Bundle Trust Board (Open Session) 30 May 2024

Agenda attachments

ITEM 0 Trust Board Open Agenda 30 May 2024
ITEM 0 Trust Board Open Agenda 30 May 2024-en-cy-C

0 09:30 - OPENING ITEMS

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

2 Board Member Register of Interests
Board Member Register of Interests

3 Minutes of Previous Meeting: 28 March 2024
ITEM 03 2024-03-28 Trust Board Minutes

4 Action Log and Matters Arising
ITEM 04 ACTION LOG

5 09:35 - Chair's Report
ITEM 05 Chair's Report to Trust Board - May 2024

6 09:45 - Chief Executive's Report
ITEM 06 CEO REPORT TO TRUST BOARD MAY 2024 FINAL

7 10:00 - Questions from Members of the Public

7.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

8 10:10 - Staff Story - Emma Worrall

9 10:40 - Progress on Actions to Mitigate Avoidable Patient Harm
ITEM 09 Realtime Mitigations 20240530
ITEM 09.1 Reducing Patient Harm Action Plan

10 11:00 - Monthly Integrated Quality and Performance Report (MIQPR)
MIQPR Annual review of Metrics
ITEM 10 MIQPR SBAR TB April 2024
ITEM 10.1 Annex 1 MIQPR TB April 2024

10.1 11:15 - COMFORT BREAK

11 11:30 - Risk Management and Board Assurance Framework
ITEM 11 Executive Summary Risk Management Report Trust Board 300524

12 11:40 - Integrated Medium-Term Plan (IMTP) 2024 - 2027 - Delivery & Assurance
ITEM 12 IMTP Year End 2324 Position and Forward Assurance Plan for 2024-25 Board

13 12:00 - Financial Position Month 12 2023/24
ITEM 13 Finance Report Month 12 23-24 - TB - final

14 12:10 - Financial Performance Month 1
NB. Items 14.2 and 14.4 have been circulated separately by e mail.
ITEM 14 Finance Report Month 1 2425 - TB final
ITEM 14.1 Month 12 2023-24 - Welsh Ambulance Services NHS Trust - Monitoring Return - final
ITEM 14.3 Month 01 2024-25 - Welsh Ambulance Services NHS Trust - Monitoring Return - final

15 12:20 - Annual Board and Committee Effectiveness 2023/24
ITEM 15 SBAR to Board on Effectiveness 2023-24 (May 2024)
ITEM 15.1 Committee remits delegated by Board 24-25
ITEM 15.2a Audit Committee Annual Return 2023-24 DRAFT
ITEM 15.2b Audit Committee TOR 24-25 FINAL for approval by Trust Board
ITEM 15.3a Academic Partnerships Committee Annual Report 2023-24
ITEM 15.3b Academic Partnerships Committee TORs 24-23 FINAL for approval by Trust Board
ITEM 15.4a FPC Annual Report 2023-24
ITEM 15.4b FPC TORs 24-25 FINAL for approval by Trust Board
ITEM 15.5a PCC Annual Report 2023-24
ITEM 15.5b PCC TOR 24-25 FINAL for approval by Trust Board
ITEM 15.6a QUEST Annual Report 2023-24
ITEM 15.6b QUEST Committee TOR 24-25 FINAL for approval by Trust Board

ITEM 15.7a Remuneration Committee 2023-24 Annual Report
ITEM 15.7b Remuneration Committee TORs 24-25 FINAL for approval by Trust Board
ITEM 15.8a WASPT Annual Return 2023-24
ITEM 15.8b WASPT TOR 24-25 FINAL for approval by Trust Board
ITEM 15.9 Annex 9 - Committee Priorities 2024-25

15.1 12:35 - COMFORT BREAK

16 12:50 - Audit Wales Annual Report
ITEM 16 4056A2024_WAST_Annual_Audit_Report_2023_Eng
ITEM 16.1 2023-24 NHS Audit Plan WAST

17 13:00 - Interim Amendment to Model Standing Orders
ITEM 17 SBAR Interim Standing Orders Changes
ITEM 17.1 WAST Standing Orders - Main Document v.8 for approval at TB 300524

18 13:05 - Board Committee Reports
18.1 Academic Partnerships Committee - 23 April 2024
18.2 Audit Committee - 30 April 2024
18.3 Quest Committee - 7 May 2024
18.4 People and Culture Committee - 9 May 2024
18.5 Finance and Performance Committee - 14 May 2024
ITEM 18.1 Academic Partnership Committee report April 2024
ITEM 18.2 Audit Committee AAA Report April 2024
ITEM 18.3 Quest Committee Highlight Report May 2024
ITEM 18.4 People and Culture Committee Highlight Report May 2024
ITEM 18.5 Finance and Performance Committee Highlight Report May 2024

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

19 Minutes of Board Committees:
19.1 Quest Committee: 08 February 2024
19.2 People and Culture Committee: 20 February 2024
19.3 Audit Committee: 01 March 2024
19.4 Finance and Performance Committee: 19 March 2024
ITEM 19.1 2024-02-08 Quest Open Minutes
ITEM 19.2 2024-02-20 PCC Open Minutes
ITEM 19.3 2024-03-01 Audit Committee Open Minutes
ITEM 19.4 2024-03-19 FPC Open Minutes

20 NHS Wales Joint Committee Update Reports:
20.1 Welsh Health Specialised Services Committee (WHSSC) Joint Committee Briefing - 19 March 2024
20.2 Shared Services Partnership Committee (SSPC) Assurance report 21 March 2024
ITEM 20.1 JC Briefing (Public) 19 March 2024
ITEM 20.2 SSPC Assurance Report 21 March 2024

20.1 CLOSING ITEMS

21 13:30 - Any Other Business

22 Date and time of next meeting
Extraordinary meeting on Friday 12 July at 09:30 and Normal Board meeting Thursday 25 July at 09:30 at 09:30 in Cardiff MRD

23 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).

24 Acronyms
ITEM 24 Acronyms

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

MEETING OF THE TRUST BOARD

Held in Open Session on Thursday 30 May 2024 from 09.30 to 13:35

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.	Board Member Register of Interests	To State Conflicts	Colin Dennis	Verbal	
3.	Minutes of Previous Meeting: 28 March 2024	Approval	Colin Dennis	Paper	
4.	Action Log and Matters Arising	Review	Colin Dennis	Verbal	
5.	Chair's Report	Information	Colin Dennis	Paper	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
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
8.	Staff Story – Emma Worrall	Discussion	Angela Lewis	Verbal	30 Mins
9.	Progress on Actions to Mitigate Avoidable Patient Harm	Assurance	Jason Killens	Paper	20 Mins
10.	Monthly Integrated Quality and Performance Report (MIQPR), to include the MIQPR Annual Review of Metrics	Assurance	Rachel Marsh	Paper	15 Mins
COMFORT BREAK – 15 Minutes					
11.	Risk Management and Board Assurance Framework	Assurance	Trish Mills	Paper	10 Mins

No.	Agenda Item	Purpose	Lead	Format	Time
12.	Integrated Medium-Term Plan (IMTP), End of Year Position 2023/24 and forward assurance plan for 2024/25.	Assurance	Rachel Marsh	Paper	20 Mins
13.	Financial Position for Month 12, 2023/24	Assurance	Chris Turley	Paper	10 Mins
14.	Financial Performance Month 1	Assurance	Chris Turley	Paper	10 Mins
15.	Annual Board and Committee Effectiveness 2023/24	Approval	Trish Mills	Paper	15 Mins
COMFORT BREAK – 15 Minutes					
16.	Audit Wales Annual Report 16.1 Audit Plan	Assurance	Fflur Jones	Paper	10 Mins
17.	Interim Amendment to Model Standing Orders	Approval	Trish Mills	Paper	5 Mins
18.	Board Committee Reports				
18.1	Academic Partnership Committee – 23 April 2024	Assurance	Kevin Davies (in lieu of Hannah Rowan)	Paper	5 Mins
18.2	Audit Committee – 30 April 2024	Assurance	Peter Curran	Paper	5 Mins
18.3	Quest Committee - 7 May 2024	Assurance	Ceri Jackson (in lieu of Bethan Evans)	Paper	5 Mins
18.4	People and Culture Committee – 09 May 2024	Assurance	Ceri Jackson	Paper	5 Mins
18.5	Finance and Performance Committee – 14 May 2024	Assurance	Kevin Davies (in lieu of Joga Singh)	Verbal	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.**					
19.	Minutes of Board Committees:	Information	Colin Dennis	Paper	

No.	Agenda Item	Purpose	Lead	Format	Time
	19.1 Quest Committee: 08 February 2024 19.2 People and Culture Committee: 20 February 2024 19.3 Audit Committee: 01 March 2024 19.4 Finance and Performance Committee: 19 March 2024				
20.	NHS Wales Joint Committee Update Reports: 20.1 Welsh Health Specialised Services Committee (WHSSC) Joint Committee Briefing – 19 March 2024 20.2 Shared Services Partnership Committee (SSPC) Assurance report 21 March 2024	Information	Colin Dennis	Paper	
CLOSING ITEMS					
21.	Any Other Business	Discussion	Colin Dennis	Verbal	5 Mins
22.	Date and time of next meeting – Extraordinary meeting on Friday 12 July at 09:30 and Normal Board meeting Thursday 25 July at 09:30 at 09:30 in Cardiff MRD	Information	Colin Dennis	Verbal	
23.	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	
24.	Acronyms	Information	Colin Dennis	Paper	

Lead Presenters

Name of Lead	Position of Lead
Colin Dennis	Chair of the Board
Jason Killens	Chief Executive Officer
Peter Curran	Non-Executive Director and Chair of the Audit Committee
Kevin Davies	Non-Executive Director
Ceri Jackson	Interim Vice Chair, Non-Executive Director, and Chair of the Chairty Committee
Angela Lewis	Director of People and Culture
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Chris Turley	Executive Director of Finance and Corporate Resources
Fflur Jones	Audit Wales

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Welsh Ambulance Services University NHS Trust

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CYFARFOD BWRDD YR YMDDIRIEDOLAETH

Cynhelir mewn Sesiwn Agored ddydd Iau 30 Mai 2024 o 09.30 tan 13:45

Cyfarfod a gynhaliwyd yn MRD Caerdydd, Tŷ Merton , Croescadarn Close, Pontprennau, Caerdydd, CF23 8HF a thrwy Zoom

AGENDA

Rhif.	Eitem ar yr agenda	Diben	Arweinydd	Fformat	Amser
EITEMAU AGORIADOL					
1.	Croeso gan y Cadeirydd, ymddiheuriadau, a chadarnhad o gworwm	Gwybodaeth	Colin Dennis	Ar lafar	5 Munud
2.	Cofrestr Buddiannau Aelodau'r Bwrdd	I ddatgan gwrthdaro	Colin Dennis	Ar lafar	
3.	Cofnodion y Cyfarfod Blaenorol: 28 Mawrth 2024	Cymeradwyaeth	Colin Dennis	Papur	
4.	Cofnodion Gweithredu a Materion sy'n Codi	Adolygu	Colin Dennis	Ar lafar	
5.	Adroddiad y Cadeirydd	Gwybodaeth	Colin Dennis	Papur	10 Munud
6.	Adroddiad y Prif Weithredwr	Gwybodaeth	Jason Killens	Papur	15 Munud
7.	Cwestiynau gan Aelodau'r Cyhoedd	Gwybodaeth	Estelle Hitchon	Ar lafar	10 Munud
EITEMAU I'W CYMERADWYO, SICRWYDD A THRAFODAETH					
8.	Stori Staff – Emma Worral	Trafodaeth	Angela Lewis	Ar lafar	30 Munud
9.	Cynnydd ar Gamau i liniaru niwed cleifion y gellir ei osgoi	Sicrwydd	Jason Killens	Papur	20 munud
10.	Adroddiad Ansawdd a Pherfformiad Integredig Misol (MIQPR) MIQPR - Adolygiad blynyddol o Fetrigau	Sicrwydd	Rachel Marsh	Papur	15 Munud
11.	Rheoli Risg a Fframwaith Sicrwydd y Bwrdd	Sicrwydd	Trish Mills	Papur	10 Munud

Rhif.	Eitem ar yr agenda	Diben	Arweinydd	Fformat	Amser
EGWYL – 15 munud					
12.	Cynllun Tymor Canolig Integredig (IMTP) 2024 – 2027 – Cyflenwi a Sicrwydd	Sicrwydd	Rachel Marsh	Papur	20 munud
13.	Sefyllfa Ariannol Mis 12, 2023/24	Sicrwydd	Chris Turley	Papur	10 Munud
14.	Perfformiad Ariannol Mis 1	Sicrwydd	Chris Turley	Papur	10 Munud
15.	Adolygiadau Effeithiolrwydd Blynyddol y Bwrdd a'r Pwyllgorau a'r Cylch Gorchwyl Diwygiedig	Cymeradwyaeth	Trish Mills	Papur	15 Munud
EGWYL – 15 munud					
16.	Adroddiad Blynyddol Archwilio Cymru	Sicrwydd	Fflur Jones	Papur	10 Munud
17.	Gwelliannau i Reolau Sefydlog Enghreifftiol	Cymeradwyaeth	Trish Mills	Papur	5 Munud
18.	Adroddiadau Pwyllgorau'r Bwrdd				
18.1	Pwyllgor Partneriaethau Academaidd – 23 Ebrill 2024	Sicrwydd	Hannah Rowan	Papur	5 Munud
18.2	Y Pwyllgor Archwilio – 30 Ebrill 2024 21.2a 2023 Adroddiad Blynyddol Archwilio Cymru ar gyfer WAST 21.2b Cynllun Archwilio 2024	Sicrwydd	Peter Curran	Papur	5 Munud
18.3	Pwyllgor Quest – 7 Mai 2024	Sicrwydd	Bethan Evans	Papur	5 Munud
18.4	Pwyllgor Pobl a Diwylliant – 9 Mai 2024	Sicrwydd	Ceri Jackson	Papur	5 Munud
18.5	Y Pwyllgor Cyllid a Pherfformiad – 14 Mai 2024	Sicrwydd	Joga Singh	Ar lafar	5 Munud
EITEMAU CYDSYNIO **Mae'r eitemau sy'n dilyn er gwybodaeth yn unig. Os bydd aelod yn dymuno trafod unrhyw rai o'r eitemau hyn gofynnir iddo hysbysu'r Cadeirydd fel y gellir neilltuo amser i wneud hynny.**					

Rhif.	Eitem ar yr agenda	Diben	Arweinydd	Fformat	Amser
19.	Cofnodion Pwyllgorau'r Bwrdd: Pwyllgor QuEST: 08 Chwefror 2024 Y Pwyllgor Pobl a Diwylliant: 20 Chwefror 2024 Pwyllgor Archwilio: 01 Mawrth 2024 Pwyllgor Cyllid a Pherfformiad: 19 Mawrth 2024	Gwybodaeth	Colin Dennis	Papur	
20.	Adroddiadau Diweddaru Cydbwyllgor GIG Cymru: Briff Cyd-bwyllgor Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (WHSSC) – 19 Mawrth 2024 Adroddiad Sicrwydd SSPC 21 Mawrth 2024	Gwybodaeth	Colin Dennis	Papur	
EITEMAU CAU					
21.	Unrhyw Fater Arall	Trafodaeth	Colin Dennis	Ar lafar	5 Munud
22.	Dyddiad ac amser y cyfarfod nesaf – Cyfarfod arbennig ddydd Gwener 12 Gorffennaf am 09:30 a dydd Iau 25 Gorffennaf am 09:30 yn MRD Caerdydd	Gwybodaeth	Colin Dennis	Ar lafar	
23.	Gwahardd y 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 (Mynediad i Gyfarfodydd) 1960).	Penderfyniad	Colin Dennis	Ar lafar	
24.	Acronymau	Gwybodaeth	Colin Dennis	Papur	

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

Prif Gyflwynwyr

Enw'r Arweinydd	Swydd yr Arweinydd
Colin Dennis	Cadeirydd y Bwrdd
Jason Killens	Prif Swyddog Gweithredol
Peter Curran	Cyfarwyddwr Anweithredol a Chadeirydd y Pwyllgor Archwilio
Ceri Jackson	Is-gadeirydd Dros Dro, Cyfarwyddwr Anweithredol, a Chadeirydd y Pwyllgor Cadeiryddion
Angela Lewis	Cyfarwyddwr Pobl a Diwylliant
Rachel Marsh	Cyfarwyddwr Gweithredol Strategaeth, Cynllunio a Pherfformiad
Trish Mills	Cyfarwyddwr Llywodraethu Corfforaethol / Ysgrifennydd y Bwrdd
Joga Singh	Cyfarwyddwr Anweithredol a Chadeirydd y Pwyllgor Cyllid a Pherfformiad
Chris Turley	Cyfarwyddwr Gweithredol Cyllid ac Adnoddau Corfforaethol
Fflur Jones	Archwilio Cymru

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

UNCONFIRMED MINUTES OF THE OPEN MEETING OF THE WELSH AMBULANCE SERVICES NHS TRUST BOARD, HELD on THURSDAY 28 MARCH 2024 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
Bethan Evans	Non-Executive Director
Estelle Hitchon	Director of Partnerships and Engagement
Paul Hollard	Non-Executive Director
Ceri Jackson	Non-Executive Director and Interim Vice Chair of the Board
Angela Lewis	Director of People and Culture
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Director of Corporate Governance/Board Secretary
Hugh Parry	Trade Union Partner
Hannah Rowan	Non-Executive Director (Virtual)
Andy Swinburn	Executive Director of Paramedicine
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

Attendees

Steve Owen	Corporate Governance Officer (Virtual)
Alex Payne	Corporate Governance Manager

Apologies

Professor Kevin Davies	Non-Executive Director
Peter Curran	Non-Executive Director
Joga Singh	Non-Executive Director
Jonny Sammut	Director of Digital Services

DRAFT

19/24 WELCOME AND APOLOGIES FOR ABSENCE

Welcome and apologies.

The Chair welcomed all to the meeting, and noted apologies were received from, Professor Kevin Davies, Joga Singh, Peter Curran, and Jonny Sammut.

Declarations of interest.

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

RESOLVED: That the declarations of interest on the register were formally recorded and the apologies from Professor Kevin Davies, Joga Singh, Peter Curran, and Jonny Sammut were formally recorded.

20/24 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 meeting held on 25 January 2024 were presented and confirmed as a correct subject to changing the titles of Bethan Evans and Estelle Hitchon to the correct ones, as they had been erroneously inverted.

Action Log:

The Board received the action log:

Minute 07/24. Progress on Actions to Mitigate Avoidable Patient Harm. *A discussion to be held at a Board Development Day regarding the Consult and Close target and consider what was the appropriate target.* This has been programmed in for a Board Development Session in the Summer. Action closed.

Minute 12/24. Structured Assessment. *In terms of the Long-Term Strategic Framework and measuring progress. It was asked if there were any examples of Trusts and Health Boards performing well in this area.* Audit Wales advised that

Hywel Dda's long-term strategic objectives are built into their interactive Board Assurance Framework (BAF) and interactive Performance Assurance Report which ensures regular monitoring of progress. They have built into some long-term outcomes which are displayed in the BAF against each of their strategic objectives, however they recognise that these are also a work in progress. The Cardiff and Vale University Health Board are currently looking at their arrangements for monitoring and reporting progress to Board. Action closed.

RESOLVED: That

(1) The Minutes of the meeting held on 25 January 2024 were confirmed as a correct record subject to correcting the titles of Bethan Evans and Estelle Hitchon; and

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

21/24 CHAIR'S REPORT AND UPDATE

The Chair presented the report as read noting that the Board had welcomed two new Non- Executive Directors, Peter Curran - who has recently joined the Trust and Ian Mathieson, who was due to begin in April 2024. He also noted that this would be Paul Hollard's last Trust Board meeting.

RESOLVED: The update was noted.

22/24 CHIEF EXECUTIVE'S UPDATE

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

The Senedd's Equality and Social Justice Committee initiated an inquiry into the culture review findings of the South Wales Fire and Rescue Service. As part of this inquiry, the Committee requested written evidence from the Trust. Additionally, he provided verbal evidence with the Director of People and Culture, Angela Lewis, to the Committee on 18 March 2024.

Capital and Estates. The significant contributions and efforts made by the relatively small team headed by Chris Turley should be acknowledged. Despite the challenges and workload, the team has demonstrated exceptional dedication, professionalism, and effectiveness in managing a diverse range of ongoing activities as indicated below.

The South-East Fleet Workshop has been fully operational since October 2023. Blackweir was disposed of in December 2023, and a revenue investment was made in Blackwood. The vacated space at Blackwood is temporarily used to support the

Mobile Data Vehicle Solution (MDVS) project for the installation of new vehicle equipment.

Dolgellau Site Lease and Procurement: Discussions are ongoing with the landlord to finalise the lease for the new site. The occupancy is estimated to begin in late Summer 2024.

Ruthin Site Development: Full planning permission was granted in August 2023, but tender costs exceeded the budget. Collaboration with Fire and Rescue Service colleagues is being explored for partnership working.

Monmouth Station replacement: Collaboration with South Wales Fire and Rescue Service and Gwent Police continues, but estimated costs exceed achievable budgets. Central financial support may be required.

Fforestfach site negotiations: Negotiations for a lease agreement are progressing well, and indicative plans have been developed.

Decarbonisation/Environmental Financial Advisory Board (EFAB) Projects: Work is underway on completing all five EFAB project schemes, with planning for 2024/25 schemes already in progress.

Other projects such as Newport Ambulance Station, Llangunnor, and North Wales Clinical Contact Centre are also progressing with various stages of development.

Prioritisation of Capital Allocation and All Wales Capital Programme: Work has commenced on prioritising schemes for the remaining 2024/25 Discretionary Capital allocation. Efforts are being made to indicate the Trust's requirements against the All Wales Capital Programme for the next 10 years, including estates schemes and decarbonisation projects.

111 Clinical Assessment Software (CAS) Replacement. There had been an urgent need for the Trust to replace its existing system before the contract expires in May 2024. Despite the typical 12-18 month timeline for such a project, significant preparatory work has already been undertaken by various teams, including Information and Communication Technology (ICT), Operations, Procurement, and Finance, to facilitate the purchase. Currently, efforts are underway across multiple departments to install and prepare the new system for launch on 30 April 2024.

The programme is progressing smoothly, with training underway for over 300 staff and the development of new procedures. Additionally, 54 Call Priority Streaming System (CPSS) protocols are under review, and approximately 50 servers are being installed across various sites and fallback centres. Collaboration with Health Boards is ongoing to ensure their systems are ready to accept electronic patient

information. Initial feedback from trained 111 teams indicates enthusiasm for the new system, noting its modernity and user-friendliness. Overall, despite the time constraints, the implementation of the new system seems to be well-coordinated and on track.

A pilot scheme, The Mental Health Response Vehicle (MHRV) aimed to reduce Emergency Department (ED) conveyance for mental health patients was underway. Currently, mental health patients experience prolonged waits in Emergency Departments (ED), with an average of five hours and a significant portion spending over 12 hours there. The MHRV Service complements the efforts of the Clinical Support Desk (CSD), where Mental Health Practitioners (MHPs) provide a hear and treat function, resulting in a nearly quadrupled consult and close rate for historic mental health patient cases. The see and treat MHRV Service has achieved a 77% consult and close rate.

Currently, the Trust is collaborating with Aneurin Bevan University Health Board to implement a 10-week MHRV Pilot operating from Friday to Sunday, between 13:00 and 01:00, in the Gwent area. The pilot involves Trust personnel providing mobile mental health crisis assessments with the goal of directing individuals to appropriate mental health treatments and pathways. Presently, 75% of patients are treated at the scene, 11% are conveyed to mental health support services, and 14% are conveyed to the ED for physical treatment. This initiative aims to optimise resources, improve patient outcomes, and enhance the efficiency of mental health crisis response and care delivery.

The Clinical Directorate recently welcomed ambulance colleagues from the South-East Coast Ambulance Service (SECAMB) for a visit towards the end of last year. During the visit, the Trust had the opportunity to articulate its strategic direction and ambitions for expanding its community care services. The discussions focussed on the significant value that Advanced Paramedic Practitioners (APP) have already contributed and the anticipated additional benefits in the future. This exchange of ideas and experiences underscores the Trust's commitment to advancing community care and collaborating with other ambulance services to enhance patient outcomes and service delivery.

Peter Green, Clinical Development Lead, and Ryan Higgins, Advanced Paramedic Practitioner (APP), recently visited the London Ambulance Service (LAS) to gain insights into their Emergency Operations Centre (EOC) operations and the role of their APPs within the dispatch model. Contrasts between the two services were observed, including differences in the volume of 999 calls received, the allocation of resources to calls, and minimal to no hospital delays.

The Paramedic3 Trial is ongoing across Wales and has enrolled 161 patients so far; with 310 Paramedics trained for the trial. Originally planned to conclude

recruitment in April 2024, the trial has been extended until August 2024. Additionally, the RAPID2 project is underway in South Wales, with fifteen paramedics having completed Stage 3 theatre placements and being fully trained to begin patient recruitment.

It's exciting news to share with the Board that starting 01 April 2024, the Trust will transition into becoming a University NHS Trust, making it the second UK ambulance service in the UK to achieve this status. This milestone underscores the commitment to education, development, and research within the sector. The Cabinet Secretary for Health and Social Care has officially bestowed the university badge upon the Trust, symbolising the dedication to advancing knowledge and expertise.

Effective 1 April 2024, the name will change to the Welsh Ambulance Services University NHS Trust, and in the coming days, the Trust will begin to roll out new branding, complete with the new title and a bilingual Crown Badge. This bilingual approach pays homage to King Charles III and his ascension to the throne.

Comments:

The Board noted the progress made in safeguarding and dementia work. These are critical areas where dedicated efforts can significantly enhance the well-being and safety of individuals within our community. The strides made in safeguarding demonstrate a commitment to protecting vulnerable populations and ensuring their rights and dignity are upheld.

It is noteworthy that work is underway to assess the Trust's requirements within the All Wales Capital Programme for the next decade. This forward-looking approach reflects a proactive stance in ensuring that the Trust's infrastructure and resources align with future needs and demands. Members sought an update on the thoughts going forward where potentially there may be a different model.

Chris Turley explained that Welsh Government (WG) had requested input on how best to allocate resources over the next decade across all NHS organisations in Wales. This request aims to inform the prioritisation of spending within the All Wales Capital Programme, from a government perspective. Fortunately, the Trust is already well-positioned, having mapped out a significant portion of its capital plan.

This week, the Trust has submitted its requirements to the Welsh Government. While more granular detail will likely emerge in the early years, there are indications of a prioritised list of estates that need improvement or replacement over time, beginning in year three. Additionally, the fleet replacement programme is set to commence during this period.

DRAFT

Chris Turley continued, the Trust is committed to collaborating closely with WG colleagues over the next six months to ensure that its perspective and priorities are well-represented in the ongoing prioritisation exercise. This collaborative effort underscores the importance of ensuring that the Trust's voice is heard and considered in shaping the future direction of healthcare infrastructure and resource allocation in Wales.

Furthermore, he added the Trust recognises that plans beyond year four may evolve and change significantly. Therefore, it will remain vigilant and adaptable, ready to respond to any shifts or developments in healthcare priorities and needs. This forward-thinking and flexible approach will enable the Trust to effectively navigate future challenges and opportunities, ensuring that resources are allocated in a manner that best serves the needs of the community and aligns with strategic objectives.

The Board acknowledged the many positives highlighted in the report, particularly regarding the progress made in the CAS replacement project. They recognised and appreciated the dedication and hard work of the team involved in this significant endeavour.

It is praiseworthy to see the Trust's efforts in promoting the Welsh language, particularly in the context of 111 call answering and bilingual recruitment. These initiatives reflect a commitment to linguistic diversity and inclusivity, ensuring that Welsh-speaking individuals can access healthcare services effectively and that opportunities for employment are accessible to Welsh speakers.

Jason Killens provided an update to the Board regarding the new commissioning arrangements. Effective from 01 April 2024, the new NHS Wales Joint Commissioning Committee (JCC) will be established. Abigail Harris, who has served as the Director of Strategy at Cardiff and Vale University Health Board for several years, has been confirmed as the Interim Chief Commissioner.

Furthermore, Stephen Harry will continue in his role as the Chief Ambulance Services Commissioner for the next three to six months. He will also assume responsibility for 111 commissioning from 01 April 2024. These updates signal significant changes in commissioning leadership within the healthcare system, aimed at enhancing coordination and effectiveness in service delivery across Wales.

The CEO Roadshows are set to commence on 15 April in North Wales, starting in Wrexham, and will continue across various locations in Wales throughout the week. The purpose of these roadshows is to engage with stakeholders and staff members, providing updates on key initiatives, discussing organisational priorities, and fostering open communication. As the roadshows progress, efforts will be made to further develop the format to ensure maximum engagement and effectiveness. This

may involve incorporating interactive elements, soliciting feedback, and tailoring content to address specific interests and concerns of attendees.

The Chair brought attention to an issue raised during a recent WAST Live event regarding concerns about fumes from vehicles at Emergency Departments (EDs). In response, Jason Killens was asked to provide further information and clarification on this matter.

Jason Killens addressed concerns about diesel fumes at Emergency Departments (EDs) because of handover delays. Running vehicles in confined areas has led to fumes that are unpleasant for staff. To address this issue, the Trust is taking several measures:

1. Environmental monitoring will continue periodically to assess the situation.

2. Collaborating with Emergency Department colleagues to provide shorelines and electrical supplies that vehicles can plug into, reducing the need for running engines.

3. Issuing guidance to staff with practical steps they can take to minimise the risk and exposure to fumes.

Liam Williams advised that the Trust is actively collaborating with industry partners to minimise staff exposure to diesel fumes and other pollutants, thus prioritising their health and well-being. Additionally, the Trust is exploring other avenues and strategies to further mitigate risks related to vehicle emissions and environmental pollutants.

RESOLVED: That the update was noted.

23/24 QUESTIONS FROM MEMBERS OF THE PUBLIC

Estelle Hitchon reminded viewers that the Board welcomed questions from members of the public; no questions had been received.

RESOLVED: There were no questions from members of the public

24/24 PROGRESS ON ACTIONS TO MITIGATE AVOIDABLE PATIENT HARM

Jason Killens presented the report as read and highlighted the following for the Board's attention:

The Trust remains dedicated to collaborating with Health Board colleagues to address and eliminate long waiting times associated with handover delays, particularly those of significant duration.

The goal of eradicating handover waits exceeding four hours remains a priority, with 2,091 such instances recorded in February 2024, compared to 1,586 in February 2023. While achieving complete eradication by the set deadline may be unrealistic given the prevailing circumstances, the progress made by Cardiff & Vale UHB serves as a beacon of success and underscores the potential for improvement.

The Trust's 2024-27 Integrated Medium Term Plan (IMTP) outlines a series of transformative actions aimed at addressing the impact of handover delays. Recognising the critical need for transformation, these actions are designed to improve operational efficiency, enhance patient care, and mitigate the effects of handover challenges on service delivery.

Comments:

In terms of the overall lost hours in December there had been a 40% reduction this year compared to last year the Board thought it would be helpful to have that wider perspective. Jason Killens noted a significant reduction in the overall number of very long waits and the total number of hours lost. However, he indicated that the Trust may not necessarily recognise this improvement from its perspective.

Lee Brooks highlighted that December 2023 experienced a significant improvement compared to December 2022, with 10,000 fewer lost hours. This reduction underscores the challenges faced during December 2022 and the progress made in addressing operational issues. However, despite this improvement, December 2023 still recorded 23,000 lost hours, which Lee Brooks deemed as still too high.

Following a query in terms of Immediate Release Requests, Lee Brooks noted a correlation between areas with the highest number of lost hours and challenges in releasing ambulances for Immediate Release Requests (IRR). He highlighted that while this issue occurs across Wales, there are significant variations in different regions. Lee Brooks suggested that this information should be brought to the attention of the Quest Committee to facilitate a focused approach in addressing the challenges associated with lost hours.

The Board sought an update in terms of Same Day Emergency Care (SDEC). Andy Swinburn commented that workshops have and continue to take place and are actively engaged in various activities and initiatives, to improve the position with SDEC.

Liam Williams provided an update on the Fit to Sit plan, acknowledging variability in its application and implementation across Health Boards in Wales. He mentioned seeking feedback from Health Board colleagues to gain a better understanding of when a patient is considered fit to sit within a hospital environment, recognising that clinical risk in Emergency Departments (EDs) is a factor in some instances.

He also highlighted the College of Emergency Medicine's efforts to challenge risk within EDs and ensure that risk is distributed evenly across hospitals nationwide. The Trust is committed to keeping patients at the centre and reinforcing the escalation process that Trust staff can follow to address concerns regarding patient care and safety.

RESOLVED: The Board

(1) NOTED the continued level of avoidable patient harm; and

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

25/24 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT

Rachel Marsh drew the Board's attention to the following areas:

The 111 call answering performance has generally stabilised, but there was a notable increase in patient demand, with February 2024 experiencing a 17% higher demand compared to February 2023. Despite this increased demand, the service has managed to maintain resilience. However, with a commissioned 4% reduction in call handlers anticipated in 2024/25, there may be concerns about future performance if demand continues to remain at these elevated levels.

Ambulance Care (Patient Experience) performance for February 2024 demonstrates positive results in several areas:

1. Oncology performance achieved 71.28%, meeting the 70% target.
2. Renal performance remains above target at 73.69%.
3. Advanced discharge & transfer journey booked in advance performance increased to 85%, although still below the 95% target.
4. Overall demand for Non-Emergency Patient Transport Services (NEPTS) is increasing but remains below pre-pandemic levels.

In February 2024, EMS (Emergency Medical Services) abstraction levels increased to 30.26%, just above the benchmark figure of 30%. Additionally, EMS Response sickness abstractions stood at 8.13%, exceeding the benchmark of 5.99%.

In February 2024, the Professional Appraisal Development Record (PADR) rates did not achieve the 85% target but showed steady improvement, reaching 79.25%. Additionally, compliance for Statutory and Mandatory training increased slightly to 77.73%. While PADR rates did not reach the target, the upward trend indicates progress in addressing patient inquiries and complaints. Similarly, the slight increase in compliance for Statutory and Mandatory training suggests a positive trend in staff training and development efforts.

Comments:

In response to a query regarding the commissioning of fewer call handlers, Rachel Marsh advised that this matter will be reviewed as part of the new commissioning arrangements. There is further scope to engage in discussions with commissioners regarding funding, which could potentially address concerns related to staffing levels.

Additionally, Rachel Marsh highlighted that a demand and capacity review will be conducted to gain a better understanding of the level of resources needed to effectively manage call volumes. This review will provide valuable insights into staffing requirements and help ensure that the appropriate level of resources is allocated to meet demand.

Furthermore, Rachel Marsh mentioned that the implementation of the CAS will bring efficiencies into the system, which could help optimise resource utilisation and improve overall service.

Angela Lewis acknowledged that staff sickness levels have been above the target of 6%, but she noted that they have declined again. She attributed this trend to seasonal challenges and potential burnout and stress from additional work responsibilities. She stressed the importance of ongoing efforts and processes to address these issues but highlighted the need for the Trust to take a more holistic approach to sickness absence management going forward.

Rachel Marsh clarified how the Trust measures conveyance of patients to destinations other than Emergency Departments (EDs). This includes conveyance to Minor Injuries units, Acute Medicines units, and SDECs (Same-Day Emergency Care units). This metric represents a percentage of all verified incidents.

However, Rachel Marsh added that this metric is no longer part of the performance framework for Wales, as it does not provide a comprehensive view of the entire healthcare system. Moving forward, the Trust aims to adopt more meaningful metrics as part of the new response model. For example, there may be a focus on increasing the number of patients treated at home or in the community, which

aligns with the broader goal of enhancing community-based care and reducing unnecessary hospital admissions.

Lee Brooks expressed concerns that percentage measures could be misleading and difficult to convince staff of attainability. He emphasised the importance of moving beyond percentage measures and focusing on raw numbers and volumes instead. He suggested that ambitions should be focused around increasing activity safely, rather than solely focusing on achieving certain percentage targets.

Estelle Hitchon referred to the patient experience surveys, integrated into the Civica software, which provided valuable feedback from individuals who take the time to share their experiences. These surveys offer insights into the quality of care and services provided by the Trust, highlighting instances where patients have had positive experiences.

Liam Williams advised the Board of information governance (IG) issues regarding the future use of the Civica software for collecting patient experience data and the need to seek consent. There's a dedication to overcoming these challenges by leveraging learnings from English Trusts, where certain measures have facilitated progress in this area.

RESOLVED: The Trust:

(1) Considered the January/February 2024 Integrated Quality and Performance Report and actions being taken and determine whether:

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

26/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK (BAF)

Trish Mills presented the report and updated the Board as follows:

All the risks on the Corporate Risk Register have undergone a thorough review since the last Board meeting. They have also been individually reviewed by all the relevant committees. There has been excellent engagement on this, including within the Board Assurance Framework (BAF). In fact, the Executive Leadership Team (ELT) was able to reduce the score of two risks and close one during their meeting yesterday.

As reflected in the BAF, there is a noticeable presence of blue, which indicates new additions, actions, and controls to mitigate risks. This signifies positive progress and proactive measures taken to address and manage risks effectively. Overall, there

has been significant movement across all areas, demonstrating the commitment to risk management and continuous improvement within the Trust.

The highest-rated risks, 223 (*the Trust's inability to reach patients in the community causing patient harm and death)* and 224 (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*), remained static in score at 25. It's important to emphasise that these risks receive significant attention and scrutiny at the Quality Patient Experience and Safety Committee (Quest).

Furthermore, these risks are also discussed at other key Committees, including the Finance and Performance Committee (FPC) and the People and Culture Committee (PCC). This ensures that multiple perspectives are considered, and appropriate actions are taken to mitigate these risks. Additionally, discussions at the ELT further reinforce the importance of addressing these risks and ensuring patient safety remains a top priority for the Trust.

Risk 163 (*Maintaining Effective & Strong Trade Union Partnerships)* is currently rated at 20. Angela Lewis has been actively engaged in work over the last quarter, particularly focusing on local development partnership programmes. As a result of these efforts, there is a belief that the risk score associated with this risk will decrease. However, it is important to recognise that this risk is inherently volatile and may fluctuate over time.

Risk 201 (*A loss of stakeholder confidence that damages the Trust's reputation*) remains static at 20.

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).* Despite efforts such as the agreement on a framework for the release of ambulances by Health Board Chief Operating Officers in the event of a major incident, the score for this risk remains static at 20.

The Risk Management Policy is before the Board for endorsement following approval at Audit Committee on 01 March 2024. This is the Trust's first Risk Management Policy and replaces the previous Risk Management Strategy. Risk Management guidelines which were available for staff. Related procedures will be finalised in line with publication to support the delivery of the Policy.

RESOLVED:

(1) Members considered and discussed the contents of the report;

(2) Received assurance on the review and attention to the principal risks, their review at ELT and at relevant Committees;

(3) Noted the ratings and mitigating actions for each principal risk; and

(4) Approved the Risk Management Policy.

27/24 NHS WALES STAFF SURVEY

Angela Lewis drew the Board's attention to the following key areas:

Out of 1006 colleagues a response rate of 23.2% was recorded. It is important to note that this figure does not include volunteers and engagement scores, which are typically key factors looked at across the NHS in Wales. Despite efforts to encourage participation, the Trust's engagement scores have experienced a slight decline from 72% to 67%. Similarly, across the broader NHS, engagement scores have decreased from 75% to 73%.

While there has been a dip in engagement scores, it's noteworthy that the decline is not as significant as anticipated. This suggests that there may still be room for improvement in terms of fostering employee engagement and satisfaction.

There has been some very encouraging feedback from colleagues who participated in the engagement survey. They expressed strong sentiments about their work environment, highlighting factors such as trust among colleagues and a genuine passion for patient care. It is reassuring to see that colleagues feel supported and valued within the Trust, and their dedication to going the extra mile for patients is commendable. These positive indicators not only reflect the strength of the team culture but also underscore the commitment of staff members to delivering high-quality care and service excellence.

During discussions at the Executive Leadership Team (ELT) meeting, some of the challenges highlighted in the engagement survey were addressed. Concerns were raised regarding potential issues such as excessive workload, burnout, and safety concerns in the workplace. It is important to acknowledge these concerns and take proactive steps to address them. Additionally, there were concerns about how issues raised by staff may not be adequately addressed, which can contribute to feelings of frustration and dissatisfaction among employees.

Angela Lewis added it was encouraging to note that the feedback from the engagement survey aligns with insights and intelligence gathered through

previous channels such as roadshows and surveys. This consistency indicates that the Trust has been actively engaging with the workforce and staying attuned to their needs and concerns over the past few months.

On 08 April, the Trust will receive the next level of detail, providing much richer intelligence on each Directorate. This detailed insight will enable the Trust to focus its efforts more effectively, tailoring interventions and initiatives to address specific needs within different parts of the Trust. By homing in on areas where improvement is needed, the Trust can ensure that its actions are targeted and impactful; ultimately leading to a positive and supportive work environment for all colleagues.

Angela Lewis stressed the importance of the alignment between the work on the People and Culture Plan and the Integrated Medium-Term Plan (IMTP) for 2024/25. The feedback from colleagues, particularly regarding health and well-being, resonates strongly with the initiatives outlined in these plans.

Moving forward, the Trust will continue to integrate feedback from colleagues into planning processes, ensuring that initiatives are responsive to their needs and concerns. This holistic approach will contribute to fostering a positive organisational culture where staff feel valued, supported, and empowered to thrive.

Comments:

It is concerning to hear that 29% of colleagues, as highlighted by Paul Hollard, have experienced harassment, and bullying but did not report it. However, the measures in place should provide support for those affected. Despite this issue, the overall report seems to reflect a positive outlook.

The Board expressed concern with the data around Line Manager satisfaction, particularly with regards to the levels of disagreement or neutrality, it appears that a significant portion of colleagues are not having a positive experience with their Line Managers. While it is encouraging that around 60% of colleagues are having a positive experience, there is clearly room for improvement to ensure that all employees feel supported and valued by their line managers. Moving forward, it may be beneficial to assess the reasons behind the dissatisfaction or neutrality expressed by some colleagues.

Angela Lewis explained that the Trust was launching the 'WAST Way' initiative focusing on the basics of management as a positive step towards addressing the need for improved leadership and management skills within the Trust.

Jason Killens added it was important to recognise and acknowledge the great

work that many managers are already doing to lead and manage their teams effectively. Their efforts play a crucial role in supporting and developing their employees, and it's essential to celebrate their successes. At the same time, it is also important to consider the context in which survey responses are provided.

Members queried if there was a plan to address issues at both the organisational and Directorate levels. Angela Lewis explained there would be a focus on tailoring interventions based on the size and specific needs of each Directorate. For smaller directorates where it may not be feasible to conduct separate initiatives, a more holistic approach at the organisational level will be taken. However, for larger directorates with over 20 people, there will be more tailored interventions to address their specific challenges.

The Board expressed concern that 73% of colleagues are coming to work despite not feeling well enough to do so. This raises several important considerations, particularly in the context of efforts to reduce sickness absence within the organisation. Angela Lewis informed Members of the initiative to collaborate with Directorate leads to delve into the underlying reasons why colleagues might feel the need to come to work despite being unwell.

The Board felt it was concerning, that regarding whether the Trust acts fairly in terms of career progression and promotion, that only 37% of respondents feel that the Trust acts fairly in this regard. There must be an opportunity to delve deeper into the reasons behind this perception and take actionable steps to address any underlying issues.

Angela Lewis acknowledged that the recurring perception of favouritism in cultural reviews underscores the importance of addressing this issue head-on. The perception of favouritism can erode confidence and morale within the Trust, impacting employee engagement and overall organisational effectiveness. Collaborating with Trade Union colleagues to address concerns related to favouritism is also crucial. They can provide valuable insights and input into the development of policies and practices that promote fairness and equity, as well as serve as advocates for employees who feel their rights may have been infringed upon.

Jason Killens added that the nuanced nature of fairness is essential for addressing perceptions of unfairness within the Trust. Fairness is not always about treating everyone the same; it involves considering individual circumstances, the environment, and the specific situation at hand.

The Board recognised the potential challenges associated with transitioning to a more diverse recruitment base was crucial for ensuring the success of diversity initiatives within the Trust. Moving towards a diverse recruitment base requires a

proactive approach to address potential barriers and ensure that the Trust is "change ready" to embrace diversity effectively.

RESOLVED: The Board:

(1) NOTED the contents of the report;

(2) COMMENTED on insights shared; and

(3) SUPPORTED delivery of our People and Culture ambitions, by actively amplifying the voices of our people and effectively role modelling our desired behaviours.

28/24 INTEGRATED MEDIUM TERM PLAN (IMTP) 2023 – 2026, Q4 DELIVERY & ASSURANCE

Rachel Marsh presented the report as read noting the Finance and Performance Committee had received the report at its last meeting on 19 March 2024.

RESOLVED: The Board Noted the overall delivery of the IMTP detailed in this paper as an interim Q4 position.

29/24 INTEGRATED MEDIUM-TERM PLAN 2024-2027

Rachel Marsh explained the purpose of the report is to update the Board on the progress of developing the 2024-2027 Integrated Medium-Term plan (IMTP) in the context of the Welsh Government Planning Framework and the Emergency Ambulance Services Committee (EASC) and 111 Commissioning Intentions for 2024/25, and to seek approval of the plan to submit to Welsh Government on 28 March 2024. Rachel Marsh drew out the following for the Board's attention:

There had been acknowledgment during the ELT conversation last week that staff play a critical role in delivering patient care which underscores the importance of prioritising staff well-being, development, and support within the Trust.

Financial sustainability alongside other types of sustainability, such as environmental and societal impacts, is crucial for ensuring the Trust's long-term success and its ability to fulfil its responsibilities as an anchor organisation within the community.

In the plan, the Board will notice a shift towards a more comprehensive three-year approach, offering a longer-term perspective on the Trust's goals and objectives. This extended timeframe allows for a deeper exploration of what success will entail for various stakeholders, including patients, staff, and other

facets of the Trust.

The development of the Integrated Medium-Term Plan (IMTP) this year followed a structured approach involving several phases or workstreams:

1. Engagement: This phase involved actively engaging with various stakeholders, including staff, the public, patients, trade unions, commissioners, and key partners.

2. Gathering Intelligence: In this phase, data and information were collected from multiple sources, including performance data, NHS Wales data, and other relevant sources.

3. Developing and Agreeing Priorities: Based on the gathered intelligence and stakeholder input, priorities were identified, developed, and agreed upon.

4. Integrated Technical Planning: This phase involved conducting integrated technical planning, which considers the implications of the IMTP across various areas such as fleet management, estate management, digital infrastructure, workforce planning, and financial management.

5. Writing the Plan: Once priorities were identified, and technical planning was completed, the actual drafting of the IMTP took place.

6. Governance, Assurance, and Approval: The final phase involved governance, assurance, and approval processes to ensure that the IMTP meets quality standards, aligns with the Trust's goals and strategies, and receives necessary approvals from relevant stakeholders or governing bodies.

To enhance patient services, the Trust is accelerating efforts to transform the response to patients' needs when they contact us or use our services. This will involve several key steps:

1. Introduction of Clinical Navigation Role: A new clinical navigation role within the Emergency Medical Service will be introduced. Senior clinicians will review all incoming calls to ensure appropriate screening and dispatch of ambulances for emergency and life-threatening situations. This role aims to expedite ambulance dispatches while ensuring patient safety.

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2. Expansion of Remote Integrated Clinical Service: The Trust will expand the capacity of its remote integrated clinical service to accommodate more patients remotely. This service allows the Trust to provide comprehensive care remotely, leveraging technology to meet patients' needs without requiring them to visit healthcare facilities in person.

Furthermore, the Trust is committed to expanding its mental health response services, including the rollout and expansion of Level 2 full-service provision. Connected Support Cymru will also play a crucial role in supporting remote clinicians, enabling them to provide comprehensive care remotely. Additionally, it will facilitate face-to-face responses when necessary. Through these initiatives, the Trust aims to adapt response capabilities to better meet the diverse needs of patients, ensuring they receive appropriate care and support.

Rachel Marsh added that from the perspective of patients, whether they contact via 111 or 999 it is crucial for the Trust to ensure that regardless of the access point consistent pathways and outcomes for patients are given. With the implementation of the new Clinical Assessment Software (CAS) system, the platforms available to remote clinicians will align, enabling a more unified approach to patient care delivery. This means that regardless of how patients reach the Trust, they can expect the same level of care and support tailored to their needs.

Rachel Marsh added that from a staff perspective, it is vital that the plan includes details for ensuring a positive workplace experience. The ongoing efforts, supported by the Executive Leadership Team (ELT), are directed towards driving improvements in areas highlighted by staff feedback. One critical area is addressing shift overruns, which was acknowledge should be within the Trust's control. While progress has been made this year, there is a clear imperative to do more to eradicate these overruns entirely. Additionally, enhancing flexible working arrangements remains a priority, and the Trust is actively engaged in positive developments in this regard, with ongoing initiatives extending into the next year. Furthermore, improving the digital experience for staff is essential for ensuring seamless access to and utilisation of digital platforms, thereby enhancing their day-to-day work life. There is an ongoing commitment to making these platforms more accessible and user-friendly, with the aim of simplifying tasks and processes for staff.

Moreover, the convergence of commissioning arrangements for 111 and EMS presents an opportunity to explore the creation of a unified remote integrated clinical care service that encompasses both 999 and 111 calls. This integrated approach has the potential to bring about positive benefits for patients, offering seamless access to comprehensive clinical care regardless of the initial

point of contact. By aligning commissioning structures, the Trust can better meet the evolving needs of patients and enhance the efficiency and effectiveness of healthcare services.

Achieving financial sustainability is a crucial pillar of the plan. The plan has been balanced with a £6.4 million savings target, which represents a 2.2% savings plan. While this is a significant challenge, it is noted that future years may present even greater difficulties. Therefore, the Financial Sustainability Programme will continue, with a heightened focus on income generation to supplement savings efforts.

Efficiency improvements are embedded throughout the IMTP, encompassing both clinical and administrative services. Robotic process automation is a key priority, as it streamlines processes and enhances operational efficiency across various functions within the Trust.

Rachel Marsh advised the Board that the IMTP has the support and endorsement of the Commissioner. His continued presence for the next three to six months will provide valuable continuity and assistance as the plan is implemented.

Rachel Marsh concluded by saying that the resources allocated this year enable the Trust to further advance its clinical transformation efforts. Over the years, the Trust has been diligently working on these initiatives, and now it has the opportunity to allocate resources strategically to accelerate progress in this area.

Financial Plan

Chris Turley provided a comprehensive revenue financial plan, emphasising it related to the upcoming fiscal year of 2024/25. This plan was developed over several iterations, and its key components have been communicated to members in previous months. As such, there were no unexpected elements.

A recent Executive Leadership Team (ELT) discussion has solidified the remaining elements necessary to implement the plan, including the associated resourcing plan.

The recent Finance and Performance Committee (FPC) meeting in March saw a productive discussion with thorough scrutiny, and the questions raised were addressed satisfactorily.

Comments:

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Bethan Evans shared feedback from the Finance and Performance Committee meeting, indicating that the Committee was content to endorse the plan. They recognised that it was supported by a balanced financial plan, despite the inherent risk associated with the £6.4 million savings target. The Committee also expressed confidence that the 3.67% revenue uplift would be passed through to the Trust.

She further mentioned they noted that the plan demonstrated ambition in delivering some of the longer-term aspirations. They also noted that the plan included very ambitious targets and discussed the resources and capabilities needed to achieve them. They also acknowledged the Trust's reliance on various external factors to execute the plan. The Committee commended the officers for presenting a clear, coherent, and ambitious plan and expressed their satisfaction in endorsing it.

The Board recognised that focusing attention on the areas where commitments have been made was a positive step forward from previous years is encouraging, especially with a clear visual indicator of progress and areas of focus.

Jason Killens was pleased to hear that the plan is generating excitement and that it feels like a year of action. He referred Members to the plan's appendix which illustrated swim lanes across the quarters which were a helpful visualisation to track progress and ensure alignment with objectives.

The Board sought to have a deeper understanding of the potential challenges and opportunities that may arise from the dependencies on system partners in delivering the plan.

Jason Killens explained that the Trust will continue to have emergency 999 response service commissioned through the new Joint Commissioning Committee (JCC). There is also a desire at local level for Health Boards as commissioners to commission the Trust as one of its providers as a national provider on a local level. This will help Health Boards respond to some of the local challenges they have. Furthermore, there is recognition the Trust is more than just a transport organisation, beyond transporting patients, the Trust plays a crucial role in providing emergency medical care, coordinating responses to crises, and supporting the broader healthcare system.

Following further discussion, the Board approved the plan for submission to Welsh Government, subject to any final editing. Members noted this decision signals alignment among them regarding the priorities, objectives, and initiatives detailed in the plan, and demonstrates their commitment to driving positive change and improvement within the Trust. The Board also approved

the 2024-2025 financial plan.

RESOLVED: The Board approved the IMTP 2024-2027 and the 2024-25 financial plan. The IMTP 2024-27 will be submitted to WG on 28 March 2024, subject to any final editing.

30/24 INITIAL REVENUE BUDGET 2024-25

Chris Turley advised that further to the detail provided in the finance section of the IMTP this update provides additional analysis of how the proposed balanced financial plan for 2024/2025 is translated into delegated budgets, the key assumptions made, and any remaining choices required in doing so.

The current planned resource envelope (planned income) for the Trust for the financial year 2024/25, as per the financial plan within the IMTP, totals £289.8m of which £277.0m is via (former) EASC commissioned services (£237.0m is planned EMS, £29.3m is Ambulance Care and £10.7m for 111 related services), £7.0m from other NHS Welsh Organisations, £4.6m from Welsh Government (WG) and £1.2m from other sources, of which £0.6m is assumed to be delivered via WAST Savings programme.

Key risks and issues identified in the financial plan include the need to ensure full recovery of all the updated income assumptions via commissioners, delivery of a £6.4m savings target as a minimum and the control of increasing costs such as enhancements that were put in as a result of the COVID-19 pandemic, a cost of living crisis, and continuing service and demand pressures, including that resulting from the ongoing challenges and levels of hospital handover delays.

The Board's acknowledgment of the report's presentation at the last FPC meeting on 19 March 2024, where it received endorsement for Board approval, reflects the thorough review and scrutiny it underwent before reaching the Board. This endorsement from the FPC further validates the comprehensive nature of the report and the strategic decisions outlined within it.

Comments:

The Board recognised the inherent risks associated with the plan, which were highlighted during the FPC meeting and approved the initial 2024/25 revenue budget.

RESOLVED: Trust Board Approved the initial 2024/25 revenue budget, building on the WAST Financial Plan included in the IMTP, and as endorsed and recommend by the Finance & Performance Committee at its meeting on 19 March 2024.

31/24 FINANCIAL PERFORMANCE MONTH 11

Chris Turley presented the report noting that a presentation had been reviewed and discussed in detail at the last FPC meeting. In terms of highlights, he drew the Board's attention to the following from the report:

1. The Trust is reporting a small revenue year to date surplus (£0.108m) for month 11 2023/24.
2. In line with the balanced financial plan approved as part of the submitted 2023-26 IMTP, and in year financial performance to date, the Trust continues to forecast a breakeven position for the 2023/24 financial year.
3. Capital expenditure is on track with plans to fully achieve in year.
4. In line with the financial plans that support the IMTP, gross savings of £6.079m have been achieved in month 11 against a target of £5.461m.
5. Public Sector Payment Policy is on track with performance, against a target of 95%, of 96.3% for the number, and 98.4% of the value of non NHS invoices paid within 30 days.

In terms of the 2023-24 Capital Programme the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2023/24 is £22.598m. This includes £18.277m of All Wales Approved schemes and £4.321m for Discretionary schemes.

RESOLVED: The Board

(1) Noted and gained assurance in relation to the Month 11 revenue financial position and performance of the Trust as of 29 February 2024;

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

(3) Noted the Month 10 and 11 Welsh Government monitoring return submissions included within Appendices 1 – 4 (as required by WG).

32/24 STRATEGIC EQUALITY PLAN (SEP) 2024-28

Angela Lewis gave the Board a PowerPoint presentation which outlined the development of the Strategic Equality Plan (SEP).

There have been extensive consultation efforts undertaken by the Trust, involving community groups, Non-Executive Directors, staff networks, and Directorate leads. Public consultation has also been conducted which is also crucial for ensuring that the perspectives and needs of the community are considered in the planning process.

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The Trust has implemented a rigorous governance process to ensure the realism and achievability of its plan. The SEP has incorporated direct feedback from Leaders in the Trust to enhance clarity around measures of success and emphasising leadership leading by example are key aspects for ensuring that the plan is well-rounded and effective. This approach helps to align the document with the Trust's goals and priorities while also fostering accountability.

The monitoring of progress was crucial for ensuring the successful implementation of the plan. The roles of the Non-Executive members of the People and Culture Committee in overseeing and providing assurance on progress are vital. Their ongoing involvement will help keep the initiative on track and ensure that any necessary adjustments can be made along the way to achieve the desired outcomes.

Angela Lewis added that the Trust continues to promote Equality, Diversity, and Inclusion (EDI) and ensuring its integration throughout the Trust is crucial for creating a supportive and inclusive workplace culture. This commitment is evident across various themes and particularly within the SEP.

She added it was essential for the Trust Board to play a role in shaping and influencing EDI initiatives, ensuring that they align with the needs of the communities served. By providing insight and actively listening to diverse voices, the Board can be assured that policies and practices are inclusive and responsive.

Hannah Rowan, as the EDI Champion, expressed gratitude on behalf of the Board, to the team for their efforts in developing the SEP. She highlighted that while the SEP provides an overarching strategic framework for the next few years, there will also be a detailed action plan accompanying it. This action plan will allow for specific tracking of improvements, identification of what is working well, and areas where additional attention or resources may be needed over time. This approach ensures that progress towards EDI goals is monitored effectively, and adjustments can be made as necessary to achieve desired outcomes.

Comments:

The Board were keen to understand how the Trust would be assessing performance of each directorate. Angela Lewis explained that assessing the performance of directorates and identifying areas for improvement typically involves a robust governance process. Feedback will be generated through the EDI steering group and monitored by the People and Culture Committee.

Members held a conversation which focused on supporting a diverse workforce and fostering an inclusive environment which involves actively promoting diversity and inclusion. The Trust's aim was to create a welcoming and supportive environment where all employees feel valued, respected, and empowered to contribute their best work.

RESOLVED: The Trust Board approved the final draft Strategic Equality Plan 2024-28 prior to the required publication deadline of 31 March 2024.

33/24 GENDER PAY GAP REPORT & WORKFORCE EQUALITY MONITORING REPORT 2022-2023

Gender Pay Gap

Angela Lewis explained that as the Trust is a public sector body, it is required to publish workforce data and assess the diversity of the workforce in relation to the population it serves. To do this, the Trust is reliant upon staff voluntarily completing the equality monitoring questions on the Electron Staff Register (ESR) and sharing their personal data. There are still many staff who have not yet provided this data. Therefore, the data published is not a full picture of the workforce. Actions have been identified within the EDI Workplan to work with the ESR Lead to develop guidance on how to update equality monitoring data on ESR and will develop a communication plan to build trust and confidence amongst staff to share this data and address these gaps.

The People and Culture Committee (PCC) has been proactive in reviewing past data and focusing on initiatives to drive progress forward. Reflecting on the progress made since the data from last year has provided valuable insights into the effectiveness of previous initiatives and areas for further improvement.

Angela Lewis added it is positive that the gender pay gap has not increased, but it is also important to acknowledge that it has not improved either. This highlights the need for continued efforts to address this issue. The work being done around flexible working, removing barriers to progression, and supporting opportunities for the female workforce is crucial. Additionally, implementing policies like carers' leave and aligning with legislation such as the Carers Act will contribute to making a difference in promoting gender equality and supporting diverse needs within the workforce.

Furthermore, it is encouraging to see that the work of the PCC is directly impacting the female workforce positively. Initiatives like leadership development programmes, support mechanisms, and reverse mentoring through networks like the Voices Network are making positive contributions. However, it must be acknowledged that there is still room for improvement.

Workforce Equality Monitoring

Angela Lewis advised the Board that the Workforce Equality Monitoring Report does not include bank staff, therefore, the total headcount of staff for 2022-2023 is 4383. The data for this report is pulled from different data tabs on the ESR which lacks some capability to breakdown data in relation to the workforce.

When assessing whether the workforce is reflective of the population it serves, there are some shortfalls in the following areas:

1. Non-White population in Wales 6.2% (Census data 2021)
2. WAST Staff from Black, Asian, Minority Ethnic (BAME) background 1.83%
3. People with a disability in Wales 21.1% (Census data 2021)
4. WAST Staff with a disability 5.93%

Angela Lewis expressed her concerns about the representation of individuals from Black, Asian, and Minority Ethnic (BAME) backgrounds within the workforce, especially considering the slight improvement has not reached the desired levels. Active efforts are being made to engage with the student population, universities, and organisations like Health Education and Improvement Wales (HEIW) and the Equalities Commission. Creating pathways for diverse talent from educational institutions is crucial, and while the desired diversity may not be reflected in the student population currently, these efforts can lay the groundwork for future improvements.

The Trust will be hosting a recruitment conference which will promote it as an inclusive and welcoming organisation. It will provide an opportunity to showcase the values and culture that make the Trust an attractive place to work for individuals from diverse backgrounds.

Comments

The Board noted there had been some limitations on the data being available and asked what steps the Trust was doing to improve this. Angela Lewis explained it was an issue with the Electronic Staff Register (ESR), that limitations in the current ESR pose challenges for accurately capturing gender identity data. There are also limitations in terms of reporting.

These concerns have been fed back in to the system and with the implementation of a new ESR, in 2024/25, things are expected to improve. While awaiting the implementation of a new ESR in 2024/25, the Trust can continue to explore alternative routes to accommodate colleagues who wish to identify in a way that suits them**,** but it is difficult because of those limitations

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and that is across the NHS in Wales, so it is a significant challenge.

In terms of the disability data, it was queried if a working age could be used as data to ensure more accurate comparison for future reports. Angela Lewis agreed to take this forward as an action.

Furthermore, there were several errors in the Welsh translation of the supporting documents which Angela Lewis agreed to arrange for them to be rectified.

RESOLVED: The Trust Board approved the Gender Pay Gap Report for 2022-2023 and the Workforce Equality Monitoring Report for 2022-2023 prior to publication deadline of 31 March 2024; subject to ensuring the accuracy of the supporting Welsh translated documents.

34/24 GOVERNANCE REPORT

Trish Mills presented the report for the Board to note drawing attention to:

Use of the Trust Seal

Three legal transactions were Sealed on the 25 January 2024 which follow the respective approvals sought at the Trust Board meeting on the same day. These were:

1. The renewal Lease of Unit 1A Spring Meadow Business Park, Rumney, Cardiff, CF3 2ES. The parties to this Lease renewal are the Welsh Ambulance Services NHS Trust and Sunflower UK Logistics Propco (2002) Ltd.

2. The disposal of land and buildings lying to the East of Y Gruffydd Road, Swansea (SA2 0GP) to Swansea Bay University Health Board and the need to executive as a deed the engrossment Transfer Deed.

3. The execution of the WAST Control Centre Lease (for additional space) with the Dyfed Powys Police and Crime Commissioner. The parties to the agreement were the Trust and the Dyfed Powys Police and Crime Commissioner (Carmarthen Headquarters, Llangunnor, Carmarthen, SA13 2PF).

The Board were updated on the decisions made in the private session of the Trust Board on 23 November 2023, 8 December 2023, and 25 January 2024; details of which were contained in the report.

RESOLVED: The Board noted the update.

35/24 BOARD COMMITTEE REPORTS

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

Quality, Patient Experience and Safety (Quest) Committee Meeting – 8 February 2024

The Chair of the Committee, Bethan Evans drew the Board's attention to the following areas that were discussed the Quest Committee meeting on 8 February 2024:

1. Lost hours due to handover delays were just under 27,000 hours in January and far more than what is acceptable. System pressures continue to present patient safety risks and extended waits in the community.

2. The Committee raised an alert following their April meeting as to the effect of the backlog and volume of concerns on the Putting Things Right and Operational Quality teams.

3. The Chair's Action taken between meetings to approve the Infection Prevention and Control Policy was ratified.

4. During this meeting, the Committee focused on the clinical indicator of Stroke. Further progress has been made with improving the Clinical Indicator dashboard which now includes the time-based metric for stroke; 'call to scene,' 'time on scene' and 'call to hospital door.'

5. The Patient story concerned Alison Cassidy who recounted the experience of her daughter Emma, who has a rare genetic disorder, severe learning disabilities and epilepsy. She needed urgent dental care requiring general anesthetic at Glan Clwyd Hospital and was advised by Health Care Professionals in the Health Board to access the Non-Emergency Patient Transport Service (NEPTS) to take Emma to her appointment (she was unable to be transported safely due to seizure risk being elevated by the dental pain).

6. The Committee reviewed progress on implementation of the Quality Strategy. The Board will recall that the strategy covers quality culture/duty of candour; quality management system; and integrating the citizen's voice. Whilst it was recognised that there were some areas

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where progress has been slower, a tremendous amount of work was acknowledged, and the newly appointed Quality Leads are central to taking this forward.

7. The Healthcare Inspectorate Wales (HIW) Annual Report 2022-23 was reviewed. The Committee noted that the issues raised, including system pressures and safeguarding, are frequent areas of discussion and oversight.

8. The Data Protection Policy was approved. This policy aligns to the requirements of the Data Protection Act 2018 and the UK General Data Protection Regulations. These cover the handling, security, and confidentiality of personal information.

