*Compared to the performance of answering Welsh language calls for the 111 service, NEPTS has achieved 98.8% of answering their Welsh language calls. This can be attributed to the lower numbers of calls received to the NEPTS service.

6.3 Meetings (Standards 21 – 30)

When the Trust arranges a meeting with a member or members of the public, attendees will be asked if they wish to use the Welsh language at the meeting. Where individuals express a desire to use Welsh at a meeting, the Trust will respect and accommodate that preference. Board meetings have Non-Executive Directors who speak Welsh, and all meetings of the Board are livestreamed via Zoom. We are researching into the possibility of utilising Welsh language subtitles for future Board meetings.

6.4 Public Events (Standards 31 – 32)

In relation to face to face services offered at the event, the event's invitation or advertisement will ask persons to inform us if they wish to use the Welsh language. Where this occurs, we provide a translation service at the event.

6.5 Documents and Forms (Standards 36 - 38)

Forms to be completed by members of the public are available in Welsh. Documents produced by the Trust for the public are made available in Welsh if the subject matter of the document suggests that it should be produced in Welsh, or if the anticipated audience, and their expectations, suggests that the document should be produced in Welsh. If separate Welsh language versions are required, the English language version will state that the document or form is also available in Welsh.

6.6 Publicity and Advertising Material (Standards 33 – 34)

A national bilingual communications campaign for NHS 111 Wales has recently finished. The aim of the campaign was to increase awareness, understanding and trust in NHS 111 Wales, including the website, and help patients with urgent care needs to get the right care, in the right place, first time.

The first phase of this multi-channel marketing campaign started on 14 November 2022 with paid and organic social and digital out-of-home advertising. From 28th

February 2023, phase two began with a new TV ad airing on ITV, S4C and Video on Demand – you can watch the TV advert here. The second phase of the campaign also included a digital radio advert, digital advertising, social media (organic and paid), out-of-home advertising and influencer activity. A social media and poster asset package was available for stakeholders to download and share.

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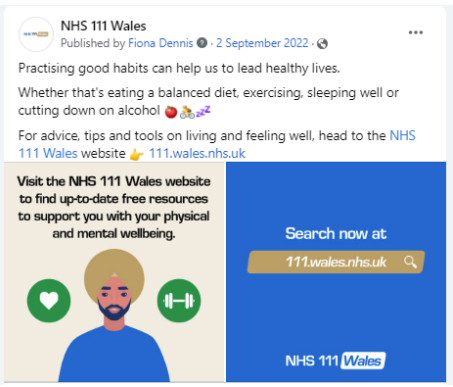
6.7 Websites and Online Services (Standards 39 – 43)

The Trust operates two websites: a Corporate website that has been redeveloped with a facility to switch between the two languages, and the NHS Direct Wales website which was rebranded in May 2020 to GIG 111 Cymru www.111.wales.nhs.uk.

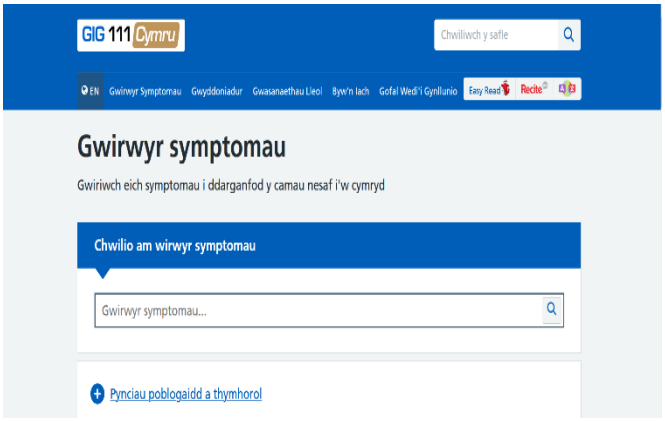
6.7.1 111 Website

During the reporting period the website received **4,550,981** (4,187,031) visits of which **12,554 (0.27%)** (33,664 (0.62%) visits were to the Welsh language website.

From the launch of the newly branded NHS 111 Wales website, the website has been operating its own Welsh and English social media Twitter accounts @GIG111Cymru with **105** (81) followers and @NHS111Wales with **7,282** (7,022) followers.



111 Website Symptom Checkers



Listening to website user feedback, we continue to work closely with colleagues across the Trust to extend the range of symptom checkers available in Welsh through the website, allowing users to check their symptoms and receive online advice about what to do next. During this reporting period, **14** new checkers were developed and made available in Welsh and English:

Leg injury	Facial pain and swelling	Knee pain and swelling	Foot pain and swelling	Ankle injury	Fatigue	Fainting
Belching	Testicular pain	Palpitations	Hallucinations	Burns	Finger injury	Sleep problems

The total number of **bilingual** symptom checkers now available is **65**.

111 Website Developments

A new ‘Planned care’ section was hosted on the 111 Website homepage on behalf of Welsh Government, providing data on how long people in each Local Health Board were waiting to be referred to or under the care of a specialist.

During December, an increase in the search term ‘Scarlet Fever’ had already been identified prior to reported cases in the media and calls to 111 telephony service. To support the worried well and other users, information was developed on looking after a sick child, Strep A and Scarlet Fever. This was quickly translated into Welsh.

With a four day bank holiday over the festive period, users were also reminded about planning ahead and advised what they could do out of hours with and without a prescription. An all Wales pharmacy rota was also made available.

Working with the 111 Project team, a number of pages throughout the site have been redesigned with Welsh language in mind, including the Health A-Z, Check Your Symptoms and Services Near You to create design consistency and improve accessibility and optimisation for mobile users, who are our greatest majority of visitors.

6.8 Social Media (Standards 45 – 46)

The Trust operates separate Welsh language and English social media accounts for Facebook and Twitter.

Below is a breakdown of the engagement on Trust's social media accounts during the reporting period.

Twitter

	@Ambiwlans_Cymru		@WelshAmbulance	
	2022-23	2021-22	2022-23	2021-22
New followers	42	59	1,385	1,906
Total impressions	113,351	191,100	2,440,000	4,806,500
***Retweets (without comments)**	625		4,693	
Likes	485	366	12,400	16,188
***Link clicks**	38		7,300	

* Orange figures/percentages represent the 2021/22 reporting period.
* New additions therefore no previous comparable data available.

Note: the total amount of Tweets differs between both accounts for the following reasons:

- 'Tweets' include quoted Tweets which are published more frequently on our English account due to other agencies, such as other UK ambulance services, not putting out content in Welsh.
- Link clicks include users clicking on links we provide in the captions. For example, during industrial action, on a selection of posts we used a link to go to the FAQ page.

Facebook

	Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru		Welsh Ambulance Services NHS Trust	
	2022-23	2021-22	2022-23	2021-22
New followers	27	59	1,959	4,647
New page likes	10	28	1,029	2,237
***Total page visits**	1,259		43,566	
***Total page reach**	65,794		939,342	
***Reaction/likes, comments and shares**	491		100,0084	

* New additions therefore no previous comparable data available.
* Orange figures/percentages represent the 2021/22 reporting period.

6.9 Signs and Notices (Standards 47 - 49)

All new or replacement signage is produced bilingually with the Welsh positioned so that it is likely to be read first. During the reporting period new external and internal signage was produced for the Trust's new offices in Cwmbran.

6.10 Reception Services (Standards 50 - 53)

Where we do have a reception service the online module 'Croeso Cymraeg Gwaith' is available to staff working in reception areas in order to develop their Welsh language skills and be able to greet visitors bilingually. Welsh language support is also available from the Trust's Welsh Language Service Manager.

6.11 Awarding Contracts (Standards 57 - 59)

Invitations to tender will be published bilingually if the subject matter of the invitation to tender suggests that it should be produced in Welsh, or if the anticipated audience, and their expectations, suggests that the text should be produced in Welsh. Tenders may be submitted in Welsh, and a tender submitted in Welsh will be treated no less favourably than a tender submitted in English.

No requests for tenders or contracts were issued in Welsh and none were received in Welsh during this reporting period.

6.12 Education Courses (Standard 63)

Any education course that we offer to the public we invite the audience to let us know their language preference of either Welsh or English for participating in the course. 'Shoctober' is an annual, month-long awareness campaign that runs every October and is designed to engage, educate, and inform primary school age learners about appropriate use of 999 services and vital lifesaving skills. Schools are asked for their audience language preference in order to deliver the sessions in either Welsh or English.

7. Compliance with the Policy Making Standards (Standards 69 – 77)

All new policies implemented by the Trust are subject to an Equality Impact Assessment (EqIA) of which Welsh language is a standard equality strand where staff formulating new or revised policies are asked to consider the positive and/or negative impacts that could result from that policy for the Welsh language. Support from the Welsh Language Services Manager is available to any colleague completing an EqIA and is a standard procedure for all new and revised policies.

From April 2017, the Trust established a revised Trust wide policy process which ensures there is a robust structure in place within which to review existing or develop new policies.

8. Compliance with the Operational Standards (Standards 79 – 114)

The set of Operational Standards deals with the way the Trust uses the Welsh language internally and gives employees the right to receive Human Resources services in their chosen language.

8.1 Policy on the Internal Use of Welsh (Standard 79)

As part of the Trust's new Welsh Language Framework a new policy to promote the use of the Welsh language within the Trust will be developed for the formal and social use of Welsh amongst our workforce through regular learning and greater participation in a variety of formal and informal language networks and events. Part of this work is the introduction of a Welsh Language Award as one of the categories for the Trust's annual Staff Awards. The award is to recognise staff who have helped to promote the Welsh Language and improve bilingual provision in healthcare.

From the five nominations received for the Welsh Language Award 2022, Cerrie Douglass, Clinical Support Desk Clinician was this year's winner for her use of the Welsh language within the complex nature of the clinical support desk.

8.2 Employment Documents (Standards 80 – 81)

We have not been asked by any member of staff for any employment related documents to be supplied in Welsh i.e., documents that outline training needs or requirements; documents that outline performance objectives; documents that outline or record a career plan; forms that record and authorise annual leave; forms that record and authorise absences from work and forms that record and authorise flexible working hours.

We have ensured that the following documents: change of hours letters, secondment extensions and contract of employment have been translated should any member of staff wish to receive them through the medium of Welsh. Where NHS Wales Shared Services Partnership (NWSSP) issues contracts of employment (via the recruitment process within TRAC), these are sent in both Welsh and English.

8.3 Recruiting and Appointing (Standards 106 – 109)

Guidance/process flow charts are used to assist managers prior to any post being advertised. The process provides details of translation services as well as some standard advert and job description wording to assist managers. A translation Service Level Agreement with Betsi Cadwaladr University Health Board has been established to support the Trust's translation needs.

The assessment form we introduced for all managers to complete to help assess Welsh language requirement for posts continues to be utilised. This forms part of a number of other check points, prior to a post being released for advert.

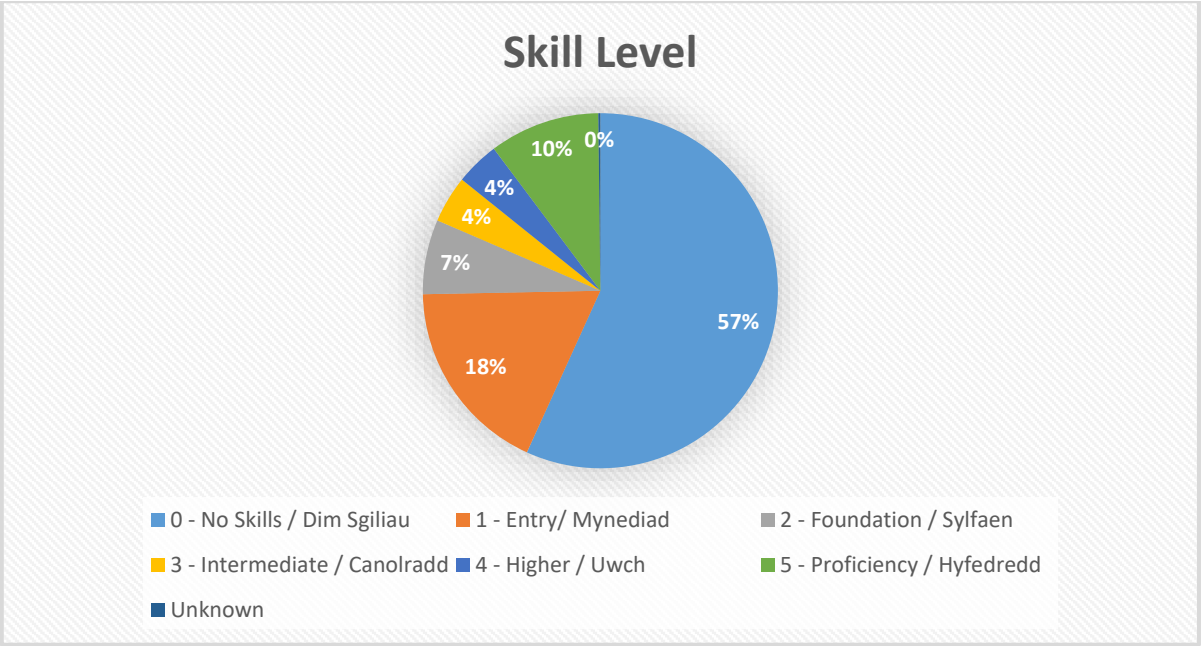
8.4 Assessing and Recording Welsh Language Skills across the Workforce (Standards 96 and 116)

From a total of **4,375** members of staff **3,906 (89.28%)** **4,283 (87.23%)** of the Trust's workforce have self-assessed and recorded their Welsh language skills on ESR. Below, Welsh language listening/speaking skills recoded on ESR per directorate:

Directorate	Required	Achieved	Compliance %
Corporate Governance	7	7	100%
Chief Executive Directorate	19	15	78.95%
Digital Directorate	52	51	98.08%
Finance & Corporate Resources Directorate	107	98	91.59%
Medical & Clinical Directorate	56	55	98.21%
Operations Directorate	3883	3437	88.51%
Partnerships & Engagement Directorate	12	12	100.00%
Quality, Safety & Patient Experience Directorate	130	127	97.69%
Strategy, Planning & Performance Directorate	17	14	82.35%
People & Culture Directorate	92	90	97.83%

8.5 Welsh Language Skills of Staff Profile – Listening/Speaking

0 - No Skills	1 - Entry	2 - Foundation	3 - Intermediate	4 - Higher	5 - Proficiency	Unknown	Grand Total
2450	772	293	185	172	434	8	4314



8.6 New and Vacant Posts (Standard 117)

The table below confirms posts advertised between 1 April 2022 and 31 March 2023:

Total number of posts advertised: **405** (456). All job descriptions are translated into Welsh.

Category	Number of posts categorised		Percentage of posts advertised	
	2022-23	2021-22	2022-23	2021-22
Essential	6	8	1.4%	1.7%
Desirable	393	441	97%	97%
Needs to be learned	0	0	0%	0%
Not necessary	6	6	1.4%	1.3%

* Orange figures/percentages represent the 2021/22 reporting period.

Welsh essential posts advertised:

- Non Emergency Patient Transport Service (NEPTS) Call Taker

Job interviews for vacant posts were facilitated in Welsh following requests from the job applicant.

In order to ensure that our service users receive services in their language of choice a dedicated Welsh language workstream has been developed as part of the overall WAST Strategic Workforce Plan. Work will progress in 2023-24 in identifying the levels of Welsh language skills of Trust staff and identify those skills gaps in delivering the active offer to our service users.

8.7 Training (Standard 97)

We offer the following training through the medium of Welsh in accordance with this Standard:

- recruitment and interviewing
- performance management
- complaints and disciplinary procedures
- induction
- dealing with the public
- health and safety

We have not undertaken training for Performance Management or Complaints and Disciplinary Procedures during the period that this report covers. Generally, training for these areas is conducted when a key change in policy and/or procedure is agreed, and where we would have to ensure that managers are aware of the change and its implication on their management of staff through one of these processes.

We can however confirm that should training in these areas be necessary, candidates will be asked if they would like the training in Welsh. A session through the medium of Welsh (number dependent) would be arranged or via the use of a simultaneous translation service.

8.8 Training carried out during the reporting period.

Type of Training	Number who attended the Welsh version	Number who attended the English version	Percentage that attended the Welsh version
Recruitment and Interviewing	None delivered		
***Performance Management**	0	26	0
Complaints and Disciplinary Procedures	None delivered		
**** Induction**	0	424	0
Dealing with the Public	None delivered		
*****Health and Safety**	0	72	0

*A revised PADR process was introduced in November 2022 to include the wellbeing and newly introduced Trust behaviours element. A presentation was developed to go through all aspects of the PADR process and the pay progression process. This is currently available in English but will be made available in Welsh in 2023/24.
** No one requested for our induction to take place in Welsh, however, every 'WAST Welcome Day' where new members of staff are introduced to the Trust has an element of Welsh within it (greeting delivered bilingually, Welsh WAST behaviours video and reference to the Welsh language standards and learning materials, some of which are delivered in Welsh).
*** This is an internationally delivered IOSH accredited training course, and not available in Welsh.

8.9 Training to Improve Welsh Language Skills (Standards 99 - 101)

The online module ‘Croeso Cymraeg Gwaith’ has been key to the Trust in supporting staff who are at the beginning of their journey to learn Welsh and **303** **(294)** members of staff have registered onto the Welsh language beginners e-learning module facilitated by the National Centre for Learning Welsh with **97** having completed the course.

8.10 Welsh Language Awareness Training (Standards 102 – 103)

The Trust’s ’Welcome days’ includes Welsh language awareness and a total of **424** **(340)** staff undertook this training during the reporting period.

8.11 Promoting the Welsh Language

The 7th of December 2022 marked Welsh Language Rights Day which is the date on which the Welsh Language (Wales) Measure, the legislation that made the rights possible, was passed by the Senedd.

This video was developed by the Trust to support Welsh Language Rights’ Day and promoted on its social media platforms. In addition, advice, and guidance to Trust staff on how they can comply with the Welsh language standards was also promoted.

9. Complaints (Standard 115)

Below, is a list of complaints received during 2022/23 along with a summary of the actions taken. Five complaints were received:

	Complaint	Response and action
1	Welsh Language Commissioner initiated an investigation and determined that the Trust failed to comply with standards 1 and 7 that deal with sending and receiving correspondence.	Staff who deal with external correspondence have subsequently received compliance awareness sessions on sending and receiving correspondence in Welsh.
2	Complaint received from member of the public with regards to the 111 website that the "Services offered" section on each of the primary care provider's page does not contain any information as to what services are available in Welsh.	Local Health Boards have been contacted to provide information on their Welsh language services provision within primary care which can be reflected on the 111 website.
3	Complaint received via Member of the Senedd about the standard of the Welsh language telephone line service for arranging hospital transport (NEPTS).	Improvement work was carried out on the NEPTS telephony system and call routing for Welsh language calls.
4	Complaint received from the Welsh Language Commissioner that on the 111 website it incorrectly states that a number of dentists have a Welsh language service.	After submitting a response to the Welsh Language Commissioner the Commissioner later confirmed that she will not be conducting a statutory investigation as it was the duty of the local health boards in line with standard 65 to publish information on their websites about which primary care providers provide their services in Welsh. The Commissioner asked if it was possible for the Trust to consider integrating this information (already collected and recorded by the local health boards) into the https://111.wales.nhs.uk/ website, or consider stating on the relevant pages of the NHS 111 website that information about which primary care providers provide their services in Welsh should be available on each health board's individual websites. The messaging for each dental practice has been amended so as to indicate

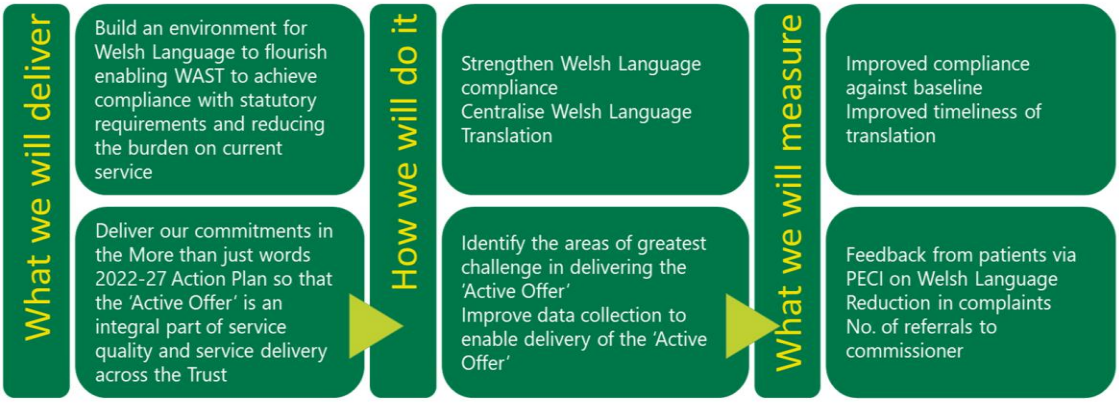
		that service users are advised to contact the service directly to discuss provision / access to the service in the medium of Welsh.
5	Complaint received in relation to the NEPTS webpage that only included an English video and that the Welsh language version of a patient questionnaire was only accessed via the English version of the webpage**.**	The video on the NEPTS webpage is now available in Welsh and links on the patient questionnaire have been checked and now go to the Welsh language web pages.

10. Priorities for 2023-2024

Welsh Language Framework

We will be implementing our Welsh Language Framework that will ensure there is structure, rigour, governance, and consistency for the development of the Welsh language throughout the Trust that encompasses compliance with the statutory requirements of Welsh Language Standards under the Welsh Language (Wales) Measure 2011 and delivery of the actions within the More than just words 2022-27 Action Plan.

Welsh Language Deliverables from within the framework have been included in the Trust's Integrated Medium Term Plan (IMTP) 2023-26 where progress will be reported via the Trust Board's People and Culture Committee.



Centralising of Welsh Language Translation will enable the Trust to meet the increase in demand in Welsh language translation requirements of the Welsh Language Standards and have a fit for purpose translation service that can respond to WAST service users and staff in a bilingual way.

More Than Just Words

Work has progressed on delivering the actions within Year 1 of the action plan which has been submitted to Welsh Government for review. As to ensure that Welsh language is promoted at the highest level of the organisation and there is broad understanding of the active offer the Trust's Board Secretary (Trish Mills) has been named as the Executive Champion at the Board for Welsh Language together with Non-Executive Director (Bethan Evans) as an additional champion.

In line with Action 10 and 18 of 'More than just words', a dedicated Welsh language workstream has been developed as part of the overall WAST Strategic Workforce Plan. Work will progress in 2023-24 in identifying the levels of Welsh language skills of Trust staff and identify those skills gaps in delivering the active offer to our service users.

Further Information

For further information on the Welsh Language Standards please contact:

Melfyn Hughes
Welsh Language Services Manager

Welsh Ambulance Services NHS Trust
Tŷ Elwy
Ffordd Richard Davies
St Asaph
Denbighshire
LL17 0LJ

E-mail: Melfyn.hughes@wales.nhs.uk

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

YMDDIRIEDOLAETH GIG GWASANAETHAU AMBIWLANS CYMRU

ADRODDIAD BLYNYDDOL SAFONAU'R GYMRAEG 2022-2023

Cynnwys

Rhagair

Croeso! Welcome!
Fel Cadeirydd a Phrif Weithredwr Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru, rydym wrth ein bodd cyflwyno ein pedwerydd adroddiad ar weithredu Safonau'r Gymraeg.

Mae Mesur y Gymraeg (Cymru) 2011 yn nodi fframwaith cyfreithiol sy'n gosod dyletswydd ar Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru, ynghyd â sefydliadau cyhoeddus eraill, i gydymffurfio â'r Safonau sy'n ymwneud â'r Gymraeg ac yn darparu cyfle i gryfhau'r gofynion a gwella safon a hygyrchedd gwasanaethau drwy gyfrwng y Gymraeg.

Mae ymrwymiad clir gan y Bwrdd i weithredu'r Safonau ac yn ystod 2022/23 rydym wedi parhau i godi ymwybyddiaeth o ofynion y Safonau drwy gynnwys gofynion y Gymraeg mewn sesiynau sefydlu staff ynghyd â hyrwyddo'r modiwl ar-lein 'Croeso Cymraeg Gwaith' sydd wedi bod yn allweddol wrth gefnogi aelodau staff sydd ar ddechrau eu taith i ddysgu Cymraeg.

Mae Cyflawniadau'r Gymraeg wedi'u cynnwys o fewn Cynllun Tymor Canolig Integredig (CTCI) 2023-26 yr Ymddiriedolaeth sy'n ymgorffori cynllun gweithredu i roi strategaeth Mwy na geiriau Llywodraeth Cymru ar waith, gyda chanolbwynt ar gynnig gweithredol y Gymraeg ar draws ein gwasanaethau. Caiff cynnydd yn erbyn yr CTCI ei fonitro gan Bwyllgor Cyllid a Pherfformiad yr Ymddiriedolaeth, fodd bynnag mae gan y Pwyllgor Pobl a Diwylliant oruchwyliaeth benodol o'r Gymraeg ac un o'i flaenoriaethau ar gyfer 2023/24 yw hyrwyddo'r amcanion cydraddoldeb strategol.

Mae'r Adroddiad Blynyddol hwn yn nodi ein cydymffurfedd â'r Safonau ac mae wedi'i gefnogi gan ddata ar gyfer y cyfnod adrodd 1 Ebrill 2022 i 31 Mawrth 2023. Rydym yn cydnabod ein bod wedi gwneud cynnydd, ond mae gwelliannau pellach wedi'u cynllunio i wella cyflenwad ein gwasanaethau iaith Gymraeg. Er mwyn cyflawni'r gwelliannau hyn, rydym wedi bod yn gweithio'n agos gyda Chomisiynydd y Gymraeg i sefydlu datrysiadau sy'n diwallu ein hanghenion gweithredol ac yn sicrhau hawliau siaradwyr Cymraeg.

Mae'r adroddiad hwn hefyd yn adlewyrchu effaith gadarnhaol gweithredu Mwy na geiriau a'r egwyddor "Cynnig Rhagweithiol", sy'n golygu cyflenwi gwasanaeth cyfrwng Cymraeg heb fod angen i ddefnyddiwr y gwasanaeth gofyn amdano.

Colin Dennis, Cadeirydd

Jason Killens, Prif Weithredwr

1. Cyflwyniad

Dyma bedwerydd Adroddiad Blynyddol o waith Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru yn arddangos sut y mae Safonau'r Gymraeg wedi cael eu gweithredu.

Ar 30 Mai 2019, symudodd yr Ymddiriedolaeth o weithredu ei Chynllun yr Iaith Gymraeg o dan Ddeddf yr Iaith Gymraeg 1993 i weithredu Safonau'r Gymraeg fel rhan o Fesur y Gymraeg (Cymru) 2011.

Mae'r Ymddiriedolaeth wedi parhau i ymateb yn gadarnhaol i Safonau'r Gymraeg gan ei bod yn ei weld fel cyfle i wella safon a hygyrchedd ei gwasanaethau drwy gyfrwng y Gymraeg.

2. Ynglŷn â ni

Rydym yn dîm o fwy na 4,000 o bobl sy'n gwasanaethu'r 3.1 miliwn o bobl yng Nghymru, ynghyd â chefnogaeth anhepgor yr Ymatebwyr Cyntaf Cymunedol, a gyrwyr ceir gwirfoddol sy'n cludo cleifion o'u cartrefi i apwyntiadau ysbyty a nôl.

Mae'r ganolfan gyswllt 111 yn darparu cyngor a chymorth i filoedd o gleifion, ac yn eu cyfeirio at y gwasanaethau cywir drwy ein gwasanaethau 'Ymgynghori a Chau' . Mae hyn yn cynnwys gwasanaeth GIG 111 Cymru, sy'n darparu cyngor gofal iechyd 24/7 ar lein ac ar y ffôn.

Mae ein Gwasanaeth Cludiant Cleifion Di-frys (NEPTS) yn cynnig gwasanaeth trin galwadau penodol sy'n delio â dros 1,000 o alwadau'r dydd yn genedlaethol gan gleifion cymwys sydd angen cludiant ambiwlans di-frys. Mae'r gwasanaeth NEPTS yn cludo cannoedd o filoedd o gleifion i fan ofal, neu gartref, bob blwyddyn.

Mae ein derbynwyr galwadau brys a staff canolfannau cyswllt clinigol yn delio â dros hanner miliwn o alwadau'r flwyddyn, 24/7 a 365 diwrnod y flwyddyn ac rydym ar reng flaen cyflenwi gwasanaeth, yn sicrhau bod cleifion yn cael y cyngor a chymorth cywir.

3. Cefndir i Safonau'r Gymraeg

O dan Fesur y Gymraeg (Cymru) 2011, rhaid i holl sefydliadau cyhoeddus yng Nghymru cydymffurfio â dyletswyddau iaith, sy'n sicrhau nad yw'r Gymraeg yn cael ei thrin yn llai ffafriol na'r Saesneg. Mae'r dyletswyddau'n annog hyrwyddo'r Gymraeg, defnydd o'r Gymraeg o fewn gweinyddiaeth fewnol ac yn ei wneud yn ofynnol bod darpariaeth yn cael ei gwneud ar gyfer hygyrchedd y Gymraeg i'r cyhoedd.

Mae Adran 44 o fesur 2011 yn caniatáu i Gomisiynydd y Gymraeg gyhoeddi hysbysiad cydymffurfedd, sy'n ei wneud yn ofynnol i gorff gydymffurfio ag un neu fwy

o'r safonau sy'n benodol gymwys iddo. Yna, cyflwynwyd Rheoliadau Safonau'r Gymraeg (Rhif 7) 2018 i sefydliadau'r sector iechyd yng Nghymru.

Yn unol ag adran 44 o fesur 2011, diben Safonau'r Gymraeg yw darparu'r canlynol:

- Eglurder i sefydliadau ynglŷn â'r Gymraeg
- Eglurder i siaradwyr Cymraeg ynglŷn â pha wasanaethau y gallant ddisgwyl eu derbyn yn Gymraeg.
- Mwy o gysondeb mewn gwasanaethau Cymraeg a gwella'r safon ar gyfer defnyddwyr

4. Cynllun Gweithredu Mwy na geiriau 2022-27

Mae **Cynllun Gweithredu Mwy na geiriau 2022-27** y Llywodraeth, a lansiwyd ym mis Awst 2022, yn nodi sut gall gwasanaethau Iechyd a Gofal Cymdeithasol Cymraeg gyda'i gilydd, yrru cynnydd o dan y thema gyffredinol diwylliant ac arweinyddiaeth a'r tair thema ganlynol:

- Thema 1 – Cynllunio'r Gymraeg a pholisïau gan gynnwys data.
- Thema 2 – Cefnogi a datblygu sgiliau Cymraeg y gweithlu presennol a'r dyfodol.
- Thema 3 – Rhannu arfer da a dull galluogi.

Mae'r Ymddiriedolaeth wedi'i hymrwymo i ddarparu'r gweithrediadau fel y'u nodwyd yn y Cynllun Gweithredu fel bod y 'Cynnig Rhagweithiol' yn rhan annatod o safon y gwasanaeth a chyflenwi gwasanaethau ar draws yr Ymddiriedolaeth.

5. Atebolrwydd a Chefnogaeth

5.1 Arweinwyr a Phencampwyr y Gymraeg

Ochr yn ochr â Rheolwr Gwasanaethau'r Gymraeg yr Ymddiriedolaeth, Ysgrifennydd Bwrdd yr Ymddiriedolaeth, Trish Mills yw arweinydd gweithredol y Gymraeg sydd wedi bod yn allweddol wrth hyrwyddo datblygiad Fframwaith Iaith Gymraeg newydd sydd wedi'i gynnwys yn CTCI yr Ymddiriedolaeth ac wedi bod yn agor trafodaethau yn Gymraeg sylfaenol. Yn ogystal, mae gan Fwrdd yr Ymddiriedolaeth Cyfarwyddwr Anweithredol, Bethan Evans, sef Pencampwr y Gymraeg y Bwrdd ac sydd wedi bod yn ymwneud â hyrwyddo'r Gymraeg o fewn yr Ymddiriedolaeth i'n staff ac yn allanol i'n defnyddwyr trwy lwyfannau cyfryngau cymdeithasol yr Ymddiriedolaeth.

Trish Mills, Ysgrifennydd y Bwrdd

Bethan Evans, Cyfarwyddwr Anweithredol

5.2 Grŵp Cynghori'r Gymraeg

Mae Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru wedi sefydlu Grŵp Cynghori'r Gymraeg. Mae'r grŵp hwn yn darparu dull ar gyfer arolygu pob agwedd o Safonau'r Gymraeg ac er mwyn sicrhau y cynhelir gwasanaeth boddhaol ar gyfer holl gleifion ac aelodau'r cyhoedd sy'n defnyddio gwasanaethau'r Ymddiriedolaeth.

5.3 Tîm Arweinyddiaeth Cyfarwyddwyr Cynorthwyol

Mae Tîm Arweinyddiaeth Cyfarwyddwyr Cynorthwyol yr Ymddiriedolaeth (ADLT) yn gyfrifol am gefnogi Tîm Rheoli Gweithredol yr Ymddiriedolaeth wrth ddatblygu a darparu cynlluniau ac amcanion strategol, targedau ariannol a chydymffurfedd â gofynion deddfwriaethol, safonau ac arferion.

5.4 Pwyllgor Pobl a Diwylliant

Mae Pwyllgor Pobl a Diwylliant yr Ymddiriedolaeth yn darparu sicrwydd i'r Bwrdd ar ei drefniadau arweinyddiaeth, yn monitro cynnydd ac yn ceisio sicrwydd bod yr Ymddiriedolaeth yn cyflawni ei chyfrifoldebau statudol ynglŷn â Safonau'r Gymraeg.

5.5 Bwrdd yr Ymddiriedolaeth

Y rhan terfynol o lwybr llywodraethu Adroddiad Blynyddol Safonau'r Gymraeg yr Ymddiriedolaeth yn dilyn ei llwybr cymeradwyaeth gan Grŵp Cynghori'r Gymraeg yr Ymddiriedolaeth, ADLT, y Tîm Rheoli Gweithredol a'r Pwyllgor Pobl a Diwylliant bydd i Fwrdd yr Ymddiriedolaeth adolygu a thrafod y cynnydd a wnaed wrth gydymffurfio â'r Safonau.

5.6 Gweithdrefn cwyno

Derbynnir pryderon ynglŷn â chydymffurfedd â Safonau'r Gymraeg mewn sawl ffordd e.e., gohebiaeth i'r Prif Weithredwr. Bydd yr holl gwynion a dderbynnir yn cael eu hymchwilio a darperir ymateb gydag unrhyw gamau cywiro gofynnol. Byddai materion yn ymwneud â diogelwch cleifion yn cael sylw o dan Reoliadau Gweithio i Wella.

Os oes gan aelod o'r cyhoedd pryder yn ymwneud â phrofiad diweddar o ddefnyddio gwasanaethau'r Ymddiriedolaeth, gallant cofnodi eu pryder mewn sawl ffordd trwy ddefnyddio'r ffordd sydd mwyaf addas iddynt: anfon e-bost at y tîm cwynion: Amb_PuttingThingsRight@wales.nhs.uk neu lenwi ffurflen ar-lein: Ffurflen Gyflwyno Pryderon Ar-lein

6. Cydymffurfedd â'r Safonau Cyflenwi Gwasanaethau (Safonau 1 i 77)

Mae'r set hon o safonau yn nodi sut y mae gofyn i'r Ymddiriedolaeth defnyddio'r Gymraeg mewn gwahanol sefyllfaoedd fel y gall siaradwyr Cymraeg gael mynediad dirwystr at wasanaethau gyfrwng Gymraeg; er enghraifft, wrth anfon gohebiaeth, delio â galwadau ffôn, cyflenwi gwasanaethau ar-lein neu wyneb yn wyneb.

6.1 Gohebiaeth (Safonau 1 i 7)

Mae'r Ymddiriedolaeth wedi defnyddio dull cyson o ddefnyddio papur â phennawd a llofnodion e-bost ac mae'n ei gwneud yn ofynnol i bob aelod o staff ddefnyddio papur â phennawd dwyieithog yr Ymddiriedolaeth. Rydym hefyd wedi annog yr holl staff i gynnwys neges ar lofnodion e-bost yn nodi bod yr unigolyn yn 'croesawu gohebiaeth yn y Gymraeg neu'r Saesneg'.

6.2 Galwadau ffôn (Safonau 8 i 20)

Nid yw Safonau'r Gymraeg fel y'u gosodwyd ar yr Ymddiriedolaeth yn gosod unrhyw ofyniad cyfreithiol i ateb galwadau 999 yn Gymraeg. O dan Reoliadau Safonau'r Gymraeg (Rhif 7) 2018 Paragraff 35: Nid yw Safonau 8 i 10 ac 13 i 16 yn gymwys i alwadau a wneir i'r rhif ffôn 999.

Mae galwyr i'r gwasanaeth 111 ac i'r gwasanaeth NEPTS yn derbyn cyfarchiad dwyieithog. Pan fydd yr Ymddiriedolaeth yn sefydlu cysylltiad ffôn gyda defnyddiwr gwasanaeth am y tro cyntaf, bydd y defnyddiwr yn cael ei ofyn a oes well ganddo dderbyn galwadau gan yr Ymddiriedolaeth yn y dyfodol yn Gymraeg neu yn Saesneg. Bydd y dewis iaith yn cael ei nodi a'i barchu. Mae galwadau i 111 a NEPTS yn cynnig opsiwn iaith i alwyr.

6.2.1 Arolygu'r gwasanaeth 111

Yn ystod y flwyddyn ariannol 2022/23, cafodd y gwasanaeth 111 heriau perfformiad sylweddol mewn perthynas â galw digynsail yn y gaeaf. Yn ystod y misoedd hyn, roedd y galw ar y gwasanaethau ar adegau yn herio ein gallu technegol a staffio i ateb y galwadau mewn modd amserol. Roedd y lefel hwn o weithgaredd yn fwy na'r hyn a welwyd yn ystod frig pandemig COVID-19.

Arweiniodd y brigiad Strep A ym mis Rhagfyr, gweithredu diwydiannol hir, ochr yn ochr â seibr-ymosodiad cenedlaethol dros gyfnod o chwe mis at effaith ar berfformiad cyffredinol y gwasanaeth.

Gwelwyd yr effaith hwn mewn perfformiad cyfradd ateb mewn galwadau Cymraeg a Saesneg.

Cyfradd galw ac ateb galwadau Cymraeg gwasanaeth 111 GIG Cymru 2022-2023

Galw am y Gymraeg	Cyfanswm y galwadau a atebwyd ar gyfer 111	Galwadau Cymraeg a gynigiwyd	Cyfanswm y galwadau a atebwyd yn Gymraeg	% o alwadau yr atebwyd yn Gymraeg
01/04/22 – 31/03/23	**766,718**	**15,735**	**2,853**	**18.1%**
01/04/21 – 31/03/22	**680,161**	**15,341**	**6,949**	**45%**

* Mae ffigurau/canrannau oren yn cynrychioli cyfnod adrodd 2021/22.

Gwelliannau i'r gwasanaeth 111 sy'n gysylltiedig â'r Gymraeg

Er mwyn rhoi sylw i berfformiad y safon hon mae'r canlynol ar y gweill ac wedi'i gynllunio ar gyfer 2023/24.

1. Datblygiadau gwasanaeth a thechnegol sylweddol i wella perfformiad cyfradd ateb cyffredinol.
2. Recriwtio parhaus o dderbynwyr galwadau Cymraeg i'r gwasanaeth 111.
3. Hyfforddiant ymwybyddiaeth y Gymraeg ar ddechrau cyflogaeth.
4. Hyfforddiant ymwybyddiaeth y Gymraeg rheolaidd gan ddefnyddio'r fideos a'r deunyddiau hyfforddi mewnol â ffocws.
5. Cynnwys cynllun gwella'r Gymraeg o fewn CTCI y gwasanaeth 111.

Yn ogystal, mae ateb galwadau 111 yn Gymraeg ar gyfer y Gwasanaeth Cludiant Cleifion Di-frys bellach yn ddangosydd perfformiad allweddol ar lefel y Bwrdd yn yr Adroddiad Ansawdd a Pherfformiad Integredig Misol (AAPhIM).

6.2.2 Gwasanaeth Cludiant Cleifion Di-frys (NEPTS)

Croesewir pob galwr i'n Canolfan Gyswllt NEPTS gyda chyfarchiad dwyieithog ac yna ein system Ymateb Llais Integredig (IVR) sy'n caniatáu i alwyr ddewis eu hiaith ddewisol yn Gymraeg neu yn Saesneg o'r pwynt hwn. Yn dibynnu ar eu dewis, bydd pob neges yn cael ei chyflwyno yn eu dewis iaith.

Caiff galwyr Cymraeg eu cyfeirio drwy'r IVR i'n derbynwyr galwadau Cymraeg. Os yw ein derbynwyr galwadau Cymraeg yn brysur gyda galwyr eraill, bydd y galwr yn cael ei ail-gyfeirio i'r derbyniwr galwadau Cymraeg neu Saesneg nesaf sydd ar gael i osgoi amser aros diangen. Mae'n bwysig nid yn unig darparu profiad galwad Cymraeg llawn ond hefyd sicrhau nad oes oedi hir yn digwydd os yw ein holl dderbynwyr galwadau Cymraeg yn delio â galwadau eraill.

Defnyddir ein Hasesiad Anghenion Claf i wirio cymhwysedd pob claf ar gyfer cludiant ambiwlans ac mae wedi cael ei gyfieithu'n llawn i'w ddefnyddio gan ein derbynwyr galwadau Cymraeg i wella profiad y galwr.

Cyfradd galw ac ateb galwadau Cymraeg NEPTS 2022-2023

Galw am y Gymraeg	Cyfanswm galwadau a atebwyd ar gyfer NEPTS	Galwadau Cymraeg a gynigiwyd	Cyfanswm y galwadau a atebwyd yn Gymraeg	% y galwadau a atebwyd yn Gymraeg
01/04/22 – 31/03/23	**200,864**	**1,878**	**1,856**	**98.8%**

*Mae data galwadau canolfan NET wedi'i gynnwys ar gyfer yr adroddiad blynyddol hwn er mwyn ei halinio gyda'r set data a ddarparwyd gan y gwasanaeth 111. Wrth symud ymlaen, caiff data cymaradwy o'r flwyddyn flaenorol ei gynnwys.

*O'i gymharu â pherfformiad ateb galwadau iaith Gymraeg ar gyfer y gwasanaeth 111, mae NEPTS wedi llwyddo i ateb 98.8% o'u galwadau Cymraeg. Gellir priodoli hyn i'r rhif is a dderbynnir gan wasanaeth NEPTS.