9. This was the last meeting for Paul Hollard whose tenure as a Non-Executive Director ends on 31 March 2024. Paul was thanked by the Chair for his contribution to Quest where he consistently champions matters of patient safety, patient experience and quality.

10. The Committee reviewed the 2023 Medicines Management Assurance Report. This is the first report of its kind and content on future reports was discussed. Assurance was taken on this report, and it was good to see that the previous internal audit on medicines management was a good lever for change.

11. The Clinical Audit Plan update for Q3 was received with no escalations. The 2024/25 (Q1) Clinical Audit Plan was also agreed.

12. An update was received on a revised Audit tracker with 12% of Quest related management actions closed in the quarter and a number of historical actions revisited to open discussions on potential revisions of management actions due to the passage of time.

13. The Committee's annual effectiveness review was conducted and the draft annual report and changes to terms of reference agreed. Priorities for 2024/25 were also agreed. Final reports will be presented to the Board in May 2024.

14. 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. Both

have been reviewed in accordance with their schedules and the scores remain static.

People and Culture Committee (PCC) meeting – 20 February 2024

The Chair of the PCC, Paul Hollard drew the Board's attention to the following areas:

1. A staff story was received which concerned Darren Anthony. Darren is a newly qualified Emergency Medical Technician 2 (EMT) who joined the Trust in September 2020 after working in various private and public sector jobs, including the leisure industry. Darren had applied to the Trust 13 years ago but had to decline the offer due to family reasons. Darren completed the Level 4 diploma for Associate Ambulance Practitioners, which is an accredited education programme for EMT 2 roles. He was determined to excel on the course and achieved the highest marks. He also won the Skills for Health Apprentice of the Year Award for his achievement. He is also applying for the paramedic qualification, which he did not expect to have a chance to do.

2. The draft Health and Well-being Plan 2025-2029 was received for comment. The draft plan set out the principles for the approach to improving the health and well-being of our people and to provide strategic leadership to the Trust's health and well-being activities.

3. The Committee held its annual effectiveness review for 2023/24 and agreed changes to its terms of reference and focus for 2023/24. The annual report and proposed changes will be reviewed by the Audit Committee in April and the Board in May.

4. The Committee approved two policies, those being the All Wales Flexible Working Policy and the Homeworking Policy.

5. The people and culture elements of the IMTP 2024-27 were reviewed with members requesting a focus on evaluating impact of initiatives and the markers of success.

6. The Welsh Ambulance Services Partnership Team highlight report was received following their meeting on 15 December 2023, with members noting discussions.

7. In private session the Committee reviewed progress on four suspensions over four months (an increase from the previous quarter) and two cases lodged with the Employment Tribunal (a decrease from the previous quarter). Members were assured on actions in place to manage these

cases and an action was raised to ensure a consistent approach on payment during suspension.

8. The Audit Tracker was reviewed, and the Committee noted good progress in closing off items.

9. The reasonable assurance Retention of Staff Internal Audit report was received, with key matters arising including finalisation and ratification of the 'Moving on Interview' process, with a clear timetable for its roll out; and evaluation of the effectiveness of the initiatives that have recently been introduced to improve staff retention.

10. The Committee's cycle of business is on track with no escalations required.

11. Risks Discussed: The four risks within the remit of this Committee were reviewed as below:

    1) 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).
    2) 201 – (Damage to the Trust's reputation following a loss of stakeholder confidence) remains at 20 (4x5).
    3) 163 – (Maintaining effective and strong Trade Union partnerships) remains at a score of 16 (4x4).
    4) Risk 558 (deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences) remains unchanged and scores 15 (3x5).

The Committee also discussed risks 223 and 224 and noted the dynamic and consistent review of these risks across the Trust ensuring constructive collaboration between both.

Audit Committee meeting – 1 March 2024

Ceri Jackson, on behalf of the Chair of the Committee Peter Curran updated the Board as follows:

1. The reasonable assurance rated Vehicle Replacement Programme Internal Audit raised an issue of compliance with the Standing Orders, that being the approval of individual contracts by the Board in accordance with the Scheme of Reservation and Delegation (SoRD). Trish Mills explained that a governance practice note has therefore been developed and shared with auditors to provide clarity on the practical application of the SoRD with respect to awards of contracts by the Board and logistics that flow from that.

2. The 2024/25 Internal Audit Plan was approved.

3. The Board will recall previous AAA reports from this and other Committees noting that the number of Policies within their review date fell below reasonable levels during the Covid-19 pandemic as the policy work plan was largely paused and efforts directed to support the response. Work continued to ensure this was on track.

4. The Audit Wales Update was received as was the WAST 2023 Structured Assessment. The Board will be aware that Fflur Jones, Audit Wales, presented the Structured Assessment to the Trust Board meeting in January given the timing of the release of the report. Members noted the positive report and the improvements year on year, and thanked all teams involved.

Finance and Performance Committee Meeting – 19 March 2024

Bethan Evans, on behalf of the Chair of the Committee Joga Singh drew the Board's attention to the following areas:

1. A verbal update was received on progress with the Strategic Demand and Capacity Review. The timeframe for this to be presented at the Emergency Ambulance Services Committee (EASC) had changed given their transition to new Joint Commissioning Committee and a full update will be provided to this Committee later in the year.

2. An update was provided on the Financial Sustainability Programme (FSP) with significant progress made. In line with the savings plan that supports the IMTP, gross savings of £6.08m have been achieved against a year-to-date target of £5.462m.

3. The Digital KPIs relating to data and analytics, ICT systems, service provision and the IMTP for the period 1 January to 31 March 2024 were reviewed by exception.

4. The Value Based Healthcare Report was received and detailed the activities of the Value Based Healthcare Working Group (VBHC) and the key workstreams within its portfolio.

5. Upcoming changes to waste legislation in Wales requires the Trust to robustly recycle waste into additional segregated waste streams. New contractual arrangements and internal communications to staff are in place to meet these requirements.

6. The Committee held its annual effectiveness review and approved its

annual report for review by the Audit Committee in April and the Board in May. It also approved revisions to its Terms of Reference

7. The following internal audits were received: Decarbonisation, Vehicle Replacement Programme, Strategy Development, and ICT Contract Management.

Remuneration Committee Meeting – 8 March 2024

The Chair of the Committee, Colin Dennis presented the report as read.

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, and Assure process.

36/24 MINUTES OF COMMITTEES

The minutes of the following Board Committees were received.

1. Quality, Patient Experience and Safety Committee - 31 October 2023
2. People and Culture Committee -16 November 2023
3. Audit Committee - 30 November 2023
4. Finance and Performance Committee - 15 January 2024

The following NHS Wales Joint Committee update reports were received:

1. NHS Wales SSP Committee -18 January 2024
2. Welsh Health Specialised Services Committee Meeting Briefing - 30 January 2024
3. Emergency Ambulance Services Committee (EASC) dated 30 January 2024
4. Welsh Health Specialised Services Committee (WHSSC) Meeting 27 February 2024

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

37/24 ANY OTHER BUSINESS

The Chair noted this was to be Paul Hollard's last meeting and thanked him for his contribution over the past several years.

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Jason Killens acknowledged Paul's remarkable 50-year career in the NHS and expressed gratitude for Paul's courage and openness in sharing his personal journey with cancer. Paul's bravery in sharing his story not only inspires others but also fosters a culture of openness and support within the Trust. It is heartening to know that Paul's journey has led to positive outcomes, and his resilience serves as an example to all.

Paul Hollard thanked Colin and Jason for their kind words and wished the Trust ongoing success for the future.

38/24 EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC – 25 JANUARY 2024

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 28 March 2024.

Date of next Open meeting: 30 May 2024

Meeting closed at 12.27.

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ACTION LOG

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST BOARD

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
Minute 24/24	28 March 2024	Progress on Actions to Mitigate Avoidable Patient Harm	Overall lost hours at ED, to include details of the variation in performance across Wales for the Quest Committee's consideration.	Rachel Marsh	30 May 2024	Update for 30 May 2024 Action transferred to Quest	Complete
Minute 33/24	28 March 2024	The Workforce Equality Monitoring Report 2023 and the Gender Pay Gap Reports for 2022-23	People with a disability in Wales 21.1% using Census data 2021. It was queried if a working age could be used as data to ensure more accurate comparison for future reports.	Angela Lewis	30 May 2024	Update for 30 May 2024 The census data on disability has been age-standardised and is based on numbers per household, therefore, this figure should be used as being reflective of the local population of Wales. The census data only provides differences in geographical areas across Wales e.g. Blaenau Gwent has the highest percentage of disabilty (24.6%) and Monmouthshire has the lowest (17.7%).	Complete
Minute 33/24a	28 March 2024	The Workforce Equality Monitoring Report 2023 and the Gender Pay Gap Reports for 2022-23	To ensure accuracy of Welsh translations on the supported documents.	Angela Lewis	28 March 2024	Update for 30 May 2024 Any errors in the Welsh language versions have been corrected. The documents have also been amended to include the new Trust logo. The documents have been sent to the Comms Team to upload to the website.	Complete

AGENDA ITEM No	5
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	0

CHAIR'S REPORT

MEETING	Trust Board
DATE	30 May 2024
EXECUTIVE	Colin Dennis, Chair
AUTHOR	Colin Dennis and Trish Mills, Director of Corporate Governance/Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. On 25 April we held a Board Development session where we discussed the evolution of the clinical model within the Trust, had a focused discussion on engagement with Trust stakeholders, and a focused session on the Financial Sustainability Programme and the outcomes of work commissioned regarding commercialisation opportunities.

2. Over the last month I have met with each of the Non-Executive Directors for their respective annual appraisals.

3. I have been busy since our last meeting in January with the following: -
   - Regular meetings and briefings with Jason Killens, Chief Executive, and other Executives;
   - Regular meeting with the Minister for Health and Social Care together with Jason Killens;
   - Regular meetings with Ceri Jackson, Interim Vice-Chair, who herself has been very active in visiting Trust colleagues;
   - Bi-monthly meetings with Non-Executive colleagues to discuss a wide range of issues. Jason Killens joins us for the first half hour of that meeting and briefs us on current pressing matters;
   - Routine meeting with Head of Internal Audit, Osian Lloyd;
   - Panel membership of the WAST Live events;
   - Routine meetings with Trade Union colleagues;
   - Attended the regular Chairs Peer Group (all Health Body Chairs) 02 April;
   - Attended the Leadership Symposium in Builth Wells on the 10 April;
   - Attended various Chief Executive Roadshows w/c 15 April, including Wrexham, Beaumaris, Lampeter and Cardiff;

- Attended the AACE Chairs meeting and AACE Council meeting;
- Attended the Welsh NHS Confederation Management Committee on 30 April;
- I have taken the opportunity to visit various Trust sites and colleagues over the last two months, and these include visiting colleagues in the Clinical Contact Centre in Vantage Point House on the 11 April.

4. Lastly, I was able to attend the meeting of the Charity Committee on the 04 April where the Committee received updates regarding the Charity's performance and progress on the recruitment for the Head of Charity.,

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	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

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

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

CHIEF EXECUTIVE REPORT: 30 MAY 2024	
MEETING	Trust Board
DATE	30th May 2024
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 28th March 2024. 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 30th May 2024.

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 28th March 2024.

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, Association of Ambulance Chief Executives (AACE), Emergency Ambulance Services Committee (EASC), Joint Commissioning Committee (JCC) and senior elected representatives.
- Holding 3 full day Partnership Development sessions with Trade Union partners as well as participating in a WASPT committee effectiveness review meeting.
- Attending a North Wales Cross Sector Chief Executive meeting to explore collaboration opportunities.
- The Chair and I met the Minister for Health and Social Care to provide an update on current system challenges and organisational achievements.
- I undertook an operational shift with a paramedic based in the Aneurin Bevan University Health Board area.
- I attended a Board Development meeting with Powys Teaching Health Board to share our ambitious service change proposals and discuss opportunities for further partnership working.
- The Executive Leadership Team came together for 2 days focused on team effectiveness and our ongoing development together with moving forward specific aspects of our future ambitions such as those connected to business development/commercial activity.
- Over 120 of the Trust's senior leaders and managers attended a Leadership Symposium on 10th April with learning topics focussed on supporting the continued development of the Trust's cultural improvement journey.
- I was pleased to meet with the David Davies, the Secretary of State for Wales and Peter Fox MS to discuss the future development opportunities for Monmouth Ambulance Station.
- Seven Staff Roadshows were held during the week commencing 15th April. Over 500 staff and volunteers attended to learn more about the Trust's clinically led

planned service changes and learn more about the Wellbeing and Occupational Health offer, what the 'good looks like' in the future, our clinical indicators and the Duty of Quality.

- I was delighted to attend the very successful Paramedic 'Big Bang' recruitment event when 90 job offers were made to student and qualified paramedics.
- Together with the Chairman and our Executive Director of Paramedicine, Andy Swinburn I attended a general scrutiny session of the service by The Senedd Health and Social Care Committee.

OPERATIONS DIRECTORATE

Manchester Arena Inquiry (MAI)

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

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

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

6. Welsh Government and EASC (now JCC) have been briefed during the process and are set to receive the final submission on completion of internal governance endorsements.

Quality and Support Days

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

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

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

10. Three Quality and Safety days have been held so far, and themes and trends will be collated and fed back through the Senior Leadership Team.

Directorate Structure

11. The Ambulance Care Organisational Change Process (OCP) is almost complete, with filling of the last few posts currently underway. The OCP has allowed the service to begin to disaggregate the coordination elements of the service into its own dedicated service area. This will allow for improvements to be realised through consistency in service delivery, improved focus on quality assurance, and improved use of technology to support patients with booking and making enquiries regarding their transport.

12. The Operations Quality (OQ) OCP concluded on 10th March 2024, and finalising job evaluations and recruitment processes have begun. Interviews have been scheduled for early May for key positions including a role which will have ownership of the coroner responsibility for the Directorate alongside the Service Manager for OQ. It is anticipated that once all posts are filled, the department will be able to push forward with required Standard Operating Procedure (SOP) reviews which are currently outstanding and improve consistency of and compliance to HM Coroner requests. Additionally, there will be equitable learning and development provision across the three EMS Coordination Centres, increased leadership and management support within the department, and more opportunity and capacity to support the creation, development, and improvement of EMS Coordination processes and procedures.

13. In January 2024 the Senior Leadership Team and Executive Leadership Team approved the EMS Coordination plans for change and supported the plans with a recurring investment of £350k. These plans consider the demand and capacity reviews undertaken by ORH and involve the move to a single allocator model, the realignment of dispatch boundaries and desks to ensure equity of workload across areas, and the review of rosters to ensure that the resource modelling reflects the demand across the service. In conjunction, a new structure has been agreed that provides career progression from entry as a Band 3 Emergency Medical Dispatcher (call taker) right through to Director level within the organisation. The existing structure does not provide the necessary support to colleagues and has been widely accepted as insufficient to meet the needs of a forward-thinking emergency contact centre.

14. Colleagues within EMSC were engaged during February 2024 to start to socialise the proposals and Trade Union partners have been briefed. The OCP process of formal

consultation with staff commenced in early May. Alongside this process the EMSC Reconfiguration Project Board has commissioned distinct working groups to work with colleagues to help shape the implementation process and to ensure that outcome changes are implemented as smoothly as possible, particularly given the change in the dispatch operating model.

FINANCE AND CORPORATE RESOURCES

Finance

15. The outturn revenue financial position for the financial year ending 31st March 2024 reported a small surplus of £85k (subject to audit).

16. The Finance Team supported the production of a balanced revenue financial plan for 2024/25 year as detailed in the IMTP, following Trust Board approval in March 2024. Delegated budgets have now been rolled out and formal meetings between the Executive Director of Finance & Corporate Resources and Chief Executive and each Director would be completed next month.

17. The Finance Team continues to play a key part in helping the organisation to work through the significant savings plan and delivery required for the 2024/25 financial year which totals £6.421m. Themes and schemes to aid delivery have been identified and focus will now turn the delivery of the savings required for 2024/25. The Finance Team also continues to support the Financial Sustainability Programme (FSP) and the identification of schemes/themes for this and future financial years.

18. Two of the agreed objectives for the Finance Team for the 2024/25 financial year include:

- Developing our digitalisation of WAST financial performance and monitoring using dashboards and Qliksense tools
- Developing a programme of enhanced finance training for budget holders and non-finance managers

19. The 2023/24 capital programme delivered to plan despite a number of in year movements with the Trust achieving it's CEL with a small underspend of £10.06 against a budget of £21.932m (subject to audit).

20. Work is progressing in several areas to evaluate 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 and reconciling and reviewing this data has commenced to ensure consistency and accuracy. This will continue to be a key underpinning element of the continuing progress on our Value Based Healthcare (VBHC) agenda.

21. The Trust's 2023/24 draft financial statements were submitted to Welsh Government 3 May 2024 and the audit of the financial statements commenced on 7

May 2024. The audit certification deadline for the 2023/24 financial statement has been moved forward from 31 July to 15 July 2024. The audited accounts are expected to be signed by the Auditor General for Wales no later than on 15th July.

Capital & Estates

22. Dolgellau Ambulance Station – The updated procurement process has been completed and at time of writing is it anticipated that Trust Board (Closed Session) will be presented with an updated business case for approval of the revised amount, subject to endorsement by the Executive Leadership Team and Finance and Performance Committee. Discussions continue between NWSSP and the landlord regarding the lease. Currently, the programme is estimating between 20 to 24 weeks for completion. However, timescales are dependent on confirming the lease and the Trust taking occupation of the building before a contractor can start on site. The earliest estimate for staff occupation is November/December 2024, subject to the the lease being agreed by end of May 2024.

23. Llangunnor CCC – The Project Board continues to meet and has finalised the design and layout plans. The specifications for tender are being prepared so that the business case can be developed on the basis of tendered costs. It is anticipated that further value engineering or consideration of phasing will be required given anticipated costs, noting that this programme was always anticipated to span two financial years. Dyfed Powys Police is progressing the necessary actions to facilitate the enabling works to allow the Trust to take occupation of the space.

24. North Wales CCC Estate – The North Wales CCC Project Board continues to oversee this work. The estates work package is progressing with the move to RIBA stage 4 and preparation for the procurement process. Initial work to clear spaces within Ty Elwy and support preliminary works has concluded and work is ongoing to further enhance capacity for the required infrastructure.

25. Monmouth – The challenges with the current facility are acknowledged and the scheme has been prioritised within the 2024/25 Discretionary Capital allocation process. Work is underway to consider a number of options on a WAST only basis after discussions regarding a collaborative solution with South Wales Fire & Rescue Service and Gwent Police concluded that costs were likely to be unachievable within current budgets. Therefore, a Project Board will be established to develop the preferred option for the site and a business case prepared for further consideration in due course.

26. Thanet House – This scheme focusses on relocating staff from Thanet House, Swansea to Matrix House less than 1 mile away. The Matrix House building presents an opportunity to acquire a floor of the building owned by NWSSP on a rent-free basis, with minimal internal reconfiguration requirements. It is anticipated that the works will comprise of additional resilience and power back up. The project is currently being established and discussions are ongoing with NWSSP regarding the lease. This project will complete within the 2024/25 financial year.

27. Bangor Fleet Workshop – The project focusses on establishing a revised location for the Fleet Workshop within the Bangor area and will commence with the establishment of a Project Board and site searches supported by NWSSP Estates Services. It is anticipated that an element of the capital allocation will be for the provision of workshop equipment, but it is hoped that a unit can be sourced which will require minimal internal reconfiguration.

28. Decarbonisation/EFAB – All 5 2023/24 EFAB Project schemes were completed by the first week in May, with 4 of the 5 schemes completed by the end of the 2023/24 financial year. The summary below outlines work completed at each site:

- Blaenau Ffestiniog - Installed PV panels to roof, an air source heat pump has been installed and some additional works to include fire door replacement.
- Cardiff - Installed PV panels to the roof of Block B along with infrastructure upgrades including a Mansafe system (for safe maintenance of PV and roof access).
- Wrexham - All internal and external lights changed to LED, the existing PV array have been repaired and a Mansafe system installed.
- Bryncethin – The roof has been replaced and insulation installed in the crew room and garage, a redundant tank was removed, access to the roof has been improved and double gazing installed in the offices.
- Glynneath – The roof has been replaced and installation improved to the garage and crew areas, a redundant tank was removed, PV panels, LED lighting and an air source heat pump were installed, improvement made to roof access and some internal redecoration works completed.

29. Work is underway to prepare for the 2024/25 schemes, with a lessons learned exercise having been completed to ensure improvements to processes for the new financial year, and confirmation of scope. It is anticipated that these schemes will progress to tender early in Quarter 2.

Bids for All Wales Capital

30. Swansea Ambulance Station – This scheme has been re-highlighted to Welsh Government as part of a recent All Wales Capital prioritisation process. A preferred site within Fforestfach has been identified and negotiations regarding lease agreements are progressing well. The project is currently in RIBA stage 2 and indicative plans have been developed for use of the site. A resource schedule is in development to quantify further resources required for the initial stages of developing the proposals needed for inclusion within any BJC to Welsh Government.

31. Newport Ambulance Station – This scheme was also included as part of the All Wales Capital prioritisation process. Noting that the outcome of the AWC exercise is not yet known, work continues on the project start up elements including development of the Project Initiation Document, Terms of Reference and initial site searches. That said, further site searches will need to be conducted to establish suitable options.

32. Llanelli Ambulance Station – the Project Board will oversee NWSSP work on site searches to determine any current options for the development of a business case into Welsh Government. Again, as part of the AWC prioritisation process, it is not yet known what level of Welsh Government support the scheme will receive, but work continues to scope out the parameters of the project and options for progressing this scheme.

Improvements Across the WAST Estate

33. In 2023/24 a number of smaller improvement packages were delivered across a number of Trust sites, funded through an allocation of revenue funding. Whilst the scope of these works was varied and spanned across approximately 50 sites, a number of notable achievements to benefit the welfare of staff are highlighted below:

- Drainage repairs across a number of sites.
- Internal decoration and improvements to facilities within Blackwood Ambulance Station.
- Internal decoration at Brecon and Bronllys Ambulance Stations.
- Internal improvements to Hawthorn including the replacement of doors and windows.
- Relocation of 111 Team from Withybush Hospital to Haverfordwest Station.
- Replacement of the kitchen and a number of internal improvements have been completed at Merthyr Tydfil Ambulance Station.
- Improved external security and internal decoration improvements at Newport Ambulance Station.
- Internal and infrastructure enhancements undertaken at Tenby Ambulance station.
- Improved internal and external security and access, and resilience enhancements to Vantage Point House.
- Replacement of bins to support the segregation of waste in line with new waste management regulations that came into force from April 2024.

Fleet

34. In relation to the completion of the 2022/23 programme (2023/24 element), which included some agreed and planned carry over of monies into the last financial year by Welsh Government, the only outstanding order relates to 15 Ford Transit Customs, initially ordered in April 2022. These have been received and delivered to the nominated convertor and are expected to be delivered in the coming weeks.

35. 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 Welsh Government allocated was significantly less than required. The reduced funding resulted in a detailed re-prioritisation process and a decision was made to order 41 Emergency Ambulance chassis.

36. Those 41 Mercedes chassis have all been delivered to the nominated contractor, Wietmarscher Ambulanz-und Sonderfahrzeug GmbH and they are undertaking the

conversions of the chassis to coach built box bodied Emergency Ambulances. The commissioning program is being coordinated in unison with the MDVS roll out programme to minimise vehicle down time.

37. The 2024/25 Trust Board approved Fleet Replacement Programme and BJC was submitted to Welsh Government on 23 November 2023 requesting funding for the replacement of 157 vehicles at a cost of £24.4M. It contained an element of catch up from 2023/24. Indications from Welsh Government suggested that only part funding will be available.

CORPORATE GOVERNANCE

38. In March, the Corporate Governance Directorate team gathered for a two day event in Cardiff, a purposeful retreat dedicated to enhancing our collective work ethos and delving deep into the People and Culture plan. Embracing the methodology of appreciative inquiry, we celebrated the transformative impact we've achieved together in areas of corporate governance and the Welsh language. This was a time to acknowledge our past successes and to strategise our future direction. The focus was on refining our operational processes to improve everyday service delivery, boosting the integrated governance programme, and fostering team growth and satisfaction. These sessions were not just about looking inward but also preparing us to serve our business community more effectively, ensuring that as a directorate, we are fully aligned with our core objectives, our values and the strategic direction of the Trust.

39. We closed the applications for the roles of Vice Chair, Academic Non-Executive Director, and Non-Executive Director to chair our Finance and Performance Committee on 10th May. These key positions are integral to our leadership structure, each with a unique contribution towards the oversight and strategic direction of our organisation. With interviews scheduled for June, at the time of writing, we are in the process of carefully reviewing the applications to select candidates who demonstrate not only exceptional expertise and experience but also a commitment to our values and vision.

40. The comprehensive journey of our effectiveness reviews for all 7 board committees and the advisory group WASPT has reached a successful completion. This process was aimed at scrutinising and enhancing the operational efficiency of our committees. The findings from these reviews were presented to the Audit Committee on 30th April, marking a significant step in our commitment to transparency and continuous improvement. Today, this report stands before the Board, ready for further consideration and action. It reflects our ongoing dedication to governance excellence and our commitment to the duty of quality.

41. The Covid-19 Inquiry continues with the Module 3 statement signed and filed with the Inquiry Team. Work now commences on the redaction process of the 450 documents submitted in evidence of the statement. This is in addition to the significant piece of work to review the disclosure provided by other Core Participants in this module.

42. Work is underway to assess the externally commissioned report received as part of the Risk Management Transformation Programme. The report provides advice on the approach the Trust may take to develop a series of strategic risks and risk appetite statements as well as a review of best practice BAFs. The team has begun to outline an action plan and key milestones working towards the delivery of a strategic BAF that incorporates these elements and more closely reflects the Trust's strategic objectives. The next tranche of the work is underway in relation to Risks 223 and 224 and a revised way of articulating these ensuring the most efficient and effective way of managing them internally given the score has remained unchanged for a significant time.

43. In March, the Trust hosted the first event of the Ambulance Q network, 'Ambulance Q 24', at the Principality Stadium, Cardiff. The aim of the event was to bring NHS Ambulance Services together to understand cross-organisational challenges, opportunities for improvement and seek new ways of working, to build a network of like-minded people focusing on shared learning, collaboration, and co-delivery of improvements in patient care. The event had a Welsh language component including an automated bilingual registration platform, bilingual displays, and bilingual greetings as well as introductions from WAST staff. The introduction of the Trust's new bilingual crown badge will promote the Trust's commitment to the Welsh language to our service users and our people. In April, a WAST Strategic Workforce Plan collaborative engagement workshop was held which successfully outlined actions for implementation within the Welsh language theme. Following Trust Board approval, the team will proceed to develop an implementation plan dedicated to executing these actions effectively.

STRATEGY, PLANNING AND PERFORMANCE

Strategy, Planning and Transformation

44. The Integrated Medium Term Plan was submitted following Trust Board approval on 28th March 2024. Since then, work has been ongoing with colleagues across the Trust to confirm the delivery milestones, programme delivery structures and benefits set out in the plan. We have also been formally asked to develop a delivery plan against the Six Goals for Urgent and Emergency Care programme.

45. A major element of the IMTP over the next 3 years is the transformation and delivery of further revisions to our integrated clinical model across WAST services (999, 111 and Ambulance Care). A week of clinical workshops were held during May in Cwmbran bringing together clinical, operational and corporate colleagues to start the process of designing the new model. A further output, being led by the Head of Transformation, will be the development of a restructured transformation programme into a single holistic programme and a more streamlined approach to wider IMTP and local delivery plan (LDP) assurance. This will release people to focus on delivery and allow the team to prioritise Project Management capacity, directing this towards projects within the Transformation Programme with support to Directorates to follow a 'Project Path Framework' for wider IMTP work.

46. The new Project Path Framework developed by the Transformation Support Office has been approved by the Integrated Strategic Planning Group and is available on Siren along with a comprehensive toolkit and template documentation for project leads across the Trust. The next step will be engaging through communication and awareness training to promote the resources, making processes more efficient across the Trust.

47. In support of IMTP and LDP delivery, the team has been developing Verto, a project management software system. The system has been 'soft launched' for two projects coming out of the emerging Transformation Programme. This will need to be carefully managed due to capacity and other competing priorities, but we have re-energised implementation and will start to incrementally testing the system with a view to rolling it out further across the Trust to support delivery and assurance.

48. The Planning Team continues to work with the health boards and collaborative regional programmes as they consider the strategic changes across the South East Region and strengthened work on collaborative plans and the implications for WAST going forward. Recently, they have been working with the South East Wales Ophthalmology Programme to consider potential options to support the region with travel to cataract outpatient appointments and surgery. The team has also worked with Health Boards on commissioning of services set out in WAST's strategy and IMTP, including the pilot of a Mental Health Response Vehicle in Gwent. The trial period, supported by Regional Partnership Board funding via Aneurin Bevan, has been successfully completed and evaluation is underway. Early indications echo findings from other services across the UK, which have shown good results. This will be a service option that can support our wider transformational change across 999 and 111 services.

49. The team has also been leading on collaborative work with Aneurin Bevan, following a workshop on 7th March 2024 and there are fortnightly meetings with the Health Board aimed at delivering some of the outputs of that workshop.

50. In terms of other Health Board engagement, the team has been involved in the following live workstreams:

- Hywel Dda Clinical Service Model – a range of workshops aimed at transforming the way specialties are delivered by the Health Board, with a particular focus on fragile services. This may lead to changes in flows and journey times across both 999 and Ambulance Care.
- Swansea Bay Refreshed Urgent Care Board - focussed on target interventions, again with potential changes in flow.
- Powys – further progress on the Hereford and Worcester stroke model which will change flows into England for the Powys population.

51. The Assistant Director of Planning & Transformation has been leading two key areas of work for the Trust: a project to determine the model for transfer and discharge services (aligned to work on a new clinical model across all our frontline services) and

a service review of business areas across Corporate and Operational services. The original design for Transfer and Discharge services was based on engagement with Health Boards prior to the pandemic. This has been modelled by ORH and presented options to re-engage with Health Boards, as they continue with their own strategic service reconfigurations and regionalisation agenda. A key component of the work to develop a model for transfers and discharge is the implementation of new protocols (known as MPDS) in the Computer Aided Dispatch (CAD) system that will improve our handling of requests for inter hospital transfers, enabling specifically designed questions to assess the response required incorporating, for example, equipment needs, also enabling us to monitor demand more effectively by specialities to support strategic service reconfigurations across Wales.

52. The service review has been ongoing during a busy operational period for the Trust. However, there has been some positive outputs already, particularly in our ability to better understand the structures and interconnectedness of services across the Trust. Whilst there has been some slippage, it is expected that a report will be made to the Executive Leadership Team in Quarter 2.

Commissioning & Performance

53. Quarter 4 was a busy period for the Commissioning & Performance Team as it supported the development of the 2024/27 IMTP with commissioning and performance information, in particular, negotiating the commissioning intentions for 2024/25 for 111, EMS and NEPTS and working through the metrics for the Ministerial templates.

54. Equally, the team continues to support ELT with all the accountability meetings they have to attend, ensuring that Executives go into these meetings with papers that clearly articulate the challenging context the Trust is operating in, its plans and current quality & performance. Whilst the Trust received positive feedback in its structured assessment for its Quality and Performance Framework, an area of focus remains ensuring consistently good practice across the Trust in this regard. The Quality and Performance Management Steering Group is meeting monthly in support of this with its work plan going to ELT in the coming weeks. In the first quarter a major area of focus will be around development metrics that better measure the Trust's strategy.

55. The EMS Operational Transformation Programme Board met for the last time on 3 May 2024, with the programme's closure and evaluation report going to the Strategic Transformation Board. This programme delivered an uplift of 343 FTEs, re-rostered every EMS Response roster (146) across Wales and implemented a new responding resource; CHARU. The project closure report, will in due course, also come before Trust Board given the scale and impact of the change that has been delivered.

56. Finally, a major area of focus for the Commissioning & Performance Team in Quarter 4 has been the final stages of the 2023 EMS Demand & Capacity Review. The Review provided an initial estimate of the patient flows for the updated clinical model and different resourcing scenarios based on a traditional conveyance model

(prohibitively expensive) and new ways of working. The report is planned to go to the next Trust Board. The team is supporting associated work on the expansion of APPs, rebasing UCS and related technical planning.

CLINICAL DIRECTORATE

Visit to Yorkshire Ambulance Service (YAS)

57. Members of the Clinical Directorate, EMSC and Integrated Care recently visited YAS to gain an insight into the implementation of their rapid clinical screening. A warm welcome was received by the team along with an honest perspective of the role and how it supports the overall strategic vision for their organisation. Operating what is described as a 'push' model, the individuals undertaking the screening have an opportunity to review the call details and make clinical judgements on the appropriate routes of referral such as an urgent care centre, specialist asset or falls service. The team witnessed a large number of calls that were swiftly transferred to other services without the requirement for secondary triage, with YAS reporting around 1,000 patients a month being transferred to other providers (including private triage/validation hubs). Their focus surrounding the patient receiving the right advice or care has also expanded in other areas with the development of additional skills for their paramedics in relation to mental health. The information gained from the visit was highly valuable and will inform the development of our own future models.

Palliative Care Paramedic (PCP) Rapid Response Service

58. The Trust is currently piloting a Palliative Care Paramedic (PCP) Rapid Response Service in the Swansea Bay University Health Board area. The PCP Rapid Response Service has been set up to help support avoidable hospital admissions where appropriate, and to help ensure the required support is provided for patients with a palliative care need in the patient's usual place of care/home. The car is a dedicated resource that WAST can dispatch to palliative and end of life patients who access 999 due to sudden or unplanned crisis events.

59. The decision regarding the appropriateness of the call may be made by the APP navigator or by the PCP themselves. In addition, on scene ambulance clinicians are also able to request the support of the PCP via their local APP navigator for patients that they have identified as being someone who would benefit from their support. This service provides another mechanism for the Trust to be able to help to fulfil the wishes of the patients at their end of life.

End of Season Flu Campaign

60. The Flu Campaign within the Trust came to an end in February 2024 with the Trust reporting a final uptake of staff vaccinated of 36.5% of WAST staff and a 44.2% engagement rate. The number of staff vaccinated is a decrease of 8% from last year's

campaign and this is also reflected in the number of patient facing staff choosing to receive the vaccine. The campaign has considered the impact of changes to the peer vaccinator process, external vaccination settings as well as staff working from home. Learning from this year's campaign, an extensive set of recommendations have been devised that are based upon streamlining processes, removing duplication of effort and continuing to improve our engagement with the workforce.

Clinical Conferences

61. The directorate recently hosted two Clinical Conferences across Wales aimed at exploring the clinical services that are provided by the Trust, the different roles, career pathways and the professional development options available to staff. An exciting range of speakers delivered a jam-packed agenda that covered a variety of current and topical clinical areas. The afternoon saw the attendees actively participate in workshops based around improving clinical skills in the areas of maternity, palliative care, airway management and mental health. Excellent feedback on the event was received with around 150 staff having attended from across Wales.

DIGITAL SERVICES

Mobile Data Vehicle Solution

62. The MDVS project continues to deliver at pace, with over 587 vehicles now installed with the new technology. All barring a small number of EMS vehicles have been completed, with the new (40) Emergency Ambulance fleet being installed as they arrive at the Commissioning Centre. Plans are in place to re-locate a small number of MDVS screens in older Rapid Response Vehicles with significant progress being made with the NEPTs fleet, it is anticipated that all installation activity to be completed by the end of June 2024.

63. Feedback received from operational users has in the main been positive, though several minor areas of concern were highlighted, each having been investigated with actions either taken or in progress to address these.

111 CAS – Technical Update

64. In recent months, the ICT Department has focused on preparing the technical infrastructure essential for the new 111 system. This preparation included installing, configuring, and testing all servers and system software, as well as establishing connections between the new system, the Trust 999 system, and Health Boards systems to enable electronic case transfers.

65. Since its launch on 30 April 2024, the system has demonstrated good and sustained performance, particularly under heightened live 'user-loads'. Moving forward, the next steps include decommissioning the previous Capita system and continuing to support and enhance the functionality of the new system.

Cyber Security Posture and Monitoring

66. The ICT Department has responded proactively to a recent cyber incident affecting another Ambulance Trust with which we share a common supplier. This incident has provided the Trust with a valuable opportunity to improve our cyber security posture.

67. In direct response, we have implemented enhanced patching levels and undertaken significant infrastructure upgrades to bolster our defences against potential future threats. We have enhanced our cyber monitoring levels and continue to monitor the situation closely.

MIQPR/Always On 'Go Live'

68. The Health Informatics team has successfully deployed the initial version of the "Always On" reporting system, which represents a fully automated adaptation of the MIQPR. This initiative is a direct response to the Duty of Candour and involved collaborative efforts from the Digital, Strategy, and Quality Directorates to establish operational functionality.

69. Significant technical advancements were necessary to enhance data collection processes across the Trust, moving away from manual methods such as emails and manual data entry. This improved data, integrated with existing data from our core operational systems, was then structured to facilitate automated and reportable outputs. Additionally, a new dashboard was designed to not only mirror the traditional MIQPR report but also to enhance it, providing added value.

70. This dashboard is now accessible to all Trust employees, and we are actively developing further iterations to incorporate additional metrics.

PARTNERSHIPS AND ENGAGEMENT

71. The Trust was awarded University Trust status in April in recognition of its commitment to develop its current and future workforce and to drive research and innovation. The new name is the Welsh Ambulance Services University NHS Trust, and a phased re-branding exercise to reflect this, as well as a new Crown Badge following the coronation of King Charles III, has begun in earnest. The world-class research the service leads on was celebrated in a story about drone-delivered defibrillators, which generated a wealth of media coverage.

72. The CEO Roadshows were a good opportunity to engage with staff and volunteers and articulate the Trust's ambition for the future, which is to be a 'gateway' to the right care, in the right place, every time. Colleagues will be instrumental in that transformation journey, as will stakeholders, and a plan to engage with partner organisations and garner their support is in development. Key to developing our strategy is understanding more about how partners and stakeholders view the national ambulance service of Wales, and a 'reputation audit' throughout April and May – in which more than 200 stakeholders were invited to share their views about the service,

including progress made and opportunities in the future – offered a rich insight in that regard. A social media survey which ran in parallel will help to shape the way the Trust uses social media in the future. Both audits will influence our engagement strategy with stakeholders and the public as we explain more about the refresh of our clinical model.

73. The advert for the Trust's first Head of Charity role is now live, and work to develop a brand identity to raise the profile of the charity is underway. Plans to host Long Service Awards in June are also gathering pace. Almost 300 colleagues have been invited to celebrate 20, 30, 40 and 50 years of NHS service at one of three events across Wales. Next month is also when the Trust becomes a public body covered by the Well-being of Future Generations (Wales) Act, one of a number of bodies which either weren't covered by, or didn't exist, when the Act first came into being in 2015. Work to develop and publish the Trust's wellbeing objectives is in progress.

QUALITY SAFETY AND PATIENT EXPERIENCE DIRECTORATE

Implementation of NHS 111 Wales Clinical Digital System

74. On 30th April our service went live with a new NHS 111 Wales clinical digital system. This system was conceptualised, designed, built and implemented by colleagues from across the Welsh Ambulance Service and, our partners Priority Solutions and MIS Emergency Systems. The work required to deliver this has been significant for the organisation as the timescales were extremely constrained. As well as the design and build teams, the requirements for building training packages to support our colleagues working in the NHS 111 Wales service and deliver them flexibly and at pace was significant. All of our people across the NHS 111 Wales service have engaged positively offering significant discretionary effort to ensure that the service launched on time, on budget and most importantly, safely for the population of Wales.

75. Alongside this work, we have worked with Commissioners and Welsh Government to commission an independent review of our NHS 111 Wales online digital presence. This comprehensive review will report in June and will inform discussions with Welsh Government and Commissioners decisions on the opportunities to exploit digital opportunities that empower patients accessing NHS 111Wales through the online presence. We genuinely believe that we could leverage digital capabilities to further empower and support patients in need of healthcare advice and guidance and expect this work to enable this.

All Wales Learning From Events Programme

76. The Welsh Ambulance Services University NHS Trust recognises that organisational learning plays a vital role in the continuous improvement and development of healthcare organisations. Creating a culture of learning is crucial for our organisational improvement and the delivery of person centred, high quality services, whilst supporting staff wellbeing. Since September 2023, the Trust, represented by the then Deputy Head of Patient Safety, has been participating in the All Wales Enhancing

Learning Programme. Through this programme, an all Wales framework for Learning from Events has been developed to provide a consistent, but adaptable approach to capture and share learning both internally and with system partners. Next steps are for the Trust to develop a bespoke version of the Framework to determine improvement opportunities in harnessing and sharing learning across the organisation and externally and also to highlight and replicate current good practice.

Infection, Prevention and Control

77. The majority of Respiratory Protection Equipment (RPE) within the Trust is currently provided in the form of tight fitting re-useable and disposable face masks and powered air purifying respirators (PAPR). In June 2023 a multidisciplinary Task and Finish Group was set up to look at the approach taken by the Trust and recommend any changes necessary to ensure the Trust remains prepared for any future respiratory acquired communicable disease outbreaks. The outcome of the Task and Finish Group was to recommend that PAPR with hoods are available on all Emergency Medical Service vehicles, removing the requirement for fit testing. The additional financial investment has been approved and the implementation of the project has commenced. This is an important step to maintain the safety of our people and the patients they care for.

Safeguarding

78. The Safeguarding Team have updated Docworks with a new Dementia Referral Form available and the PREVENT Referral Pathway has been digitalised. Live Fear Free Referrals are available digitally to all colleagues, anyone can refer domestic abuse or sexual violence incidences via Docworks.

79. The team were delighted to be presented with the 'Best Safeguarding Team' Award in recognition for their commitment to safeguarding and protecting vulnerable people across Wales and the UK.

80. The Trust have successfully appointed to the role of Assistant Director of Safeguarding and Vicki Maxwell joined the Directorate on Monday 20 May 2024.

PEOPLE AND CULTURE DIRECTORATE

Culture

81. At the recent round of CEO staff roadshows colleagues took the opportunity to promote the Trust's Strategic Equality Plan and as a result the EDI Steering Group are working to build on the feedback received and develop meaningful actions.

82. Staff and volunteers attended Aberystwyth Pride on the Proms in April to begin our Pride celebrations across Wales this year. The LGBTQ+ Network recruited new members at this event and had the opportunity to network with other LGBTQ+ networks and their members within the Ceredigion area. The Trust will also be

attending Pride events at Swansea, Cardiff, Llanelli and Wrexham, signalling our commitment to ensuring that all of our people feel a sense of belonging and inclusion in the workplace.

83. Central to the purpose of the Culture Champions Network is the role modelling of positive workplace behaviours, enabling individuals and teams to be 'Our Best'. In response to valuable feedback from our Culture Champions in a recent survey, the purpose and expectations of the network has been further refined and the focus for this year will be on increasing visibility and impact of the network.

Capacity

84. Work is ongoing to provide data for our first Workforce Race Equality Standards Report (WRES). The data provided in the WRES report will give a baseline for the Trust to assess the experiences of our Black, Asian and Minority Ethnic staff; it will also feed into an NHS Wales WRES report which will be used to inform future actions for NHS healthcare providers as part of Welsh Government's Anti-Racist Wales Action Plan.

85. The Trust reported a decrease in sickness absence for March; 7.67% from 8.50% in February 2024. This is the lowest monthly percentage since June 2023. Long term absence decreased from 6.34% in February to 5.31% in March and short-term absence increased from 2.16% in February to 2.35% in March. Anxiety/stress/ depression remains the highest reason for absence, with MSK the second highest. Indicative figures for April also appear to be positive.

86. The launch of the revised All Wales Flexible Working Policy has now taken place. The revised policy will ensure our colleagues from day one of employment can request flexible working arrangements. The new policy supports the Trust's aspiration to welcome and encourage a more flexible work environment.

Capability

87. The Trust is participating in a series of learning events in this year's NHS Wales Equality Week which will cover a range of equality, diversity and inclusion topics. Working in partnership with the Equality Leadership Group, the Trust will be delivering a session on 'Sexual Safety in the NHS' to staff across NHS Wales. NHS Equality Week will also be preceded this year by the first ever NHS Staff Networks event. This virtual event will bring together network members from across NHS Wales where they will learn about network development and have the opportunity to network with other networks. Some of our Network Chairs will be leading a session on 'Growing a National Network', providing advice on how to maintain network inclusivity and events over large geographical areas.

88. The energy and engagement by colleagues at the recent Leadership Symposium was exceptional. Our focus remained on the themes of leadership and culture, explored through the lens of human factors. Internal teams and colleagues actively contributed to the event by showcasing tools and techniques, proposing suggestions to improve our services, and encouraging leaders to play a more proactive role in our culture change journey.

89. In line with our commitment to nurturing leaders, the People and Culture team provided an update on the work underway to develop a comprehensive framework for supporting leadership and management within WAST. Feedback gathered from the Symposium will be critical in shaping our next event later this year, ensuring it continues to meet the evolving needs of our organisation.

90. Mandatory In-Service Training (MIST) for 2023/24 ended in March with 92% of our road based workforce attending. Whilst this is a significant improvement on previous years attendance, compliance with this requirement needs to improve. The 2024/25 MIST programme started last month with 402 ACA1, ACA2, EMT and Paramedic colleagues already having attended to date. Feedback from those attending continues to be positive indicating the value placed on the experience by colleagues.

91. The first cohort of Trainee EMTs to commence their Higher Apprenticeship since the Trust attained University Status met at Matrix House 22 April - they will be joined by further intakes in May (Cardiff) and June (Newtown) and swell the student numbers across our Workforce Education & Development Centres as we develop ACA colleagues across the country and prepare for induction of this years Newly Qualified Paramedic (NQP) intake. The annual graduate recruitment exercise took place in Swansea with the Trust making offers of employment to 90 NQPs and experienced Paramedics.

RECOMMENDATION: That Trust Board are invited to discuss and note the contents of this report.

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

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

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

MEETING	Trust Board
DATE	30th May 2024
EXECUTIVE	Jason Killens, Chief Executive
AUTHOR	Rachel Marsh, Executive Director Strategy, Planning & Performance Hugh Bennett, Assistant Director Commissioning & Performance
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 original report was accompanied by a supporting action plan designed to mitigate patient harm. Updates have been provided at every subsequent Board meeting.
2. Good progress continues to be made on actions that the Trust can control both from a tactical and more strategic perspective; however, the Trust does not control the biggest variable that is affecting patient safety, namely, the levels of handover lost hours with handover lost hours in April 2024 at nearly 24,000 hours.
3. Long response times coupled with extended lengths of time in ambulances waiting for handover leads to avoidable patient harm. For the 3-month period March 2024 to April 2024;
    - 1,667 patients could have come to severe harm as a result of being held on an ambulance for longer than an hour outside an ED;
    - 26,973 patients will not have received a response due to the operation of the Clinical Safety Plan or through the patient cancelling the ambulance; and
    - There were 51 severe cases of avoidable harm, including death, referred to health boards under the Joint Investigation Framework.
4. This report sets out the actions that are being taken to mitigate and reduce risk

and harm.

RECOMMENDATIONS: Trust Board is asked to:

(1) NOTE the continued level of avoidable patient harm.
(2) 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**
21 May-24	**Executive Director of Strategy, Planning & Performance & Executive Director of Operations**
30 May-24	**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 the Board with an update on actions being taken to mitigate this patient harm.

BACKGROUND

2. The 28 July 2022 Trust Board received the first iteration of a report and actions to mitigate real time avoidable patient harm which has then been updated for every Board meeting.

ASSESSMENT

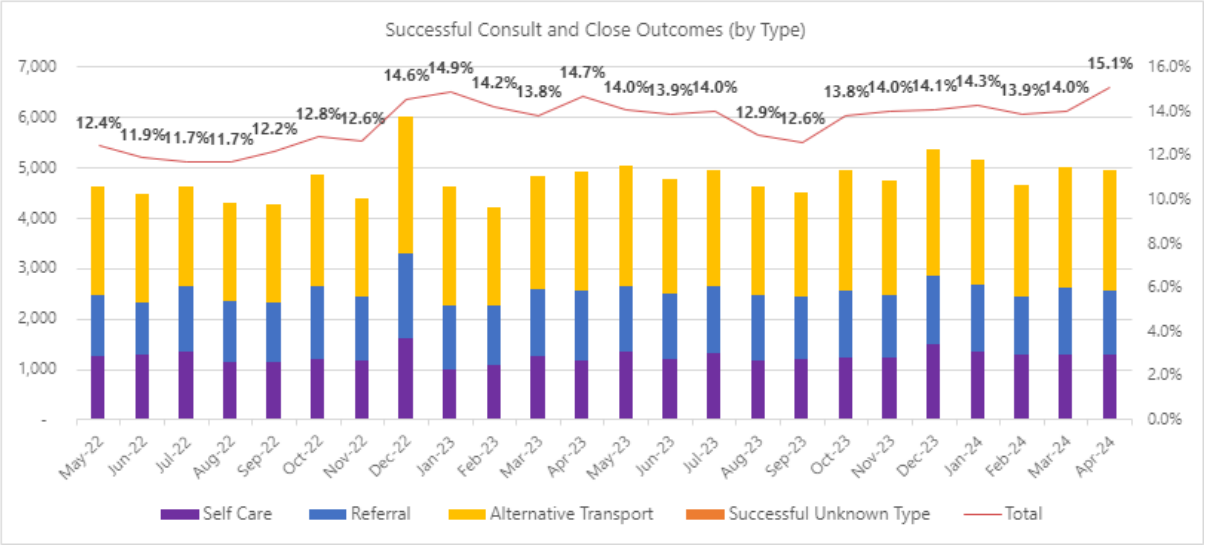
Patient Harm & Mitigations

3. *Appendix 1* contains an updated action plan with a narrative update on each action. Many of the actions contained in the Board report from July 2022 have been completed and removed. Of the 27 actions live when last reported to Board:

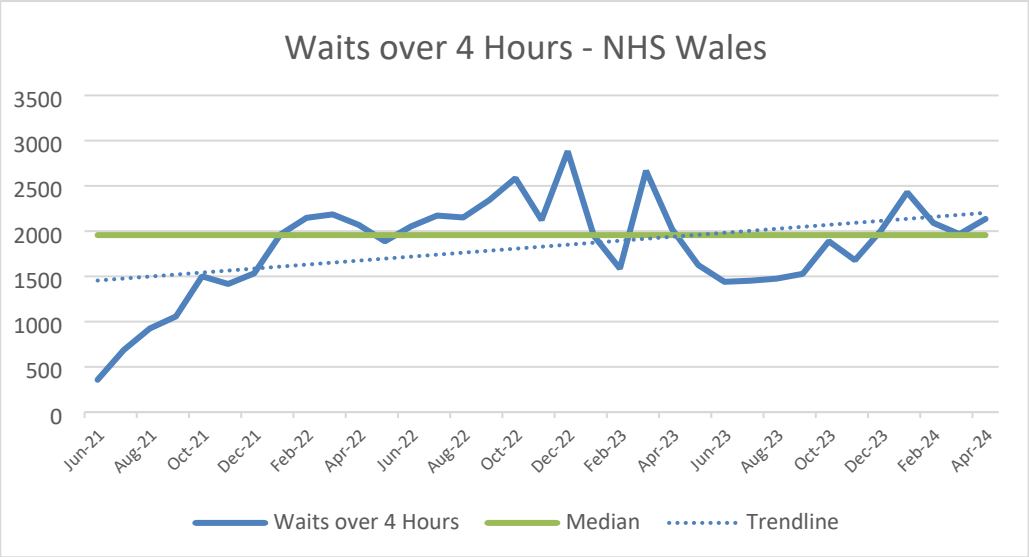
   - 5 are red (significantly off target);
   - 3 are amber (off target);
   - 14 are green (on target); and
   - 1 have been completed.

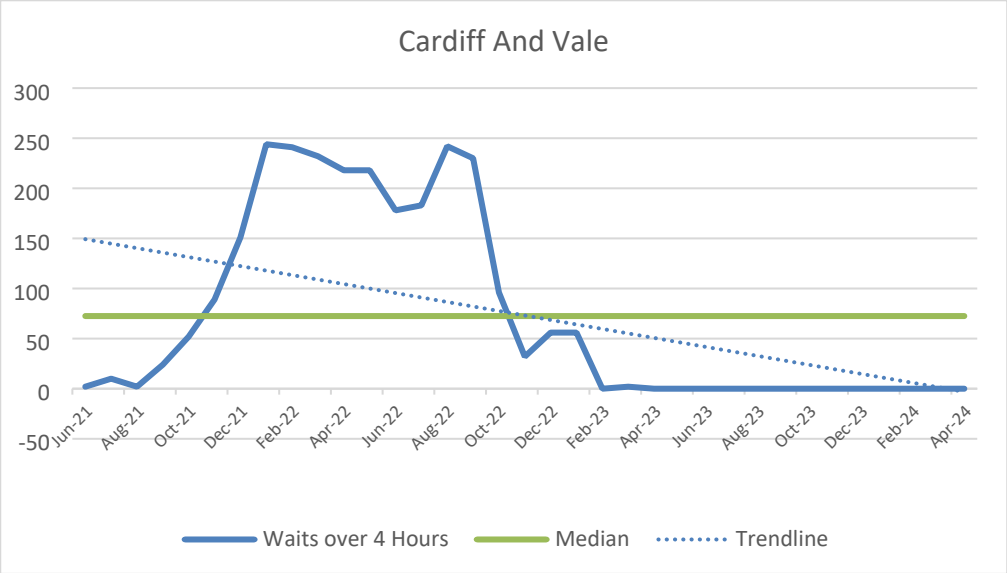
4. The five red (significantly off target) are:

   - **Sickness absence to 6% by March 2024**: whilst missing the target and being RAG rated red, the Trust achieved 7.67% in March 2024 which demonstrates a significant shift in the right direction over the last 12 months.
   - **Consult & Close ambition 17% by Q4 2023/24**: the Trust achieved 15.1% in April 2024, which is the highest rate the Trust has achieved. In terms of volumes of calls closed remotely, the Trust is also trending upwards.



- **Reduction in emergency department handover lost hours:** EASC set a target of 15,000 hours lost by the end of Q2 and 12,000 hours lost by the end of Q3. Handover lost hours in April 2024 were 23,614 compared to 23,082 in April 2023.
- **Eradication of handover waits of > 4 hours**: there were 3,404 over four hour patient handovers in April 2024, compared to 2,730 in April 2023. The expectation is that these would have been eradicated by end of 2023/24. Cardiff & Vale UHB has demonstrated material improvement and is a positive outlier when compared to other health boards. Recently, Welsh Government have re-iterated to Health Boards that the reduction in long handovers is a priority for this year with an expectation that over 1 hour waits would be reduced by 30% by December 2024.



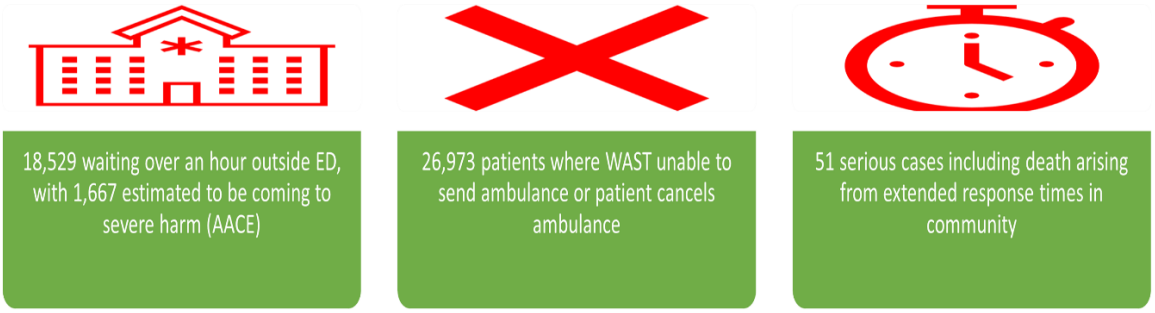


- **Implementation of Same Day Emergency Care (SDEC) services in each Health Board**: SDEC referrals accounted for 0.25% of verified demand. Trust modelling indicates 4% of the Trust's verified EMS demand could go into SDECs if the nationally agreed referral pathways

were in place. It is important to note that SDECs do not only take referrals from WAST, but also from other sources, including Emergency Departments. Therefore, SDECs have been implemented, but the pathways into them from WAST are not working as initially intended.

5. Whilst a RAG rated green action, based on the Trust completing its actions, 237 immediate release requests for Amber 1 incidents were declined by health boards in April 2024: AB 8, BCU 166, CTM 3, HD 5 and SB 55.

6. The Trust continues to estimate patient harm as part of its MIQPR. The visual below attempts to show the three areas of harm, updated with data for the last three months to the end of April 2024 and is similar to the picture reported in the previous iteration of the this report i.e. no real improvement.



6. Health boards have previously been required to develop handover reduction action plans, which are monitored at their Integrated Quality, Planning & Delivery (IQPD) meetings by Welsh Government. Handover has also been discussed at the Integrated Commissioning Action Plan (ICAP) meetings but these are currently paused as commissioning arrangements transition into the new Joint Commissioning Committee. Reference was made at the last JCC meeting that these will be re-introduced.

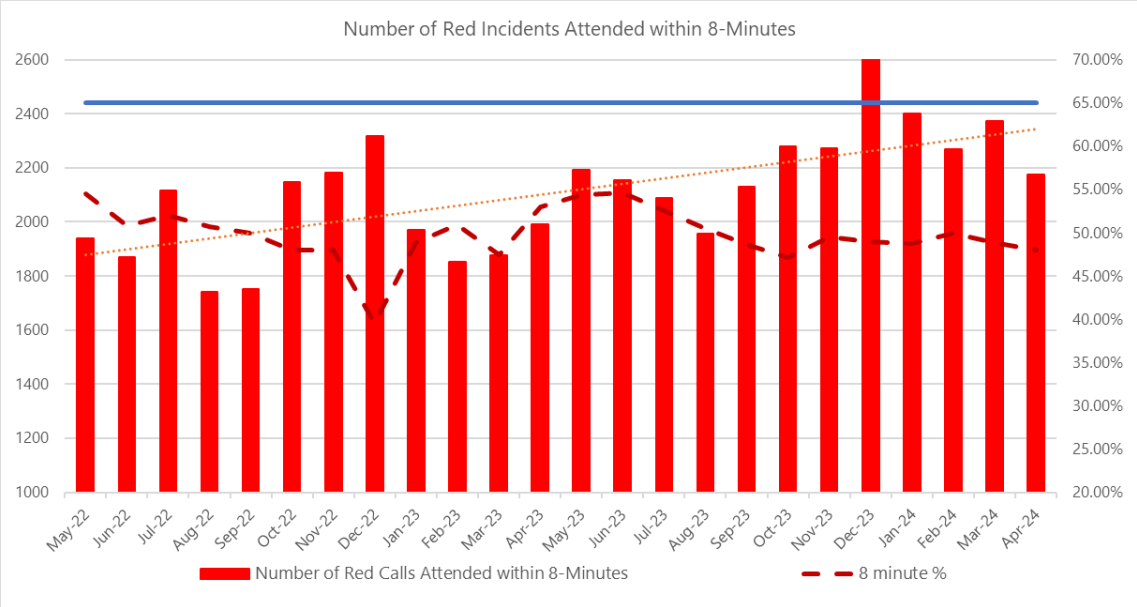
7. The Trust has now been asked to model three scenarios by the CASC for 2024/25:-

   - Scenario One: Handover lost hours remain at 25,000 hours and the Trust delivers on improvements within its own gift as per the 2024-27 IMTP: full roll out of CHARU, 17% consult & close, abstractions (including sickness at 6%) 30%, resultant high production and 32 more APPs.
   - Scenario Two: every Health Board to achieve the no more than four hours handover ambition (with C&V UHB continuing to perform at its higher level); and the same Trust improvements.
   - Scenario Three: delivery of the WG target for handover of no wait over one hour: and the same Trust improvements.

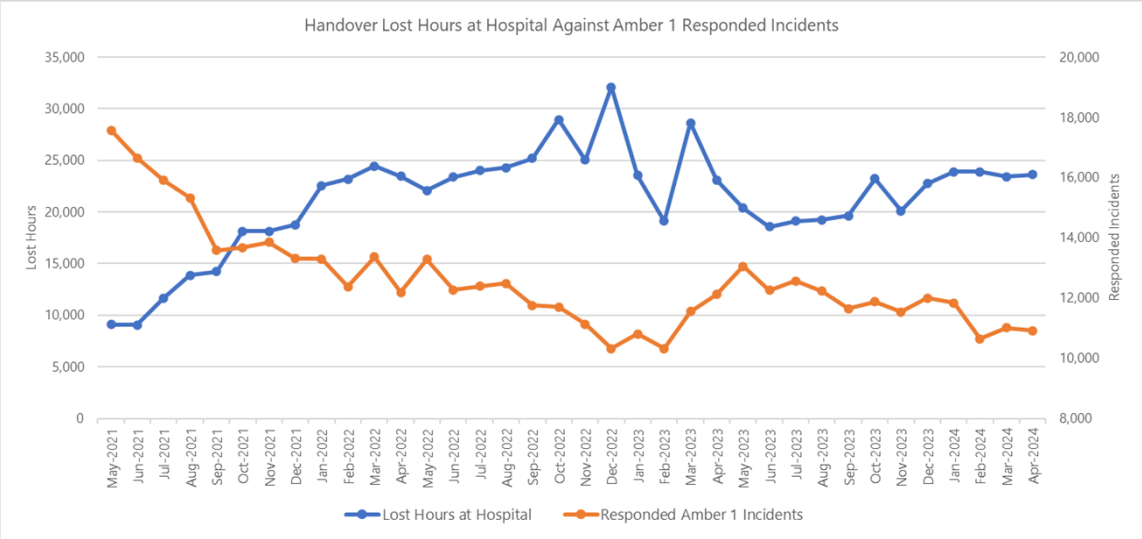
8. This modelling has been completed and shared with the CASC. The same approach has been used in the strategic 2023 EMS Demand & Capacity Review.

9. The Trust has received some degree of challenge from those health boards where handover levels had improved, with a view that performance is not improving; however, the Trust is responding to more Red incidents, but the denominator

(demand) has gone up, so this is not reflected in improved performance against the WG 8 minute target. A deep dive was undertaken in the Cardiff area to explore this issue in more depth.



10. Amber 1 activity is affected by handover, with the number of incidents responded to falling as handover increases.



11. Given the long-standing nature of the system pressures and long handover times, the Trust has commenced work to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and, Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for our ambulance trolleys.

12. The Trust's 2024-27 IMTP sets out a range of transformative actions, transformation being a necessity to try and address the impact of handover. Key planned deliverables include:-

- 111 digital platform: a business case that identifies what could be achieved;
- 111CAS: a new platform that will support integration between 111 and 999. The platform went live as planned on 30 April 2024;
- 111 demand & capacity review: subject to potential agreement and funding with the new commissioners, a review that informs patient safety performance parameters, efficiencies and the capacity to deliver (expected to commence in June 2024, as planned);
- Expansion of the remote clinician capacity and the scoping of the integration of 111 and CSD. An additional 23.2 FTEs are being invested into the control centres in 2024/25 and workshops on future clinical workshop completed;
- Clinical Model: the review of the current clinical response model and potential move to a new clinical model. Initial five-day workshops completed, initial write up completed, with programme now being developed at pace;
- 999 EMSC: the reconfiguration of the EMSC, to improve leadership, team structures, workloads and alignment to patient flows;
- CHARU: full roll out and improved utilisation;
- APPs: further expansion and improved utilisation. 32 FTEs APP funded for 24/24 and Task & Finish Group includes improved management information as part of its terms of reference; and
- Ambulance Care: movement to the agreed tighter scope of practice, that enables a focus on core routine/planned activity.

13. The Trust will formally report the outputs from the collaborative and independent strategic 2023 EMS Demand & Capacity to Finance & Performance Committee and Trust Board in July 2024. The review provides a quantified estimate of the capacity and impact of a traditional ambulance model v the future clinical model; in particular, the impact on conveyance to emergency departments.

14. There is some increased attention from Welsh Government on the red response times and an action plan has been requested which will need to articulate all of the actions within our gift that are currently being undertaken which will impact positively on response times.

RECOMMENDATIONS: Trust Board is asked to: -

(1) NOTE the report.
(2) CONSIDER whether there are any further actions available to the Trust to mitigate patient harm.

Appendix 1

Patient Harm Mitigations & Winter Resilience Actions

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
WAST ACTIONS – Operational				
1.	Immediate Release: Continue working with health boards to increase compliance, focusing on the validation process	Lee Brooks	• There were 483 requests made to health board EDs for immediate release of Red or Amber 1 calls in April 2024, compared to 511 requested in April 2024. In the Red category 124 were accepted and released, seven were not. In the Amber 1 category, 115 were released, but 237 were not. The Red position is relatively positive, but Amber 1 remains a concern. • The health board breakdown for Red not released, Apr-24 was: AB , BCU 2, HD 2 and SB 1. • The health board breakdown for Amber 1 not released, Apr-24 was: AB 8, BCU 166, CTM 3, HD 5 and SB 55. • Agreement has been reached with health boards around the validation process	Complete
2.	Clinical Safety Plan (CSP) & Resource Escalation Action Plan (REAP) annual review	Lee Brooks	• Both the CSP and the REAP were reviewed in advance of the festive season. Both are considered robust.	Complete
3.	Introduction of limited Emergency Department “cohorting” to support reduction in shift overruns	Lee Brooks	• Some further “cohorting” (pods) was reintroduced for winter 2023/24 at sites where accommodation can be made available by health boards to alleviate shift overruns and release crews to return to base. ED Holding Area Survey completed and results presented to Strategic Transformation Board (STB) on 26 Feb-24: some positive signals and STB has asked the Operations Directorate team to consider next steps. • At this point in time pods remain open at Morriston and the three DGHs in BCU.	On-going

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
4.	Patient handover actions.	Exec team	• Some English ambulance services operate a system whereby handovers are mandated or forced after a certain period of time e.g. WMAS and LAS. This will be reviewed by the Executive team.	Keep under review.
WAST ACTIONS – Tactical				
5.	Sickness absence (and abstractions): Improve internal sickness efficiency to IMTP 2023/24 target and abstractions to ORH benchmark	Lee Brooks Angie Lewis	• Improvement trajectory agreed as part of IMTP 22/23 that returns us to pre pandemic sickness' rates over the lifetime of the IMTP. • In Mar-24, sickness absence was 7.67% (target 6% by March 2024). Whilst missing the 6% target, given the nature of the service, this is good performance and trending in the right direction. • The Trust will continue its focus through the Managing Attendance Programme into 2024/25, with a wider focus on abstractions as well. Abstractions have come down and achieved the 30% benchmark in Jan-24, Feb-24 and Apr-24 for the first time since before the pandemic.	6% by 31 March 2024
6.	National 111 awareness campaign	Estelle Hitchon	• The Director of Partnerships & Engagement has met with the WG policy lead/Head of Urgent Care and Head of Marketing for WG Dept of Health, Social Care and Early Years to discuss a more sustainable approach to digital development (including website) and 111 communications more generally. It is acknowledged that there is limited capacity within WAST and that sustainable solutions will need to be sought to ensure that the ambition of 111 as a "digital first" service with the ability to defray low acuity needs via a digital solution is realised.	On-going
7.	Winter Forecasting & Modelling		• The Trust has undertaken winter modelling which it has made available to Welsh Government and reported to EASC. • The modelled most likely scenario (MLS) for December 2023 was Red 8 minute 45% and Amber 1 median three hours and 29 minutes. Actual performance was 49% and one hour and 36 minutes respectively.	19 Nov-23 Complete

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
			• Focus now switches to forecasting and modelling for the spring and also working on three scenarios as directed by the CASC. Completed.	
8.	Additional Winter 111 Mitigations	Lee Brooks	• The service is managed well, with good workforce planning, good production and improved efficiencies (call duration and rosters); however, demand was 18% higher in Q4 compared to Q4 2022/23 and 11% higher in the last three months to end of April. It is imperative that the Trust now undertake a collaborative and independent 111 demand & capacity review, as agreed with the new Joint Commissioning Committee (JCC). • In year monies for website development currently being actioned, in particular, new dental assets (live) and an independent report on the website (due w/c 20 May-24).	Actioned / being actioned Demand outstripping capacity
9.	Winter Overtime	Lee Brooks	• The Trust targeted production and overtime to forecast demand peaks in the first half of winter. The Trust has achieved 94.7% EA UHP for the last three months to end of Apr-24, benchmark 95%.	Complete
10.	Additional Winter NEPTS Discharge Capacity	Lee Brooks	• The Six Goals Programme made an allocation of £10,000 her health board. • Whilst some Health Boards booked additional NEPTS transport through WAST using a dedicated spend code related to this allocation, this was not consistently applied. We understand that in some cases, whilst the spend was made through WAST, the allocation was coded internally. It has therefore not been possible to fully identify how each Health Board utilised their allocation.	Offer made. £70,000 allocation
11.	Operations Senior Planning Team (winter)		• The Operations Senior Planning Team is live and meeting every week.	From 20 Nov-23 Complete
WAST ACTIONS – Strategic / Transformational				

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
12.	Maximise the opportunity from Consult & Close for 999 calls – stretch to 15% and beyond	Lee Brooks Andy Swinburn	• 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. • Performance has continued to recover with the Trust achieving 15.1% in Apr-24. A corrective action plan remains in place. • The Trust's 2024/25 ambition is 17% (also a WG target) with recent demand & capacity modelling suggesting that the updated clinical model could see a maximum figure which is higher again. • The corrective action plan has a number of threads: capacity, technology, process, culture and abstractions, with the new telephone system considered key by the Executive Director of Operations. Also, the Trust is proceeding with the EMS strategic demand & capacity review, which will develop the remote clinical assessment model and quantify the cost/benefits of this approach. • The Trust is investing a further 23.2 FTEs into the control centres in 2024/25.	March 24
13.	Recruit and train more Advanced Paramedic Practitioners	Andy Swinburn	• The Trust uplifted its APP establishment by a further 15.7 FTEs in 2023/24 (funded through internal movements). For 2024/25 the Trust is funding a further uplift of 32 APPs (additional funding, not internal movements). • The above uplifts will increase the APP establishment to 120.7 FTEs.	Q4 2023/24
14.	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. • A series of meetings have been held with each of the Health Board CEOs in order to listen to their priorities and understand how we might work more productively at a strategic level with them. • An updated reputation audit, quality assured by The Consultation Institute, was conducted with key stakeholders in April and early May-24. • Work is ongoing to develop and build relationships with key stakeholders within the new JCC arrangements.	Ongoing

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
15.	Overnight falls service extension and future modelling	Wendy Herbert	• Night Car Scheme extension agreed to 31 September 2024 (2 regional resources) • Utilisation rates continue to be monitored: • Nighttime utilisation:- Q2 65% Q3 64% Q4 to date 64% April 2024 - 67% • Daytime utilisation:- Q2 57% Q3 56% Q4 to date 58% April 2024 – 54% • Combined day and night Q2-Q3 58% Combined day and night Q4 to date 59% Combined day and night April 2024- 55% There is now also an additional Level1 nighttime resource through RPB and Gwent Resilience Plan ringfenced to ABUHB. AB dedicated level 1 62% for April 2024 The 2023 EMS Demand & Capacity Review has completed its modelling of falls level 1 and level 2 resources. This will now need to be considered further by the Trust, commissioners and health boards. There is an immediate focus on the contract beyond September 2024. The 2023 EMS Demand & Capacity Review will be formally reported to Trust Board in Jul-24.	Live.

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
16.	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?	Audit Wales	• 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. • The audit is proceeding with field work now underway. Trust awaiting the outcome.	24/25 Q1+Q2
17.	Full roll out of CHARU	Andy Swinburn	• Current position (May 2023 EMS Operational Transformation Programme Board) is 30 FTE vacancies (20%) against the 153 FTEs modelled requirement (including those just recently recruited, but not yet live). Recruitment into more rural areas remains challenging. • ELT have identified an issue around the utilisation (compared to the modelled levels) of CHARUs. The CHARU Task & Finish Group is currently investigating this issue. The initial results indicate that the Trust is reaching more Red calls with CHARUs than it did with RRVs (there are significantly less CHARUs than the previous RRV resource). • Further analysis continues.	Revised completion date: Q1 24/25 (recruitment into hard to reach areas)
18.	Virtual Ward now Connected Support Cymru (CSC)	Liam Williams	• Currently awaiting WG feedback on the submitted business case. • Further meetings arranged with between the Executive Director of Quality & Nursing and Six Goals Programme/WG/. Trust has also approach WG with a smaller ask to facilitate 7 FTE CSD clinicians to provide a continuation of the Luscii solution - this would enable a proof of value pilot to further inform a business case.	Apr-24 subject to funding

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
19.	Red screening		• Red review went live on 19 June 2023. • Red review for protocol six breathing difficulties, currently undertaken when CSD UHP is over 100%. • The Trust has now formally modelled the resource required for rapid clinical screening which is now being undertaken by the 2023 EMS demand & capacity review. The review has modelled 25.2 FTEs. The Trust is investing 23.2 FTEs this year. • The ratios of responding resources to incidents is kept under weekly review through the Operations Performance meeting. The ratios being achieved are good. See below.	Live
20.	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. • Work is progressing based upon a planning assumption that the desired ratio is between 1.1 and 1.3. The Trust is currently achieving 1.27 (w/c 29 Apr-24) for Red all allocation code set. • The Trust has undertaken an initial analysis of CHARU (see above) effectiveness with further analysis being completed currently.	Live
21.	Integrated Commissioning Action Plans (ICAPs)	Rachel Marsh	• The ICAP meetings focused on ambulance response performance, handover delay performance and the development of actions to reduce handover delays and improve ambulance response times. • The 2024/25 ICAP structure is being reviewed to consider the planned changes with regards to the new Joint Commissioning Committee (JCC). Currently meetings are **paused** as part of transition into JCC.	Paused
22.	Future Clinical Service Model		***Future Clinical Service Model*** • A series of five clinical workshops have been undertaken in May to provide dedicated time and space to continue the thinking and early development of proposals to transform the organisation's future clinical service model.	Live

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
			• The workshops focused on a number of the key components of the emerging future model, including telephony processes, design of the rapid clinical screening function, continued thinking around the RICS concept (Remote Integrated Care Service) and Community Response Service. • The workshops also focused on developing its change management principles & future approach, programme delivery and assurance processes, development of draft Logic Models(s), early metrics & benefits and key information to inform the QIA. . • Work is underway to consolidate all feedback and ideas. • A key output of the workshop includes proposals for a set of prioritised actions (that are within WASTs gift to commence in the short term) to drive improvement in readiness for winter. ***Visualisation*** • Work is continuing with the appointed graphic designers to develop a series of key visuals to support the proposed transformation change. • Work will continue to develop a strategic Case for Change document .	
23.	Strategic 2023 EMS Demand & Capacity Review		• The draft final report has been received. • The report is due to go to Finance & Performance Committee and Trust Board in Jul-24. • The report clearly shows that the traditional conveyance model (based on current levels of handover) is prohibitively expensive and that change is not an option. • The report models an initial “best estimate” of a future clinical service model, with much more emphasis on telephone triage and servicing demand in the community.	Jan-24 Reprogrammed to Q1 for JCC.

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
SYSTEM STAKEHOLDER ACTIONS				
24.	Reduction in handover lost hours to 15,000 by Q2 and 12,000 hours in Q3	HB CEOs	• Apr-24's handover lost hours were 23,614 compared to 23,082 in Apr-23 i.e. they have gone up. The Trust's implemented rosters are based on 6,000 handover lost hours and are simply not designed to cope with this extreme level of loss. • C&V UHB being a clear outlier from other health board in demonstrating sustained improvement and no +4 hour waits • The Trust continues to lose between 25%-30% of its conveying capacity to handover.	Q3 / Q4 targets
25.	NHS Wales eradicates all emergency department handover delays in excess of 4 hours	HB CEOs	• There were 3,404 +4 hour patient handovers in Apr-24, compared to 2,730 in Apr-23. • The target was originally to have 0 by September 2022. • The NHS Wales 2024/25 Performance Framework target is no waits over one hour, but the system is some distance from achieving this (it would equate to an estimated 7,500 lost hours per month). • The CASC has asked the Trust to model three different levels of handover: 25,000 hours, no waits over 4 hours (2 in C&V) or 12,000 hours and the 7,500 hours as above. This has been completed as part of the 2023 EMS Demand & Capacity Review.	End of 2023/24
27.	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. • In Apr-24 0.25% of verified demand was referred into SDECs. This level of activity is still very low. • The Trust is working on improving the accuracy of reporting SDEC demand, by using ePCR, but the activity is still expected to be low.	Q4 22/23

Ref	Description	Owner	Progress Update	Planned Delivery Date & RAG Rating
			• A series of workshops were held in Mar-24 and Apr-24 alongside NHS exec colleagues; however, many issues remain e.g. no SDECs operating at some hospitals, challenge from clinicians about the need for SDECs, data quality, the use of SDECs for "bedding down" patients i.e. overflow from hospitals etc.	
28.	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 the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance. • The Trust also has a presence on all the individual goal boards. • At the April Integrated Quality, Planning & Delivery (IQPD) meeting with WG, it was agreed that the Trust will produce its own six goals plan. This is a positive development.	Ongoing

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

AGENDA ITEM No	10
OPEN	OPEN
No of ANNEXES ATTACHED	1

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – April 2024

MEETING	Trust Board
DATE	30th May 2024
EXECUTIVE	Rachel Marsh – Executive Director of Strategy, Planning & Performance
AUTHOR	Hugh Bennett - Assistant Director, Commissioning & Performance Mark Thomas – Commissioning & Performance Manager Melanie O'Connor - Commissioning & Performance Officer
CONTACT	Hugh.Bennett2@wales.nhs.uk Mark.Thomas12@wales.nhs.uk Melanie.O'Connor@wales.nhs.uk

EXECUTIVE SUMMARY

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

2. Our response times to 999 callers remains of concern with red 8-minute performance at 48% in April 2024 and Amber 1 median at 1 hour and 8 minutes, which the Trust knows leads to avoidable patient harm. The Trust continues to work on actions within its control to mitigate this risk including, for example, maintaining high levels of EA production and fully rolling out the CHARU service. Work continues on an action plan to increase the consult and close rates to the target 17%, as this is modelled to have a significant impact on response times. The Trust lost nearly 23,620 hours to handover in April 2024, and this level of lost capacity is difficult to compensate for, despite all the actions being taken. The 2024/25 budget includes further investment in activities designed to shift demand left and mitigate the impact of handover lost hours.

3. 111 performance had stabilised in 2003, however, more recently performance has deteriorated. Whilst patient demand was 4.8% lower in April 2024, compared to April 2023, it was 18% higher in Q4 2023/24 compared with Q4 2022/23. There is also a 4% commissioned reduction in call handlers in

2024/25. The new 111CAS went live on 30 April 2024 as planned. This new system was delivered at high pace to mitigate a non-delivery issue beyond the Trust's control.

4. Ambulance Care, in particular, Non-Emergency Patient Transport Service's (NEPTS) performance has been stable, with oncology remaining above target and renal performance achieving its target. Both the NET Centre and NEPTS transport are due to be re-rostered in 2024/25, a key efficiency.

5. The Trust continues to focus on its people, with a range of actions in place to improve workplace experience including, for example, reducing shift overruns, whilst also continuing with the more strategic focus on the People & Culture Plan. Sickness absence was 7.58% in April 2024 compared to 7.71% in March 2024. The 23/24 IMTP ambition was to reach 6%. The Trust will continue its focus on sickness absence. It is of note that the EMS abstractions did hit the 30% benchmark in January, February, and April respectively, for the first time since the pandemic.

6. The Trust continues at pace its programme of transformation, as detailed in its 2024-27 IMTP, which is strategic necessity to mitigate the wider system pressures, in particular, handover lost hours.

RECOMMENDATION: Trust Board is asked to: Consider the April 2024 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
23.05.24 Executive Director Strategy, Planning & Performance 29.05.24 Executive Leadership Team 30.05.24 Trust Board

REPORT APPENDICES
Appendix 1 – Top Indicator Dashboard

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

SITUATION

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

BACKGROUND

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

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

3. As previously agreed, the metrics which form part of this committee/Board report are updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against the Trust's plans (IMTP) and strategies. A revised set were agreed for 2023/24. All the updates for the revised set have now been completed, with the exception of: a metric on the duty of candour which is in development; completed symptom checkers; and value indicators for 111/CSD – it is likely that this one will be difficult to determine.

ASSESSMENT

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

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

5. **999** call answering times were very good in April with the 95th percentile at 3 seconds in April 2024, compared to 34 seconds in March 2024, and achieving the 6 second target. The 65th percentile and median performance remain consistently good.

6. **111 call answering performance remains broadly stable,** although the call abandonment performance was at 10.9% in April and off target (5%). The Trust had almost recruited up to the 198 FTE call handler commissioning control total for 2023/24 with very good levels of production. It should be noted that the Trust is anticipating a reduction in the commissioned level of call handler FTEs next year (-4%). Demand in April 2024 was 4.8% lower than April 2023, but was 18% higher in Q4 2023/24, compared to the same period last year. If this level of demand is sustained, alongside a reduction in capacity, then future call abandonment performance will start to be a concern. In the short term, there will also be a planned short-term dip in staffing numbers linked to the 111 CAS go

live and the need to re-programme training capacity away from new recruits and towards the existing workforce on the new system. This will have some short-term impact on performance, something that has been seen in early May, in particular, through the bank holiday weekend. It will take a number of months for new system to stabilise i.e. staff to familiarise themselves with it etc.

7. **111 Clinical response:** clinical ring back times for patients with the highest priority remained above target at 98.4%. Unfortunately, response times for lower priority calls remain some way below target. This drop in performance has been affected by a rise in call demand, but also high clinician sickness absence. Clinician sickness has seen a material deterioration in April, rising to 15.4% compared to 11.8% in March. As with call handling performance, there is likely to be some further deterioration linked to staff abstracted to undertake training for the new system.

8. **Ambulance Response** (safety / patient experience): the red 8-minute response performance for April 2024 was 48%, remaining below the 65% target; however, the Trust is reaching more red patients in 8 minutes, but the denominator (demand) has also grown. The Amber 1 median in March was 1 hour 8 minutes and the Amber 1 95th percentile was 5 hours 26 minutes. These long response times have a direct impact on outcomes for many patients.

9. Traditionally the factors which affect response times are demand and capacity (recruitment and lost hours). Recruitment is good, see slide 20 for information on staff in post v establishment, but the lost capacity through handover at hospital remains extremely challenging. The Trust's main focus in the first half of 2024/25 is to implement a material change in how it responds to patient demand by updating its clinical model, before winter. A series of workshops were undertaken in early May 2024, with additional leadership capacity also being put into this area: both designed to move this at pace. Areas of focus include: -

    - Further investment into remote clinical capacity (+23 FTEs);
    - Further investment in APPs (+32 APPs);
    - Development of the remote integrated care service (111 clinicians and CSD clinicians);
    - Continued focus on a range of responses that support non-conveyance, where it is clinically safe and appropriate to do so: Connecting Support Cymru, mental health response pilot, Falls response etc.
    - Formal reporting of the 2023 collaborative and independent EMS Demand & Capacity review.

10. The one area of particular focus for recruitment is CHARU: with the Trust recruiting up to the modelled 153 FTEs; and connected to this a focus on CHARU productivity, with on-going analysis work on their contribution (initial findings positive, further work being undertaken) etc.

11. As above, the extreme level of lost hours to **handover outside Emergency Departments** remains the critical component of long waiting times and patient safety incidents. 23,614 hours were lost during April 2024. There has been a noticeable improvement in Cardiff & Vale's handover lost hours linked to an organisational focus, with other health boards reporting that they are seeking to learn lessons. Performance into May has remained very challenging with days where over 1,000 hours were lost. WG have re-iterated to Health Boards the critical importance of improvements in this area.

12. **Ambulance Care (Patient Experience)**: Oncology performance in April 2024 was 73.6%, hitting the 70% target. Renal performance also remains above target at 74.01%. Advanced discharge & transfer journey performance decreased compared to the previous month to 79% and remains below the 95% target. Overall demand for NEPTS continues to increase but remains below pre-pandemic levels. The Trust has a comprehensive Ambulance Care Transformation Programme in place, which includes delivering a range of efficiencies and improvements, for example: aligning clinic patient ready times to ambulance availability and addressing oncology performance. The Trust is expecting to re-roster NEPTS transport in 2024/25 which will better align capacity with demand patterns.

13. **National Reportable Incidents (NRIs) / Concerns Response**: the Trust reported six NRI's to the NHS Executive in April 2024, a slight increase from the four reported in March 2024; and 16 serious patient safety incidents were referred to health boards under the Joint Investigation Framework. In April 2024 complaint response times improved to 62%, an improvement on the 56% recorded in March 2024, but remaining below the 75% target, with cases remaining complex. Reviews of lower graded concerns are being undertaken to ensure proportionate investigations are undertaken. The Trust is currently recruiting to a new structure for the Putting Things Right (PTR) team, which will increase capacity and leadership, including a new Head of Service, who has now arrived.

14. **Clinical outcomes**: The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 77.82% in April 2024, remaining below the 95% performance target. Work is ongoing to improve reporting and compliance through the ePCR system. The return to spontaneous circulation (ROSC) compliance rate increased to 22.92% in April 2024 compared to 21% in March 2024.

15. The Trust is now able to report on call to door times for Stroke and STEMI patients. For April 2024, these highlight call to hospital door times of two hours and 8 minutes for stroke patients and two hours and two minutes and thirty seconds for STEMI. Clearly these times are too long and are representative of the longer response times for all calls as a result of the pressures and issues outlined in this report.

16. In April 2024, 7,975 patients **cancelled** their ambulance, and the Trust was unable to send an ambulance due to application of CSP levels to approximately 170 callers. The Trust believes that 50% of this combined number is unmet demand and is likely to be popping up elsewhere in the system. Anecdotal evidence from health boards supports this view, but data linking planned for 2024/25 is a key enabler to properly evidence this.

Our People (workforce resourcing, experience, and safety)

17. **Hours Produced**: the Trust produced 121,578 Ambulance Response unit hours in April 2024 and delivered an emergency ambulance unit hours production (UHP) of 96%, achieving the 95% target. Key to the number of hours produced are roster abstractions.

18. **Response Abstractions:** EMS abstraction levels decreased to 29.47% in April 2024, achieving the 30% benchmark figure, continuing the achieved benchmark in January and February. EMS Response sickness abstractions stood at 8.17% (benchmark 5.99%).

19. **Trust sickness absence:** the Trust's overall sickness percentage was 7.58% in April 2024, a slight decrease on the 7.71% recorded in March 2024. Actions within the IMTP concentrate on staff well-being with an aim to continue to reduce this level supported by the ten-point plan. The 7.58% is above the 2023/24 IMTP ambition of 6% but is a good improvement.

20. **Staff training and PADRs:** PADR rates did not achieve the 85% target in April 2024, but have been steadily improving (78.46%). Compliance for Statutory and Mandatory training increased to 82.73%.

21. **People & Culture Plan**: The Trust launched its People & Culture Plan in April 2023 and workstreams are being delivered around behaviours, in particular, sexual safety, Freedom to Speak Up, 111 culture review, flexible working, and the introduction of a staff pulse survey tool. The Executive Leadership Team undertook a pan-Wales round of CEO Roadshows in April 2024. Feedback from attendees has been reviewed.

Finance & Value

22. **Financial Balance**: The reported outturn performance at Month 1 is a surplus of £19k and the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

Partnerships & System Contribution

23. The consult & close rate was 15.1% in April 2024, the highest level recorded by the Trust. The IMTP ambition (and Welsh Government target) remains 17% at this

point in time. The Trust has a recovery plan in place, which has recovered performance to a new high, further work continues into 2024/25 including investing an additional 23 FTEs into the Clinical Support Desk and developing updated clinical model at pace.

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

Summary

25. The indicators used at this high-level highlight that the 111, EMS and Ambulance Care performance are stable; however, 111 and EMS performance are not where the Trust would want them to be.

26. 111 has seen a clear improvement in performance over the past 12 months and the service is undoubtedly more resilient, however, the current elevated levels of demand plus a commissioned reduction in call handlers and clinicians may mean that the improved performance comes under pressure in 2024/25. Implementing the new 111CAS may also have a short-term impact on performance, as staff familiarise themselves with the new system. The Trust and commissioners will need to keep the level of demand under review: a 111 demand & capacity review is planned for 2024/25.

27. EMS performance has been recognised as challenging for a long time. Transformation of our service offer is a necessity (not an option) for reducing handover lost hours along with handover reduction by health boards. The Trust also needs to continue its focus on core activities like abstractions, production, and utilisation.

RECOMMENDATIONS: Trust Board is asked to: Consider the April 2024 Integrated Quality & 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.

Welsh Ambulance Services University NHS Trust

Monthly Integrated Quality & Performance Report

April 2024

Annex 1 – Top Indicator Dashboard

GIG CYMRU NHS WALES

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services University NHS Trust

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

by Commissioning & Performance Team

Section 1: Monthly Indicators / Top Indicator Dashboard

Top Monthly Indicators	Target 2023/24	2 Year Average	Mar-24	Apr-24	RAG
Our Patients					
Timeliness Indicators					
NHS111 Call Handling Abandonment Rates	< 5%	11.4%	13.2%	10.9%	R
111 Clinical Triage Call Back Time (P1)	90%	98.2%	98.0%	98.4%	G
999 Call Answer Times 95th Percentile	00:06	00:27	00:34	00:03	G
999 Red Response within 8 minutes	65%	49.8%	48.9%	48.0%	R
999 Amber 1 Median	00:18	01:22	01:22	01:08	R
Oncology Journeys arriving within 45 mins and up to 15 minutes after appointment time	70%	71.9%	73.7%	73.6%	G
Advanced Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	83.7%	86.5%	79.4%	R
Clinical Outcomes / Quality Indicators					
Return of Spontaneous Circulation (ROSC)	Increasing Trend	18.4%	21.00%	22.90%	G
Stroke Patients with Appropriate Care	95%	77.3%	72.80%	77.82%	R
Stroke Call to Hospital Door Times	Reduction Trend	02:22	2:25	02:08	G
ST-Elevation Myocardial Infarction (STEMI) with Appropriate Care	95%	42.7%	40.91%	43.59%	R
National Reportable Incidents reports (NRI)		5	4	6	
Can't Send & Cancelled by Patient Volumes	Reduction Trend	10,679	11,115	8,799	G
Concerns Response within 30 Days	75%	36.1%	56%	62%	R
Our People					
Capacity					
Hours Produced for Emergency Ambulances	95-100%	94%	93%	96%	G

Top Monthly Indicators	Target 2023/24	2 Year Average	Mar-24	Apr-24	RAG
Health & Well-being					
Sickness Absence *(all staff)*	6.0%	8.88%	7.67%	N/A	R
Mental Health Absence Rates	Reduction Trend	2.29%	2.07%	N/A	A
Staff Turnover Rate	Reduction Trend	10.14%	8.73%	8.89%	A
Statutory & Mandatory Training	>85%	78.98%	81.89%	82.73%	A
PADR/Medical Appraisal	>85%	74.24%	78.80%	78.46%	A
Number of Shift Overruns	Reduction Trend	3849	4010	4000	G
Inclusion & Engagement / Culture					
NEPTS % of Total Calls Answered in Welsh	Increasing Trend	1.2%	1.5%	1.6%	A
Value					
Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100%	99.90%	G
EMS Utilisation Metric (CHARU)	Increasing Trend	30%	28.5%	26.8%	R
Average Jobs per Shift (All Vehicles)	Increasing Trend	2.38	2.27	2.25	R
NEPTS on the Day Cancellations	Reduction Trend	19.8%	19.8%	19.1%	A
Partnerships / System Contribution					
Inverting the Triangle					
Successful Consult & Close Outcome	17.0%	13.5%	14.0%	15.0%	R
% Of Total Conveyances taken to a Service Other Than a Type One Emergency Department	Increasing Trend	11.3%	11.46%	11.14%	R
Number of Handover Lost Hours	15,000	23,306	23,403	23,614	R
NHS111					
NHS111 Dental Calls	Increasing Trend	6,563	7,277	7,500	G
Consult & Close Volumes by NHS111	Increasing Trend	1,054	946	981	G

In-Month RAG Indicates =

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

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

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

TBD: Status cannot be calculated (To Be Determined)

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

(Responsible Officer: Lee Brooks)

Abandonment Rate R

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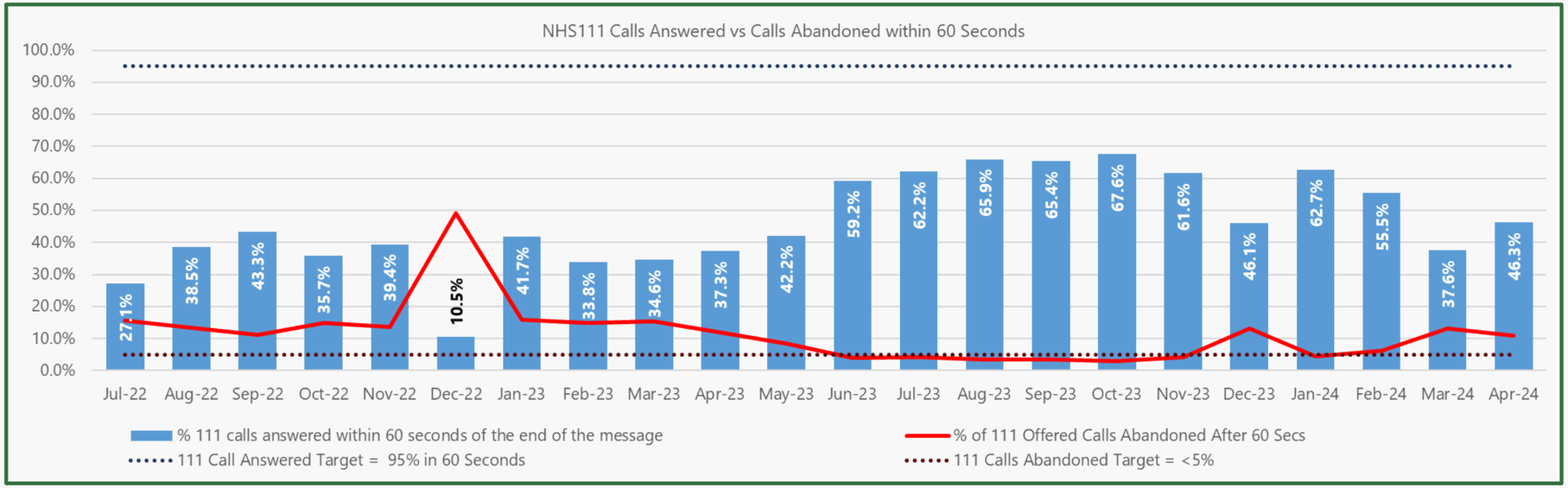
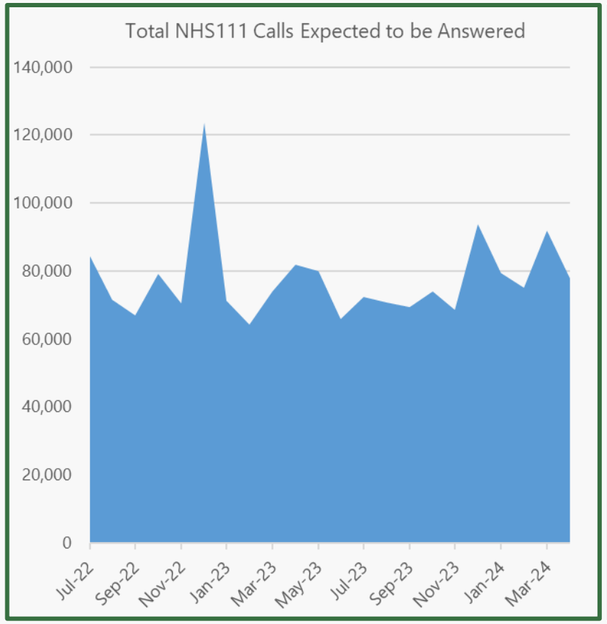
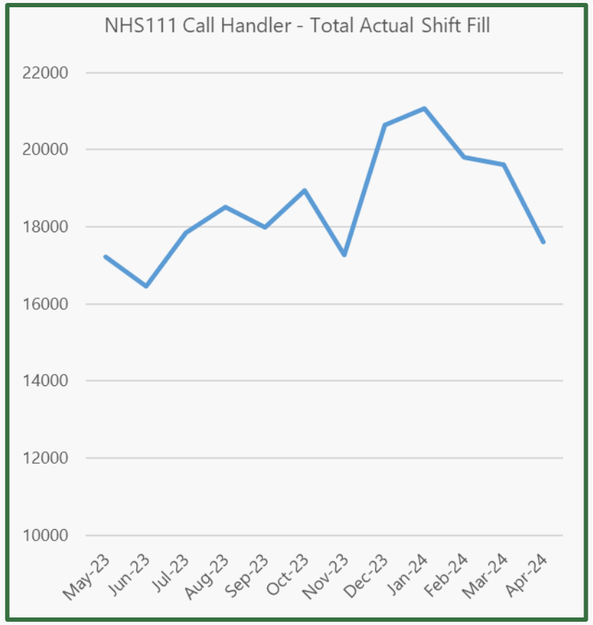
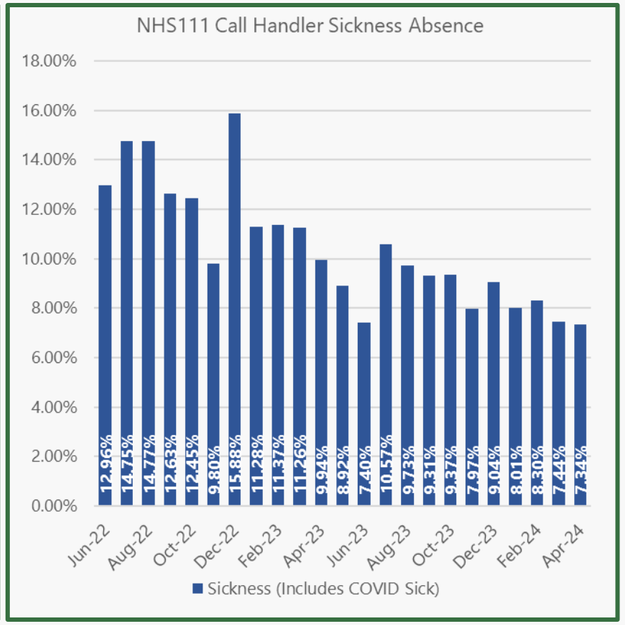
Influencing Factors – Demand and Call Handling Hours Produced









Analysis

The 111-call abandonment rate improved from 13.2% in March 2024 to 10.9% in April 2024 but failed to achieve the 5% target. The percentage of 111 calls answered within 60 seconds increased, from 37.6% in March 2024 to 46.3 % in April 2024, but continues to be below the 95% target.

The drop in performance during March 2024 was due in part to a **spike in demand** with demand in Q4 18% higher than in Q4 last year. In addition, the **new 111CAS system went live** on 30th April 2024. In the run up to implementation, staff were abstracted for training, and after go-live, staff are familiarising themselves with the system, which is having some impact on efficiency at this early stage.

Abstractions due to sickness absence decreased, reaffirming the longer-term downward trend.

Remedial Plans and Actions

Key actions include:

- Recruitment up to commissioned levels;
- A focus on realising the benefits of the new 111CAS;
- A demand & capacity review that takes account of the increased demand the Trust is seeing, what levels of performance commissioners want and the mix of capacity and efficiencies to achieve this.
- Expectation is that the project initiation will start in June with further timescales to be discussed, with an anticipated timescale of 6-9months.

Expected Performance Trajectory

The service is much improved and there is an expectation that performance will improve. However, there are risks including demand, levels of commissioned call handers being lower than last year and an unknown impact of the new system on efficiency.

Our Patients: Quality, Safety & Patient Experience
111 Clinical Assessment Start Time Performance Indicators

(Responsible Officer: Lee Brooks)

P1CT G

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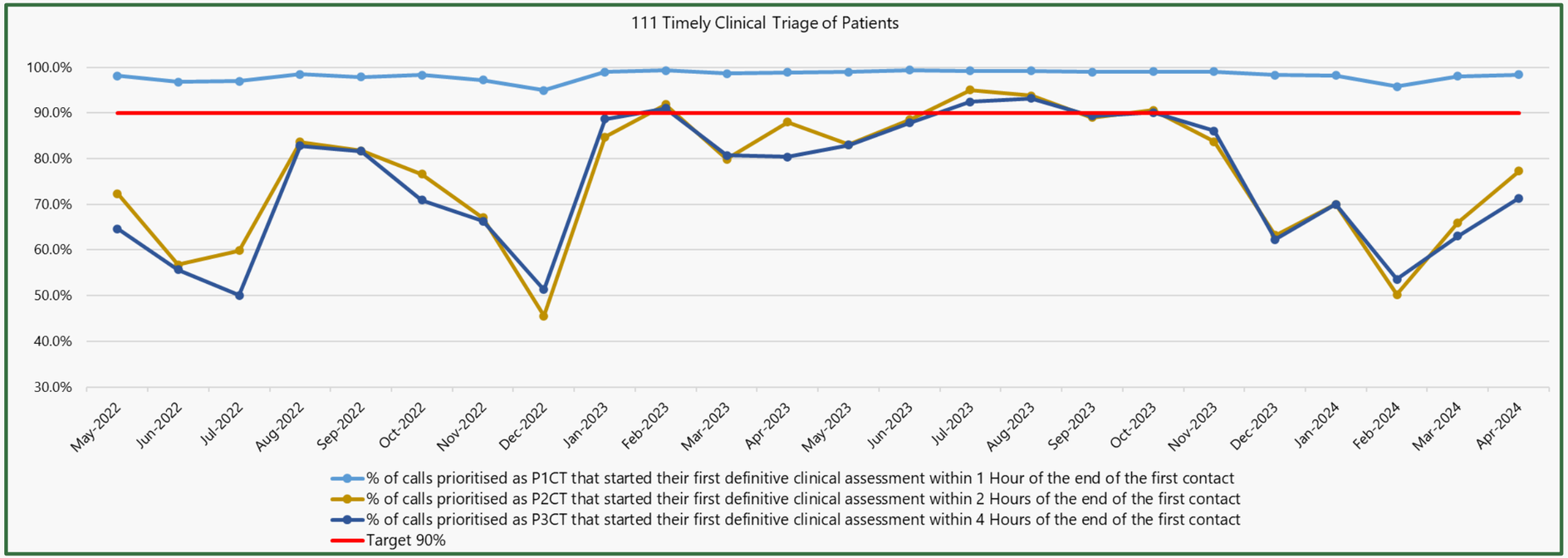
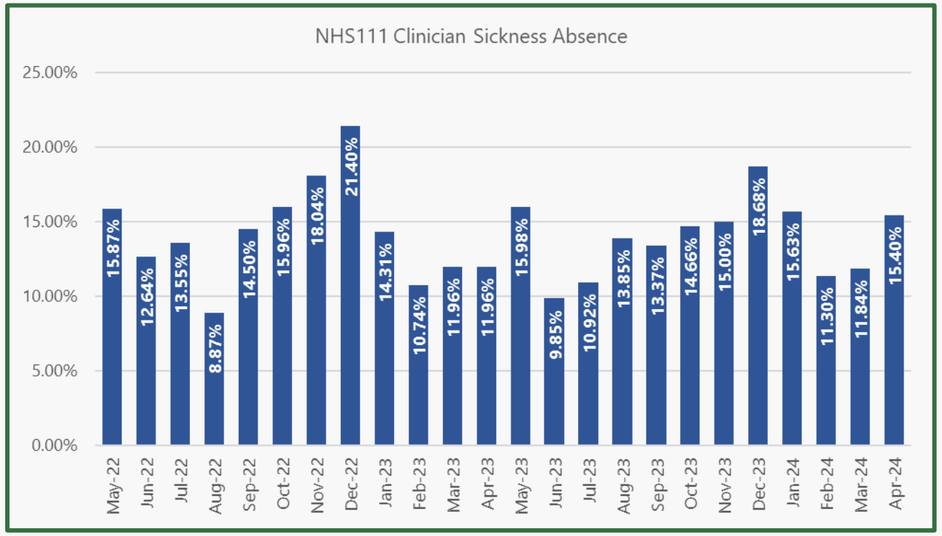
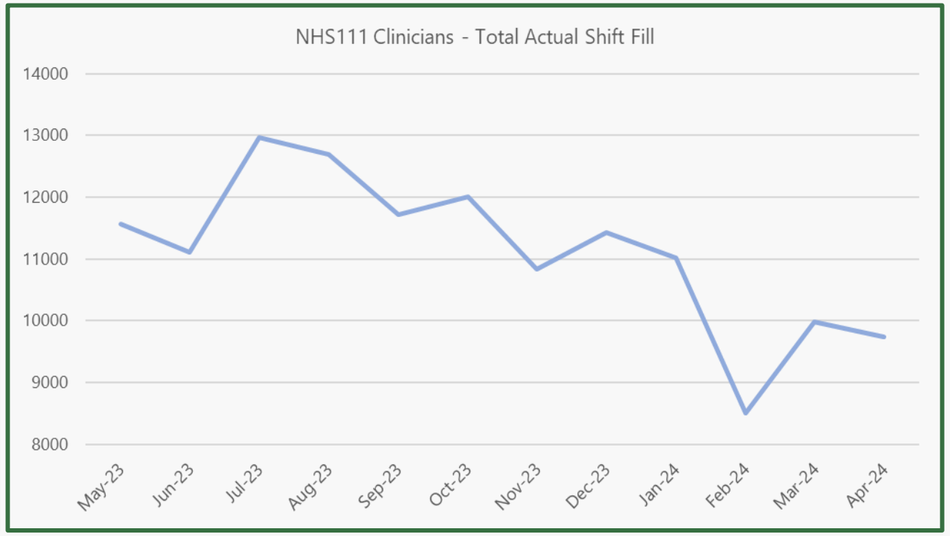
Influencing Factors – Demand and Clinical Hours Produced







Analysis

The highest priority calls, P1CT, achieved the 90% target, recording 98.4% in April 2024.

Lower category calls both improved during April 2024, reversing a previous deterioration in performance due to a slightly improved shift fill levels in March and April.

However, overall, numbers of hours produced has been decreasing because of **abstractions for training** in the new system, a **pause in recruitment** whilst work on the new system took place and continued **high levels of sickness**. Clinician sickness absence was 15.40% in April 2024.

Remedial Plans and Actions

The key actions include:

- A focus on delivering the benefits of the new 111CAS.
- Recruitment up to commissioned levels of clinicians
- A demand and capacity review to determine appropriate levels of capacity to meet increasing demand

Expected Performance Trajectory

The new 111CAS will bring performance benefits, however, demand is increasing materially, and the number of commissioned clinicians will be lower in 2024/25, it is unclear what performance levels will be able to be achieved.

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

(Responsible Officer: Lee Brooks)

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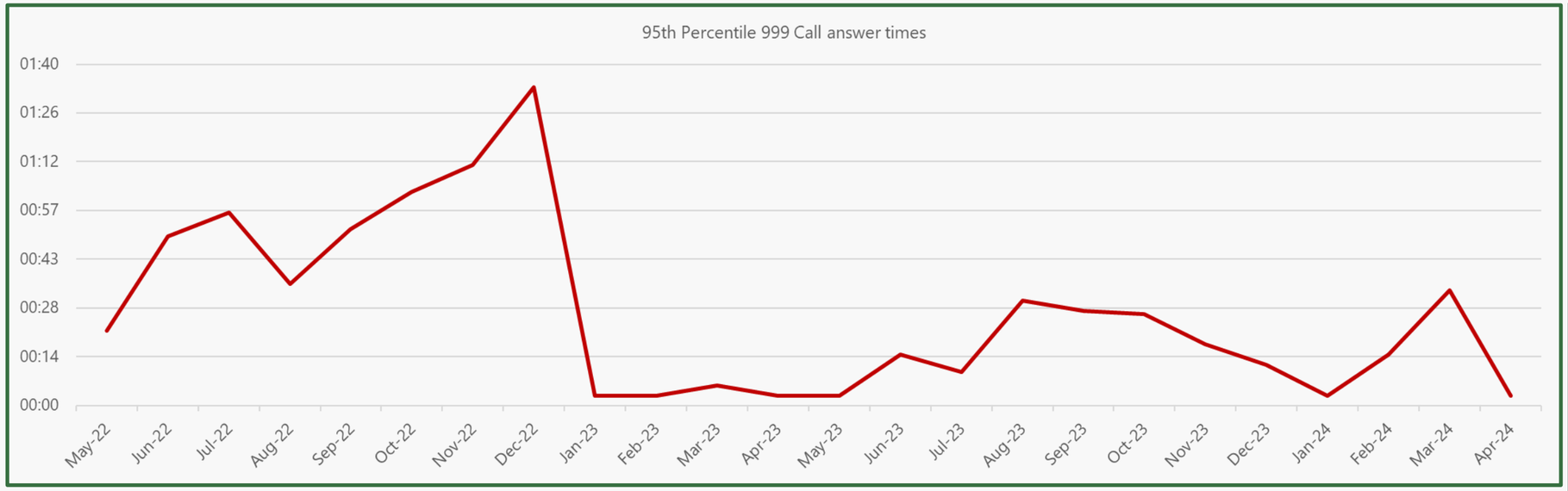
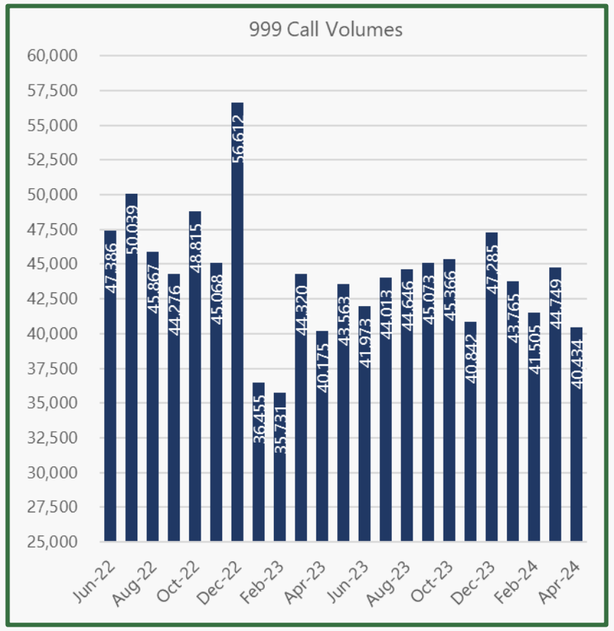
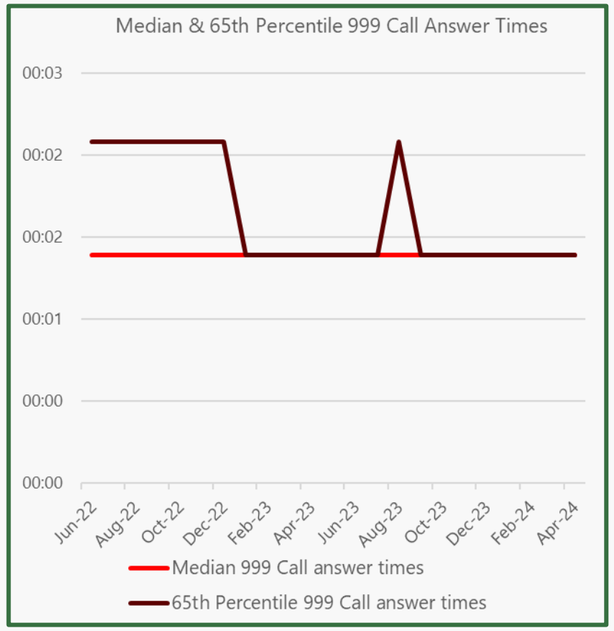
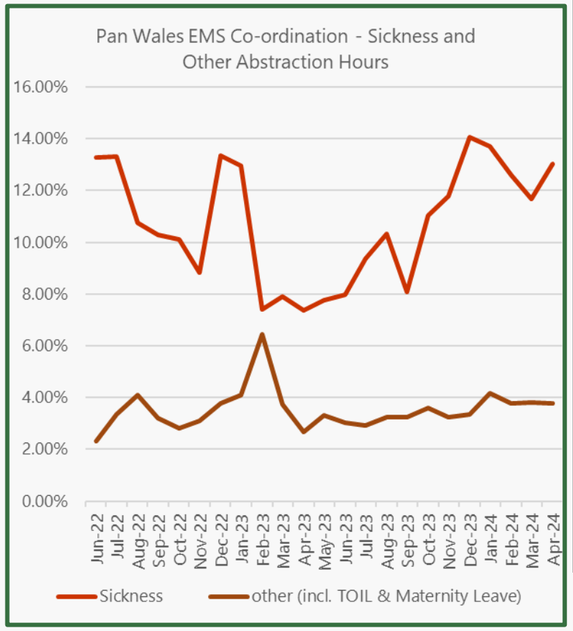
Influencing Factors – Demand and Hours Produced









Analysis

The 95th percentile 999 call answering performance improved in April 2024, at 3 seconds, achieving the 6 second target. The median call answer time for the 999-service remained consistent at 2 seconds in April.

The improvement was due in part to a **reduction in demand**, with 40,434 calls received in April 2024, compared to 44,749 calls received during March 2024.

Sickness increased to 13.02% in April 2024 from 11.68% in March 2024.

Remedial Plans and Actions

- Over establishment has been approved for EMSC by the Executive Director of Operations with call takers are 22% above establishment (137 FTEs v 112 FTEs)
- Further recruitment drives planned for April to August
- Three workstreams are being progressed to improve utilisation of resource including
  - **Roster Review. A** dispatch roster review for Allocators and Dispatchers..
  - **Boundary changes.** Realignment of dispatch boundaries to balance workload and pressures for individual dispatch teams.
  - **Broader Ways of Working**. This project is looking to create efficiency, effectiveness and improved productivity through a review of processes and procedures as well as providing consistency and reduction in variation across centres.

Expected Performance Trajectory

The median and 65th percentile are performing very well and are stable. The above changes should provide further resilience. There is some resilience to demand increases, but this needs to be kept under review.

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

Influencing Factors – Demand, Hours Produced and Hours Lost

(Responsible Officer: Lee Brooks)

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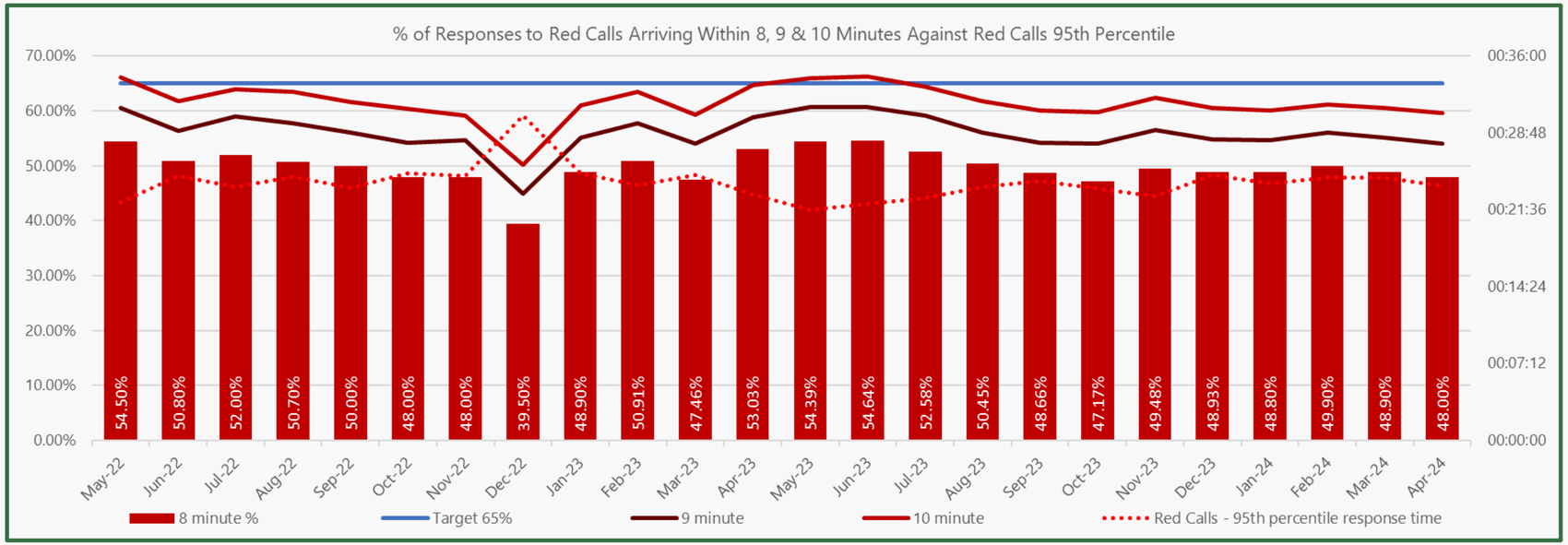

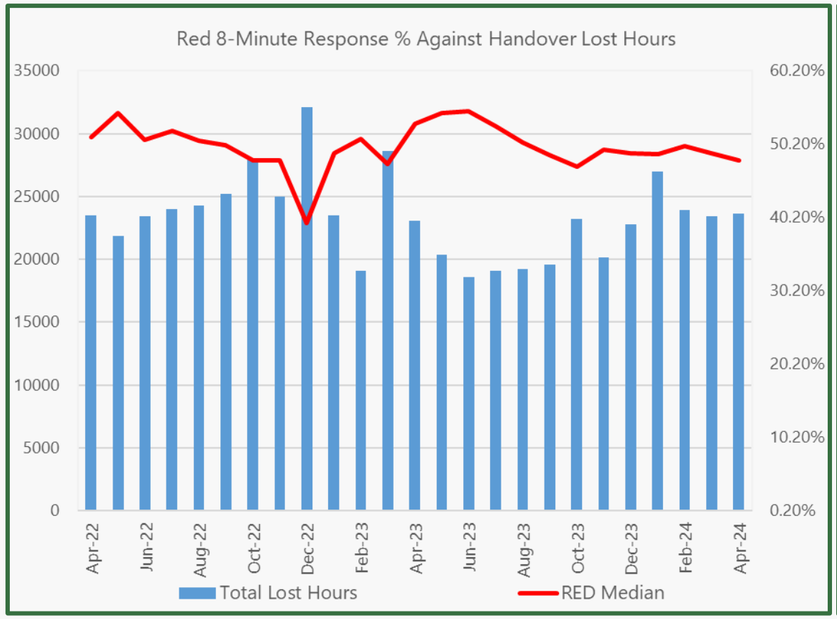

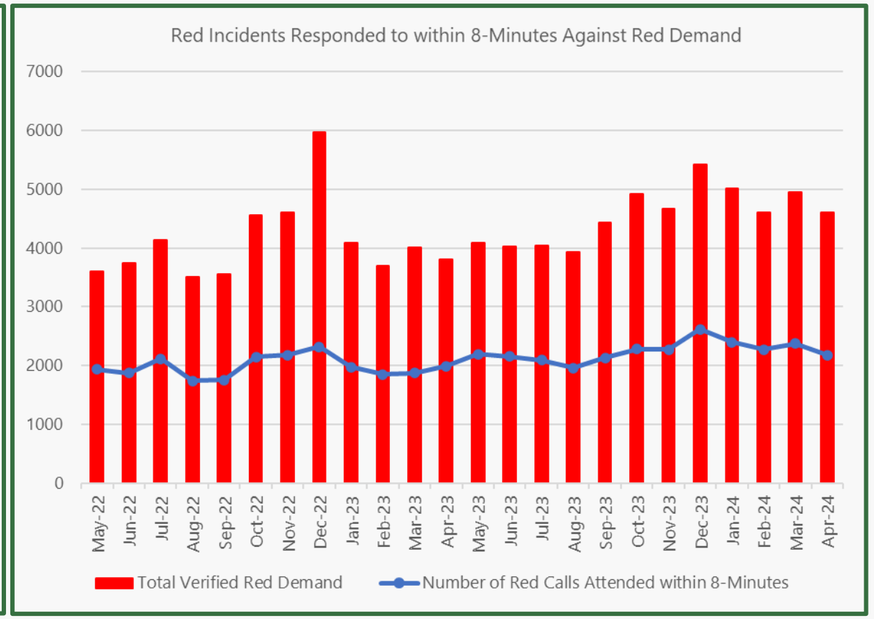

Analysis

Red 8-minute performance continues to remain below the 65% target and decreased marginally during April 2024 to 48%.

Red 10-minute performance for March 2024 was 59.6%, a slight reduction from 60.6% in March 2024.

One of the main determinants is **red demand**, which has **increased** over the last few years. As red demand has increased, so too has the number of red incidents responded to within 8-minutes, with the figure for April 2024 being 2,176. i.e. the Trust is reaching more red calls in 8 minutes, but the denominator is also increasing.

The lower left graph demonstrates the correlation between overall Red performance and **hospital handover lost hours**. There were 23,614 lost hours in April 2024.

Remedial Plans and Actions

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

- To maintain commissioned establishment levels overall.
- Full roll out of the Cymru High Acuity Response Unit (CHARU), now largely complete (127 FTEs v target of 153 FTEs) with the exception of some hard-to-reach areas.
- Continued focus on production and abstractions (EA production was 96% UHP in April and CHARU production 73% against full roll out);
- The rapid deployment, before winter 2024/25, of the first phase of actions towards an updated clinical model e.g. rapid clinical screening, as outlined in our IMTP.

Expected Performance Trajectory

Modelling has been completed for Spring 2024. This continues to indicate a level of Red performance below target (most likely scenario 52%) and Amber 1 (one hour and 12 minutes).

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

(Responsible Officer: Lee Brooks)

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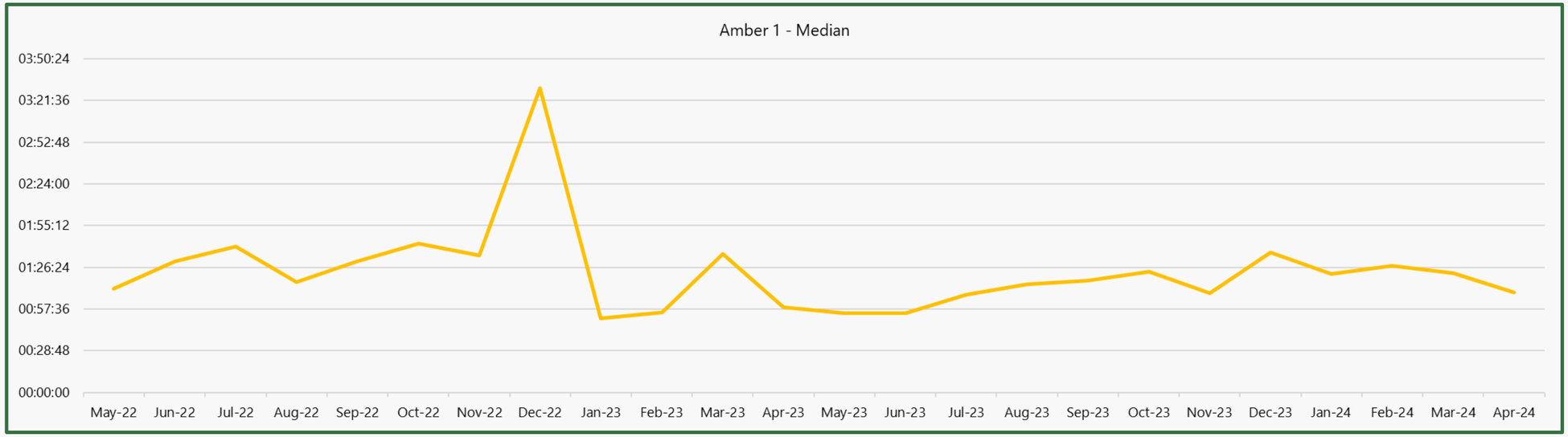
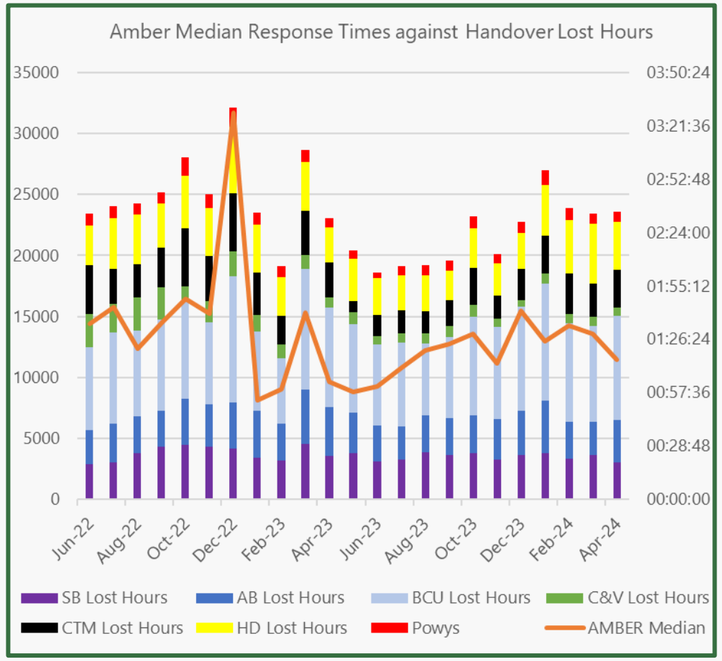
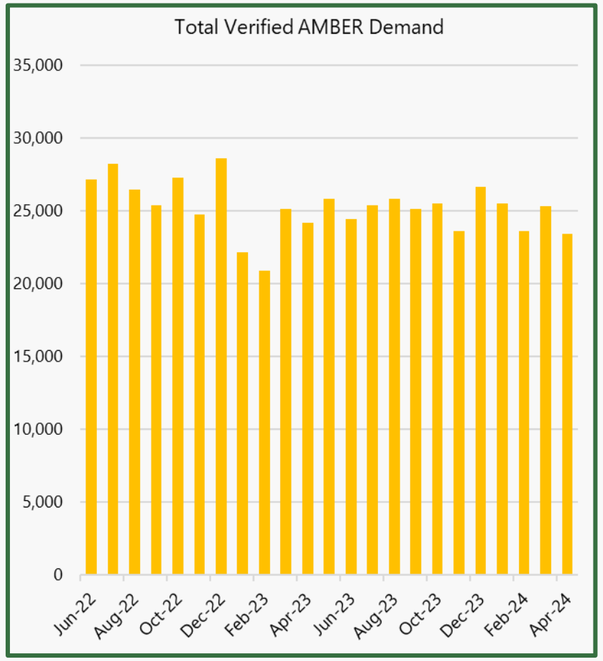
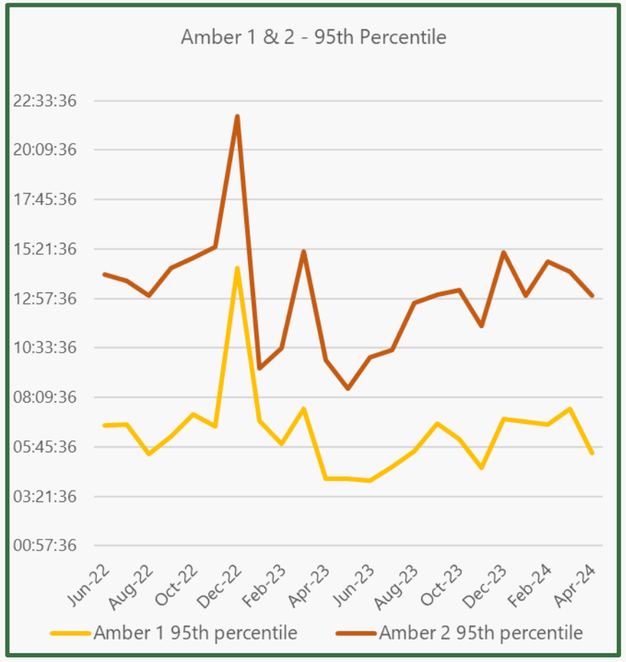
Influencing Factors – Demand, Hours Produced and Hours Lost









Analysis

Amber 1 median performance time improved slightly during April 2024 to 1 hour 8 minutes,. Amber demand increased slightly in the month (+187) and there remains an extreme level of hospital handover lost hours. The ideal Amber 1 median response time remains at 18 minutes.

The Amber 1 95th percentile improved slightly during April 2024 to 5 hours and 26 minutes.

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

The Trust has also recently seen abstractions return to the 2019 review benchmark of 30% and the numbers of hours produced remains good against commissioned levels (EA UHP at 96%)

Remedial Plans and Actions

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

Expected Performance Trajectory

The Trust is currently developing a new clinical model and is also nearing the completing of a new 2023 EMS Demand & Capacity Review.