6.3 Cyfarfodydd (Safonau 21 i 30)

Pan fydd yr Ymddiriedolaeth yn trefnu cyfarfod gydag aelod neu aelodau o'r cyhoedd, gofynnir i'r mynychwyr os ydynt yn dymuno defnyddio'r Gymraeg yn y cyfarfod. Pan fydd unigolion yn mynegi awydd i ddefnyddio'r Gymraeg mewn cyfarfod, bydd yr Ymddiriedolaeth yn parchu ac yn bodloni'r dewis hwnnw. Mae gan gyfarfodydd y Bwrdd Cyfarwyddwyr Anweithredol sy'n siarad Cymraeg, a chaiff pob cyfarfod Bwrdd ei ffrydio'n fyw drwy Zoom. Rydym yn ymchwilio i'r posibilrwydd o ddefnyddio isdeitlau Cymraeg ar gyfer cyfarfodydd Bwrdd yn y dyfodol.

6.4 Digwyddiadau cyhoeddus (Safonau 31 i 32)

Mewn perthynas â'r gwasanaethau wyneb yn wyneb a gynigir yn y digwyddiad, bydd gwahoddiad neu hysbyseb y digwyddiad yn gofyn i bobl rhoi gwybod i ni os ydynt yn dymuno defnyddio'r Gymraeg. Pan fydd hyn yn digwydd, byddwn yn cyflenwi gwasanaeth cyfieithu yn y digwyddiad.

6.5 Dogfennau a Ffurflenni (Safonau 36 i 38)

Mae ffurflenni i'w cwblhau gan y cyhoedd ar gael yn y Gymraeg. Mae dogfennau a gynhyrchwyd gan yr Ymddiriedolaeth i'r cyhoedd ar gael yn Gymraeg os yw testun y ddogfen yn awgrymu y dylid ei chynhyrchu yn Gymraeg, neu os yw'r gynulleidfa a ragwelir, a'u disgwyliadau, yn awgrymu y dylid llunio'r ddogfen yn Gymraeg. Os oes angen fersiynau Cymraeg ar wahân, bydd y fersiwn Saesneg yn datgan bod y ddogfen neu ffurflen hefyd ar gael yn Gymraeg.

6.6 Cyhoeddusrwydd a Deunyddiau hysbysebu (Safonau 33 i 34)

Mae ymgyrch cyfathrebu dwyieithog cenedlaethol ar gyfer GIG 111 Cymru wedi gorffen yn ddiweddar. Bwriad yr ymgyrch oedd codi ymwybyddiaeth, dealltwriaeth a ffydd yn GIG 111 Cymru, gan gynnwys y wefan, a helpu cleifion gydag anghenion gofal brys cael y gofal cywir, yn y lle cywir, y tro cyntaf.

Dechreuodd cam cyntaf yr ymgyrch farchnata aml-sianel hon ar 14 Tachwedd 2022, gyda hysbysebu cymdeithasol a digidol y tu allan i'r cartref taledig ac organig. O 28 Chwefror 2023, dechreuodd cam dau gyda hysbyseb deledu newydd ar ITV, S4C a Video on Demand – gallwch wylio'r hysbyseb teledu yma. Roedd ail gam yr ymgyrch hefyd yn cynnwys hysbyseb radio digidol, hysbysebu digidol, cyfryngau cymdeithasol (organig a thaledig), hysbysebu y tu allan i'r cartref a gweithgaredd dylanwadwyr. Roedd pecyn cyfryngau cymdeithasol a phecyn asedau poster ar gael i randdeiliaid eu lawrlwytho a'u rhannu.

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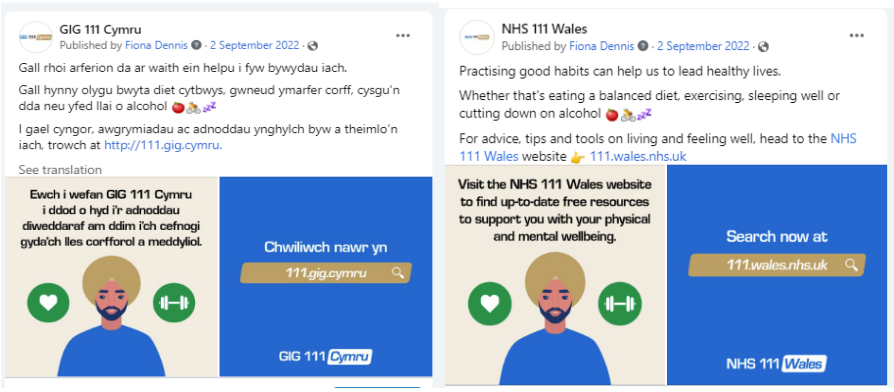
6.7 Gwefannau a Gwasanaethau ar-lein (Safonau 39 i 43)

Mae'r Ymddiriedolaeth yn cynnal dau wefan: Gwefan corfforaethol sydd wedi cael ei ail-ddatblygu gyda chyfleuster i newid rhwng y ddwy iaith, a gwefan Galw iechyd Cymru a chafodd ei ail-frandio ym Mai 2020 i GIG 111 Cymru www.111.wales.nhs.uk.

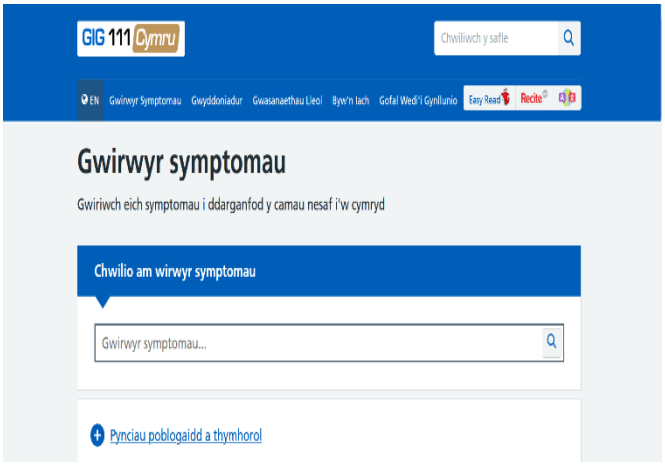
6.7.1 Gwefan 111

Yn ystod y cyfnod adrodd, derbyniodd y wefan **4,550,981** **(4,187,031)** golwg, gyda **12,554 (0.27%)** **(33,664 (0.62%)** golwg i'r wefan Cymraeg.

Ers lansio gwefan newydd GIG 111 Cymru, mae'r wefan wedi bod yn gweithredu ei chyfrifon cyfryngau cymdeithasol Twitter Cymraeg a Saesneg ei hun @GIG111Cymru gyda **105** **(81)** o ddilynwyr ac @NHS111Wales gyda **7,282** **(7,022)** o ddilynwyr.



Gwirwyr symptomau gwefan 111



Trwy wrando ar adborth defnyddwyr y gwefan, rydym yn parhau i weithio'n agos gyda chydweithwyr ar draws yr Ymddiriedolaeth i ehangu'r ystod o wirwyr symptomau sydd ar gael yn Gymraeg drwy'r wefan, gan alluogi defnyddwyr i wirio eu symptomau a derbyn cyngor ar-lein ynglŷn â beth i wneud nesaf. Yn ystod y cyfnod adrodd hwn, datblygwyd **14** gwiriwr newydd a'u rhoi ar gael yn Gymraeg a Saesneg:

Anaf coes	Poen a chwyddo ar yr wyneb	Poen neu chwydd y pen-glin	Poen neu chwyddo troed	Anaf ffêr	Blinder	Llewygu
Torri gwynt	Poen neu Chwydd y Ceilliau	Crychguriadau	Rhithweledigaethau	Llosgiadau	Anaf bys	Problemau cysgu

Cyfanswm y gwirwyr symptomau **dwyieithog** sydd bellach ar gael yw **65**.

Datblygiadau gwefan 111

Cynhaliwyd adran 'Gofal Wedi'i Gynllunio' newydd ar hafan gwefan 111 ar ran Llywodraeth Cymru, gan ddarparu data ar ba mor hir roedd pobl ym mhob Bwrdd Iechyd Lleol yn aros i gael eu cyfeirio atynt neu i fod o dan ofal arbenigwr.
Yn ystod mis Rhagfyr, roedd cynnydd yn y term chwilio 'y dwymyn goch' eisoes wedi'i ganfod cyn achosion a adroddwyd yn y cyfryngau a galwadau i wasanaeth teleffoni 111. Er mwyn cefnogi'r bobl iach gofidus ac eraill, datblygwyd gwybodaeth am ofalu am blentyn sâl, Strep A a'r Dwymyn Goch.' Cyfieithwyd hwn yn gyflym i'r Gymraeg.

Gyda gŵyl y banc pedwar diwrnod dros y cyfnod yr ŵyl, atgoffwyd defnyddwyr am gynllunio ymlaen llaw ac fe'u cynghorwyd am yr hyn a allent ei wneud y tu allan i oriau a heb bresgripsiwn. Roedd rota fferyllfa Cymru gyfan hefyd ar gael.

Trwy weithio gyda Thîm Prosiectau 111, mae sawl dudalen ar draws y wefan wedi'u hail-ddylunio gyda'r Gymraeg mewn golwg, gan gynnwys y Gwyddoniadur, Gwirwyr Symptomau a Gwasanaethau Lleol i greu cysondeb dylunio a gwella hygyrchedd ac optimeiddio ar gyfer defnyddwyr dyfeisiau symudol, sef ein mwyafrif o ymwelwyr.

6.8 Cyfryngau cymdeithasol (Safonau 45 i 46)

Mae'r Ymddiriedolaeth yn gweithredu cyfrifon cyfryngau cymdeithasol Cymraeg a Saesneg ar wahân ar gyfer Facebook a Twitter.

Isod mae dadansoddiad o ymgysylltu ar gyfrifon cyfryngau cymdeithasol yr Ymddiriedolaeth yn ystod y cyfnod adrodd.

Twitter

	@Ambiwlans_Cymru		@WelshAmbulance	
	2022-23	2021-22	2022-23	2021-22
Dilynwyr newydd	42	59	1,385	1,906
Cyfanswm yr argraffiadau	113,351	191,100	2,440,000	4,806,500
***'Retweets' (heb sylwadau)**	625		4,693	
'Likes'	485	366	12,400	16,188
***Clics ar ddolenni**	38		7,300	

* Mae ffigurau/canrannau oren yn cynrychioli'r cyfnod adrodd 2021/22.
* Ychwanegiadau newydd felly nid oes unrhyw ddata blaenorol tebyg ar gael.

Noder: mae cyfanswm y nifer o Tweets yn amrywio rhwng y ddau gyfrif oherwydd y rhesymau canlynol:

- Mae 'Tweets' yn cynnwys Tweets dyfynedig sy'n cael eu cyhoeddi'n fwy aml ar ein cyfrif Saesneg o ganlyniad i asiantaethau eraill, megis gwasanaethau ambiwlans y DU eraill, yn peidio â rhoi cynnwys yn Gymraeg.
- Mae cliciau ar ddolenni yn cynnwys defnyddwyr yn clicio ar ddolenni rydyn ni yn darparu yn y capsiynau. Er enghraifft, yn ystod gweithredu ddiwydiannol, ar ddewis o bostiadau defnyddion ni ddolen i fynd i'r dudalen Cwestiynau Cyffredin.

Facebook

	Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru		Welsh Ambulance Services NHS Trust	
	2022-23	2021-22	2022-23	2021-22
Dilynwyr newydd	27	59	1,959	4,647
'Likes' newydd ar y dudalen	10	28	1,029	2,237
***Cyfanswm yr ymweliadau â'r dudalen**	1,259		43,566	
***Cyfanswm cyrhaeddiad y dudalen**	65,794		939,342	
***Ymateb/'likes', sylwadau a rhannu**	491		100,0084	

* Ychwanegiadau newydd felly nid oes unrhyw ddata blaenorol tebyg ar gael.
* Mae ffigurau/canrannau oren yn cynrychioli'r cyfnod adrodd 2021/22.

6.9 Arwyddion a Hysbysiadau (Safonau 47 i 49)

Mae'r holl arwyddion newydd yn cael eu cynhyrchu'n ddwyieithog gyda'r Gymraeg wedi'u lleoli fel ei bod yn debygol o gael ei darllen gyntaf. Yn ystod y cyfnod adrodd, cynhyrchiwyd arwyddion allanol a mewnol newydd ar gyfer swyddfeydd yr Ymddiriedolaeth yng Nghwmbrân.

6.10 Gwasanaethau derbynfa (Safonau 50 i 53)

Pan fo gennym wasanaeth derbynfa, mae'r modiwl ar-lein 'Croeso Cymraeg Gwaith' ar gael i'r staff sy'n gweithio mewn ardaloedd derbynfa er mwyn datblygu eu sgiliau Cymraeg ac i fod yn gallu cyfarch ymwelwyr yn ddwyieithog. Mae cymorth Cymraeg hefyd ar gael gan Reolwr Gwasanaethau'r Gymraeg yr Ymddiriedolaeth.

6.11 Dyfarnu contractau (Safonau 57 i 59)

Bydd gwahoddiadau i dendro yn cael eu cyhoeddi'n ddwyieithog os yw pwnc y gwahoddiad i dendro yn awgrymu y dylai gael ei gyhoeddi yn y Gymraeg, neu os yw'r gynulleidfa ddisgwyliedig, a'u disgwyliadau, yn awgrymu y dylai'r testun cael ei gyhoeddi yn y Gymraeg. Gellir cyflwyno tendrau yn Gymraeg, ac ni chaiff tendr sydd wedi'i gyflwyno yn Gymraeg ei drin yn llai ffafriol na thendr wedi'i gyflwyno yn Saesneg.

Ni chafodd unrhyw dendr na chontract ei gyhoeddi yn Gymraeg ac ni dderbyniodd unrhyw un yn Gymraeg yn ystod y cyfnod adrodd hwn.

6.12 Cyrsiau hyfforddi (Safon 63)

Ar gyfer unrhyw gwrs addysg rydym yn ei gynnig i'r cyhoedd, rydym yn gwahodd y gynulleidfa i roi gwybod i ni am ei dewis iaith, nail ai Cymraeg neu Saesneg, i gymryd rhan yn y cwrs. Mae 'Shoctober' yn ymgyrch ymwybyddiaeth flynyddol mis o hyd sy'n rhedeg pob mis Hydref ac sydd wedi'i chynllunio i ymgysylltu, addysgu, a hysbysu dysgwyr oedran ysgol gynradd am ddefnydd priodol o wasanaethau 999 a sgiliau achub bywyd hanfodol. Gofynnir i ysgolion am eu dewis iaith er mwyn darparu'r sesiynau naill ai yn Gymraeg neu Saesneg.

6. Cydymffurfedd â'r Safonau Llunio Polisi (Safonau 69 i 77)

Mae holl bolisïau newydd a weithredir gan yr Ymddiriedolaeth yn destun Asesiad o'r Effaith ar Gydraddoldeb (EqIA) y mae'r Gymraeg yn llinyn cydraddoldeb safonol lle gofynnir i staff sy'n llunio polisïau newydd neu ddiwygiedig ystyried yr effeithiau cadarnhaol a/neu negyddol a allai ddeillio o'r polisi hwnnw ar gyfer y Gymraeg. Mae cefnogaeth Rheolwr Gwasanaethau'r Gymraeg ar gael i unrhyw gydweithiwr sy'n cwblhau EqIA ac mae'n weithdrefn safonol ar gyfer pob polisi newydd a diwygiedig.

O fis Ebrill 2017, sefydlodd yr Ymddiriedolaeth gweithdrefn polisi diwygiedig ar draws yr Ymddiriedolaeth sy'n sicrhau bod strwythur cadarn ar waith, a thrwy hynny i adolygu polisïau presennol neu ddatblygu polisïau newydd.

8. Cydymffurfedd â'r Safonau Gweithredol (Safonau 79 i 114)

Mae'r set hon o Safonau Gweithredol yn delio â'r ffordd y mae'r Ymddiriedolaeth yn defnyddio'r Gymraeg yn fewnol ac yn rhoi'r hawl i gyflogeion dderbyn gwasanaethau Adnoddau Dynol yn eu hiaith ddewisol.

8.1 Polisi ar ddefnyddio'r Gymraeg yn fewnol (Safon 79)

Fel rhan o Fframwaith y Gymraeg newydd yr Ymddiriedolaeth bydd polisi newydd i hyrwyddo defnydd y Gymraeg o fewn yr Ymddiriedolaeth yn cael ei ddatblygu ar gyfer y defnydd ffurfiol a chymdeithasol y Gymraeg ymhlith ein gweithlu drwy ddysgu rheolaidd a mwy o gyfranogiad mewn amrywiaeth o rwydweithiau a digwyddiadau ffurfiol ac anffurfiol. Rhan o'r gwaith hwn yw cyflwyno Gwobr y Gymraeg fel un o gategorïau ar gyfer Gwobrau Staff blynyddol yr Ymddiriedolaeth. Mae'r wobr er mwyn cydnabod staff sydd wedi helpu hyrwyddo'r Gymraeg a gwella darpariaeth ddwyieithog yng ngofal iechyd.

O'r pum enwebiad a dderbyniwyd ar gyfer Gwobr y Gymraeg 2022, Cerrie Douglass, Clinigydd Desg Gymorth Glinigol oedd yr enillydd eleni am ei defnydd o'r Gymraeg o fewn natur cymhleth y ddesg gymorth glinigol.

8.2 Dogfennau cyflogaeth (Safonau 80 i 81)

Nid yw unrhyw aelod o staff wedi gofyn i ni ddarparu unrhyw ddogfen sy'n gysylltiedig â chyflogaeth gael ei darparu yn Gymraeg h.y., dogfennau sy'n amlinellu anghenion neu ofynion hyfforddi; dogfennau sy'n amlinellu amcanion perfformiad; dogfennau sy'n amlinellu cofnod neu gynllun gyrfa; ffurflenni sy'n cofnodi ac yn awdurdodi gwyliau blynyddol; ffurflenni sy'n cofnodi ac yn awdurdodi absenoldeb o'r gwaith a ffurflenni sy'n cofnodi ac yn awdurdodi oriau gweithio hyblyg.

Rydym wedi sicrhau bod y dogfennau canlynol: newid i oriau, estyniadau secondiad a chontract cyflogaeth wedi cael eu cyfieithu os bydd unrhyw aelod o staff yn dymuno eu derbyn drwy gyfrwng y Gymraeg. Pan fo Partneriaeth Cydwasanaethau GIG Cymru (NWSSP) yn dyfarnu contractau cyflogaeth (drwy'r broses recriwtio o fewn TRAC), anfonir y rhain yn Gymraeg ac yn Saesneg.

8.3 Recriwtio ac Apwyntio (Safonau 106 i 109)

Defnyddir siartiau llif arweiniad/proses i gynorthwyo rheolwyr cyn hysbysebu unrhyw swydd. Mae'r broses isod yn rhoi manylion y gwasanaethau cyfieithu yn ogystal â rhywfaint o eiriad hysbyseb a swydd-ddisgrifiad safonol i gynorthwyo rheolwyr. Mae Cytundeb Lefel Gwasanaeth cyfieithu gyda Bwrdd Iechyd Brifysgol Betsi Cadwaladr wedi'i sefydlu i gefnogi anghenion cyfieithu'r Ymddiriedolaeth.

Mae'r ffurflen asesu a gyflwynwyd gennym ar gyfer pob rheolwr i'w chwblhau i helpu asesu gofynion y Gymraeg ar gyfer swyddi yn parhau i gael ei defnyddio. Mae hyn yn rhan o nifer o bwyntiau gwirio eraill, cyn i swydd gael ei rhyddhau ar gyfer hysbyseb.

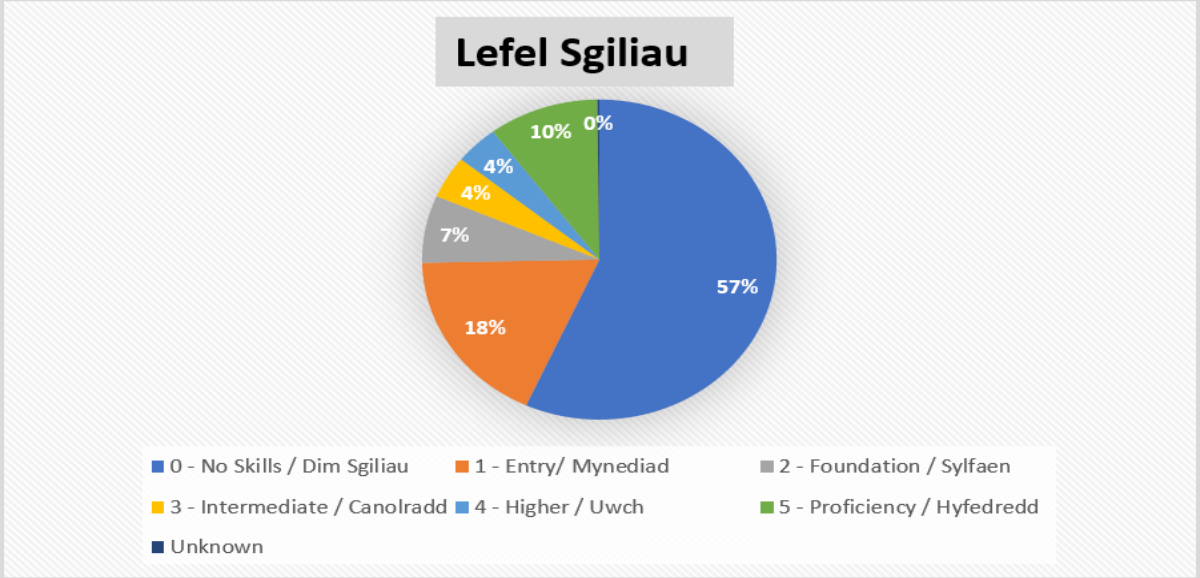
8.4 Asesu a chofnodi sgiliau Cymraeg ar draws y gweithlu (Safonau 96 a 116)

O gyfanswm o **4,375** o aelodau staff, mae **3,906 (89.28%)** **4,283 (87.23%)** o weithlu'r Ymddiriedolaeth wedi hunanasesu a chofnodi eu sgiliau Cymraeg ar y Cofnod Electroneg Staff (ESR).
Isod, sgiliau gwrando/siarad Cymraeg sydd wedi'u cofnodi ar ESR fesul cyfarwyddiaeth:

Cyfarwyddiaeth	Gofynnol	Cyflawnwyd	% Cydymffurfedd
Llywodraethu Corfforaethol	7	7	100%
Cyfarwyddiaeth y Prif Weithredwr	19	15	78.95%
Cyfarwyddiaeth Ddigidol	52	51	98.08%
Cyfarwyddiaeth Gyllid ac Adnoddau Corfforaethol	107	98	91.59%
Cyfarwyddiaeth Feddygol a Chlinigol	56	55	98.21%
Cyfarwyddiaeth Weithrediadau	3883	3437	88.51%
Cyfarwyddiaeth Bartneriaethau ac Ymgysylltu	12	12	100.00%
Cyfarwyddiaeth Ansawdd, Diogelwch a Phrofiad Cleifion	130	127	97.69%
Cyfarwyddiaeth Strategaeth, Cynllunio a Pherfformiad	17	14	82.35%
Cyfarwyddiaeth Bobl a Diwylliant	92	90	97.83%

8.5 Sgiliau Cymraeg y proffil staff – Gwrando/Siarad

0 – Dim sgiliau	1 - Mynediad	2 - Sylfaen	3 - Canolradd	4 - Uwch	5 - Hyfedredd	Anhysbys	Cyfanswm
2450	772	293	185	172	434	8	4314



8.6 Swyddi newydd a Swyddi gwag (Safonau 117)

Mae'r tabl isod yn cadarnhau'r swyddi a hysbysebwyd rhwng 1 Ebrill 2022 a 31 Mawrth 2023:

Cyfanswm y swyddi a hysbysebwyd: **405** **(456).** Caiff yr holl swydd-ddisgrifiadau eu cyfieithu i'r Gymraeg.

Categori	Nifer y swyddi wedi'u categoreiddio		Canran y swyddi a hysbysebwyd	
	2022-23	2021-22	2022-23	2021-22
Hanfodol	6	8	1.4%	1.7%
Dymunol	393	441	97%	97%
Angen ei dysgu	0	0	0%	0%
Ddim yn angenrheidiol	6	6	1.4%	1.3%

* Mae ffigurau/canrannau oren yn cynrychioli'r cyfnod adrodd 2021/22.

Swyddi Cymraeg hanfodol a hysbysebwyd:

- Derbynnydd galwadau'r Gwasanaeth Cludiant Cleifion Di-frys (NEPTS)

Cafodd cyfweliadau am swyddi gwag eu hwyluso yn Gymraeg yn dilyn ceisiadau gan ymgeisydd y swydd.

Er mwyn sicrhau bod ein defnyddwyr gwasanaeth yn derbyn gwasanaethau yn eu dewis iaith, mae ffrwd waith pwrpasol wedi cael ei datblygu fel rhan o Gynllun Gweithlu Strategol cyffredinol WAST. Bydd gwaith yn mynd rhagddo yn 2023-24 i nodi lefelau sgiliau Cymraeg staff yr Ymddiriedolaeth a nodi'r bylchau yn y sgiliau hynny wrth ddarparu'r cynnig rhagweithiol i'n defnyddwyr gwasanaeth.

8.7 Hyfforddiant (Safon 97)

Rydym yn cynnig y canlynol drwy gyfrwng y Gymraeg yn unol â'r Safon hwn:

- recriwtio a chyfweld
- rheoli perfformiad
- gweithdrefnau cwyno a disgyblu
- sefydlu
- delio â'r cyhoedd
- iechyd a diogelwch

Nid ydym wedi ymgymryd â hyfforddiant ar gyfer Rheoli Perfformiad na Weithdrefnau Cwyno a Disgyblu yn ystod y cyfnod y mae'r adroddiad hwn yn ei gwmpasu. Yn gyffredinol, cynhelir hyfforddiant ar gyfer y meysydd hyn pan gytunir ar newid allweddol mewn polisi a/neu weithdrefn, a phan fyddai'n rhaid i ni sicrhau bod rheolwyr yn ymwybodol o'r newid a'i oblygiadau ar eu rheolaeth o staff drwy un o'r prosesau hyn.

Fodd bynnag, gallwn gadarnhau os bydd angen hyfforddiant yn y meysydd hyn, gofynnir i ymgeiswyr os hoffent gael yr hyfforddiant yn Gymraeg. Byddai sesiwn drwy gyfrwng y Gymraeg (yn dibynnu ar y rhif) yn cael ei threfnu neu drwy ddefnyddio gwasanaeth cyfieithu ar y pryd.

8.8 Hyfforddiant a gynhaliwyd yn ystod y cyfnod adrodd.

Math o hyfforddiant	Nifer a fynychodd y fersiwn Gymraeg	Nifer a fynychodd y fersiwn Saesneg	Canran a fynychodd y fersiwn Gymraeg
Recriwtio a chyfweld	Dim un wedi'i ddarparu		
***Rheoli perfformiad**	0	26	0
Gweithdrefn cwyno a disgyblu	Dim un wedi'i ddarparu		
** **Sefydlu**	0	424	0
Delio â'r cyhoedd	Dim un wedi'i ddarparu		
***Iechyd a diogelwch**	0	72	0

*Cyflwynwyd gweithdrefn PADR diwygiedig ym mis Tachwedd 2022 i gynnwys yr elfen newydd llesiant ac ymddygiad yr Ymddiriedolaeth. Datblygwyd cyflwyniad i fynd drwy holl agweddau'r weithdrefn PADR a'r broses cynnydd cyflog. Mae hwn ar gael yn Saesneg ar hyn o bryd ond bydd ar gael yn Gymraeg yn 2023/24.
** Nid oes unrhyw un wedi gofyn i'm sefydlu digwydd yn Gymraeg, fodd bynnag, mae gan bob Diwrnod Croeso WAST lle caiff aelodau staff newydd eu cyflwyno i'r Ymddiriedolaeth elfen o Gymraeg ynddo (rhoi cyfarchiad dwyieithog, fideo ymddygiadau WAST Gymraeg a chyfeiriad at safonau'r Gymraeg a deunyddiau dysgu, a darperir rhai ohonynt yn Gymraeg).
*** Cwrs hyfforddi achrededig IOSH a gyflwynir yn rhyngwladol yw hwn, ac nid yw ar gael yn Gymraeg.

8.9 Hyfforddiant i wella sgiliau Cymraeg (Safonau 99 i 101)

Mae'r modiwl ar-lein 'Croeso Cymraeg Gwaith' wedi bod yn allweddol i'r Ymddiriedolaeth wrth gefnogi staff sydd ar ddechrau eu taith i ddysgu Cymraeg ac mae **303** (294) o aelodau staff wedi cofrestru ar y modiwl e-ddysgu Cymraeg i ddechreuwyr a hwylusir gan Y Ganolfan Dysgu Cymraeg Genedlaethol gyda **97** wedi cwblhau'r cwrs.

8.10 Hyfforddiant Ymwybyddiaeth o'r Iaith Gymraeg (Safonau 102 i 103)

Mae 'Diwrnod Croeso' yr Ymddiriedolaeth yn cynnwys ymwybyddiaeth o'r Gymraeg ac ymgymerodd cyfanswm o **424** (340) o aelodau staff â'r hyfforddiant hwn yn ystod y cyfnod adrodd.

8.11 Hyfforddi'r Gymraeg

Nododd 7 Rhagfyr 2022 Diwrnod Hawliau'r Gymraeg sef y dyddiad y pasiwyd Mesur y Gymraeg (Cymru), y ddeddfwriaeth a wnaeth yr hawliau'n bosibl, gan y Senedd.

Datblygwyd y fideo hwn gan yr Ymddiriedolaeth i gefnogi Diwrnod Hawliau'r Gymraeg a'i hyrwyddo ar ei llwyfannau cyfryngau cymdeithasol. Yn ogystal, hyrwyddwyd cyngor, ac arweiniad i staff yr Ymddiriedolaeth ar sut y gallant gydymffurfio â safonau'r Gymraeg.

9. Cwynion (Safonau 115)

Isod, mae rhestr o gwynion a dderbyniwyd yn 2022/23, ynghyd â chrynodeb o gamau gweithredu a gymerwyd. Derbyniwyd pum gwyn:

	Cwyn	Ymateb a cham gweithredu
1	Cychwynnodd Comisiynydd y Gymraeg ymchwiliad a phenderfynodd fod yr Ymddiriedolaeth wedi methu â chydymffurfio â safonau 1 a 7 sy'n delio ag anfon a derbyn gohebiaeth.	Mae'r staff sy'n delio a gohebiaeth allanol wedi derbyn sesiynau ymwybyddiaeth gydymffurfio ar gyfer anfon a derbyn gohebiaeth yn Gymraeg fel canlyniad.
2	Cwyn a dderbyniwyd gan aelod o'r cyhoedd ynglŷn â gwefan 111, nad yw'r adran "Gwasanaethau a gynigir" ar bob un o dudalennau'r darparwr gofal sylfaenol yn cynnwys unrhyw wybodaeth ynghylch pa wasanaethau sydd ar gael yn Gymraeg.	Cysylltwyd â Byrddau Iechyd Lleol i ddarparu gwybodaeth am eu darpariaeth gwasanaethau Cymraeg o fewn gofal sylfaenol y gellir ei adlewyrchu ar wefan 111.
3	Cwyn a dderbyniwyd gan Aelod o'r Senedd ynglŷn â safon y gwasanaeth llinell ffon Cymraeg ar gyfer trefnu cludiant ysbyty (NEPTS).	Cynhaliwyd gwaith gwella ar system teleffoni NEPTS a chyfeirio galwadau ar gyfer galwadau Cymraeg.
4	Cwyn a dderbyniwyd gan Gomisiynydd y Gymraeg bod gwefan 111 yn datgan yn anghywir bod gan nifer o ddeintyddfeydd wasanaeth Cymraeg.	Ar ôl cyflwyno ymateb i Gomisiynydd y Gymraeg, cadarnhaodd y Comisiynydd yn ddiweddarach na fydd yn cynnal ymchwiliad statudol gan mai dyletswydd y byrddau iechyd lleol yn unol â safon 65 oedd cyhoeddi gwybodaeth ar eu gwefannau ynglŷn â pha ddarparwr gofal sylfaenol sy'n darparu eu gwasanaethau yn Gymraeg. Gofynnodd y Comisiynydd a oedd yn bosibl i'r Ymddiriedolaeth ystyried integreiddio'r wybodaeth hon (a gasglwyd gan y byrddau iechyd lleol) i wefan https://111.wales.nhs.uk/, neu ystyried datgan ar dudalennau perthnasol gwefan GIG 111 y dylai gwybodaeth am ba ddarparwyr gofal sylfaenol sy'n darparu eu gwasanaethau yn Gymraeg fod ar gael ar wefannau unigol pob bwrdd iechyd. Mae'r geiriad ar gyfer pob deintyddfa wedi'i ddiwygio er mwyn nodi y dylai

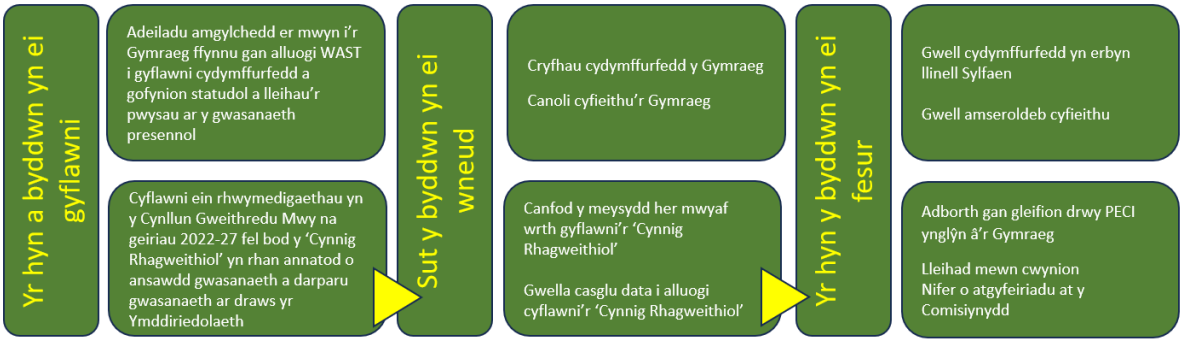
		defnyddwyr gwasanaeth cysylltu â'r gwasanaeth yn uniongyrchol i drafod darpariaeth / mynediad at y gwasanaeth drwy gyfrwng y Gymraeg.
5	Cwyn a dderbyniwyd ynglŷn â thudalen we NEPTS a oedd yn cynnwys fideo yn y Saesneg yn unig ac mai dim ond trwy fersiwn Saesneg y dudalen we y cafwyd mynediad at fersiwn Gymraeg holiadur cleifion.	Mae'r fideo ar dudalen we NEPTS bellach ar gael yn Gymraeg ac mae'r dolenni yn yr holiadur cleifion wedi cael eu gwirio a bellach yn mynd at y tudalennau we Cymraeg.

10. Blaenoriaethau ar gyfer 2023-2024

Fframwaith Iaith Gymraeg

Byddwn yn gweithredu ein Fframwaith Iaith Gymraeg a fydd yn sicrhau bod yna strwythur, trylwyredd, llywodraethu a chysondeb ar gyfer datblygu'r Gymraeg ar draws yr Ymddiriedolaeth sy'n cwmpasu cydymffurfedd â gofynion statudol Safonau'r Gymraeg o dan Fesur y Gymraeg (Cymru) 2011 a chyflawni'r camau gweithredu o fewn Cynllun Gweithredu Mwy na geiriau 2022-27.

Mae cyflawniadau'r Gymraeg o'r tu mewn i'r fframwaith wedi'u cynnwys yng Nghynllun Tymor Canolig Integredig (CTCI) 2023-26 lle bydd cynnydd yn cael ei adrodd gan Bwyllgor Pobl a Diwylliant Bwrdd yr Ymddiriedolaeth.



Bydd canoli cyfieithu'r Gymraeg yn galluogi'r Ymddiriedolaeth i gwrdd â'r cynnydd yn y galw am ofynion cyfieithu Cymraeg Safonau'r Gymraeg, a chael gwasanaeth cyfieithu sy'n addas i'r diben a all ymateb i ddefnyddwyr gwasanaeth a staff WAST mewn ffordd ddwyieithog.

Mwy na geiriau

Mae gwaith wedi symud ymlaen i gyflawni'r camau gweithredu ym Mlwyddyn 1 y cynllun gweithredu a gyflwynwyd i Lywodraeth Cymru i'w adolygu. Er mwyn sicrhau bod y Gymraeg yn cael ei hyrwyddo ar lefel uchaf y sefydliad a bod dealltwriaeth eang o'r cynnig rhagweithiol mae Ysgrifennydd Bwrdd yr Ymddiriedolaeth (Trish Mills) wedi'i henwi'n Bencampwr Gweithredol y Bwrdd i'r Gymraeg ynghyd â Chyfarwyddwr Anweithredol (Bethan Evans) fel pencampwr ychwanegol.

Yn unol â Gweithrediad 10 a 18 'Mwy na geiriau', datblygwyd ffrwd waith Gymraeg penodol fel rhan o Gynllun Gweithlu Strategol cyffredinol WAST. Bydd gwaith yn mynd rhagddo yn 2023-24 i nodi lefelau sgiliau Cymraeg staff yr Ymddiriedolaeth a nodi'r bylchau yn y sgiliau hynny wrth ddarparu'r cynnig rhagweithiol i'n defnyddwyr gwasanaeth.

Gwybodaeth bellach

I gael rhagor o wybodaeth am Safonau'r Gymraeg, cysylltwch â:

Melfyn Hughes
Rheolwr Gwasanaethau'r Gymraeg

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Tŷ Elwy
Ffordd Richard Davies
Llanelwy
Sir Ddinbych
LL17 0LJ

E-bost: Melfyn.hughes@wales.nhs.uk

FINANCE AND PERFORMANCE COMMITTEE
HIGHLIGHT REPORT TO BOARD

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

Trust Board Meeting Date	28 September 2023
Committee Meeting Date	18 September 2023
Chair	Joga Singh

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. During the finance and the operational updates, the key assumption within the Trust financial and current financial reporting of funding of £5.7m for the additional 100 WTEs (whole time equivalents) appointed in 2022/23 was a point of discussion and concern as that final funding sources had not started to flow through and there was now some urgency to have clarity on this going into Quarter 3. **Outstanding clarity of funding sources** for this was driving some cautious and prudent financial management and the impact of this on discretionary spend such as overtime has been escalated to the Chief Ambulance Services Commissioner (CASC) as has modelling on the service impact. An update on the very latest position from the CASC in relation to this was also provided.

2. The annual **Sustainability Report**, which forms part of the Trust's Annual Report amalgamates both qualitative and quantitative information separately provided to Welsh Government and data sets and includes sustainability updates on environmental initiatives and the Trust's ISO14001 accreditation. The Committee noted that the Sustainability Report, on the face of it, presents a headline value of a significant increase in WAST's carbon emissions between 2021/22 and 2022/23. This significant increase is predominantly due to a change in the data collection required by Welsh Government and the inclusion of aspects of emissions data which were previously not applicable. Some areas of good progress and reductions in emissions were also highlighted.

   The report is attached at **Annex 1 for the Board's approval and is endorsed by the Committee.** The Assure section of this AAA report provides further details on the Trust's Environment, Decarbonisation and Sustainability work programme.

3. The Committee was assured that, in line with other NHS Wales organisations, WAST has conducted a detailed independent inspection of all sites within scope, which details a nil return in relation to the presence of **Reinforced Autoclaved Aerated Concrete (RAAC)** in all buildings up to 2000. In addition, further detail has been sought for buildings where WAST colleagues share estate with the

Fire and Rescue Services.

ADVISE

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

4. The **Operational Update for Q2** was received together with further detail on attrition rates in EMS (Emergency Medical Service) Coordination which was requested at the last meeting. Vacancy in EMS Coordination continues to be a challenge and focus for the team however members were assured that colleagues were doing everything that can be done to improve the situation. An update was provided on the approval for increase in the Putting Things Right establishment to ensure appropriate resourcing was in place for the demand.

5. The Committee noted that the Audit Committee will be monitoring the **policy position** going forward following concerns by members being included in the 'alert' section of their July AAA report to the Board.

6. The Committee noted the recent **review of the national commissioning functions**. This included the Welsh Health Specialised Services Committee (WHSSC), the National Collaborative Commissioning Unit (NCCU) and the emerging 111 commissioning arrangements. The key outcome is that by the 1 April 2024 WHSSC, the NCCU and the 111 commissioning arrangements, will be merged into one national commissioning function. Benefits are potentially to be realised by combining 111 commissioning with EMS and NEPTS (non-emergency patient transport service) commissioning.

7. Members **reflected** that there had been good focus on the impact of the financial challenges on our patients and our people; and the challenge of balancing volume of papers and presentation time is one that will have particular focus at effectiveness reviews this year. Interaction with presenters who do not normally attend the meeting could be improved. Members felt that this was not in any way to indicate a lack of respect, and thanked those presenters for the clarity of their papers and messages.

ASSURE

(Detail here assurance items the Committee receives)

8. The Committee received a presentation on the **financial position for Month 5 2023/24** due to the date of this meeting coming close to end of month. The Board will have a detailed paper on the financial position before it for its September meeting. The cumulative year to date revenue position is a small overspend of £0.027m, with the year-end forecast being one of break even, based on the assumptions presented, including that relating to the £5.7m for the 100 WTEs above. The capital plan is forecast to be fully spent by the end of the financial year however inflationary pressures and reduced competition are driving up costs.

9. Gross savings of £3.1m have been achieved against a year to date target of £2.7m. The financial plan does not include any additional savings scenarios submitted into Welsh Government as requested by them in August 2023. An update was provided on the **Financial Sustainability Programme** and this will be a regular quarterly update going forward. The governance of the programme was reviewed, and members recognised there had been good progress and were assured that schemes

were being scoped and advanced, and that the programme was also aiming to embed a foundational understanding of financial management across the Trust upon which future financial sustainability can be achieved.

10. A priority of the Committee for 2023/24 is oversight and monitoring of the **digital strategy**. The Committee reviewed progress on the plan and approved key digital system and service metrics to support monitoring of this area. Progress against the four missions in the strategy of 'digital patient', 'digital workplace', 'intelligence through data', and 'digital foundations' since 2022 has been significant and ranges from implementation of ePCR and ECNS, to EMS CAD, telephony and network upgrades, and clinical intelligence data layers and dashboards. Notwithstanding this excellent work, gaps in the plan have been identified as were vacancies in the team, and these will be progressed by the new Digital Director, Jonny Sammut, who joins the Trust on 27 September.

11. The Committee was updated on the work being undertaken in support of the Trust's **Environment, Decarbonisation and Sustainability** work programme. WAST has produced a Decarbonisation Action Plan (DAP) in response to the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan. Progress has moved from a starting point of Red/Amber to Amber. The Committee noted the extensive requirements for qualitative and quantitative reporting to Welsh Government and NWSSP and the pressure this causes the small WAST team. The introduction of 67 EV chargers over 54 sites was commended as was the significant amount of work underway by the small team.

12. An update on progress against the April 2022 limited assurance **Waste Management Internal Audit** was received with revised actions noted for the outstanding recommendations. One recommendation was for the presentation to this Committee of an annual Waste Report which was received at this meeting.

13. The WAST **Integrated Medium-Term Plan (IMTP) 2023-26** has now been approved by Welsh Government and an update on progress against the plan was received as at the end of Q1. The accountability conditions that accompany the plan are awaited from Welsh Government. Progress was discussed and areas marked as 'red' will be drawn out in the report to the Trust Board

14. The Committee received an initial suite of **Digital KPIs** that have been developed to provide assurance on the performance, work activities and contribution of the Digital Directorate to the Trust's Strategy and IMTP. This month's spotlight was on cyber security and in the private session members were presented with greater detail of this area through the cyber highlight report for the period April to July 2023 and a detailed cyber activity report for July 2023.

15. The **Monthly Integrated Quality and Performance Report** (MIQPR) for August 2023 was received and is before the Board at the September meeting. The Committee noted:

    - There is work ongoing to define some of the newer KPIs.
    - Good performance in 111 abandonment rates being lower than 5%, also on clinical response ring back times which are hitting targets, however this may be affected by Winter pressures over the coming months.
    - Red response for August was at 50.4% and Amber 1 response at 1 hour 14mins. These are lower than we would want meaning patients are waiting for longer in the community. Whilst Red response is very important for life threatening issues majority of harm comes in Amber category,

however the Committee could see all that was being done to try and improve this ahead of Winter pressures.

- Consult and close rates have dipped, and the Committee noted the Clinical Support Desk action plan in place and the support being provided to that team.
- Handover times were slightly increased in August at just over 19,000 despite levels set through the Emergency Ambulance Services Committee of no more than 15,000 by the end of September, which are not on track to be achieved. Whilst improvements in certain areas are evident, on a national basis there continues to be a struggle to achieve a reduction in handover. A workshop will be held w/c 18 September on improving flow through EDs and WAST will participate in that.

16. The Committee was assured that good progress was being made against the 71 applicable actions for WAST from the **Manchester Arena Inquiry**.

17. A Welsh Government gateway review of the WAST **Mobile Data Vehicle Solutions** was received with an overall delivery confidence assessment of Amber/Green, meaning successful delivery appears probable, however constant attention will be needed to ensure risks do not materialise into major issues threatening delivery. Five recommendations were made to assist in ensuring a successful project outcome is achieved and these have been satisfactorily progressed. A third and final project assessment review will be planned for 12 months post project completion.

18. The **Committee priorities** for 2023/24 are on track as is the cycle of business.

RISKS

Risks Discussed: There are eight principal risks within the remit of this Committee with all scores remaining static following ELT review and are current as of 1 September 2023. The Committee were assured that the mitigating actions were appropriate, and all relevant risks had been reviewed and Members were assured of new actions were being added to mitigate risks.

Risk 424 (prioritisation or availability of resources to deliver the Trust's IMTP) has seen an increase in the likelihood score from 12 (3x4) to 16 (4x4) given the level of risk the organisation is experiencing in the current financial climate and with no further recurrent funding agreed to deliver the Trust's transformational plans. This score is aligned to the Trust's financial Risk 139.

Risks 139 (failure to deliver our statutory financial duties in accordance with legislation), **458** (a confirmed funding commitment from EASC and/or WG is required in relation to funding for recurrent costs of commissioning) and **Risk 424** (prioritisation or availability of resources to deliver the Trust's IMTP) scores remain static at 16 (4x4) due to the challenging financial climate.

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

Risk 594 (the Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death) remains at 15 (3x5). The operations update

provided details on the EPRR multi-agency exercises planned which should further mitigate this action.

New Risks Identified: The decarbonisation, environmental and sustainability risks were highlighted and risk 542 is currently in development at a Corporate Risk Register level but will need further consideration and may need to be separated into several risks rather than one composite risk. New legislation being introduced from 1 April 2024 will have a significant impact on the Trust in relation to segregation of waste.

COMMITTEE AGENDA FOR MEETING		
Operations Quarterly Report	Financial position for month 5 2023/24	Financial Sustainability Programme Report
Integrated Medium Term Plan 2023-26 delivery and assurance	Monthly Integrated Quality and Performance Report	Digital Strategy Plan
Mobile Data Vehicle Solution Welsh Government Project Assurance Review	Environment, Decarbonisation and Sustainability Update (including Sustainability Report 2022/23)	Manchester Arena Inquiry Progress Update
Cycle of business monitoring report and review of Committee priorities	Risk Management and Corporate Risk Register	

COMMITTEE ATTENDANCE						
Name	**15 May 2023**	**17 July 2023**	**18 Sep 2023**	**13 Nov 2023**	**15 Jan 2024**	**19 Mar 2024**
Joga Singh						
Kevin Davies	Until 11.30am	Chair				
Bethan Evans						
Ceri Jackson						
Martin Turner		Left at 11.30	Left at 12.00			
Chris Turley		Navin Kalia				
Rachel Marsh		Hugh Bennett				
Lee Brooks	Sonia Thompson	Judith Bryce[1]	Judith Bryce			
Liam Williams	Wendy Herbert					
Angie Lewis	Liz Rogers					
Leanne Smith			Aled Williams			
Hugh Parry						
Damon Turner						
Trish Mills						

	Attended
	Deputy attended
	Apologies received
	No longer member

[1] Lee Brooks in attendance for EPRR item

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

Welsh Ambulance Services NHS Trust

Sustainability Report

2022-23

Version 3.0 21.08.2023

PREFACE

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

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

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

CONTENTS

1.0 EXECUTIVE SUMMARY

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

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

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

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

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

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

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

2.0 INTRODUCTION

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

2.1 NHS WALES DECARBONISATION STRATEGIC DELIVERY PLAN

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

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

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

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

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

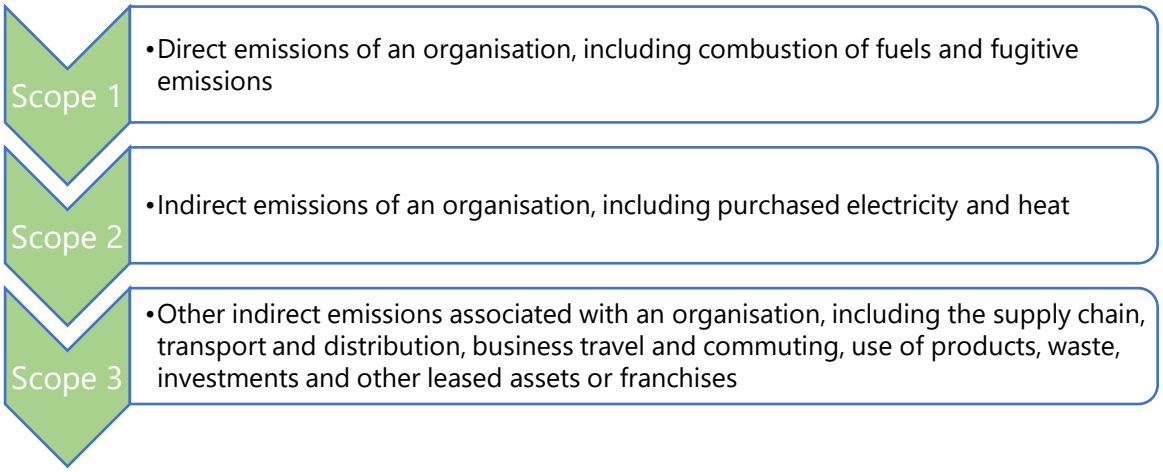


Figure 1: Emission scopes as defined by the Green House Gas Protocol (GHGP).

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

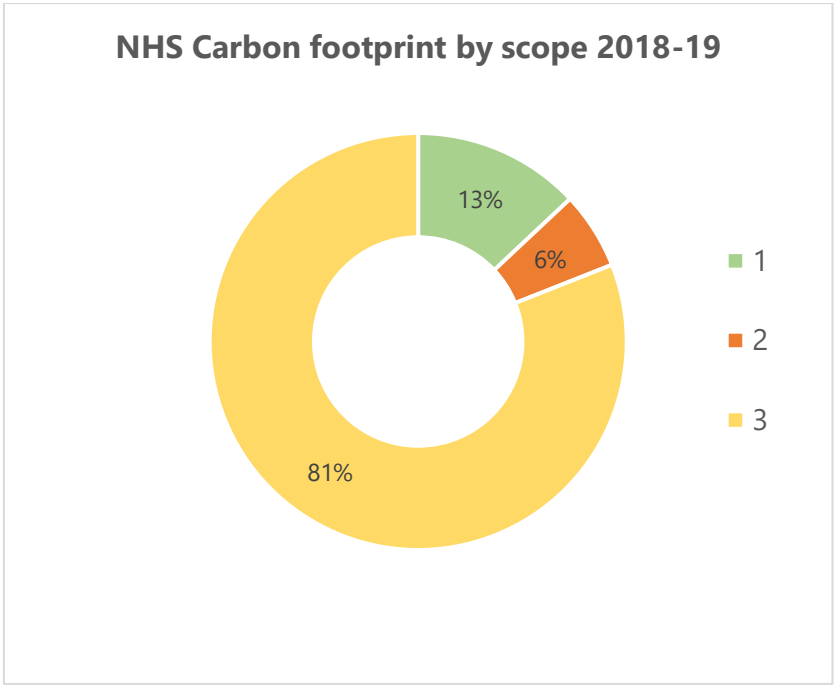


Figure 2: NHS carbon footprint by scope 2018-19 (Carbon Trust , 2021)

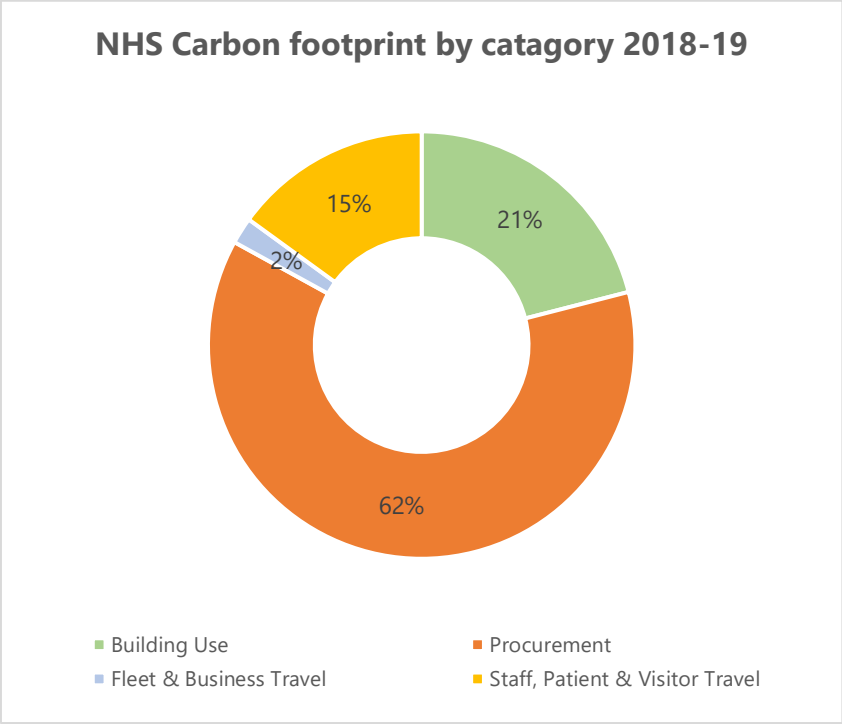


Figure 3: NHS Carbon footprint by category, 2018-19 (Carbon Trust , 2021)

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

2.2 PUBLIC SECTOR NET ZERO CARBON REPORTING.

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

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

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

Table 1: Carbon reporting, category, and tier.

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

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

3.0 CARBON REPORTING DATA

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

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

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

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

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

- Greenhouse Gas Emissions
- Waste

- Use of Resources

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

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

Additional narrative will be included in connection to performance and targets, with any issues relating to data availability already noted within Table 1. HM Treasury guidance on sustainability reporting has been reviewed for consideration of incorporation, some aspects of which have been included. This report will be made available on the WAST website, under publications via the following link. https://ambulance.nhs.wales/about-us/publications/

Table 4: Greenhouse gas emissions table: WG: Sustainability Report Guidance

Greenhouse Gas Emissions		2021-22	2022-23
Non-Financial Indicators (Kg CO^2e)	**Total Gross Emissions**	**32,341,716**	**773,378,849**
	Gross Emissions - Fleet Fuel	13,066,596	13,039,762
	Gross Emissions - Natural Gas & LPG	732,989	605,076
	Gross Emissions - Electric	951,327	855,981
	Gross Emissions - Business Travel	503,687	543,227
	Gross Emissions- Clinical & domestic Waste	48,751	38,561
	Gross Emissions – Medical Gas	n/a	739,904,200
	Gross Emissions- FGas	n/a	971,686
	Gross Emissions- Water	2,604	2,654
	Gross Emissions- Fleet Waste	639	781
	Gross Emissions - Commuting & homeworking	275,193	283,737
	Gross Emissions- Supply Chain	16,759,929	17,146,514
	Gross Emissions- Land sequestration.	n/a	-14535
Related Energy Consumption (KwH)	Electricity - Non-renewable	3,265,800	3,272,725
	Electricity- Renewable	14,132	104,425
	Gas	3,417,040	3,083,010
Energy consumption in litres*/kWh**	Fleet Fuel- Diesel*	4,010,878	3,963,344
	Fleet Fuel – Petrol*	193,653.00	8,911.13
	Fleet Fuel- Electricity**	0	40,037
Financial Indicators (£) ***	Expenditure on Energy	£1,156,991	£1,543,566
	Expenditure on Official Business travel	£538,089	£697,353

*** Taken from EFPMS report 2021-22 & 2022-23

3.1 ELECTRICITY

With the exception of 2020-21, electricity has achieved a gentle reduction in use. Considering however the increase estate portfolio, increased numbers of building-based roles and associated electronic equipment required, plus a significant increase in workforce on 2018-19 figures, this reduction shows movement in the right direction.

Disposal of ineffective estate and inclusion of newer more efficient buildings has supported this downward trend, alongside increased energy efficiency of electronic

hardware. With the financial support of the WG, via the Estates Funding Advisory Board (EFAB), installation of direct renewable energy systems at 12 sites across Wales was achieved. This has shown a positive effect on external power requirements, generating 104,425 kWh of renewable power during 2022-23, a saving of over 27,000 Kg CO^2e and £43k on average gross cost rates.

Figure 4: PV installations Lampeter Ambulance Station, Bennett Street and Beacon House 2022-23.

Electric vehicle charging point (EV) related electricity usage, is reported outside of this category. Increased costs due to energy uncertainty globally has seen an overall energy cost increase per kWh on previous years values.

Calculated baseline comparison shows:

18% reduction of electricity use since 2018-19. *(Figure 5)*

22% reduction of electricity per m^2 since 2018-19. *(Figure 6)*

18% reduction of electricity per employee (WTE) since 2018-19. *(Figure 7)*

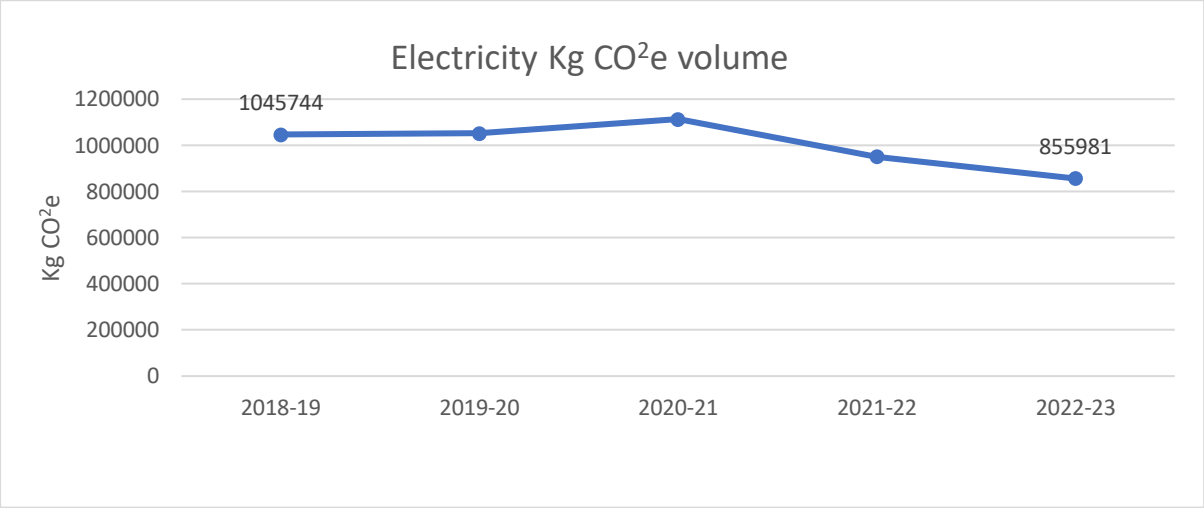


Figure 5; Electricity use in volume (per Kg CO^2e) 2018-19 to 2022-23

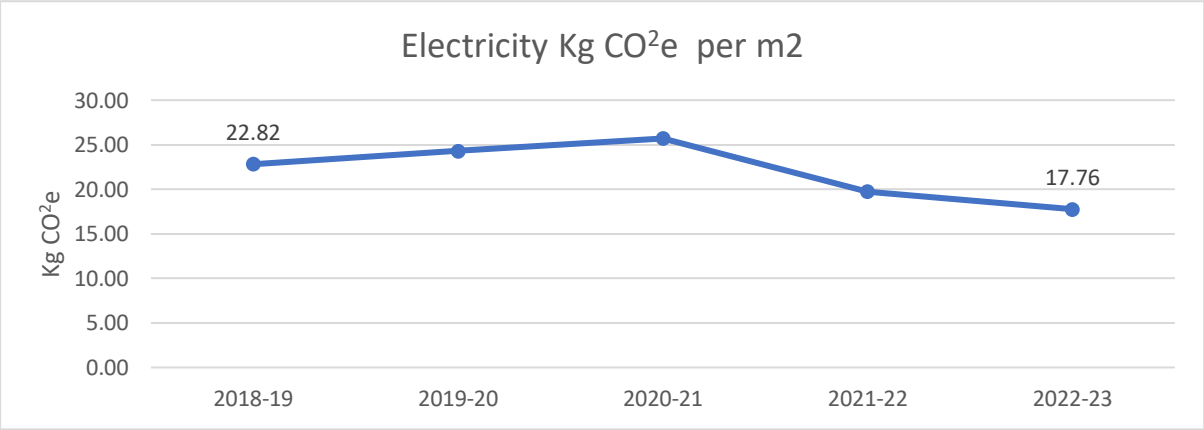


Figure 6: Electricity per m^2 of WAST estate (Kg CO2e) 2018-19 to 2022-23

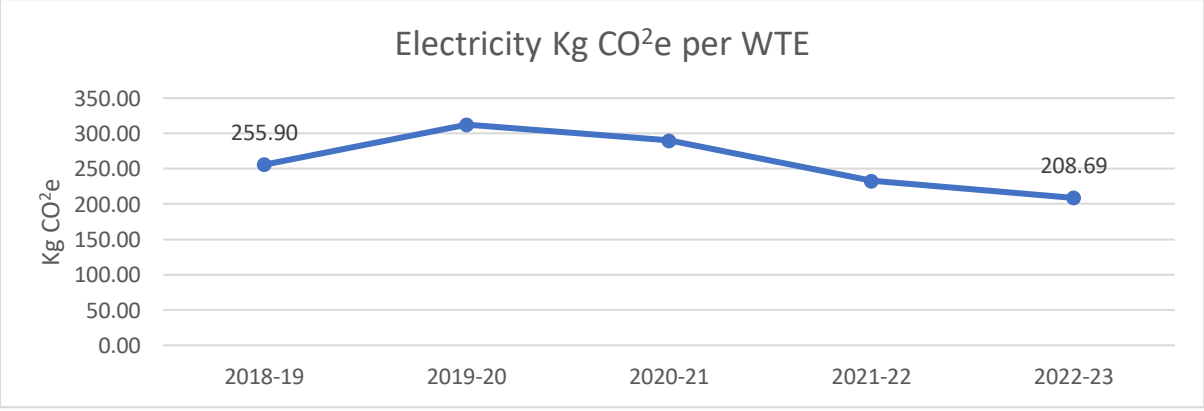


Figure 7 , Electricity use per employee, whole time equivalent (WTE) (Kg CO2e) 2018-19 to 2022-23

3.2 HEATING – NATURAL GAS/ LPG

Similar to electricity, heating fuel has achieved a gentle reduction in use across the Trust, again considering the increase estate portfolio, plus a 27% increase in workforce on 2018-19 figures, this reduction shows movement in the right direction.

Disposal of ineffective estate and inclusion of newer more efficient buildings has supported this downward trend, alongside the installation of air source heat pumps (ASHP) as an alternative to natural gas or LPG boilers (*Fig 8*). Plus, replacement glazing, from single to double glazed units at Port Talbot and Crickhowell Stations, help to support a secure building envelope requiring less heating.

Figure 8: Air Source Heat Pump: AAC Flintshire Dobshill

Increased costs due to energy uncertainty globally has seen an overall energy cost increase per kWh on previous years values.

Calculated baseline comparison shows:

24% reduction of heating fuel use since 2018-19. *(Figure 9)*

28% reduction of heating fuel per m^2 since 2018-19. *(Figure 10)*

23% reduction of heating fuel per employee (WTE) since 2018-19. *(Figure 11)*

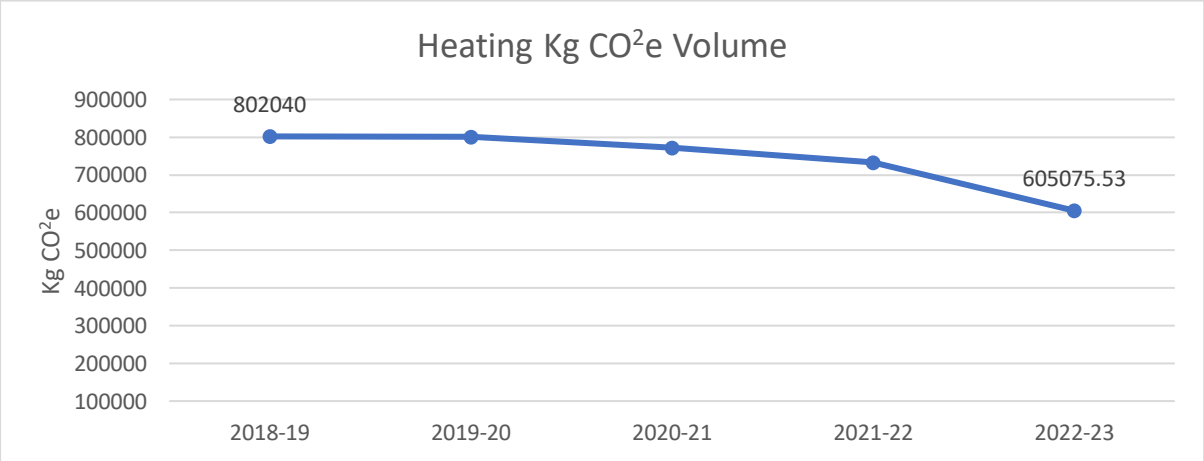


Figure 9: Heating Fuel use in volume (per Kg CO2e) 2018-19 to 2022-23

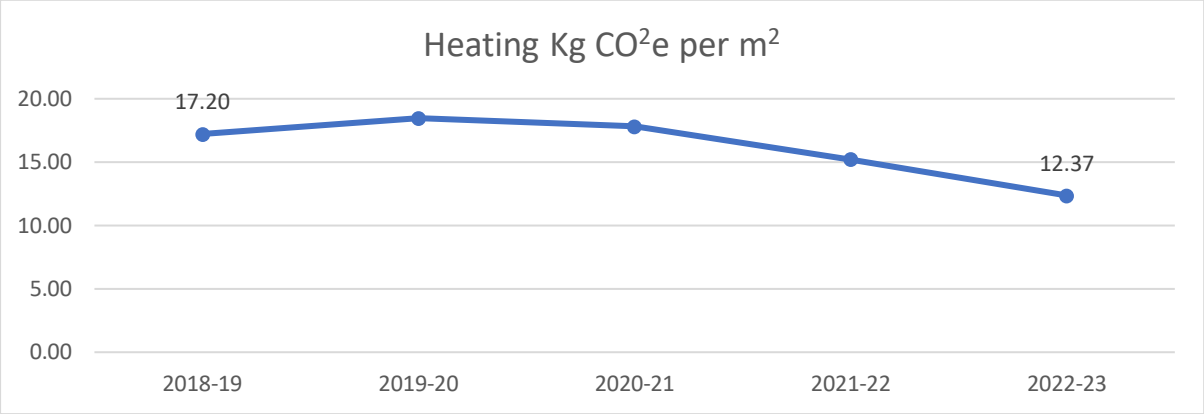


Figure 10: Heating fuel per m² of WAST estate (Kg CO2e) 2018-19 to 2022-23

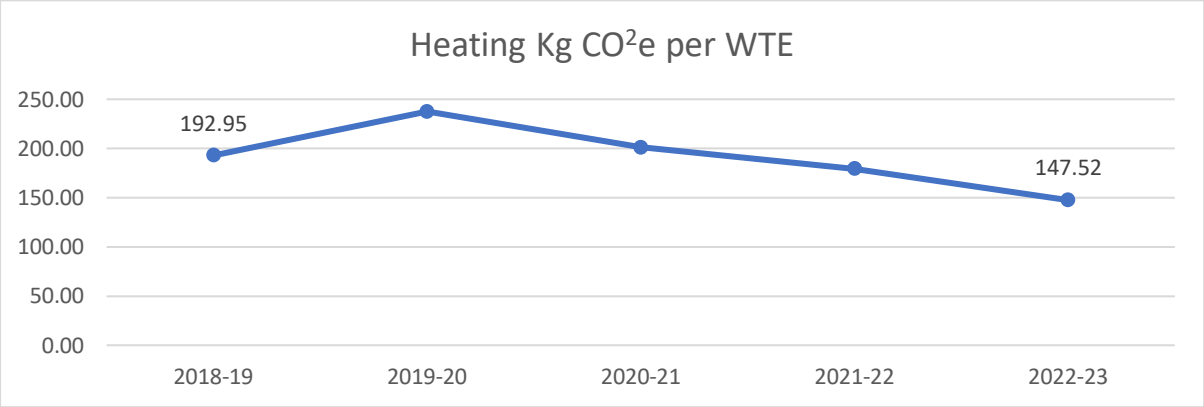


Figure 11; Heating fuel use per employee, whole time equivalent (WTE) (Kg CO2e) 2018-19 to 2022-23

3.3 WATER USE

Table 5: Finite resource data - 2021-2023: Utility invoices, various suppliers.

Finite Resource Consumption			2021-22	2022-23
Non-Financial Indicators (m^3)	Water Consumption (All Estate)	Supplied	17479	17809
		Abstracted (Bore Hole)	0	0
		Sewerage	12385	13755
		Annual water consumption per FTE	4.28	4.34
Non-Financial Indicators (Kg CO^2e)	Water Consumption (All Estate)	Total emissions	2604	2654
		Annual water emissions per FTE	0.64	0.65
Financial Indicators (£million)	Water Consumption Costs (All Estate)	Water Supply Costs (All Estate)	£32,968	£35,407
		Sewerage Cost (All Estate)	£31,974	£34,772

With the exception of 2020-2021, water use emissions have remained constant since 2018-19. An increased focus on water saving should be seen as a priority for this finite resource. Changes to water saving devices, such as low flush toilets and push button taps, will support a reduction, however vehicle washing remains the significant focal point of usage. Ensuring effective equipment is used will support a downward usage trend, alongside practical controls of its use.

Calculated baseline comparison shows:

2% reduction of water use since 2018-19. *(Figure 12)*

7% reduction of water use per m^2 since 2018-19. *(Figure 13)*

1.5% reduction of water use per employee (WTE) since 2018-19. *(Figure 14)*

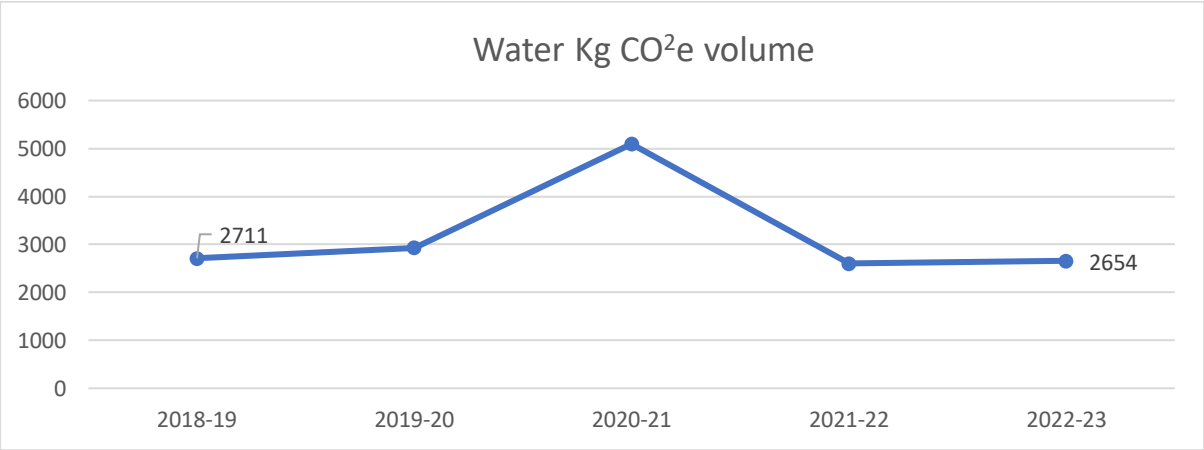


Figure 12 :Water use volume (Kg CO2e) 2018-19 to 2022-23

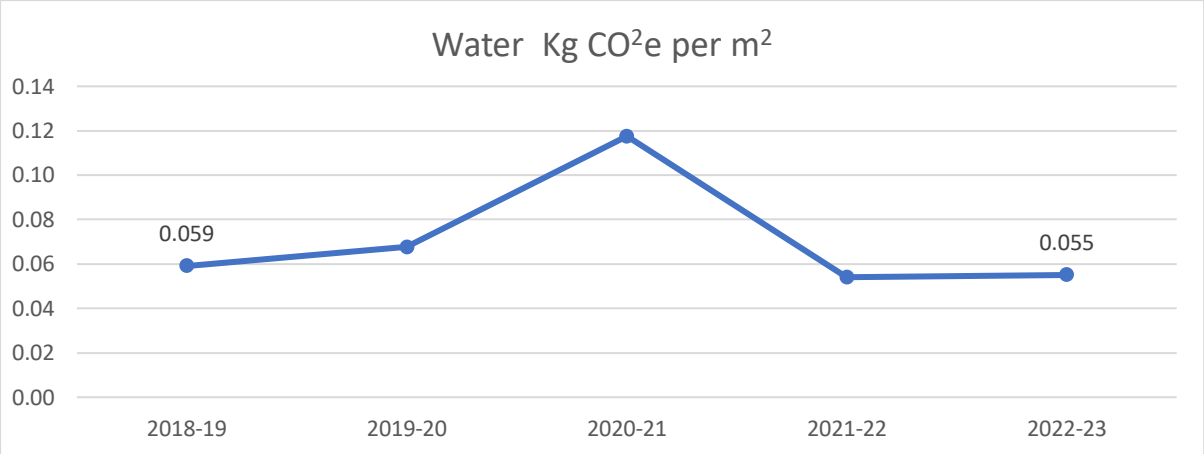


Figure 13 : Water use per m² (Kg CO2e) 2018-19 to 2022-23

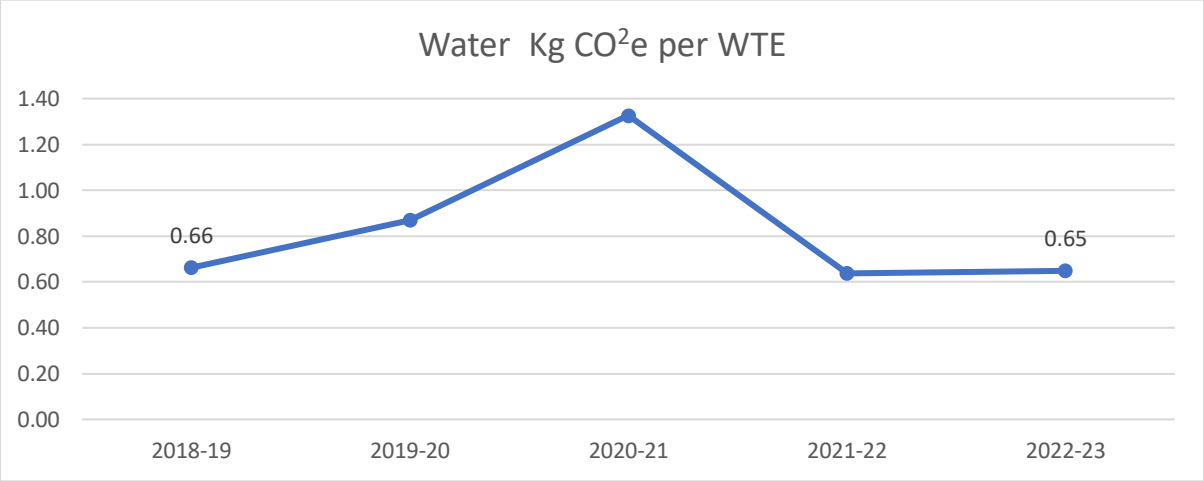


Figure 14: Water use per employee, whole time equivalent (WTE) in (Kg CO2e) 2018-19 to 2022-23

3.4 F-GAS (NEW FOR 2022-23)

The addition of reported Fluorinated gases (Fgas) emissions has significantly increased the Trust's reported carbon footprint by nearly 1 million Kg CO^2e. F-gasses are used in various industrial applications, within WAST this includes air conditioning and heating, ventilation, and cooling (HVAC). F-gasses are greenhouse gasses with high global warming potential (GWP). GWP was developed to allow comparisons of the global warming impacts of different gases, specifically it is a measure of how much energy the emissions of 1 tonne of a gas will absorb over a given period of time, relative to the emissions of 1 ton of carbon dioxide (CO_2) (Epa.gov, 2023).

Table 6: Global Warming Potential compassions of Fgas. .

F Gas	GWP
CO^2 comparison	1
R407C	1774
R401A	1182
HFC-32	677

Changes to retrofit of new and current estate will see a shift change, with the potential for passive ventilation use as an option, rather than initial move to mechanical ventilation. Therefore, removing potential increases in emissions alongside financial review costs for servicing and maintenance, required for currently used systems.

3.5 FLEET FUEL

In line with a fleet growing in numbers, and increased numbers of patient transfers, emissions from fleet fuel has grown significantly from 2018-19 baseline data. Apart from 2020-21, which is in all probability related to the COVID 19 pandemic. However, a promising downturn in emissions can been seen between 2021-22 and 2022-23. Efficient vehicles, increased servicing, and the introduction of hybrid vehicles have supported this downward trajectory. Unfortunately, due to funding constraints the replacement fleet programme will not see further electric vehicles purchased in the 2023-24 financial period, with the 2024-25 period unknown. The effect on emissions totals for WAST fleet will be monitored during the 2023-24 period.

During 2022-23, twenty-four electric plug in hybrid vehicles (PHEV) were purchased from Toyota, to replace older diesel rapid response vehicles. Changes to vehicle

commissioning has also seen a reduction in weight of the vehicles by nearly 100kg, with a redesign of the auxiliary electrical system requiring less charging connectivity. Solar panels have also been fitted to the vehicles to maximise on available renewable energy. The combined electrical charging and regenerative vehicle braking system delivers a 45-mile travel distance on electrical charge.

To support the new PHEV fleet, 66 electric vehicle (EV) charging points were installed across 52 sites, this will increase in 2023-24 with an additional 8 charging points being installed, includes 2 x 75kWh super chargers. The choice of Pod Point, as hardware provider for this service was determined in order to provide consistency with other NHS bodies.

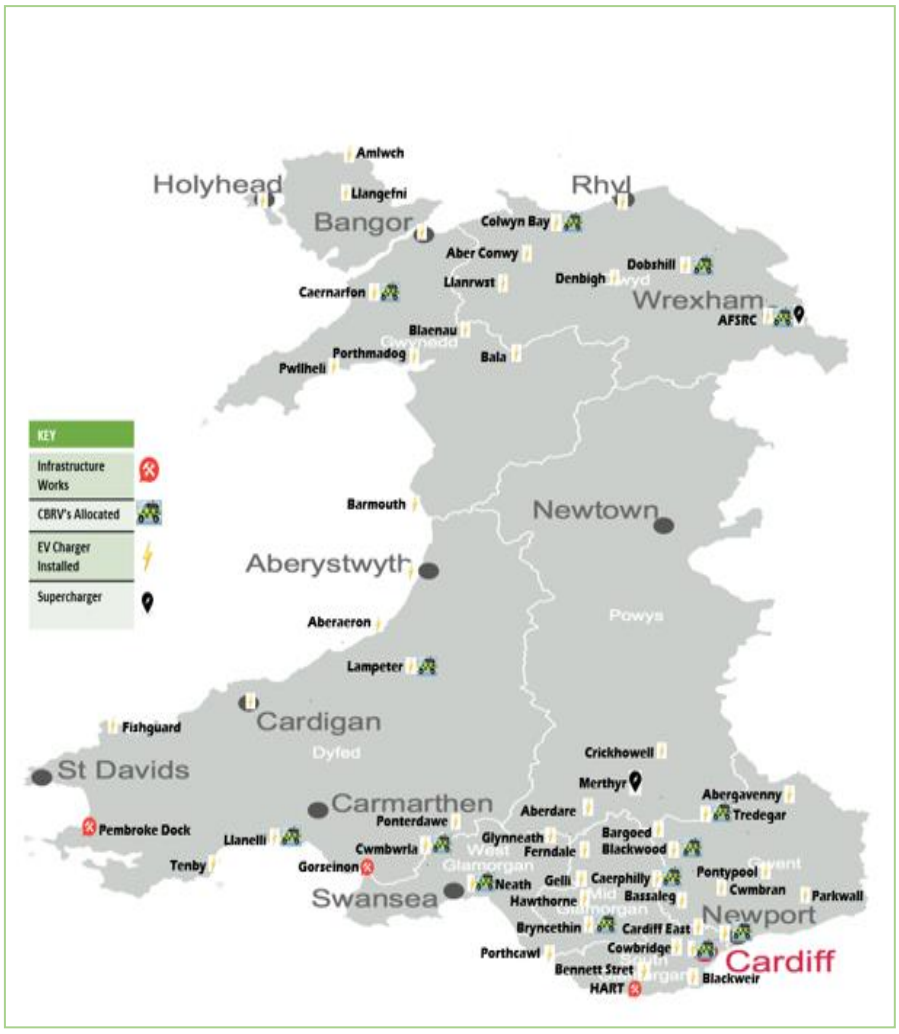


Figure 15: Electric Vehicle charging points within WAST estate 2022-23

Calculated baseline comparison shows:

6% increase of fuel emissions since 2018-19. *(Figure 16)*

5% reduction of fuel emissions per vehicle since 2018-19. *(Figure 17)*

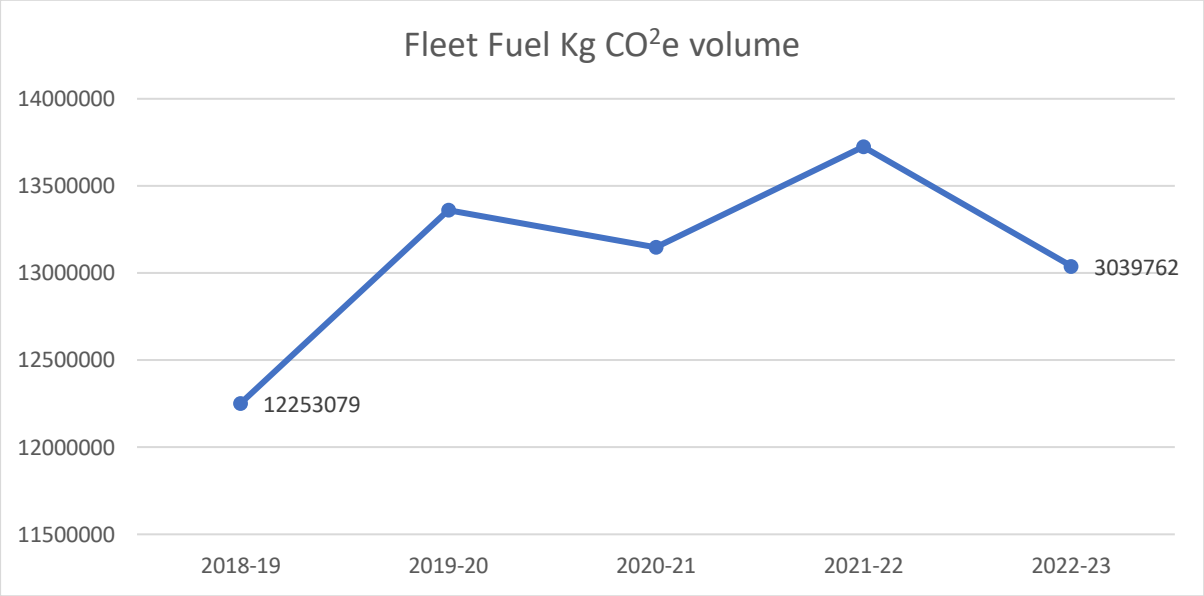


Figure 16 Fleet fuel volume of use in (Kg CO2e) 2018-19 to 2022-23

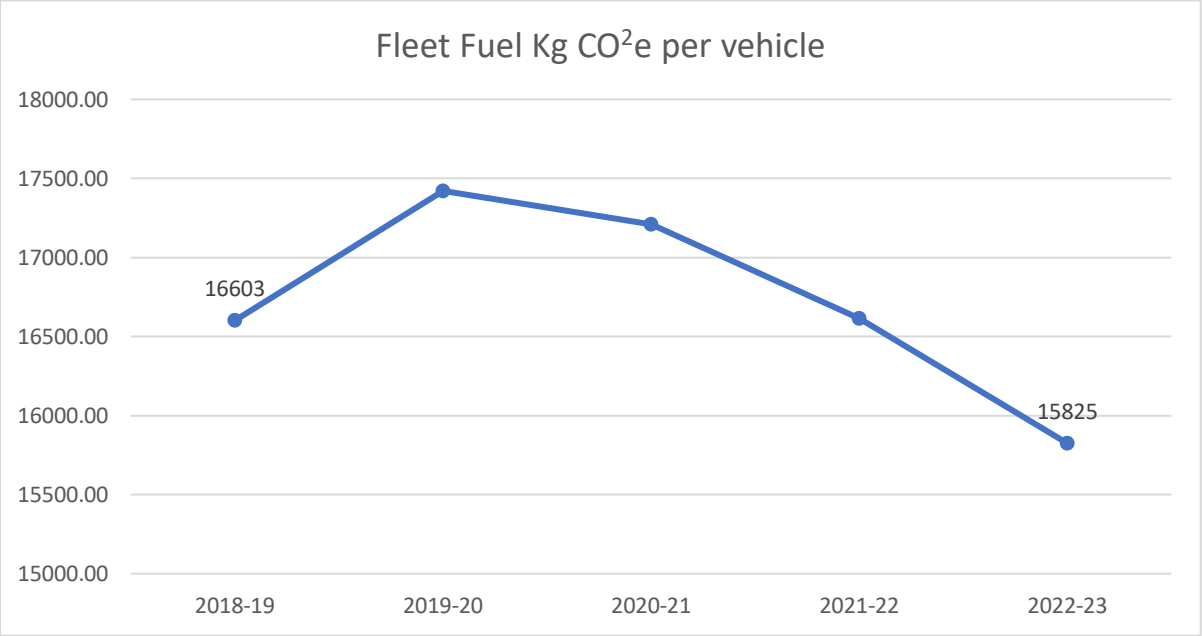


Figure 17 Fleet fuel emissions per vehicle in (Kg CO2e) 2018-19 to 2022-23

3.6 BUSINESS MILES

2020-21 saw business miles emission plumet during travel restrictions of the COVID 19 pandemic, however since this time business miles have increased significantly, although, not to benchmark levels. Progression of a Trust Sustainable Travel Plan has been slow due to lack of resource, be that as it may, agreement to prioritise active travel, public transport and low emissions pool car use using a travel hierarchy will support a business mile emissions reduction, alongside financial savings.