Our Patients: Quality, Safety & Patient Experience

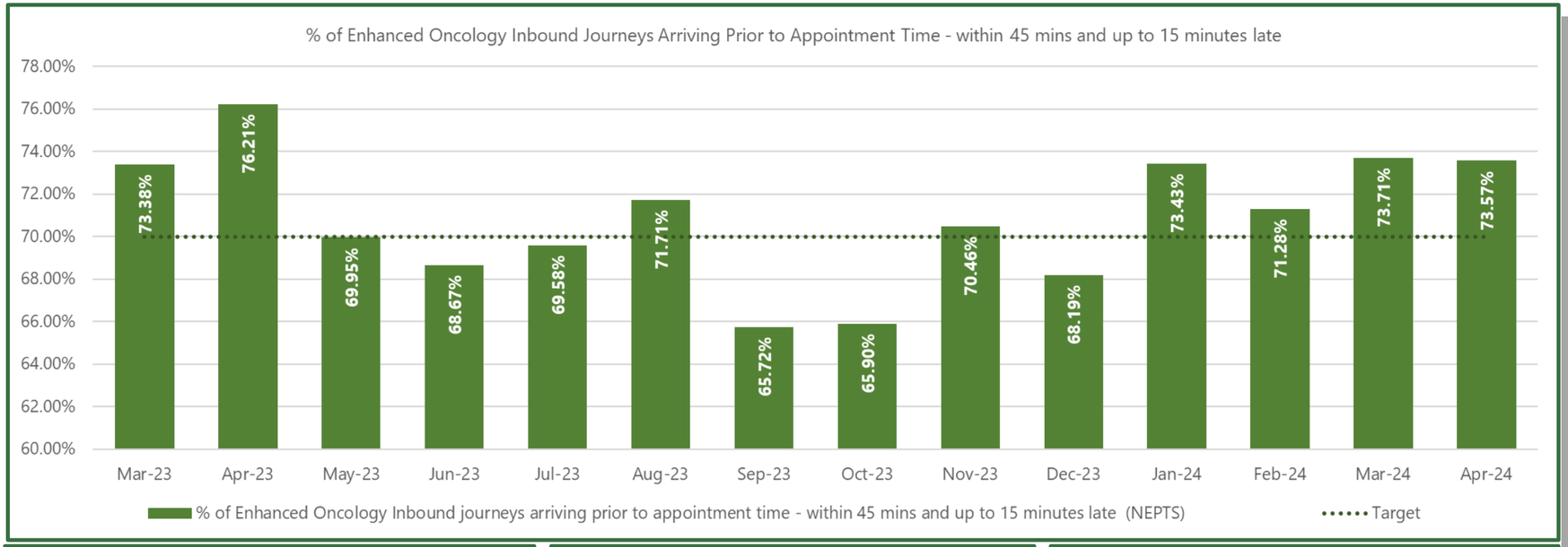
Patient Experience – Influencing Ambulance Care Indicators

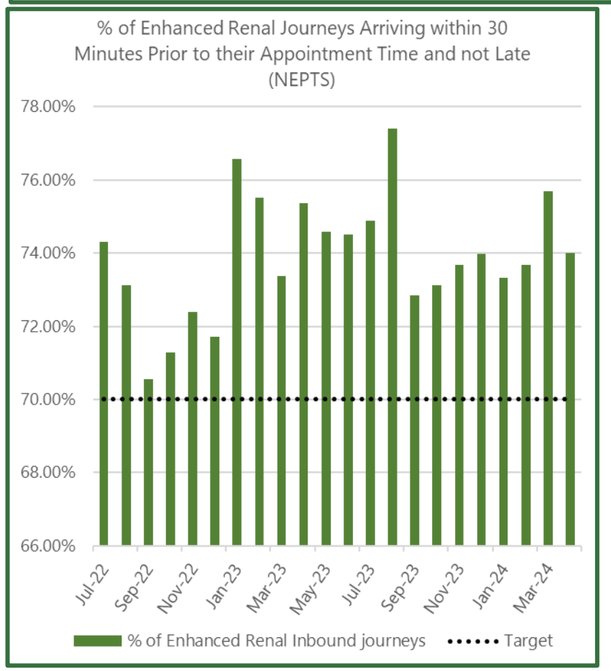
(Responsible Officer: Lee Brooks)

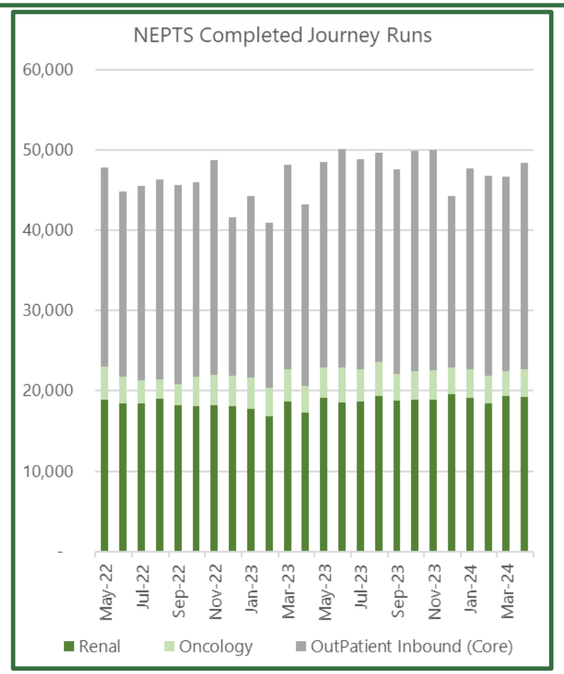
Oncology	Welsh Calls
G	A

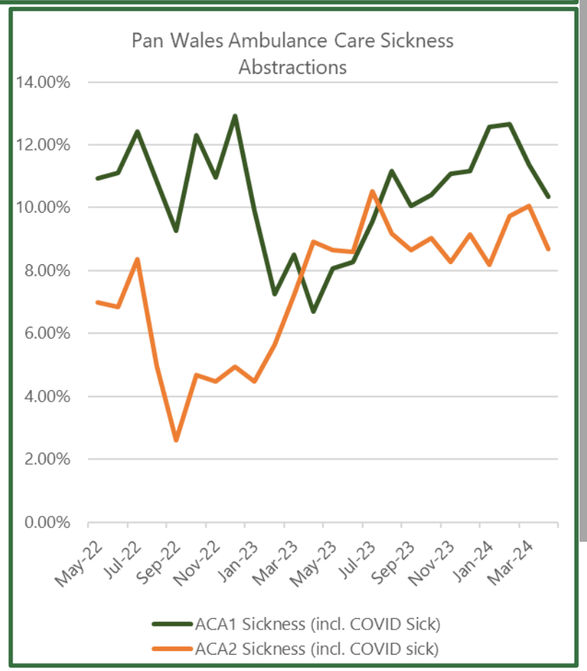
FPC

CI









Analysis

Ambulance Care (NEPTS element) performance minimal decreased during April 2024. 73.57% of enhanced oncology journeys arrived within 45 minutes prior and up to 15 minutes late to their appointment time, a minimal decrease from 73.71% in March 2024, still achieving the 70% target. Enhanced Renal journeys, saw a slight decrease, from 75.70% in March 2024 to 74.01% in April 2024 and continues the pattern of the last two years of exceeding the agreed performance standard.

Remedial Plans and Actions

Oncology performance continues to be an area of focus for the service, and we continue to invest both time and resources on these journeys. This is demonstrated through the performance achieved, which has remained above target so far this year.

Renal performance continues to perform above the required standards.

Call volumes answered increased in April 2024 (19,821) compared to March 2024 (16,939). The average speed of call answering improved in April 2024 (00:02:54) for the third consecutive month compared to March 2024 (00:03:01).

ACA1 (NEPTS) sickness decreased in April 2024 to 10.35% compared to 11.37% in March 2024. However, ACA2 (UCS) sickness also decreased to 8.67% in April 2024 compared to 10.06% in March 2024.

Remedial Plans and Actions

The journey booking team have reviewed both the existing service standards, which are uncontracted historical measures and not fully funded. This has already been discussed with the NEPTS DAG including a proposal to change hours of operation and the standard to reflect available resources.
Opening hours and delivery methodology have been reviewed and a proposal of reduced opening hours presented and subject to evaluation and modelling by Omda.
A more detailed proposal will be developed over the next quarter

Remedial Plans and Actions

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

Our Patients: Quality, Safety & Patient Experience Clinical Indicators

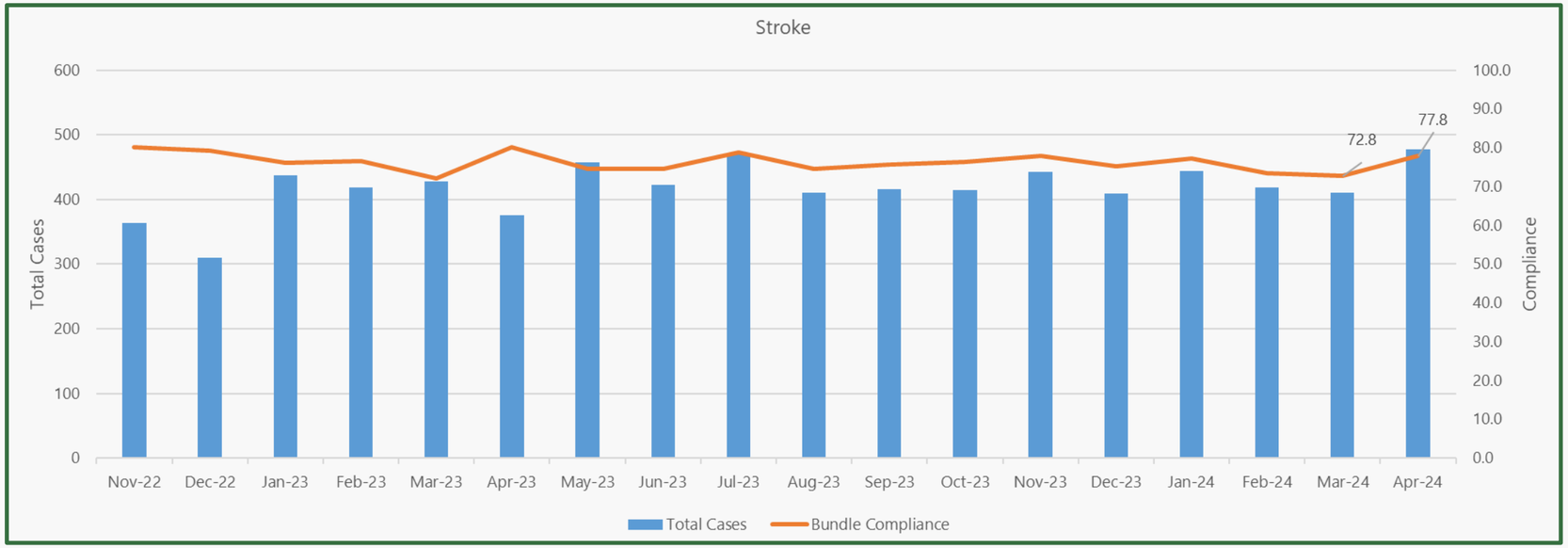
(Responsible Officer: Andy Swinburn)

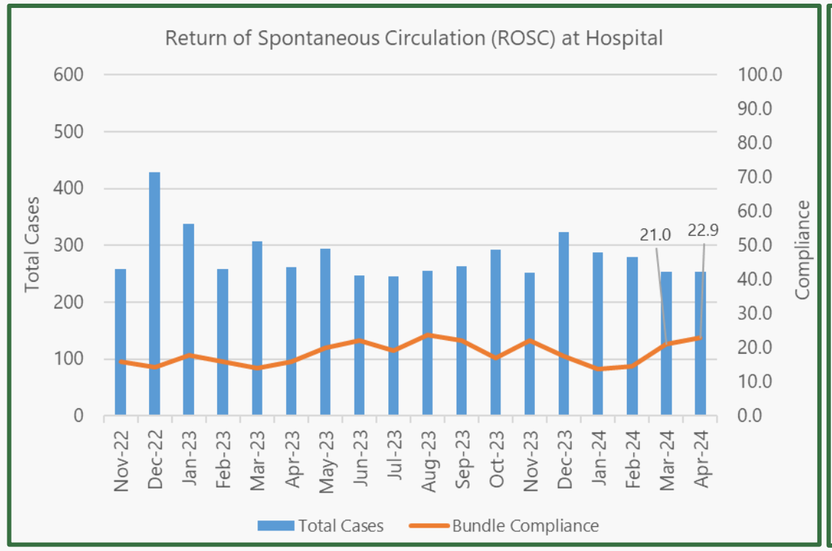
Stroke/STEMI	ROSC
G	R

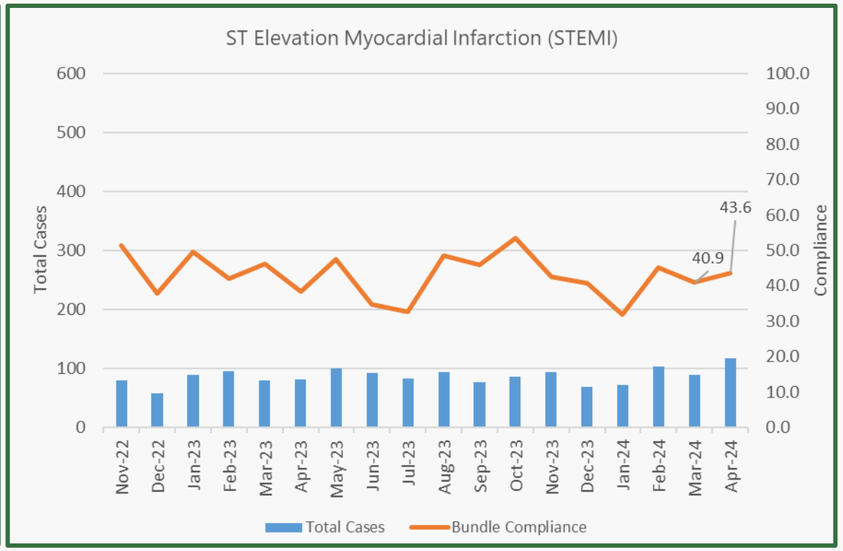
Self-Assessment: Strength of Internal Control: Moderate

QUEST

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







Analysis

The percentage of stroke patients receiving an appropriate care bundle in April 2024 was 77.8%, an increase from 72.8% recorded in March. This was against a total case number of 478 in April. There is a correlation between documenting FAST (a test to detect symptoms of stroke) and care bundle compliance, this has informed the improvement plan.

The Return of Spontaneous Circulation at hospital (from cardiac arrest) rate for April 2024 was 22.9% an increase from 21% in March. This was against a total case number of 253 during the month of April. The highest rate recorded since the implementation of ePCR was seen in August 2023, achieving 23.8%.

Due to the nature of this metric, common cause variation occurs which can result in a marked reduction in performance from small numbers of unsuccessful resuscitations attempts. The factors that influence this may include response times, bystander resuscitation and response type/numbers.

As a result of the recent decline in the Return of Spontaneous Circulation at hospital rates, the Clinical Intelligence & Assurance Team undertook work to understand the reason. This so far has identified an improved clinical picture as information is documented in the narrative and not the specific field on the electronic Patient Clinical Record for the Clinical Indicators which are reported on using raw data. An update and option appraisal will be presented at June meeting of the Clinical Intelligence & Assurance Group.

The percentage of ST-elevation myocardial infarction (heart attack) patients receiving an appropriate care bundle in April 2024 was 43.6%, an increase from 40.9% in March. This was against a total case number of 117 in April. There is a correlation between documenting aspirin and care bundle compliance, this has informed the improvement plan.

All Clinical Indicators remain within the normal bundle control limits.

Updates to the electronic Patient Clinical Record were rolled out in December 2023, including some of those that affect the Clinical Indicators. We continue to work with the suppliers, with more changes scheduled during May 2024.

Following the switch to electronic Patient Clinical Record , the way data is collected when with the patient has changed. Automated Clinical Indicator reports are generated from data directly inputted onto the electronic Patient Clinical Record by clinicians. There are advantages to the new process, however this has not yet been realised with the monthly results. A recovery plan has been implemented to improve compliance to the reports.

As a result of the anticipated low compliance, risk 535 was generated with three key mitigations to work on:
Design of the electronic Patient Clinical Record User Interface
Clinician interaction with the electronic Patient Clinical Record
Accuracy of the scripting to extract the data from the data warehouse to create the report

Our Patients: Quality, Safety & Patient Experience Clinical Indicators

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

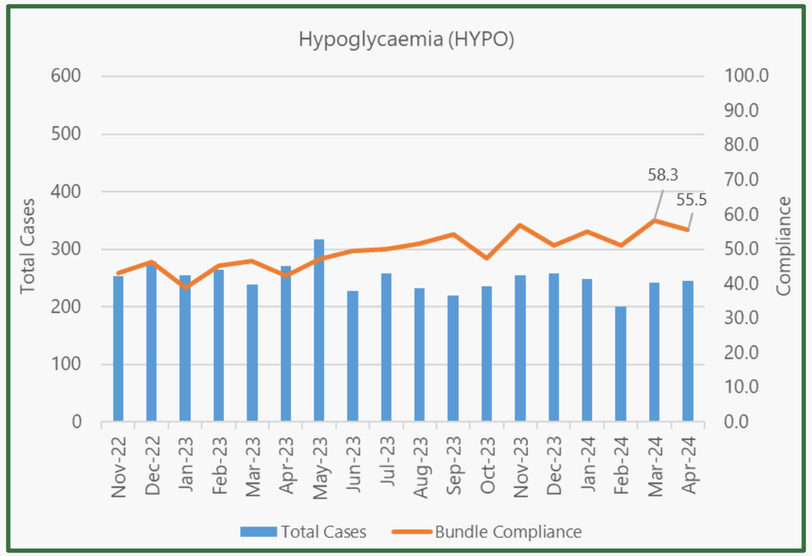
(Responsible Officer: Andy Swinburn)

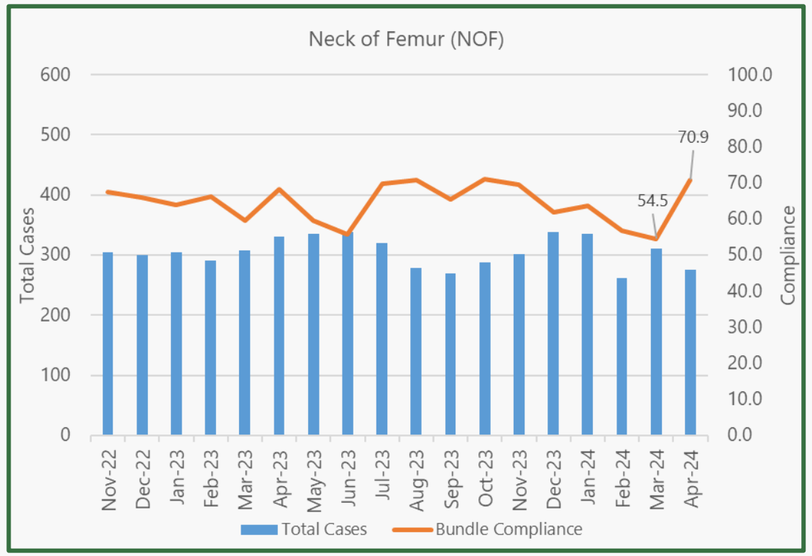
Call to Door

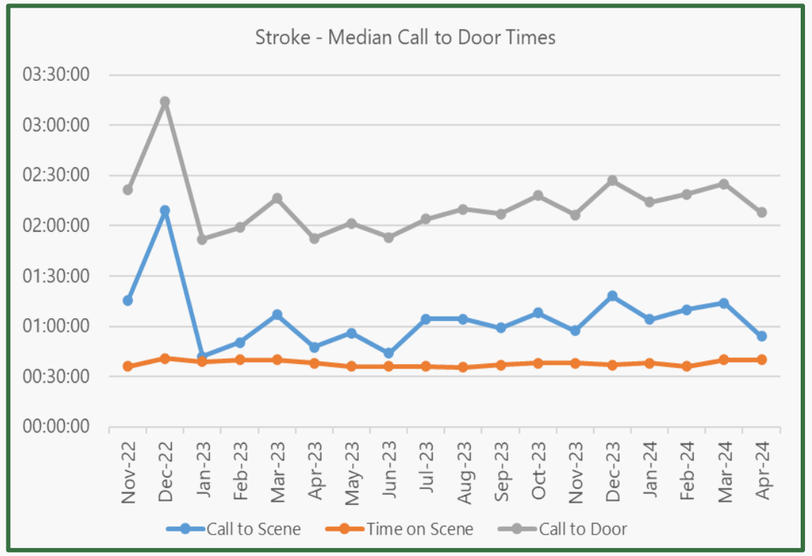
G

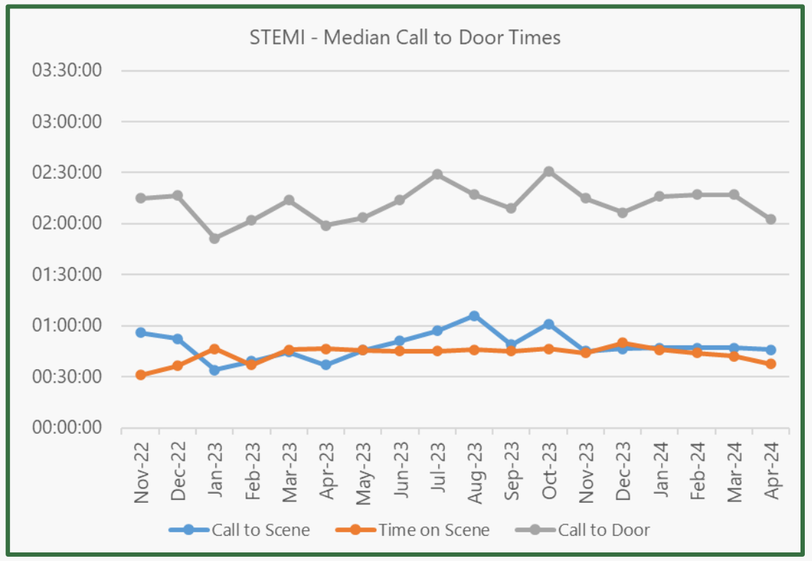
Self-Assessment: Strength of Internal Control: Moderate

QUEST









Analysis

The percentage of hypoglycaemic (diabetic with low blood glucose) patients receiving an appropriate care bundle in April 2024 was 55.5%, a decrease from 58.3% in March. This was against a total case number of 245 in April. There is a correlation between documenting blood glucose levels and care bundle compliance, this has informed the improvement plan.

The percentage of Fractured Neck of Femur (hip fracture) patients receiving an appropriate care bundle in April 2024 was 70.9%, an increase from 54.5% in March. There is a correlation between documenting pain score and care bundle compliance which has informed the improvement plan and contributed to this improvement.

Clinical Indicators relating to call to door times for STEMI (heart attack) and Stroke are now reported on as part of the Ambulance Service Indicators . These show the breakdown for:
Time the call started to time of arrival at scene
Time on scene of the conveying vehicle
Time the call started to time of arrival at hospital

Remedial Plans and Actions

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

Full deployment at pace of the Clinical Indicator Improvement Plan
Focussed communication with WAST clinicians to use the bespoke electronic Patient Clinical Record fields for Clinical Indicators (in addition to the narrative)
Supporting Senior Paramedics to have conversations with clinicians about Clinical Indicators
Health Board focussed clinical workshops to promote understanding of Clinical Indicators and care bundles
Invest in resources to utilise Natural language Processing, a form of Artificial Intelligence to interrogate the clinical narrative on electronic Patient Clinical Records
Review the scripting used for reports in a structured way for each Clinical Indicator bundle, monitor and repeat annually
Implementation of the clinical supervision policy to embed Clinical Indicators
Plan resources required to provide clinical data at an individual level to all clinicians

The Trust's introduction of the Cymru High Acuity Response Unit model, based on improved clinical leadership and enhanced training, will further improve outcomes for patients and is our main response to improve Return of Spontaneous Circulation from cardiac arrest) rates. Since May 2023 there has been an increase in their numbers and availability.

Expected Performance Trajectory

The electronic Patient Clinical Record - Compliance Approval Group are exploring options to improve electronic Patient Clinical Record completion and compliance to Clinical Indicators with prompts when a record is being closed to enable clinicians to easily return to the required field for completion. Live testing will commence during May and will be implemented in a stepwise approach.

This, along with continuing improvements in clinical supervision and the support of Health Board Clinical Leads and Senior Paramedics working closely with the Clinical Improvement, and Clinical Intelligence and Assurance Teams will contribute to an increase in compliance rates.

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

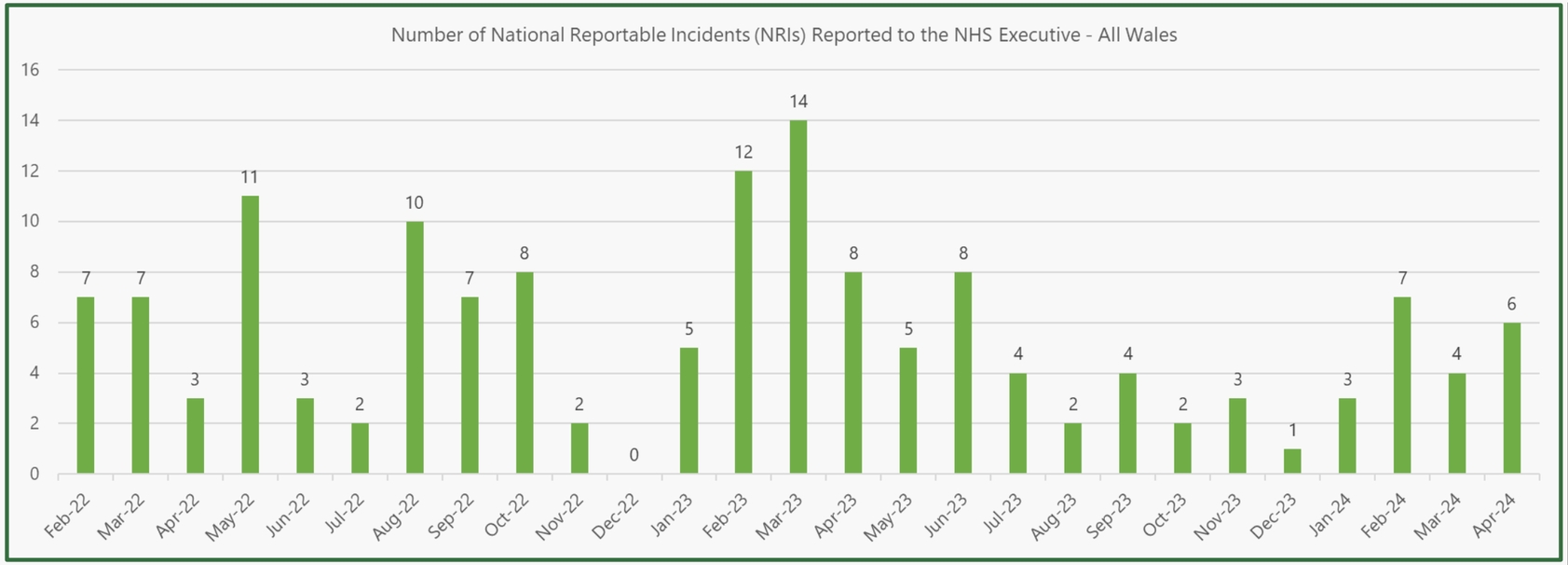
(Responsible Officer: Liam Williams)

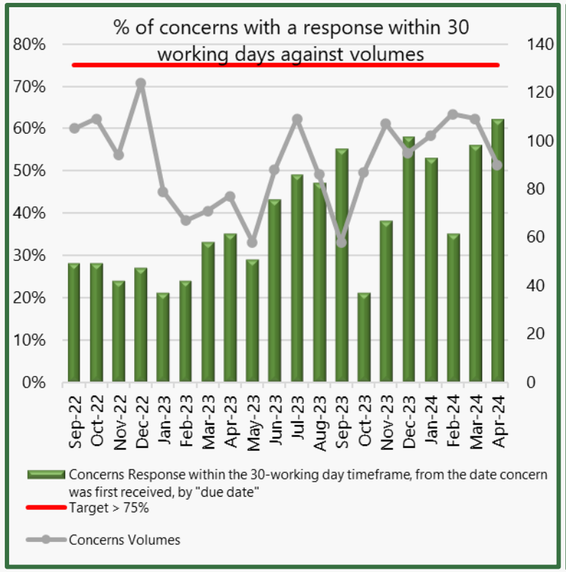
Concerns.
R

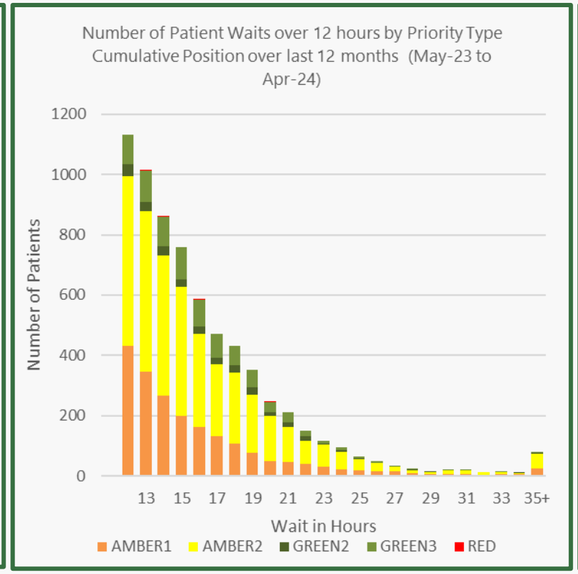
Self-Assessment: Strength of Internal Control: Moderate

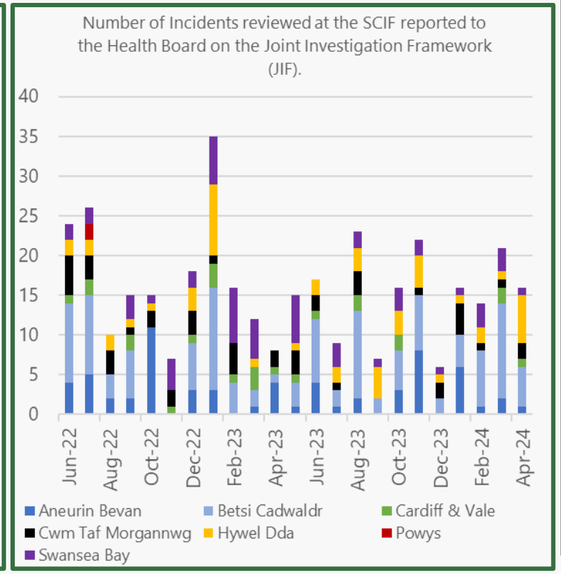
QUEST

Health & Care Standard
Health - Safe Care / Timely Care









Analysis

There has been a month-on-month improvement in the percentage of complaints being responded to within 30 working days (62% for April). This is the highest figure achieved since March 2022 and represents a renewed focus within the complaints team and the initial benefit realisation of the additional staffing resource. Although this remains below the national the national target figure of 75%, the incremental improvement is an important step towards achieving this figure in future. The dip in acknowledging complaints within 5 working days was anticipated due to onboarding of new staff, induction and training requirements. Next month's figures should demonstrate a swift return to usual performance levels. NRIs were reported to the NHS Wales Executive in the previous month, with 3 of them occurring in the BCUHB region. These were identified for reporting during the MDT SCIF meetings, which occur at a weekly frequency. Rapid Review meetings are undertaken by the Patient Safety team three times a week to review all incidents of Moderate harm and above (as per the view of the person reporting the incident). This initial proportionate review ensures that the cases escalated to SCIF are appropriate for the Terms of Reference for the group and those requiring a multi-perspective view on whether external reporting triggers have been met. Both the Rapid Review and SCIF processes consider the enactment of the Duty of Candour which is included in the performance information for the first time.

In April 2024, 584 patients waited over 12 hours for an ambulance response and 69 compliments were received from patients and/or their families.

Remedial Plans and Actions

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

Expected Performance Trajectory

The PTR team will, over coming months, begin to focus on ensuring that recent improvements in the timeliness of complaints responses are sustainable and that we are reducing the longest waiting complaints. It is anticipated that this may negatively impact the headline 30 working day compliance percentage due to the way in which the metric is calculated; however, the organisation recognises the necessity of building strong foundations to being able to maintain an improved position in future (noting the large percentage swings over the last year) and developing a mature quality management approach to its work. There are high staff vacancy and absence levels in the Patient Safety team and the remaining team members are focused on maintaining statutory and national priorities, including identification, reporting, investigating and closure of NRIs and the enactment of the Duty of Candour.

**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change **NB: 30 Day Compliance reported from Power BI and therefore data is not yet validated*

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

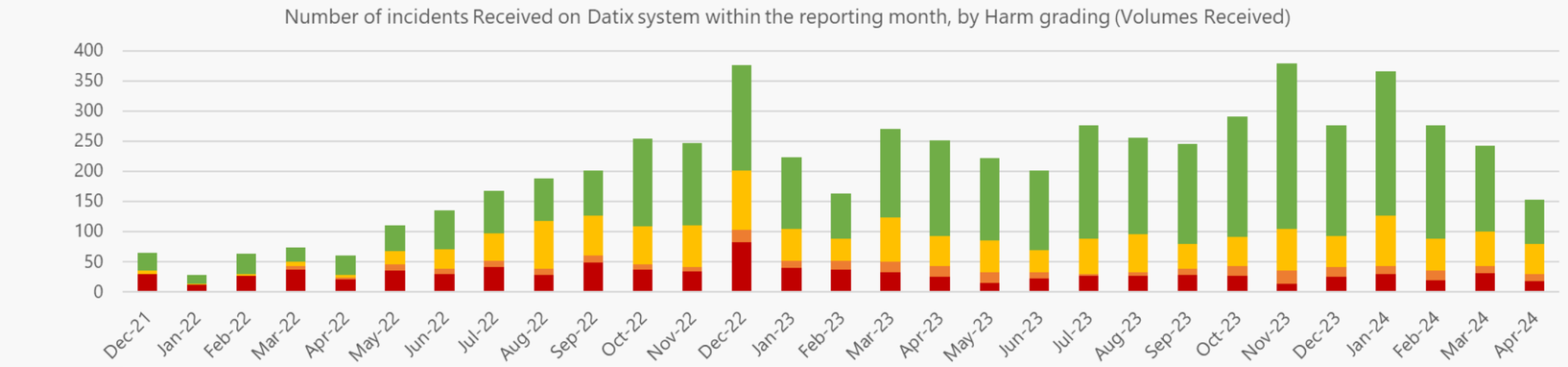
Our Patients: Quality, Safety & Patient Experience
Patient & People Safety Indicators

(Responsible Officer: Liam Williams)

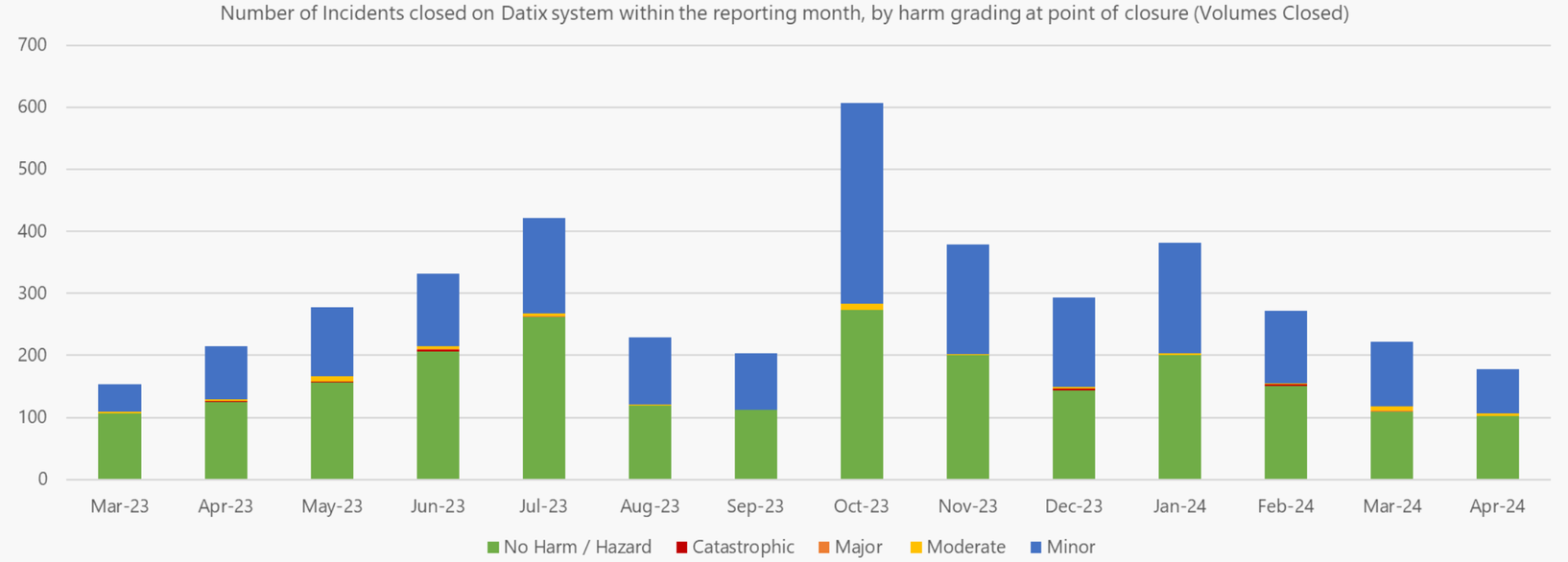
Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care



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



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.

A decrease in incident reporting during April 2024 is observed across all harm gradings. This is understood to be related to periods of reduced demand and the organisation operating at a lower REAP level at points during April. However, the overall month-on-month picture also demonstrates 4 data points on a downward trend, and this is attributed to work being undertaken by the Quality Assurance team to promote effective incident reporting and removing some categories of standard reporting where they are captured elsewhere in performance data to remove duplication of effort.

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 – 23
- Minor harm – 74
- Moderate harm -50
- Severe Outcomes - 11
- Catastrophic - 18

(*NB: Volumes received).

The bottom graph highlights the 178 Incidents that were closed on the Datix system in April 2024. Monthly volumes should be interpreted with caution as incidents can be duplicated on the system (for example two crews submitting the same incident), however as noted above work is being undertaken to rectify these duplications.

Remedial Plans and Actions

A detailed Putting Things Right Recovery Plan has been presented and accepted by QUEST Committee. This includes SMART actions, expected performance trajectories and key dependencies over the coming financial year.

The Trust is represented at national networks including Duty of Candour, Complaints, Ombudsman, Learning, Mortality, Claims, Redress and Datix Cymru development groups as resources allow. Work is progressing in respect of the development of dashboards and the aggregation of data and information to inform patterns, trends and learning opportunities as part of the quality management system.

Expected Performance Trajectory

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

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

Data source: Datix

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

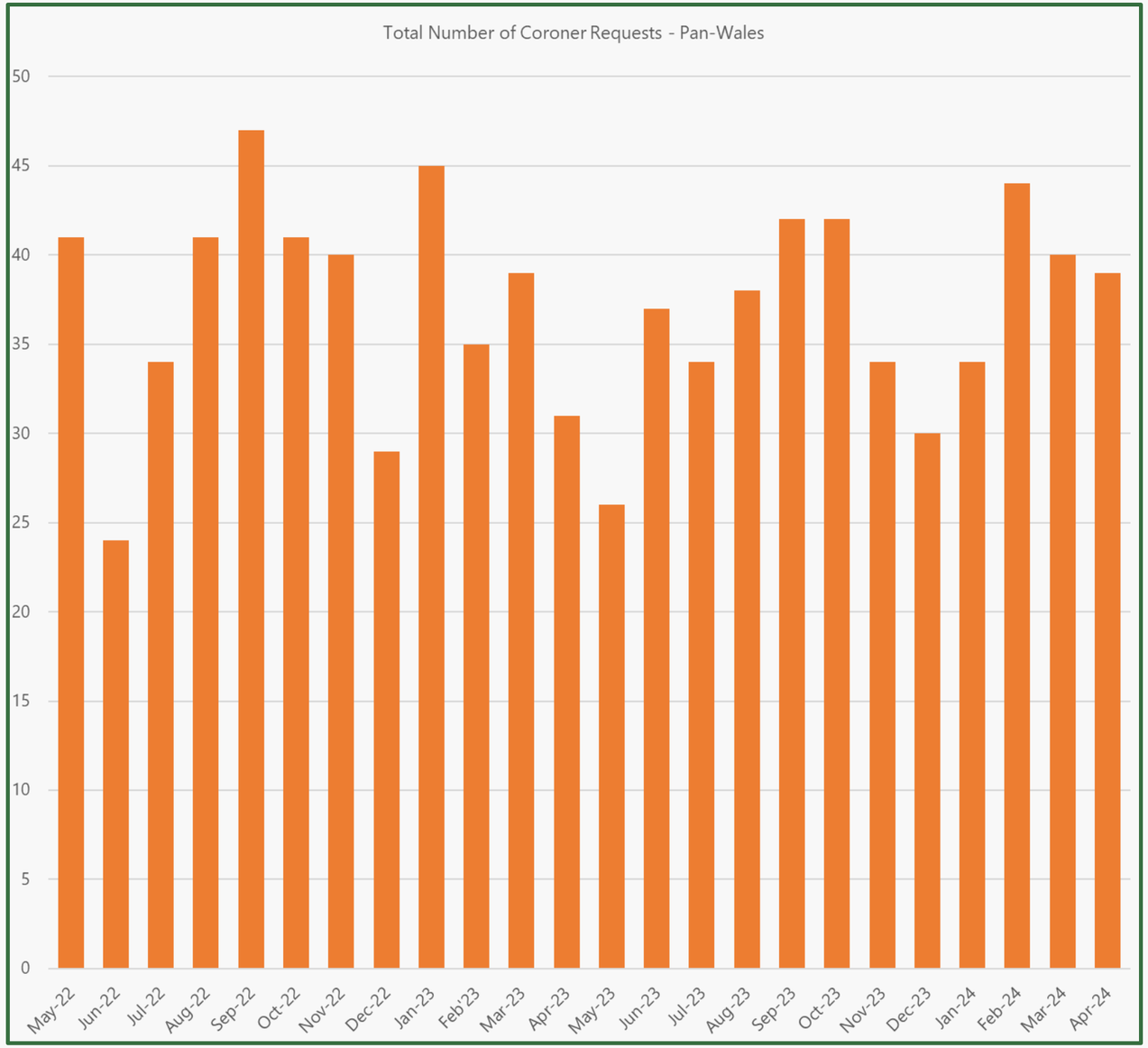
(Responsible Officer: Liam Williams)

Coroners Self-Assessment: Strength of Internal Control: Moderate

Mortality Self-Assessment: Strength of Internal Control: Moderate

QUEST

Health & Care Standard
Health – Safe Care



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

Analysis

Coroners: The complexity of the cases remains high, with multiple statements and actions per approach. This is in addition to the work required to manage cases where the Trust has been given IP status. The number of cases in which the Trust is an IP raised in April 2023 and continues higher, we now consider this to be the new normal. Cases continue to be registered and distributed. Delayed statement requests are escalated to ensure that the Trust does not receive a Schedule 5 summons.

Ombudsman: There has been a reduction in initial approaches to the Trust by the PSOW. All PSOW cases are now being managed via Datix Cymru. A deeper dive into the cases has been undertaken and will be reported as part of the next quarter report. The Ombudsman is considering issues surrounding joint investigations and the issues of elderly patients laying on floors waiting for ambulances.

Mortality Review: The Trust continues to participate in Health Board led mortality reviews as appropriate, with attendance from the Patient Safety Team and clinical colleagues as available. Data and information is also provided by the Trust as required to the Medical Examiner Service to inform their reviews of deaths in acute care. Feedback from the Medical Examiner Service in respect of themes and trends include timeliness in response to patients in the community, handover of care delays, lack of ceilings of care in place for patients and patients on the end-of-life care pathway being conveyed to acute care. Currently the focus of the Medical Examiner Service is undertaking reviews in the acute care setting and the plan is for all non-coronial deaths, including community deaths to be reviewed by the Medical Examiner Service from September 2024 (moved from April 2024). An increase in referrals for the Trust is expected when this occurs. There is a backlog of the review of referrals currently. Following initial screen cases are currently escalated to the Serious Case Incident Forum and an analysis and mapping exercise of all cases up to 31.03.2024 is currently underway (due to be completed Q2 2024/5).

Remedial Plans and Actions

Coroners: There continues to be additional work due to the ongoing recovery of the Trust solicitor/claims manager, who is unable to travel for long distances. A temporary staff member's contract has been extended to the end of April 2024 to try and minimise the impact of the additional work. The Legal Services Team is not yet fully staffed following OCP, and work continues to ensure that the Team is fully formed as soon as possible.

Ombudsmen: *All cases are recorded and monitored on the Datix system.*

Mortality Review: The Trust is in the process of developing the internal mechanisms in order to facilitate mortality reviews aligning to the national approach. This includes consideration of the resources required in the new Putting Things Right (PTR) Team structure with additional roles included in the Patient Safety Team. Recruitment to the new structure is expected to be completed by July 2024. Representation and contribution by the Trust at the All-Wales Mortality Working Group continues. The Patient Safety Team are engaged in the meetings led by the Once for Wales Datix Cymru Team who are developing the Datix Cymru Mortality Module. The Learning from Deaths Forum, chaired by the Assistant Director of Quality & Nursing is established and is currently meeting on at least a quarterly basis, with oversight and reporting to the Clinical Quality Governance Group. Following the publication of the next iteration of the All-Wales National Mortality Framework which includes the processes in primary care, the Learning from Deaths Forum will oversee the updates to the Trust's Framework.

Expected Performance Trajectory

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

Ombudsmen: Learning has been placed in a PTR, for sharing pan Wales.

Mortality Review: Whilst the multiple benefits of the Medical Examiner Service are recognised there will undoubtedly be significant resource implications for the Trust, particularly as the process expands to every non-coronial death in NHS Wales by the end of September 2024 and the Health Boards (who are at different levels of maturity regarding mortality reviews) start to develop and embed their processes. Following the recruitment to the new PTR Structure (expected by July 2024) improvements in the timely review of MES referrals is expected which is detailed in the Putting Things Right Recovery Plan (April 2024).

Mortality Reviews Data source: Internal Web Application

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

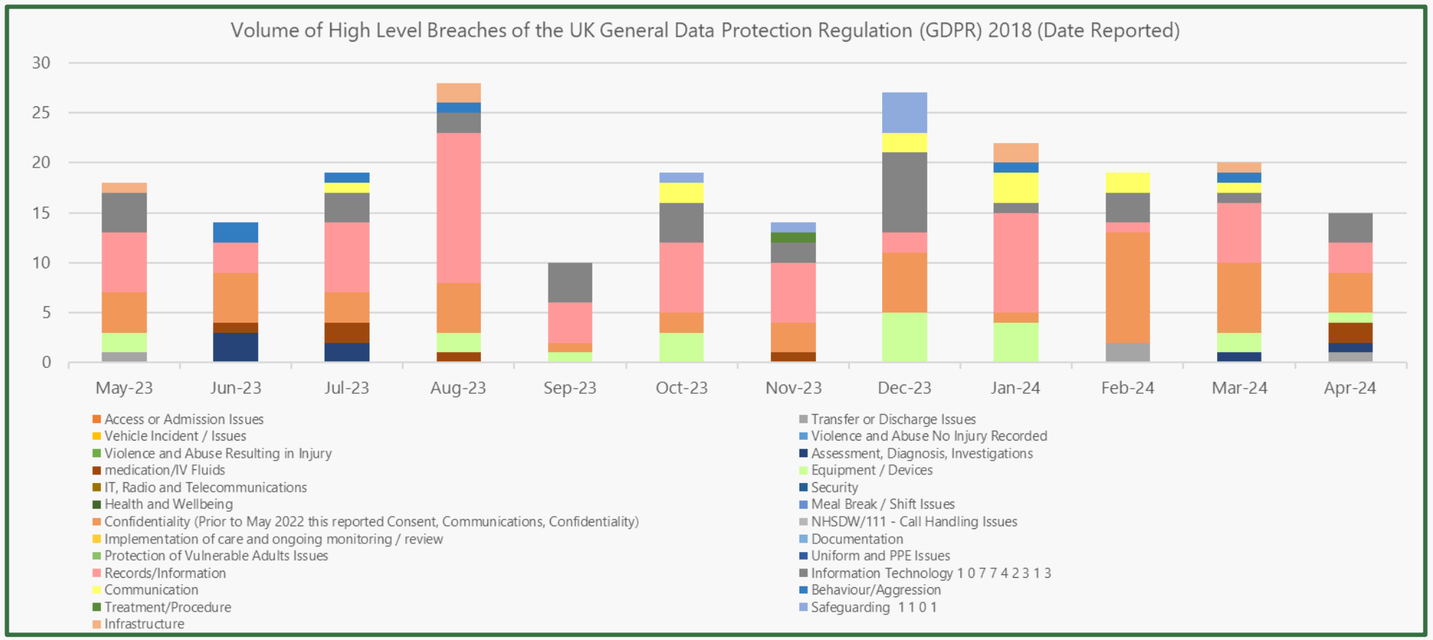
(Responsible Officers: Jonny Sammut & Liam Williams)

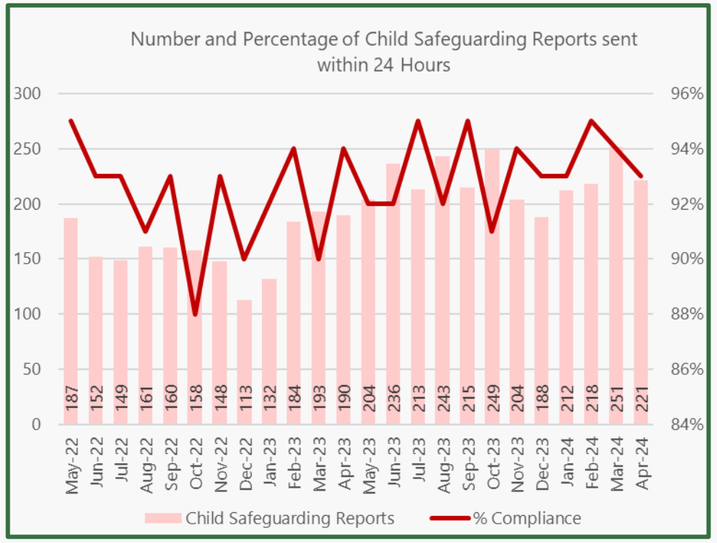
Safeguarding Data source: Doc Works

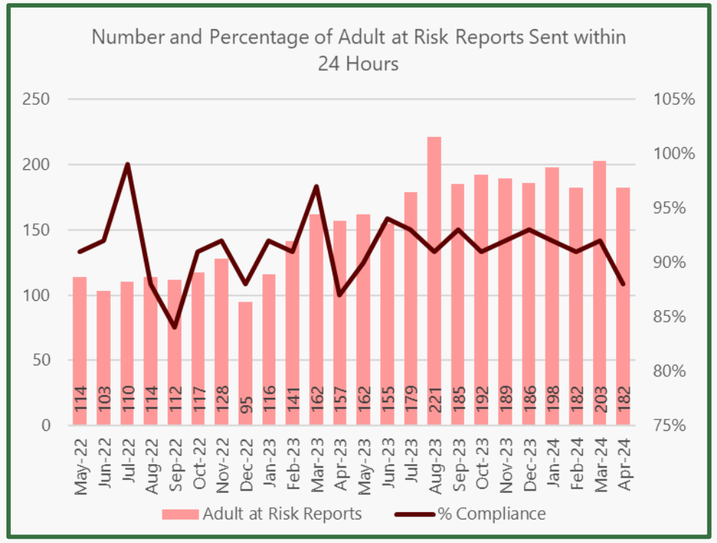
Self-Assessment: Strength of Internal Control: Strong

QUEST

Health & Care Standard
Health – Safe Care







Analysis

Safeguarding: In April 2024 staff completed a total of 182 Adult at Risk Reports, 88% of these were processed within 24 hours. Whilst the Trust does not report on Adult Social Need reports, 544 referrals were received and processed to the local authority during this reporting period. There have been 221 Child Safeguarding Reports in April 2024, 93% of these were processed within 24 hours.

Data Governance: In April 2024, there were 15 information governance (IG) related incidents reported on Datix Cymru categorised as an Information Governance (IG) breach. Of these 15 breaches, 4 related to IG/Confidentiality, 3 Records/Information, 1 equipment/devices, 3 Information Technology, 1 Assessment Investigation and Diagnosis, 2 medication, and 1 transfer/discharge.

Public Engagement: During April, the Patient Experience and Community Involvement Team attended 25 community engagement opportunities, engaging with approximately 402 people. This month engagement has included attendance at the North Wales African & Caribbean Society, alongside our colleagues from BCU Health Board. Where we spoke to members about accessing and using local health services and listened to experiences and concerns the group had. We attended Women's Institute and Men's Shed groups in Cardiff where we had discussions about the Welsh Ambulance Service as well as providing CPR and Defib awareness sessions with members. In Cwm Taf we facilitated 6 workshops for children at a local secondary school to raise awareness of and learn practical lifesaving skills within a community where there are complex health needs. The workshops were well received, students enjoyed the practical exercises. We have also continued to engage with local LLais branches across Wales and met with colleagues from the Cardiff & Vale and North Wales of LLais branches in April; as well as attending the LLais National Conversation event in Cardiff where LLais launched their 3-year strategic plan, reflected on the first year of Llais and identified opportunities for future working. Through the month we have also continued to make a range of Patient Experience Surveys (PREMs) available to the public, asking people to provide feedback about their interactions with our services. We acknowledge that response rates to some of these surveys remains low and isn't truly reflective of all patient's experience, though we are working with colleagues to try and increase return rates. Engagement and survey outcomes remain largely consistent and tell us that people 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 generally 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 longer than wanted delays when waiting for their transport home following their appointment.

Remedial Plans and Actions

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

Data Governance: During the reporting period, of the 15-information governance related incidents reported on Datix, 0 incidents were reported to the Information Commissioner's Office (ICO). The IG Team continues to review and provide advice on reported incidents. Remediation actions are continuing on some incidents.

Public Engagement: Community involvement and engagement with patients/public forms an integral part of the Trust's strategic transformation ambitions to 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. Response rates to some of our PREM's surveys is disappointingly low and we acknowledge that this means we cannot report a truly reflective picture of what it feels like to be a user of some of our services. We are actively working with colleagues across the Trust in a number of different departments to try and agree on solutions that would allow us to directly contact more patients to ask for feedback about their experiences with us. In the interim we are also exploring other options to increase survey engagement and in April met with colleagues from South East Coast Ambulance Service (SECAmb) who have had similar experiences and faced the same barriers to capturing real time patient feedback. SECAmb have recently been successful in placing stickers with QR Codes to their PREMS surveys in the back of all their EMS vehicles, allowing patients, if well enough, or family members to provide feedback about their experience. We have begun to look into the possibility of replicating that approach here at WAST.

Expected Performance Trajectory

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

Data Governance: The IG Toolkit submission for FY23/24 was submitted end of March. Of the 11 categories being assessed, 5 met the Minimum Expectations standard. An Improvement Action Plan for the next submission has been developed and will be shared with the Information Governance Steering Group in June 2024.

Public Engagement: All feedback received is shared with relevant Teams and Managers and continues to be used to influence ongoing service improvement. Patient experience and community engagement information is now shared weekly at the Senior Quality Team meeting.

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

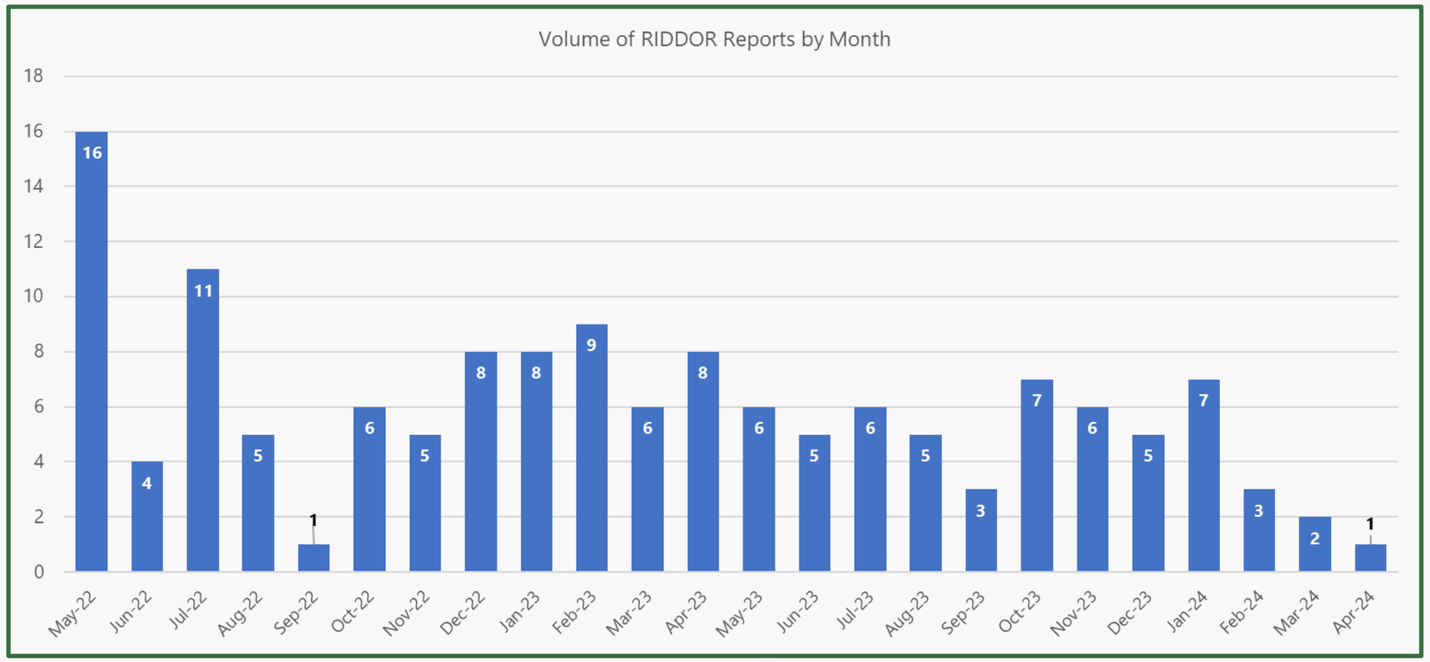
Our Patients: Quality, Safety & Patient Experience
Health & Safety (RIDDORS) Indicators

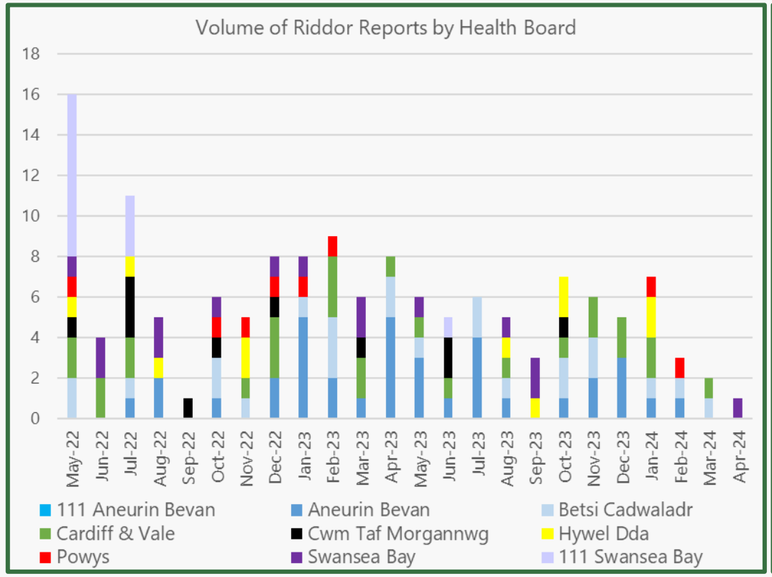
(Responsible Officer: Liam Williams)

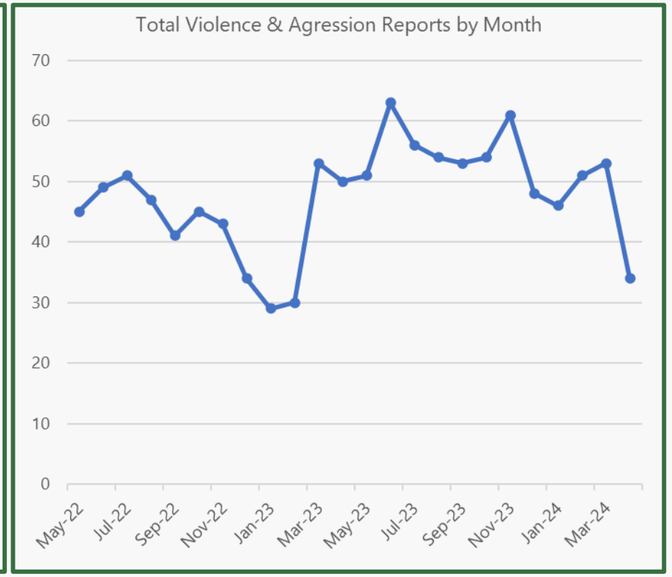
Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care







Analysis

RIDDOR: There were 1 incident requiring reporting under RIDDOR during April.

The staff member absent from work for over 7 days because of their injury that resulted from loose fabric becoming entangled and curtain rail falling onto their left arm causing injury.
The report was not submitted within the reporting required time frames. Health and Safety team will continue to work with Incident Handlers to ensure reports are submitted within the required timescales.

Manual handling continues to be the highest category of incidents reported under RIDDOR.

Violence and Aggression: A total of 34 incidents have been reported of V&A in April.
1 Physical Assaults on staff were reported during the month with incidents of verbal abuse amounting to 33 for the month.
There was 1 report for inappropriate sexual behaviour experience by our call centre staff.
12 incidents were reported as Moderate in harm and 16 noted as low harm which is lower than the trend seen since August 2023.
Verbal abuse continues to be the major category of reporting received with aggressive and threatening behaviour toward staff still at high levels in our contact centres.

Remedial Plans and Actions

RIDDOR: The new DSE/Manual Handling Advisor has reviewed the manual handling incidents for the past two years and is currently interview individuals to identify any human factors involved in their incident.

Violence and Aggression: The V&A Team have visited the 111 call centres and completed visit to the EMSC areas to gain a better understanding of the incidents of verbal abuse received and the challenges of reporting the incidents on Datix. This work has yielded valuable information that will contribute to risk assessments designed to manage ongoing V&A risks in our call centres.

Expected Performance Trajectory

RIDDOR: As we approach the summer months the incidents of slip trip and fall incidents is seeing a decrease as are manual handling injuries as manual handling training is being rolled out by training school.

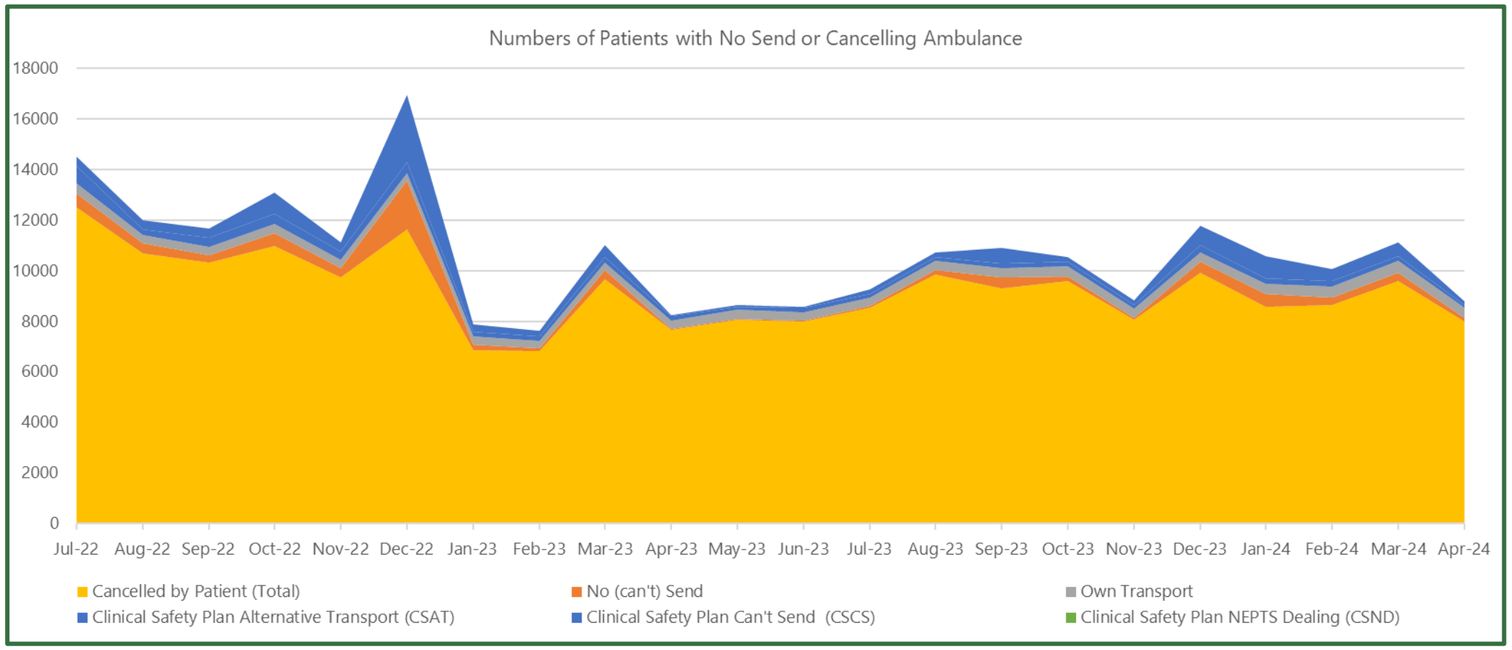
Violence and Aggression: Controls for risk assessments within EMSC/111 will be reviewed as the new software used in the call centres is embedded.
May the 30th will see the launch of a revised Obligatory Response to Violence supported by a further Welsh Health Circular 2024 in conjunction with the All Wales Anti-Violence Collaborate.