Calculated baseline comparison shows:

35% reduction of business mile emissions since 2018-19. *(Figure 18)*

49% reduction of business mile emissions per WTE since 2018-19. *(Figure 19)*

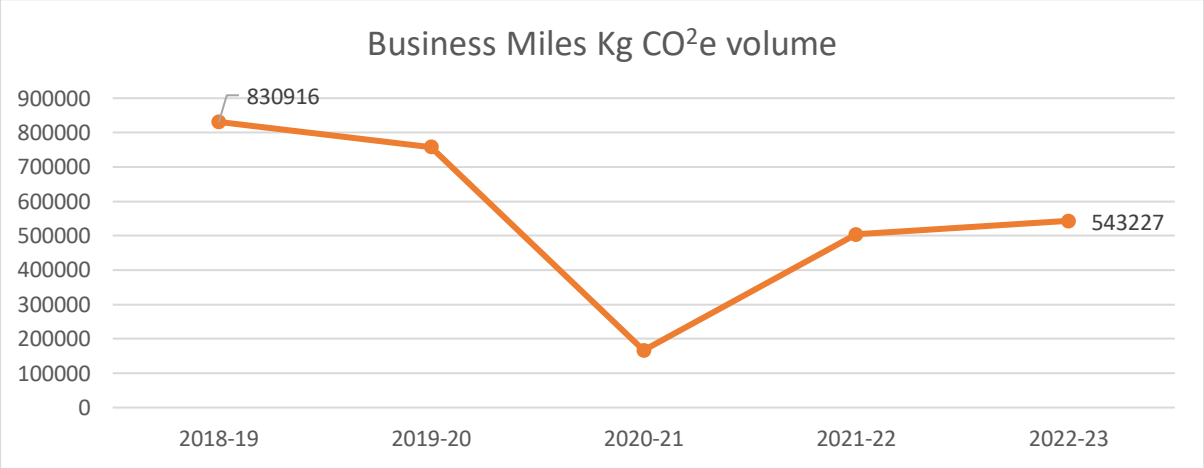


Figure 18 Business miles volume of use in (Kg CO^2e) 2018-19 to 2022-23

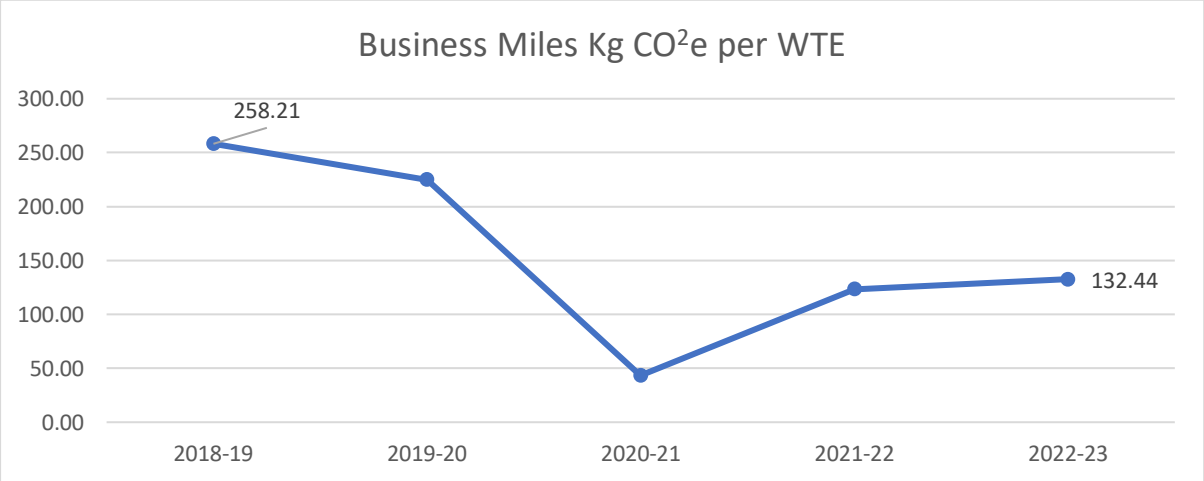


Figure 19 Business miles per WTE in (Kg CO^2e) 2018-19 to 2022-23

3.7 MEDICAL GASSES

The addition of reported medical gas emissions has significantly increased the Trust's reported carbon footprint by over 730 million Kg CO^2e. It should be noted however that this figure may not be completely correct. The carbon factor for Entonox has not been made available for reporting, therefore the carbon calculation for pure nitrous oxide has been used. A request has been made to amend the reporting factors for future years to ensure correct emission calculations are achieved. As with F-Gas nitrous oxide (NO^2) emissions are directly related to its GWP. Even though the individual GWP score is much lower than F-gas scores, the volume of Entonox used and released during bottle servicing, consequentially means the carbon footprint of the Trust has increased significantly. The introduction of Penthrox during 2023-24, will hopefully support a reduction in these specific emissions as Penthrox has a significantly lower GWP.

Table 7 Table 5: Global Warming Potential compassions of medical gasses

F Gas	GWP
CO^2 comparison	1
Nitrous oxide	298
Penthrox	4

3.8 DOMESTIC & CLINICAL WASTE

Table 8: Waste data - 2021-2023: various disposal contractors.

Waste		**2021-22**	**2022-23**
Non-Financial Indicators (tonnes)	Total Waste	321.64	252.73
	Landfill	1.19	1.93
	Composted	0	0
	Recycling	108.00	74.32
	Incinerated with energy recovery	212.45	176.48
	Incinerated without energy recovery	0	0
Non-Financial Indicators (Kg CO^2e)	Domestic Waste	5,251	4,577
	Clinical Waste	43,500	35,190
	Total Disposal Cost	£106,812	£99,121

Financial Indicators (£million)	Landfill	£323	£650
	Reused/Recycled	£25,382	£26,219
	Composted	0	0
	Incinerated with energy recovery	£81,107	£72,252
	Incinerated without energy recovery	0	0

With the exception of 2020-2021, domestic and clinical waste emissions has seen a progressive reduction in emissions. This is largely due to alternative treatments for the majority of waste, which in the past, was sent to landfill. Recycling waste sits at approximately 49% of the domestic waste produced within the Trust. This percentage must be increased to meet the targets set by WG for this strategy and other public body requirements. New waste legislation for Wales, due to be implemented by April 2023, will see the removal of current recycling processes of dry mixed recycling and cardboard, replaced with 6 different waste streams, segregating waste at source will be a challenge for some site, not just due to lack of space for additional bins both internally and externally, but also extremely small recycling percentages at some buildings, as low as 14%. This new legislation also provides for fines relating to non-compliance therefore building and locality managers will be advised monthly of their recycling rates, with support for those who's percentages fall short of expectations.

Calculated baseline comparison shows:

29% reduction of waste volume emissions since 2018-19. *(Figure 20)*

32% reduction of waste emissions per m^2 since 2018-19. *(Figure 21)*

44% reduction of waste emission per employee (WTE) since 2018-19. *(Figure 22)*

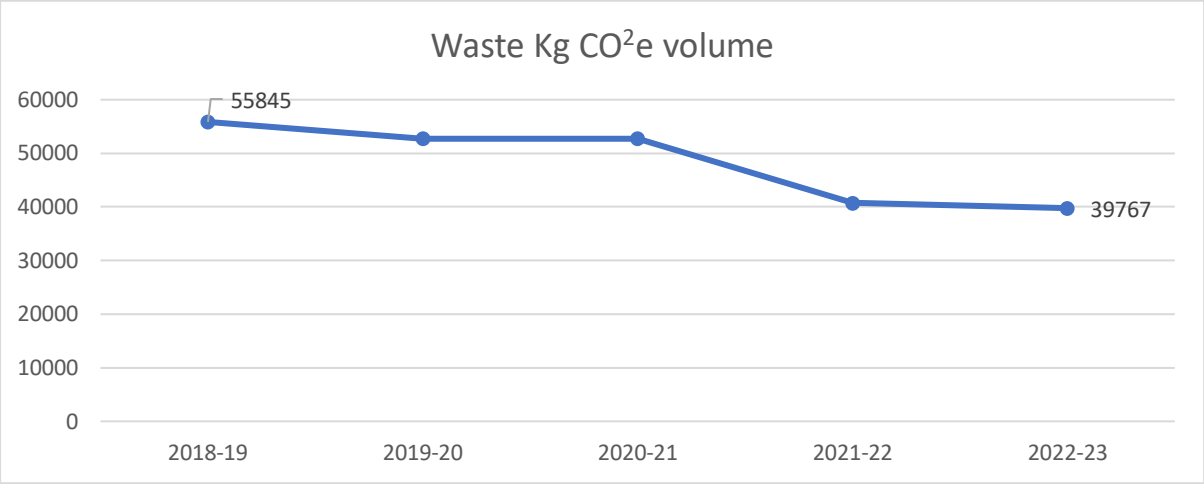


Figure 20: Waste emissions in volume. (Kg CO^2e.) 2018-19 to 2022-23

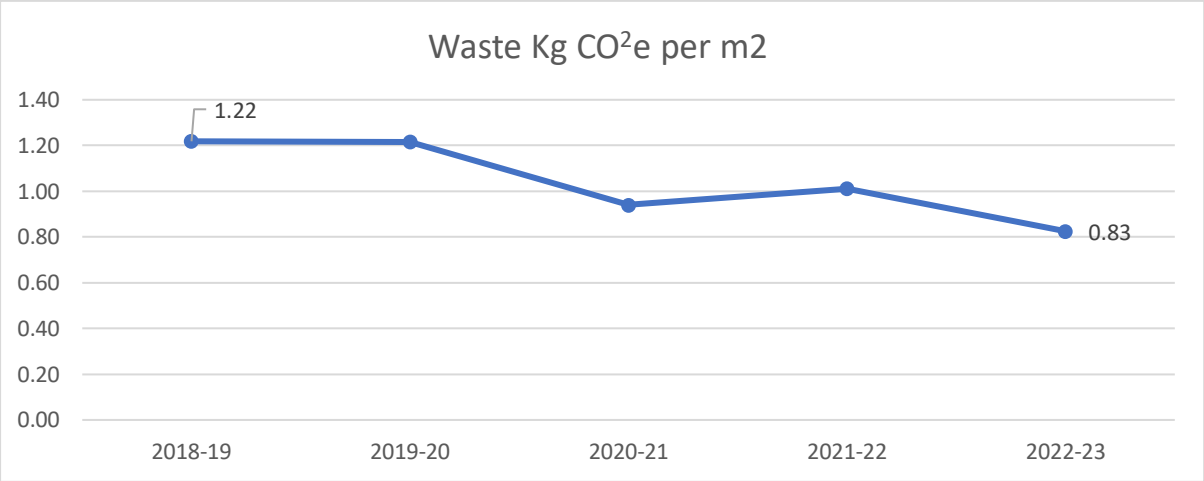


Figure 21 Waste emissions per m^2 in Kg CO^2e. 2018-19 to 2022-23

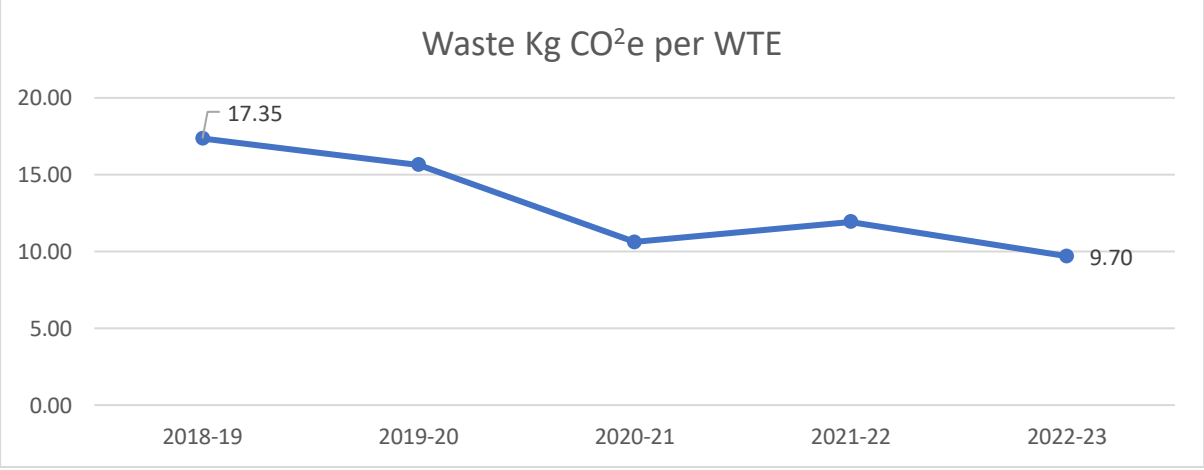


Figure 22 Waste emissions per WTE, in Kg CO^2e. 2018-19 to 2022-23

It should be noted that fleet waste is also reported as an emission. This waste has seen an increase in emissions on last years reported data by 142 Kg CO^2e, yet WAST fleet numbers for 2022-23 were down on 2021-22 figures. It should however be noted that WAST workshops maintain vehicles for HCS (NWSSP) who's numbers may have increased, plus better reporting structures within the Team has provided better understanding of waste than on the previous year.

3.9 MISCELLANEOUS REPORTED EMISSIONS

Various additional emissions are reported under scope 2 using calculation methodology as indicated via the reporting guidance document, this includes:

3.9.1 Commuting and Homeworking

Both commuting and homeworking are calculated using a tier 1 approach. Guidance has been provided for average percentage and calculation factors. Emissions have increased from 2021-22 figures due to an increase in workforce. To ensure correct reporting additional work will be required to understand number of hybrid working staff, plus their working patterns, and all employee commuting transport options.

3.9.2 Land Use

2022-23 reporting has included the carbon sequestration emission reduction for land use. The Trust has little unused land, however the additional of 2500 native trees to AAC Flintshire Dobshill has seen an offset subtracted from the Trusts emission total. 2023-24 will see potential biodiversity works at sites such as Ty Elwy and Blaenau Ffestiniog Station.


Figure 23: AAC Flintshire Dobshill- Gardd Gobaith. Images by author

3.9.3 Supply Chain

Due to the significant percentage of emissions related to procurement found during benchmarking calculations, supply chain emissions are reported as Scope 3. These emissions are calculated using standard industry classification codes (SIC) which relates to their waste stream, plus supply cost. This information is supplied by NWSSP procurement on an annual basis. Scrutiny of this data is challenging due to limited item description. Discussions are ongoing with NWSSP procurement relating to a streamlined process for data collection with more robust descriptions, allowing the Trust to investigate any changes that could be made to particular procurement streams.

4.0 SUSTAINABILITY UPDATES

4.1 ISO14001

The Welsh Ambulance Services NHS Trust (WAST) is the only ambulance service in the UK to have achieved ISO14001 accreditation for all of its activities. This accreditation has been held for 9 years.

The certification was originally awarded on the basis of the audit findings from sample sites in North Wales in August 2015, with the balance of the remaining qualifying sites to be visited by BSI in 2016 and 2017. This 3-year rolling programme has continued, with recertification completed in 2023 by BSI, with all previous non-conformances closed, and no new non-conformances raised.

An integral part of ISO14001 is the environmental management system, known as environmental governance system (EGS) within WAST. The EGS commits the Trust to reducing its impact on the environment by:

- Reducing risk of pollution to Air, Land and Water
- Upgrade utility monitoring and targeting all properties.
- Reduce carbon emissions and demands on natural resources by improving building thermal insulation.
- Reduce pollution potential in emergency situations.
- Reduce carbon footprint by closing buildings and relocating services.
- Increasing Recycling
- Reducing waste
- Improve staff awareness training.
- Disposal of poor estate
- Introducing renewable technology such as PV as well as energy storage where appropriate.

To support the EGS initiatives linked with the NHSDSDP, continue in the following areas.

- Thermally efficient new builds
- Retro-fitting energy efficient controls, plant, and equipment
- Improving the thermal performance of the fabric of existing buildings
- Retrofitting zero and low carbon technologies (includes on-site renewables)
- Partnership projects with other public bodies (Local Councils, Fire, Police etc.) in sharing buildings or facilities and rationalisation of their respective estates
- Improving drainage systems to facilitate vehicle washing.

4.2 CYCLE RESPONSE

Since conception the Cycle Response Unit (CRU) has grown significantly, both with the number of trained staff and the number of cycles used. The CRU now consists of 10 hybrid cycles, 4 specialised pitch and 6 genesis longitude, the latter being designed and built in Wales. With 24 trained staff of which include, Senior Paramedics, Advanced Paramedic Practitioners. Due to its success and associated expansion, the unit has now

moved to a purpose-built facility within the new ambulance complex in Pentwyn, Cardiff

The unit operates most Saturdays within Cardiff, covering between 10 to 20 miles a shift, within a 1.5 mile of the city centre.

The use of this active travel team not only means increased levels of response for patients, but also reducing the need for road-based response, reducing vehicle miles and corresponding fossil fuel emissions.

Figure 24: Cycle Response Unit (CRU) Pentwyn Cardiff

4.3 NEPTS PAPERLESS LIAISON BOOKING SYSTEM

The NEPTS liaison booking system completely transitioned during spring 2022, from paper via fax, to electronic booking. Paper and printing savings will be monitored over the next 12 months in order to quantify the volume of supplies saved, and their associated carbon emissions.

4.4 COMMUNITY SWAP SHOP

An internal WAST Community Swap Shop was introduced to support environmental goals and financial requirements of the Trust. Items that were no longer required, but are still serviceable such as:

- Furniture
- Consumables / Stationary
- Uniform
- Response Bags
- Clinical consumables/equipment.

WAST staff are able to view and add items on to the swap shop list, contacting the owner for collection. Supporting the waste hierarchy and saving supply chain costs.

ACADEMIC PARTNERSHIPS COMMITTEE
HIGHLIGHT REPORT TO BOARD

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

Trust Board Meeting Date	28 September 2023
Committee Meeting Date	15 August 2023 (moved from 18 July)
Chair	Hannah Rowan

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. As previously reported to the Board, the Trust's application for University Trust Status includes the requirement to have **a Non-Executive Director (NED) from academia**. The Committee's Task and Finish Group have adapted the standard Welsh Government role profile and person specification to seek a candidate with a strong academic, commercial or innovation background who will bring that experience to the Board table in support of the Trust's ambitions. It is also important that they have broad corporate experience, in order to be able to contribute to the work of the Board more generally. The Committee recommended the role profile to the Trust Board Chair so that a recruitment campaign could be started as soon as possible with the Public Appointments Unit.

ADVISE

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

1. The reflections of the members and those in attendance at this meeting was that there was a **step change in the momentum and direction of the Committee**. One of the Committee priorities this year was to focus on the adoption of the new NHS Wales research governance framework, which was presented in this meeting. Colleagues showcased the significant amount of research and innovation underway at the Trust and discussions during the meeting provided a launchpad to better connect these related elements. There was a desire from members to proactively focus research and innovation efforts towards our strategic objectives, exploring how this approach might address some of the challenges being faced by the Trust and NHS bodies in Wales more widely.

2. The Committee welcomed the Welsh Government and Health and Care Research Wales national **NHS Research & Development Framework**. The involvement of WAST colleagues in the development of this framework nationally was recognised. A self-assessment will now be conducted against this

framework ahead of the Health and Care Research Wales annual review meeting in October. This Committee will monitor our progress against the new framework. Hannah Rowan, Committee Chair, highlighted a renewed emphasis on research from a national perspective with the introduction of a Welsh Government mandated Non-Executive Director **Research Champion**. Hannah holds the Research Champion role for our Board and provided an overview of the group's aims, including promoting and raising the profile of research.

3. The **Research and Innovation Annual Report 2022/23** was received by the Committee and is attached at **Annex 1** for the Board's review. The report includes a range of policy developments, projects, and activities conducted and reported through the R&I department. The R&I being conducted within the Trust is enabling improvements to the care provided and the publication of this work helps to benefit and influence practice in Wales and further afield. The Committee commended the team for the work they have done throughout 2022/23 and noted the reach of research across both clinical and non-clinical WAST colleagues in recent publications.

4. A further iteration on a **mapping exercise** that was commenced in 2022 was presented at this meeting, illustrating the breadth of partnerships and projects in which colleagues across WAST are involved . This, together with the **innovation dashboard**, showed extensive involvement in research, innovation and commercial relationships from the clinical, quality , finance, fleet, estates, digital, and people and culture directorates. It was clear that there is a small but dedicated community of individuals across the Trust who continue to develop our research, innovation and commercial relationships with some interfaces across the organisation well established, and others embryonic.

5. An update was provided on the **income generation** workstream under the financial sustainability programme in private session. It was noted that the Finance and Performance Committee have oversight of this area of work however this Committee will keep a close eye on a mindset shift towards embracing commercial opportunities where appropriate as part of this work.

6. The Committee approved its **cycle of business for 2022/23**. Given the maturing nature of the areas in the remit of the Committee and the University Trust Status journey, the cycle of business will continue to evolve for this fairly new Committee. This is particularly pertinent as the approach of this Committee is a mixture of scrutiny (particularly with respect to refreshed UTS priorities, obtaining and maintaining UTS status), partnering (ensuring the right partners are on the Committee, that we have appropriate arrangements in place with partners), connecting (existing and new partners to research/programmes of work in WAST), and inquisitorial (drilling down into elements of the priorities and other programmes where we are partnering with academic and industry to foster and promote).

7. Nigel Rees, Assistant Director of Research and Innovation, was **welcomed** to his first meeting of the Committee. Fflur Jones from Audit Wales, and Sara Mills Head of Culture and Organisational Development also joined our meeting. New attendees reflected that the Committee Chair took time to welcome them and explain wider context of items and the work of the Committee generally which was appreciated.

ASSURE

(Detail here any areas of assurance the Committee has received)

8. The Task and Finish Group established by the Committee in April 2023 reported on progress against its work plan. An update was provided on the current position of the Trust's application for **University Trust Status**, with recent discussions with Welsh Government confirming that this will be recommended for approval to the Minister. The Group developed the academic NED role profile as set out in the alert section and will continue with the other elements of its work plan over the course of quarter 3 including an approach to garner interest in the NED role amongst academic contacts. Those elements include the proactive plan for management of conflicts of interest, and the logistic and timing of a change of name and brand related to University Trust Status.

9. The **Committee's priorities for 2023/24** are to scope out the next 12 months of University Trust Status, and to focus on the research governance framework. Both are on track with no escalations reported.

RISKS

Risks Discussed: There are no formal risks on the corporate risk register for this Committee.

New Risks Identified: No risks raised

The papers for this meeting can be found by following this link to the Committee page on our website.

COMMITTEE AGENDA FOR MEETING		
1. Research Governance Framework	2. Research and Innovation Annual Report 2022/23	3. Research and Innovation Dashboard
4. Research Champion Role	5. Task and Finish Group – Academic NED role profile	6. Committee cycle of business
7. Engagement mapping	8. Committee priorities	

COMMITTEE ATTENDANCE				
Name	**25 April 2023**	**15 August 2023**	**24 October 2023**	**16 January 2024**
Hannah Rowan				
Prof Kevin Davies				
Paul Hollard				
Martin Turner				
Estelle Hitchon				
Angela Lewis		Catherine Goodwin		
Andy Swinburn				
Leanne Smith		Jon Hopkins		
Jonathan Turnbull-Ross				
Duncan Robertson				
Nigel Rees				
Chris Evans				
James Houston				
Jo Kelso		From item 5.4		
Trish Mills				

COMMITTEE ATTENDANCE				
Mark Marsden				
Keith Rogers				
Academia Rep				

	Attended
	Deputy attended
	Apologies received
	No longer member

Llywodraeth Cymru
Welsh Government

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

2022 – 2023

RESEARCH AND INNOVATION ANNUAL REPORT

Welsh Ambulance Services NHS Trust

Contents

Executive Summary

The Welsh Ambulance Services NHS Trust (WAST) has a longstanding reputation for developing and delivering high quality Research and Innovation (R&I). The year 2022 has been a difficult time to conduct R&I following the COVID-19 pandemic and continued challenges being faced with the cost-of-living crisis. Despite this, 2022 has been another year of innovative and ground-breaking research across the NHS and for WAST. We have contributed to many R&I policy and governance developments, and our Clinical Strategy recognises R&I as being core to many roles and is integral to informing policies, guidelines, and practices to provide effective, efficient, and high-quality care.

Andy Swinburn
Director of Paramedicine - WAST

The R&I department would like to say thank you to all the people who make R&I happen, including our R&I Office and research partners, but most importantly to our staff, patients and members of the public who have dedicated their time to shaping, and participating in R&I research to improve the care we provide.

Introduction

The *UK Life Sciences Vision* recognises that to be sustainable, the NHS needs to focus on the right interventions early in the course of disease [1] which reflects WAST ambitions of inverting the triangle of care and our priorities which align with '*A Healthier Wales*' strategy and long-term plan for health and social care [2]. The R&I response was key to tackling the COVID-19 pandemic, and the most profound example of the need for such right interventions early, demonstrating what can be achieved when the R&I community, Government, NHS, wider society, and others work together.

The effects of the COVID-19 pandemic continue to have a major impact on NHS service delivery and all our lives. And within this context, along with R&I partners such as Health and Care Research Wales, Welsh Government, Universities, and other Ambulance services nationally and internationally, WAST has contributed to the development of many R&I governance processes, policies, and decisions over the past year.

In the early phases of the pandemic WAST was required to rapidly pause our R&I portfolio and support initiatives such as the COVID-19 vaccine Trials Delivery Group and Urgent Public Health studies such as the TRIM study led by our partners in Prime Centre Wales and Swansea University exploring what triage model is safest and most effective for the management of 999 callers with suspected COVID-19. We also worked with many others such as the Wales COVID-19 Evidence Centre conducting rapid evidence syntheses in areas such as the use of Personal Protective Equipment in General Practice and Ambulance settings [3] and exploring what innovations help with the recruitment and retention of ambulance staff [4].

As we recovered from the pandemic, the R&I portfolio continued to resume and involved activating paused studies and developing and setting up new ones. The PARAMEDIC 3 Trial was such a study, and thanks to the efforts of many, is now live

across all areas of Wales. We continued to set up the RAPID 2 Trial of Fascia Iliaca Compartment Block for hip fracture, which followed on from the RAPID 1 trial that was led by WAST and partners in Prime Centre Wales and funded by Health & Care Research Wales Research for Patient & Public Benefit (RfPPB). Our program of research with drones has continued, and we secured funding and delivered a foundation study with Welsh Blood Service and Snowdonia Aerospace on the delivery of blood products by drone. We have also secured National Institute for Health Research (NIHR) funding to continue our work with Warwick University on drone delivery of defibrillators to cardiac arrest. New and innovative partnerships have also been forged with York University and others in areas such as Artificial Intelligence and Robotics.

The Reid review of government-funded R&I in Wales recognises that research impact in Wales is higher than the UK average, but also, how Wales also has a relatively small research community from which impact can be delivered [5]. We therefore continue to build our capacity for R&I across the organisation, embedding it within everyday practices, and WAST has continued to grow a skilled workforce within the R&I office of research officers, administration, and finance support. Our people across the organisation are utilising and developing a broad range of R&I skills and knowledge, including those delivering R&I, trials and supervising or receiving training at all levels from undergraduate to post-doctoral and beyond. This is enabling us to grow the number of principal investigators and chief investigators to develop and lead future R&I. The world-class R&I being developed and delivered here in Wales is helping us address the complex challenges we face and making a positive impact on care we provide and the lives of many people across Wales and beyond.

This report presents R&I activities that the Trust have engaged in between 2022-2023 which includes highlights of some of the developments in R&I Governance and policy during this time. Along with improving health, R&I improves the wealth of our nation, and our activities continue to contribute to the economy, supporting many jobs in

WAST, the Life Sciences, Industry, Academia and more. We therefore present our grant capture which continues to grow. A selection of highlights are then introduced which serves as a snapshot of our R&I portfolio [Appendix 1] and finally we include some of key publications for this period [Appendix 2].

R&I Governance & policy:

The UK has an ambitious vision to transform clinical research delivery across the UK which is set out in '*Saving and improving lives: the future of UK clinical research delivery*' [6]. This relies on efficient and innovative approaches to study set-up and delivery, increasing efforts to make participation in research as easy as possible and empowering health and care staff to carry out research. We continue to learn and adapt to the challenging context of delivering high quality R&I within ambulance services which has benefited from the collective efforts of many who unite around the principle of research being key to understanding and improving care and saving lives.

The WAST Clinical Strategy *Delivering Clinical Excellence in Wales* [7] reflects this approach by encouraging and developing our clinical leaders to actively support high-quality R&I that is responsive to our population's care needs and translate evidence-based findings into our models of care. This needs to be underpinned by robust governance, and the principles of good practice in the management and conduct of health and social care research across the UK are set out in the UK Policy Framework for Health and Social Care Research [8].

The R&I office and HCRW support infrastructure continues to ensure that R&I in WAST is conducted to the highest scientific and governance standards, as set out in the UK Policy Framework for Health and Social Care Research [8] and to ensure that the public continue to feel safe when they take part in R&I. This policy framework enables researchers to develop innovations which will help to improve the quality of health and care in the UK.

In 2022, WAST continued to work closely with many partners and groups, some of which are included below:

- The NHS R&D Leadership Group
- NHS R&D Leadership Group
- Wales Innovation Leads Network
- The Research Management Operational Governance Group
- National Ambulance Services Research Group
- The Primary and Emergency Care Research Centre Prime Centre Wales
- Bevan Commission
- Rural health and care Wales
- Swansea Trials Unit
- The Cross-Party Group on Medical Research
- REASON: Research and Innovation (UKRI) Trustworthy Autonomous Systems (TAS) program. York University

In 2022 WAST contributed to the joint review by HCRW, Social Care Wales and Health Education and Improvement Wales project developing career and training/development pathways for health and social care researchers to enable capacity and capability in health and social care research in Wales. This resulted in the publication of the *Making Research Careers Work* report in February 2022 [9] which set out recommendations to improve opportunities in research career pathways for health and social care researchers. The HCRW Faculty is a core pillar of the national research career pathway, which WAST is well represented on. The HCRW Faculty provides support, guidance and training for its members who are health and social care researchers from a range of professional backgrounds and across all career stages.

In 2022 WAST continued its contribution to the influential Innovation Leads network, which has developed a collaborative approach to Innovation, influencing major policy

and strategy initiatives such as the health component the Innovation strategy *Wales innovates: creating a stronger, fairer, greener Wales* [10]. The Innovation Leads network along with the Executive Leads for Innovation have collaborated on aligning innovation 'Pull' (health and care) priorities with the 'Push' (delivery leads from our Innovation, Technology and Partnerships program) support offer. An innovation action plan has been co-produced through these groups and other stakeholders which will provide the basis of our activities in 2023 and beyond. Many governance and policy initiatives are being supported through the Innovation Leads network such as the All-Wales Intellectual Property Rights policy which we aim to adopt in WAST in 2023.

Summer/ autumn 2022 saw the launch and implementation of work on a Framework for NHS R&D. This framework has been developed by HCRW through a co-creation process with key stakeholders including WAST. This framework outlines what 'research excellence looks like' within NHS organisations in Wales where research is embraced, integrated into services, and is a core part of the organisation's culture. WAST will continue to support this work and implementation of the framework through 2023.

R&I Learning and Development

WAST continues to collaborate with our Learning & Development teams who are leaders in our sector. We continue to work together on R&I in areas such as Virtual Reality and tele-simulation. All of the R&I we conduct includes opportunities for learning and development, such as study training materials, Good Clinical Practice and others. We support R&I from undergraduate to doctoral teaching and supervision and disseminate support to the wider range of HCRW funded opportunities. Our people make up some of the wider alumni of NHS Wales staff on programs such as the Bevan Exemplars, and Intensive Learning Academy. WAST continues to present and attend national and international conferences such as the 999 EMS forum conference, European Resuscitation Council, NHS R&D Forum, Medi Wales and others.

Finance

The Research and Innovation department has had 6 funded studies for the 2022 – 2023 period and received £5.5M of total funding for the following projects.

999 R.E.S.P.O.N.D

Funded by RfPPB (Research for Public and Patient Benefit).

PARAMEDIC3

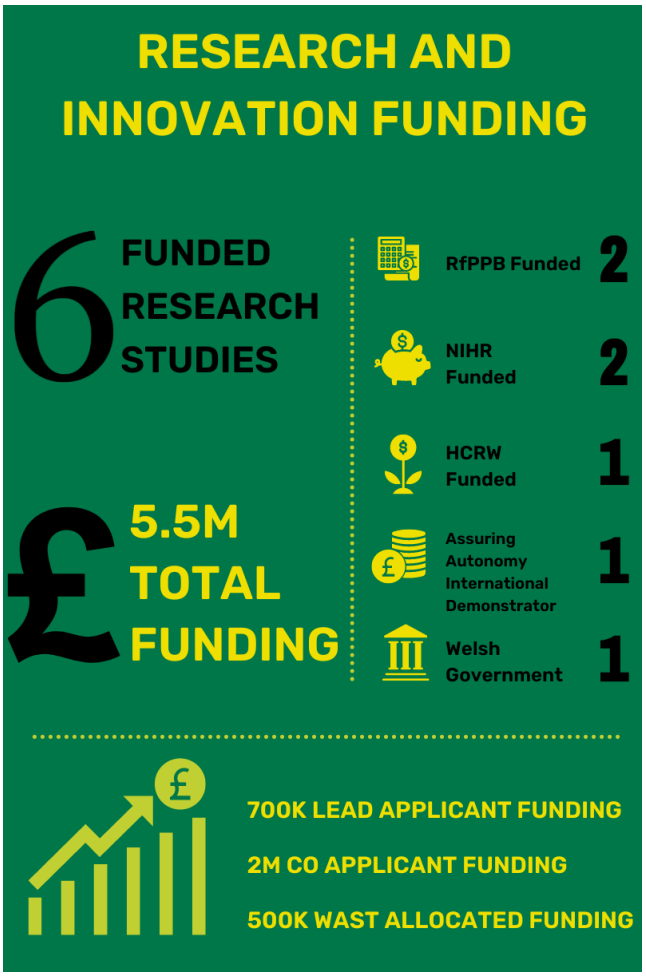
Funded by NIHR (National Institute for Health Research) and HCRW (Health Care Research Wales) support costs and excess treatment costs.

RAPID 2

Funded by NIHR.

Drone Project (Sky Bound)

Funded by RfPPB.



ASSIST

Funded by Assuring Autonomy International Demonstrator Programme and Matched Industry funding.

Welsh Blood Drone Project

Funded by Welsh Government.

Highlights

Paramedic 3 Trial live across Wales

After a long journey of development and set-up, 2022 saw a milestone for the PARAMEDIC 3 Trial becoming live across all areas of Wales. The PARAMEDIC 3 Trial research delivery team within the R&I Office, but most importantly our staff in the field who have completed the training and continue to deliver this study within their challenging working environment.

Dr Chris Moore joins HCRW Faculty

Following completion of the prestigious HCRW Research Time Award, our Head of Medicines Management Dr Chris Moore continues to lead and collaborate on important Research along with supporting funding panels and study steering committees. Chris is now a member of the newly formed HCRW Faculty which provides support, guidance and training for health and social care researchers to enable them to conduct their research with impact and progress along their individual research career pathways.

Ed Harry and Bewryn Jones

Ed and Berwyn are both Advanced Paramedic Practitioners and amidst a very high standard of competition, they were both successful in being awarded Research Capacity Building Collaboration (RCBC) Wales PhD Scholarships. RCBC Wales Scholarships aim to increase research capacity and capability in nursing, midwifery, pharmacy, and allied health professions, and to contribute to the development of clinical academic roles. They offer a range of awards, from First into Research fellowships, to PhDs, through to support for those wishing to undertake postdoctoral studies.

We wish Ed and Berwyn good luck for their studies and future Clinical Academic careers.

Dr Mike Brady grows R&I in NHS 111 Wales

Dr Mike Brady Consultant Clinician NHS 111 Wales is leading the development of R&I in 111 and remote triage. He was recently the Wales Principal Investigator for the NIHR funded TRIM study led by Swansea University exploring what triage model is safest and most effective for the Management of 999 callers with suspected COVID-19.

Mike led the introduction of ECNS and the novel Implementation of Low Code which has achieved prestigious recognition, including winner of the Allied Health Professionals and Health Care Scientist Advancing Healthcare Awards for digital and technology innovation and winner of Technology and Digital Impact Award of the MediWales Innovation Awards 2022. Mike has ongoing Health Research Authority/HCRW approved studies reporting and reviewing ECNS outcomes and continues. Mike has an impressive publication record, is an Associate Editor for the journal of Paramedicine and continues to support his colleagues publishing service evaluations in the 111 setting.

ASSIST

The **Assuring safe artificial intelligence in critical ambulance service response (ASSIST) project** (ASSIST) study took place between October 2019 and July 2022 and was funded by the Assuring Autonomy International Program. ASSIST was a collaboration between WAST, the University of York Industry partners, senior researchers, clinicians, and ambulance leaders which aimed to: (1) explore ambulance service stakeholder perceptions on the safety of OHCA AI decision-support in call

centres, and (2) develop a clinical safety case for the OHCA AI decision-support system. This project is now completed, and we continue to disseminate and publish our findings [Appendix 2].

Drones

We previously collaborated on a Snowdonia Aerospace UK Space Agency and WG funded simulation study of drone delivery of Automated External Defibrillator (AED) in Out of Hospital Cardiac Arrest (OHCA) in the UK. We successfully deployed an AED beyond live of visual sight (BVLOS) and have published this work [4]. This group along with Welsh Blood Service and other partners secured follow-on funding and delivered a foundation study of drone-based delivery services to support the Welsh NHS, augmenting emergency ambulance and routine health delivery services, to potentially replace some carbon-based transport.

The 3D Project was a collaboration between WAST and Warwick University, funded by the Resuscitation Council UK [RC (UK)]. 3D was a usability study of Drone Delivered Defibrillators which sought to determine what additional burden there is for a lone bystander after introducing a drone-delivered AED to a simulated cardiac arrest scenario. This study was successfully delivered and reported on and has informed the development of a successful funding bid in 2022 by Warwick University and WAST to the NIHR for drone delivery of AEDs in clinical trials.

WAST led 999 R.E.S.P.O.N.D. study awarded Research for Patient & Public Benefit (RfPPB) funding.

999 R.E.S.P.O.N.D. is a WAST led collaboration with EMRTS, and researchers from Bristol and Warwick Universities and was awarded 2022 HCRW RfPPB funding. This study is exploring when deploying specialist critical care resources, how are risk and severity indicators in 999 callers' utterances identified and brokered amongst those involved in the

dispatch decision, and how might dispatch teams be supported to optimise clinically appropriate deployment to the patients most in need of this scarce resource?

Summary

2022 – 2023 has been a progressive and productive time for Ambulance Service research in Wales despite challenges with demand, the COVID-19 pandemic, and a cost-of-living crisis. We have delivered and supported a range of studies of both international and national significance and continue to deliver research efficiently and effectively for the Trust.

The Trust has contributed to the development of R&I processes, policies and decisions and continues to develop and strengthen its governance processes in relation to R&I. The R&I being conducted within the Trust is enabling improvements to the care provided and the publication of this work helps to benefit and influence practice in Wales and further afield. The department will strive to continue to attract, deliver and report on high quality and robust research and innovation to aid continuous learning and contribute to the improvement of health care in Wales.

References

1. Life Sciences Vision (2021) Available from: https://www.gov.uk/government/publications/life-sciences-vision

2. Welsh Government. (2018). A Healthier Wales: our Plan for Health and Social Care. Retrieved from: https://gov.wales/topics/health/publications/healthier-wales/?lang=en

3. Antonia Needham, Tom Winfield, Lauren Elston, Jenni Washington, Ruth Lewis, Alison Cooper, Adrian Edwards (2022) Use of Personal Protective Equipment in General Practice and Ambulance settings: a rapid review. medRxiv 2023.03.10.23287113; doi: https://doi.org/10.1101/2023.03.10.23287113

4. Deborah Edwards, Judit Csontos, Elizabeth Gillen, Judith Carrier, Ruth Lewis, Alison Cooper, Adrian Edwards (2022) What innovations help with the recruitment and retention of ambulance staff: a rapid evidence summary. medRxiv 2022.11.29.22282890; doi: https://doi.org/10.1101/2022.11.29.22282890

5. Reid, G., 2018. Review of government funded research and innovation in Wales. *Welsh Government. Retrieved from: https://gweddill. gov. wales/docs/det/publications/reidreview-en. pdf*.

6. Saving and Improving Lives: The Future of UK Clinical Research Delivery. Available from: https://www.gov.uk/government/publications/the-future-of-uk-clinical-research-delivery/saving-and-improving-lives-the-future-of-uk-clinical-research-delivery

7. Delivering Clinical Excellence in Wales Clinical Strategy 2020 – 2025. Available from: https://ambulance.nhs.wales/files/publications/strategies-and-plans/clinical-strategy-2020-2025-pdf/

8. UK Policy Framework for Health and Social Care Research. Available from: https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/uk-policy-framework-health-and-social-care-research/

9. Making research careers work: a review of careeer pathways in health and social care in Wales (healthandcareresearchwales.org). Available from: https://healthandcareresearchwales.org/sites/default/files/2022-02/making_research_careers_work_eng.pdf

10. Wales innovates: creating a stronger, fairer, greener wales. Available from: https://www.gov.wales/wales-innovates-creating-stronger-fairer-greener-wales-html#:~:text=The%20innovation%20ecosystem%20will%20support,adoption%20of%20innovation%20at%20scale.

11. Rees, N., Howitt, J., Breyley, N., Geoghegan, P., & Powel, C. (2021). A simulation study of drone delivery of Automated External Defibrillator (AED) in Out of Hospital Cardiac Arrest (OHCA) in the UK. *Plos one*, *16*(11), e0259555.

12. How drones delivering defibrillators could save lives in Britain | Daily Mail Online

13. Smith, C.M., Sheehan, A., Rees, N. and Powell, C., 2022. 781 Drone delivered defibrillators (The 3D Project): a simulation study. *Emergency Medicine Journal: EMJ*, *39*(3), pp.258-258.

14. Rees N, Holding K, Sujan M. **Information governance as a socio-technical process in the development of trustworthy healthcare AI**. Front Comput Sci 2023;5.

15. Sujan, M., Thimbleby, H., Habli, I., Cleve, A., Maaløe, L. and Rees, N., 2022. Assuring safe artificial intelligence in critical ambulance service response: study protocol. *British Paramedic Journal*, *7*(1), pp.36-42.

Appendix 1 – WAST R&I Research Portfolio

Current Research Projects	
Study Title / Logo	**Study Information**
PARAMEDIC3 **P**re-hospit**A**l **RA**ndomised trial of **MEDIC**ation route in out-of-hospital cardiac arrest (PARAMEDIC-3) PARAMEDIC3 Medication Route in Cardiac Arrest	The PARAMEDIC3 trial will conduct a multi-centre, pragmatic, individually randomised, parallel group, superiority trial with internal pilot and economic evaluation to determine the clinical and cost effectiveness of an intraosseous access first strategy, versus current NHS treatment. Adult patients who sustain an out-of-hospital cardiac arrest that require vascular access will be randomised in a 1:1 ratio to either an intraosseous first strategy (intervention) or an intravenous first strategy (control) group. The control group reflects current NHS practice. Randomisation will occur at the point that a randomisation envelope (or equivalent) is opened. Participants will be followed-up to six-months following cardiac arrest.
999 R.E.S.P.O.N.D. emer**R**g**E**ncy di**SP**atch decisi**ON**s in covi**D**-19 999 R.E.S.P.O.N.D.	999 R.E.S.P.O.N.D is a collaborative research study between the Welsh Ambulance Services NHS Trust, Emergency Medical Retrieval & Transfer Service, the University of Warwick, Wales Air Ambulance Charity, and the University of Bristol. The project is the first of its kind in the UK and designed to be translatable to training and policy. The study aims to explore the way in which the decision to dispatch a critical care team is made by the teams in ambulance control rooms. It is well documented that getting the right information to make decisions in the heat of the moment is difficult, and the recent pandemic created pressures and disruption to the system which had an impact on risk assessment decision making pathways. The appropriate dispatch of EMS needs to balance patient safety and resource. It is therefore hoped that this study will be able to improve the process of getting critical care to the people who need it most.
HEAR2 **H**ealth **E**xperiences of **A**sylum seekers and **R**efugees: how well are their interpretation needs met? HEAR 2 Health Experiences of Asylum seekers and Refugees how well are interpretation needs met?	People who are classified as Asylum Seekers or Refugees in the UK are entitled to NHS health care, which includes interpretation services for their language needs. There has been very little research on this topic, but preliminary studies have reported that interpretation is often not offered nor provided in the best language for the individual. Interpretation is often provided during consultations by family members or friends, but this has been highlighted as poor practice, particularly in some conditions such as mental or sexual health. The study aims to 1) Provide information about demand and patient experience' and evaluate the quality of interpretation services delivered in primary and emergency care in Wales, and 2) to assess the feasibility of a comprehensive evaluation of interpretation services in these settings across the UK, including a description of currently commissioned interpretation services.

CATNAPS **C**o-producing an **A**mbulance **T**rust **N**ational fatigue risk management system for improved staff **A**nd **P**atient **S**afety CATNAPS	The aim of the CATNAPS study is to develop a new approach to fatigue management for the UK ambulance sector that meets the needs of staff and operations and is most likely to improve patient and staff safety. The study brings together a team of patients, staff with lived experience, fatigue experts, ambulance service researchers and managers, international expertise, and companies currently working with ambulance services on fatigue management. This study will define the action ambulance services should be taking to monitor and respond to tired crews and help staff sleep better and speak to senior managers to find out what is currently being done to manage fatigue.
OHCAO Out of Hospital Cardiac Arrest Outcomes OHCAO	This National (UK) Collaborative Project hosted at the University of Warwick Clinical Trials Unit on behalf of the National Ambulance Service Medical Directors. The project has been funded by BHF and Resuscitation Council UK with the aims of establishing the epidemiology and outcome of Out of Hospital Cardiac Arrest (OHCA), exploring sources of variation in outcomes and pushing for quality improvements and research for OHCA patients in the UK.
RAPID 2 **R**andomised trial of clinical and cost effectiveness of **A**dministration of **P**rehospital fascia **I**liaca compartment block for emergency hip fracture care **D**elivery RAPID2	Hip fractures are a very common injury for elderly people. About one in three patients who break their hip die within one year and many patients lose mobility and independence. Pain relief before the patient reaches hospital is often inadequate and causes side effects which may slow down recovery. We have recently completed a small study testing whether a local anaesthetic injection into the hip area called Fascia Iliaca Compartment Block (FICB) given by paramedics at the scene of injury is safe and acceptable. We met all the criteria that we set at the beginning of the study and concluded that it is feasible to undertake a full trial. The aim of RAPID2 is to find out whether the local anaesthetic injection reduces pain, is safe, and improves the patient health outcomes, as well as how much is costs the National Health Service (NHS).
3D Drone Project / Sky bound	The 3D Drone Project/Sky bound aims to explore optimisation and integration of drone-delivered AEDs into the pre-hospital response to out-of-hospital cardiac arrest. There are several barriers to successful bystander AED use, and many are related to the difficulties bystanders face in finding public-location AEDs, as well as the reluctance to leave a patient to find one. Delivering AEDs by drone may overcome many of these barriers, save more lives each year, and make the inequitable national out of hospital cardiac arrest response more equitable.
BALANCE COVID-19 impact on health and well**B**eing within an **A**mbu**LAN**ce servi**CE**. 	The study aims to understand the impact of the COVID-19 pandemic on the staff of the Welsh Ambulance Services NHS Trust (WAST). It is intended to look how the pandemic has influenced staff health and wellbeing, both in the short and long term. The methodology will include a mixed methods design to achieve three objectives: Objective 1 (O1): To determine the relationships between staff sickness levels and number of confirmed COVID-19 cases in Wales. Objective 2 (O2): To understand the impact of working through the pandemic on mental and physical health and wellbeing from the point of view of Welsh Ambulance Service staff. Objective 3 (O3): To understand how the

	Welsh Ambulance service responded to the COVID-19 pandemic in terms of monitoring, managing and ameliorating the impact on health and wellbeing of staff.
Pre-Feed Diary (PHd) Predictors and effects of **PRE**hospital **FEED**back: A mixed-methods **DIARY** study 	Within the limited existing research on prehospital feedback, qualitative studies suggest that emergency ambulance staff have a strong desire to receive feedback but that they perceive current feedback provision to be lacking in structure, relevance, credibility, and routine implementation. The aim of this research project is to explore the extent, characteristics, mechanisms, and effects of existing prehospital feedback in the United Kingdom from the recipients' point of view and to describe individual differences in the desire for enhanced feedback. This study is a longitudinal prospective mixed-methods study involving a baseline survey and diary study methods.
BHF Call Handler Study (PHd) Improving outcomes of out of hospital cardiac arrest (OHCA): Applying behavioural science to enhance telephone assistance and increase rates of cardiopulmonary resuscitation.	Prompt bystander cardiopulmonary resuscitation (CPR) is the most important factor determining survival from out of hospital cardiac arrest (OHCA) increasing survival up to 4-fold. However only 35%-45% of people trained in CPR attempt it when required. Telephone-assisted CPR (t-CPR), where trained call-handlers in the ambulance service provide real-time instructions to callers on how to perform CPR, increases the provision of CPR, and increases survival. However, even in settings where t-CPR is well established, up to a third of bystanders do not deliver CPR even when in receipt of instructions on the telephone. Performing CPR is behaviour, but behavioural science has tended not to be systematically applied to CPR. Behavioural science can contribute by specifying the determinants of behaviour and therefore what to target to change CPR behaviour. The aim of this study is to examine ambulance service OHCA calls to identify barriers to CPR and techniques used by call handlers to facilitate CPR as well as exploring call handlers' perceptions of what helps people to follow their instructions and how they overcome common barriers they encounter.
PEACE **P**rotecting **E**mergency Medical Services (EMS) Staff from **A**ggression and Violence in **C**onflict **E**ncounters PEACE	Emergency Medical Services (EMS) staff worldwide have long been at risk of encountering violence and aggression. The overall aim of this project will be to explore protecting EMS Staff from aggression and violence in conflict encounters. The objectives of this research are to explore general views on V&A directed towards EMS staff, explore views on characteristics associated with V&A such as intoxication, drugs, altered mental status and the role of medical illness and mental health problems, and explore the impact of policy changes and campaigns to gauge attitudes, understandings, and impact of the initiatives. The study involves two work packages, PEACE1 which will involve a survey of the public and PEACE2 will interview EMS staff and construct a grounded theory exploring this issue from their perspective.
Ambulance Staff Workshop Climate and Wellbeing	This research study investigates the workplace climate and workplace wellbeing of ambulance services staff, in terms of workplace issues such as employee voice, job satisfaction, and attitudes to work and wellbeing, in new times of COVID-19. This multiphase mixed methods study will undertake research via online diaries, online survey

	and online interviews. The study is an innovative international collaboration between Swansea University and the Welsh Ambulance Services NHS Trust (WAST) in Wales, UK, and Swinburne University, RMIT University and Ambulance Victoria in Australia.
Reducing inappropriate hospital admissions Reducing hospital admissions: A Realist Evaluation of Welsh Ambulance Service's gatekeeping stratagem	Each day in Wales approximately 1,200 emergency NHS calls are responded to and 800 people are transported to hospital by ambulance, contributing to the 2,100 patients attending Welsh EDs (The Welsh NHS Confederation, 2015). The introduction of minor-injury units has yet to have an impact on ED attendance, prompting the call for a universally agreed unscheduled care triage model. The aim of this study is to understand admission avoidance programmes within the context of Welsh Ambulance Services; to clarify how admission avoidance processes work, for whom, and under which conditions; and to understand the effects of culture and organisational practises on everyday paramedic admission avoidance work.
REASON **RE**silient **A**utonomous **SO**cio-cyber-physical Age**N**ts	The REASON research project will fund a team of 13 investigators and seven post-doctoral researchers across the five universities. Testbeds at each university will validate the foundational research in domains including health and social care, emergency response, and multimodal transportation. The project has two stages; first looking at how autonomous systems can be developed to be more resilient individually, and secondly looking at the socio-technical resilience of autonomous systems of systems. For example, an autonomous system of systems may support the end-to-end patient journey for a person requiring emergency assistance from a first responder, followed by admittance, care and discharge from hospital, and long-term care at home.
Welsh Blood Drone Project	The Welsh Ambulance Services NHS (WAST) Trust and Snowdonia Aerospace LLP (SAC) have been working collaboratively since 2019 investigating the potential of using drones to support emergency services. In October 2021 the project group facilitated a workshop exploring the use of drones in health care. The Welsh Blood Drone Project vision is to establish a trans-Wales BVLOS Drone service for Emergency Services. Core to this is the establishment of an innovative drone delivery service between the WBS sites at Talbot Green in South Wales and Wrexham in North Wales.
Heroism Meta synthesis	This literature review study aims to identify, appraise, and synthesis the qualitative literature to develop theory on heroism and paramedic practice. The aim of this research is to identify what the published literature reveals about heroism and paramedic practice.

PARAMEDIC2 **P**rehospital **A**ssessment of the **R**ole of **A**drenaline: **M**easuring the **E**ffectiveness of **D**rug administration **I**n **C**ardiac arrest **2**	The PARAMEDIC2 trial is a double-blind placebo-controlled trial looking at whether adrenaline is helpful or harmful in Out of Hospital Cardiac Arrest. Answering this question will help to improve future treatment of people who have a cardiac arrest. It is a Clinical Trial of a Medicinal Product and is therefore regulated by the Medicines Health Regulatory Authority (MHRA) The trial was being delivered by the University of Warwick in partnership the University of Surrey and the Welsh, West Midlands, Northeast, South Central and London Ambulance Services.
STRETCHED **STR**ategies to manage Emergency ambulance **T**elephone **C**allers with sustained **H**igh needs - an **E**valuation using lnked **D**ata	The NHS is under sustained pressure, particularly in emergency and urgent care, with 999 calls increasing by 6% every year, although fewer than 10% relate to patients with life threatening conditions. All UK ambulance services have identified a clinical and operational problem with persistent high users of the 999 service and have set up 'Frequent Callers' services, ranging from within-service to cross-sectoral multi-disciplinary case management approaches. These callers are known to be at high risk of mental health crises, such as self-harm and other crises of a varied nature. Current responses can be punitive and may simply shift unmet demand from one part of the system to another. There is a lack of evidence about what works in this setting and how. The study aims to evaluate effectiveness, safety, and efficiency of case management approaches to the care of people who frequently call the emergency ambulance service; and gain understanding of barriers and facilitators to implementation.
InFORM **I**mproving care for people who **F**requently call 999: co-production of guidance through an **O**bservational study using **R**outine linked data and **M**ixed methods.	People who frequently call the 999-ambulance service, at least five times a month, may have long term problems rather than a medical condition requiring urgent treatment. They need the right help but calling 999 may not work best for them or others trying to access emergency care. Ambulance services are exploring different ways to help these callers such as multidisciplinary case management, but without fully understanding the problem or how it benefits the patient. The study aims to create guidance for optimal care for people who frequently call 999 based on previous evidence, epidemiology and stakeholder views and experience.
TIME **T**ake home naloxone **I**ntervention. **M**ulticentre **E**mergency setting feasibility trial	Opioid drugs such as heroin are involved in fatal overdose more often than any other drug, and deaths from overdose are increasing, with tragic consequences for families, friends, and communities. Naloxone is a medicine that reverses opioid drug overdoses and is routinely used by paramedics and doctors in emergency settings. 'Take Home Naloxone' (THN) kits contain a dose of naloxone, a means of administering this dose, and written/graphic instructions. Despite the increasing popularity of THN, very little is known about the relative harms and benefits of this intervention, especially on a population level. The study involves collecting information about deaths, overdoses, and related emergency ambulance calls and emergency department attendances and admissions. We will compare these figures with those from two areas where THN is not distributed in this way and also carry out interviews and focus groups to find out about the experiences and views of patients and staff regarding THN.
ARRIVE	Paramedics are being employed in primary care roles - working directly for general practices, or by arrangement with a local ambulance service. The main task the paramedics undertake is home visits for people unable to attend

Ambulance paramedics **R**esponding to urgent patient **R**equests **I**n general practice for home **V**isits - **E**valuation development. 	the general practice. Using paramedics rather than GPs to undertake such tasks may help address challenges in GP capacity, but the impacts for patients and health services are unknown. The research of ARRIVE Stage 1 aims to gain information about the service design and rationale of paramedics in primary care roles in Wales. We will speak with staff involved in the delivery of such services. Knowledge gained will be used to inform Stage 2 of the ARRIVE, which will examine the feasibility of an evaluation of paramedics in general practice.
PhRASE **P**re**H**ospital **R**ecognition and **A**ntibiotics for 999 patients with **SE**vere sepsis: a feasibility study 	Sepsis is a common condition killing between 36,000 and 64,000 people every year in the UK. Early recognition and management of sepsis has been shown to reduce mortality and improve the health and well-being of people with sepsis. Paramedics frequently come into contact with patients with sepsis and are well placed to provide early diagnosis and treatment. This feasibility study aims to find out whether paramedics can identify; collect blood cultures from; and administer intravenous (IV) antibiotics to, patients with sepsis. We aim to determine the feasibility, safety and acceptability of our trial design and data collection methods, so that we can make a decision about whether to proceed to a full randomised controlled trial, which can answer questions about whether the intervention is effective for patients and worthwhile for the NHS.
REACT 2 pa**R**am**E**dic decision making during out of hospital cardi**AC** arres**T** 2.	REACT2 is a mixed methods research study which aims to explore, describe, and understand how paramedics make decisions regarding the commencement of resuscitation efforts. The collected data will be analysed to provide an understanding of how these decisions are made and the trade-offs paramedics accept in these decisions. The study consists of two stages, stage 1 will involve interviews with paramedics in Northeast England, and stage 2 will involve a national survey involving paramedics across England and Wales.
PASTA **P**aramedic **A**cute **S**troke **T**reatment **A**ssessment 	Stroke is responsible for a high global burden of mortality and disability. The most effective single emergency treatment for ischaemic stroke is thrombolysis using intravenous recombinant tissue Plasminogen Activator within 4.5 hours of symptom onset (rtPA), but outcomes are highly time dependent. PASTA is a cluster randomised control trial aiming to determine the feasibility, clinical and cost-effectiveness of an enhanced paramedic role during pre-hospital and acute hospital care to reduce time from admission to brain imaging and thrombolysis for appropriate stroke patients.
RAPID Rapid Analgesia for Pre-hospital Hip Disruption (RAPID): a feasibility study for a randomised controlled Trial 	Led by the Trust in collaboration with Swansea University and ABMU. The study aims to determine the feasibility of undertaking a randomised controlled trial (RCT) to test the clinical and cost-effectiveness of paramedics providing fascia iliaca compartment block (FICB) as early pain relief to patients who have fractured a hip at the scene of their injury.
CDM TBI	The CDM TBI is a mixed methods study which aims to understand the ambulance clinician's perceptions, experiences and decision-making processes when assessing older adults with a head injury and the factors and resources they draw upon to make their decisions. The study objectives are to collect information about ambulance

Ambulance clinician approach to acute head injuries in older adults: A mixed-methods study in clinical decision-making	clinicians and their approach to older adults with a head injury, and to explore ambulance clinicians' perceptions of older adult head injuries and TBI, specifically their experience of assessing and triaging these patients.
BACK-On-LINE Internet based personalised self-management support system for people with back pain BACK-on-LINE™ let us help you to help yourself	The BACK-on-LINE study aims to evaluate feasibility, acceptable and potential usefulness of a web-based intervention tool designed to help people with low back pain in the workplace to better self-manage and stay in work. The tool will be launched to the workforce in NHS Wales for a period of 6 months and data will be collected on usage, usability/acceptance, validated questionnaires, and feasibility for use. Potential impact on pain, disability, physical activity levels, sickness absence, seeking healthcare resources as well as cost of set up, maintenance and support of the BoL platform will be established.
The COMPARE Study The impact of COVID-19 on Emergency Medical Service led out of hospital cardiac arrest resuscitation: A Qualitative study.	What has been the impact of the COVID-19 pandemic on Emergency Medical Service-led resuscitation in out-of-hospital cardiac arrest? A qualitative enquiry, using semi structured interview questions within the context of UK Emergency Medical Service staff who have resuscitated patients in OHCA during the COVID-19 pandemic. The data collected will undergo thematic analysis. The study aims to explore Emergency Medical Service views on the impacts of the COVID-19 pandemic on resuscitation during OHCA by understanding the impact of the COVID-19 pandemic on communication during resuscitation, undertaking resuscitation procedures and perception of risk to Emergency Medical Service staff
CESSATION Female ambulan**CE** **S**taff experience**S** of menop**A**use **T**rans**I**ti**ON** CESSATION	Menopausal symptoms can have a significant impact on female health and wellbeing and are known to affect workplace attendance and performance. The three main aims of the CESSATION study are to identify the current menopause guidance, policies and support offered by UK ambulance services; understand the work and personal impacts of the menopause on female ambulance staff; and identify service developments and interventions that may best support female ambulance staff during the menopause transition. CESSATION is a mixed-methods study that comprises three phases. The outputs from this study will be the identification of potential menopause-related service developments and interventions to support ambulance staff.
Impact of Multi Agency Evaluation of multi-agency working within the Social Services and Well-being (Wales) Act 2014	The Social Services and Well-Being (Wales) Act 2014 is a piece of legislation for local authorities and health boards, which aims to change the way social services are delivered through integrating health and social care, empowering people, giving people control in decision making and promoting consistent, high-quality services nationally. University of South Wales are leading on a programme of research, which aims to assess the impact of the Social Services and Well-being (Wales) Act 2014 on the well-being of people who need care and support and carers who need to support. This will be done across five domains: voice and control, well-being, co-production, multi-agency working and prevention and early intervention. This study focuses on the multi-agency domain and aims to understand the extent to which the Act has promoted integrated care and support from different teams for people in Wales.
The CARA Study The **C**OVID-19 **A**mbulance **R**esponse **A**ssessment Study.	Ambulance personnel already work under great pressure, and it is likely that this staff group will meet the initial needs of people in the community with suspected or confirmed COVID-19. As such, this is likely to lead to increased pressure which could possibly impact on staff health and wellbeing. This study will recruit UK ambulance personnel to complete a short online questionnaire assessing their current perceived preparedness and wellbeing during the

	current accelerative phase of COVID-19 outbreak. Subsequently, during the peak and decelerative phases of the pandemic wave, staff who have consented to be re-contacted will complete two further brief questionnaires. This should enable a larger picture of the effects upon health care providers to be gained. In addition, CARA asks about participants' levels of readiness to work in these unfamiliar circumstances and examines issues surrounding daily working practices at a time of increasing pressure and demand.
RIGHT-2 **R**apid **I**ntervention with **G**lyceryl Trinitrate in **H**ypertensive Stroke **T**rial-**2**	RIGHT-2 is led by Nottingham Stroke Trials Unit and funded by the British Heart Foundation. It is a Multicentre prospective randomised single-blind blinded-endpoint parallel group trial, which is seeking to determine whether Glyceryl Trinitrate improves outcome in patients with ultra-acute stroke. RIGHT-2 is Clinical Investigational of a Medicinal Product (CTIMP) and is therefore regulated by the Medicines and Healthcare products Regulatory Agency (MHRA)
PRINCIPLE **P**latform **R**andomised trial of **IN**terventions against **C**OVID-19 **I**n older people	There is an urgent need to identify effective treatments for SARS-CoV-2 infection that helps people recover quicker and reduces the need for hospital admission. We have established an open, adaptive, platform trial to evaluate treatments suitable for use in the community for treating COVID-like-illness that might help people recover sooner and prevent hospitalisation. The trial has co-primary endpoints: 1) Time taken to self-reported recovery from randomisation; and 2) hospitalisation and/or death. The main objective of the trial is to assess the effectiveness of the interventions in reducing time to recovery and in reducing the incidence of hospitalisation and/or death.
EDARA **E**valuating the **D**iversion of **A**lcohol **R**elated **A**ttendances	This project is evaluating the effectiveness, cost-effectiveness, efficiency and acceptability of Alcohol Intoxication Management Services (AIMS) in managing alcohol-related Emergency Departments' attendances. AIMS are designed to receive, treat and monitor intoxicated patients who would normally attend Emergency Departments and to lessen the burden that alcohol-misuse places on unscheduled care. They are usually located close to areas characterised by excessive intoxication and are open at times when levels of intoxication peak (e.g. Friday and Saturday evenings). AIMS therefore offer the potential to mitigate some of the pressures on Emergency Departments as well as ambulance services and the police at times when there is a sustained increase in demand.
TIER **T**ransient **I**schaemic Attack: paramedic **E**mergency **R**eferral study	A feasibility trial led by the Trust in collaboration with Cwm Taff health Board and Swansea University. The study aims to develop and assess the feasibility of paramedic referral of patients with low-risk suspected Transient Ischaemic Attack (TIA) directly to TIA clinic for early specialist review, without going to the Emergency Department (ED).
ERA	This research is led by Swansea University and aims to find out how ambulance services can make the best use of information technology to support people with good quality care out of hospital.

Electronic **R**ecords in **A**mbulances	
PHECG-2 Use and impact of the **P**re-**H**ospital 12-lead **E**lectro **C**ardio **G**ram in the primary PCI era. Mixed method study (PHECG-2) 	Using routinely collected data from a large national audit, a review of ambulance records, and qualitative methods, we will assess the association of having pre-hospital ECG (PhECG) with patient outcomes, and research patient, practitioner and contextual factors contributing to the decision to record (or not) a PHECG. We will aim subsequently to develop an intervention to increase the proportion of eligible patients that receive a PHECG, and to produce a proposal for further funding to test this intervention in a subsequent randomised trial.
ASSIST **AS**suring **S**afe artificial **I**ntelligence in ambulance **S**ervice 999 **T**riaging 	The aim of this project is to contribute to the development of a real-world Body of Knowledge for assurance cases of AI in critical sectors, using the example of the Corti AI triaging system to be tested within the Welsh Ambulance Service NHS Trust (WAST). The objectives of the project are to: O1: Understand and specify the operating environment for the Corti AI system within the Welsh Ambulance Service and determine safety assurance requirements at the clinical system level. O2: Develop a self-contained safety case argument that logically, traceably and coherently brings together diverse evidence from the sociotechnical context, the user-interface and the detailed software engineering of the system. O3: Collaborate with stakeholders to drive standardisation and best practice for the safety assurance and regulation of AI products into UK ambulance services and critical sectors.
Effects of Homeworking Exploring that effects home working has on 999 telephone triage clinicians in response to Covid-19	In response to COVID-19, organisations such as NHS England and Welsh Assembly Government advised healthcare providers to implement remote consultations using video, telephone, email, and text message services, in addition they asked all clinical staff to work from home where possible. This research aims to undertake a review of the literature in relation to home working for 999 telephone triage nurses and paramedics and qualitatively explore how home working, in response to COVID-19 affected this practice. This information will help inform longer-term flexible and agile working practices and any future pandemic responses from an operational perspective, but also a professional and personal welfare perspective.
TRIM What **TRI**age model is safest and most effective for the **M**anagement of 999 callers with suspected Covid-19	999 emergency ambulance calls related to COVID-19 have increased enormously during the coronavirus pandemic. In some areas, the volume of calls has tripled. Ambulance services cannot send an ambulance to every caller within a reasonable timeframe and not every patient with suspected COVID-19 can be taken to hospital. Ambulance services use different models to sort out - or triage – callers, but little is known about what model of triage works most safely and effectively during a pandemic. We will survey all ambulance services in England, Wales and Scotland to categorise triage models used in the call centre and on scene during the 2020 pandemic. We will then retrieve outcomes of patients treated within different models from NHS datasets, including deaths; hospital and ITU admissions; Emergency Department attendances; and COVID-19 diagnosis We will interview health service staff to understand experiences and concerns. We will deliver findings quickly to help implement the best model for sorting and treating 999 callers with suspected COVID-19 symptoms.

PECC-19 **P**aramedic **E**xperiences of providing **C**are during the 2020 **C**OVID-**19** Pandemic (PECC-19): A qualitative study using Grounded Theory	The Coronavirus COVID-19 (SARS-CoV-2) is a family of viruses causing disease in animals and humans, ranging from the common cold to serious respiratory illnesses. COVID-19 was first reported on 31ST December 2019 in Wuhan, China and on the 6th March 2020, 100,000 worldwide cases were reported in over 90 countries, alongside the first death in the UK, representing the most significant pandemic of a generation. Paramedics are in the front-line response to the 2020 COVID-19 Pandemic, and research may improve our understandings and response to such future pandemics. The aim of the study is to explore Paramedic perspectives of providing care during the 2020 COVID-19 Pandemic and develop theory in order to inform future policy and practice.
Body Worn Cameras Attitudes towards the use of Body Worn Cameras (BWCs) within ambulance and pre-hospital care in Wales: A mixed methods study.	The Body Worn Cameras student research project aims to assess the current attitudes towards the potential introduction of Body-Worn-Cameras within pre-hospital. Existing literature on this topic will be reviewed to assess any current conceptions on the topic and then 10-12 interviews will be undertaken with Welsh Ambulance Services NHS Trust staff to ascertain attitudes towards body worn cameras.
E-learning versus Telesimulation - an evaluation study Evaluation of the effectiveness of telesimulation based learning compared to e-learning in prehospital practitioners.	Simulation based medical education is particularly useful in high stress environment where pre-hospital practitioners deal with acutely ill patients. Simulation based training ensures a safe platform for both practitioners as well as patients where learning is ensured without harm. During Covid-19 pandemic, the teaching and training sessions have been severely affected due to social distancing, lockdown and quarantine periods that teachers and learners have been subjected to for safety to person and public. This project is an investigation into what is the best practice and how effective it is to conduct tele simulation-based education under strict rules of social distancing and to compare it to an e-learning/ online teaching session. A scenario-based virtually attended, interactive simulation session will be designed for paramedics. An e-learning module will also be provided on the same topic. Participants will be divided into 2 equal sized groups. All participants will complete the same questionnaire prior to the teaching. The groups will then complete both session A and session B. The groups will alternate as to what session they complete first. Following completion of each session a self-evaluation questionnaire will be administered asking participants to rate their experience. The questionnaire will also allow participants to give qualitative feedback on the sessions.
KESS (MSc) Evaluating Measures of Stress and Post-traumatic stress disorder	The aim of this student research study is to identify measures vulnerable to stress and be potentially used to help identify people with an increased risk of, or currently suffering from, post-traumatic stress disorder (PTSD). Due to restrictions imposed by the COVID-19 pandemic, this study was terminated prior to completion of data collection, however a novel online study was undertaken and suggested that PTSD may not always be associated with inhibition deficits.

POCT (Pathway to Portfolio) Point of Care Testing (POCT) for community based Advanced Paramedic Practitioners	The Point of Care Testing (POCT) research study aims to identify potential candidates for community based POCT by APPs within pre-hospital care, which could be explored in a future feasibility trial. In Wales APPs educated to MSc level were introduced to provide alternatives to hospital care, to support the Welsh Government strategy of people only attending hospital where essential. POCT can improve patient outcomes by providing a faster result and a shorter timeframe to therapeutic interventions, improve treatment optimisation, detect, and manage chronic disease progression and management and decrease the need for hospital visits. However, there is uncertainty over issues such as what devices or POCT tests may be beneficial and feasible in the pre-hospital care setting and whether there are any cost benefits.
PERCH (PTP) Preliminary Exploration of paramedic Roles in Care Homes	The role of paramedics has expanded into various aspects of community paramedicine, including care homes, this includes urgent home visits on behalf of general practices (often instead of GPs) and aspects of proactive care such as reviews and assessments. However, this does raise questions over quality and safety, workforce and capacity and training. The aim of the PERCH study is to carry out background work to support the development of a portfolio application for a research study into paramedics/APPs working proactively in care homes.
PARA VR (PTP)	The Welsh Ambulance Services NHS Trust (WAST) are currently engaged in a collaboration with Chester University on program of developing Virtual Reality (VR) training for Paramedics. We have had discussions with British Heart Foundation (BHF) Cymru around extending the PaRAVR program to develop and test a prototype of VR training for CPR with school children. BHF are supportive of such collaboration.

Appendix 2 – Publications in 2022

Smith, C.M., Sheehan, A., Rees, N. and Powell, C., 2022. 781 Drone delivered defibrillators (The 3D Project): a simulation study. *Emergency Medicine Journal: EMJ*, *39*(3), pp.258-258.

Rees N, Holding K, Sujan M. Information governance as a socio-technical process in the development of trustworthy healthcare AI. Front Comput Sci 2023;5.

Sujan, M., Thimbleby, H., Habli, I., Cleve, A., Maaløe, L. and Rees, N., 2022. Assuring safe artificial intelligence in critical ambulance service response: study protocol. *British Paramedic Journal*, *7*(1), pp.36-42.

Rees, N, Williams, J, Hogan, C, Smyth, L and Archer, T, (2022) Heroism and paramedic practice: A constructivist metasynthesis of qualitative research. Front. Psychol., 07 November. https://doi.org/10.3389/fpsyg.2022.1016841

Hooper, A., Nolan, J. P., Rees, N., Walker, A., Perkins, G. D., & Couper, K. (2022). Drug routes in out-of-hospital cardiac arrest: a summary of current evidence. *Resuscitation*.

Gutiérrez-Fernández, A., Hogan, C., Rees, N., Fernández-Llamas, C., & John, N. W. (2022, September). An Immersive Haptic-enabled Training Simulation for Paramedics. In *2022 International Conference on Cyberworlds (CW)* (pp. 79-85). IEEE.

Kingston, Mark, Jenna Jones, Sarah Black, Bridie Evans, Simon Ford, Theresa Foster, Steve Goodacre, Marie-Louise Jones, Sian Jones, Leigh Keen, Mirella Longo, Ronan A. Lyons, Ian Pallister, Nigel Rees, Aloysius Niroshan Siriwardena, Alan Watkins, Julia Williams, Helen Wilson, and Helen Snooks (2022) "Clinical and cost-effectiveness of paramedic administered fascia iliaca compartment block for emergency hip fracture (RAPID 2)—protocol for an individually randomised parallel-group trial." *Trials* 23, no. 1 (2022): 1-15.

Sujan, M., Thimbleby, H., Habli, I., Cleve, A., Maaløe, L., & Rees, N. (2022). Assuring safe artificial intelligence in critical ambulance service response: study protocol. *British Paramedic Journal*, *7*(1), 36-42.

Rabeea'h, W.A., Snooks, H., Porter, A., Khanom, A., Cole, R., Edwards, A., Edwards, B., Evans, B.A., Foster, T., Fothergill, R. and Gripper, P., John, A. Petterson, R. Rosser, A. Tee, Anna. Sewell, B. Hughes, H. Phillips, C. Rees, N. Scott, J. Watkins, A. (2022) STRategies to manage Emergency ambulance Telephone Callers with sustained High needs: an Evaluation using linked Data (STRETCHED)–a study protocol. BMJ open, 12(3), p.e053123.

Hawkes, C.A., Kander, I., Contreras, A., Ji, C., Brown, T.P., Booth, S., Siriwardena, A.N., Fothergill, R.T., Williams, J., Rees, N. and Stephenson, E., 2022. Impact of the COVID-19 pandemic on public attitudes to cardiopulmonary resuscitation and publicly accessible defibrillator use in the UK. *Resuscitation Plus*, p.100256.

Allen, M., (2022) NHS 111 Wales website: an evaluation of signposting changes. Family Medicine. Available from: https://www.pavilionhealthtoday.com/fm/nhs-111-wales-website-an-evaluation-of-signposting-changes/

Brown, C., Armstrong, D., Gibbins, A., Roynon, R., Groves, A., Richards, A., McCarthy, C., Bowen, R., White, H. and Brady, M., 2022. Benefits of a collaborative approach to service evaluation in urgent care. *Emergency Nurse*, *30*(6).

AUDIT COMMITTEE
HIGHLIGHT REPORT TO BOARD

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

Trust Board Meeting Date	28 September 2023
Committee Meeting Date	14 September 2023
Chair	Martin Turner

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Welsh Government's annual review of the model **Standing Orders**, Scheme of Reservation and Delegation of Powers, and Standing Financial Instructions in July 2023 resulted in some amendments being required to the documents. These relate primarily to the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 including the introduction of the duty of quality and duty of candour, and the change from the Community Health Councils to the Citizens Voice Body (Llais). **The changes are recommended to the Trust Board for their approval** and are a substantive item on the Trust Board agenda.

2. A **change of prescribed Committee attendees** was made with Judith Bryce, Assistant Director of Operations, National Operations and Support, attending in the place of the Executive Director of Operations, Lee Brooks. **The Board is requested to approve the change**.

ADVISE

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

3. The **Audit Process and Reporting Handbook** was presented to the Committee. The handbook provides context around the internal and external audit work at the Trust and sets out the stages of fieldwork for those the subject of an audit. The Committee approved the handbook, which includes the roles and responsibilities for management, this Committee and other Board Committees as they relate to audit reviews. A revised approach to reporting was also approved which will position this Committee to focus on the overall framework and escalations where audit management actions are not met in reasonable timescales.

4. The Audit Committee chair held a **pre-meet** with Internal Audit and Audit Wales before the meeting in line with best practice.

5. Members **reflected** that the papers for the meeting were clear and concise making it easier for members to understand the key issues and recommended actions. The Chair thanks those who wrote papers and presented items and those who attended the meeting as observers.

ASSURE

(Detail here any areas of assurance the Committee has received)

6. The Board received alerts in the AAA reports Committees in July regarding the **Trust policies that were beyond their review dates**. The Audit Committee were assured at this meeting that a prioritisation programme had been agreed based on risk assessments for each policy and noted the list of policies due to be revised in 2023/24 and 2024/25. For non-critical policies a criteria for extension of policies was agreed. The development of a new Policy on Policies was noted, and the inclusion of wider definitions and processes for all forms of written control documents including Standard Operating Procedures was welcomed.

7. There is good progress against the **2023/24 Internal Audit Plan** and two **Internal Audits** (Health and Safety; Follow Up) reviews were completed during the quarter and presented to the Committee, both of which had ratings of reasonable assurance. The Health and Safety Internal Audit was reviewed in detail at the People and Culture Committee in August.

8. The **Audit Wales Update** was received and the Committee noted:

    - Review of unscheduled care part one (flow out of hospital) reports being drafted with Parts two and three – accessing unscheduled care; and national arrangements and leadership structures, to begin shortly.
    - Workforce planning An assessment of workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. The review will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. It is anticipated this will be reported to the Committee in November.
    - Structured assessment 2023. The fieldwork is complete for the core assessment work, and the report will be presented to the Audit Committee in November.

    Planned work including a deep dive into digital to begin in Autumn 2023, and a follow up of the Review of Quality Governance Arrangements will begin in late 2023/24.

9. The **losses and special payments** made during the period 1 April 2023 to 31 August 203 amounted to £66.5K.

10. The Committee was assured that an **induction programme** was in place for new Board members which set out the roles and responsibilities of all those who are members of or attend the Board. This documents is updated periodically and includes a range of essential reading for the new member and a programme of introductory meetings on a three month timescale. It is accompanied by a process for Non-Executive Directors to obtain their IT, email, expenses and ESR access, and badging to allow for a smooth transition. The next iteration of this is a Committee specific induction document which is in development.

11. In **private session** the committee received the counter fraud update 1 June to 31 August 2023, as well as the report on tenders and single tender waiver requests. The Local Counter Fraud Service (LCFS) provided an update on its work including fraud awareness sessions delivered, prevention and deterrence support and guidance. This quarter has seen an increase in dual working fraud risk and the securing of the Counter Fraud Awareness E-Learning as a mandatory training course. There are 20 recorded ongoing investigations by LCFS – an increase of one from last quarter - with a number of potential offences ranging from working whilst sick, to secondary employment.

12. The **2023/24 Committee Priority** (review of Board member induction programme and annex) was

reviewed and is on track with that programme being presented at this meeting. A new priority was added as a transfer from the Finance and Performance Committee, that being the oversight of the development and effectiveness of the Quality and Performance Management Framework.

13. The **Committee's cycle of business** was reviewed and is on track.

RISK MANAGEMENT

The Committee is responsible for the review of the risk management framework and is not assigned individual risks for oversight. The Committee noted that risk 160 related to sickness absence has maintained a score of 20 given the fragility of this area and sickness absence trends. Both the People and Culture Committee and Executive Leadership Team will continue their close monitoring of this risk.

The Committee reviewed progress against the risk management transformation programme. Areas of focus for the risk management improvement programme plan during 2023 are to deliver a risk management framework as a key enabler of our long-term strategy and decision making. This will be achieved by further developing the risk management framework, transitioning to a strategic BAF that reflects more closely the Trust's strategic objectives against its long-term strategy – Delivering Excellence: Vision 2030. This is in addition to designing and delivering a programme of training and education on both the risk management framework and the BAF.

COMMITTEE AGENDA FOR MEETING		
Head of Internal Audit Progress Report	Health and Safety Internal Audit	Follow Up Internal Audit
Audit Wales Update	Amendments to Standing Orders and Standing Financial Instructions	Revised audit process
Risk Management and Board Assurance Framework	Losses and Special Payments	Whistleblowing (speaking up safely)
Board Induction Programme	Committee cycle of business, monitoring report, priorities report and membership update	Policy Report

COMMITTEE ATTENDANCE					
Name	**20 April 2023**	**25 July 2023**	**14 Sept 2023**	**30 Nov 2023**	**1 Mar 2023**
Martin Turner					
Paul Hollard					
Joga Singh					
Ceri Jackson					
Chris Turley					
Lee Brooks		Judith Bryce	Judith Bryce		
Liam Williams	Duncan Robertson				
Angie Lewis					
Osian Lloyd (IA rep)					
Audit Wales rep		Andrew Doughton	Fflur Jones		
Paul Seppman					
Damon Turner					
Trish Mills					
Carl Window					

	Attended
	Deputy attended
	Apologies received
	No longer member

AGENDA ITEM No	**16**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**0**

GOVERNANCE REPORT

MEETING	Trust Board
DATE	28 September 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report sets out where applicable the **Chair's Action** taken since the last Board meeting, **use of the Trust Sea**l. and **decisions made in private session.**

Chair's Action

2. There have been no decisions made by Chair's Action since the last meeting of the Trust Board on the 27 July 2023, therefore no ratification of Chair's actions is required.

Use of the Trust Seal

3. The Trust Seal has not been used since the last meeting of the Trust Board on the 27 July 2023, however at the meeting of the Trust Board on the 27 July 2023 the Board approved the affixing of the Seal as cited in paragraph 3.1, and noted the use of the Trust Seal as cited in paragraph 3.2: -

3.1 Licence for alterations for Unit 3, Phoenix Park, Telford Street, Newport, NP19 0LW. The licence was between the South Wales Chamber of Commerce, Enterprise and Industry Limited (landlord) and the Trust, to enable minor works to be completed. The Board noted that it was not requested to approve the licence, just the affixing of the Trust Seal in accordance with Standing Orders;

3.2 On the 26 January 2023 the Board was notified of the use of the Trust Seal (reference 0239) for fence installation at Cardiff Make Ready Depot. The transaction was not finalised, and amendments were required to the Engrossment licence for Works and the Engrossment Deed of Covenant. These documents were re-executed as deeds with the Trust Seal (reference 0246) on the 27 July 2023.

Decisions in Private Session

Closed Trust Board - 27 July 2023

4. At the private meeting of the Trust Board on the 27 July 2023 the Board approved the transfer of additional non-Trust non-emergency patient transport services from the Powys Teaching University Health Board to the Welsh Ambulance Services NHS Trust. It was intended that this transfer would complete by the 01 August 2023.

Closed Trust Board - 10 August 2023

5. The Trust Board held a meeting in private session on the 10 August 2023 and received and approved the financial savings submission to the Welsh Government. The Board approved the recommended options up to the 10, 20% and 30% savings proposed for submission to the Welsh Government.

KEY ISSUES/IMPLICATIONS
Not applicable.

REPORT APPROVAL ROUTE
Not applicable.

REPORT APPENDICES
Not applicable.