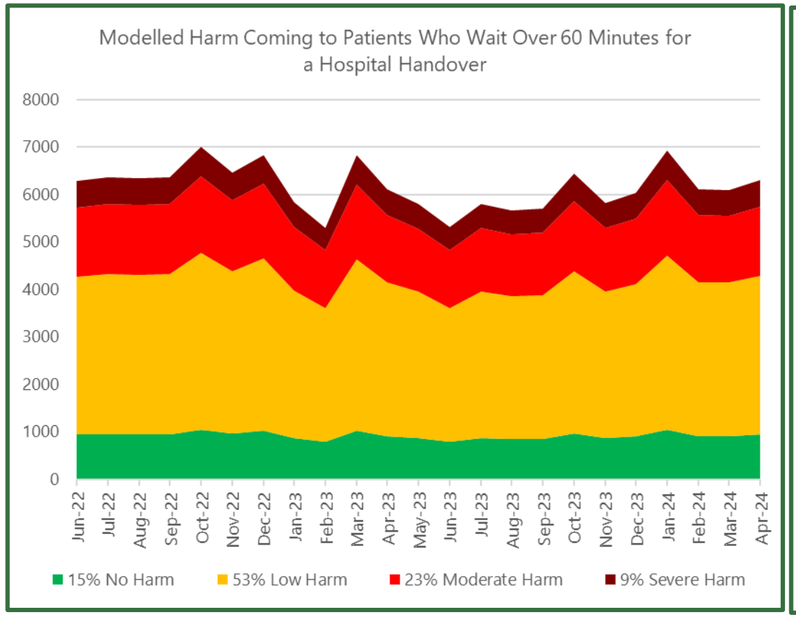
**NB: Data correct on the date and time it was extracted; therefore, these figures are subject to change*

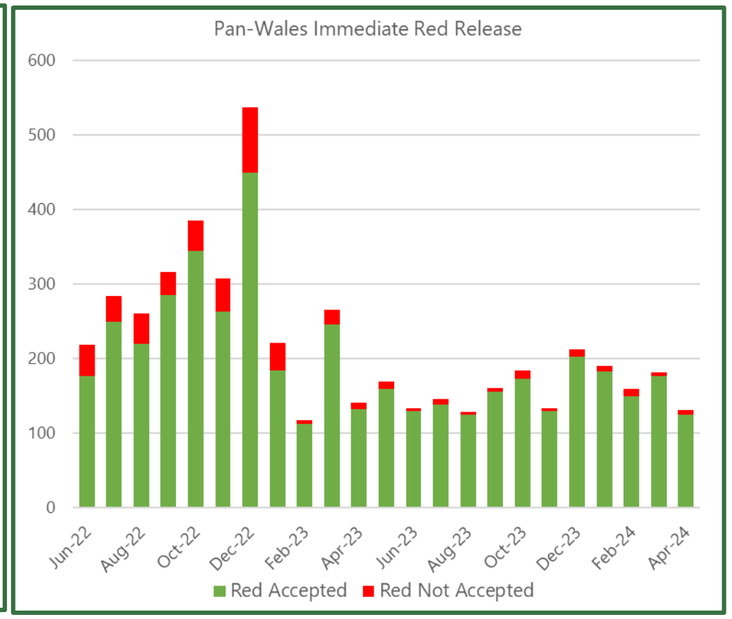
Data source: Datix

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

(Responsible Officer: Andy Swinburn) G FPC







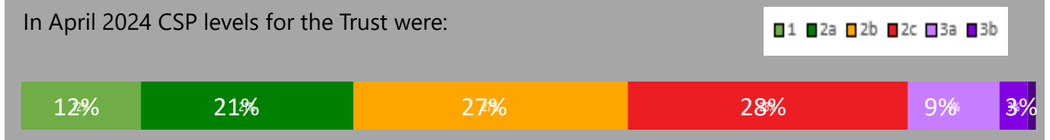
Analysis

In April 2024, 104 ambulances were stopped due to Clinical Safety Plan (CSP) alternative transport and 170 were stopped due to CSP 'Can't Send' options. In addition, 7,975 ambulances were cancelled by patients (including patients refusing treatment at scene) a decrease from 9,605 in March 2024.

There were 483 requests made to Health Board EDs for immediate release of Red or Amber 1 calls in April 2024. Of these 125 were accepted and released in the Red category, with 6 not being accepted. Further to this, 115 ambulances were released to respond to Amber 1 calls, but 237 were not.

The graph in the bottom left shows that in April 2024 of the 6,304 patients who waited outside an ED for over an hour to be handed over to the care of the hospital, the Trust could assume that 15% (945 patients) would experience no harm, 53% (3,341 patients) would experience low harm, 23% (1,449 patients) would experience moderate harm and 9% (567 patients) would experience severe harm.

In April 2024 CSP levels for the Trust were:



Remedial Plans and Actions

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

Expected Performance Trajectory

The Trust continues to monitor CSP levels both daily through the ODU and weekly through the Weekly Operations Performance Meeting and mitigations are actioned to reduce the impact on the Trust's ability to respond to demand. See also slides on Red performance and Amber performance, in particular, remedial actions.

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

Our Patients: Quality, Safety & Patient Experience
Patient Experience Surveys

(Responsible Officer: Liam Williams)

Self-Assessment: Strength of Internal Control: Moderate

PCC

Health & Care Standard
Health – Safe Care

April 2024		
NEPTS (134 responses)	Benchmark	Score
How long did you wait for your transport to take you home after your appointment.	85	81
Were you happy with the transport you received?	85	92
999 (3 responses)	Benchmark	Score
The 999-call taker who answered your call was reassuring.	85	100
The 999-call taker who answered your call explained what was going to happen next.	85	100
You felt confident in the call taker ability to manage your call and provide appropriate advice.	85	100
The length of time I waited for an ambulance to arrive was acceptable.	85	38
111 (13 responses)	Benchmark	Score
Do you feel your call to 111 Wales was helpful?	85	48
Did you follow the advice given to you by NHS Direct Wales?	85	90
Would you consider using NHS 111 Wales again?	85	88
WAST Overall - Friends & Family Test How was your overall experience with the service today?	Ranked from very poor to very good.	
○ Ambulance care	88.99% Good	9.17% Poor
○ Integrated Care (NHS 111 Wales Telephone line only)	62.50% Good	37.50% Poor
○ EMS (including CSD)	50% Good	50% Poor
○ NHS 111 Wales Online	79.17% Good	16.67% Poor
	* Where totals above do not add up to 100%, this is because a 'Do Not Know' answer was given, these are excluded from overall total.	

Analysis
Within the NEPTs survey the responses provided did not hit the benchmark in relation to the questions 'How long did you wait for your transport to take you home after your appointment and 'Were you happy with the transport your received', therefore not providing the level of service the patient expected. However, 92% in the 111-survey confirmed they took the advice given by NHS 111 Wales.

Response rates to the 999 and 111 surveys are low and it's acknowledged that these do not reflect an entirely representative picture based on overall call volumes, but we are consistently trying to improve public engagement with these surveys using all options open to us

Remedial Plans and Actions
We continue to make available 4 core Patient Experience surveys, covering the Trust's main service delivery areas:

- 999 EMS Response (incorporating CSD)
- Ambulance Care (NEPTS)
- NHS 111 Wales Telephony
- NHS 111 Wales Online

We are continuing to work on a DPIA to be submitted to the ICO for their consideration about us of SMS text messages to directly distribute survey requests to service users. Though this has been delayed as we work through the Trust's DCR Table to determine which dispatch codes should be excluded from this feedback process. We have met with colleagues at South-East Coast Ambulance Service who have successfully placed QR codes in the back of all their EMS vehicles to increase patient feedback and we plan to explore use of the same model here at WAST. We have now received feedback from WAST's IPC and Fleet Teams and are progressing with this initiative.
We also continue to work closely with the Trust's Falls Improvement Lead to deliver targeted survey looking at the experiences of people who are responded to by either a Level 1 or Level 2 falls responder. Patients who are left at home with no further intervention required are left an invitation to share their experience with us by completing a survey. The invitation contains a QR code that can be scanned to access an online survey, contact details for the PECI Team are also included allowing people to request a hard copy survey is sent to them. In April 38 people completed a Falls Survey with a majority of respondents rating their experience with the Falls service as 'Very Good'. Using this method of requesting patient feedback has proved successful and we are currently working with the Volunteer Team to implement a similar process to capture feedback from patients attended to by a Community Welfare Assistant.
Capturing service user experience through the use of surveys is a mandatory requirement and a new reporting framework is submitted to the NHS Executive and Welsh Government on a quarterly basis outlining how many surveys have been completed. Throughout this month we have also continued to engage with the Once for Wales Programme Board who have been reviewing the 'All Wales Patient Experience Question Set' and the updated 'People's Experience Framework'. The Framework and new questions will be presented to Executive Directors of Nursing at their next meeting for final approval. If approved we expect Welsh Government to issue an updated Welsh Health Circular in June, which will provide our updated mandate to capture service user experience through the use of experience surveys.

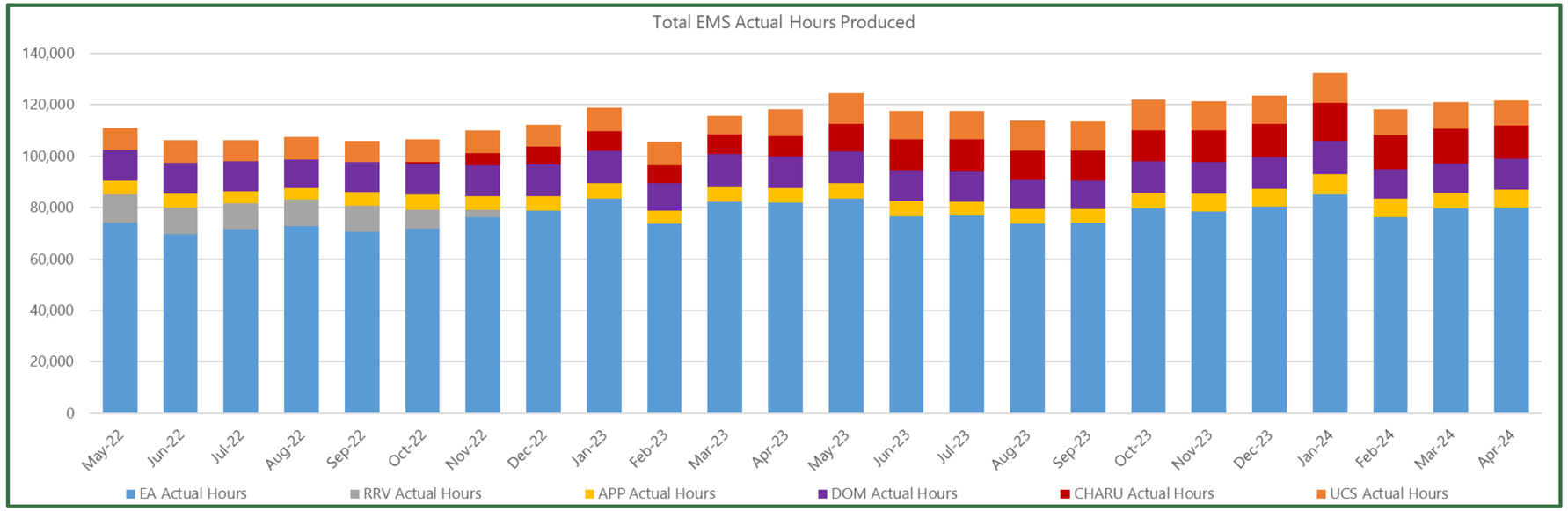
Expected Performance Trajectory
Work to further integrate our systems with Civica to push email/text surveys to patients. Using Other methods of survey delivery such as QR codes in EMS vehicles to compliment this, with an overall aim of increasing visibly of experience surveys and maximising opportunities to capture patient experience data through experience surveys.

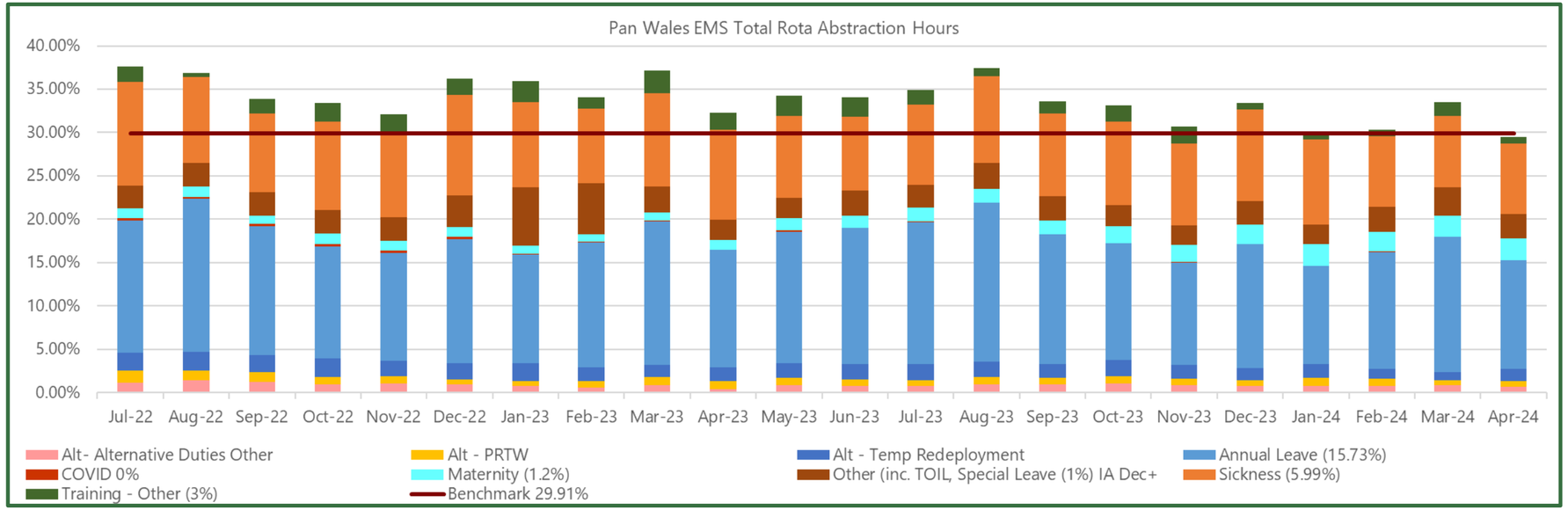
Our People
Capacity - Ambulance Abstractions and Production Indicators

(Responsible Officer: Lee Brooks)

EA Production	Abstractions
G	R

CI PCC FPC





Analysis

The total hours produced is a key metric for patient safety. The Trust produced 121,578 hours in April 2024, compared to the 118,141 hours produced during April 2023. The Trust is delivering good levels of production.

As shown in the bottom graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced, as are the total number of staff in post. In April 2024, total EMS abstractions (excluding Induction Training) stood at 29.47%. This was a decrease from the 30.49% recorded in March 2024 meaning the Trust achieved the 30% (which is the benchmark figure). The highest proportion of abstractions was due to annual leave at 12.48% followed by sickness at 8.17%. This figure for sickness abstractions for April 2024 was a decrease when compared to the same month last year (10.36%).

Emergency Ambulance Unit Hours Production (UHP) achieved 96% in April 2024 which equated to 80,076 Actual Hours. This is a 2.3% decrease on the Actual Hours produced during April 2023 but is above plan.

In April CHARU UHP was 73% against the full roll out requirement (note this requirement is not fully funded by commissioners).

Remedial Plans and Actions

Continued focus on managing attendance across the Trust and managing abstractions from rosters.
Full roll out of CHARUs.
Continued focus on staff in post to establishment, aiming for 95% benchmark.
Smoothing of staff between urban and rural areas.

Expected Performance Trajectory

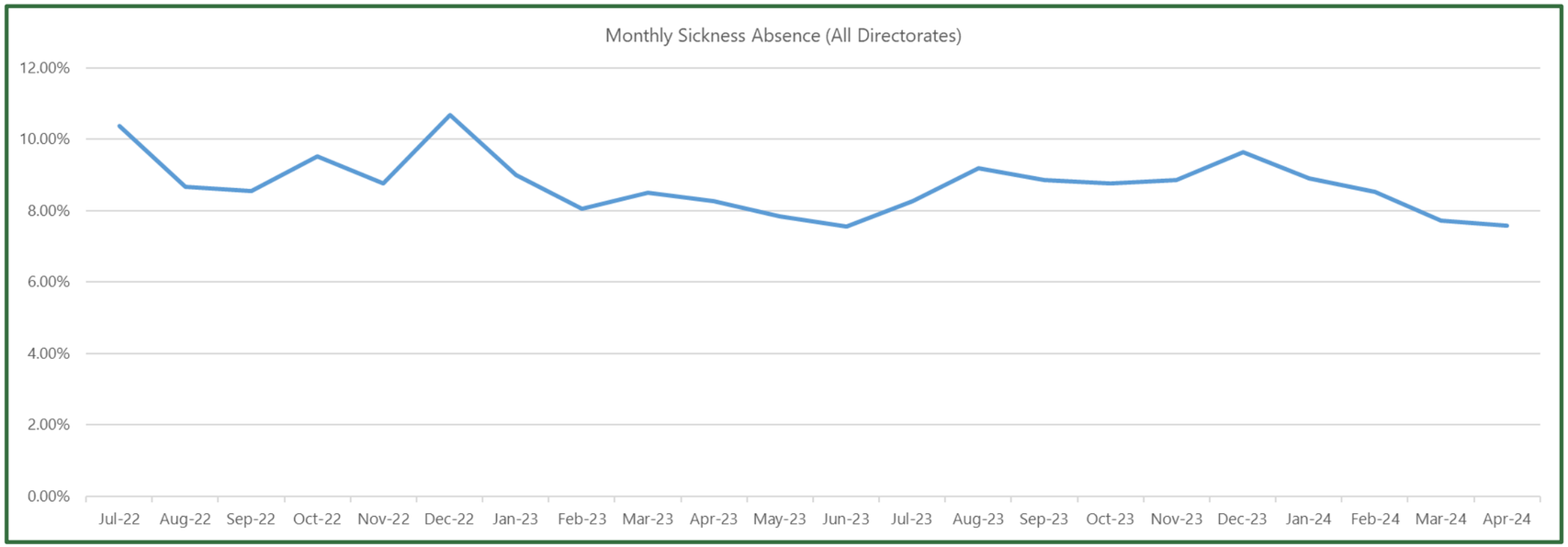
UHP estimates, based on recruitment levels, estimated abstractions and overtime have been provided to ELT. Production is good. The Trust has an ambition to reduce sickness to 6% and abstractions to 30% by March 2024. This has not quite been achieved, but the direction of travel is good, with the abstractions benchmark being achieved in January and February and sickness absence (whole Trust) below 8% for March 2024 (see next slide).

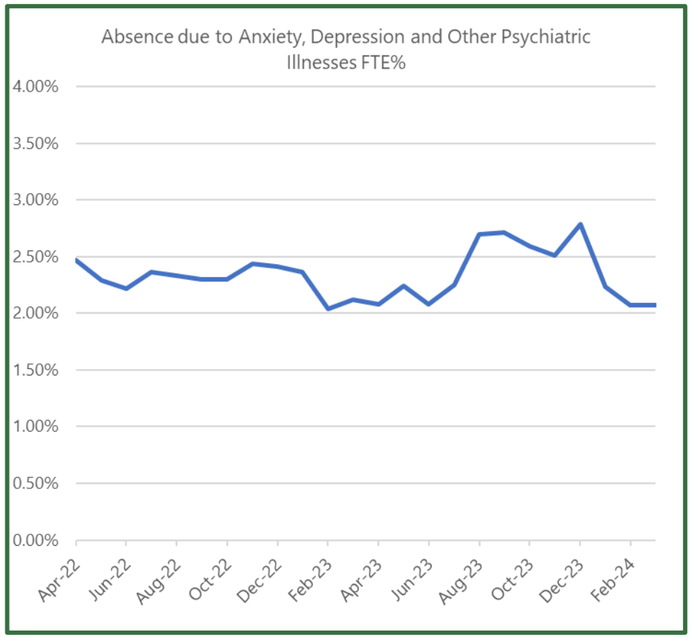
Our People
Capacity - Sickness Absence Indicators

(Responsible Officer: Angela Lewis)

Mental Health
A

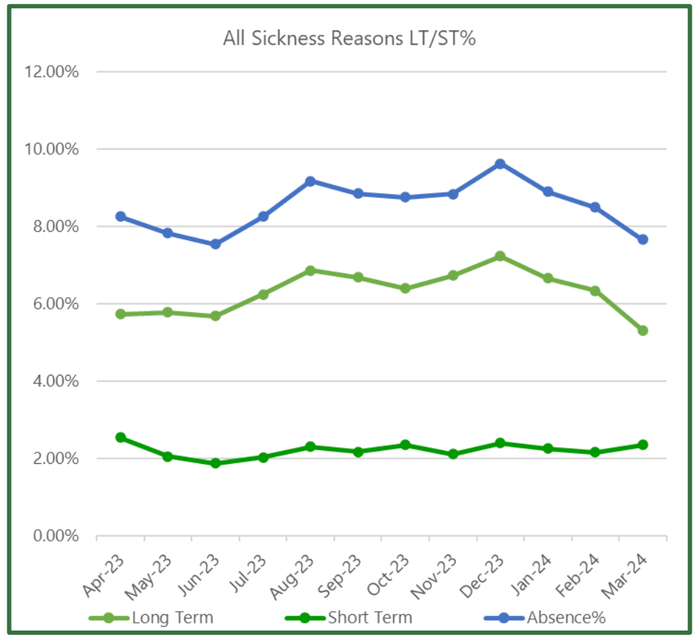
CI





Average working days lost per FTE (Annual)	
19.43 days	
Single month Absence %	
7.67%	
Long Term	**Short Term**
5.31%	2.35%
Mental Health	**Other MSK**
S10 Stress/Anxiety	(excluding Back)
2.07%	0.87%

March 2024



Analysis

There was a decrease in overall sickness absence rates between March 2024 and April 2024, dropping from 7.67% to 7.58%. Long term absence decreased from 6.34% in February to 5.31% in March and short-term absence increased from 2.16% in February to 2.35% in March.

The highest reason for short term absence in February 2024 was Anxiety/ Stress/ Depression, other musculoskeletal problems and cold, cough, flu-influenza.
Long term sickness case management continues and indicative figures for April 2024 shows a decrease to 5.47% from 6.23% in March.
Indicative figures for short term absence in April 2024 shows an increase to 3.13% from 3.24% in March.

Absence due to Mental Health has had an upwards trajectory since June 23, however, it is now at 2.07%, which is back in line with figures seen during the early part of 2023.

Our occupational health waiting times have greatly improved, our KPI of 10 working days from receipt of management referral to first offer of appointment is met and currently colleagues are waiting for 3 to 5 working days. From receipt of Wellbeing referrals to first call (from one of our Wellbeing Practitioners), the waiting time is still 2 days. The team continue to triage all referrals and enquiries to ensure prioritisation of anything that requires urgent attention.
Our contract with our new our Employee Assistance Programme; a launch will take place in May this year.

Remedial Plans and Actions

- Monitoring continues with ongoing reviews in both long term and short-term absences with monthly meetings to track sickness and provide support.
- MAAW training and bitesize training sessions continue to be scheduled on a bi-monthly (MAAW) and monthly basis (Bitesize sessions).
- In line with the Improving Attendance Action Plan, the People Services Advisors have undertaken audits on short term absence occurrences within the Operations Directorate.
- Audits for all Directorates, will be undertaken on a monthly basis over the next 6 months and the People Services Team will provide targeted support to line managers on reasonable adjustments and the appropriate use of discretion in areas identified as hot spots.
- We have recently recruited 2 Occupational Health Advisors to cover maternity leave, we also recruited a Clinical Team Lead.

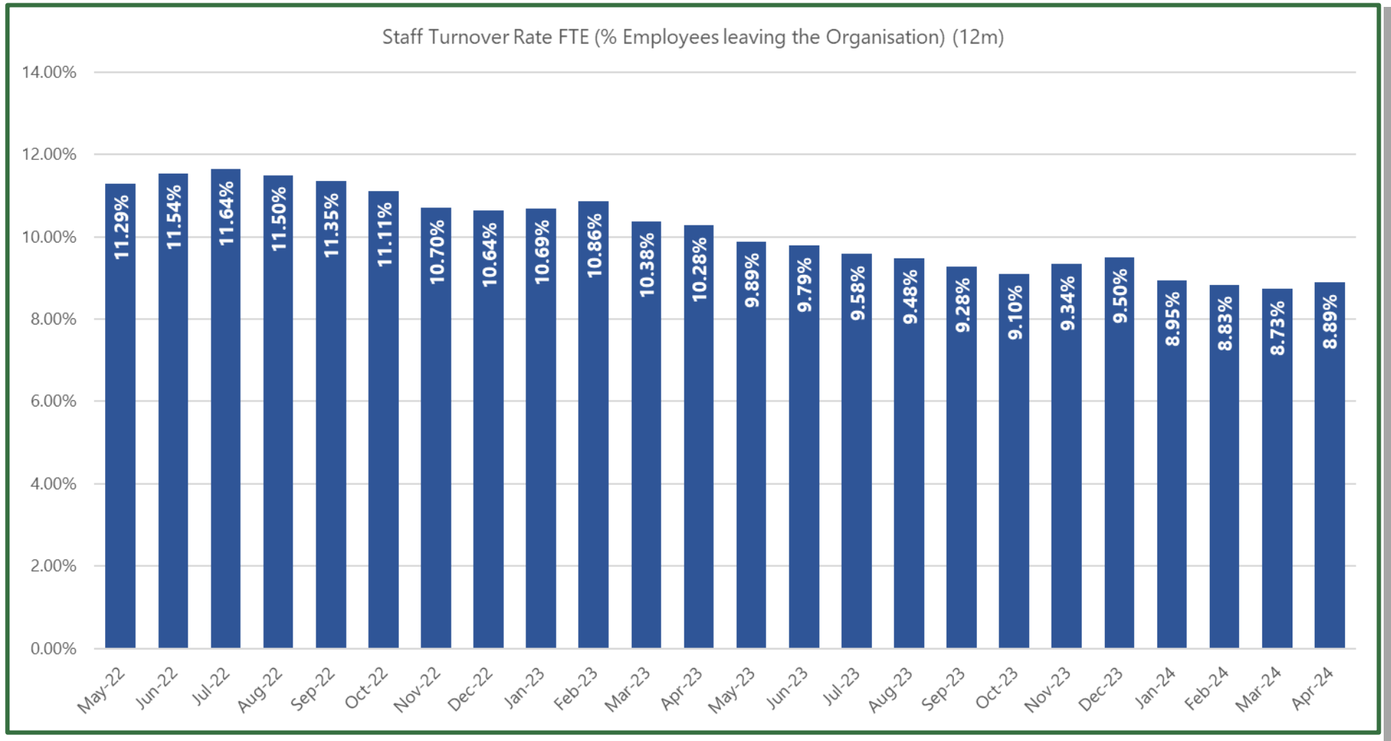
Expected Performance Trajectory

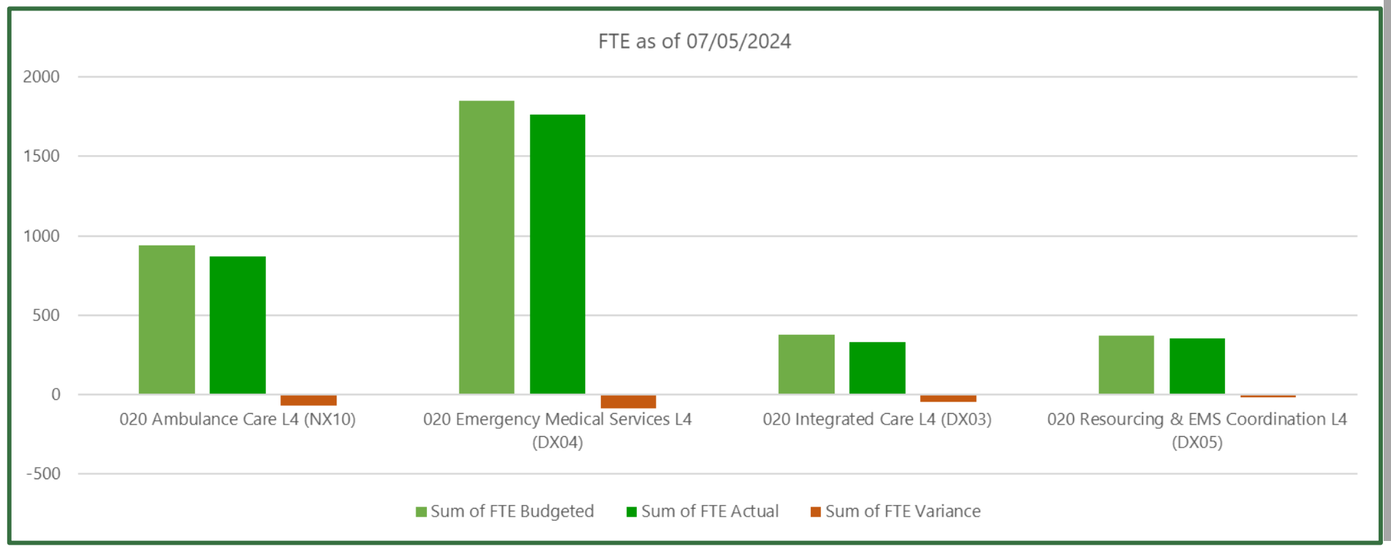
The Trust has indicated through its IMTP that sickness levels will fall in this financial year, but that there remain risks to delivery.
NB: Sickness data will always be reported one month in arrears. It should be noted that the figures reported in this presentation are official to 31st March 2024. All figures for April 2024 are indicative only (as of 23.04.24).

Our People
Capacity - Turnover

(Responsible Officer: Angela Lewis)

Turnover
A





Analysis

Staff turnover rates in April 2024 were 8.89%, which is a slight increase from the 8.73% recorded in March 2024, however, rates have generally been declining since they peaked in July 2022. April saw 30 leavers (27.26 FTE) from WAST compared to 35 in March and 26 in February. (Turnover in months at the end of the quarter are generally higher). This was balanced with 44 joiners (40.27 FTE) in April. Of those leaving, the majority were from Ambulance Care (9 people) and Paramedic (4 people). 10 leavers were due to retirement, 4 were granted flexible retirement, 3 were dismissals,12 were resignations and 1 was death in service.

Shift overrun average times have been steadily increasing again following a two year low recorded in June 2023, however, the average figure for April 2024 was 40 minutes and 49 seconds compared to 41 minutes in March 2024. Shift overruns are a key element of staff wellbeing and work is ongoing to mitigate these in conjunction with handovers, as although not shown here there is a clear correlation.

Remedial Plans and Actions

We continue to improve our data collection through Our MI system (Opas G2), so that we can produce accurate and reliable data. We have defined our standard reports, I.e. which reports need to be run regularly, on a daily, weekly or monthly basis, etc. Also, building our own customised reports for which we can report on themes and trends and identify areas that may require additional support. From this information we can complete appropriate analyses and target our Occupational Health and Wellbeing provision (including themes/promotional events) in an appropriate way.

Our MI reports can be used to support strategic decision-making regarding the service, also to provide impact analysis and highlight value for money. We are still working closely with the Welsh health boards to standardise our reporting.

The Wellbeing team continue to support colleagues and managers who are facing large-scale changes through holding regular meetings and facilitating drop-in sessions for colleagues. We are currently offering support to managers through scheduled events; Occupational Health - Guidance on Management Referrals. We have facilitated two events already; attendance has been good at both.

Our provider for our Employee Assistance Programme has now been appointed and a launch will be conducted in May/June.

Our self-booking option for Occupational Health continues to prove popular and has improves and streamlines the service. We continue to evaluate the service through gathering feedback from our colleagues, we are improving this process by updating our questionnaire and will be circulating this through Opas G2.

The clinical team continue to support People Services and managers through sickness absence meetings. Team members from OH/Wellbeing/TRiM continue to promote the service using our Occupational Health & Wellbeing vehicles, also through presenting to new starters within WAST and through attendance at managers' meetings.

Working with People Services, our Head of Workplace Wellbeing has been offering psychological support for staff for their long-term sickness. The team continue to deliver Drop-in sessions across all our Clinical Contact Centres, (CCCs) dates for 2024 have been advertised. These are delivered in person at the EMSCs and online via Teams. The REACT (Recognise, Engage, Actively Listen, Check Risk, Talk) training is still proving popular, new dates have been advertised on Siren.

The Wellbeing team were present at each of the CEO roadshows in April, sharing information, providing advice and guidance, and promoting the service.

We are still in the process of writing the Health and Wellbeing Strategy for 2025/29. The team has implemented outcome measures and integrated them into OPAS G2, our MI system, this means that we will be sending questionnaires to colleagues around mental health assessment measures.

The Health Surveillance programme is starting with HAVS within the month of May, starting at the fleet workshops – H&S are beginning a scoping exercise on the equipment used.

We are finalising the plan for the pilot Health Check Programme Health Diagnostics, to look at reducing risk of cardiac ill health in our older workforce, by implementing a screening programme.

We are continuing MMR audits for staff (we have already completed some of this for frontline staff. Letters have gone out and promotional materials around this were provided at the CEO roadshows.

Expected Performance Trajectory

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

The Occupational Health and Wellbeing provision is regularly reviewed to ensure that services/interventions offered are relevant, appropriate, and up to date, our focus is on continuous improvement.

The team recently conducted a feedback exercise for the In Work Support programme, (currently funded by Welsh Government), to which the team have been referring colleagues for physiotherapy. Overall, this has proved successful, turnaround times for referral to therapy are good. We continue to monitor turnaround times/general quality of service for our colleagues. Accessing this service has assisted in making considerable savings for the service.

The team attended each of the CEO roadshows in April, successfully promoting the service and raising awareness of the OH and Wellbeing offer.

Our People
Culture - Staff Vaccination Indicators

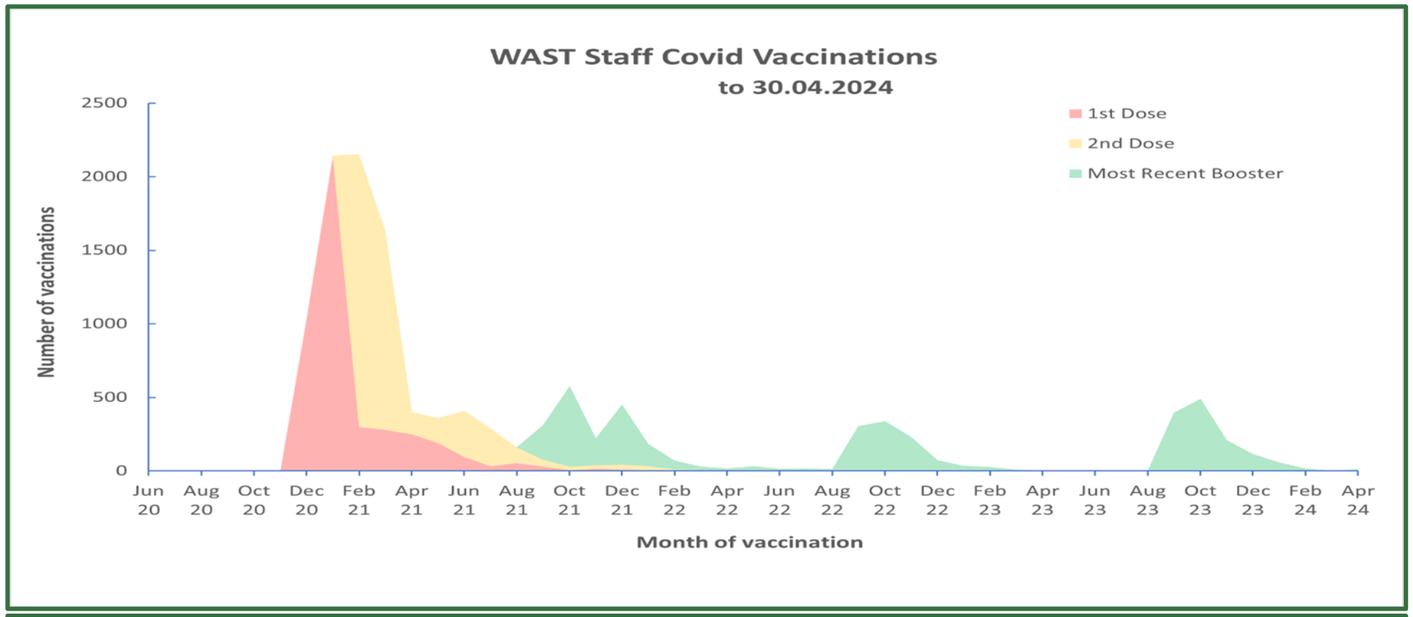
(Responsible Officer: Angela Lewis)

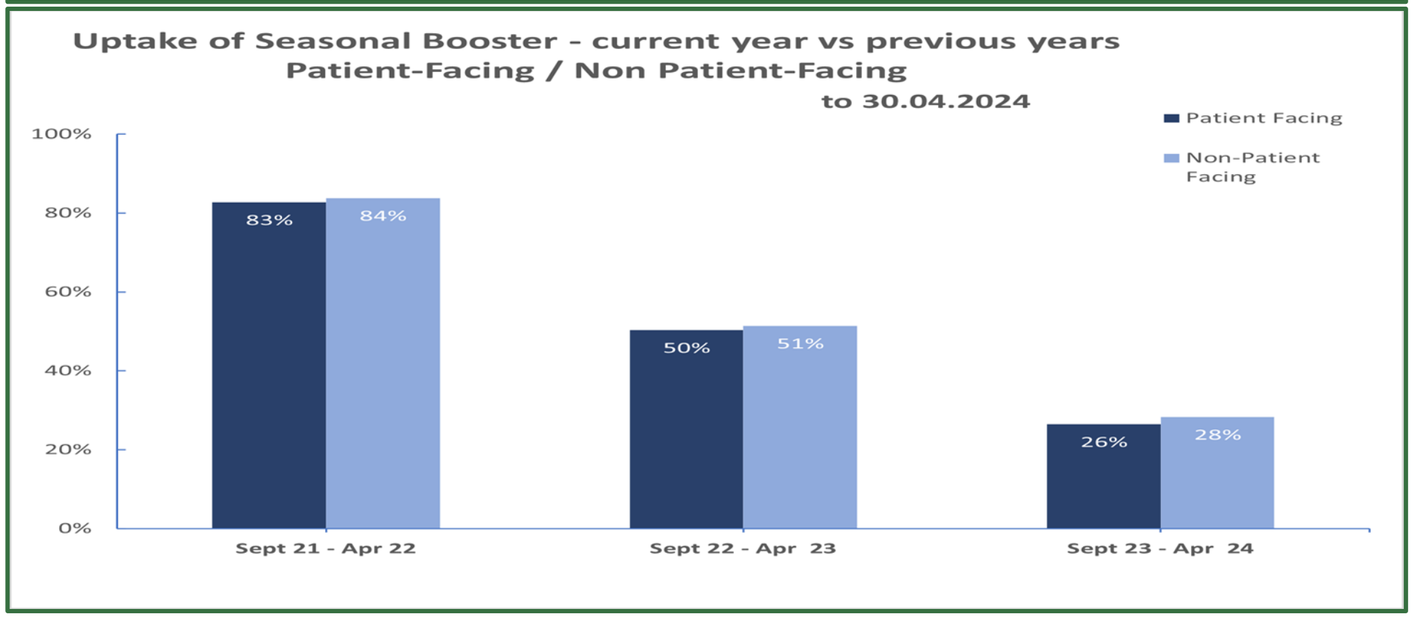
Self-Assessment: Strength of Internal Control: Moderate

PCC

CI

Health & Care Standard - Health (PPI)





Analysis

Flu: The target set out by Welsh Government is to improve on last year's flu vaccination uptake. However, this was unfortunately not met during this year's campaign.

The Trust's final uptake of staff vaccinated was 36.5% of WAST staff, which is a decrease of 8% from last year's campaign. The number of patient facing staff that are recorded as receiving the vaccine for the 2023-24 campaign has also noticeably decreased by 15.2%, reporting 31.1% at the end of the campaign. This equates to 820 out of 2,639 being recorded as having the flu vaccine during this campaign, in comparison to 1171 out of 2527 during the previous campaign.

This is reported alongside a 44.2% engagement rate for the organisation and for those that engaged via Microsoft Form, 36.5% decided to receive the vaccination this year. The remaining 7.7% decided to decline the flu vaccine and opt-out

The Charitable bid for an incentive of vouchers has had a positive effect on the engagement rate of staff completing the form. 11.3% (491 WAST staff) completed the form to state they have had the vaccine elsewhere during this campaign, in comparison to 6.8% (289 WAST staff) in the previous campaign, therefore, a 4.5% increase.

COVID-19: As of the end of April 2024, 93% of Patient-Facing staff have received both the first and second COVID-19 vaccination dose.

As of the end of April 2024, 93% of Patient-Facing, and 92% of Non-Patient-Facing, staff have received the second COVID-19 vaccination dose.

85% of Patient-Facing, and 84% of Non-Patient-Facing, staff have received at least one of the Covid-19 boosters offered in the last 3 years.

As of the end of April 2024, 26% of Patient-Facing, and 28% of Non-Patient-Facing, staff have received this season's Covid-19 Booster. The season started in September 2023.

This is compared to 50%/51%, respectively, for the equivalent time period in 22/23 and 83%/84%, respectively, for the equivalent time period in 21/22.

Remedial Plans and Actions

Flu: The 202/24 WAST Flu campaign ended at the end of February 2024. The end of season report has been shared and discussed at the Clinical Directorate Business meeting and ELT.

COVID-19: The four UK CMOs agreed it was appropriate to pause the alert level system, which was suspended on 30th March 2023.

Routine testing was also paused for all symptomatic health and social care workers, care home residents, prisoners and staff and residents in special schools during the spring of 2023.

Expected Performance Trajectory

It is evident via the report that lessons have been learnt from this campaign and consequently, there is an extensive list of areas that require continued development for future flu campaigns.

***NB: COVID Vaccinations for the past 2 years have only reported using the WAST definition of Frontline Patient Facing employees and therefore only includes those employed within Emergency Services, and Patient Transport Services..*

****NB: Flu data accurate at time of publication and subject to change / COVID-19 vaccination data correct at time of publication and subject to change.*

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

Our People
Capability - PADR and Training Rates Indicators

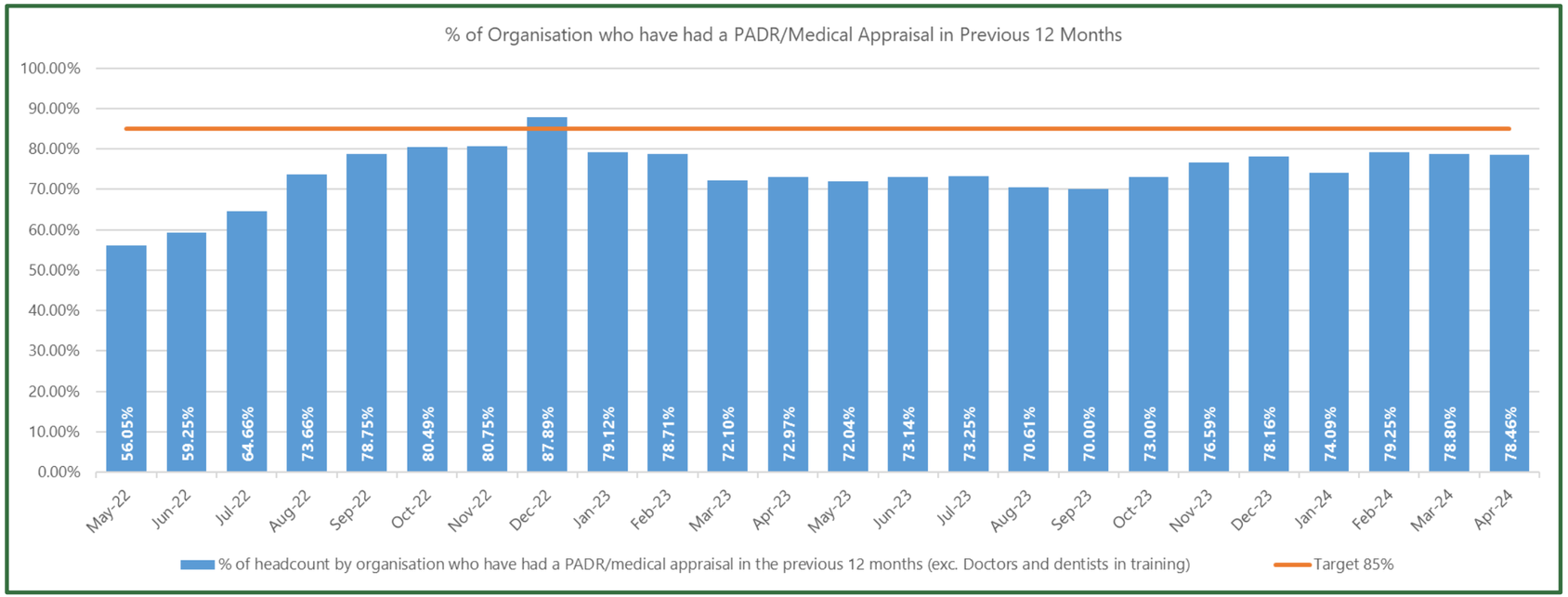
(Responsible Officer: Angela Lewis)

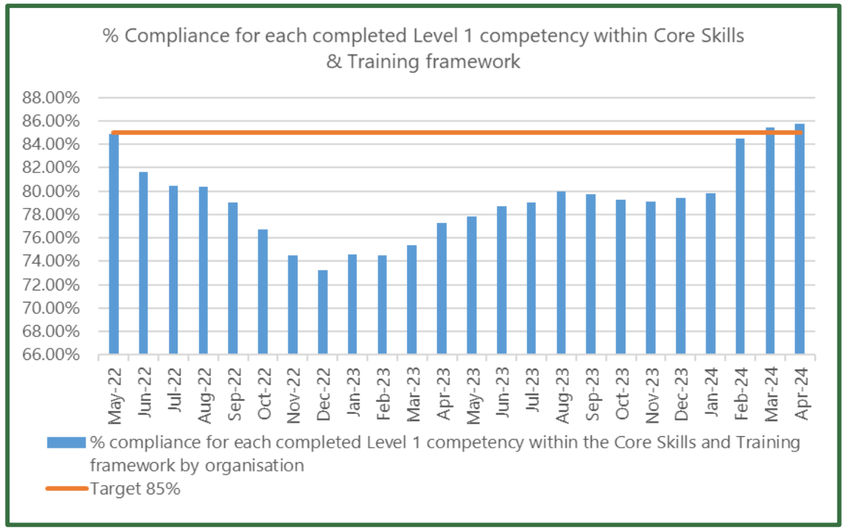
PADR	Stat & Mand
A	A

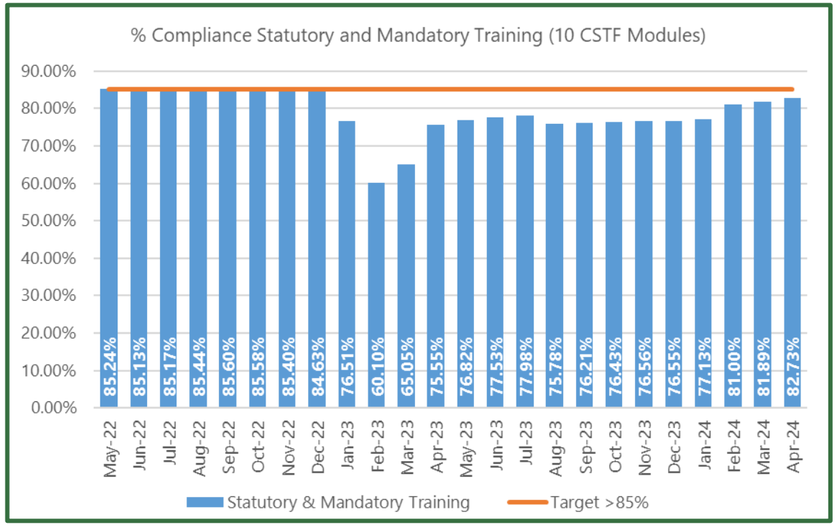
CI PCC

Health & Care Standard Health – Staff & Resources

Self-Assessment: Strength of Internal Control: Strong







Analysis

PADR rates for April 2024 78.46% decreasing slightly when compared to the previous month to 78.80% and remains below the 85% target. Over the reporting period this target has only been achieved once, in December 2022, but the current rates are 7.5% higher than the same month last year.

In April 2024 Statutory & Mandatory Training rates reported a combined compliance of 82.73%; with only Dementia Awareness (93.61%) and Moving & Handling (90.88%), achieving the 85% target. Equality & Diversity (83.36%), Safeguarding Adults (77.86%). Fire Safety (77.22%), Violence Against Women, Domestic Abuse & Sexual Violence (75.49%), Information Governance (72.93%), Paul Ridd (69.47%), Welsh Language Awareness (62.43%) and Fraud Awareness (61.07%), all remain below this target.

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

Remedial Plans and Actions

Engagement in the PADR process serves as a key metric for evaluating team cultural health. By increasing engagement with the PADR process, our goal is to enhance employee development opportunities, support better communication between managers and employees, and develop a culture of accountability and continual improvement. We intend to assess PADR engagement levels (Q1) across teams to pinpoint areas with higher participation rates and gather insights into effective practices and strategies for PADR participation, with the aim of supporting teams with lower participation rates (Q2/3).

There has been a continuation of the climb toward achievement of the 85% target across the remainder of the Core Skills Training Framework competencies which is projected to continue to increase as more learning content is moved to the user friendly LMS365 environment enabling easier access to these reportable competencies and the wider suite of Ambulance Service specific learning hosted outside ESR.

Expected Performance Trajectory

Performance is improving as compliance has risen.

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

Data source: ESR

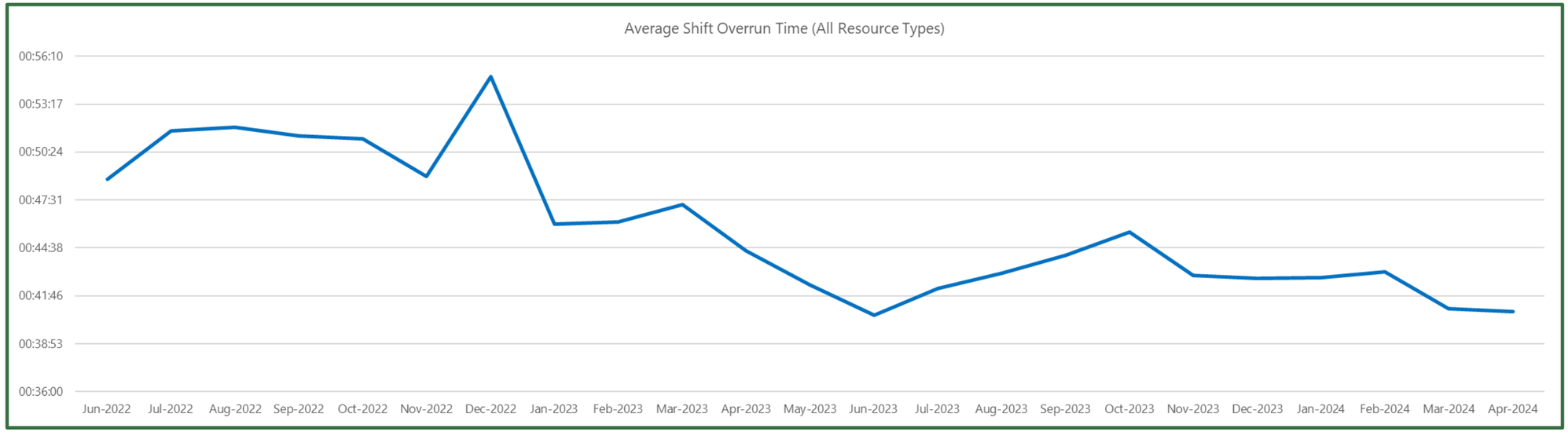
Welsh Ambulance Services University NHS Trust

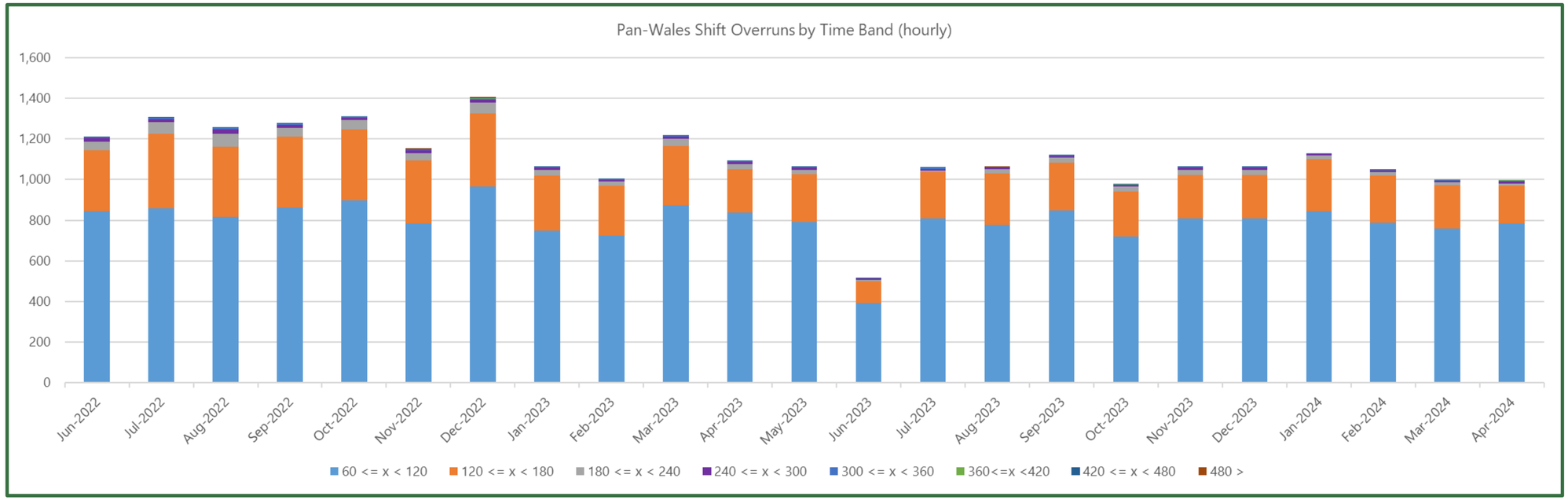
Our People
Health and Well-being – Shift Overruns

(Responsible Officer: Angela Lewis)

Overruns
G

CI





Analysis

The average figure for April 2024 was 40 minutes and 49 seconds compared to 41 minutes in March 2024. The graph indicates a downward trend.

The highest volume of shift overruns occur within the 0 to 60-minute category, accounting for 73.6% of the total. 20% fall within the 61 to 120-minute category, 5.7% in the 121 to 180-minute category, 0.5% in the 181 to 240-minute category and 0.3% in the 241 minutes and over category.

Remedial Plans and Actions

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

As part of the Trust's winter resilience planning, it is introducing "pods" at some hospital locations to aid staff finishing on time. These are continuing, at this time, into 2024/25.

Expected Performance Trajectory

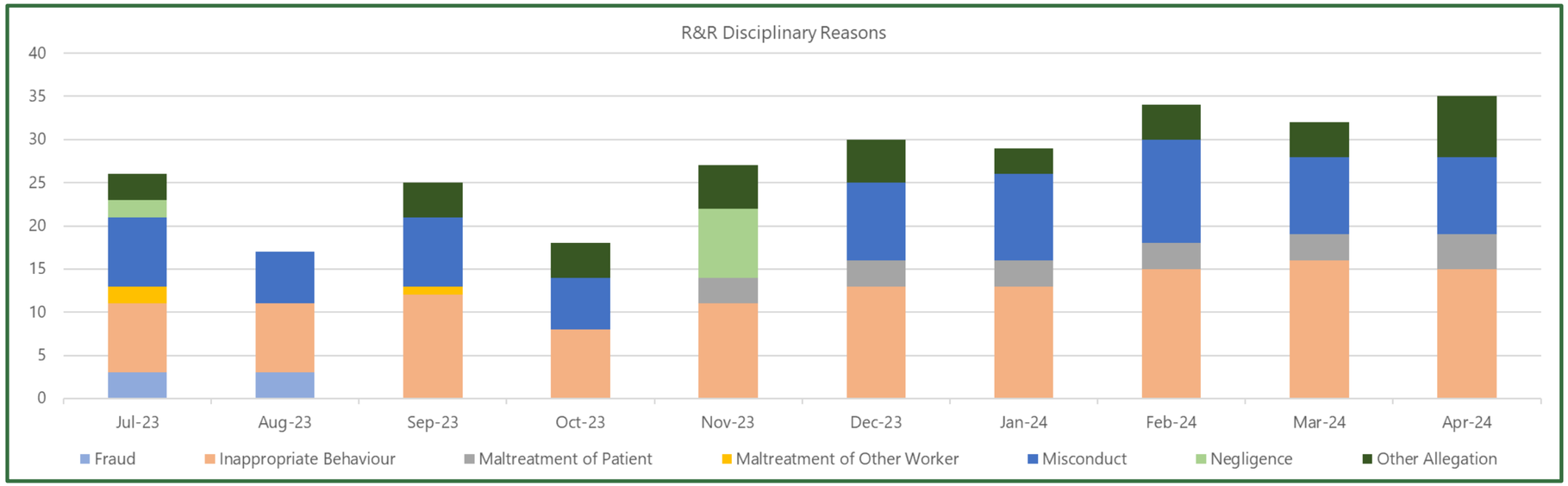
Overruns correlate with handover lost hours. As we have moved out of winter both levels had started to drop. We may expect this to stabilise before moving into higher levels again next winter.

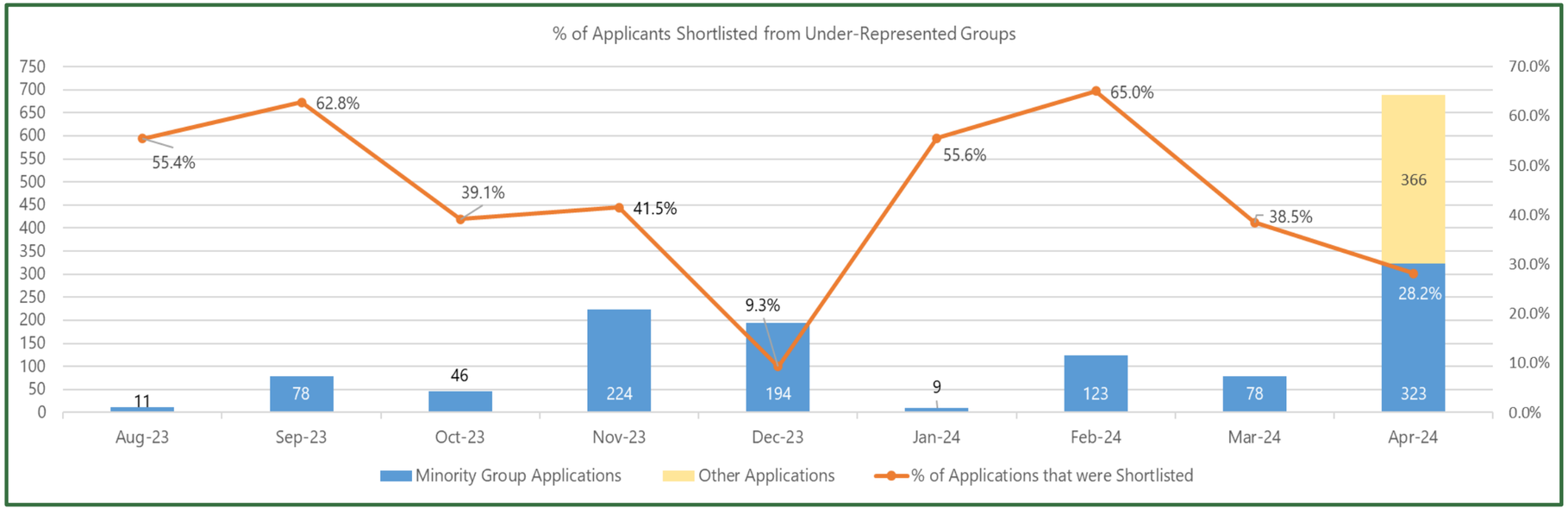
Our People
Culture – Number of R&R Disciplinary Hearings and Number of Applicants Shortlisted from Under-Represented Groups

(Responsible Officer: Angela Lewis)

Self-Assessment: Strength of Internal Control: Moderate

PCC





Analysis

There were 35 open formal disciplinary cases recorded at the end of April 2024, a slight increase compared to the month of March 2024 where 32 open cases were recorded. Of these Disciplinary cases, the majority are again due to allegations of inappropriate behaviour, followed by misconduct.

There were 12 open formal Respect and Resolution cases submitted by employees, an increase from the number recorded in March. These are a mixture of both Respect and Resolution Grievances and Dignity at work.

In April we processed a total of 689 applications and planned 302 interviews.

Of the 689 applications, a total of 323 applications were from under-represented groups in April 2024, 212 were in the category of Ethnicity, 56 within Disability and 55 within Sexual Orientation.

In April, 28.2% of all applications from under-represented groups made it through shortlisting and were invited for interview. This was a decrease from the 38.5% in March 2024, while the volume of applications increased, from 78 to 323.

Remedial Plans and Actions

R&R Formal Disciplinary Cases: Continue to monitor. The Trust has a substantial programme of work in place, connected to behaviours.

Applications: The inclusive recruitment work is ongoing to develop targeted recruitment campaigns and events.

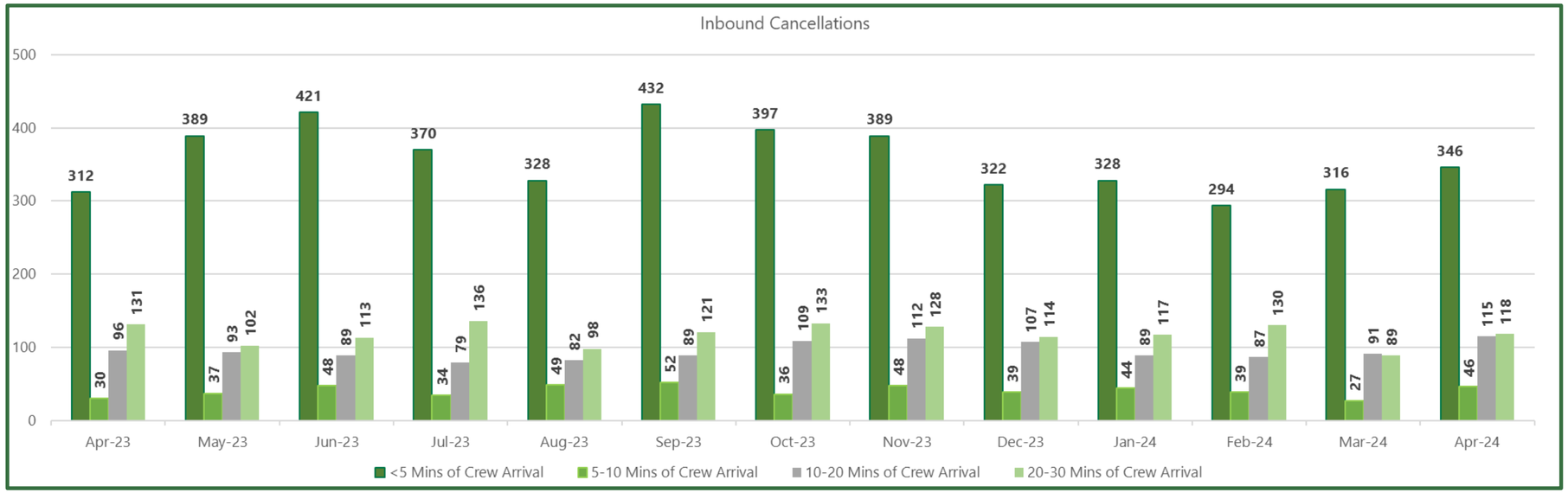
Expected Performance Trajectory

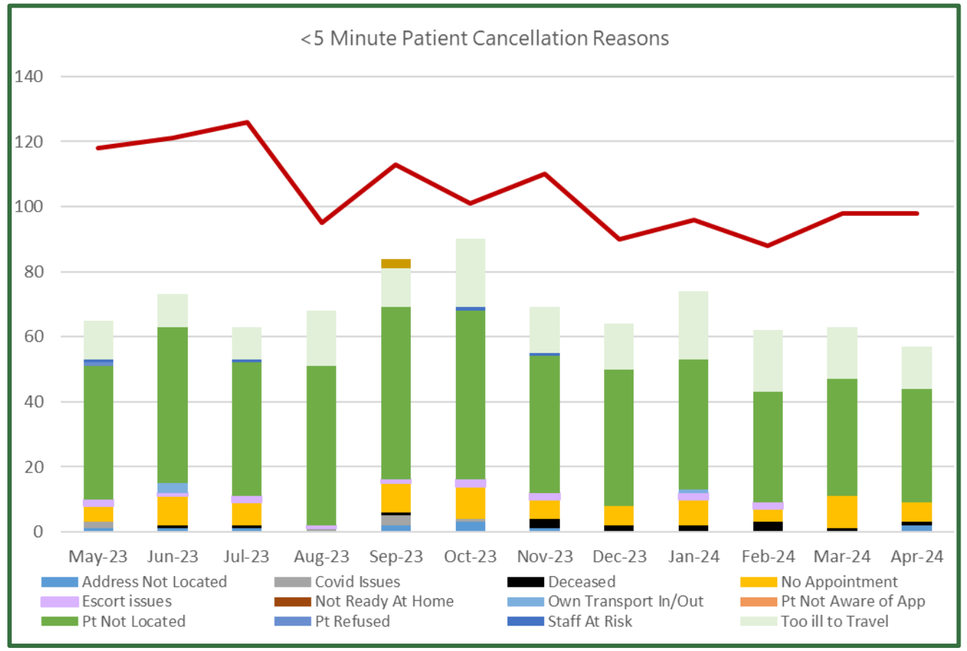
Continue to monitor levels, no trajectory for this measure.

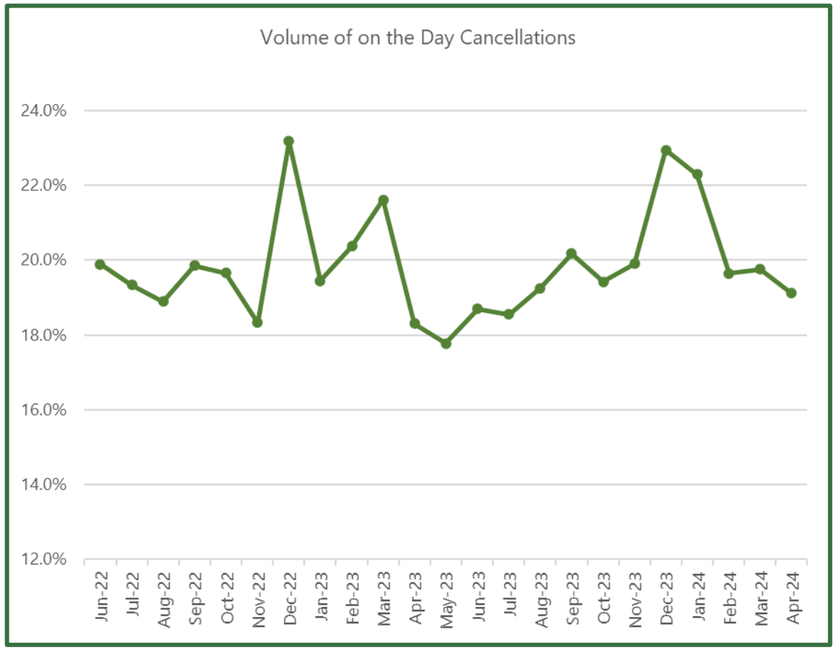
Finance, Resources and Value
Value: Ambulance Care Indicators

(Responsible Officer: Lee Brooks)

Cancellations
A







Analysis

Inbound cancellations of 5 minutes or less of the crew arrival time saw an increase in April 2024 to 346, compared to 316 in March 2024. The total number of cancellations within 30 minutes increased from 523 in March 2024 to 625 in April 2024.

Cancellations within 5-minutes of arrival appears to have seen an overall increase during the past 12 months. In April 2024 there were 98 cancelled by patient* entries made within 5-minutes of crew arrival, remaining consistent with the previous month (98). The top reasons for less than 5-minute cancellations included: 35 patient not located, 13 too ill to travel and 6 no appointment.
During the past 16 months there has been a minimum of 30 patients not located in the 5-minutes or less each month.

Same day cancellations decreased slightly from 19.8% in March 2024 to 19.1% in April 2024.

Remedial Plans and Actions

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

This work is at an advances stage and should go live in Q2, once evaluated and, if successful we will explore a wider geographical rollout.

Expected Performance Trajectory

Until this work is completed, we do not anticipate a significant shift in the trajectory as many of the factors affecting this are outside of our direct control.

Please note that that figures may be lower than overall totals due to some records having no cancellation date.

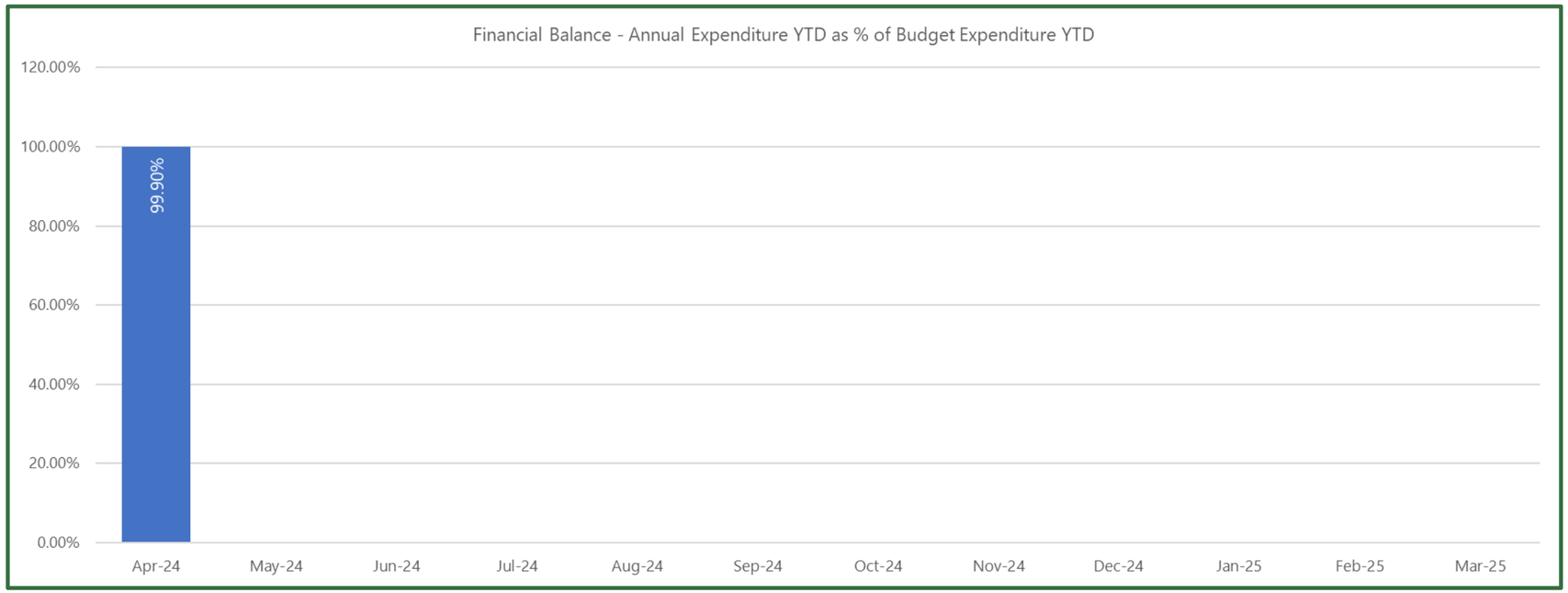
**Please note that MDTs do not appear to provide specific cancellation reasons for either inbound or outbound journeys. There are at present multiple and duplicated reasons both crews, control and the liaison desk can select.*

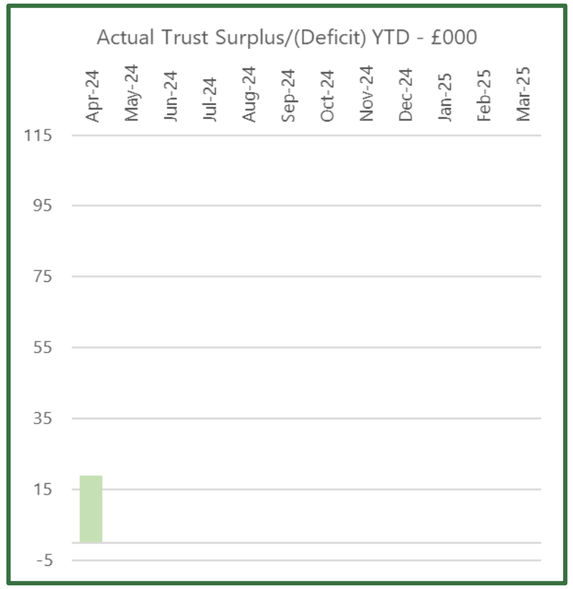
Finance, Resources and Value
Value - Finance Indicators

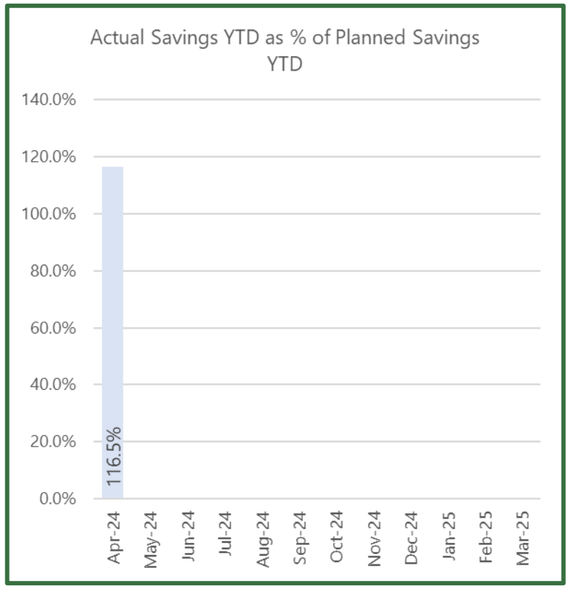
(Responsible Officer: Chris Turley)

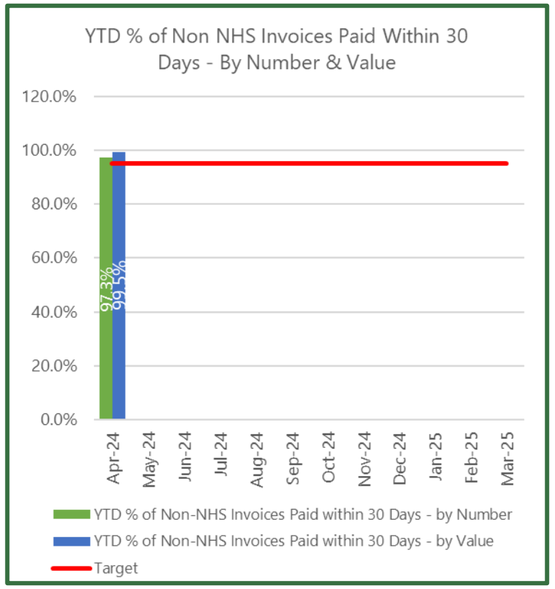
G

FPC









Analysis
The reported outturn performance at Month 1 is a surplus of £19k.

For Month 1 the Trust is reporting planned savings of £0.569m and actual savings of £0.663m (an achievement rate of 116.5%).

The Trust's cumulative performance against PSPP as at Month 1 is 97.3% against a target of 95%.

At Month 1 the Trust is forecasting to achieve both its External Financing Limit and its Capital Expenditure Limit.

Remedial Plans and Actions
There is no remedial plan required given the Trust is forecasting to breakeven; however, as the Trust moves into 2024/25 key areas of focus include:-

- Undertaking a review of commercial opportunities for income generation (Report being considered by FSP group).
- A continued focus on the Trust's financial sustainability programme.
- Improved governance for Value Based Health Care, with a particular focus on benchmarking; and
- An improved approach to benefits realisation

Expected Performance Trajectory
The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP for the 2024/25 financial year; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to deliver a planned level of savings in the 2024/25 financial year of c£6.4m.

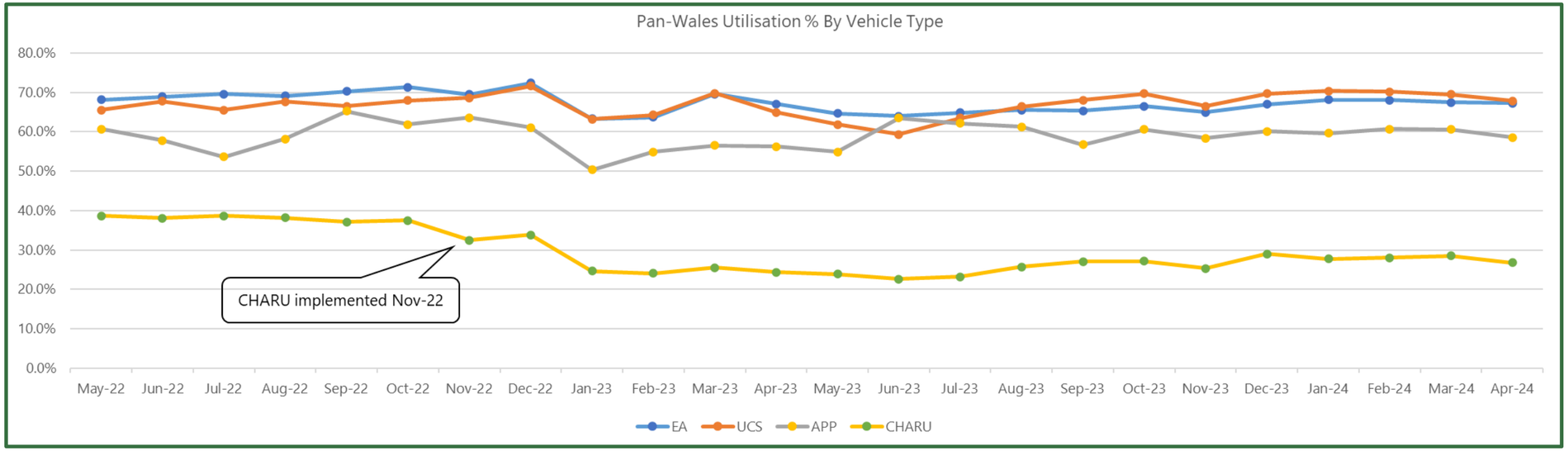
Finance, Resources and Value
EMS Utilisation & Average Job/Shift Times

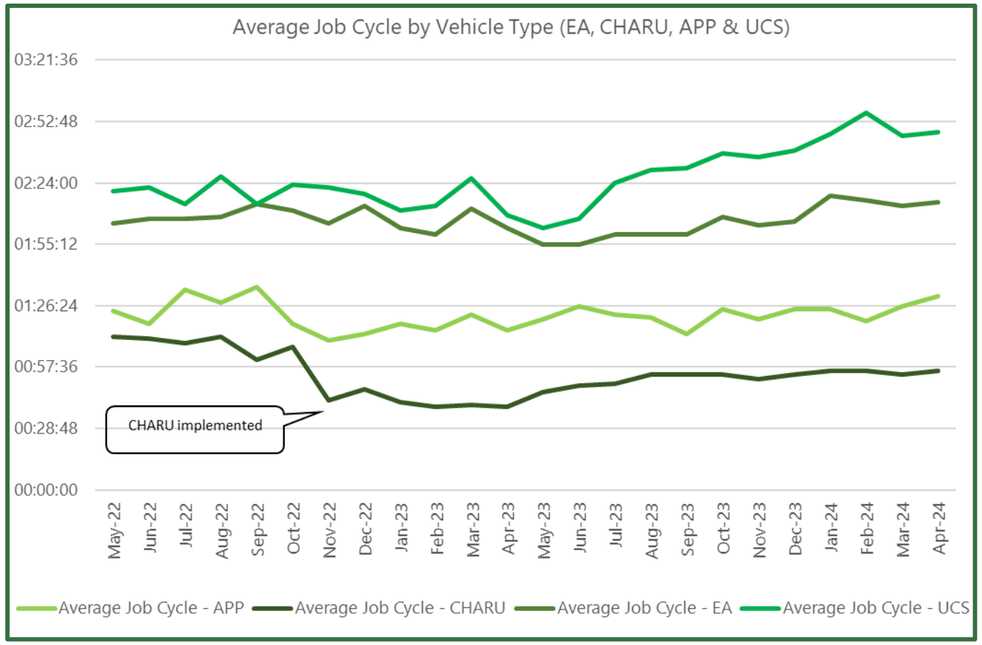
(Responsible Officer: Lee Brooks)

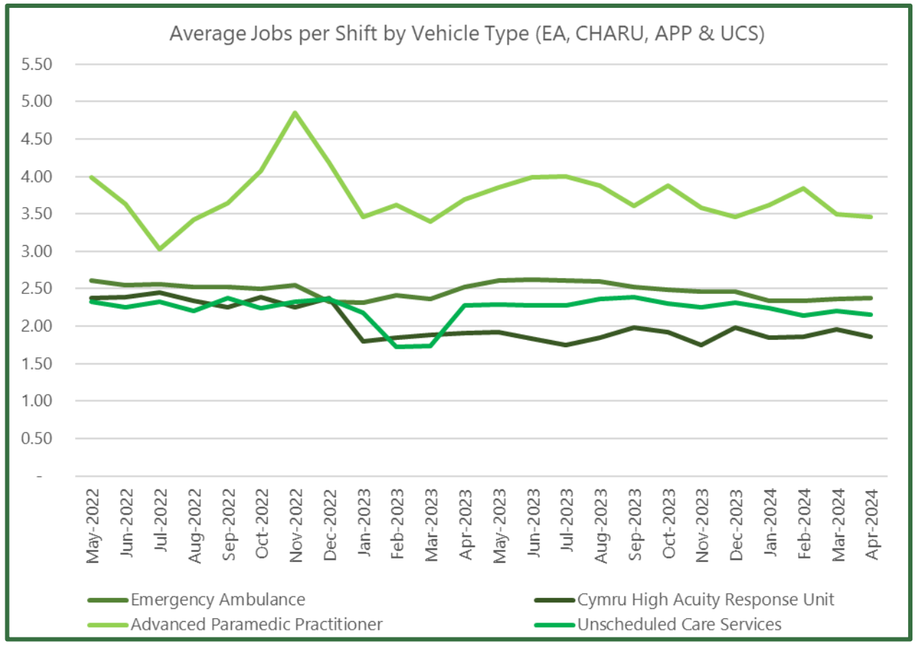
Job Cycle R

CHARU Utilisation R

FPC







Analysis

Pan Wales Utilisation metrics in April 2024 were 58% for all vehicles types, decreasing slightly from March 2024 (58.6%). UCS achieved the highest rate during the month at 67.9% while EA was at 67.3%. Both have seen a generally stable trend over the past two years. The optimal utilisation rate for EAs needs to lower so that they are free to respond to incoming calls.

As demonstrated in the bottom left graph, the average job cycle in April 2024 increased to 2 hours 15 minutes for EAs, to 2 hours and 48 minutes for UCS and CHARU increased to 56 minutes. The average for APPs increased to 1 hour and 31 minutes.
Overall average jobs per shift was 2.25 in April 2024, indicating a slight decrease from March 2024 (2.27). EAs 2.37 jobs per shift, UCS crews 2.15 jobs per shift This is less than half of what would be ideal and a product of handover delays.

APPs attended on average 3.46 jobs per shift, and CHARU's 1.86 jobs per shift. The CHARU data is under review. See below.

Remedial Plans and Actions

EA and UCS jobs per shift is fundamentally a product of handover delays.
For APPs, the newly created APP Recruitment Task & Finish Group will give a focus on further improvement, in particular, improved information and a re-roster.
CHARU is a particular area of focus. Initial analysis indicates that CHARU contribution to Red compares favourably with the previous resource: RRVs. Further analytical work being undertaken.

Expected Performance Trajectory

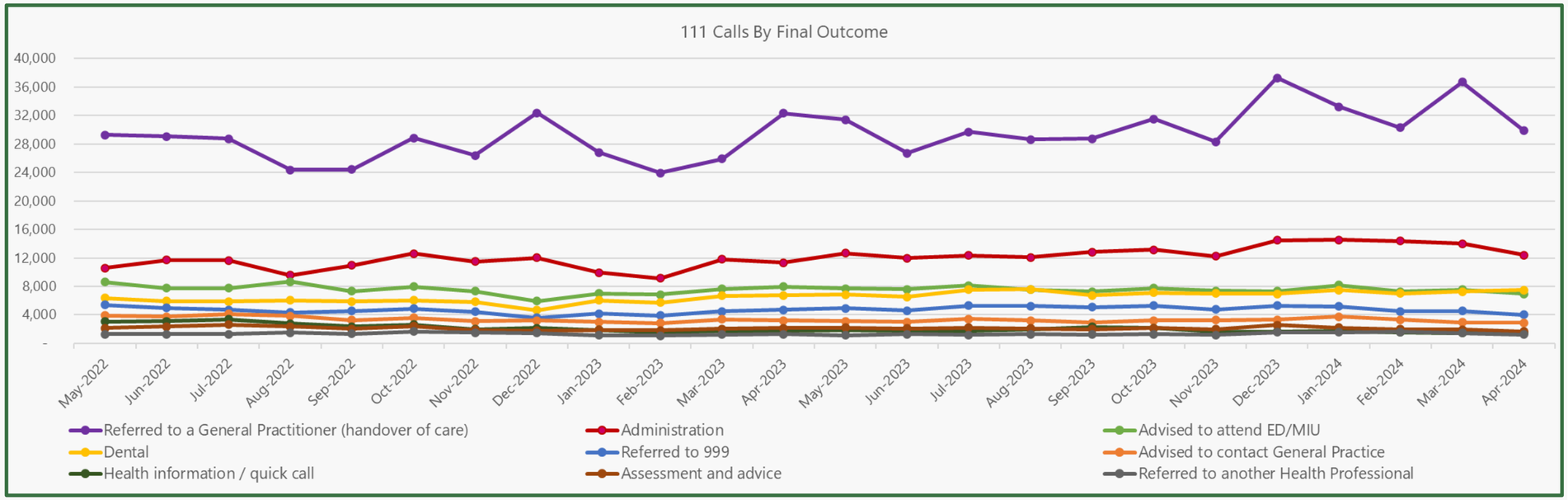
The Trust ability to reduce the high utilisation rates for EA and UCS is a product of handover, which it does not control. The Trust would expect an increase in APP and CHARU utilisation during 2024/25 linked to the remedial actions identified above.

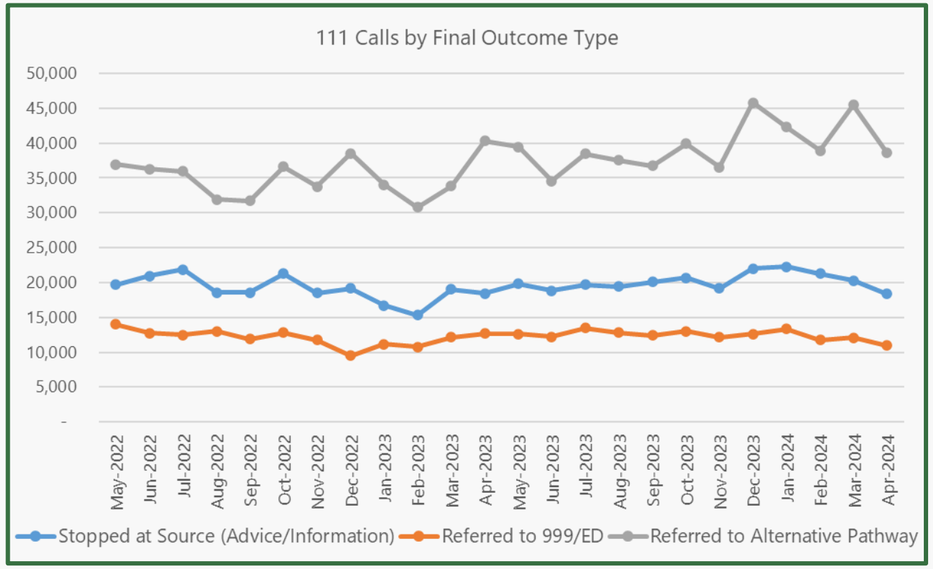
Partnerships / System Contribution
NHS111 Hand Off Metrics and NHS111 Consult & Close Indicators
Influencing Factors – Demand and Clinical Hours Produced

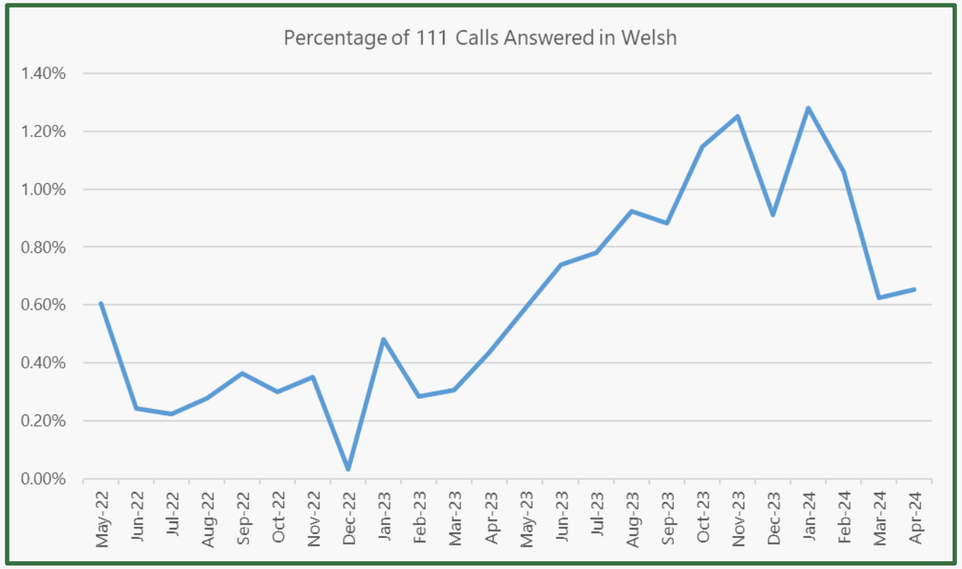
Dental	C&C Volumes
G	G

FPC

(Responsible Officer: Lee Brooks)







Analysis

During April 2024, 67,954 calls were received into the 9 categories displayed in the graph opposite, a decrease compared to the 77,865 received during March 2024.

Calls Referred to a General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 43.93% of all calls during April 2024.

As the bottom left graph highlights, in April 2024, 18,382 calls into 111 were provided with information or advice, with no onward referral, a decrease from the 20,294 in March 2024, and a decrease from the 18,446 during April 2023.

The percentage of 111 calls answered in Welsh increased marginally from 0.63% in March 2024 to 0.65% in April 2024. This equated to only 30.2% of all 111 calls being offered in Welsh being answered, an increase from the 27.2% answered in March 2024.

Remedial Plans and Actions

There is currently a 111 Measures Task and Finish Group. This is a collaborative meeting between WAST its commissioners and DCHW. The focus is the development of a nationally reportable 111 data set. Similar to what is currently in place for Ambulance Service Indicators (ASIs). Part of this work involves looking at the reporting of disposition final outcomes.

Expected Performance Trajectory

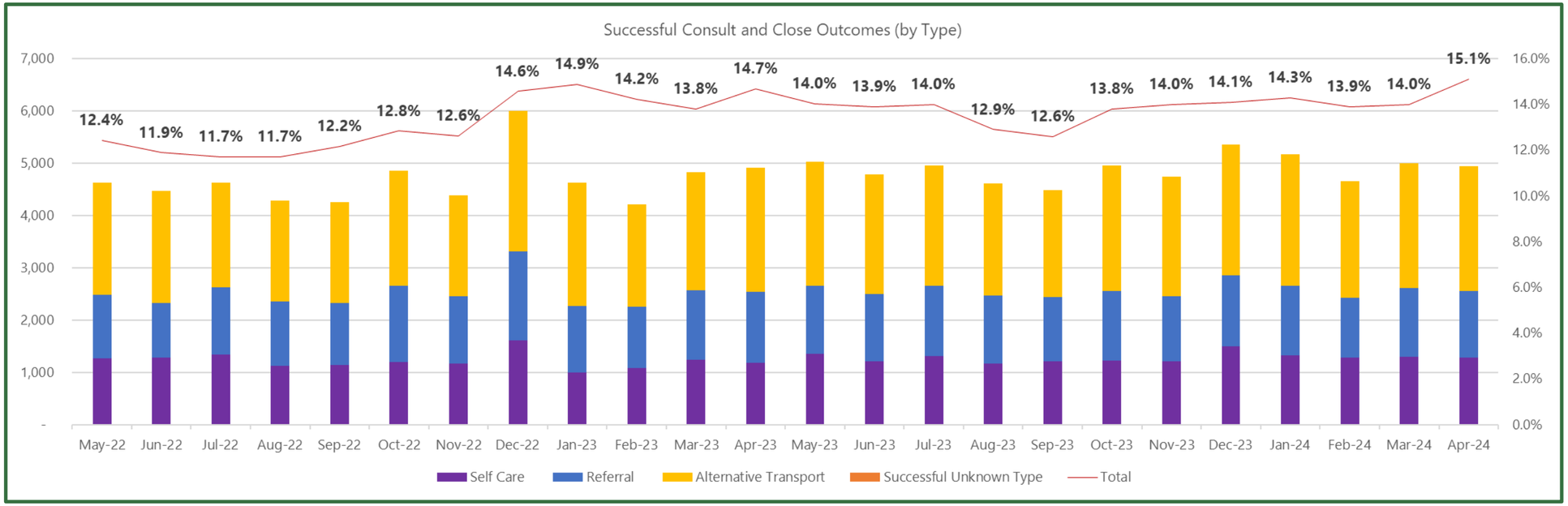
No performance trajectory is set at this time, as the Trust develops is measures and systems around these metrics. Once these have been developed there will be an opportunity to develop benchmarks. The focus remains to shift left, where it is clinically safe and appropriate to do so.

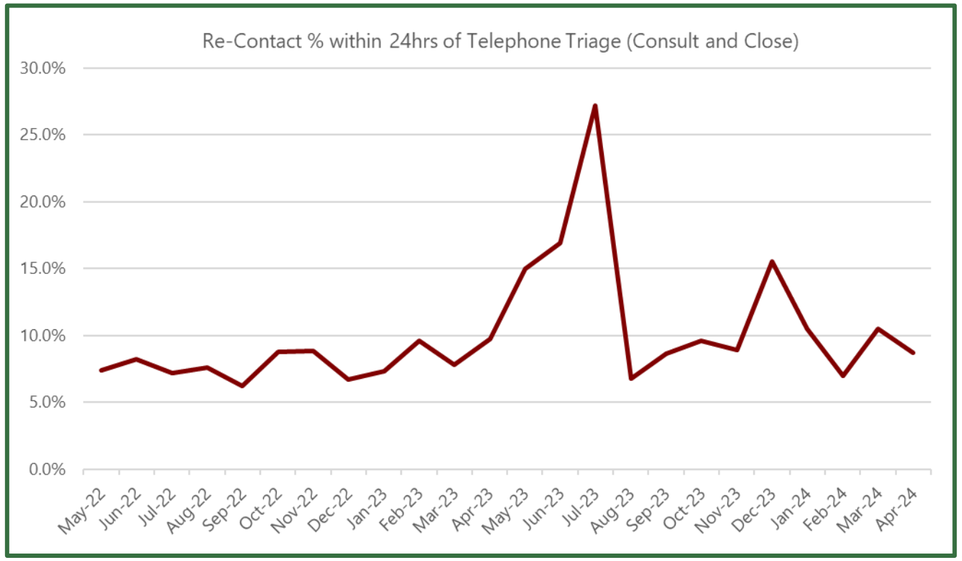
Partnerships / System Contribution
Consult & Close Indicators

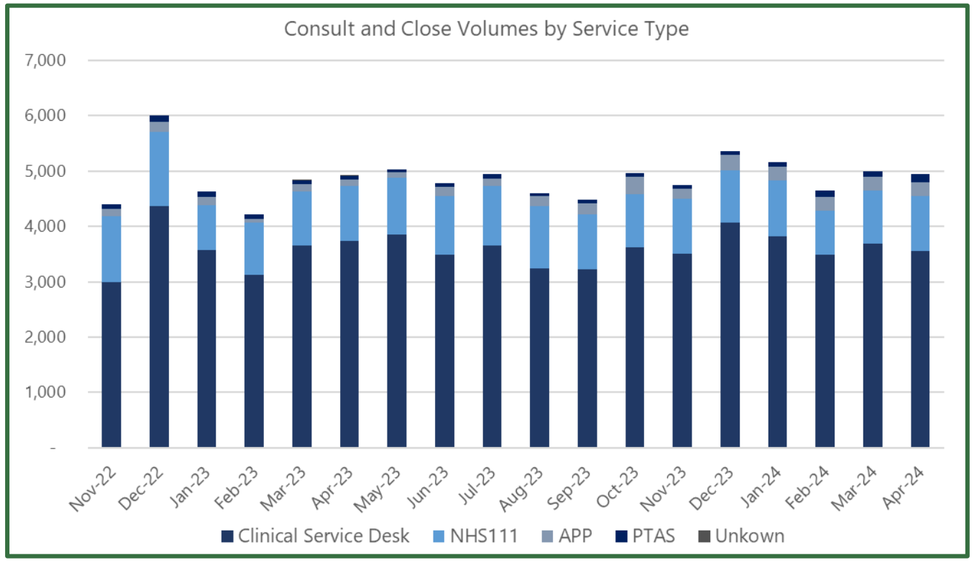
(Responsible Officer: Lee Brooks)

C&C Outcomes
R

FPC







Analysis

Consult and Close, with contributions from Clinical Service Desk (CSD) (10.8%), NHS111 (3%), WAST APP (0.8%) and the Health Boards using Physician Triage and Streaming Service (PTAS) (0.4%) achieved 15% in April 2024, an increase of 1% compared to March 2024, however remaining short of the 17% IMTP ambition. In April 2024, the number of 999 calls resulting in a Consult and Close outcome was 4,945, down from 4,992 in March 2024.

Of the calls successfully closed in April 2024, 1,277 patients received an outcome of self-care; 1,274 patients were referred to other services (including to Minor Injury Units and SDEC) and 2,396 were advised to seek alternative transport services to acquire treatment.

Re-contact rates in April 2024 were 8.7%, a decrease on the 10.5% seen in March 2024.

Remedial Plans and Actions

- Work underway reviewing processes, has yielded efficiencies in remote clinical support which is recognised by those calling.
- Implementation of 15 recommendations from commissioner review.
- Progressing process with 111 to pass calls electronically from CSD, saving time.
- Recruitment of additional 23 FTEs for 24/25.
- Future Service Model transformation workshops arranged for early May.

Expected Performance Trajectory

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

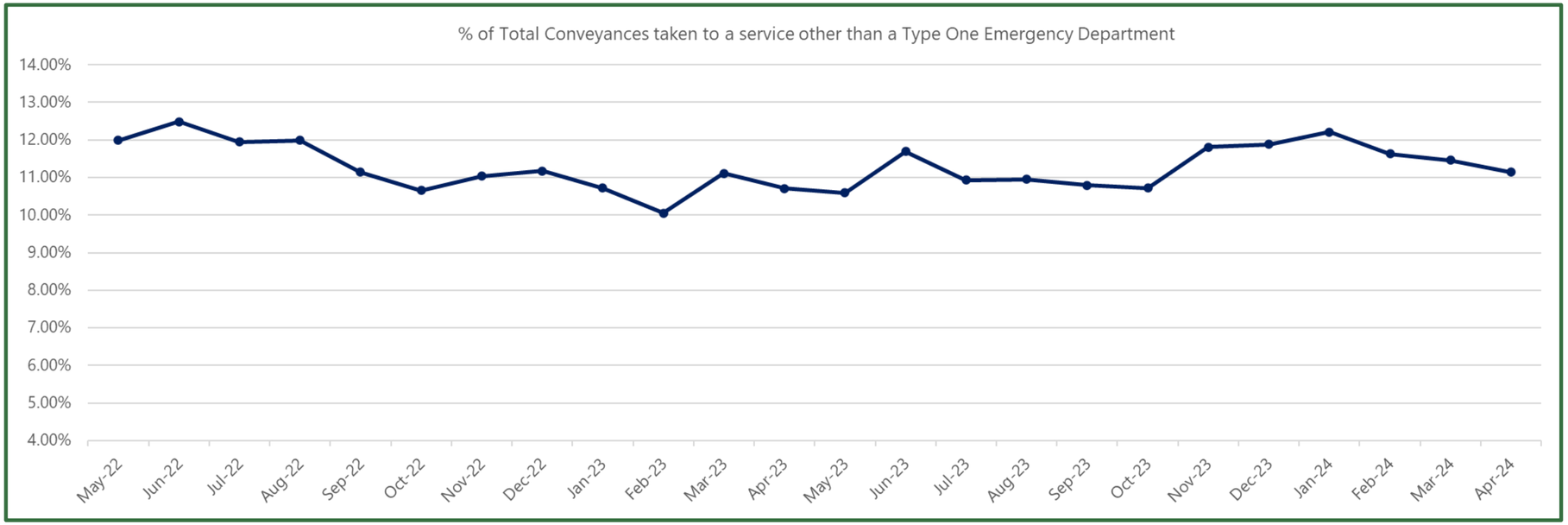
Partnerships / System Contribution
Conveyance to ED Indicators

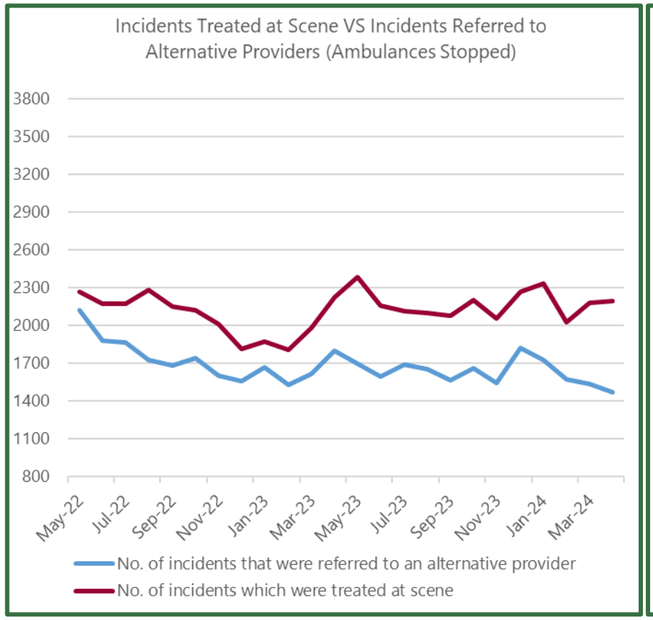
(Responsible Officer: Andy Swinburn)

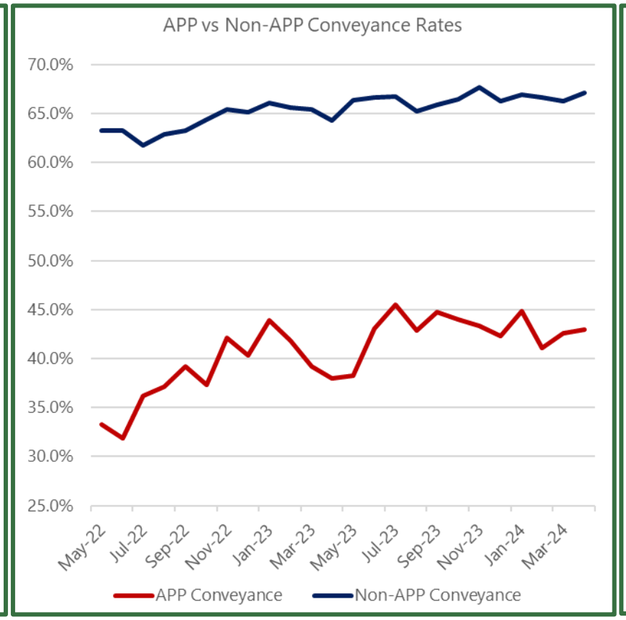
Conveyances
R

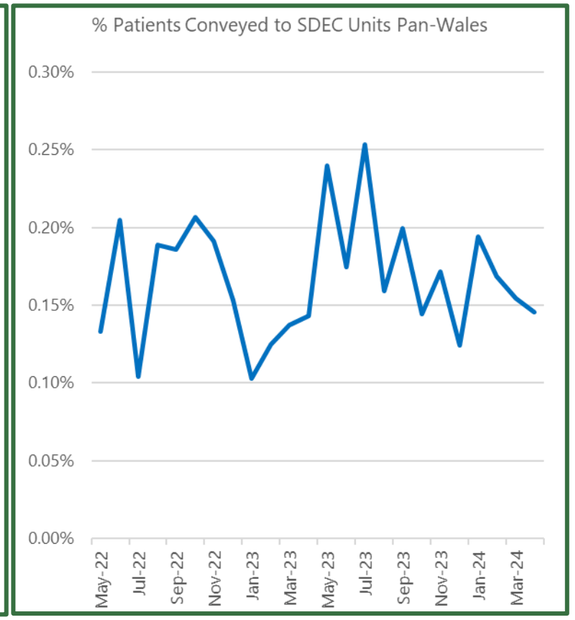
FPC

Ministerial Measure









Analysis

In April 2024 11.14% of patients (1,600) were conveyed to a service other than a Type One ED, while 38.68% of patients were conveyed to a major ED, as a percentage of verified incidents.

The combined number of incidents treated at scene or referred to alternate providers decreased slightly, from 3,717 in March 2024 to 3,661 in April 2024.

APP conveyance rates increased slightly to 43% in April 2024, after experiencing a generally increasing trend since June 23.

Patients conveyed to SDEC's remained consistent at 0.15% in April 2024 and March 2024.

Remedial Plans and Actions

Continued provision of information to external stakeholder about the effectiveness of SDECs.
Further investment in the APP workforce in 2024/25 (+32 APPs).
Establishment of APP Recruitment Task & Finish Group, with focus on re-rostering to demand keys, improved placement (training) experience, more certainty for TAPPs about where they will be located.
Review of performance systems for APPs to improve data quality.

Expected Performance Trajectory

The 2023 EMS Demand & Capacity Review (strategic) models various future states. The modelled scenarios indicate that the Trust will need to fully invert the triangle with health boards significantly reducing handover e.g. 12,000 hours or 7,500 hours, alongside varying levels of investment. Further in year tactical modelling for winter will be required to determine a performance trajectory for 2024/25. This cannot be undertaken at this point in the year.

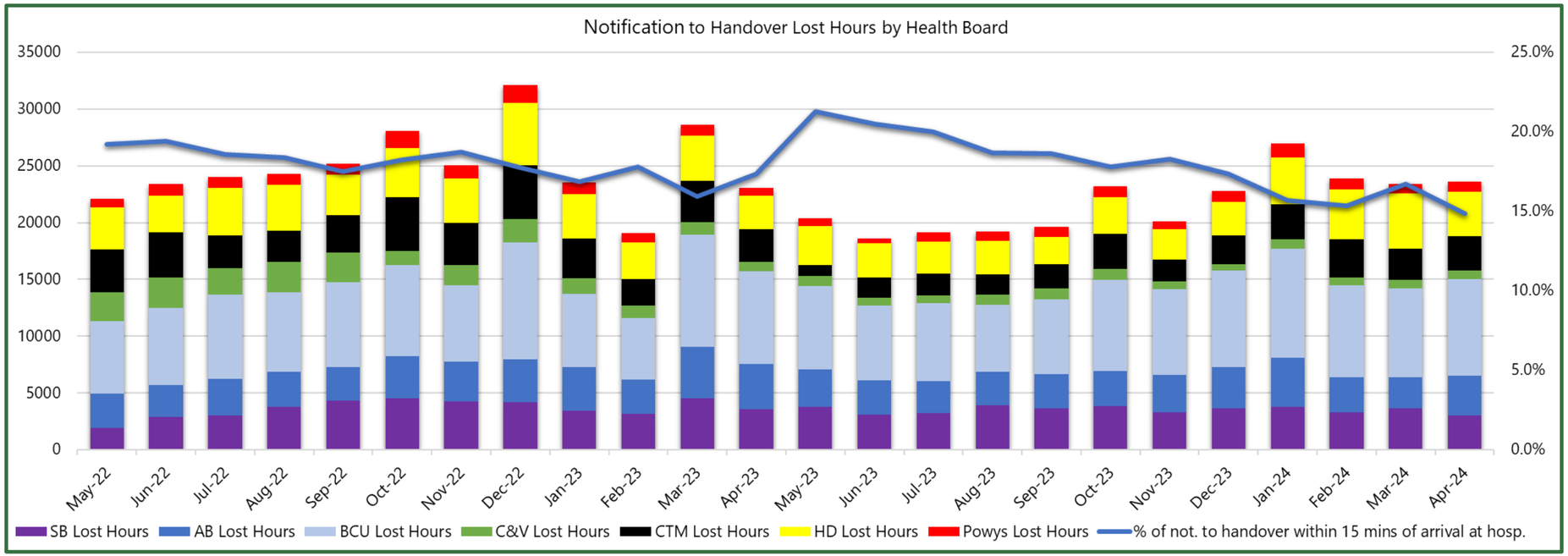
Partnerships / System Contribution Handover Indicators

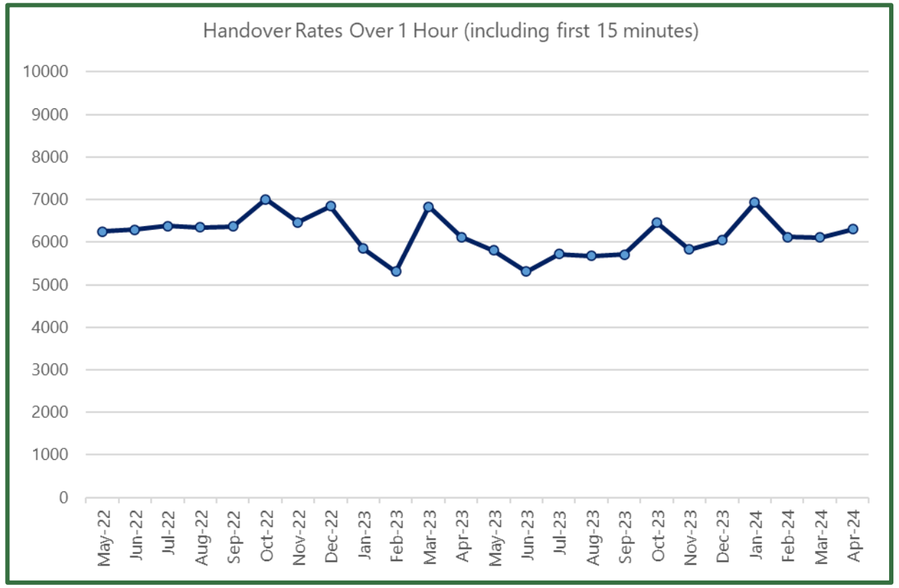
(Responsible Officer: Health Boards)

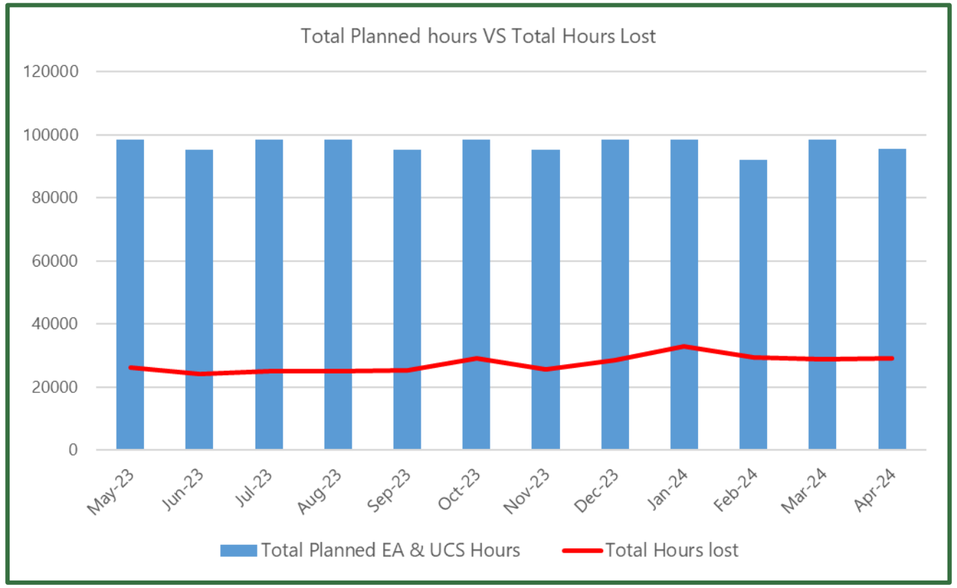
Lost Hours
R

CI

QUEST







Analysis

260,930 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months (May-23 to Apr-24), compared to 299,336 over the same timeframe the previous year. There were 23,614 hours lost in April 2024, a slight increase from the 23,403 lost in March 2024 (although over 1 less day). April 2024 levels were 532 hours above where they were during April 2023 (23,082).

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

- The Grange University Hospital (ABUHB) at 3,361 lost hours
- Ysbyty Gwynedd Hospital (BCUHB) at 3,056 lost hours
- Glan Clwyd Hospital (BCUHB) at 3,016 lost hours
- Morriston Hospital (SBUHB) at 2,889 lost hours
- Wrexham Maelor Hospital (BCUHB) at 2,196 lost hours

Notification to handover lost hours averaged 787 hours per day during April 2024 compared to 755 hours a day in March 2024.

In April 2024, the Trust could have responded to approximately 7,3449 more patients if handovers were reduced, which highlights the impact the numbers are still having on service.

Remedial Plans and Actions

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

Healthcare Inspectorate Wales (HIW) has undertaken a local review of WAST to consider the impact of ambulance waits outside Emergency Departments, on patient dignity and overall experience during the COVID-19 pandemic.

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

Expected Performance Trajectory

The Welsh Government handover target for 2024/25 is no waits over one hour; this equates to 7,000 hours lost to handover delay. There would need to be a 70% reduction in handover levels in 2024/25 for this to be achieved.

We may expect to see some further handover reduction in 2024/25, but achieving the one-hour Welsh Government target would require a massive improvement.

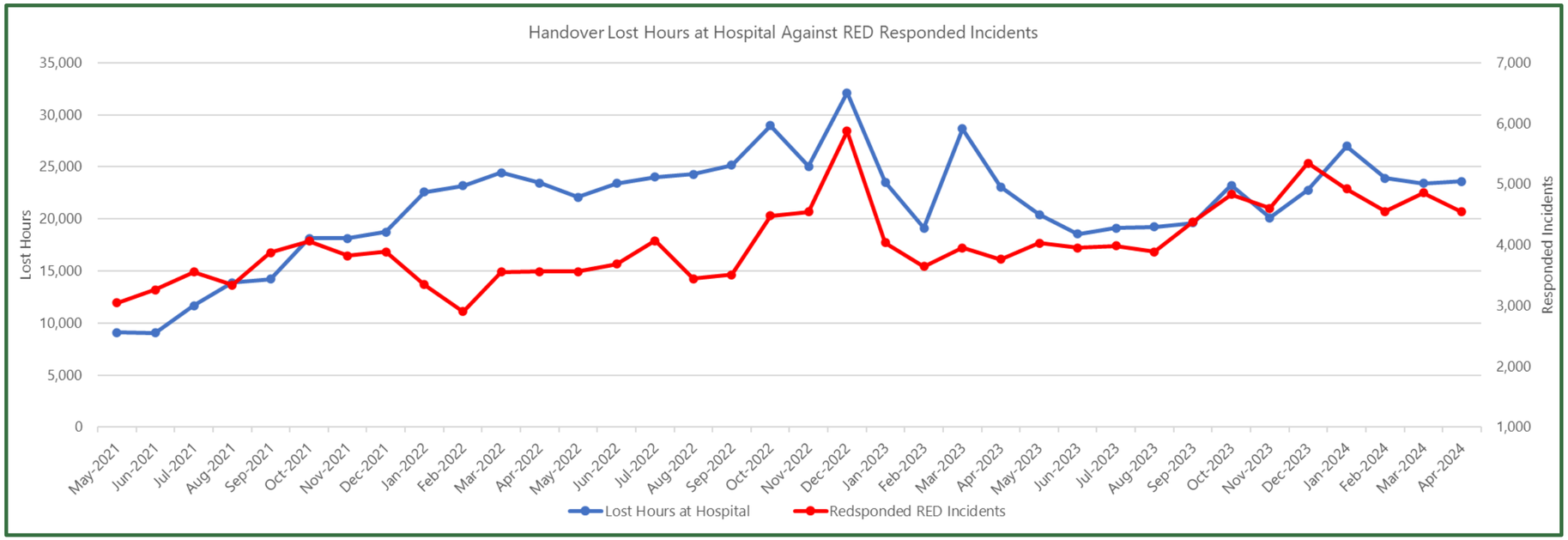
**NB: Data correct at time of abstraction.*

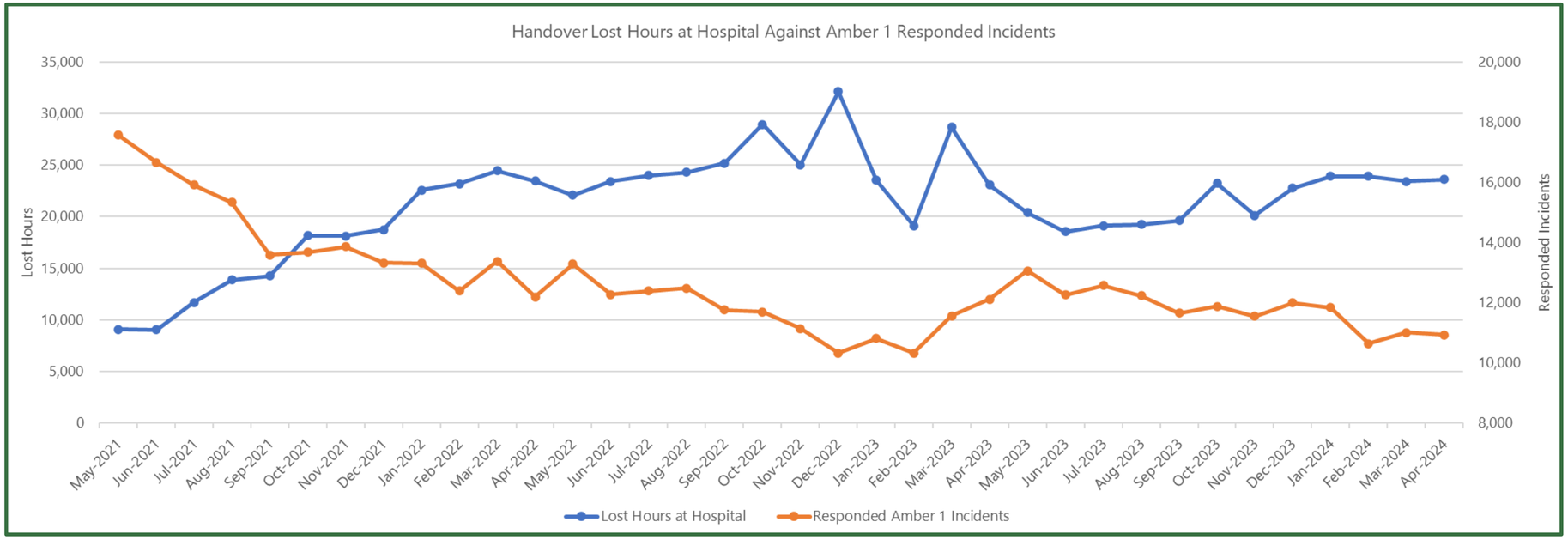
Partnerships / System Contribution

Handover Lost Hours Against Red & Amber 1 Responded Incidents

(Responsible Officer: Health Boards)

CI QUEST





Analysis

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

However, as the bottom graph illustrates, as the response to Red increases, there is an impact on Amber 1 responses, particularly at times of high demand, such as during December 2022. During these periods, the number of Amber 1 incidents attended decreases, notwithstanding that some of these patients within the Amber 1 category will still be seriously ill, although during December 2023 Amber 1 responses also increased slightly when compared to November 2023.

The bottom graph also highlights that as lost hours have increased since mid-2021, so Amber 1 responses have declined, due to the increased system pressures. However, as lost hours reduced during the first half of 2023, so Amber 1 responses increased, from 10,326 in December 2022 to 13,055 in May 2023. Therefore, it was possible to see the reduction of pressure within the system and subsequent performance improvement through the Amber 1 metric.

Remedial Plans and Actions

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

Expected Performance Trajectory

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

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

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

Definition of Indicators

Indicator	Definition	Indicator	Definition
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.		
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

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

AGENDA ITEM No	11
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	4

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Trust Board
DATE	30th May 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance/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 08 May 2024 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 the risk ratings, controls, assurances, gaps and mitigating actions.

5. The risks continue to be reviewed in relation to the mitigating actions identified and taken with a view to supporting risks to achieve their target score.

6. Updates are highlighted in blue on the BAF which show changes to actions, controls, and assurances.

7. This executive summary continues to outline the broader discussions across the senior leadership teams and the Committees on the higher rated risks and signposts the Board accordingly. 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).

8. **Risks 223** (*the Trust's inability to reach patients in the community causing patient harm and death*) and **Risk 224** (*Significant handover of care delays outside accident and emergency departments impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe & effective service for patients*) scoring 25 and remain unchanged because of sustained and extreme pressure across the Welsh NHS urgent and emergency care system which is negatively impacting on patient flow leading to avoidable patient harm and death.

    8.1. Work is underway in relation to these two risks to consider how the Trust might articulate and manage them internally in the future given that their score has remained catastrophic over a significant period.
    8.2. Options for the management of these risks have been considered with external support as part of the Risk Management Transformation Programme.
    8.3. Whilst good progress continues to be made on the actions that the Trust can control, the extreme pressure continues across the unscheduled care system with handover lost hours of 23,616 for April 2024. This means that incidents of premature death and avoidable harm will likely continue. This is because we are unable to respond to patients in a way that we would wish and means that the scores will remain static at the highest score of 25. The score is not based on the volume of cases of catastrophic harm, it is based on any one individual that experiences avoidable harm. The quality dimension of each of these risks will always be a challenging one to reduce whilst patients and the Trust are experiencing delays in the way in which they currently are.
    8.4. The Quality, Patient Experience and Safety Committee (QUEST) reviewed both risks at its meeting in May 2024 with the Agenda items reflecting the controls and mitigations discussed at this meeting. These risks are escalated in the QUEST AAA report for this meeting.
    8.5. Both risks were presented to the Finance & Performance Committee (FPC) and the People & Culture Committee (PCC) meetings in May 2024 to continue to ensure that all perspectives and elements of the risks are considered and reviewed.
    8.6. The Executive Director of Quality & Nursing and Executive Director of Operations continue to report to Committees on the depth of review that is undertaken on these risks during the reporting cycle.
    8.7. The controls and assurances have been updated during this period which are highlighted on the BAF, and which seek to address gaps in assurance.
    8.8. Both risks are reviewed in conjunction with each other to reflect the actions from the avoidable harm paper presented to each Board meeting and to ensure the synergy between the two.
    8.9. These risks are regularly and dynamically reviewed and closely monitored by management, Board Committees, at the Trust Board meetings as well as at internal forums.

8.10. The Chief Executive's report outlines the participation in, and discussion at, regular stakeholder meetings with NHS Wales CEOs, the Director General of NHS Wales and Commissioners where stakeholder actions relate to these risks.

9. **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.

9.1. Sickness absence remains a key challenge for the organisation and whilst there has been a significant reduction in absence levels, the score remains static as these are higher than desired.
9.2. Each of the Committees have reviewed sickness absence through the MIQPR and the Board has before it the MIQPR and accompanying slides with further detail on the mitigations.
9.3. A significant number of actions have been identified during the last review which will continue to be monitored.
9.4. The controls and assurances have been strengthened and included in the BAF report. A further review at the end of quarter 1 2024/25 will include a review of the score.

10. **Risk 163** (*Maintaining Effective & Strong Trade Union Partnerships)* was rated 20.

10.1. The score has been reduced to 16 (4x4) in this review period because of a tailored bespoke development programme for managers and Trade Union Partners at all levels has been launched to address issues.
10.2. The programme of engagement and relationship building will continue throughout 2024/25.
10.3. Work is underway to deliver the action plan in partnership.

11. **Risk 201** (*A loss of stakeholder confidence that damages the Trust's reputation*) remains static at 20.

11.1. The current risk score remains at 20 given that many of the mitigations are outside the Trust's control.
11.2. The PCC undertook a deep dive of this risk at its meeting in May 2024.
11.3. The reputation audit was discussed at the Welsh Ambulance Services Partnership Team in May 2024 and will be the subject of a future Board development discussion.

12. **Risk 594** (*The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death)* remains at a score of 20 reflecting the continued challenges across the unscheduled care system.

12.1. Further work to determine resources following the Manchester Arena Inquiry remains underway.

13. The BAF reflects the significant work undertaken, to keep under review, the Trust's principal risks and as a result there have been several movements on the Corporate Risk

Register (CRR) and BAF. The Committee AAAs refer to the changes in risks under their remit; however, this activity is detailed below for convenience and to illustrate the movement during this last quarter as follows:

13.1. **Risk 424** *Resource availability (revenue, capital and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)* has reduced in score from 16 (4x4) to 12 (3x4).

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

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

13.4. One risk has been closed having achieved its target score of 8 (2x4) from 16 (4x4) and will be removed from all registers. This is **Risk 458** *A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning to deliver the IMTP and/or any additional services*.

14. Detailed reviews, discussion and challenge continue to take place with the Executive Leadership Team (ELT) and Assistant Director Leadership Team (ADLT) on each of the risks monthly in support of achieving this activity and movement on the CRR and BAF.

RECOMMENDATION:

1. Members are asked to consider and discuss the contents of the report and:
   a) Note the reduction in two risk scores:
      Risk 163 from 20 (5x4) to 16 (4x4) and
      Risk 424 from 12 (3x4) to 12 (3x4)
   b) Note the de-escalation of two risks to the Directorate Risk Registers:
      Risk 543 achieving target of 10 (2x5)
      Risk 283 achieving target of 8 (2x4)
   c) Note the inclusion of two new risks:
      Risk 542 at a score of 16 (4x4)
      Risk 623 at a score of 15 (3x5)
   d) Note the closure of Risk 458 from all registers.
   e) Receive assurance on the review and attention to the principal risks, their review at ELT and at relevant Committees.
   f) Note the ratings and mitigating actions for each principal risk.

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 considered by the following Committees, as relevant to their remit, during the forthcoming reporting period: ADLT (29 April 2024) ELT (08 May 2024) Quality, Safety & Patient Experience (07 May 2024) People & Culture Committee (09 May 2024) Finance & Performance Committee (14 May 2024) Additionally, all Principal Risks were considered by the Audit Committee at its last meeting on 30 April 2024.

REPORT ANNEXES
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

Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
223 QuEST	The Trust's inability to reach patients in the community causing patient harm and death.	**IF** significant internal and external system pressures continue **THEN** there is a risk of an inability and/or a delay in ambulances reaching patients in the community **RESULTING IN** patient harm and death	Executive Director of Operations	**25 (5x5)** ➡
224 QuEST	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service.	**IF** patients are significantly delayed in ambulances outside A&E departments **THEN** there is a risk that access to definitive care is delayed, the environment of care will deteriorate, and standards of patient care are compromised **RESULTING IN** patients potentially coming to harm and a poor patient experience	Executive Director of Quality & Nursing	**25 (5x5)** ➡
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 People & Culture	**20 (5x4)** ➡
201 PCC	A loss of stakeholder confidence that damages the Trust's reputation.	**IF** there is an inability of the Trust to deliver its core services because of system or organisational pressures **THEN** there will be a loss of stakeholder confidence in the Trust **RESULTING IN** a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, damage to	Director of Partnerships & Engagement	**20 (4x5)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		reputation and increased external scrutiny		
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death.	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective, timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.	Executive Director of Operations	**20 (4x5)** →
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 **RESULTING IN** a negative impact on colleague experience and/or services to patients.	Director of People & Culture	**16 (4x4)** ↓ **20 (5x4)**
NEW 542 FPC	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	**IF** there is a lack of resources and available technology and infrastructure **THEN** there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	Executive Director of Finance & Corporate Resources	**16 (4x4)**

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		RESULTING IN negative environmental and social impacts causing and reputational damage		
458 FPC **CLOSED**	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning.	**IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis **THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients. **RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage.	Executive Director of Finance & Corporate Resources	**16 (4x4)** ➡
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems.	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or	Director of Digital Services	**15 (3x5)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		theft of personal/patient data and patient harm or loss of life		
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 People & Culture	**15 (3x5)** ➡
NEW 623 FPC	Failure to comply with Data Protection Legislation	**IF** the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality **THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used **RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage.	Director of Digital Services	**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	Executive Director of Strategy Planning & Performance	**12 (3x4)** ➡

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		staff and key outcomes within the IMTP not being delivered		
424 FPC	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	**IF** resources are not forthcoming within the funding envelope available to WAST (link to risk 139) **THEN** there is a risk that there is insufficient capacity to deliver the IMTP **RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing.	Executive Director of Strategy Planning and Performance	**12 (3x4)** ↓ **16 (4x4)**
543 FPC **De-escalate to the DRR**	Major disruptive incident resulting in a loss of critical IT systems	**IF** there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems **THEN** there is a risk of a loss of critical IT systems **RESULTING IN** a partial or total interruption in WAST's effective ability to deliver essential services.	Director of Digital Services	**15 (3x5)** ↓ **10 (2x5)**
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)	Executive Director of Finance & Corporate Resources	**8 (2x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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		
283 FPC **De-escalate to the DRR**	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	Executive Director of Strategy Planning & Performance	**8 (2x4)** ↓ **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.	ocal 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

Annex 4 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	15/04/2024	TREND	25 (5x5)
		Date of Next Review:	15/05/2024	➡	

IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death

	Likelihood	Consequence	Score
Inherent	4	5	20
Current	5	5	25
Target	2	5	10

IMTP Deliverable Numbers:

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

Risk Commentary Q4 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 because of the Trust not being able to reach patients in the community. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. **Handover lost hours in February and March 2024 were 23,896 (Feb) and 23,404 (March).**
Only Cardiff & Vale University Health Board has demonstrated material improvement and is a positive outlier. The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes, and extended recovery times. Delays across the system continue to be the focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.