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	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

WELSH AMBULANCE SERVICES NHS TRUST

CONFIRMED MINUTES OF THE OPEN MEETING OF THE ACADEMIC PARTNERSHIP COMMITTEE OF THE WELSH AMBULANCE SERVICES NHS TRUST HELD ON TUESDAY 25 APRIL 2023 VIA TEAMS

MEMBERS:

Hannah Rowan	Non-Executive Director and Committee Chair
Kevin Davies	Non-Executive Director
Paul Hollard	Non-Executive Director
Martin Turner	Non-Executive Director

IN ATTENDANCE:

Kate Coombs	Life Sciences Hub Wales
Alex Crawford	Assistant Director of Planning and Transformation
Estelle Hitchon	Director of Partnerships and Engagement
Caroline Jones	Corporate Governance Officer
Jo Kelso	Head of Workforce Education & Development
Angela Lewis	Director of Workforce and OD
Mark Marsden	Trade Union Partner
Trish Mills	Board Secretary
Alex Payne	Corporate Governance Manager
Cari-Anne Quinn	Life Sciences Hub Wales
Keith Rogers	Trade Union Partner
Andy Swinburn	Director of Paramedicine

APOLOGIES:

Duncan Robertson	Interim Assistant Director of Research, Audit & Service Improvement
Chris Evans	Research Innovation and Improvement Lead
Jonathan Turnbull-Ross	Assistant Director of Quality Governance

11/23 WELCOME AND INTRODUCTION

The Chair welcomed everyone to the meeting, and that Kevin Davies' extensions as Vice Chair of the Board and therefore membership of the Committee has continued.

The Chair confirmed that both Kevin Davies and Paul Hollard would be joining the meeting shortly.

12/23 DECLARATIONS OF INTEREST

The standing declarations of interest of Hannah Rowan and Professor Kevin Davies were recorded, and no other members had declarations to disclose.

13/23 MINUTES OF THE LAST MEETING

The minutes of the meeting held on 17 January 2023 were approved as a correct record.

14/23 ACTION LOG AND MATTERS ARISING

The Action log was reviewed and updates were given on the actions around mapping engagement and sharing of the data dashboard with Members.

RESOLVED: That the Action log was REVIEWED and UPDATED.

15/23 TASK & FINISH GROUP UPDATE

Trish Mills gave a brief update on the Academic Partnerships Task and Finish group where the group's terms of reference had been agreed and were now being presented for approval by the Committee. The Committee were also presented with a highlight report from the Task and Finish group's meeting on 3rd April 2023, which set out the key areas of discussion from that meeting.

Members noted the contents of the highlight report and approved the Task and Finish group's terms of reference. Members then discussed the upcoming appointment of a new Non Executive Director (NED) and recognised the importance of recruiting the correct person into the role. Members agreed that it was vital that the incoming NED was equally committed to all Trust business as well as helping to achieve University Trust Status.

RESOLVED: That terms of reference for the Academic Partnerships Task and Finish Group were APPROVED.

16/23 LIFE SCIENCES HUB WALES

Cari-Anne Quinn and Kate Coombs gave a presentation on the work which was undertaken by the Life Sciences Hub Wales (LHSW). Members heard how the LSHW was well placed to support aspects of innovation and commercial developments, as innovation and engagement with commercial partners was an avenue of potential opportunity which could be utilised as the Trust sought to advance its long term strategy.

Members were informed that the presentation was only the first step in understanding what was possible through working with LSHW and would be followed by a question-and-answer session with Committee Members to explore the potential opportunities this may bring. It was noted that any further work beyond that which was already underway with LSHW would need to be undertaken by organisational leads and reported back to both the Executive Management Team and the Committee.

Members received the presentation and queried what LSHW could do to help bring together the various services within its scope to help the Welsh Ambulance Service to not only be the best version of an ambulance service possible, but also to allow the Trust to offer and provide additional services to other organisations across the wider healthcare system.

Cari-Anne Quinn informed Members that the main purpose of LSHW was to use industry, technology, and innovation to achieve practical applications which achieved the desired goals of the individual organisations. Through partnership working, it was entirely possible that this could be accomplished. This would involve LSHW working with the Trust to ascertain and understand what the desired outcomes were, and which tools could be used to make these a reality. Actions were agreed for:

Research, Innovation and Improvement Lead to share the data dashboard with members.

For there to be consideration of how the Committee works with related partners, including the LSH. This relates to existing action 49/22 - mapping of engagement with stakeholders.

For there to be consideration of how the Committee works with related partners and how the Trust's WIIN function sits within this work and engages with the Committee. This relates to existing action 49/22 - mapping of engagement with stakeholders.

RESOLVED: That contents of the presentation were DISCUSSED and NOTED.

17/23 INTEGRATED MEDIUM TERM PLAN) (IMTP) 2023-2026 - ELEMENTS RELATIVE TO THE COMMITTEE

Alex Crawford updated Members on the elements of the IMTP relevant to the Committee, including research, development and innovation and those priorities for University Trust Status that were rolled over from the IMTP 2022-25. The report set out three priorities for University Trust Status, these were:

● Priority One: Digitisation enabling better outcomes (IMTP sections 4.1, 4.2 & 7)

● Priority Two: Advanced practice and specialist working, consult and close and service transformation, including research (IMTP sections 4.2 & 8.3)

● Priority Three: Decarbonisation, fleet modernisation and sustainability (IMTP section 6)

The IMTP also set out deliverables which would be implemented through a Task and Finish group, reporting into the Academic Partnership Committee (APC) which included the structures, leadership and academic representation required at Board level as the Trust transitioned to University Trust Status (UTS) as well as the 'brand' required for UTS, aligned to the Trust's purpose and its strategic direction.

Furthermore, the IMTP also included a set of priorities for research and innovation to be delivered during the term of the plan, with an ask that APC focusses on the following key issues:

- Championing research and innovation
- Understanding where we have partnerships with key stakeholders
- Promote collaboration
- Supporting the ongoing research and innovation agenda
- What can we learn from new partnerships
- Keeping a line of sight to alignment with Trust purpose and strategy
- Developing the WAST 'brand'
- Delivery of leadership and structures through T&F group

Members welcomed the update and recognised the strong governance arrangements which were in place, noting that delivery of the relevant elements of the plan would be through directorate, programme or project structures.

These would then report through Strategic Transformation Board to Finance and Performance (F&P) Committee, and whilst APC was not required to provide this monitoring and scrutiny function, the F&P Committee may request deep dives through other governance arrangements, such as APC.

RESOLVED: That

1. the update was NOTED.

2. the focus of APC on the key issues set out in the report were CONFIRMED.

3. the Committee was ADVISED on any further key issues set out in the report that should be considered by the Committee in line with the IMTP deliverables around research, innovation and University Trust Status.

18/23 HIGHLIGHT REPORT FROM JANUARY 2023 MEETING

The Academic Partnership Committee highlight report was presented as read and for information purposes only, having previously been circulated to Members for review. No further queries were raised by Members.

RESOLVED: That the contents of the highlight report were NOTED.

19/23 SUMMARY OF ACTIONS, DECISIONS MADE AND KEY MESSAGES

The Chair summarised the discussions and drew out the actions, decisions and key messages from the meeting. Actions were agreed for the following:

- Research, Innovation and Improvement Lead to share the data dashboard with members.

- Income generation discussion and ideas for delivery/support to be programmed as a substantive item at the next meeting, and commissioned accordingly.

- For there to be consideration of how the Committee works with related partners, including the LSH. This relates to existing action 49/22 - mapping of engagement with stakeholders.

- For there to be consideration of how the Committee works with related partners and how the Trust's WIIN function sits within this work and engages with the Committee. This relates to existing action 49/22 - mapping of engagement with stakeholders. Duncan Robertson to initiate discussion with Jonathan Turnbull-Ross.

20/23 ANY OTHER BUSINESS

Members were invited to give their thoughts around income generation and which areas of the Trust could be utilised to achieve this aim. Members discussed various options across several directorates, including digital services and clinical support where there was potential for income generation.

Members were also asked to share their understanding of the reasons and justifications for pursuing University Trust Status, in particular the benefits of attaining UTS and what difference it would make to the Trust, patients and stakeholders.

Members reflected on the changing nature of the ambulance service, becoming more clinically focussed whereas traditionally, the focus was simply upon the conveyance of patients. Members cited a number of reasons which justified the work involved in striving for UTS and felt that the cost of doing so was worthwhile. It was felt that UTS would elevate the Trust's standing and give it a much louder and stronger voice amongst peers.

21/23 DATE OF NEXT MEETING:

11 July 2023

CONFIRMED MINUTES OF THE PEOPLE AND CULTURE COMMITTEE MEETING (OPEN SESSION) HELD REMOTELY VIA MICROSOFT TEAMS ON 09 MAY 2023

Chair: Paul Hollard

PRESENT:

Paul Hollard	Non-Executive Director and Chair
Hugh Bennett	Assistant Director, Planning and Performance
Julie Boalch	Head of Risk/Deputy Board Secretary
Judith Bryce	Assistant Director of Operations
Alex Crawford	Assistant Director of Planning and Transformation
Sarah Davies	Workforce and OD Project Manager
Colin Dennis	Chair of the Trust
Bethan Evans	Non-Executive Director
Dr Catherine Goodwin	Assistant Director Inclusion, Culture and Wellbeing
Wendy Herbert	Assistant Director of Quality & Nursing
Estelle Hitchon	Director of Partnerships and Engagement
Melfyn Hughes	Welsh Language Services Manager
Fflur Jones	Audit Wales
Jo Kelso	National Ambulance Training College
Jason Killens	Chief Executive Officer
Trish Mills	Board Secretary
Donna Morgan	NWSSP Audit and Assurance
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Jeff Prescott	Corporate Governance Officer
Liz Rogers	Deputy Director of Workforce and OD
Hannah Rowan	Non-Executive Director
Andy Swinburn	Director of Paramedicine
Chris Turley	Executive Director of Finance and Corporate Resources
Nicola White	Head of Health and Safety
Liam Williams	Executive Director of Quality and Nursing

APOLOGIES:

Angie Lewis	Director of People and Culture Services
Paul Seppman	Trade Union Partner
Lee Brooks	Executive Director of Operations
Joga Singh	Non-Executive Director
Mark Marsden	Trade Union Partner

24/23 WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed all to the meeting of the People and Culture Committee and advised that the meeting was being audio recorded. Apologies were recorded from Lee Brooks, Paul Seppman, Joga Singh, Angela Lewis and Mark Marsden.

25/23 DECLARATIONS OF INTEREST

No new declarations were made in addition to the standing declarations which were already noted on the Trust register.

RESOLVED: That no new declarations were received.

26/23 MINUTES OF PREVIOUS MEETING AND ACTION LOG

The Minutes of the Open meeting held on 14 March 2023 were considered and agreed as a correct record. The Action log was considered, reviewed, and updated.

RESOLVED: That the Minutes of the meeting held on 14 March 2023 were AGREED.

27/23 DIRECTOR OF PEOPLE AND CULTURE DIRECORATE UPDATE

Liz Rogers gave an update on recent developments within the People and Culture Directorate, drawing out the main highlights for Members attention. These included the procurement of the MS365 Learning Management System, enabling all WAST staff to engage with learning content in a familiar and intuitive environment, in response to repeated feedback from colleagues.

Other positive developments saw the Trust apply for and gain Centre status to deliver ILM qualifications across Leadership & Management (Levels 2-4 initially) and Coaching & Mentoring (Level 5 initially). Gaining Centre Status would enable design/co-design, delivery, assessment and evaluation that met the needs of the Trust as it evolved with a genuine focus on the skills, knowledge and understanding that Trust staff needed to deliver the service, now and into the future.

Members received the update and noted the key developments within the Directorate, recognising the importance and significance of the work being undertaken, particularly in regards to the Trust achieving Centre status and the benefits this would bring to those in leadership and management roles.

RESOLVED: That the update was NOTED.

28/23 OPERATIONS QUARTERLY REPORT

Judith Bryce pesented the Operations Quarterly Report as read, focussing only on the main points of the report for discussion with the Committee. Members attention was drawn to the recent disruption as a result of industrial action, the closure of the Covid-19 mobile testing units, and the work which must now be undertaken to review and implement the recommendations arising from the Manchester Arena public enquiry.

Other significant developments included the work which was underway to prepare documentation and submissions for the Covid-19 Public Inquiry. This involved the preparation of submissions that was capacity consuming across the Directorate, requiring the involvement of the Trust's most senior team members.

In January 2023, approval was given for analgesia (pain relief) to be issued to volunteer Community First Responders (CFRs). The plan to increase numbers of volunteers has successfully increased CFR teams by more than 130 new volunteers trained during 2022/23. There will be an additional 30 more volunteers trained in the new financial year due to phasing into April. Recruitment into the volunteer management and support team has also progressed well.

Finally, the Committee was updated on the reinstatement of the Intelligent Routing Platform, which had been suspended in late 2022 due to the significant impact upon Trust resources. The report noted that as a result of system rule changes, no more than 2% of the Trust's weekly call answering activity was for other services, which was much more manageable alongside a reduced call answer wait time for 999 users in Wales.

Members received the report and queried whether any feedback had been provided following the approval for CFRs to administer analgesia. Judith Bryce stated that this was a very recent development and unfortunately, it was too early for any feedback to have been provided. Members also noted the reinstatement of the Intelligent Routing Platform within the Trust and welcomed the changes which had resulted in reduced drains upon existing capacity.

RESOLVED: That the update was NOTED.

29/23 STAFF STORY

Dr Catherine Goodwin provided Members with an update on an earlier staff story from a member of staff who had discussed their experiences of racism, discrimination and issues they had observed around different faiths, particulary in regard to designated prayer space across Trust sites and religious holidays.

Members agreed two actions as a result of the observations and agreed to explore potential prayer space across Trust sites and to also look into time off for non-Christian festivals such as Eid and Ramadan as concerns were raised around non-christians working holidays such as Easter and Christmas but not getting the same consideration for other faith based hoidays.

RESOLVED: That the staff story was NOTED.

30/23 PEOPLE AND CULTURE PLAN

Liz Rogers presented the People and Culture Plan to Committee for endorsement prior to approval at Trust Board. Members were informed that the plan comprised a single overarching narrative, underpinned by an enabling framework which clearly outlined the Tust's ambitions in relation to Equality, Diversity and Inclusion, Culture and Behaviours, Wellbeing, Leadership and Management and Education and Training.

Liz Rogers expanded upon the plan, explaining that it was designed to be agile and dynamic in nature, with actions for years two and three to be formulated during the first year of delivery, in response to the evaluated impact of the preceding year's actions. The Plan centred around the 3Cs (Culture, Capacity and Capability) and was underpinned by The King's Fund's ABCs (Autonomy, Belonging & Contribution) of Core Needs at Work.

Members were informed that a "rich picture" had also been developed, with the aim of bringing to life the Trust's culture change vision for what it would look and feel like to work in the Welsh Ambulance Services NHS Trust in three years' time.

Members received the plan and noted the aims and overall vision for the Trust moving forward. Members queried how these aims would be communicated to staff and how progress against the stated goals would be measured given the scale of the tasks. Liz Rogers stated that a communication strategy would be developed to utilise all existing platforms such as Siren and other Trust publications to promote the plan to colleagues along with assistance from Trade Union partners to help promote the message to their members. In terms of monitoring effectiveness,

a number of metrics would be monitored along side feedback from staff to help determine progress.

RESOLVED: That The Committee RECEIVED and ENDORSED the plan for approval by Trust Board.

31/23 SPEAKING UP SAFELY UPDATE

Dr Catherine Goodwin outlined the current plan to roll out the freedom to speak up process across the Trust along with the closing report for the task and finish group. The report explained how the Trust was working towards becoming an inclusive psychologically safe organisation, providing multiple pathways for everyone to feel they can raise concerns.

These pathways included reverse mentoring to increase understanding, bystander training to increase confidence, and raising awareness of micro-aggressions to enable all staff to reflect on their own behaviours. In addition, the Trust's Voices Network provided people with a safe space and support to talk through options with Trade Union partners able to advocate for members.

The report noted that the All-Wales Speaking Up Safely process was being finalised and once that was published, the Trust would adopt that policy.
There was no date for this as yet but the Trust was part of the working group and had developed some of the toolkits in partnership.

Members received the report and welcomed the very positive approach and progress which had been made. Members commented on the importance of the work and observed that the measures and actions being undertaken would stand the Trust in good stead in terms of being at the forefront of addressing issues around speaking up safely and changing behaviours.

RESOLVED: That the Committee received the report and the contents, including the closure date, were NOTED and SUPPORTED.

32/23 CORPORATE RISK REGISTER AND BOARD ASSURANCE FRAMEWORK

Julie Boalch gave an update on the Corporate Risk Register and Board Assurance Framework (BAF), providing assurance in respect of the management of the Trust's principal risks, specifically the 6 risks that are relevant to Committee's remit. These were:

● Risk 160: High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service.
● Risk 163: Maintaining Effective & Strong Trade Union Partnerships.
● Risk 199: Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation.
● Risk 201: Damage to Trust reputation following a loss of stakeholder confidence.
● Risk 557: Potential impact on services as a result of Industrial Action.
● Risk 558: Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures.

Additionally, the report also provided an update on the Trust's two highest scoring risks which are assigned to the Quality, Safety & Patient Experience Committee (QuEST) for oversight (Risk 223: The Trust's inability to reach patients in the community causing patient harm and death & Risk 224: Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service).

Members were informed that each of the principal risks were presented to the Trust Board on 30th March 2023 and were updated as of 30th April 2023. Each risk had been reviewed in full during that period, including controls, assurances, gaps and mitigating actions.

Members received the report and noted the current position in relation to risks that were relevant to the Committees remit along with the Trust's two highest scoring risks which were assigned to Quest.

RESOLVED: That the contents of the report were NOTED.

33/23 WELSH AMBULANCE SERVICES PARTNERSHIP TEAM (WASPT) ADVISORY GROUP HIGHLIGHT REPORT

Trish Mills provided an update on the key areas discussed at the last WASTP meeting held on April 13th 2023. No alerts were identified for the attention of the Committee although advisories were given around WASPT sub-structures, elements of the IMTP 2023-26, the challenging revenue and capital financial plan for 2023/24, diesel engine exhaust emissions, and the issues of Trust staff portering patients at hospitals.

Members noted that the Executive Director of Quality and Nursing had presented an update on the issue of diesel engine exhaust emissions to the WASPT advisory group with a risk being developed in regard to this. The existing risks to delivery of the IMTP and the financial position were also discussed.

RESOLVED: That update was NOTED.

34/23 ENGAGEMENT FRAMEWORK DELIVERY PLAN AND REPUTATION AUDIT

Estelle Hitchon gave a verbal update on the latest position with the engagement framewok before giving a presentation on the reputation audit. Members were informed that consultation with an external provider was currently underway and work on the engagement framework was temporaraily paused, pending the outcome and recommendations from that provider.

Members heard that the reputation audit was conducted in Q3 of 2022/23, with a wide range of stakeholders targeted. Most participants were identified by sector only and given a mix of open and closed questions as well as some free text options where applicable. Of those approached, 46 had provided responses.

Of those responses, a number of clear views and perceptions were expressed about how the Welsh Ambulance Services NHS Trust was being run and how it was performing, with a wide range of opinions, both positive and critical. It was clear from the responses that those who had responded understood and appreciated the significant pressure that the Trust had been under in recent years and continued to be under.

Members received the update and recognised the concerns which had been raised by some of the stakeholders who had taken part in the reputation audit. Consequently, Members queried what more could be done in order to address these concerns. Estelle Hitchen noted that further discussion and exploration of the feedback would be required in order to gain a better understanding of the reasons and comments which were fed back to the Trust. Members agreed a Board development session would be the best forum for this to happen and that this should take place when timing allows. Once this had been done and Members had been afforded the opportunity to fully digest and take in the feedback, the findings could then be discussed further at Trust Board.

RESOLVED: That the update was NOTED.

35/23 CYCLES OF BUSINESS

Trish Mills provided the Committee with the updated Cycle of Business as the final step in the 2023/24 effectiveness review process. Members were informed that the cycle of business would be used to build the quarterly Committee agenda, with a monitoring report being provided to each meeting and where issues of escalation

were required i.e. where cycle needed to be adjusted or reporting was overdue, these would be drawn out in a short paper by the Board Secretary.

Members reviewed and approved the 2023/24 cycle of business and noted the cycle of business monitoring document which had been provided along with the report.

RESOLVED: That

1. the 2023-24 cycle of business at Annex 1 was REVIEWED and APPROVED.

2. the cycle of business monitoring document at Annex 2 was NOTED.

36/23 MONTHLY INTEGRATED QUALITY AND PERFORMANCE REPORT

Hugh Bennett gave a brief overview of the main points from the Monthly Integrated Quality and Performance report. The report contained information on 26 key indicators which painted a poor picture in terms of the quality and safety of the Emergency Medical Services (EMS). 111 call answering rates remained problematic, although the clinician call back rates were above or close to target. Non Emergency Patient Transport Services (NEPTS) performance was stable with the Urgent Care Services (UCS) being rebased through a modelling exercise.

The Emergency Ambulance Services Committee, Welsh Government and the 111 Programme Board were very supportive of the Trust through the pandemic, investing in a range of mitigations; however, funding for further initiatives is currently limited and is expected to worsen significantly in 2023/24. For 111 and NEPTS, the Trust could look to take a range of actions to optimise the balance between patient demand and capacity. However, for EMS and UCS, the Trust could not take sufficient actions within its control to mitigate the impact of the extreme handover lost hours. As a result, the People and Culture Committee, the Finance and Peformance Committee and the Quality, Patient Experience and Safety Committee had expressed serious concern about the impact of handover lost hours on patient safety and staff well-being. It remained critical to patient safety that handover lost hours were reduced in line with Ministerial expectation and that further actions to shift patient demand were supported.

Members received the report and raised concerns around the current performance of the Trust and the impact that this was having upon staff and patients. Members queried whether anything more could be done to help reduce the number of complaints and concerns being raised by service users and what additional support could be given to the staff who were dealing with those complaints.

Liam Williams confirmed that actions were being taken to try and reduce the backlog of complaints. Additional supervisions had been implemented and discussions had taken place with the Wellbeing team to see what support could be given to staff who were working on those concerns in order to help the deal with the current workload.

RESOLVED: That the March 2023 Integrated Quality and Performance Report and actions being taken, determining whether:

a) the report provided sufficient assurance.

b) whether further information, scrutiny or assurance was required, or

c) further remedial actions were to be undertaken through Executives was CONSIDERED.

37/23 WORKFORCE PERFORMANCE SCORECARD REPORT

Liz Rogers provided an overview of the key People and Culture performance data and trends up to March 2023 and the associated improvement actions. The report drew Members attention to a number of areas, including increased sickness absence for March, albeit with indicative figures denoting a reduction for April 2023, the impact of Industrial Action on delivery of MIST training (affecting Statutory and Mandatory training compliance rates and conclusion of the 2022-23 Flu vaccination programme, with 44.5% uptake.

In addition, the Committee was asked to note the following headlines:

Time to Hire: Currently the pan-Wales target was 44 days and the Trust had been improving consistently, returning a figure of 46.4 days in January, 43.6 days in February and 34.6 days in March 2023. This figure could be improved by ensuring that steps such as shortlisting and giving outcomes were within the targets set. Currently the target for shortlisting is 3 days and the Trust came in at 2.9 days. The target for delivering outcomes was 3 days and currently, the Trust was at 10 days. Members were informed that the Trust had implemented a vacancy control panel to help manage recruitment across the organisation. This would be closely monitored to ascertain the impact on achieving the desired KPIs. Alongside this, there would be a continuous drive to ensure managers were aware of the implications of any delay during recruitment on the KPIs.

Statutory and Mandatory Training Compliance: Completion of Statutory & Mandatory training at level 1 for the ten CSTF (Core Skills Training Framework) topics was at 77.26% for the Trust at the end of March 2023; this was the figure reportable to WG against a target of 85%.

PADRs: Completion rates across the organisation had increased to 73.69% - an increase of 8.51% on the figure reported at the last meeting of the People and Culture Committee and an increase of 14.42% over the last year.

Members received the update and noted the improvement in performance, especially around PADR compliance and recruitment times.

RESOLVED: That the Committee RECEIVED and COMMENTED on the reported performance and associated actions.

38/23 IMPROVING ATTENDANCE PROJECT PROGRESS UPDATE

Liz Rogers gave a presentation setting out the sickness absence data, up to and including February 2023. Members heard how the continual monitoring and focus on sickness absence had enabled support and access to internal and external interventions contributing to the decreasing absence rates. In February 2023, the reported Trust wide sickness absence had decreased to 7.99%, which was the lowest rate since May 2021, seeing a decrease in short term as well as long term absence.

However, indicative data for March 2023 suggested that there would be a slight increase in absence rates to 8.43%. This would predominantly be due to a rise in short term Covid-19 absence. In addition to management of sickness absence training for managers, further bespoke training and support had been undertaken with additional sessions booked across Ambulance Care (NEPTS) and Resource and EMS Response. This intervention had contributed to the reduction in absence across those Directorates.

The average length of days during a period of sickness had seen a reduction to 21.86 days compared with 24.8 days in April 2022 and a deep dive into mental health absence data had been undertaken. The Trust saw an increase in mental health related absence levels from 20.2% in January 2022 to 25.71% January 2023. It was noted that Mental health absence was made up of 94% front line staff and 6% non-front line. Work would continue to review trends and what further information could be established and what actions could be taken to reduce this.

Members received the presentation and noted the increased levels of stress related absence, particularly amongst EMS staff. Members noted that increased handover delays and missed meal breaks were likely to be contributing factors in stress related absence although there were likely to be several other contributing factors to stress amongst the workforce.

RESOLVED: That the update was NOTED.

39/23 FLU INCENTIVE

Andy Swinburn provided information and details of the Seasonal Influenza Campaign 2022-23 and the uptake of the flu vaccination during that period. The Report showed that the Trust's final uptake of staff vaccinated against the flu was 44.5%, a 6% increase from last year's campaign. There was also an increase seen in the uptake of patient-facing staff which was 5.2% higher on the previous year, ending the campaign with 46.3% receiving the vaccine.

Andy Swinburn acknowledged that despite the increase in uptake, the levels were still well below those seen in previous years. The report looked at the various reasons for this and offered a number of suggestions on how this could be improved.

Members received the report and noted the findings and issues documented in the seasonal influenza campaign. Members also commented that uptake of the flu vaccine being offered by the Trust may also have been affected by external factors such as staff receiving the vaccine elsewhere, such as alongside Covid-19 booster jabs or from their GPs.

RESOLVED: That the findings and issues documented in the seasonal influenza campaign 2022-2023 were NOTED.

40/23 WALES ANTI-RACIST ACTION PLAN UPDATE

Dr Catherine Goodwin introduced the Trust's Anti Racist Action Plan 2023. The report noted that although Welsh Government were producing separate plans and recommendations, the Trust felt that it was helpful to promote an anti discrimination approach that highlighted intersectionality by also including an LGTBQ+ Action Plan.

Members heard how the plans were essential for the Trust's continued cultural journey towards a truly inclusive organisation, with the recent staff story and the findings from the sexual safety survey reinforcing the need to be proactive.

Members welcomed the plans and recommendations and fully supported their impementation.

RESOLVED: That the implementation of the action plan recommendations were SUPPORTED.

41/23 RETENTION AND EXIT INTERVIEWS & RECRUITMENT BREAKDOWN FOR CANDIDATES FROM MINORITY COMMUITY BACKGROUNDS

Liz Rogers provided two reports on retention and exit interview and a deep dive into recruitment data regarding candidates from Black, Asian and Minority Ethnic communities and their outcomes through the Trust's recruitment processes. The report on minority community applicants looked at various themes and factors from the previous 12 months in order to ascertain and understand why more applicants from this group were not successfully recruited.

Data showed that the Trust received a positive level of applications from Black, Asian and Minority Ethnic communities at circa 9% compared to census data of 5%. However, a significant number of those applicants were not successful following shortlisting. Despite this, those who did get to interview stage showed good levels of success with 26% receiving offers.

A number of additional factors were identified, including issues with qualifications, failed driving assessments and candidates withdrawing or not attending interviews. The data showed that of the 89 applicants from minority communities undertaking interviews, 23 candidates (26%) were successful. As a percentage, this was a positive outcome and suggested that when candidates from minority ethnic communities got to interview stage, they had good outcomes.

Liz Rogers then moved on to discuss the report on exit interviews which looked at the reasons given by staff for leaving which had increased in the last two years. The report noted the limited amount of feedback available through exit interviews and the work the team had since started on reviewing the exit interview process to relaunch it. Liz Rogers explained that a new 'Moving On Interview' Process had been developed which would supersede the existing Pre-Exit Interview Policy. This would apply to employees who were voluntarily leaving their role, regardless of whether they were leaving the Trust or commencing a new role in another department.

The report stated that the new process was still in the pilot stage and while some data had already been gathered, more time was needed to gain a more accurate picture and understanding of the reasons behind staff choosing to leave their roles. Given this, a further update on exit interviews was proposed for later in the year.

Members received the reports and noted the options and recommendations contained within. It was also noted that work would continue on reviewing recruitment processes to make them as accessible as possible. Members agreed to receive further updates on exit interviews later in the year.

RESOLVED: That:

1. the options and recommendations in the report were NOTED;

2. the outcomes of the review of information were NOTED;

3. the team will work on reviewing recruitment processes to make them as accessible as possible whilst ensuring standards was NOTED;

4. this information will be used as the benchmark to measure interventions against was NOTED; and

5. the Committee AGREED to receive further updates on progress;

6. Members NOTED and COMMENTED on the Exit Interview Report and AGREED to receive a further report on progress later in the year.

42/23 HEALTH AND SAFETY PERFORMANCE REPORT

Nicola White introduced the Health and Safety update and asked Committee Members to note the key aspects of the report. These were summarised as:

There had been further recent improvement regarding timely reporting of RIDDOR incidents (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) within the Trust however, this required focused attention in order to meet RIDDOR reporting timescales. This had resulted in a compliance increase of a further 25% in Q4 from Q3 resulting in 83.3% for Q4. This improvement was because of the implementation of the workforce review. Of the 23 RIDDORs reported in Q4 2023, two were outside of the Health and Safety Executive reporting requirements with the cause being Handler delays.

•A further Annual Plan has been developed for improving the management of health and safety.

•Statutory Health and Safety, Fire Safety and Manual Handling training compliance are below Trust's and Welsh Government standards. Managers are to encourage staff to bring their training levels up to Trust expectations.

•The rolling Workplace Risk Assessment compliance is at 27% with 73% requiring review. Managers are to be encouraged to undertake this review. A workshop with

the Health and Safety and Estates functions is scheduled in May 23 to explore improvements from themes generated from workplace audits.

Members received the report and noted the contents and key aspects summarised above. Members then discussed the results of a recent assessment around diesel fumes which were generated during handover delays as a result of needing the vehicles engine running in order to provide heat in the winter or cooling in the summer months. It was recognised that while test results showed that the fumes were well below the minimum standard and fully complied with requirements, it was still nonetheless a unpleasant environment to work in. Members acknowledged that although there was no immediate solution to this issue, bringing down handover times and reducing the time each vehicle was sat outside of emergency departments would have a very positive effect on reducing the emissions.

RESOLVED: That the contents of the report and the key aspects were NOTED.

43/23 WELSH LANGUAGE STANDARDS COMPLIANCE UPDATE

Melfyn Hughes updated the People and Culture Committee on the progress in developing the Trust's Welsh Language Framework. Members were informed of the 'More Than Just Words' Strategic Framework from Welsh Government which was designed to strengthen Welsh language provision in health and social care. Under this Framework, the Welsh language would be normalised, and the Active Offer embedded across the Health and Social Care Sector with clear lines of accountability to deliver Welsh language plans and services.

In addition, when developing the Welsh Language Framework, the Trust's Welsh Language Deliverables had been included in the Integrated Medium Term Plan 2023/26. This incorporated an action plan to implement the Welsh Government 'More Than Just Words' strategy with a focus on an active offer of Welsh across Trust services.

Members received the update and commented on the assurance they felt in regards to the progress being made in developing the Trust's Welsh Language Framework. Members then queried whether more could be done at all levels of the organisation and particularly at public meetings such as the Trust Board for Members to practice and utilise their Welsh language skills.

Members agreed that wherever possible, regardless of whether someone was a fluent Welsh speaker or not, every effort should be made to encourage, promote and enable them to use the language, even if this was at a basic conversational level for things such as salutations when answering calls, or welcoming people when introducing a meeting.

RESOLVED: That the Committee was ASSURED on progress in developing the Trust's Welsh Language Framework.

44/23 INTERNAL AUDIT TRACKER

Julie Boalch gave an update on the internal audit tracker and informed Members that there were currently 16 Internal Audit recommendations assigned to the Committee for oversight. Of those, only one recommendation relating to the Recruitment Practices review was currently overdue.

There were two outstanding recommendations relating to the Taking Care of the Carers report with one request to extend the deadline from the agreed deadline of November 2022 to the end of September 2024, so that the Health & Wellbeing Strategy can be delivered in full. The other extension was to take account of the staff survey being further delayed until Spring 2023.

In addition, the Audit Tracker was currently undergoing a full review and would be available for the next Audit Committee for scrutiny. Internal Audit were also undertaking their annual review of the tracker.

RESOLVED: That the update was NOTED.

45/23 POLICY UPDATE

Julie Boalch gave a verbal update on the current position with Trust Policies and explained that she was currently undertaking a Policy prioritisation exercise following the pressures of the last couple of years and the work which was still outstanding in regards to new policies coming through as well as current policies which were due for renewal.

The purpose of this was to enable to the Trust to know exactly where it was up to with its key policies and to determine a postion statement. A meeting had been scheduled with the Policy Group and this matter was an agreed agenda item for discussion. To support this, contact had been made with all Trust Directorates asking them to review and prioritise all the policies which fell under their remit.

Once this feedback had been received and reviewed by the Policy group, a recommendation would be made to the Executive Management Team setting out the programme of work which would need to be preformed over the next couple of years in order to finalise and implement the policies within the Trust.

Members received the update and noted the planned actions and progress being made. There were no further questions or comments.

RESOLVED: That the update was NOTED.

46/23 STAFF STORY UPDATE

The staff story update was given earlier (Minute 29/23) in lieu of the Staff Story item.

47/23 PEOPLE AND CULTURE COMMITTEE HIGHLIGHT REPORT

The People and Culture Committee Highlight report from 14th March 2023 was for information only.

RESOLVED: That the contents of the highlight report were NOTED.

48/23 LOCAL COUNTER FRAUD SERVICE REFERRAL FLOWCHART

The contents of the Local Counter Fraud service referral flowchart and summary were received and noted by the Committee.

RESOLVED: That the Committee RECEIVED and NOTED the summary and flowchart contained within Appendix 1.

49/23 SUMMARY OF ACTIONS AND DECISIONS, AND REFLECTION

Paul Hollard reflected on the day's discussions and invited Members to comment on the meeting before reviewing any actions which had been agreed.

Follow up actions were agreed around the staff story to explore potential prayer space across Trust sites and to also look into time off for non-Christian festivals such as Eid and Ramadan.

RESOLVED: That Members reflected upon the meeting and resulting actions were AGREED.

50/23 ISSUES TO BE RAISED AT BOARD

The Chair informed Members that discussions with Trish Mills would take place outside of the meeting to determine which items would be taken forward and raised at Board.

51/23 ANY OTHER BUSINESS

There was no other busines.

52/23 DATE OF NEXT MEETING

The date of the next meeting is 17 August 2023.

WELSH AMBULANCE SERVICES NHS TRUST

CONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 11 MAY 2023 VIA TEAMS

Meeting started at 13:30

PRESENT:

Bethan Evans	Non-Executive Director and Chair
Professor Kevin Davies	Non-Executive Director
Paul Hollard	Non-Executive Director
Ceri Jackson	Non-Executive Director

IN ATTENDANCE:

Andrew Clement	Partners in Healthcare, Resource Development Coordinator (left after item 015/23)
Stephen Clinton	Assistant Director of Operations
Lisa Harte	Internal Audit
Leanne Hawker	Head of Patient Experience and Community Involvement
Wendy Herbert	Assistant Director of Quality and Nursing
Jon Hopkins	Health Informatics Management
Fflur Jones	Audit Wales
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Jane Palin	Assistant Director of Quality and Nursing
Gareth Parry	Operations Assistant Community Support ((left after item 015/23)
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Duncan Robertson	Assistant Director of Clinical Development
Andy Swinburn	Director of Paramedicine
Gareth Thomas	Patient Experience and Community Involvement Manager
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Liam Williams	Executive Director of Quality and Nursing
Jennifer Wilson	National Volunteer Manager (left after item 015/23)

Apologies:

Lee Brooks	Executive Director of Operations
Cheryl Merrick	Llais Wales (formerly Community Health Council)
Hannah Rowan	Non Executive Director
Leanne Smith	Interim Director of Digital Services

013/23 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies had been received from Lee Brooks, Cheryl Merrick, Leanne Smith and Hannah Rowan.

Declarations of Interest

There were no further declarations of interest to those listed in the register.

Minutes

The Minutes of the meeting held on 9 February 2023 were confirmed as a correct record subject to amending the wording under Minute 11/23, bullet point 2 regarding WISH ambulance; it was agreed that Ceri Jackson would provide the amended wording.

Action Log

The action log and the AAA report from the last Quest meeting was considered:

Action 002/23: Operations update, future reports to include an update on the Intelligent Routing Platform pilot. Details contained in update, action closed.

Action 004/23a: Patient safety report, backlog of National Reportable Incidents; the Committee requested an update to be given at the next meeting. Verbal update provided with a further update to be given at the 10 August meeting. Action to remain open.

Action 005/23: Patient safety report, next report to contain details of how many Serious Case Incident Forums were linked to Immediate Release Directives being declined. Detail contained in report. Action closed.

Action 007/23a: Patient Experience and Community Involvement (PECI) highlight report; Consider how to re-frame the questions for patient surveys to improve services from the feedback given. Update include on action log. Action closed.

Action 008/23: Duty of Quality/Candour preparedness. It was asked that a risk be generated/articulated to consider the impact of implementation of non-compliance with the introduction the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ("the Act"). Action to be discussed alter in the agenda. Action closed.

Action 008/23a: Duty of Quality/Candour preparedness; clarity on the Implementation of the Quality strategy. An update was requested in respect of how this would be delivered in the next report. Item will be discussed later in the agenda. Action closed.

The Chair drew the Committee's attention to the contents of the AAA report for their information; this highlighted the key points from the Committee's last meeting on 9 February 2023.

Comments:

Kevin Davies updated the Committee following the last Vice Chairs of Health Board's meeting in which it was acknowledged there was still issues with handover delays and the work of Health Boards to address this.

RESOLVED: That

(1) the Minutes of the Open meeting held on 9 February 2023 were confirmed as a correct record subject to the revised wording under Minute 11/23; and

(2) consideration was given to the Action Log and AAA report as described above.

014/23 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2022-23 Q4

Steve Clinton introduced the Operations Quarterly Report as read, conscious that some colleagues would have already had sight of it at other meetings. He drew attention to the following areas:

Intelligent Routing Platform (IRP). The IRP was an NHS England procured solution that automated some of the manual BT call handling processes for 999 calls. The Trust was now more comfortable with the level of call volume following changes to the IRP.

Hand over delays remained significantly high during this reporting period however there has been, over the last fortnight, an element of improvement in Health Boards across Wales. It was of particular note that Cardiff and Vale University Health Board had considerably improved their hand over delays.

Consult and close rates continue to improve edging towards a 15% rate for the month.

The roster review for clinicians on the Clinical Service Desk (CSD) has now been completed and should improve the situation in CSD.

Work was shortly to commence on the 111 Integrated Information Solution (AKA Salus), implementation, which was expected to be rolled out in November 2023.

Comments:

Whilst the Committee noted there had been some positive improvement with hand over delays in the Cardiff and Vale University Health Board area, it was pleasing to note there had been improvements elsewhere in Wales.

Members were encouraged by the update on the Salus programme recognising the situation had been, in the past, problematic.

The Committee expressed their delight with the rollout of Penthrox which was now able to be administered by volunteers.

In terms of the Manchester Arena Inquiry (MAI) an update was sought on progress against the recommendations from the inquiry. Ceri Jackson agreed to seek an update on the MAI following the meeting.

Also a query arose in terms of an update regarding rural response and the challenges faced by the Trust in meeting the Red performance target. In respect of the rural response, Rachel Marsh advised that work had been undertaken to consider the variation between rural and urban Red response, however this had been paused due to other ongoing system pressures. Following further discussion it was agreed that a deep dive on the Trust's Red response in rural areas would be provided at the next meeting through the MIQPR. Andy Swinburn added that the Trust has specifically targeted and bolstered some of the rural areas with the addition of Newly Qualified Paramedics (NQP).

RESOLVED: That the report was received.

015/23 STAFF EXPERIENCE

The Committee heard from Keith Jones who was a long-standing Community First Responder (CFR) at WAST and attended a patient at their home in November 2022. When Keith arrived he was met by the patient's partner who advised him that their partner had been lying on the sofa in the living room for about three weeks. The patient explained that he was finding it difficult to breathe and Keith gave him oxygen. Furthermore the patient advised Keith that they had tried to call the GP on several occasions and in the end through lack of response just gave up.

Keith continued to monitor the patient for over four hours awaiting an ambulance and during that time the patient went into cardiac arrest. Despite attempts to resuscitate him, the patient died.

Comments:

Leanne Hawker explained that following a patient survey, 33% of those that responded had found it difficult to book a GP appointment.

Members were moved by Keith's story and felt the distress in his voice when he was recalling the events of that day. They acknowledged the very important and key role CFR's played throughout the Community. Members were aware however that this

anguish would not have been experienced had the handover delays not been so extreme.

In terms of the coroner's report, it was queried if this had taken place and if there were any implications for the Trust. Wendy Herbert advised at this stage it was not known if a coroner's inquiry would be taking place.

Following a question regarding support for CFRs, Jennifer Wilson commented that the CFR team have supported Keith throughout and the CFRs end of shift form would capture any potential debrief requirements. Gareth Parry added that the CFR team would follow up on any support they need, any links with CFR champions, occupational health, or Trauma risk Management (TRiM) referrals. Jenifer Wilson added that all the benefits of employee assistance programme was also now being offered to CFRs.

A question arose seeking clarity on whether the role of the CFR had changed as a result of ongoing system pressures. Jennifer Wilson explained that whilst all CFRs have the same level of training they are able to select which type of call they want to respond to. Clearly the roll out of CFRs being able to administer pain relief will see further changes to the role going forward. She added that these and any further changes to the role should be discussed at People and Culture Committee (PCC) meetings. The Chair of PCC agreed this would be discussed at a date to be determined.

The Committee were updated by Duncan Robertson on the roll out of the ePCR for CFR's and how this would enhance their portfolio.

The Committee discussed in detail the issue of deploying a CFR when ambulance back up may not be readily available which this story had highlighted.

Liam Williams added that whilst the Trust played its part in emergency and urgent care it should also assist where it can with other partners across the health system in ensuring patients have access to primary care. He further commented that this particular patient from an overall NHS perspective was not supported at the time of identified need. This cascaded into a trajectory of deterioration which resulted in the CFR being left in that positon. He reiterated the value of CFRs and how they have integrated successfully into the Trust, recognising their training continued to develop.

The Chair thanked the team involved and in particular to Keith for sharing this difficult story.

RESOLVED: That the STAFF story was noted recognising that the Trust continued to develop the CFR training.

016/23 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Rachel Marsh presented the latest Monthly Integrated Performance Report (MIQPR) and highlighted the following:

In terms of the 999 service, there had been an improvement in April recognising the work into improving performance had started to have an impact.