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

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

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Regional Escalation Protocol	1. Daily conference calls to agree RE levels in conjunction with Health Boards
2. Immediate release protocol	2. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)
3. Resource Escalation Action Plan (REAP)	3. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023.
4. 24/7 Operational Delivery Unit (ODU)	4. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
5. Strategic, Tactical and Operational 24 hour/ 7 day per week system to manage escalation plans	5. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required. On Call cover is reviewed weekly at SLT Performance Meetings.
6. Limited Alternative Care Pathways in place	6. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
7. Consult and Close (previously Hear and Treat)	7. The Trust ambition is to attain 17% Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Reported through integrated quality meeting. Whilst Consult and Close is in place, the action to increase compliance is detailed in action 10.
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	8. WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	15/04/2024	TREND	25 (5x5)
		Date of Next Review:	15/05/2024	→	

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

	However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.
9. Clinical Safety Plan	9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The subsequent reduction in the demand is the assurance which is dynamically monitored via ODU.
10. Recruitment and deployment of CFRs	10. Approaching 500 active CFRs at end of Q4 with a training trajectory to recruit a minimum of 250 more in the coming 12 months. Response data indicates that our CFRs are reaching more patients, especially those with life threatening conditions in 8 minutes compared to this time last year. Numbers of CFR's, percentage of contribution to performance a governance framework is in place. Monitoring through AD 1:1's and volunteer highlight report (IMTP).
11. ETA scripting	11. The ETA Dashboard is a tactic that was signed off by ELT. The dashboard supports scripting analysed by comparing with real time data. ETA performance is reviewed weekly at SLT weekly performance meeting. The effect of the ETA scripting results in cancellations of ambulances which is monitored through algorithmic review process.
12. Clinical Contact Centre (CCC) emergency rule	12. Emergency Rule is incorporated into CSP 999 levels.
13. National Risk Huddle	13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
14. Summer/Winter initiatives	14. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24.
15. CHARU implementation	15. Recruitment of 153 WTE has continued; To lift further, a trial of a rotational model is due to be trialled in Aneurin Bevan Health Board area.
16. Clinical Model and clinical review of code sets	16. Reported through CPAS and DCR Review reporting through CQGG
17. Remote clinical support enabling discharge at scene	17. Strategic Transformation Board – IMTP deliverable; Providing support to the Community Welfare Responders (CWR) initiative and supporting CFRs to discharge at scene with current non conveyance rates for CFRs in excess of 40%
18. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	18. Formally documented action plan – actions captured are contained within and monitored via the Mitigating avoidable harm paper from PIP.
19. Information sharing	19. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
20. Completed EMS Roster Review	20. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner. Monitor production against the rosters weekly at performance meeting and that provides a level of UHP as a percentage.
21. Delivered a reduction in the number of multiple vehicle attendances dispatched to red calls	21. This will increase vehicle availability generally across the Trust and is monitored through SLT weekly performance meeting.
22. Transfer of Care	22. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently, work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief
23. Virtual Ward – Connect Support Cymru	23. Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru with a further extension in place. • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach and has now completed. • Work has now commenced to recruit CWR volunteers with engagement taking place with organisations across Wales. • **St John Ambulance Cymru virtual ward now extended to the end of April 2024.**
24. ARA – Acute Release Area - GUH	24. Live until 31st March 2024

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

25. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.	25. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
26. WAST membership of the working group (Executive Director of Quality & Nursing) to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commenced in August 2022.	27. Workshop with system partners in place with executive directors of nursing attendance and to date is working well with good engagement from health board colleagues. Following the last meeting on 25.01.2023 it was agreed that sub-groups would be formed to meet more frequently to gather themes / evaluation / develop more consistency which would include aligning the outputs / outcomes with the 'Six Goals for Urgent and Emergency Care' work.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morrison hospital has increased focus on handover delays with external partners and across the media. Some plans are in train (detailed in actions) following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.
2. Blockages in system e.g., internal capacity within Health Boards which affect patient flow	
3. Local delivery units mirroring WAST ODU	
4. Handover delays link to risk 224	
5. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 12 months there is a low confidence in attaining this.	The majority of Health Boards have failed to deliver on this ambition; With the exception of Cardiff and Vale University Health Board, the remaining 5 Health Boards with acute Trusts that were required to deliver on this target, have failed to do so.
6. Handover Improvement Plans agreed between WAST and Health Boards	12. **Performance targets for Handover with Health Boards have been introduced by the commissioner**.
18. Access to Same Day Emergency Care (SDEC) for paramedic referrals	18. This forms part of the handover improvement plans in place with Health Boards; however, assurance is limited given that the uptake is low (less than 1% of total demand). There is an inconsistency in approach from Health Boards on eligibility and availability; The national Once for Wales acceptance criteria has not been uniformly deployed by Health Bards across Wales.
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of People & Culture	**Extended to June 2024**	WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional

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

			funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth. **May24 - Initial bid unsuccessful however an action within the new IMTP to grow our APP workforce by up to 40 per year for the next 3 years. Updates will progress through the IMTP within quarters. Milestone changed from March 2024 to June 2024.**
4. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]		Superseded	
5. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	Ended March 2023	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT.
6. New 2023 EMS Demand and Capacity (roster) review	Assistant Director of Planning & Performance	**August 2024**	ORH modelling underway. Initial findings January 2024, full report to Trust Board and EASC in March. **May24 - The review is scheduled to be presented to Trust Board end of July 2024. Milestone changed from March 2024 to August 2024.**
7. Swansea Bay Winter actions	Assistant Director of Operations, EMS	**Completed**	Some plans are in train following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter. Palliative Care Paramedics commenced on 15/01/2024. 22/02/2024 - POD solution now in operation which is facilitating shift breaks. Palliative care paramedics have been deployed for a pilot in care homes and nursing homes. **May24 - Significant reduction in overruns realised. In addition, during the last 2 months, 0 missed meal breaks recorded in Swansea Bay area. Completed**
8. Mental Health response pilot	Assistant Director of Operations, EMS	**Completed**	Pilot to commence in Aneurin Bevan Health Board area Nov 2023. 22/02/2024 - Mental Health pilot launched in Aneurin Bevan January 2024 with a view to run until end of March 2024. **May24 - Mental Health Response pilot finished in March 2024 – Complete. NB: there is an appetite to further the MH response pilot within the IMTP.**
9. Connected Support Cymru – is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Assistant Director of Quality Governance	**April 2024**	Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform, and a Community Welfare Responder model to enhance community resilience. • Phase 1 delivered through St John Ambulance Cymru with a further extension in place **and further extended until April 2024** • Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid-October with twelve teams piloting the approach and has now completed.

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	15/04/2024	TREND	25 (5x5)
		Date of Next Review:	15/05/2024	➡	

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

			Work has now commenced to recruit CWR volunteers with engagement taking place with organisations across Wales.
10. Maximise the opportunity from Consult and Close: - **Successful resolution without ambulance (double EMS)** - **Successful resolution without conveying to ED**		**March 2025**	Trust ambition is **to improve** Consult and Close rate, with an improvement plan in place to achieve this. The Trust has however already achieved the inclusion of Mental Health Practitioners in CSD, a key contributor to the achievement of Consult and Close rates. Consult and Close compliance remains around 14%. Action plan activities therefore continue with a review of triage processes which may lead to shorter triage durations, along with increase in staffing, which together will enable more triages to take place, **thus increasing the number of successful resolutions without a double EMS ambulance and numbers conveyed to an ED.**
11. Development of new model of care	Head of Strategy Development	2024/25	Development of the model remains ongoing
12. Development of the pathway which connects mental health users connecting via the 999 system to 111 Press 2 services	Assistant Director of Operations, Integrated Care	**Completed**	Development of the model remains ongoing. **May24 – Pathway went live on 30th April 2024. Completed**
13. Palliative Care Paramedic Unit	Assistant Director of Operations	**Extended to May 2024**	Reducing demand via APPs – 15th January Start. **15/04/2024 - 3 Month Health Board funded trial ended. Whilst utilisation was low, the results demonstrated a circa 75% ED avoidance therefore local decision made to extend for a further 2 months, however, opening the trial up to wider community and crew referrals.**
14. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	CEO	Q1 2024-2025	• Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Expected outcomes in 2023/24.
15. Winter Ambulance Handover Improvement Plan Meetings	Executive Director of Operations	**Completed**	• Weekly meetings set up with Welsh Government, NHS Executive, CASC and the Health Board COOs. All parties (including WAST) to provide updates on actions being taken to alleviate and improve handover delays. WAST to update on C&C, CWR, red dispatch and local updates from EMS HOS on initiatives.
16. Royal Glamorgan Early Diagnostic	**Executive Director of Operations**	**May 2024**	• **Initial data from Qlik shows that there has been no reduction in N2H times however data received from Health Board show indication of patient benefit to reach earlier diagnostic. Local meetings this month to discuss findings and explore opportunities.**

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:	14/04/2024	TREND	25 (5x5)
		Date of Next Review:	14/05/2024	➡	

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

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

IMTP Deliverable Numbers:

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

Risk Commentary Q4 2023/24

- The risk score remains constant at 25 for quarter 4 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 2,091 +4-hour patient handovers in February 2024, compared to 1,586 in February 2023. The target was originally to have 0 by September 2022. The EASC expectation was that these would be eradicated by end of 2023/24. Handover lost hours in February 2024 were 23,896 compared to 19,110 in February 2023. Early data from March 2024 shows**
- **some days where over 1,000 hours were lost. Cardiff & Vale UHB has demonstrated material improvement and is a positive outlier when compared to other health boards.** 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 enquiries and redress / claims. The Trust continues to receive Prevention of Future Death Reports (Regulation 28) from Coroners across NHS Wales. The Trust has received 10 reports since April 2023, including 3 reports in quarter 4 2023/4. 6 of these reports directly relate to system pressures with the coroners raising concerns about delays in responding to patients in the community and handover of care delays at emergency departments. **The Trust received the first Prevention of Future Deaths Report in February 2024 relating to pressure damage, which is a joint Report with Swansea Bay University Health Board. On 22.02.2024 a Prevention of Future Deaths Report was sent solely to the Minister for Health and Social Services, Welsh Government in respect of delays responding to a patient in community which also references handover of care delays.** The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. WAST CEO and Directors have ensured that system safety and avoidable harm remain a live topic of discussion in all relevant forums and continue to seize opportunities as they emerge that can contribute to mitigating avoidable harm. **Given the long-standing nature of the system pressures and long handover times, we have commenced work to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and, Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for our ambulance trolleys.**

Improvement actions led by Welsh Government and system partners include:

a) Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – (Welsh Government) ***by the end of April 2025***
b) National Six Goals programme for Urgent and Emergency Care: Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales. WAST is represented on the Clinical Reference Group by the Director of Paramedicine and on the overarching programme board by the Executive Director of Strategy, Planning & Performance.
c) The Trust also has a presence on all the individual goal boards. The Trust has been asked to provide a presentation on its offer to the system at the next Six Goals Programme Board (24 January 2024).
d) NHS Wales eradicates all emergency department handover delays more than 4 hours (LHB CEOs) ***revised to March 2023/24.***
e) Alternative capacity equivalent to 1,000 beds project (LHB CEOs) – 678 additional beds delivered, a significant achievement, but short of the target of 1,000.
f) Investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (Audit Wales)
g) Implement nationwide approach to emergency department 'Fit 2 Sit' (Welsh Government: Chief Medical Officer and Chief Nursing Officer) - paused.
Health boards have previously been required to develop handover reduction action plans, which are monitored at their Integrated Quality, Planning & Delivery (IQPD) meetings by Welsh Government. Handover is also discussed at the Integrated Commissioning Action Plan (ICAP) meetings (currently paused as commissioning arrangements transition into the new Joint Commissioning Committee) which are held monthly between the CASC, the Trust and each Health Board.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Executive Delivery Unit under the Joint Investigation Framework which was formalised in the National Patient Safety Policy in May 2023. Sharing of potential case of serious avoidable harm/death with Health Boards for investigation when response delay associated with system congestion is the primary cause. CNO and CMO plus peer group and COOs regularly updated on patient safety incidents.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.

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

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. **An event reviewing the effectiveness of the joint Investigation Framework is currently being scoped nationally.**
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place via local managers and the Operational Delivery Unit.
5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership. 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. REAP has undergone an annual review with v4.1 released in November 2023.
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuEST
9. 24/7 operational oversight by ODU with dynamic Clinical Safety Plan review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays.	9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays. In December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.	10. Shift reports from ODU & ODU Dashboard received by EMT, SOT and On-Call Team at start/end. On Call cover is reviewed weekly at SLT Performance Meetings.
11. Escalation forums to discuss reducing and mitigating system pressures.	11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.	12. Monthly Integrated Quality and Performance Report (October 2023 overall 76% - Safeguarding and dementia awareness remains over 91%.
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in*	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

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

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.	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 November 2023) and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.
16. Implementation of Duty of Quality, Duty of Candour, and new Quality Standards requirements in April 2023.	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of **February** 2024 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candour Implementation Group and is actively engaged in developing resources. From April 2024 the Trust will publish an annual quality report and compliance with Duty of Candour. Operational oversight occurs at the Quality Management Group and Executive oversight is via the Clinical Quality Governance Group.
17. Clinical Support Desk First in place	17.
18. Summer/Winter initiatives	18. Monitoring through SLT and STB. Senior Planning Team (SPT) is now stood up for the duration of Winter 2023/24.
	External Sources of Assurance Management (1st Line of Assurance)
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
	4. Internal Audit Report (April 2024) Serious Incidents: Joint Investigation Framework (WAST internal processes) provided 'Reasonable Assurance' with low to moderate impact on residual risk exposure until resolved. Improvement actions are monitored via the Audit Tracker.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures – recruitment in line with Organisational Change Process is progressing **with full establishment expected by July 2024.**	1.
2.	2. Implementation of the revised Joint Investigation process with good engagement seen by system partners. Several overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has **56** overdue nationally reportable incident **(NRI)** investigations, **with 63 NRIs open in total**. Shared

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	system learning from the Joint Investigation Framework is currently limited with no new learning identified to date.
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales.	3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. In October 2023, 23,232 hours were lost with 1,888 +4 hour delayed patient handovers.
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS.	4. Strengthening of patient safety reports and audit processes as e PCR system embeds.
5. Variation pan Wales / England as position not implemented across all emergency departments.	5. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.
6. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas.	6. HIW approve and sign off WAST elements of recommendations.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	TBC – Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	**Q3 2024/25**	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available **and access for the Patient safety Team is being explored**. Work on-going with Health Informatics regarding patient safety and health board dashboards **capacity in Health Informatics impacting and dates revised.** • **Local dashboards have been developed but requiring manual data extraction**
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners.	Director of Paramedicine	Q4 2024/25	• **Whilst no additional funding has been secured, ELT has agreed to offer places to all APPs completing their education, funded from a reduction in technician posts (1/2s) i.e. internal movement.** • **The net uplift to the APP establishment (after filling vacancies) is 15.7 FTEs. The Trust expects to see the APP establishment increase to over 100 FTEs in 2024/25. The current staff in post to establishment is 86.5 FTEs / 88.7 FTEs.** • **The Trust is currently undertaken the next strategic EMS demand & capacity review, which includes a future service model and expansion of APPs. The review should be available in Jan-23 (being reported to ELT 31 January 2024, with final report to March EASC).** • **The Trust engaged with HEIW and commissioners in Dec-23 as part of developing the future education requirements for EMS and is aiming to have a draft strategic workforce plan, subject to final approval, by 31 Mar-2024. An internal workshop on APPs workforce planning is arranged for 29 January 2024 (complete).** • **An APP Utilisation task & finish group now being established.** • **The 2024/25 budget (and IMTP) includes a further uplift in the APP establishment**.
5. Overnight falls service extension and future modelling	Executive Director of Quality & Nursing	31.09.2024	• **Night Car Scheme extension agreed to 31 September 2024 (2 regional resources)** • **Utilisation rates continue to be monitored:** • **Nighttime utilisation: -**

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			- Q2 65% - Q3 64% - Q4 to date 64% • Daytime utilisation: - - Q2 57% - Q3 56% - Q4 to date 58% • Combined day and night Q2-Q3 58% • Combined day and night Q4 to date 59% • The EMS Demand & Capacity Review has completed its modelling of falls level 1 and level 2 resources. This will now need to be considered further by the Trust, commissioners, and health boards. • There is an immediate focus on the contract beyond September. 2024.
6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded. Quality Report development underway – mandatory requirement to publish 2024/25 (no fixed date for publication nationally).	Executive Director of Quality & Nursing	Q4 2024/25	• Monthly updates to progress against actions following the baseline assessment and readiness returns continued. • RL Datix Dashboards and KPIs under development nationally by National Quality & Safety Group. • Key policies updated and approved further updates following release of revised Putting Things Right Regulations **which is delayed now expected release by Welsh Government in Autumn 2024 therefore timescale amended.** • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly.
7. Connected Support Cymru is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.	Executive Director of Quality & Nursing	Q1 2024/25	• Awaiting feedback on business case **from Welsh Government** • Executive Director Strategy, Planning & Performance presenting to Six Goals Programme in January on Trust's offer to the system, which will include CSC. • Preliminary end date for the community welfare responders (CWR) pilot identified as 8 February 2023. • This eyes on support to CSD clinicians, by volunteers, is producing positive results, with early data continuing to suggest a 35% consult & close rate for the cohort of patients responded to. • PDSA cycles being undertaken on Luscii (remote diagnostic technology).
8. Organisational change process (OCP) of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	**Q2 2024/25**	• OCP commenced 25.09.2023 and the consultation period has concluded with the final new structure confirmed. Next steps are to recruit to vacant positions which has commenced. It is anticipated that all positions will be filled by May 2024 (taking notice periods into account). Recruitment is progressing well with multiple applications for each post and some internal promotion opportunities. • **Final posts due to be recruited to and in place by July 2024**.
9. 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	Q4 2023/24	• Positive meeting held in August 2023 with the Chair of the TVN network. Next steps are for the Patient Safety Team to attend a TVN leads meeting to discuss opportunities for collaborative working and data / information sharing. Date to be confirmed and there has been good engagement from Health Board Tissue Viability Nurses. • Meeting held with Tissue Viability Nurses from each Health Board on 17.01.2024 and colleagues encouraged to contact WAST for data / information for Pressure Damage Panels to detect harm caused in the prehospital environment. The Patient Safety Team are also engaging with Welsh Wound Innovation Centre (WWIC).

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Current	5	5	25
Target	3	2	6

			• **Links to actions progressing in Action 16 and further engagement with the All Wales Tissue Viability Network – close.**
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	Q2 2024/25	• **Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital: access to unscheduled care services and national arrangements (structure, governance, and support).** • **WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. Expected outcomes in 2023/24.** • **The audit is proceeding. Trust awaiting the outcome. AD Commissioning & Performance has requested an update from Audit Wales.** • **Audit Wales have confirmed this has been reprofiled into 2024/25.**
11. Internal Audit to undertake a review of Serious Adverse Incidents & Joint Investigation Framework	Executive Director of Quality & Nursing	**Closed**	• Internal audit completed. • **Completed – Reasonable Assurance reported in April 2024. Improvement actions included on the Audit Tracker.** • **Close. Moved to external assurance.**
12. Winter Ambulance Handover Improvement Plan Meetings	Executive Director of Operations	**Removed**	• Weekly meetings set up with Welsh Government, NHS Executive, CASC and the Health Board COOs. All parties (including WAST) to provide updates on actions being taken to alleviate and improve handover delays. WAST to update on C&C, CWR, red dispatch and local updates from EMS HOS on initiatives. • May24 – Removed as no longer included on the Board action plan (recently reviewed) and the period has now passed.
13. Integrated Commissioning Action Plans (ICAPs)	Executive Director of Strategy, Planning and Performance	**Paused**	• The ICAP meetings focus on ambulance response performance, handover delay performance and the development of actions to reduce handover delays and improve ambulance response times. • NCCU have sought confirmation from health boards regarding the impact of financial savings plans on the delivery of actions aligned to the ICAP's. • Health boards have not identified any direct impact, but there may be a potential impact on health board's abilities to flex some services due periods of increased demand. • NCCU secured financial support from the Six Goals Program for additional ED discharge transport. • Key initiatives being discussed across ICAPs: ○ MDT Navigation Hubs. ○ Falls & frailty pathways. ○ System Escalation Processes ○ SDEC ○ System Flow (Continuous Flow Model & Effective Discharge) • WAST's 'Menu of options' are being updated and reviewed to include evidence to support initiatives and prioritisation in each health board. • The 2024/25 ICAP structure is being reviewed by the NCCU to consider the planned changes with regards to the new Joint Commissioning Committee (JCC).
14. Patient handover actions.	Executive Team	Under review	• Some English ambulance services operate a system whereby handovers are mandated or forced after a certain period of time e.g. WMAS and LAS. This will be reviewed by the Executive team.

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:	14/04/2024	TREND	25 (5x5)
		Date of Next Review:	14/05/2024	➡	

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

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

15. Work in progress to better define mitigations to safety risks and quality of care deriving from extended periods in an ambulance; these include the application of Mental Capacity Act and Deprivation of Liberty Safeguards and Fundamentals of Care including pressure area care, mobilisation and nutrition. One specific area of focus is the development of a prototype mattress for ambulance trolleys.	Executive Director of Quality & Nursing	Q3 2024/25	• Fundamentals of Care meeting, chaired by the Executive Director of Quality & Nursing held on 08.03.2024.

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:	16/04/2024	TREND	20 (5x4)
		Date of Next Review:	16/05/2024	➡	

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:

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

Risk Commentary

Sickness absence remains one of the key challenges for the organisation. Whilst there has been a significant reduction in absence levels over the past 18 months, rates remain higher than desired and therefore a continued focus on supporting good attendance at work is needed by both managers and the People and Culture team. Increased pressures on our people like handover delay, missed breaks and cost of living impact on health and wellbeing. The outcome of this is to maintain the risk at a score of 20 and review the level at the end of Q1 2024/25.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Managing Attendance at Work Policy/Procedures in place **and followed**	1. **(a) Audits undertaken by People Services Team** **(b) Outputs reviewed**
2. Respect and Resolution Policy- recognising issues at work may contribute to sick absence	2. **R&Rs addressed in timely way to reduce risks of sickness absence.** **Compassionate Practices approach engaged.** **Referral of colleagues to appropriate levels of support**
3. Updated Freedom to Speak Up Policy replacing the 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 Completed - 28/11/23 Freedom to speak Up Safely process introduced from the start of October 2023 including three Trust guardians.
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 28/11/2023 Health and Wellbeing Strategy coming to an end in 2024 to be replaced with a new plan with a focus on employee experience in line with the All-Wales Framework and the People and Culture Plan 2023-2026
5. Operational Workforce Recruitment Plans - provide evidence of sufficient resources and identify any gaps or potential areas of increased workload pressure	5.
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 receive 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. **Reported in MIQPR**
13. Suicide first aiders- additional layer of support	13. Quarterly reporting of numbers of trained suicide first aiders and numbers who have access. Mental Health Team deliver this
14. TRiM- additional layer of support	14. Quarterly reporting on access to TRiM and promotion of service Included in MIQPR
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 28/11/2023 on pause to focus on Leadership Framework with a focus on culture and its impact on the experience of work and workplace wellbeing
17. Staff surveys- assess levels of engagement and wellbeing	17. New HIVE survey tool will provide data on overall engagement and wellbeing 28/11/2023 the NHS Wales Staff Survey has also just closed and will provide information in the new year to inform us further.
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 28/11/2023 OH to lead on a refresh of stress risk assessments use

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:	16/04/2024	TREND	20 (5x4)
		Date of Next Review:	16/05/2024	➡	

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

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 and is also supported by PCC deep dives into sickness. Reporting is also shared with CASC and EASC. Discussions on sickness are reported in minutes and AAA to Board
20. External agencies support e.g., St John Ambulance, Fire and Rescue- if needed at times of increased demand pressure	20.
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. Monthly report on absence to ELT and report to every meeting of People & Culture Committee via the Workforce Report and provision of deep dives when requested.	23.
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 monthly	26. Provides a focus on cases with a clear focus on support and making sure there are plans attached to each case.
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 e.g. – mental health and causes 28/11/23 Recognition of the impact of employee experience and workplace conditions and link to absence. **Reported to ELT for information**
28. Implementation of the Managing Attendance Project 2022-23 completed and ongoing activities maintained	28. **BAU evaluating for delivery**
29. Implementation of Behaviours Refresh Plan completed	29. **BAU evaluated for delivery**
30. 2023 10-point action plans shared with EMT for assurance and RAG rated to track progress quarter	30. Offers assurance to ELMT on the activities and measures in place. Figures on absence are being reported monthly to ELT which is reflected in the minutes and AAA reports
31. Work in Confidence system implemented and Freedom to Speak Up Month in October 2023 focused attention on this	31. External Management (2nd Line of Assurance)
32. Actions from Audit of Nov 22 **completed**	32. **Audit actions completed**
33. Strengthen Freedom to Speak Up Arrangements policy and advice and roll out of platform for raising concerns (in relation to Freedom to Speak Up Arrangements) (Having additional mechanisms in place for individuals to speak up potentially reducing work related stress and anxiety which is a key reason for absence)	33. Monitor FTSU concerns and they are dealt with in agreed timeframes and assessed whether absence related to mental health and anxiety reduces.
34. **Health and Wellbeing Steering Group in place**	34. Monitored through numbers of FTSU concerns raised and continual promotion via Comms and Roadshow Events.
35. **Actions identified from the Managing Attendance Audit implemented**	35. Agendas, minutes etc.
36. **PADR review undertaken and now including wellness questions**	36. Underway and now BAU – we need to say what this means by way of assurance
37. **Scrutinising on a monthly basis all long-term sickness absence case to ensure there is a tailored, individual action plan which identifies interventions that will support a return to work as soon as reasonably possible**.	37. PADRs undertaken and questions asked
38. **Accountability meetings on attendance management between People Services and senior ops managers to ensure this issue is given sufficient focus on priorities.**	**Independent Assurance (3rd Line of Assurance)**
39. **Senior Ops Managers have accountabilities sessions on attendance management with their Heads of Service.**	1b. Internal Audits scheduled through Shared Services Partnership. Last audit on attendance was November 2022 and the last actions from this due at the end of December 2023. (last audit November)
40. **Ensure that the specific issues associated with muscular skeletal conditions is discussed regularly at the H&S Committee and relevant additional interventions are identified**	2. Audit Wales – Taking Care of the Carers report in October 2021
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
(a) Consistency and Application in Managing Attendance at Work Policy	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

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:	16/04/2024	TREND	20 (5x4)
		Date of Next Review:	16/05/2024	➡	

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

1 – 22 Education and communication with managers about resources available and how to implement it e.g., stress risk assessments	1.		
Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Scrutinising on a monthly basis all long-term sickness absence case to ensure there is a tailored, individual action plan which identifies interventions that will support a return to work as soon as reasonably possible.	Deputy Director of People & Culture		Discussion on levels of long term sick absence is undertaken in a variety of forums including EASC, ELT and PCC
2. Develop guidance and training for line managers to equip them with the confidence and skills to have meaningful and sensitive conversations related to attendance.	Deputy Director of People & Culture		Measured through ongoing participation in development sessions and feedback from TU regarding management handling of absence cases.
3. Accountability meetings on attendance management between People Services and senior ops managers to ensure this issue is given sufficient focus on priorities.	Deputy Director of People & Culture		Assurance – meetings taking place and active discussions on operational areas experiencing high levels of absence
4. Senior Ops Managers have accountabilities sessions on attendance management with their Heads of Service.	ADOs Operations		Assurance – meetings taking place and active discussions on operational areas experiencing high levels of absence
5. Case studies developed on examples of areas of business where attendance management has improved significantly to share learning across WAST	Deputy Director of People & Culture		Case studies published and discussed at leadership meetings and evidence of good practice adopted
6. Review of top 100 cases by the wider People & Culture Team on a monthly basis (Wellbeing, OCC Health, People Services)	Deputy Director of People & Culture	31/05/24	Understanding within the wider People & Culture Directorate of cases and action plans clearly identified
7. Connect to other Ambulance sector organisations to identify additional interventions they have implemented to address attendance management, share learning and consider whether to adopt in WAST	Deputy Director, People and Culture		Discuss at P&C Business Meeting and share at ELT/PCC with recommendations.
8. Ensure that the specific issues associated with muscular skeletal conditions is discussed regularly at the H&S Committee and relevant additional interventions are identified	AD Q&N	30/06/24	It is on the agenda and outcomes are available for discussion at H&SC
9. Targeted culture change reviews are undertaken in areas of the business where levels of absence are high and other metrics such as turnover indicates concerns. Alongside this these areas are also experiencing significant change.	Director of People & Culture	Ongoing	Culture review action plans are produced and taken forward. Sick absence in these areas is evaluated and monitored to assess whether reductions are achieved.
10. Implementation of new approach to regularly checking in with staff. Piloting a simple conversation framework for Managers to use with their staff on a monthly basis which provides a focus on wellbeing, goals and personal development.	AD for Culture, Inclusion & Wellbeing	Ongoing	Evaluation of pilot after 6 months to assess if there has been a reduction in sick absence in specific areas where this approach has been adopted.
11. Development of the 2024/25 Managing Attendance Plan (see below for individual actions.	Deputy Director, People and Culture	To commence 30/05/24	Key plan actions noted below
12. Delivery of actions to support managers handling attendance issues with skills, capability and confidence	Deputy Director, People and Culture	31.03.2025	
13. Coaching for managers on cases on one and locality basis.	Deputy Director, People and Culture	31.03.2025	
14. Increase manager support on data interpretation and analysis	Deputy Director, People and Culture	31.03.2025	
15. Increase manager understanding of options for colleagues who are not able to sustain their attendance e.g. flexible hours, reduced hours etc	Deputy Director, People and Culture	31.03.2025	
16. Culture work on creating the sense of team and peer responsibility / ownership	AD for f Culture Inclusion and Wellbeing	31.03.2025	
17. Analyse link between hot spots and the culture in these areas to address cultural issues	AD for Culture, Inclusion & Wellbeing	31.03.2025	
18. Improve preventative measures and pro-active work	Deputy Director of People and Culture	31.03.2025	

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:	16/04/2024	TREND	20 (5x4)
		Date of Next Review:	16/05/2024	➡	

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

19. Identify opportunities to improve roles – flexibility, control, confidence	Deputy Director of People and Culture / ADs, Operations	31.03.2025	
20. Opportunities to adapt the work environment – overruns, shift patterns, rest and recuperation	Deputy Director of People and Culture / ADs, Operations	31.03.2025	
21. Review workloads	Deputy Director of People and Culture / ADs, Operations	31.03.2025	
22. Review patterns of absence	Deputy Director of People and Culture	31.03.2025	
23. Development of a mental health referral pathway	AD for Culture, Inclusion and Wellbeing	31.03.2025	
24. Develop the team around the person model / individual support network	Deputy Director of People and Culture	31.03.2025	
25. Increase lifestyle advice and guidance	AD for Culture, Inclusion and Wellbeing	31.03.2025	
26. Undertake proactive testing to identify undiagnosed conditions	AD for Culture, Inclusion and Wellbeing	31.03.2025	
27. Review reporting on OH	AD for Culture, Inclusion and Wellbeing	31.03.2025	
28. Review opportunities on men's mental health e.g. support groups	AD for Culture, Inclusion and Wellbeing	31.03.2025	

Risk ID 201	A loss of stakeholder confidence that damages the Trust reputation	Date of Review:	11/04/2024	TREND	20 (4x5)
		Date of Next Review:	11/05/2024	➡	

				Likelihood	Consequence	Score
IF there is an inability of the Trust to deliver its core services because of system or organisational pressures	**THEN** there will be a loss of stakeholder confidence in the Trust	**RESULTING IN** a lack of stakeholder support for the Trust's long term strategic vision, a failure to deliver its strategic ambition, damage to reputation and increased external scrutiny	**Inherent**	4	5	20
			Current	4	5	20
			Target	3	5	15

IMTP Deliverable Numbers:

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

Risk Commentary Q3 2024/25

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, coupled with the levels of patient harm and poor patient experience 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, including with Welsh Government and civil service colleagues, together with politicians, commissioners and partners, media relations work, patient experience and internal communication and engagement continue, in order to build trust and credibility. The day-to-day experience of staff and patients, coupled with the need to further build relationships, mean the risk remains heightened. 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, including as it relates to support for the Trust's longer-term strategy and ambition.

CONTROLS	**ASSURANCES**
	Internal Management (1st Line of Assurance)
1. CEO and DSP meeting with HB CEOs throughout Q4 to informally discuss strategic ambition	1. Feedback reported via ELT, TSAG etc/
2. Revision of engagement framework delivery plan (approved by Board Jan 2023) to reflect feedback from stakeholders and revised timelines for strategy engagement	2. Will report via strategy programme architecture plus discussion at Board development/PCC etc. Included in 2024/25 IMTP
3. Challenging of media reports to ensure accuracy	3. Programme of daily media engagement documented on digital system
4. Media liaison to ensure relationships developed with key media stakeholders	4. Programme of daily media engagement documented on digital system
5. Routine stakeholder and staff engagement, including the recent round of Executive roadshows and WAST Live.	5. Agendas, minutes, and documents of engagement events. Informal feedback via ELT and reported via Trust Board (CEO update)
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., ELT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs.
7. Annual deep dives on reputation in place	7. Reported to Committees, documented in minutes, action logs and papers
8. Engagement of the Board on matters of reputation in development sessions. If required, escalation procedure for issues to the Board where circumstances dictate, following discussion at ELT	8. Minuted meetings, action logs and Board papers
9. Regular engagement with senior stakeholders e.g., Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders	9. Informal feedback reported via ELT and occasionally in formal correspondence (nature of discussion often precludes formal recording)
10. Monitoring external factors that may affect the Trust	10. ELT verbally updated on a regular basis with written notes if appropriate
11. Board oversight, scrutiny and challenge of performance, concerns, quality	11. What is the assurance that this control is effective
12. Internal Quality and Performance monitoring in the Trust and raising system issues	12. What is the assurance that this control is effective - reports at ELT, Finance and Performance Committee, Quality, Safety and Patient Experience Committee, People and Culture Committee, Audit Committee

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. The delivery plan is currently under review and is subject to further agreement	1.
2. Managing the narrative of the media	2.
3. Strategic collaboration – further work needed to formalise opportunities	3.

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Reputation audit year two planned	Director of Partnerships & Engagement	**April 2024**	**Audit launched on 09 April 2024, and will run until 01 May 2024.**
2. **Agree Stakeholder Influencing** Plan	Director of Partnerships & Engagement	Q1 24/25	**Currently in development.**
3. Roll out of Stakeholder Influencing Plan	**Director of Partnerships & Engagement**	**Q2 24/25 onwards**	
4. Reputation Audit deep dive on findings to be presented at Board Development	Director of Partnerships & Engagement	Q1 2024/25	**Findings will also be presented at the 09 May People and Culture Committee meeting.**

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:	15/04/2024	TREND	20 (4x5)
		Date of Next Review:	15/05/2024	➡	

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

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

IMTP Deliverable Numbers: TBC

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary Q4

The challenges across the unscheduled care system. **Handover lost hours in February and March 2024 were 23,896 (Feb) and 23,404 (March).** There is a direct correlation with ambulance availability and high levels of resources unavailable due to protracted waits at hospital E.Ds. Several incidents declared have failed to provide sufficient on the ground assurance that vehicles would be released. Health Boards have declined to incorporate testing of vehicle release into a recent mass casualty exercise. Further, a recent workshop undertaken by the EPRR team as part of the Manchester Arena Inquiry assurance process which has tested our ability to fulfil the PDA in North and South Wales, both in and out of hours, has confirmed that we would only meet the PDA in one of these four mass casualty scenarios.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Immediate release protocol	1. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report provided weekly to the DG for Health & Social Services.
2. Resource Escalation Action Plan (REAP)	2. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure. REAP has undergone an annual review with v4.1 released in November 2023.
3. Regional Escalation Protocol	3. Daily conference calls to agree RES levels in conjunction with Health Boards
4. Incident Response Plan	4. The Incident Response Plan has been ratified via EMT
5. Mutual Aid arrangement with NARU	5. AACE National Policy on mutual aid in place
6. Clinical Safety Plan	6. CSP adopted by EMT and operational; reviewed annually by SLT in December 2023, Version 2.21 of the Clinical Safety Plan was released. The reduction in the demand is the assurance which is dynamically monitored via ODU.
7. Operational Delivery Unit 24/7 cover	7. Shift reports from ODU & ODU Dashboard received by Exec, SOT, and On-Call Team at start/end of shift and cover review at weekly performance meeting
8. In hours and Out of hours command cover	8. Civil Contingency requirement as set out in the Command Policy and Incident Response Plan. Cover review at weekly performance meetings
9. Notification and Escalation Procedure	9. Published procedure in operation, reviewed 3 yearly by SLT
10. Continued escalation of risk to partners and stakeholders	10. Referenced by the Executive Director of Operations in correspondence sent to health board Chief Operating Officers dated 30 March 2023. It was further emphasised at the face-to-face COO Peer Group meeting on 14 April 2023.
	External Independent Assurance N/A
11. CEO letter to Health Boards dated 3 Jan 2023, and DOO letter to Chief Operating Officers dated 30 March 2023 to seek assurance on plans.	11. Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&VHB and ABUHB. This has been sustained form some months across C&V in a phased programme of improvement with no delays more than 2 hours. Programme of improvement underway in ABUHB commencing at 4-hour tolerance with a plan to reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs.
12. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration.	12. All Health Boards responded with assurance of plans except BCU.
13. Multi Agency Exercise to be arranged.	13. This exercise has taken place although Health Boards declined to incorporate vehicle release plans
14. Meeting with Welsh Government to outline this risk; WG agreed to write to HBs seeking assurance from EPRR leads in HBs on the ability to clear EDs and release vehicles. WG agreed to incorporate testing into the forthcoming mass casualty exercise, and a timeframe for vehicle release was proposed by WAST with 30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.	14. WG have confirmed that they have written to HB EPRR leads. Health Board COOs approved the proposals for vehicle release as outlined.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**

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:	15/04/2024	TREND	20 (4x5)
		Date of Next Review:	15/05/2024	➡	

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

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

Despite the controls listed, the single most limiting factor in providing a pre-determined response in line with the Incident Response Plan is the lost capacity due to hospital handover delays. In this area, WAST has no control. – link to CRR 223 on CRR.

The Trust is not assured that Hospital sites have plans in place that are trained and tested to release ambulances effectively and immediately in the event of an incident declaration.

Following two incidents (Pembroke Dock Ferry fire on 11th February 2023 and the Swansea gas explosion on 13 March 2023), The Trust is not assured by the effectiveness of assurances given by Health Boards (responses provided following correspondence from WAST CEO – formal returns received from LHBs except BCU). Despite these two incidents being lower-level incident declarations where the pre-determined attendance was met, the experience does not add confidence to the ability to release all resources from hospitals which would support assurance. Further testing of the pre-determined attendance levels has been undertaken as part of the Manchester Arena Inquiry recommendations; This tested the Trust's ability to fulfil the PDA in North Wales and South Wales in the event of a mass casualty scenario both in hours and out of hours. This simulation concluded that in three of these four scenarios, the Trust would be unable to fulfil the PDA. A further declared major incident at Treforest Industrial Estate in December 2023 following an explosion, failed to release resources from Morriston Hospital, Wales's dedicated burns unit (formal debrief still to be conducted).

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review of Manchester Arena Inquiry	Assistant Director of Operations	**July 2024**	This programme of work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios. The financial case associated with MAI is planned to be familiarised with ELT and EASC during Jan and Feb 2024, with the final outline case to ELT in March 2024. **A revised timeline for the governance process for the final MAI reports has been agreed, commencing in May 2024 and finalising at Trust Board the end of July 2024.**
2. Further correspondence to Welsh Government to seek assurance of testing plans following recent mass casualty exercise where Health Boards declined to incorporate vehicle release plans	Assistant Director of Operations	**July 2024**	Correspondence with Welsh Government remains ongoing. 22/02/2024 - Risk 594 has also been referenced in the context of MAI presentation to Welsh Government (6th Feb 2024). Further follow up will be provided as MAI progresses. **Welsh Government has been and will continue to be kept up to date on the developing case, as have the JCC.**
3. Request from COO network to share Action cards related to risk	**Executive Director of Operations**	**Q1**	**March 24 – This risk was discussed at both EASC management and in the COO meeting.**

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	16/04/2024	TREND	16 (4x4)
		Date of Next Review:	16/05/2024	➡	

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:

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

Risk Commentary

Proposal to reduce the score because of a tailored bespoke development programme for managers and Trade Union Partners at all levels has been launched to address issues. The programme of engagement and relationship building will continue throughout 2024/25. Also, specific workforce issues related to potential respect and resolution processes have been addressed.

Work is **well** underway to seek to improve partnership working **through the delivery of the action plan.** The engagement structures below WASPT are in place and running. The Deputy Director of P&C **and Head of Culture and OD have delivered workshop sessions** for TU **partners** and managers across the organisation **in senior and local roles**. **Personal** relationships with TUPs are **generally** good. However, there is a further prospective risk as discussions on pay commence for 2024/25 which are out of the gift of WAST but may result in further tension and industrial action if an offer made is not accepted by the trade unions. This is in the context of the current financial pressures for Welsh Government who are seeking to make significant savings. At a local level there are challenging issues to be managed such as EMT 2-3, demand and capacity reviews and changes to the workforce profile. When there are discussions on one area then there appears to be difficulty disengaging different issues.

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 because 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 are 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 **in place and operating**	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 in place from June 2023	10. Triple A reports through to WASPT and to PCC. **Any escalations are appropriately noted**.
11. Project plan in place to support the improvement in relationships based on the ACAS report from 2022.	11.Development of mentoring and training opportunities for TUPs to support their roles.
12. **AAA report of formal Partnership Forum (WASPT) reported to PCC or Board in future (return to BAU).**	12.Training for local managers and TUPs in development and **diarised delivery for February / March 2024**.
13. **AAA from SLT Partnership Forum and Corporate Partnership Forum reported to WASPT**	13.**Change in senior TU personnel on a temporary basis meaning new senior TU representative needs to be brought up to speed with work on improving partnership working.**

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. 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

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	16/04/2024	TREND	16 (4x4)
		Date of Next Review:	16/05/2024	➡	

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

			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
2. Refresh of engagement programme post Industrial Action and establish work	Deputy Director of People & Culture	30/08/23 Underway and work ongoing. Plan delivery to be completed in 2024. However, this will be subject to the national picture.	Plan agreed and being monitored via WASPT. Draft training development underway in partnership with TUPs **– list of training needs shared from TUPs.** Principles on engagement being developed (in part from the training) and as a result the partnership statement will be updated.
3. Continue the rollout of partnership training across WAST	Deputy Director of People & Culture	Ongoing	
4. Develop the next round of initiatives based on the output from recent sessions	Deputy Director of People & Culture	30.06.24	
5. Learning and Development opportunities for TU partners e.g. shadowing, digital skills, coaching and mentoring	Deputy Director of People & Culture	30.06.24	
6. Develop consultation guidance for managers	Deputy Director of People & Culture	30.06.24	
7. Consider how we celebrate success and capture the positive learning	Deputy Director of People & Culture	30.09.24	
8. Implement a rhythm of meetings to curate and focus on relationships	Deputy Director of People & Culture	30.06.24	

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	04/05/2022	TREND	16 (4x4)
		Date of Next Review:	04/05/2024	→	

IF there is a lack of resources and available technology and infrastructure	THEN there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	RESULTING IN negative environmental and social impacts causing and reputational damage		Likelihood	Consequence	Score
			Inherent			
			Current	3	4	12
			Target	2	4	8

IMTP Deliverable Numbers: TBC

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

Risk Commentary

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Oversight of implementation and delivery of Decarbonisation project and monitoring of action plan at Decarbonisation Programme Board and Capital Management Board	1. Regular meetings of the Decarbonisation Programme Board quarterly. Requirements of the Decarbonisation project have been presented to the Trust Board & Finance and Performance Committee. Challenges of the project have also been highlighted. Report goes regularly to FPC and then onto Trust Board
2. Capital and Estates directorate lead support – Director of Finance (DOF)	2. Regular briefings to DOF
3. Partnership working via Communications/Stakeholder liaison group with NHS Wales, Welsh Government and other bodies to gain support and knowledge- with the anticipation of working in collaboration.	3. Sharing of knowledge via partnership working through various forums is documented in minutes of meetings held. Requirements also form part of the action plan
4. Approach changed for heating/lighting/energy systems to become more energy efficient- replacing old inefficient plant with more sustainable technology such as natural gas boilers for air source heat pumps	4. (i) Estate Survey undertaken every 5 years. This is a 6-facet survey to understand where the back log is and the requirements for energy systems. (ii) Approved Estates SOP (iii) Estate Retrofit Guide and framework used to prepare schemes
5. Changing procurement practices for fleet, Estates, equipment, supplies, and ICT to reduce emissions	5. Fleet SOP shows move to ULEV vehicles. BJC 2024/25 details intention for move to EV for smaller and support vehicles
6. Board Development sessions with respect to Decarbonisation to raise awareness of decarbonisation requirements, additional sessions will be required.	6. Board Development session occurred on 8th November 2021 – presentation slides are available.
7. Finance & Performance Committee has oversight of decarbonisation project, decarbonisation to become a standard agenda item.	7. (i) Routine updates at every other FPC meeting (3 times a year) (ii) Annual report (which includes a Sustainability section) is approved by the Finance & Performance Committee
8. KPIs with respect to energy transmissions are communicated to Estates team annually by sustainability manager	8. KPIs to Estates team includes energy use at all WAST managed buildings
9. ISO14001 accreditation in place	9. ISO14001 – Annual audits are undertaken against the accreditation. Environmental Coordinators act as champions in the organisation.
10. Environment Strategy in place	10. Environment strategy has been approved by the Trust Board. This covers the next 5 years
11. Programme Board Risk Register	11. Programme Risk Register reviewed at every Decarbonisation Programme Board meeting
12. Reporting to WG via DCR reporting, qualitative, and quantitative reports and emissions reporting	12. Submissions to WG – quarterly DCR reporting. Annual qualitative and quantitative reporting
13. Membership of National Programme Board (WG), Transport Task and Finish Group and BELP Project Board	13. Minutes and papers of meeting
	External - Independent Assurance: • Sustainability section in Annual Report audited by Internal Audit. Annual audits by BSI on accreditation
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Establishment of further workstreams to address a Programme Plan to support strategy requirements	
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles	
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited)	
4. NED support ended April 2022	

Risk ID 542	Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Action Plan	Date of Review:	04/05/2022	TREND	16 (4x4)
		Date of Next Review:	04/05/2024	→	

IF there is a lack of resources and available technology and infrastructure	THEN there will be a failure to deliver the commitments outlined in the action plan and within the Welsh Government timelines	RESULTING IN negative environmental and social impacts causing and reputational damage

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

5. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Establishment of further workstreams to address a Programme Plan to support strategy requirements: Consider further workstreams required in support of delivering DAP actions, including grouping of similar actions	Capital Development and Estates Team	31.06.24	
2. Ability to deliver on EV infrastructure plan including electrical capacity issues for the purposes of electronic charging points for vehicles: develop an investment strategy/prioritised list of sites where further EV charging is required. Will need further investment.	Decarbonisation Programme Board	March 2025 (in line with the IA recommendation action)	
3. Procurement of an electronic fleet of vehicles – this is not currently possible for anything other than a car/van (limited): development of specifications for vehicles considering achievable and safe ULEV options where possible. NOTE: will be dependent on confirmation of 2024/25 BJC funding	Fleet Team	March 2025	
4. NED support ended April 2022: A new NED will need to be nominated to champion this risk/project at Trust Board level	Director of Corporate Governance / Board Secretary	31.06.24	
5. Resources to be able to deliver extent of DAP – work ongoing to establish actions required and potential cost impacts. Note detailed schemes are challenging to work up without appropriate resource which in turn allow for realistic financial estimates to be made about cost: Development of an investment requirements schedule (also aligned to IA recommendations). Contribute resources to support the Decarbonisation Strategy action plan	Director of Finance & Corporate Resources	31.03.25	

CLOSED 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:	16/02/2024	TREND	16 (4x4)
		Date of Next Review:	15/03/2024	➡	

				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:

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

Risk Commentary

Linked to risk 139, though funding has been sourced internally for the EMS staff, and non-recurrently from EASC, the score remains the same as clarity from Commissioners has still not been provided on any recurrent funding ask on this topic which could have a negative recurrent impact on the Trusts financial position. Other key item to note is funding for 111, WAST continues dialogue with commissioners of the service and any financial risk is mitigated by operating on a spend and cost recovery basis with commissioners.

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at FPC, and a report is submitted 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 monthly	**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 Leadership Team	31.3.24	Update: 23/24 Recurrent funding remains an issue for the 100 WTE £6m funding from commissioners. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis.
2. Develop a Value Based Healthcare system approach with commissioners. This would mean that funding would flow more seamlessly between organisations and would go some way to mitigating the risk of not receiving recurrent funding.	Deputy Director of Finance	31.3.24	Update: Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.

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:	16/04/2024	TREND	15 (3x5)
		Date of Next Review:	16/05/2024	→	

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

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

IMTP Deliverable Numbers:

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

Risk Commentary

The latest National Cyber Security Centre (NCSC) assessment indicates that the threat of Cyber-attacks remains unchanged with activities of state actors and criminal gangs still high. Whilst the Trust and wider NHS Wales organisations have in place several layers of technology to protect the Trust and its information systems, there is still a risk that users will be fooled by phishing emails which are becoming ever more sophisticated. To raise user awareness of cyber threats the Trust ICT department run regular phishing exercises as well as short security training packages, reporting the results and uptake through IGSG and into FPC. Risk has been fully reviewed in the cycle and the score remains static.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Appropriate policy and procedures in place for Information/Cyber Security	1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
2. Trust Business Continuity Procedure and Incident Response Plan	2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
3. IT Disaster Recovery Plan	3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
4. Relevant expertise in Trust with respect to information security	4. Staff undertake relevant training courses e.g., CISSP to increase knowledge and expertise
5. Data Protection Officer in post	5. In job description of Head of ICT
6. Cyber and information security training and awareness	6. Training statistics are available on ESR and from Phish threat module
7. Mandatory Information Governance training which includes GDPR	7. Training statistics reported on by Information Governance department
8. ICT tests and monitoring on networks & servers	8. Any issues would be identified and flagged and actioned
9. Information Governance framework	9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
10. Internal and NHS Wales governance reporting structures in place	10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.
11. Checks undertaken on inactive user accounts	11. Software in place to run check on inactive accounts as and when
12. Business Continuity exercises	12. Annual schedule of testing
13. Operational ICT controls e.g., penetration testing, firewalls, patching	13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when. 04/08/23 – Exploring procurement of additional penetration tests with the aim of annual testing of all critical systems.
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
15. Cyber/Info Security KPI are reported to senior management and committees	15. Monthly KPI reports now being generated routinely and fed into the Digital Leadership Group, ELT, IGSG and FPC
16. Regular cyber awareness campaigns are conducted	16. Cyber training is provided to staff and regular phishing campaigns are conducted. These are reported as part of the KPI reports
17 IT recovery Plan does include a cyber response	17. Cyber response incorporated into IT Disaster Recovery Plan
18.Information Security Policy refreshed and approved	

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:	16/04/2024	TREND	15 (3x5)
		Date of Next Review:	16/05/2024	→	

IF	THEN	RESULTING IN
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

19. Suite of business continuity exercises that departments can undertake to test their plans are available via EPRR.	19.
20. The cyber risk is reviewed and monitored	20. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources via ICT security team and reported to AD of Digital and DPO. The corporate cyber risk assessment will be reviewed monthly at the Digital Leadership Group informed by the threat and intelligence monitoring and national strategic trends.
	External Independent Assurance NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of understanding and compliance with policy and procedures by all staff members	1.
2. No organisational information security management system in place	2. SIRO in place and ISMS evolving in line with refresh of Trust information Security Policy
3.	3.
4. Departments do not communicate in a timely manner with Digital Services around putting in new processes, new projects, and procurement and this has a cyber security, information governance and resource impact	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Development of a Cyber Improvement Plan	Senior ICT Security Specialist	Next checkpoint date 25.06.2024	Implementation of Cyber Improvement Plan actions ongoing and reported into IGSG

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:	16/04/2024	TREND	15 (3x5)
		Date of Next Review:	16/05/2024		

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

	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

Risk Commentary

This risk should be considered alongside Risk 160 as the resulting increased sickness levels mentioned above will be addressed by the same controls and assurances. However, the ongoing system pressures including long handover delays, overruns, missed breaks and the perpetuating impact of increased sickness levels continues to mean this risk remains static. WAST continues to work in partnership with the system to pilot viable options for addressing the external factors. Although there has been some success in some areas, we are yet to see these being scaled to an extent that the employee experience has been impacted. Since 2020 we have not seen the previous pattern of easing over the summer months and with the current public health risk of measles and continuing risks of covid this risk remains static. The People and Culture Plan 2023-2026 is a good summary of the controls and actions addressing this risk. The old Health and Wellbeing Strategy and its replacement build on this. Nationally the Health and Wellbeing Framework due for publication in Summer 2024 also addresses the system wide employee experience challenges. The ongoing system challenges remain with long handover delays which are likely to worsen again as we head into winter pressures. Work on reducing shift overruns continues with various pilots being run to test viable options which could be implemented. Front line operations had little respite over the summer months.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
13. Health and wellbeing strategy 2020-2024 in place and shared across the Trust. The new Health and Wellbeing Plan 2025-2028 has now been drafted and is out for consultation. The aim of the new plan is to expand on consideration of employee experience to recognise that individual wellbeing interventions are not sufficient in mitigating system wide pressures.	14. New Health and Wellbeing Plan 2025-2028 aligned closely to People and Culture Plan and delivery monitored via the Health and Wellbeing Steering Group, reporting into the People and Culture Business Meetings. New All Wales Framework also in development with an emphasis on workplace experience due for publication in June 2024.
14. Occupational Health & Wellbeing team with range of support options for individual mental health interventions, MSK support, reasonable accommodations and recommendations, supported by mental and physical health expert clinicians.	15. Current waiting times now within SLA of 6 days, self-referrals and self-appointment booking. External providers meet quarterly and provide monthly engagement figures. Reporting into OHW operational team meeting and MIQPR.
15. Wellbeing support and training for line managers a peer support network and TRiM intervention for trauma information.	16. Rolling programme of workshops, attendance at team events when requested, evaluation and numbers trained reported at OHW operational meetings. Diarised meetings, webinars and workshops in place through a rolling programme. Have these happened and what was the benefit? How do we measure it.
16.	17. Tools are available on WAST intranet.
17. TRiM	18. TRiM Coordinator has regular dialogue with TRiM managers and practitioners. Project plan and training schedule in place.
18. Acting on results of staff surveys relating to staff experience, data triangulated with pulse surveys and other cultural metrics as detailed in the People and Culture Plan.	19. Each Directorate has developed their own action plan to address staff surveys. NHS staff survey high level results released 19/02/204 with directorate specific data released in April 2024.
19. HSE stress risk assessments	20. Undertaken by managers and advice is provided on how to use them by Occupational Health and Health and Safety teams.
20. KPIs are reported fortnightly to regarding Occupational Health and Wellbeing activity	21. Received at OHW operational team meeting and reported in MIQPR.
21. Wellbeing drop-in sessions for CCC and 111 staff	22. These sessions are now part of business as usual across services and a user experience form is being designed to collate more formal quantitative feedback for OHW operational team meetings. Data to date has been qualitative and the quantitative has been measured by engagement with the service.
22. Fast track physiotherapy to address MSK issues.	23. Regular review meetings with physiotherapy provider and monthly monitoring information received at People and Culture Business meetings and MIQPR
23. Occupational Health team inclusion in sickness and absence meetings	24. Have the meetings been of benefit and how do we measure it
24. Stress risk assessments	25. These are part of the IOSH Managing Safely Training.
	External - Independent Assurance - Audit Wales – Taking Care of the Carers report in October 2021 – all actions complete
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
	4. Reporting on wellbeing training take up this is now being reported into OHW Operational Team Meetings.
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 Safet. With the arrival of the new OH Manager these discussions have restarted, and	Lack of awareness about staff wellbeing services, this continues to be a challenge due to small team, non-wired colleagues and competing communication messages.

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:	16/04/2024	TREND	15 (3x5)
		Date of Next Review:	16/05/2024		

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

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

colleagues are directed to the stress risk assessment information and education sessions will be started in Q1 & Q2.

Effects of elevated reap status 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. Attendance at all events by operational staff consistently low due to service pressures.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. People and Culture Plan 2023-2026 relevant Actions	Assistant Director for Inclusion, culture and wellbeing	Annual Plan	First year due to be reviewed at next People and Culture Committee May 2024
2. Health and Wellbeing Plan 2025-2029	Assistant Director for Inclusion, culture and wellbeing	To be agreed at board autumn 2024.	New plan out for consultation until June 2024 **16/4/2024 Ongoing**

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	14/03/2024	TREND	15 (3x5)
		Date of Next Review:	14/04/2024	NEW	

				Likelihood	Consequence	Score
IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	**THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	**RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage	**Inherent**	4	5	20
			Current	3	5	15
			Target	2	5	10

IMTP Deliverable Numbers:

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

Risk Commentary

The consequences of this risk depend on the worst-case scenario which crosses of a number Domains on the Risk Scoring Matrix e.g. Loss of, or access to mass clinical data, the reputational damage this would cause, subsequent high-level involvement of ICO, Regulatory Body and Government involvement the subsequent fall out, fines and reduction in the level of clinical care. The likelihood would be small NB Just like pandemics. However, there are lower consequences of failure of statutory compliance which would warrant a higher level of likelihood even daily but in this case like near misses they indicate the need for change/improvement to demonstrate managing the risks. Therefore, the consequences will always be 5 but improvements are needed to lower the risk, and should we demonstrate meeting Statutory Requirements even if a serious incident/event/failure arises evidence provided would reduce / mitigate against the consequences.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. **Data Protection Expertise: 1 FTE Data Protection and Compliance Manager (DPCM); 1 FTE Information Governance Officer, 1 FTE Cyber Security Officer**	1. **Two Data Protection and Compliance Managers have been employed on a consultancy basis to provide cover and support backlog clearance (E).**
2. **Temporary Data Protection Officer position held by Head of ICT**	2. **Temporary Data Protection Officer**
3. **Data Protection and Information Governance Policies and Procedures (Incl. DPIAs and Cloud Assessments)**	3. **Monthly Information Governance Steering Group which includes progress** **DPC, DSA and DPIA reviews (I)** **IG Training** **IG Toolkit (System for providing a level of assurance of compliance (I)** **Incident Reporting** **Accountability to ELT** **Development of reporting (dashboard) which supports IGSG, ELT and QUEST Board Committee for scrutiny.**
4. **Contracts and agreements: Data processing, Data Sharing and Employment & Consultancy**	
5. **Register of information assets and data flows (outdated)**	
6. **Staff training on updated training module (Apr 2023)**	
7. **Incident Reporting and management (DATIX)**	
8. **NIIAS?**	
9. **Digital Notices / comms?**	
10. **Proactive engagement outbound (not inbound to team)**	
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. WAST has been carrying a DPCM vacancy since January 2023. There has been 1 unsuccessful attempt to fill the position which has led to capacity constraints. In Qtr. 4 2023/24 the Job Description will be reviewed and readvertised before the end of the financial year.	1. **See 21. Further Actions (1)**

Risk ID 623	Failure to comply with Data Protection Legislation	Date of Review:	14/03/2024	TREND	15 (3x5)
		Date of Next Review:	14/04/2024	NEW	

				Likelihood	Consequence	Score
IF the Trust fails to comply with and demonstrate it is meeting the accountability requirements under the Data Protection Act, the UK General Data Protection Regulation (GDPR) and the Common Law Duty of Confidentiality	**THEN** the Trust will breach its legal obligations and potentially cause the personal or sensitive data to be compromised, lost, or inappropriately used.	**RESULTING IN** unauthorised data breaches/loss, financial or compensatory penalties, an increased regulatory scrutiny or enforcement as well as stakeholder mistrust and reputational damage	Inherent	4	5	20
			Current	3	5	15
			Target	2	5	10

2. Unfilled and unfunded position which is required to meet Article 39 UK GDPR 2018. *The DPO must also be independent, an expert in data protection, adequately resourced, and report to the highest management level* [DPA 2018].	2. **This is a stop gap.**
3. Resource capacity constraints to update, implement or monitor the controls; and lack of engagement by management and staff which either bypass the requirements or stalled engagement.	3. **Even with increased capacity without engagement by managers and staff to meet their compliance requirements there will continue to be information reported to IGSG which will demonstrate low levels of assurance i.e. Reports on DPIA log, DSA log, Training Levels, IG Toolkit, and Implementation Plan**
4. Personal identifiable information (PII) is being processed or shared with no data processing contracts (DPC) or data sharing agreements (DSA) when legally required; or incomplete DPC or DSA due to stalled engagement.	4. **Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase IT systems, hire document scanning companies, external data consultants and analytical firms and bypass WAST's controls for appropriate due diligence or legislative required controls in managing these risks.**
5. New data, or new data processes which have either bypassed the controls or there are no information asset owner and therefore doesn't get on to the asset register or the dataflow is not mapped and creates a weakness in assurance (See 3)	5. **Data Protection and Compliance Risks not fully realised.**
6. Currently not meeting levels of IG staff training.	
7. Lack of Data Protection pre procurement controls which form part of Data Protection by Design and Default means that Departments could purchase IT systems.	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. **Recruitment of Data Protection and Compliance Manager(s) – funding agreed**	**Leanne Smith**	**Q2 2024/25**	**Interviewing 01 May 2024 – in post Q2**
2. **Seeking funding to recruit/upskill/resource DPO who will encourage engagement**	**Jonny Sammut**	**Q3 2024/25**	**Recruitment and in post Q3**
3. **Ensure compliance with the appropriate IG level training across all Directorate and Departments** **a. Demonstrate a regular series of comms on IG and DP** **b. Regular monitoring of training compliance through IGSG** **c. Targeted training compliance reporting to line manager on individuals to ensure that 85% target is reached.** **d. BAU on Siren training notices and specific guidance or advice**	**Leanne Smith**	**Q2 2024/25**	**Lock screen issued 04/24 in relation to WhatsApp and training. This will be refreshed in 06/24. Siren notice drafted for ELT 05/24**
4. **Report on physical security to IGSG – working with fleet and estates team**	**Leanne Smith and Aled Williams**	**Q2 2024/25**	**Reporting to IGSG and FPC**
5. **Implementation of Data Protection by Design and Default which includes pre procurement of IT systems, hiring of document scanning companies, external data consultants and analytical firms and bypass WAST's controls for appropriate due diligence or legislative required controls in managing these risks.**	**TBA**	**TBA**	**IG colleagues are part of the Impact Assessments TFG Series of SMART actions will be developed to address this overarching action**

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:	16/04/2024	TREND	12 (3x4)
		Date of Next Review:	16/07/2024	→	

IF WAST fails to persuade EASC/Health Boards about WAST ambitions	THEN there is a risk of a delay or failure to receive funding and support	RESULTING IN a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered		Likelihood	Consequence	Score
			Inherent	4	4	16
			Current	3	4	12
			Target	2	4	8

IMTP Deliverable Numbers:

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

Risk Commentary

The ambition is appropriate levels of patient safety and good working conditions for our staff. Clearly neither of these are currently being achieved in the emergency ambulance care pathway as evidenced by the long waits, shift overruns and volume of concerns and reportable incidents. The Trust is currently commissioned on the assumption of 6,000 hours of handover lost hours, with current levels at 26,000 (Jan-24). EASC has an ambition to achieve 12,000 handover lost hours by the beginning of quarter four 2023/24, which has not been achieved, but even if it was achieved, it would still be double what the EMS rosters are predicated on. The Trust is not fully funded on these rosters either. The Trust is not fully funded for the CHARU roster lines, with an identified shortfall of -89.5 FTEs. The Trust has made the decision to transfer staff from emergency ambulance roster lines to CHARU roster lines, which is almost complete, but this is an internal movement of staff, not an increase in establishment. Similarly, the Trust has made the decision (delivered) to recruit another intake of APPs, an additional 16 FTEs, but this is also being funded through internal movements, with a planned temporary relief gap to fund these internal movements.

The 2023 EMS Demand & Capacity Review is live with an estimated completion date of **July** 2023 **Trust Board (draft results received by end of 23/24 and in time for IMTP).** This strategic review will enable the Trust to articulate the type and level of resource that optimises response and conveyance to deliver appropriate levels of patient safety and good working conditions for our staff i.e., the ambition. If handover levels remain unchanged **and a traditional conveyance model is used to meet demand,** the review is indicating **an unacceptably high-level modelled staff requirement. The Review estimates a more reasonable figure of +300 FTEs, if handover can be reduced to 7,000 hours (handovers within one hour) supported by full triangle inversion.**
The Trust has some limited room for manoeuvre in its 2024/25 budget to put more resource into "shift left"/" invert the triangle", but if further funding is not forthcoming, post the 2023 EMS Demand & Capacity Review, the risk may need to be revised upwards.

NEPTS is also commissioned via EASC (it is commissioned at NEPTS, not Ambulance Care), with agreement that in Q1 2024/25 there should be a joint collaborative workshop between the Trust, the Joint Commissioning Committee (JCC), which is the new organisation commissioning EMS and NEPTS, and health boards.

From May 2023 111Wales has also become a commissioned service, with the 111 Board commissioning the front end of the 111Wales service from the Trust.

From the 01 April 2024 111Wales will be commissioned by the JCC as well, bringing all three patient pathways operated by the Trust under a single commissioning umbrella. This is viewed as a positive development by the Trust, supporting the development of an organisational ambition.