With regards to National Reportable Incidents (NRI). The Trust reported three NRIs to the delivery Unit in March, even though these were lower than February (12) they were still of concern.

In terms of patient harm, there had been a reduction in the number of times these required escalation to the highest levels of the Clinical Safety Plan (CSP)

Clinical Indicators, the Trust continued to work on the improvement actions in order to ensure the data being captured through the Electronic Patient Clinical record (ePCR) was accurate and complied with the various clinical bundles.

It was noted that response times to concerns continued to fall below the required performance level and work was underway implementing several measures to address this. The impact on the Putting Things Right (PTR) team and their ability to meet targets during this challenging period was recognised, and a brief update on the measures in place to address this was provided.

Hours Produced: The Trust produced 118,141 Ambulance Response ambulance unit hours in April 2023. Emergency ambulance unit hours production (UHP) was 98% in April 2023, thus achieving the 95% target. It was noted there was a 1% staff vacancy factor in EMS and when comparing this with other organisations in Wales it was quite remarkable and was a credit to all those involved in with recruitment and retention of staff.

Staff training and Personal Annual Development Review (PADR): PADR rates did not achieve the 85% target in March 2023 (72.1%), compliance for Statutory and Mandatory training also dropped significantly below the target achieving 73.69%. The reasons for this decline in Statutory & Mandatory training were being reviewed.

In respect of the funding for 100 Whole Time Equivalents, the Trust was expectant this would be forthcoming in the very near future.

Comments:

In terms of the new clinical outcome indicators for call to door time for strokes it was queried if these would be available in June. Duncan Robertson confirmed that the data was ready and would be reviewed by the Clinical Intelligence Assurance Group at which it would be decided how the data will be presented as an indicator.

Following the roll out of ePCR it was questioned if there had been any feedback. Duncan Robertson advised that ePCR had been rolled out across the Trust; staff were able to provide feedback through various channels, adding that any issues were resolved as soon as possible.

A discussion ensued in which Members considered any other measures to support the PTR Team, and also expressed their apprehension for the Team's welfare and the backlog of concerns. It was agreed that going forward, Trish Mills would consider with other colleagues how this issue could be addressed. Liam Williams outlined the challenges involved in improving performance. Wendy Herbert re-emphasised the difficulty in clearing the backlog which going forward would become more difficult due to the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Whilst there were some positive aspects within the report, the Chair commented that the challenges continued and the level of patient harm and the impact was substantial due to excessive amongst other things, handover delays. In terms of 111 call answering it was acknowledged there was a priority to re-roster the 111 team; and it was queried if there was a timeline for this. Rachel Marsh advised this was still being evaluated with the Chief Ambulance Services Commissioner, and advised that December 2023 was the proposed date.

RESOLVED: The Committee considered the March 2023 Integrated Quality and Performance report and remained concerned on performance, noting there were some improvements in some areas.

017/23 PATIENT SAFETY REPORT Q4 2022/23

Jane Palin gave an outline of the report and drew the Committee's attention to the following areas, noting that several areas of the report had been discussed in the previous item:

There was a decrease in the in the number of concerns being received but a backlog remained.

Patients waiting for extended periods of time in the community continued. During quarter four 1690 patients received a response or wait over 12 hours.

There continued to be a number of incidents being reviewed at the Serious Case Incident Forum (SCIF). During this reporting period there were 21 SCIF Meetings held, with 157 incidents discussed. 20 incidents have been reported as NRIs to the Delivery Unit (DU) and 66 incidents were referred under the Joint Incident Framework to the respective Health Board.

During the periods of industrial action, patient safety incidents were monitored with oversight from the Operational Delivery Unit and the Patient Safety Team. Additionally, recognising that there was reduced capacity for teams to report

incidents during these periods, the Patient Safety Team worked alongside colleagues in EMS Coordination to identify actual and potential patient safety incidents.

During the reporting period the Trust received two Regulation 28 (Prevention of Future Deaths) Reports and issued both responses within the 56-day target. Both were broadly related to timeliness.

There has been a significant ongoing increase in the number of clinical negligence claims (actual and potential) being received by the Trust, many of which originated from delayed responses to patients at a time of escalation. The number of open clinical claims being investigated and litigated was now at an unprecedented level in the Trust's history.

Comments:

Members were keen to ascertain the impact the Health and Social Care (Quality and Engagement) (Wales) Act 2020 had on the Trust thus far. Jane Palin explained there would be a 12 month settling in period and the Trust was very clear on the responsibilities of the Act and continued to prepare for it. Liam Williams added that one of the main impacts would be the increased volume of concerns and being able to manage them.

In terms of patients waiting for extended periods of time in the community, in particular the 166 patients who had waited over 12 hours having experienced a fall, assurance was sought whether further details on patients was captured. Liam Williams commented that the highest number of handover delays correlated directly with the longest waits for ambulances. Thematic analysis emanating from the SCIF process articulated lessons learned progressed through the Clinical Quality Governance Group. Further to those patients who had experienced a fall, the Chair queried if there was an opportunity to develop the falls model. Rachel Marsh explained that any further expansion of the falls service was subject to local discussion at each Health Board commenting that funding was currently not available. Jonathan Turnbull-Ross advised that work was ongoing to advise Health Boards on the positive impact of improving the falls service.

Further clarity was sought on the decision-making for derogations (a method of maintaining safe staffing levels on strike days by agreement, and are achieved when the Union and the employer agree that a member or service shall be exempt from taking part in industrial action) and whether this would be taken into account by the NHS Wales Executive (Delivery Unit) who were leading a national overview of patient safety incidents related to industrial action to understand the effect of strike action across NHS Wales. Liam Williams advised that where it had been identified industrial action has been a direct contributor to patient harm this has been shared with the Delivery Unit. Whilst the Trust can escalate concerns and highlight the risk, ultimately the derogations are negotiated between the employer and the Trade Unions. He added that the

learning for industrial action to date, will directly inform how future industrial action negotiations were conducted. Hugh Parry outlined the negotiation process and the challenges encountered during them.

The Chair commented on Patient Safety Investigations and the number of overdue NRI investigations querying why Cwm Taf Morgannwg University Health Board's figures were much higher than other Health Board areas. Liam Williams explained that some Health Boards had implemented the joint investigation framework earlier than others and it was agreed the Chair would seek this information after the meeting.

RESOLVED: That the report was received for discussion.

018/23 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT (BAF)

Trish Mills explained that the purpose of the report was to provide assurance in respect of the management of the Trust's principal risks, specifically risk 223 (The Trust's inability to reach patients in the community causing patient harm and death) and 224 (Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service).

The Committee were advised that detail of the actions of system partners remained in the BAF, however they were now included within a context box rather than within the 'actions' section. This will allow the Board and Committees to focus on scrutiny of the mitigating actions which the Trust was taking, whilst noting the context within which these risks remain at a score of 25.

Comments

The Committee welcomed the additional narrative in the commentary box which helped to contextualise the risks and found the guidance document on interpreting the BAF very useful.

Members sought to understand at which point, when the Trust has done everything in its gift to mitigate the risk, it no longer gives the risk a score of 25. Trish Mills explained that the context box explained the rationale of what was in the Trust's control.

Going forward, when the BAF matures further, there may be an opportunity to look at the risks differently. Liam Williams added that had the Trust reviewed the risk over the last two years, actions for the Trust and Health Boards may have evolved differently.

RESOLVED: The Committee accepted the status of the two corporate risks which it has been assigned to oversee the management of – risks 223, 224. The Committee received the relevant sections of the Board Assurance Framework and noted the ongoing mitigating controls.

019/23 PATIENT EXPERIENCE AND COMMUNITY INVOLVEMENT (PECI) QUARTERLY REPORT

Leanne Hawker explained that the report provide assurances and, an update, on the work delivered by the PECI team on how it was supporting the Trust's principles of providing the highest quality of care and service user experience as a driver for change, and delivering services which met the differing needs of each of our communities we serve without prejudice or discrimination.

The main focus of the report was to highlight how the Trust was engaging with service users and to increase the number of patient experience returns. A significant amount of work has been carried out in preparation for using the Civica system to capture patient and staff feedback. Liam Williams advised that going forward this report would be presented on a six- monthly basis.

Comments:

The Committee welcomed that reports would be presented on a six-monthly basis and queried if this approach would be shared with Health Boards. Leanne Hawker explained that the Trust was part of the all-Wales patient experience group and shared information on a reciprocal basis.

RESOLVED: That

(1) The Committee noted the activities to date and acknowledge that PECI reports will be presented bi-annually to Committee;

(2) That the Committee received the report and accepted the assurances that the Trust was meetings its statutory duties/responsibilities to consult; engage and involve the public/patients in its work.

020/23 DUTY OF QUALITY/ DUTY OF CANDOUR PREPAREDNESS

Jonathan Turnbull-Ross reminded the Committee that The Health & Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023. This update outlines the implementation of the two aspects falling out of the Act, the Duty of Candour (DoC) and the Duty of Quality (DoQ).

The Trust's quality governance infrastructure was being reviewed, in relation to the new legislation, ensuring systems and processes within its governance structure assists in capturing and recording all strategic decisions to provide noticeable evidence that all strategic decisions and plans have been made through a quality lens.

In terms of informing and educating staff regarding the new legislation, tailor made pages have been created on the intranet. There will be further training and education through information resources which will be included as part of the Trust's 'Quality Hub' as outlined in the 2023/23 Integrated Medium Term Plan (IMTP) deliverables. This

will enable staff to learn further about quality impact assessments and how to access support.

Recruitment to a key leadership position 'Senior Quality Governance Lead' was in progress; while recruitment of the Senior Quality Lead role was due to be fulfilled by Summer 2023. These roles will provide additional strategic capacity, and local expertise and capabilities to support the Trust in delivering the DoC and DoQ.

Comments:

The Committee welcomed the update and felt more assured that sufficient preparedness was in place to deal with the new legislation.

It was queried whether there had been any joint preparedness between the Trust and Health Boards. Jonathan Turnbull-Ross explained there had been positive liaison with Health Boards which would continue through the coming months.

Liam Williams commented there was still further work to ensure that the Trust focused on capturing internal data through the Quality Performance Management Framework was consistent with NHS Wales wide reporting.

It was asked if there was completion date for the Quality Management Systems dashboard. Jonathan Turnbull-Ross explained that the digital infrastructure was in place to capture the appropriate metrics and that more clarity would follow after an upcoming workshop which would consider a possible go live date.

Members recognised and acknowledged the challenges and risks around the implementation of the Duty of Candour which were likely to further exacerbate the issues already being experienced by the Putting Things Right team.

RESOLVED: The Committee reviewed the report, considered the next steps and, supported the continued prioritisation of work to ensure appropriate levels of compliance in line with Welsh Government expectations from April 2023.

021/23 QUALITY STRATEGY IMPLEMENTATION PLAN

Jonathan Turnbull-Ross explained that the report outlined progress in developing the plan which was to support the realisation of the Quality Strategy 2021-24.

He added that progress against the implementation plan had been particularly challenged due to operational demands resulting from the pandemic, pandemic recovery, winter and more recently, industrial action.
He advised the Committee that implementation remained a priority for delivery over 2023/24, noting that several areas of the plan required investment in resources to achieve success.

He asked the Committee to consider the positive progress of the Trust's position against the Welsh Government road map for the Act implementation previously reported,

including exemplar content and ideas produced by Trust staff now being adopted at NHS Wales level.

Comments:

The Committee held a discussion which considered the role of the Patient Experience Community Involvement team in terms of integrating the Citizens of Wales' voice and engaging with people to ensure inclusivity. Liam Williams stressed the importance of ensuring the Trust was coordinating and sharing information reciprocally with the relevant clinical networks going forward.

The Committee queried if there was progress in terms of embedding the quality strategy across the Trust. Jonathan Turnbull- Ross explained there had been reasonable progress adding that the infrastructure to improve quality was developing satisfactorily.

RESOLVED: The Committee noted the progress against the implementation action plan.

022/23 QUALITY IMPACT ASSESSMENT GOVERNANCE

Liam Williams explained that the duty of quality required each organisation to provide palpable evidence that all strategic decisions and plans have been made through a quality lens for both clinical and non-clinical aspects. A key element of demonstrating this were Quality Impact Assessments (QIA).

The Trust has developed a QIA Framework and template, which was agreed at the Clinical Quality Governance Group (CQGG) in November 2022. The framework and template have been updated to reflect the new Health Care Standards 2023.

Roles and responsibilities were outlined in the Trust's QIA framework which identified governance and assurance processes for the development, accountability, and monitoring of QIAs.

The CQGG will provided the necessary scrutiny and governance to ensure that the appropriate QIA process was carried out for all new and existing Trust wide service redesign/transformation, projects and cost improvements.
Comments:

Members queried how QIAs would relate to the Trust's socio-economic duty and potentially any Equality Impact Assessments (EQIA). Liam Williams explained there was a requirement to keep QIAs separate from EQIAs and outlined the reasoning behind it. He added they were separate processes with separate expectations. Trish Mills added that the EQIA had been revised to merge different impact assessments and this will include information relating to socio-economic and well-being of future generations.

The Committee recognised that going forward it would provide an evidence base of the decisions being made.

Members sought assurance that the appropriate training would be provided to staff. Jonathan Turnbull-Ross gave assurance that the relevant instinctive and user friendly training would be given and widely available. Wendy Herbert informed Members that WAST had been acknowledged as the exemplar in the QIA process across Wales with Health Board colleagues taking an interest in WAST's progress.

RESOLVED: The report was noted.

023/23 CLINICAL AUDIT PLAN 2023/24

Andy Swinburn reminded the Committee that following an 'Audit Wales' review of WAST's Quality Governance Arrangements, one of the recommendations was for the Clinical Audit Plan to be submitted to QuEST for scrutiny and approval ahead of each financial year, and then monitored on a quarterly basis.

Duncan Robertson explained that the clinical audit plan had been scrutinised and monitored by the Clinical Intelligence & Assurance Group (CIAG), and the action plan noted at Clinical Directorate Business meetings. The Clinical Intelligence and Assurance Team (CIAT) continued to review and improve on the quality of the data available.

The clinical audit plan includes three main sections:

a) Clinical audits that have been agreed by the CIAG to progress, considering the potential of the relevant ePCR data being available during the financial year.

b) Suggested topics that need further development before progressing, e.g., specifying the requirements to be audited.

c) Topics that require further consideration of their need, available data, and resources prior to inclusion in the plan.

He added that clinical audits may be linked into any themes arising from the concerns team and also for future audits to be linked in with other teams to present a wider range of audit activity going forward. Furthermore it was noted that this plan would be taken to the Audit Committee for assurance.

Comments:

The Committee welcomed the report and were pleased to see a more formal structured approach to clinical audits and looked forward to receiving any future feedback.

RESOLVED: The Clinical Audit Plan 2023/24 was approved.

024/23 UPDATE ON MORTALITY REVIEWS

Mike Jenkins informed the Committee that Welsh Government required all Health Boards and Trusts, including WAST, to undertake Mortality Reviews. In 2015 WAST Executive Medical Director supported the development of a Trust Mortality Review Group. The purpose of this group was to provide assurance that the care provided to

patients who suffered a cardiac arrest between point of contact (999 call) and arrival at hospital, was in line with resuscitation guidelines.

This method of undertaking mortality reviews identified the necessity to download Corpuls Records, this significantly increased the time taken to complete a review resulting in an increasing backlog of records awaiting a review. By January 2022 there were 740 mortality reviews waiting for review.

Following recommendations from the Delivery Unit, the Trust carried out a 10% review of the mortality review backlog. The date range of incidents reviewed were from May 2020 through to February 2022 (introduction of the electronic Patient Clinical Record). All incidents related to patients who had suffered a cardiac arrest in WAST care. Of the 74 cases reviewed several themes arose which included; poor documentation and Inappropriate Cardiopulmonary Resuscitation (CPR) due to the presence of Do Not Attempt CPR.

As part of the approach to mitigate the recommendations from the Delivery Unit, the Trust has introduced the role of Senior Paramedic (SP) with the aim of promoting clinical excellence. SP's accompanied Emergency Ambulance crew during their shift and fed back on several areas including quality of care, completions of documentation and airway logs. It has been noted that since the introduction of SP's the documentation quality has improved significantly.

Comments:

Members questioned if the sample of 10% was random or whether any criteria had been applied. Mike Jenkins commented it was purely a 10% random sample.

It was queried if any of the learning had already happened, i.e., was there a connection to Datix. As part of the mortality review, Mike Jenkins explained for the 10%, these were not Datix related; however, the Trust had already completed the learning process for staff if it was on Datix.

Liam Williams added that going forward with the introduction of SPs the Trust will have a richer understanding of any future deep dives on mortality reviews, and also more quality data can be captured from ePCRs. He further commented that having the SP's in place and the Cymru High Acuity Response (CHARU) paramedics was an excellent enabler to provide expertise to other staff.

RESOLVED: The Committee received the report and noted it for assurance.

025/23 COMMITTEE CYCLE OF BUSINESS

Trish Mills in updating the Committee advised that the cycle had been developed with direct correlation to the duties in the Committee's terms of reference. This allows the Committee to review the appropriateness of the proposed reports and their frequency.

The cycle for the Committee is a maturing document which will grow organically over the next 12 months.

The cycle of business will be used to build the quarterly Committee agenda. A monitoring report will also be provided to each meeting under the consent item, and where issues of escalation were required i.e., where cycle needs to be adjusted or reporting was overdue, these will be drawn out in a short paper by the Board Secretary.
RESOLVED: The Committee:

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

(2) Noted the cycle of business monitoring document.

026/23 INTERNAL AUDIT TRACKER UPDATE AND INTERNAL AUDITS

Trish Mills advised the Committee that the audit tracker was currently undergoing a full review and will be available for the next Audit Committee for scrutiny. In addition, Internal Audit were undertaking their annual review of the tracker.

The Committee recognised some audit recommendation had surpassed their revised date, however within the narrative there was an explanation to mitigate this.

In terms of the Audit Wales tab, those marked as overdue were either complete or close to completion.

Comments:

Liam Williams updated the Committee on the work being undertaken to respond to the recommendations as outlined in the Infection Prevention and Control audit. He added that a large focus of WAST was to consider the use of Personal Protective Equipment both now and for any future pandemic.

The Committee held a discussion in which they considered how to strengthen management responses to audits, especially in relation to the Immediate Release Directions audit in which a collaborative approach with Health Boards was required.

RESOLVED: The Committee noted the update.

027/23 REFLECTIONS & SUMMARY OF DECISIONS & ACTIONS

- The supportive challenge had been relay useful.
- Always welcome the lived experience, especially the patient/staff stories.
- Assured by the update on the Duty of Candour/Quality.
- There has been an improvement in the report writing making them more streamlined.

Actions

- Deep dive on red calls in rural areas to be included Operations quarterly report.
- Further conversation to be taken offline regarding the changing role of CFR's and discussed at the People and Culture Committee going forward.

- Agreed that a meeting be coordinated with Quest and People and Culture Committee to discuss the situation regarding the challenges faced by the PTR team.
- PECI reports would be received on a 6 monthly basis.
- Quality strategy, important to get the connections across our networks, right, and make sure that The Citizens' Voice is used to inform what we are doing. So part of the action is to make sure that we do capture that and we move forward implementing actions as necessary.

028/23 KEY MESSAGES FOR BOARD

Trish Mills will draft the update which will be presented to the Board via the Committee's AAA highlight report.

029/23 ANY OTHER BUSINESS

None.

Date of Next meeting: 10 August 2023

Meeting concluded at 17:25

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

CONFIRMED MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE (OPEN SESSION) HELD ON 17 JULY 2023 VIA TEAMS

Meeting started at 09:30

PRESENT:

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

IN ATTENDANCE:

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

APOLOGIES:

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

44/23 PROCEDURAL MATTERS

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

Minutes

The minutes of the open session held on 15 May 2023 were considered by the Committee and confirmed as a correct record.

Action Log

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

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

RESOLVED: The minutes of the meeting held on 15 May 2023 were confirmed as a correct record and the action log was considered and updated as described.

45/23 OPERATIONS QUARTERLY REPORT

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

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

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

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

Comments:

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

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

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

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

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

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

RESOLVED: That the Committee noted the report.

46/23 FINANCIAL POSITION MONTH 3, 2023/24

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

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

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

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

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

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

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

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

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

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

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

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

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

Comments:

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

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

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

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

RESOLVED: The Committee:

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

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

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

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

47/23 RISK MANAGEMENT AND CORPORATE RISK REGISTER

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

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

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

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

Risk 245 (Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations) having reached its target, has been closed.

Comments:

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

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

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

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

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

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

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

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

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

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

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

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

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

Comments:

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

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

RESOLVED: The Committee:

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

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

49/23 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

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

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

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

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

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

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

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

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

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

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

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

Comments:

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

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

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

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

Existing and proposed Metrics for 2023/24

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

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

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

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

(1) It provided sufficient assurance; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Comments:

It was questioned whether the Exercises conducted by the Trust had sufficient complexity. Judith Bryce commented that the exercises were fairly consistent with current events/incidents adding that the training scenarios were detailed and complex. However, there was always the need to adapt and be familiar to developing scenarios going forward. Jason Fernard provided the Committee with details of the Trust's involvement in Exercise Dollhouse, a multi-agency exercise which focused on a scenario involving a terrorist attack at a music event. Lee Brooks added that exercises of this nature were invaluable to the Trust's learning.

RESOLVED: That the Committee:

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

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

51/23 INTERNAL AUDIT TRACKER REPORT AND INTERNAL AUDIT REPORTS

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

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

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

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

the report highlighted the requirement for this Committee to clearly demonstrate its scrutiny of the savings programme.

Comments:

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

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

52/23 TRUST POLICY REPORT

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

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

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

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

Comments

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

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

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

pressures. She added that the policies were being reviewed in order of those that posed the highest risk.

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

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

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

53/23 MAY COMMITTEE AAA REPORT

The report was noted.

RESOLVED: The Committee noted the report.

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

The report was noted.

RESOLVED: The Committee noted the report.

REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

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

RESOLVED: Noted as above.

Meeting concluded at 12:24

Date of Next Meeting: 18 September 2023

WELSH AMBULANCE SERVICES NHS TRUST

CONFIRMED MINUTES OF THE OPEN MEETING OF THE AUDIT COMMITTEE OF THE WELSH AMBULANCE SERVICES NHS TRUST HELD ON THURSDAY 25 JULY 2023 VIA TEAMS

Meeting Commenced at 09:30

PRESENT:

Martin Turner	Non-Executive Director and Committee Chair
Paul Hollard	Non-Executive Director
Ceri Jackson	Non-Executive Director

IN ATTENDANCE:

Julie Boalch	Head of Risk/Deputy Board Secretary
Judith Bryce	Assistant Director of Operations
Andrew Doughton	Performance Audit Manager Audit Wales
Jillian Gill	Head of Financial Accounting
Navin Kalia	Deputy Director of Finance and Corporate Resources
Angela Lewis	Director of People and Culture
Olaide Kazeem	Project Accountant Financial Services
Jason Killens	Chief Executive Officer (Left during Item 27/23)
Osian Lloyd	Head of Internal Audit
Gareth Lucey	Audit Wales
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Erin Pollard	Audit Wales
Felicity Quance	Deputy Head of Internal Audit
Paul Seppman	Trade Union Partner
Marienela Stoicheri	Risk Officer
Andy Swinburn	Director of Paramedicine (Item 27/23 only)
Lisa Trounce	Business Manager, Corporate Services
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing
Carl Window	Counter Fraud Manager

APOLOGIES:

Lee Brooks	Executive Director of Operations
Fflur Jones	Audit Wales
Joga Singh	Non-Executive Director
Leanne Smith	Interim Director of Digital Services

25/23 PROCEDURAL MATTERS

The Chair welcomed all to the meeting and advised that it was being audio recorded.

Declarations of Interest, other than those listed in the Declarations of Interest register, there were no further declarations. The Committee noted that Kevin Davies was no longer a Trustee of St John, the register would be updated to reflect this. The apologies as described were noted.

Minutes: The Minutes of 2 March 2023 and 20 April 2023 were approved subject to reflecting that Paul Seppman had sent apologies for the meeting on 20 April 2023. He was unable to attend due to attending a meeting on industrial action with the Director of Paramedicine and the Executive Director of Quality and Nursing.

RESOLVED: The apologies as described were noted and the Minutes of 2 March 2023 and 20 April 2023 were approved.

26/23 2022-23 ANNUAL ACCOUNTS AND ANNUAL REPORT AND RECOMMENDATION TO TRUST BOARD

The Chief Executive was in attendance for this item.

The Committee gave detailed consideration to the Trust's accounts for the year ended 31 March 2023 which had been prepared by the Trust to comply with International Financial Reporting Standards adopted by the European Union, in accordance with HM Treasury's Financial Reporting Manual by the Welsh Ambulance Services NHS Trust under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directed.

Navin Kalia presented to the Committee with an overview of the 2022/23 Annual Accounts. The main points for the Committee's attention included:

(a) The draft accounts had been formally submitted to Audit Wales on 5 May 2023 with all statutory financial duties being met.

(b) A retained surplus for the year of £0.062m had been achieved; effectively a break-even position with total income of £296.092m and Net expenditure of £296.030m.

(c) The breakdown of income from patient care activities was £283.2m consisting of: Emergency Ambulance Services Committee, £230m, Local Health Boards, £17m, Welsh Government, £34m and income from other Trusts, £2m. The total increase from the previous year was £21.6m.

(d) The main reasons for the increase from last year included the demand and capacity phase two and phase three funding, growth and inflation and the recurrent impact of the 2021/22 pay award.

(e) In terms of expenditure, pay costs were £204m and Non pay and other costs came to £92m. The main differences for the previous year were an increase of £14.6m in pay and a net increase of £5.4m in Non-pay expenditure.

(f) With respect to the Balance Sheet, the Net Book Value as at 31 March 2023 was £99m. Debtors had increased by £1.4m with borrowings increasing by £10m as a result of recognition of finance leases re implementation of IFRS16 during the year.

(g) Presentational points on the draft Accounts had been raised by Audit Wales in which a comprehensive update was provided to the Committee.

(h) The Accounts, following today's meeting were due to be formally approved at Trust Board on 27 July 2023 for onward submission to Welsh Government by 31 July 2023.

Wales Audit of Accounts Report

Gareth Lucey presented the report and provided a summary on the following key details for the Committee's attention:

(a) It was proposed that an unqualified audit opinion would be submitted with the audit work now complete.

(b) Reference was made to some minor corrections but there were none of any significance. There were no corrections identified that impacted on the Trust's retained surplus position for the year.

(c) There were no uncorrected misstatements arising from the audit work; anything that required presentational correction had been carried out.

(d) The Committee were advised of the position concerning a Ministerial Direction regarding pension tax liabilities for certain senior clinical staff; it was no longer material and therefore did not affect the audit opinion.

(e) There were two items of expenditure recorded in the 2022/23 accounts which technically should have been recorded in the following year's accounts; however, the

amount was below the recognised threshold for materiality hence required no adjustment.

Comments:

In respect of property, plant and equipment, clarity was sought on the comments with regards to valuation. Gareth Lucey explained the comments related to the 2022/23 accounts, and as a legacy of the pandemic, a number of asset valuers issued guidance on the material value uncertainty with evaluation reports at the time. No such uncertainty had been reported by the valuer for 2022/23, therefore this narrative had been removed from the final accounts.

Annual Report 2022/23

The report was presented by Trish Mills who indicated the report consisted of two parts, the Performance Report and the Accountability Report. The Performance Report contained details of how the Trust had performed during the last year. The Accountability Report detailed the key accountability requirements and Governance Statement. The Committee noted that the Board would receive one unified document when the report was presented for approval.

Trish Mills explained there were some minor non-material date changes to two of the graphs within the report; these have since been corrected for the version going to Trust Board.

In terms of translation to Welsh, the Committee were advised that the Annual Report will be translated in time for the Annual General Meeting (AGM) scheduled on 27 September 2023. Members noted that only the front page of the Accounts will be translated.

The Committee acknowledged the work by all involved in the production of these reports and recorded a note of thanks.

RESOLVED: **The Committee proposed and agreed that the Annual Accounts and Annual Report 2022/23 be recommended for approval by the Trust Board.**

27/23 INTERNAL AUDIT ITEMS

The Head of Internal Audit (HoIA), Osian Lloyd presented the reports which consisted of his opinion for the 2022/23 financial year – which was of reasonable assurance - and several Internal Audit (IA) Reports as listed below.

The HoIA report set out details of the IA work performed throughout the last financial year. It also contained a summary of audit performance and an assessment of conformity against the public sector internal audit standards.

It was noted that during the year 2022/23 19 Audit Reviews were reported on; 15 were rated as reasonable assurance, three as limited and one was just an advisory review with no rating applied.

The Committee noted that the latest external quality assessment had been conducted by the Chartered Institute of Public Finance and Accountancy; this had confirmed that the IA work fully conformed to the requirements of the Public Sector Internal Audit Standards.

The following Internal Audit reports were received:

(a) Risk Management & Assurance: – Opinion was reasonable. Felicity Quance explained that the purpose was to review the framework of organisational assurances in place for the reporting of risk management. Four medium priority recommendations had been raised. The review had clearly demonstrated improvement in risk reporting and strengthening of the Board Assurance Framework (BAF). It was noted that the timely review of risk mitigations had been impacted by the challenges faced as a result of winter pressures and industrial action. Furthermore, it was recognised the recent appointment of a Risk Officer will benefit the risk management arrangements going forward.

Trish Mills reminded the Committee that a transitional BAF had been introduced last year and continued to mature to a much more strategic one. She further noted that work was continuing to ensure that the mitigation actions achieved the intended impact.

The Committee were pleased to see the progress being made in particular acknowledging where management challenged the recommendations made to agree a more appropriate or realistic management action.

Members queried whether and how lessons were being learned in this area. Felicity Quance commented that the Trust were kept informed of any relevant information for improvement.

(b) Savings and efficiencies: – Opinion was reasonable. Felicity Quance explained that the purpose to the report was to ensure that savings plans were specific, realistic, and measurable and that monitoring arrangements were effective. Four medium priority recommendations had been raised. It was noted in the report that achieving financial balance for the forthcoming year would be a challenge for the Trust. It was pointed out that a review of the Financial Sustainability Programme was not undertaken as this will be part of the 2024/25 Internal Audit plan. Several areas which required management attention included; the requirement to develop guidance to assist staff in assessing and approving savings plans, provide financial training and to develop a template to ensure savings information was robustly recorded and reported. It was further noted that whilst some of the individual

savings schemes had been achieved, management and processes of those that were underachieved required enhancement.

It was queried whether sufficient scrutiny had been applied in the report in terms of the impact on the Trust's ability to support patients as a result of the savings efficiencies. Felicity Quance assured the Committee that going forward this level of scrutiny would be applied to ensure that the wider impact for the delivery of savings was achieved. Liam Williams added that as part of the quality impact assessment process, the Trust would only action savings plans where they did not have detrimental impacts on patients. Trish Mills added that work was underway to identify when impact assessments required implementation.

Navin Kalia assured the Committee that the points raised in the review were being addressed as part of the Financial Sustainability Programme management going forward.

The Committee were keen to understand if the Trust could adopt areas of best practice around savings from other health boards. Osian Lloyd advised the Committee that a data base was held by Internal Audit to capture best practice across Wales and that the savings and efficiencies element would be added going forward. The database was shared with the Board Secretaries Network.

Members noted and as described by Martin Turner, that at a recent Finance and Performance Committee meeting concern had been expressed that the Trust was in part relying on non-recurring savings to balance throughout 2023/24.

(c) Trade Union Release Time: – Opinion was limited. Felicity Quance explained that the purpose of the report was to provide assurance on the deployment of the refreshed Trade Union facilities agreement and to include a review of progress made to implement recommendations raised in the 2018/19 report which was of limited assurance. It was acknowledged that whilst some progress had been made, several of the significant matters raised replicated the recommendations picked up in the 2018/19 report. Of the recommendations made, three were high priority and one was medium. As part of the review, sample testing had revealed a lack of an audit trail to demonstrate appropriate and timely request when facility time was made. The recording of detail of the facility time was currently only available using the GRS system; access to this system was not available during the review. As there was no system in place to record the system release time, it had not been possible to evidence accurate management information.

Paul Seppman explained that a great deal of TU time was not within their control and was taken up in attending various meetings. He assured the Committee that when TU staff were on shift there was an auditable trail in terms of how release was applied. He added there were challenges in managing the time effectively; however, the impact on operational shifts was kept to a minimum. He stressed the

importance of dedicating time to partnership working and the need for clinical skills to be maintained.

Carl Window assured the Committee that his team produce reports that echoed some the findings contained within the review.

Members recognised that the management response to the review had clearly demonstrated the continued good relationship with TU partners. The Committee further noted that progress on the recommendations would be monitored through the People and Culture Committee.

(d) Pain Management: – Opinion was limited. Felicity Quance explained that the purpose of the review was to consider the application of pain relief methods and the effect on patient outcomes in terms of pain relief and patient satisfaction. It was noted that this was the first time a review of this kind had been conducted. Three recommendations had been raised, two high and one medium. It should be borne in mind that clinical outcomes of the drugs administered and the cost effectiveness of drugs currently in use at the Trust were not part of the assessment. Key points raised from the review which required management attention included; poor compliance rates in Patient Group Direction (PGD, legal mechanisms that permit Paramedics to administer drugs that were not currently included in schedule 17 of the Human Medicines regulations (2012)), completion for Advance Paramedic Practitioners (APC), PGD's were not reviewed on a regular basis, a lack of oversight into pain scores, and administration of analgesia and the administration of analgesia by appropriately qualified clinicians.

(e) Information Management and Technology (IM&T) Infrastructure: - Opinion was reasonable. Osian Lloyd explained that the objective of the review was to provide assurance over the management and operation of the Trust's IM&T infrastructure. The review demonstrated that the Trust maintains a record of infrastructure assets and that the equipment is kept up to date. The key management actions included; ensuring accuracy of the asset register, formalising the alert management process, ensuring all switches which were used to connect devises on the network were recorded on the register and ensuring that the services to be provided within the back-up site were prioritised appropriately. Three medium priority findings and one high were raised.

RESOLVED: The Internal Audit reports as presented were received.

28/23 AUDIT WALES REPORTS

The Committee received the Audit Wales update report from Andrew Doughton who presented it as read and highlighted the following:

(a) The workforce review was in progress and should be available at the next Committee meeting.

(b) In terms of good practice events, the Committee were advised of upcoming events which would focusing on digital, particularly around leadership and strategy. The events were due to take place in Cardiff and North Wales on 21 and 27 September, respectively. Further details can be obtained from the Audit Wales Team.

Comments:

It was queried whether the good practice events would include how the digital strategy work linked to the impact of the duty of quality. Andrew Doughton explained they will have a citizen focussed approach and was certain that the quality aspect would be taken into consideration.

Members queried the timeline for publication in respect of the Unscheduled Care Review. Andrew Doughton explained that part one was due out soon and once available will be published on the Audit Wales website.

Detailed Audit Plan 2023

Gareth Lucey presented the plan which had recently been forwarded to Members for comment.

Work programme for 2023-2026

Andrew Doughton presented the report for the Committee's information.

RESOLVED: The Committee received and noted the Audit Wales detailed audit plan for 2023 and the work programme for 2023-2026.

29/23 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

The update was provided by Julie Boalch and the Committee were asked to note the following:

(a) All of the risks except for 100 (Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience) and 283 (Failure to implement the EMS Operational Transformation Programme) had been reviewed during July. This was in line with the reviewing schedule.

(b) Two risks had increased in score, risk 424 (Prioritisation or availability of resources to deliver the Trust's IMTP) from 12 to 16 and risk 163 (Maintaining effective and strong Trade Union Partnerships) from 12 to 16.

(c) Two risks have been closed, risk 245 (Failure to have sufficient capacity at an alternative site for EMS Clinical Contact |Centres which could cause a breach of Statutory Business Continuity regulations) and risk 557 (Potential impact on services as a result of Industrial Action).

(d) 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) has been included on the register with a score of 15.

(e) The Committee noted the update on the Risk Management Transformation Programme.

RESOLVED: The Committee:

(1) Noted the review of each high rated principal risk including ratings and mitigating actions.

(2) Noted the inclusion of the Civil Contingencies Risk on the Corporate Risk Register at a score of 15 as presented to Trust Board in May 2023.

(3) Noted the increase in score of Risk 424 from 12 to 16.

(4) Noted the increase in score of Risk 163 from 12 to 16.

(5) Noted the closure of Risk 245 from the Corporate Risk Register.

(6) Noted the closure of Risk 557 from the Corporate Risk Register;

(7) Noted the update on the Risk Management Transformation Programme.; and

(8) Received the Guidance on Interpreting the Board Assurance Framework.

30/23 AUDIT TRACKER REPORT

Julie Boalch presented the report advising the Committee there were 143 internal audit recommendations with 52 being overdue from their agreed completion dates.

The Committee were advised there were several historical recommendations overdue from the 2019/20 and 2022/21 financial years. Following advice from Internal Audit a number of these have since been closed. Members also noted that further consideration will be given to the longest overdue recommendations with a view to closing these in due course.

Work with the tracker was continuing, particularly looking at refreshing the overall process of mapping recommendations.

Comments:

A note of thanks was recorded for Internal Audit for their assistance in closing some of the more historical audits.

Trish Mills explained that at the next meeting the Committee would receive a revised Audit Tracker which will include a revised process for tracking recommendations and a new tracking format; it will also include a new guidance document.

Osian Lloyd added that several recommendations had been captured prior to the pandemic. He further added that the follow up review report, which tested a sample of recommendations that had been closed on the tracker, was near completion and would receive a reasonable assurance report at the next meeting.

RESOLVED: The Committee noted the update and:

(1) Considered the audit activity since the last Audit Committee; and

(2) Considered the proposals to address each recommendation particularly arrangements for the closure of historic recommendations.

31/23 POLICY REPORT

Julie Boalch explained that the purpose of the report was to provide an update on the status of the Trust's policies.

Several policies within their review date fell below reasonable levels during the Covid-19 pandemic as the policy work plan was largely paused and efforts directed to support the response. This has resulted in most policies being past their review date; however, it is important to note that these remain extant policies, they are in use and have not expired. The majority of policies will only require minor changes during the review process as they have already been through robust governance.

The Committee were advised that of the Trust's 93 policies, only 13 were within their review date. A prioritisation exercise was underway to address this and also the governance process was underway which will include a review of the policy on policies. The work will also look at whether any non-critical policies could be considered as a Standing Operating Procedure as opposed to a policy.

Julie Boalch assured the Committee that the majority of policies had already been subject to a robust governance process; with experts within the Trust keeping a close eye on any legislative changes that could impact on the policies.

Comments:

Trish Mills assured the Committee that the Board was aware of the current situation in respect of the status of policies.

Following a query in respect of the number of NHS Wales policies, Julie Boalch explained there were 19 NHS Wales policies relevant to the Trust and the next iteration of the report would include timelines of these policies.

RESOLVED: The Committee;

(1) Considered the contents of the report and the programme of work in development to mitigate risk and bring policies in line with appropriate review dates; and

(2) Provide a view on any of the policies within Committee's remit that should be included on the priority work plan.

32/23 STANDARDS OF BUSINESS CONDUCT POLICY

Trish Mills presented the revised Standards of Business Conduct Policy to the Committee to endorse for onward submission to Trust Board, for approval.

The Committee were reminded that a limited assurance opinion was given on the Standards of Business Conduct review which was conducted last year; one of the recommendations was to develop a revised Policy.

The Policy has undergone a wholesale revision and details of the material changes were set out in the covering report. An All-Wales approach to standards of business conduct was being developed, however the policy has been drafted on best practice principles and has been reviewed and endorsed by the Policy Group and the Executive Management Team. A focused campaign of stakeholder consultation has assisted in the presentation of a well-rounded policy to the Committee.

RESOLVED: The Committee;

(1) Noted the update on the Standards of Business Conduct Policy;

(2) Noted the next steps for the Corporate Governance Team; and

(3) Endorsed the revised Standards of Business Conduct Policy for approval by Trust Board.

33/23 LOSSES AND SPECIAL PAYMENTS FOR THE PERIOD 1 APRIL 2022 TO 31 MARCH 2023 AND 1 APRIL 2023 TO 31 MAY 2023

Navin Kalia gave an update on the losses and special payments for the following periods: Total net losses and special payments during 1 April 2022 to 31 March 2023 amounted to £380k and for 1 April 2023 to 31 May 2023 amounted to net reimbursements of £41k.

RESOLVED: The Committee received the report.

34/23 QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE REPORT – CLINICAL AUDIT PLAN 2022/23 APPROVAL

Trish Mills explained that the Quality, Patient Experience and Safety Committee (Quest) were required, in line with its terms of reference, to assure the Audit Committee of its approval of the Clinical Audit Plan annually.

RESOLVED: The Committee noted the approval of the clinical audit plan for 2022/23 by the Quest Committee.

35/23 AUDIT COMMITTEE CYCLE OF BUSINESS

Trish Mills presented the report and drew the Committee's attention to the following points which were in the Committee's terms of reference but not clearly evident in the cycle of business:

(a) Whistleblowing processes and arrangements; regular verbal updates in respect of the investigation progress will be provided by the Chair of the People and Culture Committee (PCC) as an interim measure until the speaking up safely framework was fully developed. Overall oversight will remain with PCC.

(b) Near miss reports; the National Audit Office recommends that Audit Committees review information on near misses to assist in determining whether the systems in place were sufficiently robust to mitigate future risk events. It was proposed that reports of this nature be monitored at the Quest Committee.

Comments:

Paul Hollard considered that it would be prudent for near misses to be captured at each Committee and should there be a consistent issue or trend then Audit Committee would be alerted to those by the Chair of that Committee.

The Committee were made aware by Trish Mills that near miss reports would not only cover patients but would have a much wider context, for example cyber security near misses and that would be overseen at the Finance and Performance Committee.

Trish Mills further explained that as the near miss report was being developed, that Committees deal with near misses under their remit, and the Chair of each Committee update the Audit Committee accordingly.

It was agreed that Trish Mills would provide further clarity on recommendation (b)(Approve the approach to the whistleblowing and near misses elements of the terms of reference such that the whistleblowing process and arrangements for special investigations will come to Audit Committee with regular verbal updates from the Chair of the People and Culture Committee on progress in the interim, and that QUEST will monitor near miss reporting), specifically to indicate the reporting process involved for each Committee and that the mechanism by which near misses – with respect to the criteria for escalation to Audit Committee where there are concerns regarding governance, internal controls, and management of risk - will be further considered and brought back to the Committee for endorsement.

Liam Williams provided the Committee with an overview of near misses were currently reported from a quality and patient safety point of view. Based on the level of severity the near miss incurs or not, it is recorded on Datix and reviewed either by the Health and Safety or quality Safety team; this would then determine whether an intervention was required as a result of the near miss. Thematic analysis would also be carried out, and if required would be escalated to the relevant assurance Committee. Of note he added that the volume of incidents was significant, and achieving the right response was a real challenge.

RESOLVED: The Committee

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

(2) Further clarity on recommendation be provided (b)(Approve the approach to the whistleblowing and near misses elements of the terms of reference such that the whistleblowing process and arrangements for special investigations will come to Audit Committee with regular verbal updates from the Chair of the People and Culture Committee on progress in the interim, and that QUEST will monitor near miss reporting), specifically to indicate the reporting process involved for each Committee and that the mechanism by which near misses – with respect to the criteria for escalation to Audit Committee where there are concerns regarding governance, internal controls, and management of risk -

will be further considered and brought back to the Committee for endorsement was agreed.

36/23 COMMITTEE PRIORITIES REPORT

The report updated the Committee on progress against the priorities it set for 2023/24 and was noted.

RESOLVED; The Committee noted the update.

37/23 20 APRIL 2023 AAA REPORT

The report was presented for information.

RESOLVED: The Committee noted the report.

38/23 REFLECTIONS & SUMMARY OF DECISIONS AND ACTIONS

Trish Mills asked, and it was agreed that a verbal update be provided at the Board meeting.

RESOLVED: The Board will receive a verbal update.

Meeting concluded at: 11:44

Date of Next Meeting: 14 September 2023

AGENDA ITEM No	**18**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

NHS WALES JOINT COMMITTEE UPDATE REPORT

MEETING	Trust Board
DATE	28 September 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Steve Owen, Corporate Governance Officer
CONTACT	Steven.owen2@wales.nhs.uk

EXECUTIVE SUMMARY

1. Sections x-xii of Standing Orders clarify the functions undertaken by the Emergency Ambulance Services Committee (EASC) and the Welsh Health Specialised Services Committee (WHSSC), and explain the representation of this Trust on those Committees.

2. Section xiii of Standing Orders explains the purpose of the NHS Shared Services Committee. All Local Health Boards, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee to ensure the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

3. Whilst the Trust is not a member of WHSSC or EASC the Chief Executive does attend the Committees as an Associate Member. Assurances in respect of the functions discharged by WHSSC and EASC shall be achieved by the reports of the respective Joint Committee Chair.

4. This report provides an update to Trust Board in respect of the following recently held meetings:

5. The minutes, agendas and additional reports from EASC, NHS Wales SSPC and WHSSC meetings are available from each Committee's websites via the following links.

https://easc.nhs.wales/ https://whssc.nhs.wales/ https://nwssp.nhs.wales/

RECOMMENDED: That the minutes of meetings as listed below be received.

KEY ISSUES/IMPLICATIONS
Not Applicable

REPORT APPROVAL ROUTE
Not Applicable

REPORT APPENDICES
18.1 Chair's EASC Summary - 18 July 2023 18.2 Welsh Health Specialised Services Committee Briefing - 18 July 2023 18.3 Shared Services Partnership Committee - 20 July 2023 18.4 Welsh Health Specialised Services Committee Extraordinary Briefing - 1 August 2023

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

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	**Emergency Ambulance Services Committee**
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	18 July 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link: https://easc.nhs.wales/the-committee/meetings-and-papers/july-2023/

- The minutes of the EASC meeting held on 16 May 2023 were approved.

PERFORMANCE REPORT

The Performance Report was received which included the Ambulance Service Indicators and the EASC Action Plan. In presenting the report, Ross Whitehead highlighted a number of key areas.

Members noted that:

- The latest Ambulance Service Indicators (ASIs) https://easc.nhs.wales/asi/ would be published on Thursday 20 July, reporting the June position
- 999 call volumes were 8% lower than in May 2022
- 4% reduction in incidents
- Hear and treat rates continued to improve
- See and treat rate back to the historical norm
- Improvements in response times – all on an improving trajectory as well as for those patients waiting the longest in the red and amber categories, although there was still a long way to go before the performance would be considered satisfactory (but in the right direction)
- An increase in the number of patients conveyed to hospital compared to the same period last year – this needed to be analysed further and would be presented to the EASC Management Group
- Improvement in handover delays and the number of patient waiting over 4 hours has reduced, in some areas this has been eradicated while others, though showing signs of improvement, required continued attention
- EASC Action Plan was being updated and, although it was no longer required to be submitted monthly, would be used at the Integrated Quality, Planning and Delivery meetings with Welsh Government.

Discussion took place and Members raised the issue of variation both across Wales but also within health boards. Members welcomed the dashboard approach in providing clarity and sought assurance that the data was being validated, particularly in relation to red release. Members noted that the weekly dashboard was constantly under review and enhancements would continue where members identified additional requirements.

Members discussed the impact of reducing handover delays and the expectation that this would affect performance although this had not yet been seen with performance in red consistently at the mid 50% level.

Jason Killens was asked to forecast where and when improvements would be seen and whether the assumptions made in the IMTP would be realised. Further discussion took place in relation to variation and Members noted good performance improvement in some areas whereas others were stubbornly at unacceptable levels. Further improvements were anticipated with the roll out of the Cymru High Acuity Response Units (CHARUs) and the improved utilisation of the ambulance fleet.

Stephen Harrhy raised the role of the Community First Responders, particularly in rural areas and also the variation in conveyance rates across health boards which would be important areas for the deployment of Advanced Paramedic Practitioners (APPs) in trying to avoid conveyance. Jason Killens explained that additional CFRs had been recruited & trained.

It was agreed that additional work would be required to retrospectively analyse the data from the electronic patient clinical record (ePCR) and other sources to correctly categorise the work; this would be included in the next report and would have the alternative services identified.

Members noted:

- Modelling suggested 4% of WAST activity could be dealt with in the Same Day Emergency Care (SDEC) units; this was currently at 0.2%
- The aim to make more use of video consultation, and to use to best effect
- The development of directories of services in health boards and the importance of ensuring access for WAST staff
- For lower acuity chest pain patients and some care homes analyse the data for potential opportunities to create services and track through actions (real time access)
- The importance of driving out variation in an environment of improving performance.

The version of data presented to the Committee was raised in view of the requirement for StatsWales to publish the Ambulance Service Indicators before any publication of the information. Ross Whitehead explained that ongoing meetings were taking place with the aim to resolve the issue and be agile as commissioners of the ambulance service. The aim would be to try and make progress in some areas with a view to ensuring the Committee had the most current information. Members noted that the Office of National Statistics (ONS) had been tasked to produce cross UK measures for health, which in view of the four different operating models was a complex request.

QUALITY AND SAFETY REPORT

The Quality and Safety Report was received.

In presenting the report, Ross Whitehead highlighted the presentation of the revised quality report in light of the requirements of the Duty of Candour and Duty of Quality.

Noted that:

- 25 ongoing investigations under the Joint Framework in May
- Work continuing to identify key themes in meetings with WAST and health boards

- The Welsh Risk Pool were supporting the work and seeking improvement opportunities for the tracking and reporting of joint investigations
- Reduction in the number of patients waiting over 12 hours in the community, although still a large number, the trajectory was one of improvement
- Improvement in the compliance of the clinical indicators within the Ambulance Service Indicators
- A technical error had been identified within the STEMI bundle and this would be rectified back to June 2020
- The published levels for the return of spontaneous circulation (ROSC) was 20% (the highest level achieved)
- The latest information was not available in respect of patients arriving as 'walk ins' but in the triage category one. This would be rectified as it was agreed this was an important metric for patient safety. Joint work was underway with the NHS Wales Delivery Unit (NHS Executive) to analyse those self-presenting and included stroke patients (high level of patients presenting at emergency departments).

Members responded asking about:
- learning from the North East Ambulance Service review and the potential to undertake a gap analysis to secure any insight or learning – noted that the EASC Team currently analysing the review and would report to EASC Management Group on any findings
- other reviews of ambulance services and noted that the EASC Team constantly scan for any ambulance service reviews and consider any learning. This would again be reported initially via EASC Management Group. Jason Killens also confirmed that WAST routinely undertake a gap analysis approach to any significant report on ambulance services.

EASC COMMISSIONING UPDATE

The EASC Commissioning Update Report was received. This included:
- Integrated Medium Term Plan 2023-26
- Current EASC Integrated Medium Term Plan (IMTP) Tracker
- Non-Emergency Patient Transport Services (NEPTS) Strategic Direction
- Integrated Commissioning Action Plans (ICAPs)

Members noted that:
- Work had commenced on reviewing the Non-Emergency Patient Transport Services Commissioning Framework as per the agreed commissioning cycle
- The work to develop a longer-term strategy for NEPTS following the completion of the business case and adapting to the ongoing changes within the service. The final report would be presented at a future meeting
- In relation to the EASC IMTP Tracker some of the performance ambitions had been achieved including:
  - longest red – 95th percentile 30 minutes by the end of Quarter 1 – this had been achieved and it was suggested to review Quarter 2 ambition to <18 minutes
  - longest amber – 95th percentile 8 hours by the end of Quarter 1; this had been achieved and suggested revising the Quarter 2 ambition to 4.5 hours and Quarter 3 to 3.5 hours.

Agreed to: Revise the performance ambitions as outlined above

FOCUS ON – EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS) SERVICE REVIEW

Stephen Harrhy gave an overview of the work to date and introduced Lee Leyshon, Deputy Director of Communications and Engagement to deliver the presentation on the emerging themes.

Noted:

- Discussed the factors for developing options for the service and the weightings as previous used for EMRTS developments
- In relation to the EMRT Service:
  - General support and appreciation
  - Local bases mean local services for the people who live near
  - Some consider it a 'fast ambulance'
  - Understanding of a problem to fix
  - Important about effectiveness of working with other services and agencies
  - Implications for hours of operation, for air and road, with staffing implication
  - The small mutual aid implications
- In terms of wider issues and the original service development proposal:
  - Another rural loss – like banks, dentists, GP practices, post offices etc
  - Lack of understanding of 'unmet need'
  - The rationale for the original base locations; the coastal locations and the importance of rapid response vehicles RRVs
  - That the critical care staff would want to treat as many patients as possible
  - The impact of the weather on services
- In reference to the Wales Air Ambulance Charity:
  - Potential reputational damage with a risk to funding
  - Perception of cost saving
  - Accepted the findings of the original Service Development Review
- For rural and coastal areas the following issues were regularly raised:
  - Remote and lone working in high risk occupations
  - Seasonal population variations
  - Impact of rural geography, road infrastructure and topography
  - Mobile phone coverage
  - Patient road transfer experiences and outcomes
  - Impact of climate change affecting access
- Public perception that services prioritised in urban areas when using services per head of population and the respective needs were different in rural and urban areas
- Response times was a major concern, of increased response times, losing the 'golden hour' and the impact of adverse weather. The proximity to emergency department in urban areas was raised regularly
- Data was an area of focus regularly raised in sessions including:
  - The initial data period involving the Covid period
  - The significance of the average response times
  - Using historical and forecasting data
  - Seasonal and population variation and projected demographics for rural areas
  - Understanding the under-utilisation data
- In terms of the factors and weightings:
  - Regular questions related to cost saving perception
  - Cross over between the factors suggested

  - Importance of defining the factors
  - That clinical skills and sustainability needed a higher score and a reduction to the value for money weighting.
- With regard to the engagement process:
  - Understood a complex matter
  - Questionnaire available at all sessions and online
  - Increased and regular communications
  - Commissioner trusted and the public confidence in the approach
  - Responses received included 'balanced, fair, comprehensive and diligent'; not a 'fait accompli'
- Suggestions received included:
  - Same bases different hours; all bases 24/7; base investments; all 4 into one base
  - Variations on the issues above with RRV usage
  - Make either (or both) Welshpool and Caernarfon 24/7 instead of Cardiff
  - More RRVs to be available
  - Move the South Wales bases
  - That WAST provide similar critical care skilled staff
  - Make more incremental changes from aviation contract
  - Opportunities to work with Fire and Rescue
- Broader system issues included appreciation of the scale and landscape, the vulnerabilities and the context of other services
- Concerns about WAST in out of area; handover delays, triaging of 999 calls and recruitment of staff
- For health boards – primary and secondary care in terms of loss of access to services; sustainability of services (local) and how people can have a say (want to be involved)
- For public services – need to be more integrated; recognise local service loss and its impact; involve the local populations more and more raise more awareness
- For policy and decision makers – understand the current pressures; reliance on charitable donations; road infrastructure important and involving the public in decision making.

Members raised the following:

- Thanked the CASC and the EASC Team for their thorough exemplar process; lots of learning for the system on the strength of the approach
- The timescales for the independent analysis, keen to ensure the collective perspective considered
- Sharing the data, modelling and information received from the engagement process
- The importance of the next phase.

Stephen Harrhy explained the next phase of work in terms of sharing data, learning from the approach and responding to the concerns by formally reporting at the next meeting to provide the facts for the Committee to consider. Further modelling would be available for members to scrutinise at the next meeting.

Members noted that there was a strength of feeling in the locality of the Welshpool and Caernarfon bases in their desire to maintain the status quo.

Areas for further consideration would include:

- Making the best use of resources (mindful of the very different levels of utilisation of the current service)
- Whether the EMRT Service is too specialised and what opportunities could exist for different patient groups
- How rural areas receive health care and the issues with time sensitive requirements

- The options for a new base and whether this could be delivered by the Charity in terms of infrastructure – some assurance for the next phase
- Adapting the approach in light of the comments received and amending the weightings on clinical skills and value for money
- Options for closer working between WAST and EMRTS
- The wider picture – local areas primarily mentioned bases; Stakeholder Reference Groups across health board areas did not have major concerns if the service would be improved for all of the population, and in particular providing more ability to deliver to patients in the unmet need category.

Stephen Harrhy explained that further work was required in order to make a recommendation to Members and that Members in turn would make a fully informed decision no earlier than the meeting in November. Members noted the risk of reputational damage to the Charity and the potential impact on donations. Members agreed the importance of making the best use of the commissioning allocation for EMRTS and WAST.

A factual report including data and the independent analysis of the responses received would be provided at the September meeting.

It was reiterated that it was too early to make a recommendation to EASC and **no decision had been made.**

UPDATE ON PROGRESS RELATED TO THE EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) SERVICE REVIEW

The update report on the EMRTS Service Review was received. Lee Leyshon presented the report and gave an overview of work to date in the phased approach.

Noted:
- Suggestions to slightly amend the weightings
- Plans for next report at the September meeting
- Continuation of the approach including planning of Phase 2 and maintaining work with the All Wales Communications and Engagement leads in health boards and trusts; and planning & informatics colleagues.

WELSH AMBULANCE SERVICES NHS TRUST REPORTS

The Welsh Ambulance Services NHS Trust (WAST) Provider Report was received. In presenting the report, Jason Killens highlighted:

- The use of the Clinical Safety Plan - WAST were at escalation level 2 (4 is the maximum) and in May 2023, WAST spent 1% of the time at Clinical Safety Plan (CSP) level 3b (the third highest level). The levels of escalation and CSP were significantly lower than those seen in the depths of winter, which was reflected in the lower levels of patient cancellations and "no sends"
- Red Performance and the continued roll out of the Cymru High Acuity Resource Units (CHARU), about half had been commenced and more staff are being recruited, trained and deployed with an aim to build on the roster rota work and ensure the right fleet mix across Wales. This would improve red performance and the already seen increase in the return of spontaneous circulation (ROSC) rate.

- Ambulance production levels against the plan for the latest four months at 97% against the ambition of 95%
- The progress made by health boards in reducing handover delays at emergency departments and the consequential impact on the ambulance service
- The numbers of patients conveyed at 41% into EDs in May 2023 (27% in December 2022, with the Clinical Safety Plan affecting this)
- The Non-Emergency Patient Transport Services (NEPTS) and meeting the targets for kidney patients in arriving within 30 minutes of the appointment time (performance at 75% to the target of 70%). Also, an amendment had been made for the service provided to oncology patients moving from -30/+30mins to -45/+15mins to provide a better service for this group of patients
- The first meeting of the Strategic Demand and Capacity Review had taken place at WAST with the aim of making the best use of resources available and continuing the approach.

Stephen Harrhy raised the issue of **red release** and confirmed the ongoing work to study the impact of the immediate release on the service provided. This would include validating the data before this was shared in the public domain, although it was acknowledged that this would potentially lead to a short time lag as this was a manual process. The work to develop confidence in the information included the health board Chief Operating Officers and their teams who receive the unvalidated report and therefore can challenge the data with respect to their areas. Further updates would be provided as the work progresses.

CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT

The Chief Ambulance Services Commissioner's Update Report was received. In presenting the report, Stephen Harrhy highlighted key areas which included:

- Six Goals for Urgent and Emergency Care Programme (latest highlight report shared) work continuing to deliver Goal 4 and locally based work captured through the Integrated Commissioning Action Plan (ICAP) meetings.
  - A new clinical lead, Dr Tim Rogerson, had been appointed by the Six Goals for Urgent and Emergency Care Programme. Collaborative work had started on what a good emergency department would look like and a clinical event had been planned.
  - Specific work was planned in Swansea Bay and Betsi Cadwaladr UHBs to pilot an approach undertaken in Bristol 'the continuous flow work' as well as learning the system lessons from the experience in Cardiff & Vale and more recently Cwm Taf Morgannwg UHBs.
- Connected Support Cymru (previously known as Night Sitting Service) An update report would be provided on progress at the next meeting
- Data linking – the plan to hold a workshop was still in place although it was not yet scheduled as further steps were required to ensure all information sources would be available and reliable. At that stage, a workshop would be held with all relevant health boards, WAST and Digital Health and Care Wales (DHCW) staff. Members noted that DHCW had also been commissioned by Welsh Government to develop an urgent and emergency care dashboard
- Health Education and Improvement Wales (HEIW) – Education commissioning of Paramedics and Advanced Paramedic Practitioners (APPs). Positive conversations had taken place with the EASC Team and it was suggested and agreed that Alex Howells, CEO of HEIW would be invited to periodically attend the Committee

meeting. Members suggested the importance of the timescales for this work to meet academic timetables.

EASC FINANCIAL PERFORMANCE REPORT MONTH 12 2022/23

The EASC Financial Performance Report at month 3 in 2023/24 was received. There were no variances to report on the financial position given the very early point in the financial year.

SUMMARY OF THE EASC MANAGEMENT GROUP MEETING HELD ON 22 JUNE 2023

The first summary from a meeting of the EASC Management Group was received. The aim of the report was to ensure consistency of issues identified at the ongoing meetings.

Members noted:

- Ongoing discussions on a health board by health board basis re operational matters of WAST staff undertaking supporting duties within EDs to help flow and get the balance right
- Work to ensure the consistency of data, especially in relation to immediate release.

EASC SUB-GROUPS CONFIRMED MINUTES

Approved:

- EASC Management Group 20 April 2023
- Non-Emergency Patient Transport Services Delivery Assurance Group notes 13 April 2023
- Emergency Medical Retrieval and Transfer Service Delivery Assurance Group 6 March 2023

EASC GOVERNANCE

The report on EASC Governance was received which included the:

- EASC Risk Register and suggested approach to risk appetite
- EASC Assurance Framework
- EASC Key Organisational Contacts
- Welsh Language Commissioner – Final Report and Decision Notice
- Letter to host in relation to the statutory Duty of Quality and Candour.

Noted that:

- The Risk Register had five red risks in total, three scoring the highest level at 25.
- The EASC Assurance Framework had been updated in line with the changes above to the risk register
- The latest EASC Key Organisational Contacts report was presented and Members asked to review their organisational representatives at EASC and its sub groups
- The Welsh Language Commissioner – Final Report and Decision Notice and ongoing work
- Letter to host in relation to the statutory Duty of Quality and Candour - Stephen Harrhy had signed on behalf of the Committee to confirm that EASC would use reasonable endeavours to comply with the legislation and activities where appropriate and cooperate and provide any necessary data and/or information it requires, as Host Health Board to discharge its duties under the Health and Social Care (Quality and Engagement) (Wales) Act.
  A formal report on the EASC compliance would be included in next year's Annual Governance Statement (Added to Action Log).

Members **agreed** to the use of **CTMUHBs Risk Appetite Statement** for commissioning risks until arrangements could be developed for the new Joint Committee.
FORWARD LOOK AND ANNUAL BUSINESS PLAN The Forward Look and Annual Business Plan was received and approved.
Key risks and issues/matters of concern and any mitigating actions
• Red and amber performance • Handover delays (and the development of handover improvement plans in HBs with trajectories) and the impact on services provided to HB local communities and to WAST • The ongoing formal engagement process for the EMRTS Service Review, further meetings planned for later in the year
Matters requiring Board level consideration
• Opportunity for health boards to take part in the public engagement process related to the potential changes to EMRTS Cymru working in partnership with the Wales Air Ambulance Charity. • To acknowledge the significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plans and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours – especially in relation to the quality of services patients receive
Forward Work Programme and Annual Business Plan
Considered and agreed by the Committee.

Committee minutes submitted	Yes	√	No	
Date of next meeting	**19 September 2023**			

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 18 JULY 2023

The Welsh Health Specialised Services Committee held its latest public meeting on 18 July 2023. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed using the link below:
2023/2024 Joint Committee - Welsh Health Specialised Services Committee (nhs.wales)

1. Minutes of Previous Meetings

The minutes of the meetings held on the 16 May 2023 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising

Members **noted** the progress on the actions outlined on the action log.

3. NHSE Funding Growth / Impact on Providers

Members **received** a presentation on the variation in growth and specialised services across the UK.

Members **noted** that work had been undertaken to analyse the variation in growth relating to specialised services across the different NHS sectors. The Joint Committee had requested that the work be undertaken to gain a benchmark of how Welsh services performed in comparison with those in England, Scotland and Northern Ireland.

Members **noted** the presentation.

4. Chair's Report

Members received the Chair's Report and **noted**:

- **Chair's Action** - The Chair's Action taken on 14 June 2023 to appoint Carolyn Donoghue, Independent Member (IM) at CTMUHB, as a WHSSC IM for an initial term of 2 years from 1 July 2023 until 30 June 2025, in accordance with the Welsh Health Specialised Services Committee (Wales) Regulations 2009 and the WHSSC Standing Orders (SOs); and
- **Key meetings attended**

Members (1) **Noted** the report; and (2) **Ratified** the Chair's action taken on 14 June 2023 to appoint Carolyn Donoghue, Independent Member (IM) at CTMUHB, as a WHSSC IM for an initial 2 year term from 1 July 2023 until 30 June 2025.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates:

- **Hosting Agreement with CTMUHB – Statutory Duty of Candour and the Duty of Quality -** Cwm Taf Morgannwg (CTMUHB), acting as Host Health Board (HB), requires WHSSC to use its reasonable endeavours to comply with this legislation in its activities where appropriate. WHSSC have written to CTMUHB to confirm we are aware of our duties and to advise that we will report on compliance with the duties within the Annual Governance Statement (AGS),
- **Memorandum of Understanding (MoU) with BCUHB -** WHSSC and Betsi Cadwaladr UHB (BCUHB) have developed a joint Memorandum of Understanding (MoU) to set out the arrangements for the management of contracts and commissioning for the population of North Wales from English providers. The MoU clearly describes the arrangements and responsibilities if a serious quality concern or risk materialises. The MoU has been signed by both parties and is operational with immediate effect,
- **Requests for WHSSC to Commission New Services – WHSSC has received requests to commission new services for NHS Wales**
    - Sacral Nerve Stimulation (SNS) for faecal incontinence in South Wales; and
    - Neurophysiology

  The workload associated with the adoption of new services during 2023-24 will be absorbed into the existing WHSSC Team capacity. A review of the longer-term workload impact, including the potential commissioning of Hepato-Pancreao- biliary (HPB) Surgery Services will be undertaken and will inform the 2024-25 ICP,
- **Fertility Update - WHSSC Policy development: - CP37 Pre-implantation Genetic Testing-Monogenic Disorders, Commissioning Policy - CP38, Specialist Fertility Services: Assisted Reproductive Medicine, Commissioning Policy -** The WHSSC team have been in discussion with Llais, regarding issues raised during the stakeholder engagement exercise on the above policies. In response to feedback, WHSSC will revise its Policy for Policies, and a paper describing the proposed approach is on the agenda for the July JC meeting. There is ongoing dialogue regarding the individual policies (CP37 and CP38) and a key issue to be resolved is the sequencing on any requirement for public consultation for policies, deemed to represent a significant service change which may have a budget impact, and therefore, require

incorporation into the WHSSC prioritisation and ICP approval processes.

- **Neonatal Cot Configuration Project -** At the March 2023 meeting the JC requested that the WHSSC Director of Planning sought advice from the NHS Wales Directors of Planning (DoPs) Executive Peer Group on the best approach to the strategic planning for the second phase of the neonatal cot review, to ensure that the review fully addresses the interdependencies with non-WHSSC commissioned services such as maternity, and the Clinical Services Plans of Health Boards (HBs). A positive discussion was held with the DoPs in May where it was agreed that WHSSC should lead this planning, and that the DoPs should be involved in the design of Phase 2. This has been followed up with a factual briefing to the DoPs on Phase 1.

Members **noted** the report.

6. Future Commissioning of the Wales Neurophysiology Service

Members received a report outlining the process and timeline of the work that will be undertaken for WHSSC to return to commissioning Neurophysiology services in Wales.

Members noted that the NHS Wales Health Collaborative Executive Group (CEG) has formally requested that WHSSC return to commissioning Neurophysiology services in Wales.

Members (1) **Noted** the report, **(2) Approved** the request for WHSSC to return to commissioning neurophysiology services from April 2024 onwards; and (3) **Supported** the proposed next steps and the work that will be undertaken to take this forward.

7. Sacral Nerve Stimulation (SNS) for Faecal and Urinary Incontinence in South Wales

Members received a report outlining the process and timeline of the work for WHSSC to take on the commissioning of Sacral Nerve Stimulation (SNS) for faecal incontinence and urinary incontinence in South Wales,

Members noted that the NHS Wales Health Collaborative Executive Group (CEG) has formally requested that WHSSC take on the commissioning of Sacral Nerve Stimulation (SNS) for faecal incontinence and urinary incontinence in South Wales.

Members (1) **Noted** the report, (2) **Approved** the request for WHSSC to commission Sacral Nerve Stimulation (SNS); and (3) **Support** the proposed process and timeline of the work that will be undertaken to take this forward.

8. Update on Welsh Kidney Network (WKN) Governance Review

Members received a report presenting an update on the Welsh Kidney Network (WKN) Governance Review.

Members **noted** the update on the Welsh Kidney Network (WKN) governance review.

9. WHSSC Policy for Policies Review

Members received a report which considered the implications of issues raised during the WHSSC stakeholder consultation on Clinical Commissioning Policies CP37 (Pre-implantation Genetic Testing) and CP38 (Specialist Fertility Services: Assisted Reproductive Medicine) in relation to the WHSSC 'Policy for Policies' and wider policy development in NHS Wales.

Members (1) **Noted** the report; and (2) **Supported** the proposed next steps.

10. IPFR Engagement Update – All Wales Policy

A recommendation was made and approved that this item not be discussed.

11. Appointment Process for the Individual Patient Funding Request (IPFR) Panel

A recommendation was made and approved that this item not be discussed.

12. Corporate Risk Assurance Framework (CRAF)

Members received a report presenting WHSSC's updated Corporate Risk Assurance Framework (CRAF) and outline the risks scoring 15 or above on the commissioning teams and directorate risk registers.

Members noted that as at 30 June 2023 there were 17 risks on the CRAF, 13 commissioning risks and 4 organisational risks.

Members (1) **Noted** the updated Corporate Risk Assurance Framework (CRAF) and changes to the risks outlined in this report as at 30 June 2023, (2) **Approved** the CRAF as at 30 June 2023, (3) **Noted** that the CRAF is presented to each Integrated Governance Committee, Quality & Patient Safety Committee, CTMUHB Audit & Risk Committee and the Risk Scrutiny Group (RSG) meetings; and (4) **Noted** that a desktop Risk Benchmarking exercise has been undertaken and the results were considered at the Integrated Governance Committee (IGC) meeting on 13 June 2023.

13. Annual Committee Effectiveness Self-Assessment Results 2022-2023

Members received a report presenting an update to the Joint Committee on the actions from the annual Committee Effectiveness Self-Assessment undertaken in 2021-2022 and to present the results of the annual committee effectiveness self-assessment 2022-2023.

Members **(1) Noted** the completed actions made against the Annual Committee Effectiveness Survey 2021-2022 action plan, (2) **Noted** the results from the Annual Committee Effectiveness Survey for 2022-2023, (3) **Noted** that an update on the survey findings was presented to the Integrated Governance Committee (IGC) Committee on the 13 June 2023, (4) **Noted** that the feedback will contribute to the development of a Joint Committee Development plan to map out a forward plan of development activities for the Joint Committee and its sub committees for 2023-2024; and (5) **Noted** the additional sources of assurance considered to obtain a broad view of the Committee's effectiveness.

14. WHSSC Annual Report 2022-2023

Members noted that the document will be sent to all members via email after the meeting for comment and subject to any further amendments for virtual approval. The document will be brought back to the September meeting under the corporate governance report to confirm approval.

Members **noted** the verbal update.

15. Declarations of Interest, Gifts, Hospitality and Sponsorship 2022-2023

Members received a report presenting an update on detail of the Declarations of Interest (DOI), Gifts, Hospitality and Sponsorship activities for the financial year 2022-2023.

Members (1) Noted the Declarations of Interest Register for 2022-2023, (2) **Noted** the Gifts, Hospitality and Sponsorship register for 2022-2023, **(3) Noted** that the Registers were presented and discussed at the Integrated Governance Committee meeting on 13 June 2023; and

(4) **Received assurance** regarding the WHSSC Declarations of Interest (DOI), Gifts, Hospitality and Sponsorship process.

16. Performance & Activity Report Month 1 2023-2024

Members received a report providing a summary of the performance of WHSSC's commissioned services. Further detail including splits by resident Health Board (HB) was provided in an accompanying Power BI Dashboard report.

Members **noted** the report.

17. Financial Performance Report – Month 2 2023-2024

Members received the financial performance report setting out the financial position for WHSSC for month 2 2023-2024. The financial

position was reported against the 2023-2024 baselines following approval of the 2023-2026 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2023.

The year to date financial position reported at Month 2 for WHSSC an underspend of (£0.021m) and a break even forecast year-end position.

Members **noted** the contents of the report including the year to date financial position and forecast year-end position.

18. Financial Assurance Report

Members received a verbal update advising that the report would be discussed in the in committee session.

Members **noted** the verbal update.

19. South Wales Neonatal Transport Delivery Assurance Group Update Report

Members received a report providing a summary of the South Wales Neonatal Transport Delivery Assurance Group (DAG) Annual Report for 1 April 2022 – 31 March 2023.

Members (1) **Noted** the report; and (2) **Received assurance** that the Neonatal Transport service delivery and outcomes were being scrutinised by the Delivery Assurance Group (DAG).

20. Major Trauma Network Delivery Assurance Group Quarter 4 Update Report

Members received a report providing a summary of the Quarter 4 2022-23 Delivery Assurance Group (DAG) report of the South Wales Major Trauma Network (SWTN).

Members **noted** the South Wales Major Trauma Network (SMMTN) Delivery Assurance Group (DAG) Report.

21. All Wales PET Programme Progress Report

Members receive a report providing an update on the progress made by the All Wales Positron Emission Tomography (PET) Programme.

Members **noted** the progress made by the All Wales Positron Emission Tomography (PET) Programme and its associate projects and workstreams. The risk related to the availability of capital fundng was noted.

22. Efficiency and Recommissioning Programme Update

Members received a report providing an update on the Efficiency and Recommissioning programme enabled to realise the 1% savings requested by Joint Committee when signing off the 2023-24 Integrated Commissioning Plan (ICP).

Members **noted** the report and the progress made.

23. Corporate Governance Matters

Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members **noted** the report.

24. Other reports

Members also **noted** update reports from the following joint Sub-committees:

- Audit and Risk Committee (ARC),
- Management Group (MG),
- All Wales Individual Patient Funding Request (IPFR) Panel,
- Integrated Governance Committee (IGC),
- Quality & Patient Safety Committee (QPSC; and
- Welsh Kidney Network (WKN).

25. Any Other Business

- **Retirement of WHSSC Director of Finance** – members noted that it was Stuart Davies' last Joint Committee meeting following announcing his retirement. Members thanked him for his stalwart contribution and commitment to developing specialised commissioning in Wales and wished him every success in future.

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	20 July 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Chair's Report

The Chair updated the Committee on her attendance at recent meetings, both within NWSSP and externally. A development day was held with the NWSSP Senior Leadership Team and Heads of Service in June which will help to inform the similar event planned for Shared Services Committee members in November.

The Committee **NOTED** the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- A very positive Joint Executive Team meeting had been held recently with Welsh Government;
- The Service Improvement Team are undertaking a number of areas of work including Payroll, Accounts Payable and the Customer Service Excellence programme;
- The NWSSP Procurement - Supply Chain recently hosted a visit from an Icelandic Health Care delegation to review warehouse management systems; and
- The planned move from Companies House to the Welsh Government offices in Cathays Park is progressing and is scheduled for January 2024.

The Committee **NOTED** the update.

Items Requiring SSPC Approval/Endorsement

Annual Review 2022/23

The Committee reviewed the Annual Review and noted the wide ranging and

significant achievements of NWSSP during the 2022/23 financial year.

The Committee **APPROVED** the Annual Review.

Revisions to Standing Orders

The Committee received the Standing Orders which have been updated for a number of external (e.g. Duties of Quality and Candour; establishment of Llais) and internal (e.g. changes to the Scheme of Delegation) factors. The Standing orders will need to also be formally approved by the Velindre University NHS Trust Board.

The Committee **ENDORSED** and **APPROVED** the suggested revisions to the Standing Orders prior to formal approval by the Velindre University NHS Trust Board.

All-Wales Establishment Control Programme

Establishment Control is a functionality within ESR that enables organisations to accurately report on both funded establishments and vacancy data. It is the formal process for matching data on funded posts in an organisation to the details of the staff employed in those posts. Establishment Control ensures activity connected to recruitment, workforce and budgetary changes can be actioned in a controlled way and supports the accurate reporting of vacancy data.

The Committee **APPROVED** the paper which recommends the initiation of a programme of work to scope, assess and recommend options for the implementation and roll out of Establishment Control across NHS Wales organisations.

Items for Noting

PPE Update

Audit Wales undertook a review of PPE procurement and supply during the pandemic and produced a report in April 2021 that was positive in the roles that NWSSP had taken in this regard. There were however a number of recommendations made, which were split between NWSSP and Welsh Government. While the agreed actions for NWSSP were largely implemented at the time, it was considered useful to update the Committee on the current position, particularly given the recent focus on this issue at the UK Public Inquiry. The Committee were assured that the agreed actions within the gift of NWSSP to implement, had been completed.

Annual Governance Statement

The final version of the Annual Governance Statement was provided to the Committee for noting, having earlier been approved by the Audit Committee. The Partnership Committee had reviewed the draft Statement at its meeting in May and the only significant changes since that version were the inclusion of the Head

of Internal Audit reasonable assurance opinion and the full year sustainability figures.

Audit Committee Annual Report

The report detailed the work of the Audit Committee during the 2022/23 financial year, and also included the results of the annual survey into the effectiveness of the Committee. There were no items of concern to report.

Finance, Performance, People, Programme and Governance Updates

Finance –A break-even financial position is forecast for 2023/24 however this is dependent upon a number of income assumptions and generating sufficient savings to support the transitional and removal costs relating to the transfer of significant volumes of medical records from Brecon House. Welsh Risk Pool spend to Month 3 is £6.456m compared to £10.277m at Month 3 last year. The high-level forecast for 2023/24 is £135.727m which is in line with the IMTP forecast. This requires £26.494m to be funded under the Risk Share Agreement.

People & OD Update – Both in-month and 12-month sickness absence rates are improving and remain very low. Statutory and Mandatory training rates are good, but PADR compliance needs improvement. There has been a particular focus on retention of staff in recent weeks.

Performance – The in-month May performance was generally good with 34 KPIs achieving the target against the total of 38 KPIs. The four KPIs that are current rated as amber are for Audit and Assurance and Recruitment, with two amber KPIs in each service. Professional influence benefits amount to £34M at end of May.

IMTP Q1 Progress Report - At the end of Quarter 1 83% (129) of our objectives are on track. Reporting on objectives remains on a self-assessment basis by the divisional Heads of Service, scrutinised through the Quarterly Review process.

Project Management Office Update – Two projects are currently rated as red, these are the Brecon House relocation where issues with the current building being unsafe and the cost of relocation of records, and the TrAMS project and the affordability of the proposed solution as part of the wider capital programme.

Corporate Risk Register – There are currently six red risks on the Corporate Risk Register. These cover energy costs, staffing shortages, the Legal & Risk Case Management System, Brecon House, TrAMs, and the reputational issues for NWSSP relating to the situation at BCUHB.

The Committee **NOTED** the above Reports.

Papers for Information

The following items were provided for information only:

- Declarations of Interest Annual Report 2022/23;
- Gifts & Hospitality Annual Report 2022/23;
- Counter Fraud Annual Report 2022/23;
- Welsh Language Annual Report 2022/23;
- Health & Safety Annual Report 2022/23;
- PPE Stock Report;
- Finance Monitoring Returns (Months 2 and 3); and
- 2023/24 Forward Plan.

AOB

N/a

PART B

The Part B agenda included the approval of the following contract extensions:

- International Recruitment;
- TRAC; and
- E-Expenses.

Updates were also provided on:

- TrAMs;
- Home Electronics Scheme; and
- BCUHB – procurement services and recent reports.

Matters requiring Board/Committee level consideration and/or approval

- The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.

Matters referred to other Committees

N/A

Date of next meeting	Thursday 21 September **9am – 11am**

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) EXTRAORDINARY JOINT COMMITTEE MEETING BRIEFING – 1 AUGUST 2023

The Welsh Health Specialised Services Committee held its latest public meeting on 1 August 2023. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed using the link below:
2023/2024 Joint Committee - Welsh Health Specialised Services Committee (nhs.wales)

1. All Wales Individual Patient Funding Request (IPFR) Panel Chair Recruitment

Members received a report providing a proposal regarding the recruitment of a WHSSC IPFR Panel Chair in line with the WHSSC IPFR Panel Terms of Reference (ToR) agreed in March 2023.

Following discussion they supported the recommendations outlined within the report.

Members (1) **Noted** the rationale for the eligibility requirements of the role of WHSSC IPFR Panel Chair contained within the ToR agreed in March 2023, (2) **Noted** that the current Chair will no longer be eligible for the role in September 2023 and the urgent need to proceed with a recruitment process, (3) **Supported** WHSSC to take forward the urgent recruitment of an IPFR Panel Chair; and (4) **Approved** the associated remuneration package for both the Chair and Lay Members.

Acronyms
(WAST: Welsh Ambulance Services NHS Trust)

Abbreviation	Term
AC	Audit Committee
AMPDS	Advanced Medical Priority Dispatch System
APC	Academic Partnerships Committee
APP	Advanced Paramedic Practitioner
A4C	Agenda For Change
ACS	Ambulance Car Service
ACA	Ambulance Care Assistant
AQIs	Ambulance Quality Indicators
ADLT	Assistant Directors Leadership Team
ADO	Assistant Director of Operations
AACE	Association of Ambulance Chief Executive
AVL	Automatic Vehicle Location
BAF	Board Assurance Framework
BAU	Business as Usual
BCRT	Business Continuity and Recovery Team
BJC	Business Justification Case
CMP	Capacity Management Plan
CAS	Clinical Assessment Software
CC	Charity Committee
CEO	Chief Executive (of the Trust)
CAD	Computer Aided Dispatch
CCC	Clinical Contact Centre
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CSP	Clinical Safety Plan
CSD	Clinical Support Desk
CFR	Community First Responder
C&C	Consult and Close
CPD	Continuing Professional Development
CPAS	Clinical Prioritisation Assessment Software Group
CHARU	Cymru High Acuity Response Unit
D&C	Demand and Capacity
DOM	Duty Operations Manager
DOS	Directory of Services

Abbreviation	Term
EA	Emergency Ambulance
EASC	Emergency Ambulance Services Committee
ECNS	Emergency Communication Nurse System
ECP	Emergency Care Practitioner
ED	Emergency Department
EMD	Emergency Medical Dispatcher
EMS	Emergency Medical Service
EMSC	Emergency Medical Service Coordination
EPRR	Emergency Preparedness, Resilience and Response
EMT	Executive Management Team
EPCR	Electronic Patient Clinical Record
EPT	Executive Pandemic Team
ERADI	Emergency Response Ambulance Driving Instruction
ESMCP	Emergency Services Mobile Communications Programme
FPC	Finance and Performance Committee
HCPC	Health and Care Professions Council
ICT	Information and Communications Technology
ITT	Inverting the Triangle
HART	Hazardous Area Response Team
HIW	Health Inspectorate Wales
HEIW	Health and Education Improvement Wales
HoS	Head of Service
HCS	Health Courier Services
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning and Delivery
JESG	Joint Emergency Services Group
JRCALC	Joint Royal Colleges Ambulance Liaison Committee
KPI	Key Performance Indicator
LHB	Local Health Board
LM	Locality Manager
MIST	Mandatory In-Service Training
MRD	Make Ready Depot
MTS	Manchester Triage System
MDS	Minimum Data Set
MDT	Mobile Data Terminal
MDT	Multi-Disciplinary Team
MTU	Mobile Testing Unit
NCCU	National Collaborative Commissioning Unit
NEPTS	Non-Emergency Patient Transfer Service

Abbreviation	Term
NICE	National Institute for Clinical Excellence
NSF	National Service Framework
NQP	Newly qualified paramedic
NWAS	North West Ambulance Service
NWSSP	NHS Wales Shared Service Partnership
NED (s)	Non-Executive Director (s)
ODU	Operational Delivery Unit
OTL	Operations Team Leader
OOH	Out of Hours
PADR	Personal Appraisal Development Review
PCC	People and Culture Committee
PDP	Personal Development Plan
PECI	Patient Experience and Community Involvement
PID	Project Initiation Document
PLIC	Patient Level Information and Costing system
PPLH	Post Production Lost Hours
PRINCE2	Projects in a Controlled Environment (methodology)
PREMS	Patient Reported Experience Measures
PROMS	Patient Reported Outcome Measures
PTaS	Physician Triage and Streaming
QuEST	Quality, Patient Experience and Safety Committee
REAP	Resource Escalation Action Plan
RemCom	Remuneration Committee
RITA	Reminiscence Therapy Interactive Activities
ROLE	Recognition of life extinct
ROSC	Return of spontaneous circulation
RRV	Rapid Response Vehicle
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
SP	Senior Paramedic
SPT	Senior Pandemic Team
SLT	Senior Leadership Team (Operations)
SOT	Senior Operations Team
SAIs	Serious Adverse Incidents
SCIF	Serious Case Incident Forum
SDEC	Same Day Emergency Care
SPCT	Specialist Palliative Care Team
SOC	Strategic Outline Case
SOP	Strategic Outline Programme

Abbreviation	Term
TU	Trade Union
UCS	Urgent Care Service
UHP	Unit Hour Production
USC	Unscheduled Care
VPH	Vantage Point House
VCS	Volunteer Car Service
WG	Welsh Government
WHC	Welsh Health Circular
WTE	Whole Time Equivalent