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 stakeholder's fortnightly
7. Programme structure has been established for 'inverting the triangles' including EASC	7. This is now an established programme of work with the Trust making an offer to the system via the Six Goals Programme in January 2024.
8. Commissioning intentions.	8. In year progress reported each quarter to the relevant commissioning meeting and 24/25 commissioning intentions approved for 111Wales and expected to be approved by Mar-24 EASC.
9. Governance arrangements for 111 commissioning: 111 Board, 111 Commissioning Board + 111 DAG etc.	9. Minutes of meetings and a standard agenda item

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:	16/04/2024	TREND	12 (3x4)
		Date of Next Review:	16/07/2024	→	

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

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

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 **(assumption that provider reports will continue in the JCC)**
2. Governance coordination between NCCU **(now JCC)** 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. The Trust is currently meeting every two weeks connected to the development the IMTP. This will be further reviewed as the JCC goes live in April-24 **(period of transition likely to extend through Q1).**
3. WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	3. Ministerial direction on handover reduction with significant pressure being applied to health boards through the NHS Leadership Board and NHS Executive accountability arrangements.
4. Funding does not flow in a manner to balance demand with capacity (outside of WAST's control)	4. Strategic demand and capacity review being undertaken with output due to be reported to EASC in Mar-24, with initial findings already shared. On advice from the CASC, formally reporting the findings of the review has been re-programmed into Q1 2024/25, for the new JCC. **JCC dates to be determined.**

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence EASC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	02/08/23 Checkpoint Date **(this is almost a permanent action by the CEO, so not sure it has a by when date?)**	30.09.22 Additional £3m provided for +100 FTEs into Response by 23/01/23. 12/01/23 Recurrent funding for the +100 not secure. 02.05.23 Recurrent funding still not secure. **16.04.24 Recurrent funding for +100 FTEs now secured.** 28.07.23 Funding secure for 23/24, but not recurring. 18.01.24 Offer being made to the system in January 2024 via the Six Goals Programme. The reception of the Trust's offer was mixed. A key area of focus in the 2024/25 IMTP will be data linking that enables the Trust to better prove the value of investing in the Trust; **(16/04/24) and the development of system metrics dashboard that enables the Trust to track its impact on the wider system**
2. Agree and influence EASC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	02/08/23 Checkpoint Date **(this is almost a permanent action by the CEO, so not sure it has a by when date?)**	30.09.22 4-hour handover backstop agreed and -25% reduction in handover from October 2021 baseline. 12/01/23 There has been a significant worsening picture. 02.05.23 Continued worsening picture with almost 29,000 lost in March 2023. 28.07.23 There has been some reduction, but levels remain extreme. 18.01.24 NHS Leadership Board is increasing accountability and focus of health board handover reduction actions. The emerging 2023 EMS Demand & Capacity Review models the level of resource required with no handover reduction and the level of resource required if there is a handover reduction to 12,000 hours. **26/04/24 This modelling has been further supplemented by modelling the Ministerial target of no handovers of more than one hour.**
3. Increased understanding of NEPTS by EASC	Executive Director of Strategy Planning and Performance	02/08/23 **30/06/24**	30.09.22 "Focus on" session in May 2022 EASC and NCCU represented on Ambulance Care Programme Board. 12/01/23 F&P Deep Dive made available to NCCU. 02.05.23 Continued attendance by NCCU at Ambulance Care Transformation Programme. 28.07.23 EASC want WAST to develop a LTS for NEPTS, which will increase the focus on it. 18.01.24 Ambulance Care strategy sessions held as part of the inverting the triangle programme and IMTP development held, which will now be taken forward into a collaborative workshop with commissioners in Q1 2024/25. **16/04/24 Workshop arranged for April 2024.**
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	02/08/23 Checkpoint Date	30.09.22 Meeting in place and meeting regularly. 12/01/23 Meetings continue. 02.05.23 These have lapsed due to pressures and sickness absence in the NCCU. HB to reboot, subject to ability of NCCU to undertake. 28.07.23 Availability remains a challenge, but there is regular informal dialogue between WAST and NCCU. 18.01.24 This specific meeting remains lapsed, but the Trust is currently meeting every two weeks with the NCCU on the

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:	16/04/2024	TREND	12 (3x4)
		Date of Next Review:	16/07/2024	→	

IF WAST fails to persuade EASC/Health Boards about WAST ambitions	THEN there is a risk of a delay or failure to receive funding and support	RESULTING IN a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered		Likelihood	Consequence	Score
			Inherent	4	4	16
			Current	3	4	12
			Target	2	4	8

			development of the IMTP. As the Trust moves into the new JCC from 01 April 2024 there will be a further opportunity to address this control. **16/04/24 The new commissioning arrangements are in transition and still quite fluid at the moment.**
5. Develop and roll out the Stakeholder Influencing Plan	Director of Partnerships & Engagement AD Planning & Transformation	Q2 24/25 onwards	15/03/24 This action is captured in Risk 201 on the CRR. The reputation audit being repeated in Q1 will inform the development and roll out of this plan in Q2. **16/04/24 One for Estelle.**

Risk ID 424	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	18/03/2023	TREND	12 (3x4)
		Date of Next Review:	18/06/2024	➡	

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

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	1	4	4

IMTP Deliverable Numbers: All

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

Risk Commentary

It is recommended that the risk score be reduced to 12 based on a reduction of likelihood score. There is funding allocated within the IMTP financial plan for support to deliver key areas of work that has been agreed with commissioners. The vacancies and gaps within the central Transformation team have been reduced so there are better levels of support for delivery of key workstreams and delivery of mitigations listed in this BAF.

IMTP priorities have been set and are going to Trust Board on 28th March 2024 covering the next three years, taking into account the external context in which the Trust is working. These priorities are considered realistic within the funding envelope, and this has been through rigorous prioritisation processes (revenue and capital).

In addition, the Project Path Framework has now been developed to replace the existing PPM, which will enable awareness, training, and a network of project resources across the Trust to develop consistency in delivery. This is due to be signed off at Integrated Strategic Planning Group (ISPG) on 22nd March 2024 (STB delegated authority to sign off at ISPG on 26th February 2024.

This risk will remain under review as we consider any put further controls in place but also taking account of the new commissioning landscape, financial context and our strategic developments.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Prioritisation of IMTP deliverables	1. Prioritisation session held with ADLT/ELT on 14th February 2024
2. Financial policy and procedures	2.
3. Governance and reporting structures e.g., Strategic Transformation Board (STB)	3. IMTP sets out delivery structures and meeting minutes are available for ISPG, TSAG and STB
4. Assurance meetings with Welsh Government and Commissioners	4. Agendas, minutes, and slide decks available
5. Transformation Support Office (TSO) which supports the major delivery programmes	5. Paper on TSO to Strategic Transformation Board
6. Project Path Framework (PPF) - Project and Programme Management Framework to be replaced with Project Path Framework, with toolkits, training, and networks in place to support consistency of project delivery across the Trust	6. PowerPoint pack detailing Project Path Framework
7. Regular engagement with key stakeholders	7. Stakeholder Engagement Framework
8. Financial Sustainability Programme – savings and income work streams	8. FSP programme highlight reports
9. Head of Transformation	9. Head of Transformation in Post
	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. Lack of a commercial contractual relationship with Commissioners (link to risk 458)	2. Benefits have not been fully linked at programme level through to benefits realisation plan.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review the PPF	Head of Transformation	Extended from 31.03.23 – To 31.06.23 and then to 30.09.23 in line with milestone for delivery Extend to 31.12.23 in line with timescales for sign off. Extend to 31.01.24 in line with timescales for sign off. Extend to end of Feb in line with next STB.	Currently (January 2023) working through delivery structures for 2023-26 which will inform the PPM review – changed checkpoint date to 31.06.23. Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3. Planning Framework approved by STB on 04.07.2023 which sets out the Project Path framework at a high level. Project Path Framework presented at ISPG on 27.10.23 and is scheduled for approval at STB on 27.11.23.

Risk ID 424	Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	18/03/2023	TREND	12 (3x4)
		Date of Next Review:	18/06/2024	➡	

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

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	1	4	4

		Extend to end March to allow for ISPG sign off (delegated from STB)	STB reviewed the Project Path Framework and generally good feedback but some alterations to be made and brought back to STB in January 2024 for approval. Further finalisation required; approval deferred to STB meeting 26.02.24. STB delegated authority to ISPG to finalise and sign off the PPF at the end of March.
2. Develop Benefits Realisation plans in line with Quality and Performance Management framework	Assistant Director of Planning/Assistant Director, Commissioning & Performance	Extended from 30.09.22 – to 31.03.23. Further extend to 31.06.23 and then to 30.09.23 in line with milestone for delivery Extend to 31.12.23 as priorities have taken precedence but there is work ongoing in this space. Extend to 29.02.24 as other priorities have taken precedence but there is work ongoing in this space. As above extend to end of Feb. Extend to 30.06.24 as further resources become available / return to enable this work to be done.	Reviewed action and extended checkpoint date further as approach being developed for next iteration of IMTP. Work ongoing. Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3 as part of Project Path Framework. Work continues with the Commissioning and Performance Team to align performance metrics with programme/IMTP deliverables. An evaluation methodology is being trialled with Swansea University to look at benefits realisation of small, agile projects and PDSA cycles. Work continues this but will be rolled out as part of the PPF. The PPF has a clear template for benefits realisation plans, and benefits maps will be developed in Q1 to enable programmes and directorates to develop their benefits realisation plans.
3. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)	Director of Finance	31.12.22 – checkpoint date 31.06.23 and then to 30.09.23 Extend to 31.12.23. As above extend to end of Feb. Extend to end March to allow for ISPG sign off PPF (delegated from STB)	Extend checkpoint date to 31.03.2023 on basis of new financial allocations for 2023 to be worked through with Commissioner. A business case panel process has been developed and trialled as part of the development of the project path framework and is factored into the IMTP planning cycle, to give finance colleagues a timelier view of potential developments into the next 3-year cycle. Extended in line with the roll out of PPF as the business case process is within that framework, however it has been utilised to review the recent CSC Business Case and was found to be helpful and supportive – albeit the model for developing business cases needs to be reviewed further to make the actual output more streamlined. At ADLT/ELT prioritisation (14.02.24) it was agreed that for areas that have been allocated funding a clear 'spend plan' in lieu of a business case would be needed to draw down funding so that it is clear what the benefits of funding would be.

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	09/04/2024	TREND	8 (2x4)
		Date of Next Review:	09/07/2024	➡	

IF the Trust does:	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
• 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	2	4	8
Target	2	4	8

IMTP Deliverable Numbers:

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

Risk Commentary Q4 2023/24

The risk has now been further reviewed in conjunction with the level of financial risk detailed in the Trust's financial monitoring returns submitted to WG. The score has improved in year as a result, in part due to WAST being able to resource the remaining cost of the EMS staff increase itself in year, whilst further confirmation and assurance has been received from WG on any pay award funding due. In addition, a recent letter from WG confirmed that the Trust does not need to contribute anything further to the wider NHS Wales deficit reduction plan or will see any further reduction in its income to do so, providing further confidence that for this financial the risk has reduced. It must be noted that even though the risk has reduced for this year, in the current challenging financial climate for all public sector organisations the risk will remain elevated especially as focus turns towards financial planning for the new financial year e.g., recurrent funding will still need to be agreed with Commissioners for the new financial year for the 100 WTE EMS staff.

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

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	09/04/2024	TREND	8 (2x4)
		Date of Next Review:	09/07/2024	➡	

IF the Trust does:	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
• 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	2	4	8
Target	2	4	8

GAPS IN CONTROLS	GAPS IN ASSURANCE
• Lack of formalised service contracts between Commissioner and WAST as a commissioned body	**10.** None identified.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/24 **31/03/25**	In line with the recent WAST financial position and monthly monitoring letter sent to WG, WAST can resource the cost of the EMS staff itself. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis.
2. Embed a transformative savings plan and ensure organisational buy in	ADLT and Savings subgroup	31/03/24 **31/03/25**	**The Financial Sustainability Program (FSP) continues to be a key vehicle for the Trust to fully identify its savings program. Over delivery was achieved for the 23/24 financial year and the point of strong delivery is further highlighted with the programs ability to fully identify the 24/25 £6.4m savings plan before the start of the financial year.**
3. Embed value-based healthcare working through the organisation	Executive Leadership Team and Value Based Healthcare Group	31/03/24 **31/03/25**	Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.
4. Foundational economy, Decommissioning, and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/24 **31/03/25**	The organisation utilises the NWSSP Shared Services Procurement framework to ensure contracts tendered provide best value for money while ensuring criteria within the tender docs ask bidders to highlight their ability to serve the aims of FE, Decommissioning, Decarbonisation and social as well as the economic wellbeing of Wales. **Ad hoc reports are received from Shared Services on WAST's progress in switching more expenditure to Welsh suppliers to keep the Welsh pound in Wales.**

Risk ID 283	TO BE DE-ESCALATED TO DIRECTORATE RISK REGISTER Failure to implement the EMS Operational Transformation Programme	Date of Review:	29/02/2024	TREND	8 (2x4)
		Date of Next Review:	28/05/2024	➡	

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

IMTP Deliverable Numbers:

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

Risk Commentary

The EMS Operational Transformation Programme is the Trust's strategic delivery response to the 2019 EMS Demand & Capacity Review. The programme has now largely been delivered e.g., closure of relief gap (recruitment of +300 staff), increase consult & close above the 10.2% benchmark, re-roster EMS, ensure that there was sufficient fleet and estate to support these changes and roll out the new CHARU resource. The main area outstanding is the reconfiguration of EMSC, which was initially delayed by the pandemic and then further delayed by the need to update the data used to ensure the recommended actions were still correct. This update has just been completed, so the focus is now on finishing the EMSC project within this programme. The full role out of the CHARU resource also remains an open action. The programme was subject to internal audit in 2022 and narrowly missed substantial assurance (quoracy to be reflected in PID and PID updated, both of which have been addressed).

Whilst the programme has largely delivered on its agreed outputs, it has not delivered the required levels of patient safety and staff working conditions for two main reasons: extreme handover (+20,000 lost hours v the 6,000 that the programme was predicated on) and abstractions (34% v the 30% benchmark). Handover remains extreme, but abstractions are reducing.

Subject to agreement with Strategic Transformation Board (STB), the Senior Responsible Owner for the programme, is expecting to close (and evaluate) the programme in March 2024. STB will then determine what programme arrangements are required in 2024/25 for the new actions arising out of the 2023 EMS Demand & Capacity Review.

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. Now every 6 weeks as the programme largely delivered.	1. Minutes and papers of Implementation Programme Board.
2. Executive sponsor and Senior Responsible Owner (SRO) for programme in place.	2. Project Initiation Document (PID) detailing structure and minutes of Implementation Programme Board. PID is up to date.
3. Programme Manager and Programme support office in place (for delivery of the programme).	3. Same as 2 above.
4. Programme risk register.	4. Highlight reports showing key risks reported to STB every 6 weeks.
5. Assurance meetings held with Strategic Transformation Board (STB) every 6 weeks and with CEO every 3 weeks.	5. Highlight reports presented to STB every 6 weeks.
6. Programme budget in place.	6. Programme budget monitoring report is provided to the Implementation Programme Board – every 6 weeks.
7. Programme documentation and reporting is in place to Programme Board every 6 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.
11. Timetabled completion of programme closure and evaluation report.	11. Agreed templates for these reports.
	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.

Risk ID 283	TO BE DE-ESCALATED TO DIRECTORATE RISK REGISTER Failure to implement the EMS Operational Transformation Programme	Date of Review:	29/02/2024	TREND	8 (2x4)
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IF	THEN	RESULTING IN
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	2	4	8
Target	2	4	8

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. This will be overtaken by the programme closure and evaluation report.

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 Engaged **has now largely concluded. Evaluation to next STB.**	30.09.22 Significant engagement through roster review project. 12/01/23 Largely complete. 02.05.23 There remains some minor engagement as the project concludes. 18.01.24 The main o/s action here is engaging with the TU partners on the evaluation of the roster review. A draft evaluation has been written up and will be shared with TU partners this quarter (currently awaiting new roster keys from ORH to enable comparison with roster keys implemented – the 2023 EMS Demand & Capacity Review clearly identifies that the keys current keys are insufficient to meet demand).
2. More capacity requested (transition plan)	Assistant Director of Planning & Transformation	02.08.23 **Closed and transferred to triangle inversion programme.**	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 financial pressures, but Trust has recently started the next iteration of the strategic EMS Demand & Capacity Review. 18.01.24 Trust currently making an offer to the system via the Six Goals Programme. This offer received a mixed reception. A key area of focus for the Trust is data linking that enables the Trust to more clearly demonstrate the value of investing in inverting the triangle. **This will be taken forward through the triangle inversion programme. No further action for this programme.**
3. Engage with key stakeholders to reduce handover delays	CASC	02.08.23 **Closed and transferred to triangle inversion programme.**	30.09.22 Reduction commitments agreed, but trend is still upwards. 12/01/23 Extreme and upward trend. 02.05.23 handover hours remain extreme. 28.07.23 Increasing focus through ICAP meetings, with C&V showing notable progress and early signs of progress in some other health boards. 18.01.24 Significant increase in health board accountability and focus via the NHS Leadership Board. The 2023 EMS Demand & Capacity Review models **three** scenarios: handover at 25,000 hours and the required level of ambulance resource to cope with this; handover at 12,000 with the much lower level of ambulance resource growth to cope with this level of handover**; and handover at 7,000 hours (maximum weight one hour). The review will be taken forward through the triangle inversion programme. Closed**
4. Reduce abstractions in particular sickness absence	Deputy Director of Workforce & OD	02.08.23 **Closed. BAU to monitor abstractions and sickness absence.**	30.09.22 Sickness absence reducing, but abstractions high linked to sickness, but also training abstraction linked to the +100. 12/01/23 Abstractions have reduced, but still very high. Sickness is reducing and on trend to achieving the 10% Mar-23 target. High abstractions linked to internal movements caused by internal recruitment. 02.05.23 the Trust achieved 7.99% in Feb-23, but levels are higher in Operations. Continued focus into 2023/24 to reach 6% by 31/03/23. 28.07.23 Abstractions, which includes sickness now less than 35% with benchmark to 30%. 18.01.24 Abstractions were 31% in November 2023. They did increase in December but went below 30% in January 2024 for the first time since pre-pandemic.
5. Engage with Assistant Director of Planning and Transformation on process for PID updates	Assistant Director – Commissioning & Performance	02.08.23	30.09.22 HoT recruited and now started. Initial contact made with HoT. PID is up to date. 12/01/23 PID has been further updated but requires sign off by the SRO and STB. 02.05.23 PID has been updated but needs to be signed off by Executive Sponsors. 28.07.23 PID

Risk ID 283	TO BE DE-ESCALATED TO DIRECTORATE RISK REGISTER Failure to implement the EMS Operational Transformation Programme		Date of Review:	29/02/2024	TREND	8 (2x4)
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			Inherent	4	4	16
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			Target	2	4	8

		Closed. PID being used as part of closure and evaluation report.	updated and programme aligned to new arrangements required by HoT. 18.01.24 PID up to date.

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

AGENDA ITEM No	12
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

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

MEETING	Trust Board
DATE	30 May 2024
EXECUTIVE	Rachel Marsh - Executive Director of Strategy, Planning and Performance
AUTHOR	Alexander Crawford - Assistant Director of Planning and Transformation Heather Holden – Head of Transformation Gareth Taylor – Senior Project Manager
CONTACT	alexander.crawford2@wales.nhs.uk

EXECUTIVE SUMMARY

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

RECOMMENDED:
That the Board:

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

KEY ISSUES/IMPLICATIONS

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

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

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

Appendix 1 sets out more detail for the end of year position. Finance and Performance Committee were provided with further set of assurance documents to support the position set out in this paper.

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

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

REPORT APPROVAL ROUTE
Strategic Transformation Board 8th April 2024 Finance & Performance Committee 14th May 2024

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

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

Appendix 1

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

Situation

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

Background

2. WAST submitted its previous IMTP (2023-26) to WG on 31st March 2023 following Board approval. Welsh Government recently approved WAST's IMTP on 12th September 2023. Following approval, the Director General issued accountability conditions on which our approval is based on 2nd October 2023. The approval conditions were largely financial with papers on finance and value reported through Finance & Performance Committee ('the Committee') regularly throughout the year. The Committee also received updates on the requirement to assure the Board that we had actively worked to deliver our commitments made against the (then titled) Minister's priorities for the NHS, alongside detailed assurance reports on our delivery against our IMTP.

3. We submitted our latest iteration of the IMTP for 2024-27 on 28th March 2024 following Board approval the same day.

4. The requirement set out within Welsh Government (WG) planning guidance was to submit clear narrative plans set over three years, showing clear progression over those three years, together with templates setting out how organisations would deliver against the Health Minister's (now Cabinet Secretary's) key priorities for the NHS and aligned to a Minimum Dataset (activity and performance trajectories, workforce plans and financial plan). These priorities are:

   - Enhancing care in the community, with a focus on reducing delayed pathways of care;
   - Primary and Community Care, with a focus on improving access and shifting resources into primary and community care;
   - Urgent and Emergency Care, with a focus on delivery of the 6 goals programme;
   - Planned Care and Cancer, with a focus on reducing the longest waits;

- Mental Health, including CAMHS, with a focus on delivery of the national programme.

5. We addressed the last 4 priorities as being most relevant to WAST in the IMTP within its appendices and will report on these against the milestones set out below in future IMTP assurance reports to the Board.

IMTP Assurance arrangements: Looking Back – 2023/24

6. As noted in the Finance & Performance Committee paper dated 7th July 2023, a single reporting line was established that tracked IMTP Deliverables into defined IMTP Delivery Programmes or Enabling Workstreams, and ultimately into Strategic Transformation Board (STB). Within each programme, individual actions were grouped into work packages for 2023/24, to enable more detailed tracking at project/workstream level, and higher-level tracking through Programme Boards and STB.

7. Other IMTP-related actions were managed via alternative routes such as Local Delivery Plans or Capital Management Board (list not exhaustive). These were reported discreetly upwards to the relevant Senior Leadership Team.

IMTP Assurance arrangements: Looking Forward – 2024/25

8. Work is currently underway to redefine and redesign our Clinical Service Model for the future with a series of workshops held early in May to scope and define our new clinical model. To enable delivery of the new model, it will be vital that we transition to a more integrated organisation-wide Transformation Programme that brings together our existing programmes of work into a single-holistic programme.

9. Reflecting on the current IMTP Delivery Programmes, we recognise that the scope of these has changed over time to encompass some tactical service changes and business-as-usual operations. Scope creep is very common in programme management and whilst not unexpected, it has made monitoring and assurance increasingly challenging as the portfolio has expanded. **The development of our Future Clinical Service Model provides an opportunity to refresh our approach to management of transformation and wider service changes and improvements within the IMTP and we will be moving towards a more integrated approach that distinguishes between the 'level' of change and how this is managed and monitored locally and organisationally.**

10. The Transformation Support Office is currently developing a framework for the delivery and assurance of the complete IMTP portfolio and presented this at STB on the 20th May, along with a high-level transition plan to demonstrate how this will be achieved. Following approval of the revised framework and delivery and assurance structure the team will develop a detailed transition plan and will support

each of the existing IMTP Delivery Programmes and Enabling Workstreams to adopt these new arrangements, ensuring this is carefully managed to avoid delivery disruption.

Impact of the transition

11. At each stage of transition, **the team will ensure that there is a clear line of delegation for IMTP deliverables**, but these may change materially in terms of ownership, and potentially in their prioritisation.

12. During Q1 and Q2 we expect to operate a dual approach to reporting whilst changes are embedded. This is likely to mean that rather than getting a single IMTP Delivery & Assurance report, these may vary in terms of the format and frequency.

13. In many cases, changes will be more superficial such as naming conventions, or there may be a requirement for Terms of Reference to be reviewed, ownership, objectives, and the organisation of milestones. **Importantly, our IMTP deliverables will remain unchanged, but the process and organisation of these deliverables may be revised.**

14. We expect the transition to commence in Q2 and to be finalised early in Q3.

Assessment

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

Transformation Programmes – Year End Position
During 2023/24 the defined IMTP Delivery Programmes were: - EMS Operations Programme - Inverting the Triangle Programme (EMS Transformation Programme) - Ambulance Care Programme - Gateway to Care Programme - Clinical Transformation Programme - Financial Sustainability Workstreams **The defined IMTP Enabling Programmes for FY23/24 were:** - People and Culture - Digital - Infrastructure - Fundamentals (including Quality Safety & Patient Experience, and Corporate Governance) It should be noted that the Inverting the Triangle (ITT) Programme was not included within the summary of IMTP Delivery Programme work packages.

EMS Operational Transformation – End of Year Position

Overall RAG Status: AMBER

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

Ambulance Care Transformation – End of Year Position

Overall RAG Status: AMBER

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

Gateway to Care Transformation – End of Year Position

Overall RAG Status: GREEN/AMBER

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

Clinical Transformation – End of Year Position

Overall RAG Status: GREEN

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

Financial Sustainability Programme

1. **Income Generation**

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

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

2. **Achieving Efficiency**

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

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

Overall

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

Enabling Programmes – End of Year Position

People & Culture

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

CULTURE

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

- **Develop and articulate our target culture:** due to rollout of EQIA training due to limited training capacity

- **Refresh TU partnership working arrangements:** ACAS action plan has now been developed and agreed in partnership with TUPs. Implementation of the plan is underway, but timelines have been updated in the context of IA.

CAPACITY

Develop our employee offer: GREEN

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

1. **Shift Overruns** – ED Holding Area Survey completed and results was presented to STB on the 26th of February 2024 – some positive signals from the survey and STB has asked the Operations teams to consider the next steps for 2024/25 in the IMTP as this remains a commitment to staff.

2. **Flexible Working Policy** – Developments around flexible working include,

    a. Reviewing current policy.
    b. Establishing a clear understanding of current processes and impacts of flexible working arrangements across frontline services.
    c. Reviewing current research for frontline flexible working across NHS& Emergency services.
    d. Engaging with the wider Ambulance Sector to understand flexible working practices across the UK.
    e. Developing coaching / process material.
    f. Exploring ESR functionality for requesting and recording agreed / declined flexible working requests.
    g. Engaging with WAST colleagues to understand perceptions and views on flexible working options and evaluate after changes are implemented.
    h. Continuing to establish a pathway of support for Carers within the organization.

3. **Digital Experience** – Work ongoing with the EqIA process, in order to make this more digitally accessible. Regarding Digital Literacy Skills, the development of accredited and non-accredited education programmes is underway, as is the implementation of LMS365. Also within this commitment is the expansion of Learning Launchpad content. There will be further work on simplified access to digital tools through the refresh of the Digital Plan set out in next years' IMTP.

CAPABILITY

Promote personal responsibility: GREEN/AMBER

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

Digital

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

National Data Resource Programme Support: GREEN/AMBER

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

Upgrade 999 Telephony Platform: AMBER

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

Digital Experience of Staff: AMBER

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

Operations Communication Programme: GREEN

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

Fundamentals (including Risk Management) – End of Year Position

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

Risk Management: AMBER

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

Welsh Language Policy: GREEN

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

Quality Management System Implementation: AMBER

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

Forward View – IMTP Assurance 2024/25

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

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

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

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

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

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

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

Forward View – Assurance against the Cabinet Secretary's priorities 2024/25

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

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

Cabinet Secretary Priority	**Area for WAST**	**Milestones Q1**
Primary and Community Care, with a focus on improving access and shifting resources into primary and community care	111 Skill Mix	• Group established to consider and develop scope for 111 MDT skill mix
	111 Pathways	• Dental access improved in 4x health boards by end of Q4 • Strengthened links into primary care / Out of Hours in. Urgent Primary Care Centre access by end of Q4 • Medicines management pathways in place by end of Q4
	999 Pathways: Falls & Frailty	• Level 1 falls - Assessment of the demand & capacity modelling undertaken • Level 2 falls - Undertake evaluation of our existing services
	999 Pathways: Digitised pathways	• Evaluate the effectiveness of the new digital solutions to make referrals to existing pathways and usage
	999 Pathways: Connected Support Cymru (CSC)	• Recruitment of key roles to support CSC delivery (dependent on outcome of business case)

Cabinet Secretary Priority	Area for WAST	Milestones Q1
		• Commenced recruitment of internal volunteers • Testing 'ambulance in a box' in Care Homes in AB & BCU, evaluate and conclude forward plan
Urgent and Emergency Care, with a focus on delivery of the 6 goals programme	Goal 2: New 111 System	• Full implementation of new CAS system 30th April • Decommission old system
	Goal 2: 111 website & symptom checkers	• Scoping exercise to review requirements of a 111 website – and develop options appraisal accordingly
	Goal 2: 111 re-roster	• No Q1 milestone
	Goal 3: • Develop the remote clinical assessment speciality • Develop a fully remote working clinician offer (operations/training/digital) • Develop Pre-Dispatch Outcome Risk Stratification Tools linking CAD & ePCR data • Roll out of new integrated (111/clinical support desk) care model • Connected support Cymru • Extend use of video/ phone consultation • Urgent On-Scene Community Response	• Milestones set out in the programme to deliver the future clinical service model and reporting will be in main body of IMTP assurance report
	SDEC Pathways	• Re-establish ICAPs with Health Boards (subject to JCC commissioning arrangements) • Complete data quality assurance of end destination in CAD to ensure SDEC referrals fully captured
	Goal 4: CHARU	• Complete CHARU recruitment by end Q2 • Improve utilisation rate to modelled benchmark by end Q2 (work ongoing during Q1)
	Goal 4: Rural variation	• Complete CHARU recruitment by end Q2 • Continue process of targeted recruitment and process of smoothing i.e. aligning SIP to establishment by end Q2

Cabinet Secretary Priority	Area for WAST	Milestones Q1
		• Build rurality results from 2023 EMS Demand & Capacity Review by end Q2 • Agree Implementation Plan with commissioners by end Q2 (work ongoing during Q1)
	Goal 4: Sickness reduction in EMS and EMSC	• Ongoing continuation of managing attendance and implementation of the health and wellbeing plan throughout year
	Goals 5 & 6: Transfer and Discharge model	• Engagement on modelled options for transfer services with health boards commenced • Implementation of new MTPS protocols within the Computer Aided Dispatch (CAD) system designed to allocate transfer resources more effectively
Planned Care and Cancer, with a focus on reducing the longest waits	Roster review of NEPTS Ambulance Care Assistants	• No specific milestone in Q1
	Enhanced hub for oncology patients	• Establish expected outcomes & principles to develop enhanced oncology service
	Quality assurance of external providers	• No specific milestone in Q1
Mental Health, including CAMHS, with a focus on delivery of the national programme	Develop and implement a referral pathway for 111 Press 2 teams	• Completion of 111 CAS system implementation to aid improvement in 111 press 2
	Mental Health Response Vehicles	• Collating and presenting evidence from pilot within AB, discussing outcomes and options for further pilots
	Right Care Right Person	• Engaging with Police Services in Wales, NHS partners, Local Authorities and third sector providers on changes affecting response to people in crisis
	Mental Health Practitioners in CSD	• Assess demand and capacity plan outlining future needs for the team and training requirements (as part of overall demand and capacity work for the future clinical service model)

Recommendation: That the Board:

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

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Welsh Ambulance Services University NHS Trust

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

Financial Performance as at Month 12 – 2023/24

MEETING	Trust Board
DATE	30h May 2024
EXECUTIVE	Chris Turley (Executive Director of Finance & Corporate Resources)
AUTHORS	Edward Roberts (Head of Financial Business Intelligence & Capital Planning) Steph Taylor (Assistant Head of 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, as at Month 12 (March 2024) / year end.

Following detailed consideration by the Finance & Performance Committee on 14th May 2024, the Board is asked to review, comment, note and receive assurance on the financial position of the Trust for 2023/24, *subject to audit* and ahead of the Trust Board presentation of the 2023/24 accounts in July 2024.

RECOMMENDED that the Board:

(1) Notes and gains assurance in relation to the Month 12 (and therefore draft 2023/24 year end) revenue and capital financial position and performance of the Trust as at 31st March 2024;

(2) Notes the delivery of the 2023/24 savings plan, and the context of this within the overall financial position of the Trust.

KEY ISSUES/IMPLICATIONS

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

- The Trust is reporting a small revenue surplus (£85k) as a M12, and which forms the basis of the draft accounts for the 2023/24 financial year (*subject to audit*). These accounts were submitted to Welsh Government and Audit Wales, in line with the prescribed timetable, on 3rd May 2024;
- Capital expenditure is fully spent;
- In line with the financial plans that support the IMTP, gross savings of £6.546m have been achieved against a target of £6.000m;
- Public Sector Payment Policy is on track with performance, against a target of 95%, of 96.4% for the number, and 98.5% of the value of non NHS invoices paid within 30 days.

REPORT APPROVAL ROUTE
• ELT via sharing this paper – 8th May 2024 • Finance and Performance Committee – 14th May 2024 • Trust Board – 30th May 2024 – for noting

REPORT APPENDICES
Appendix 1 *– Saving details*

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

WELSH AMBULANCE SERVICES UNIVERSITY NHS TRUST

TRUST BOARD

FINANCIAL PERFORMANCE AS AT MONTH 12 2023/24

INTRODUCTION

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

BACKGROUND

2. The key points to note in relation to the **delivery of the Statutory Financial Targets for 2023/24** (1st April 2023 – 31st March 2024) are that:

   - The revenue financial position reported is a small **underspend against budget of £0.085m**, (*subject to audit*).

   - In line with the financial plans that supported the submitted Annual Plan within the IMTP for this financial year, gross savings of £6.546m have been achieved against a target of £6.000m, thus an **over achievement against the plan set at the opening of the financial year**.

   - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 96.4% for the number, and 98.5% of the value** of non-NHS invoices paid within 30 days.

3. Any risks previously reported were continued to be reviewed and fully assessed right up to the year end, however there are now no reported financial risks included in the draft year-end position, subject to audit.

REVENUE FINANCIAL PERFORMANCE

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

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

Treatment of Covid-19 spend

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

Income

6. Reported Income against the initial budget set to Month 12 shows an underachievement of **£0.898m**. This is predominantly due to the impact of the previously reported in year change in expected funded levels from commissioners.

Pay costs

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

Non-pay Costs

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

Savings

9. As Board members will recall, the 2023/24 financial plan identified that a minimum of **£6.000m** of savings, cost avoidance and cost containment measures were required to achieve financial balance in 2023/24. This is a significant increase in that which has been able to be achieved in the recent past, and especially over the last couple of years.

10. As at Month 12 for the financial year 2023/24 the Trust achieved total savings of **£6.546m** against a target of **£6.000m**, an over achievement against the target of **£0.546m**.

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

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

13. The key points drawn from these are;

    - Workforce, efficiencies and transformation has achieved savings / cost containment of £1.075m, over-achieving cumulative target by £0.452m;

    - Fleet savings totalling £0.016m has been achieved, under-achieving cumulative target by £0.126m;

    - Through management of non-operational vacancies, £2.774m has been saved which exceeds the cumulative target to date by £0.174m;

    - There are a number of local schemes in directorates, some of which are attracting additional income rather than reducing costs and savings totalling £0.814m has been achieved, over-achieving cumulative target by £0.201m;

    - Estate savings totalling £0.128m has been achieved, achieving cumulative target;

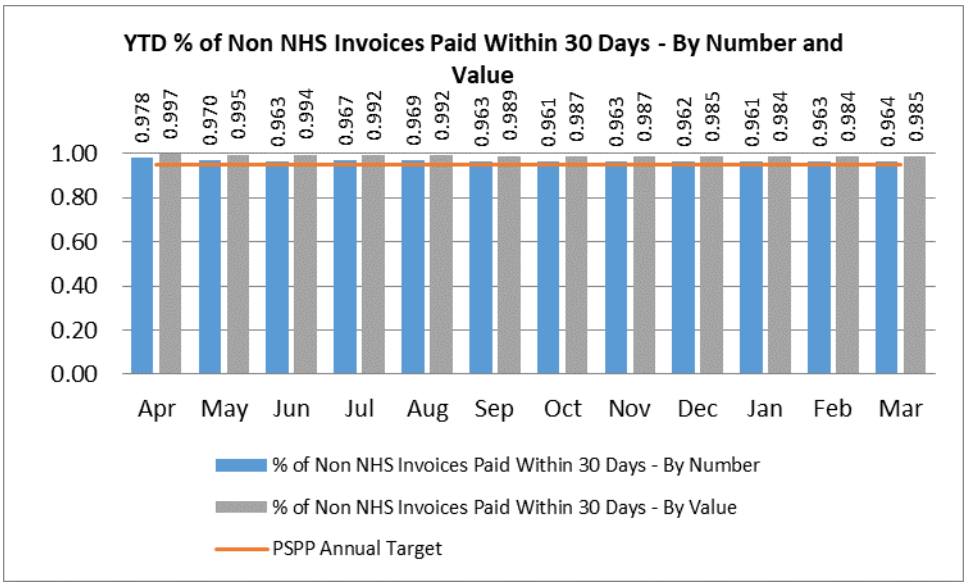
    - Digital savings totalling £0.258m has been achieved, over-achieving cumulative target by £0.038m;

    - Procurement efficiencies has achieved savings of £0.250m, under-achieving cumulative target by £0.250m

    - Income generation totalling £1.232m has been achieved, over-achieving by £0.057m.

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

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



RISKS AND ASSUMPTIONS

15. There are currently no remaining or expected financial risks to the reported draft year end position (*subject to audit*).

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

2023/24 CAPITAL PROGRAMME

17. At Month 12 the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2023/24 is **£21.931m**. This includes **£17.610m** of All Wales Approved schemes and **£4.321m** for Discretionary schemes.

18. It should be noted that, unlike previous financial year ends, WG didn't provide the facility to broker under and overspends between schemes and between years as

has been the case in the past. Whilst this always had a neutral impact bottom line, it will now result in some smaller adjustments between schemes in 2024/25.

19. Whilst the majority of schemes delivered to budget there were a few known underspends which the Trust had planned for and discussed with WG, these included underspends on ESMCP schemes and an underspend on the 2023/24 Vehicle replacement programme, this was offset with the acceleration of the 2024/25 Fleet BJC in relation to the minimum number of replacement defibrillators the Trust would need to replace, this however will need to be repaid/ recovered in the 2024/25 reporting.

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

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

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

2023/24 YEAR END

22. Finalisation of the Accounts and audit work continues in respect of the 2023/24 Trust Annual Accounts. The draft accounts were submitted to WG and Audit Wales, as per the issued guidance, on 3rd May 2024. The audit of these accounts

commenced by AW colleagues on 7th May, with the audited accounts due to be presented to Audit Committee on 10th July 2024 ahead of seeking final approval of these at specific Trust Board called for this purpose, on 12th July 2024.

23. The 2023/24 year-end audit will again be conducted virtually, maximising the use of technology and building on the experiences of the previous 4 years' audits.

RECOMMENDED that the Board:

(3) Notes and gains assurance in relation to the Month 12 (and therefore draft 2023/24 year end) revenue and capital financial position and performance of the Trust as at 31st March 2024;

(4) Notes the delivery of the 2023/24 savings plan, and the context of this within the overall financial position of the Trust.

Appendix 1

Welsh Ambulance Services NHS Trust

Savings Performance by Directorate Level 3 23-24

Reporting Month 12

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

Welsh Ambulance Services NHS Trust

Savings Performance by Theme 23-24

Reporting Month 12

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

Key
- negative = under recovered
+ positive = over recovered

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Welsh Ambulance Services University NHS Trust

AGENDA ITEM No	14
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	4

Financial Performance as at Month 1 – 2024/25

MEETING	Trust Board
DATE	30th May 2024
EXECUTIVE	Chris Turley (Executive Director of Finance & Corporate Resources)
AUTHORS	Edward Roberts (Head of Financial Business Intelligence & Capital Planning) Steph Taylor (Assistant Head of Capital Planning)
CONTACT	Chris.Turley2@wales.nhs.uk

EXECUTIVE SUMMARY

This paper presents to the Board the first Financial Performance Report of the 2024/25 financial year, the reported position as at Month 1 (April 2024). A summarised presentation of the month 1 position was presented to Finance & Performance Committee on 14th May 2024.

The Board is asked to review, comment, note and receive assurance on the financial position and 2024/25 outlook and forecast of the Trust, noting the risks to in year delivery in doing so.

RECOMMENDED that the Board:

(1) Notes and gains assurance in relation to the Month 1 revenue financial position and performance of the Trust as at 30th April 2024;

(2) Notes the delivery of the 2024/25 savings plan, and the context of this within the overall financial position of the Trust;

(3) Notes the initial capital programme for 2024/25, and

(4) Notes the Month 12 and Month 1 Welsh Government monitoring return submission included within Appendices 1 – 4 (as required by WG);

KEY ISSUES/IMPLICATIONS
Key highlights from the report for the Board to note are: • The Trust is reporting a small revenue surplus (£19k) for month 1 2024/25; • In line with the balanced financial plan approved as part of the submitted 2023-26 IMTP, the Trust is currently forecasting to breakeven for the 2024/25 financial year; • Capital expenditure plans are being finalised with plans to fully achieve in year; • In line with the financial plans that support the IMTP, gross savings of £0.663m have been achieved in month 1 against a target of £0.569m; • Public Sector Payment Policy is on track with performance, against a target of 95%, of 97.3% for the number, and 99.5% of the value of non NHS invoices paid within 30 days.

REPORT APPROVAL ROUTE
• ELT – via verbal update and presentation shared – 13th May 2024 • FP&C – 14th May 2024 – via presentation • Trust Board – 30th May 2024 – for noting
REPORT APPENDICES
Appendices 1 – 2 *– Monitoring return submitted to Welsh Government for month 1 – 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 1 2024/25

INTRODUCTION

1. This report provides the Board with a summary of the revenue financial performance of the Trust as at 30th April 2024 (Month 1 2024/25), along with an update on the initial 2024/25 capital programme. A summarised presentation of the month 1 position was presented to Finance & Performance Committee on 14th May 2024.

BACKGROUND

2. The key points to note in relation to the **delivery of the Statutory Financial Targets for month 1 2024/25** (1st April 2024 – 30th April 2024) are that:

   - The cumulative revenue financial position reported is a small **underspend against budget of £0.019m,** based on some key assumptions consistent with that within the IMTP financial plan and the Board approved budget for 2024/25. The underlying year-end forecast for 2024/25 is currently a balanced position;

   - In line with the financial plans that supported the submitted Annual Plan within the IMTP for this financial year, gross savings of £0.663m have been achieved against a target of £0.569m. The future phasing of residual savings requirements as we progress through the early part of the financial year will be key to the continuing delivery of a balanced position and forecast;

   - Public Sector Payment Policy is on track with **performance, against a target of 95%, of 97.3% for the number, and 99.5% of the value** of non-NHS invoices paid within 30 days.

3. Whilst continuing to be broadly balanced at the outset of the financial year, which is clearly encouraging, it is key to also note the following assumptions that have been made in reporting this current and forecast position:

   - The in year recovery of <u>all</u> of the income assumptions in the financial plan including growth predictions and that the current changes in commissioning have no wider impact on the Trust financially, including in relation to how it is currently funded for EMS, NEPTS services;

- The ability to deliver a minimum of c£6.421m in savings and efficiencies in year. This equates to c2.2% of the Trusts discretionary income;

- No other developments, enhancements or cost increases not currently funded within budgets will be able to be progressed until a confirmed funding source for them is found, or an agreed equivalent value of cost is stopped or reduced elsewhere. These include:

    I. Any costs relating to any proposed banding change for EMT / technician level posts;
    II. Any costs, capital or revenue, emerging from the recommendations of the Manchester Arena Inquiry, and
    III. Any and all costs associated with the recently submitted Connected Support Cymru business case, other than that already confirmed through Charitable grants.

- Despite an element of additional funding provided, some cost elements are still hard to predict through the 2024/25 financial year (and beyond) and may remain volatile, with a clear indication from WG that no further funding will follow in year in 2024/25 to manage any such variations;

- The ability to manage in year cost pressures as they arrive, within the small contingency the Trust continuities to hold, as per the IMTP / 2024/25 financial plan.

4. 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 1 are set in line with the submitted IMTP and summarised later in this report. Accepting that it is early in the new financial year, as we go through the next few months these will continue to be scrutinised and amended accordingly, with mitigations and management plans in place.

REVENUE FINANCIAL PERFORMANCE – MONTH 01 2024/25

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

Revenue Financial Position for the period 1st April - 30th April				
	Annual Budget	Year to date		
		Budget	Actual	Variance
	£000	£000	£000	£000
Income	-290,791	-23,322	-23,230	92
Expenditure				
Pay	212,985	17,279	17,208	-71
Non-pay	63,115	4,818	4,876	57
Total pay & non-pay expenditure	276,100	22,098	22,084	-14
Depreciation & Impairments / interest payable & receivable	14,691	1,224	1,127	-97
Total	**0**	**0**	**-19**	**-19**

Income

6. Reported Income against the initial budget set to Month 1 shows an underachievement of **£0.092m**.

Pay Costs

7. Overall, the total pay variance at Month 1 is an underspend of **£0.071m**.

Non-pay Costs

8. The overall non-pay position at Month 1 is an underspend of **£0.040m**.

Savings

9. As above, the 2024/25 financial plan identifies that a minimum of **£6.421m** of savings, cost avoidance and cost containment measures are required to achieve financial balance in 2024/25, this equates to c2.2% of the Trusts discretionary income.

10. As at Month 1 for the financial year 2024/25 the Trust achieved total savings of **£0.663m** against a target of **£0.569m,** as per the below table.

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

Financial Performance by Directorate

11. Whilst there is a small surplus reported at Month 1 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 so early in the financial year, but they will be continued to be closely monitored.

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

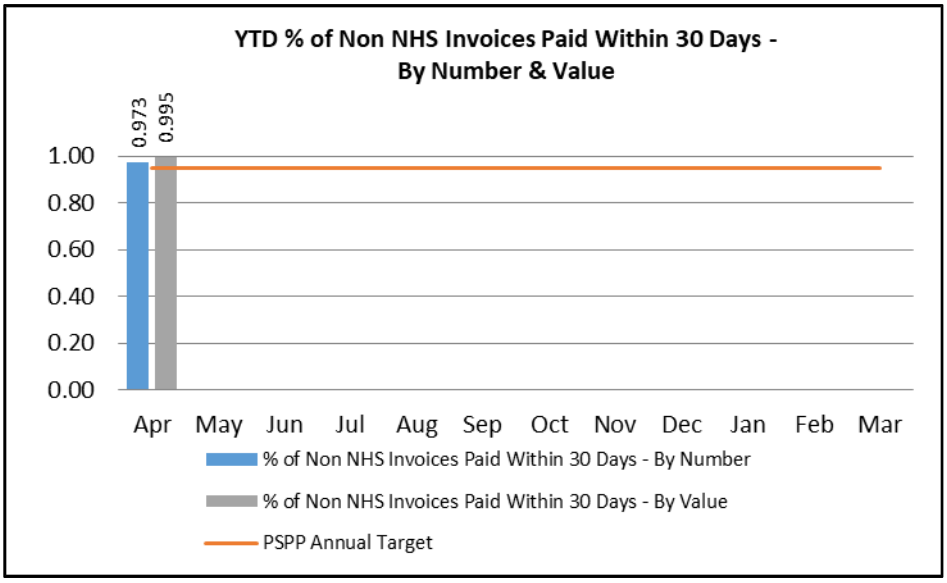
**Please note figures are rounded to the nearest whole number*

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

- Most directorates broadly in line with budget plan for Month 1;
- FinCoR surplus relates in part to interest receivable in month being in excess of budget;
- Partnership & Engagement Directorate is underspend by £4k due to staffing vacancies;
- Some additional costs per IMTP remains to be fed into delegated budgets, based on profiling of spend / actual spend incurred YTD.

PUBLIC SECTOR PAYMENT POLICY PERFORMANCE (PSPP)

13. Public Sector Payment Policy (PSPP) compliance up to Month 1 was **97.3%** against the **95%** WG target set for non-NHS invoices by number and **99.5%** by value.



INITIAL CAPITAL PROGRAMME

14. As we are in the early stages of the financial year the discretionary capital programme and resulting budgets are only now being finalised.

15. At Month 1, the Trust's approved Capital Expenditure Limit (CEL) set by and agreed with WG for 2024/25 is **£21.672m**. This includes **£16.217m** of All Wales Approved schemes and **£5.455m** for Discretionary schemes.

16. The breakdown of the current confirmed All Wales Capital funding is shown below, which now includes that which is being funded for the Fleet Replacement Programme in 2024/25 (confirmed by WG on 8th May 2024).

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

17. It should also be noted that the amount provided for the Fleet Replacement Programme in 2024/25 is circa half (52.6%) of the amount requested via the submitted BJC (£24.388m). Therefore, further urgent prioritisation works continue, linking into existing workstreams, to ensure maximum value and benefit from that which has been able to be funded.

18. A detailed update on the total initial 2024/25 capital plan for the Trust, focussing predominantly on that able to be prioritised from within the Discretionary Capital funding was presented and discussed in some detail at the meeting of the F&PC on 14th May 2024.

RISKS AND ASSUMPTIONS

19. Understandably this early in the financial year, the risks reported are still being fully assessed, however in reporting through to WG it is considered that there are currently no individual high likelihood risks but as we move through the next month or so we will continue to review the risks to ensure that the level of likelihood is assessed along with the financial value. Alongside ensuring that Trust Board and the Finance & Performance Committee remain fully appraised of such risks and any mitigating actions.

20. At the outset of this financial year there are however a number of risks that need to be documented within this initial 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. Inevitably at the start of any financial year many of these values are very indicative.

21. Given the increased requirement again in our saving target that has been required this financial year to cover increasing cost pressures, the Trust has included a risk around the identified savings (**£1.000m** low risk). As we move through the financial year the aim will be to reduce these risks down once savings are achieved and plans crystalize.

22. Also included is a risk in relation to the current financial climate, this relates to the risk associated with energy, and in particular, vehicle fuel prices (**£1.000m** low risk). Whilst we have seen a decrease in these recently, they still remain volatile therefore a low risk has been included.

23. 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.

24. A low-level risk of **£1.000m** is included re PIBS (Permanent Injury Benefit Scheme). Matched funding for this highly volatile area is provided by WG on an annual basis.

25. Also included are three additional risks, aligned to some of the income and funding assumptions previously highlighted, and which relate to the following:

I. Ongoing discussions around the costs associated with the revised job description for the EMT / Techician level posts. As was the case with the revision of the Paramedic job description, assumptions remain that any increase in costs would require discussions with WG to secure funding, given the national UK influence on this that revised A4C job profiles recently published may have.

II. Costs associated with the Manchester Arena Inquiry, and subsequent recommendations, both Capital and Revenue costs have been identified and if these recommendations are to be taken forward additional funding would be required in order to deliver on them.

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

26. As noted above, whilst there are therefore no current individually assessed high financial risks as we enter the financial year, 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 need to remain a key focus for the Trust, despite the funding uplift hat has been made available for 2024/25 and the initially reported good financial performance in M01.

27. Alongside this, the risk of non-delivery of statutory financial duties will also continue to be reviewed as part of the overall management of risks on the Trust's Corporate Risk Register.

RECOMMENDED that the Board:

(5) **Notes** and gains **assurance** in relation to the Month 1 revenue financial position and performance of the Trust as at 30th April 2024;

(6) **Notes** the delivery of the 2024/25 savings plan, and the context of this within the overall financial position of the Trust**;**

(7) **Notes** the initial capital programme for 2024/25, and

(8) Notes the Month 12 and Month 1 Welsh Government monitoring return submission included within Appendices 1 – 4 (as required by WG);

Appendix 1

Month 12 2023-24 -
Welsh Ambulance S

Appendix 2

2023-24 MMR
Month 12 WAST - Fi

Appendix 3 - E mailed separately.

Month 01 2024-25 -
Welsh Ambulance S

Appendix 4 - E mailed separately.

WAST 2024-25
MMR Template Mon

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

2nd May 2024

Your ref:

Dear Claire,

Re: MARCH 2024 (MONTH 12 2023/24) MONITORING RETURN

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

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 reflected the level of assumed funding, expenditure plans and savings requirement included and submitted and supported by our Commissioners and approved by the Trust Board in March 2023.

The Trust's performance against financial targets for Month 12 2023/24 is as follows: -

1. Actual Year to Date 23/24 (Tables A, B & B2)

Income assumptions broadly reflect those agreed within the IMTP, updated for any in year amendments required, and are used to support cost pressures identified in the Trust's detailed budget setting. The key funding assumptions at the outset of 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.

Following our previous months correspondence I am pleased to confirm that the outstanding pay funding was all resolved in month 12 including the funding for the VSM pay which was agreed in the latter months of the financial year, we are also assuming this funding will again flow into the 2024-25 financial year, via our commissioner.

The resulting reported performance at Month 12 as per Table B, and therefore the position that will be reflected in our draft accounts when submitted later this week, is a small underspend against budget / surplus of **£0.085m** *(subject to audit***)**.

The reported total pay variance against plan as at Month 12 is an underspend of £3.420m, set against the budgets set at the outset of the financial year. However, as previously reported much of this is in line with that expected given the in year variations accepted in terms of income, and is therefore offset by the non pay and income variations below.

The non-pay position at Month 12 is a reported overspend of £2.437m.

Income at Month 12 shows an underachievement of £0.898m, including the impact of that adjusted for income assumptions and de-risking the Trust's income position in year, as described in previous returns.

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)

Any risks previously reported in Table A2 were continued to be reviewed right up to year end, however there are now no expected material financial risks to the reported draft year end position, subject to audit.

4. Monthly Profiles (Table B)

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

The increase in non-pay in the latter part of the year was in respect to additional purchases of surgical and medical goods, along with additional support to Ambulance Care activity from external suppliers **(Action Point 11.1)**.

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

Agency costs for Month 12 totalled £0.143m. The current percentage of agency costs against the total pay figure remains very small, at 0.5%. This is to cover a small number of vacancies, in 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 in Month 7, where it was assumed that no funding would be required from WG for the additional PPE requirements, given the uncertainty around recharge methodology.

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

For Month 12 the Trust is reporting planned savings (including Income generation) of £6.000m and actual savings of £6.547m.

As can be seen from Table C4, the Trust overachieved it's saving target, this overachievement was offset by reinvestment in frontline services phased over the latter part of the financial year.

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

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

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

At Month 12 there was 1 invoice over 11 weeks, currently the Trust is in correspondence with the Health Board and is awaiting a payment date.

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	16	12	13	14	13	12	15	12	166
Other Non NHS Income	214	231	186	64	59	227	370	206	110	1,259	150	952	4,028
Pensions Agency	0	0	0	0	0	0	0	0	0	0	0	0	0
Vat Refund	164	1,078	0	397	858	322	1,039	440	535	297	301	406	5,837
Risk Pool Refund	108	0	41	0	0	0	4	0	80	0	26	0	259
Total	498	1,324	242	478	933	561	1,426	660	738	1,568	492	1,370	10,290

11. Public Sector Payment Compliance (Table H)

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

The quarter 4 cumulative percentage of Non-NHS invoices paid within 30 days by number was 96.4% against a target of 95%.

12. Capital (Tables I, J and K)

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

The Trust can confirm that it achieved the CEL target of £25.301m *(including the IFRS16 Leases funding)*, with a very small underspend against plan of £10.06 *(subject to audit).* Despite previous discussions with WG colleagues the usual adjustments agreed in previous years for "inter-year brokerage" between schemes was not able to be facilitated this year. Whilst this will not have any impact bottom line, this will result in the 2024-25 Capital programme being slightly more complicated due to these schemes either needing to repay or fund other schemes in 2024-25.

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 12 Financial Monitoring Return will be presented to the Trust Board on the 30th May 2024.

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

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 Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

Cadeirydd
Chair: Colin Dennis

Prif Weithredwr
Chief Executive: Jason Killens

Swyddfa Cyllid ac Adnoddau Corfforaethol

Finance and Corporate Resource Office

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

14th May 2024

Your ref:

Dear Claire,

Re: APRIL 2024 (MONTH 01 2024/25) MONITORING RETURN

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

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 reflected the level of assumed funding, expenditure plans and savings requirement included and submitted and supported by our Commissioners and approved by the Trust Board in March 2024.

The Trust's performance against financial targets for Month 01 2024/25 is as follows: -

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

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

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

Included within the income assumptions is the full pass through of 2023-24 pay funding including the VSM uplift, which was provided in the latter months of 2023-24, this wasn't included in the Month 1 payment from JCC, however discussions are ongoing and it is assumed this will pass through to the Trust.

The resulting reported performance at Month 1 as per Table B, is a small underspend against budget / surplus of **£0.019m**

The reported total pay variance against plan as at Month 1 is an underspend of £0.071m, set against the budgets.

The non-pay position at Month 1 is a reported underspend of £0.040m.

Income at Month 1 shows an underachievement of £0.092m.

Following the new tables being issued we note a new requirement in B2, "*D - Variable Pay Excluding Agency / Locum (premium) Expenditure*" whilst the guidance states "The classification of variable pay will follow the treatment in the Plan MDS and should include additional payments made to staff via the payroll system for activity outside their substantive contract." There is no mention in the table of overtime, therefore should this table be including overtime or should it only include "Medical Pay Additional Sessions and Additional Standard Time and Payment for bank shifts"? Appreciating this is the first month for this analysis, obviously once clarity is provided we will ensure any updates to this are action going forward, if required.

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)

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

However, at the outset of this financial year there are a number of risks that need to be documented within this initial reported financial position, which aligns to that fully described within the financial plan submitted as part of the IMTP.

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

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

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) £1m. Matched funding for this highly volatile area is provided by WG on an annual basis, arranged between Jillian Gill and Jackie Salmon.

Included within the table are 3 unquantified risks, these are still being worked through internally, and relate to the following:

- Ongoing internal discussions around the costs associated with the revised job description for the EMT / Techician level posts, as was the case with the revision of the Paramedic job description, assumptions would be that any increase in costs would require discussions with WG to secure funding, given the national UK influence on this that revised A4C job profiles recently published may have.
- Costs associated with the Manchester Arena Inquiry, and subsequent recommendations, both Capital and Revenue costs have been identified and if these recommendations are to be taken forward additional funding would be required in order to deliver on them.
- Cost associated with the recently submitted business case for the Connected Support Cymru project, which will only be progressed should the business case be supported and additional funding made available.

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

As noted above, whilst there are therefore no current individually assessed high financial risks as we enter the financial year, however when this is then considered alongside continuing significant service pressure and the likely balancing of this risk against patient safety, quality and experience, it is clear that, as expressed withing the IMTP, this will likely be another challenging financial year, despite the initially reported good financial performance in M01, 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 1 totalled £0.059m. The current percentage of agency costs against the total pay figure remains very small, at 0.3%. This is to cover a small number of vacancies, in 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 (nil return) however as in the latter months of 23-24 it assumes no costs or funding requirements going forward.

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

For Month 1 the Trust is reporting planned savings (including Income generation) of £0.569m and actual savings of £0.663m.

As can be seen from Table C3, the Trust overachieved its saving target in month 1 but it still forecasting to achieve the total savings target for the year.

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

These are set out in Tables D, E and E1. It should be noted as agreed across all NHS bodies the figures reported at month 1 are a roll over of the Month 12 figures and will be adjusted and agreed as we work through month 2.

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

At Month 1 there was 1 invoice over 11 weeks, the invoice was agreed to be paid as part of the agreement of balances at month 12 and the Trust is in correspondence with the Health Board and is actively chasing the payment date.

10. Cash flow (Table G)

This will be completed from month 3 as per the guidance.

11. Public Sector Payment Compliance (Table H)

As per the guidance this will be completed for quarter 1.

12. Capital (Tables I, J and K)

The capital tables will be completed from month 2 in accordance with the guidance.

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 1 Financial Monitoring Return will be presented to the Trust Board on the 30th May 2024.

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

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 Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

AGENDA ITEM No	15
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	16

ANNUAL BOARD AND COMMITTEE EFFECTIVENESS 2023/24

MEETING	Trust Board
DATE	30 May 2024
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The board is required to undertake an annual self-assessment of its effectiveness. The purpose of this report is to bring together the sources of external and internal assurance that support this assessment process for 2023/24.

2. Throughout Q4 2023/24 the committees and advisory group undertook effectiveness reviews. This consisted of a survey, a review of its effectiveness for the year taking account of the results of the survey, the ways in which it covered all areas of its remit, its membership and attendance, and review of priorities it set itself. The Audit Committee reviewed all committee annual reports when they met on 30 April 2024 and endorse the conclusions of those committees in that they have operated effectively and have on the whole discharged their responsibilities. Changes to terms of reference were made for all committees and the advisory group and they are marked up in annexures 2-8, with those changes endorsed by the Audit Committee also.

3. Good governance consists of mechanics (structures and processes) and dynamics (strategy, behaviours, and culture). This review demonstrates the strength of both of these elements and highlights areas where we continue to strive to improve our corporate governance processes.

4. The changes to operating arrangements and corporate governance practices as set out in this paper will further strengthen those mechanics and dynamics during 2024/25 and beyond.

5. The effectiveness reviews underscore a commitment to robust governance and continuous improvement across all Board committees. The Audit Committee and other committees have shown strong compliance with their roles, contributing positively to the Trust's governance framework.

RECOMMENDATION:

6. The Board is requested to

   (a) Review the external and internal sources of assurance to assure itself as to its effectiveness for 2023/24.
   (b) Note the priorities set by committees for 2024/25.
   (c) Approve changes to committee terms of reference.
   (d) Note changes to operating arrangements for the Board and committees in 2023/24.

KEY ISSUES

7. The annual report and terms of reference for the Charity Committee are not included in this paper and will be presented separately to the Corporate Trustee on 30 May 2024.

8. The Audit Committee agreed a revised approach to effectiveness review surveys in 2024/25. This will see the committees receiving the simplified three questions of 'what does the committee do well', 'what could it improve on', and 'what are the development needs', and the board receiving the more comprehensive 27 question survey. The Audit Committee will continue to use the National Audit Office Effectiveness Toolkit.

9. The changes to operating arrangements will be monitored through the local directorate plan for the Corporate Governance team, the Board Development Schedule and committee priorities.

REPORT APPROVAL ROUTE

All committee effectiveness reviews, annual reports and changes to terms of reference and operating arrangements have been reviewed by the Executive Leadership Team and each committee during Quarter 4 2023/24.

The Audit committee reviewed the suite of annual reports and changes to the terms of reference and operating arrangements on 30 April 2024.

REPORT APPENDICES

1. Annex 1 – committee matrix 2024/25
2. Annex 2a and 2b – Audit Committee draft Annual Report 2023/24 and amended terms of reference
3. Annex 3a and 3b– Academic Partnership Committee 2023/24 annual report and amended terms of reference
4. Annex 5a and 5b – Finance and Performance Committee 2023/24 annual report and amended terms of reference
5. Annex 6a and 6b – People and Culture Committee 2023/24 annual report and amended terms of reference
6. Annex 7a and 7b – Quality, Patient Experience and Safety Committee 2023/24 annual report and amended terms of reference
7. Annex 8a and 8b – Remuneration Committee 2023/24 annual report and amended terms of reference
8. Annex 9a and 9b – Welsh Ambulance Services Partnership Team (WASPT) 2023/24 annual report and amended terms of reference
9. Committee priorities 2024/25

REPORT CHECKLIST

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

BOARD AND COMMITTEE EFFECTIVENESS 2023/24

SITUATION

1. The board is required to undertake an annual self-assessment of its effectiveness. The purpose of this report is to bring together the sources of assurance that support this assessment process.

BACKGROUND

2. WAST's corporate governance framework creates a supportive environment where decisions are made transparently, resources are used wisely, and responsibilities and accountabilities are clearly defined. It involves providing strong leadership, guiding the service with a clear vision, maintaining high standards of care and ethics, and fostering a positive and inclusive culture that builds trust among our people, our patients, and our stakeholders. Additionally, it includes having robust controls and processes in place to ensure everything runs smoothly and safely, from our preparedness to respond to change, to our day-to-day operations.

3. An effective board and committee structure is vital to ensure our corporate governance framework is operating effectively, ethically, and responsibly. Regular reviews of these structures ensures our governance remains fit for purpose and demonstrates our commitment to the duty of quality. In addition, the Trust's Standing Orders and committee terms of reference require that the board and its committees self-assess and evaluate their effectiveness annually.

4. During the 2023/24 year the Trust has undertaken and engaged in a number of assessments that provide internal and external sources of assurances to support the board in undertaking its annual effectiveness review.

5. Effectiveness reviews of the seven board committees and the single advisory group were conducted in Q4 of 2023/24 and proposed changes to their terms of reference and operating arrangements were made as a result. The Audit Committee reviewed the results of these through the committee annual reports and the terms of reference amendments at their meeting on 30 April 2024 and now recommend these (set out annexes 2 to 7) to the board for approval.

6. The annual report and terms of reference for the Charity Committee are not included in this paper and will be presented separately to the Corporate Trustee on 30 May 2024.

ASSESSMENT

What follows is a review of the external and internal sources of assurance on the effectiveness of the board and its committees. This will allow the board to assess the effectiveness of the mechanics and dynamics of this structure through 2023/24.

7. Audit Wales

7.1. The Audit Wales Structured Assessment 2023 noted the following with respect to the board and its committees:

- *The Trust has an integrated and well-functioning committee structure which aligns to and provides good coverage of key strategic priorities and risks.*
- *The board and committees regularly review their effectiveness via annual self-assessments. This work included a self-assessment of compliance with the Corporate Governance in Central Government Departments: Code of Practice 2017. Findings from the 2023 round were reported to the board, including a summary of strengths and areas for improvement identified by members. Feedback showed members were happy with committee agendas and the process for escalating concerns to the board but would like to see improvements such as reducing the length of committee papers and greater focus on outcomes. The Trust is already demonstrating action to address this feedback.*
- *The Office of the Board Secretary has issued guidance and support to all directorates on the process and timelines for submitting papers for board and committee meetings. These changes, together with the establishment of clear cycles of business and timely agenda setting meetings, is improving the compliance of publishing board and committee papers by the agreed deadline. Reasonable exceptions include finance reports to the Finance and Performance Committee, which are not uploaded in advance due to the need to present the most up-to-date position.*
- *Papers are generally of a good standard and there is ongoing work to encourage more succinct presentations of key risks and issues.*
- *We have also noted a general decrease in the number of verbal presentations without accompanying papers. This supports good governance as it allows board members to read papers in advance.*

- *The board and its committees generally receive good quality information to support effective scrutiny, support, and challenge. Papers are available in advance of meetings, and their quality is generally good. However, some papers are lengthy, which is reflected in feedback in committee self-assessments and comments from committee members.*
- *Patient and staff stories are key features of board and committee agendas that are highly valued forms of intelligence to set the tone of meetings.*
- *Work continues to enable and encourage members to make greater use of board member visits to allow members to triangulate intelligence from board and committee meetings with their observations.*
- *The Trust has a broadly effective approach for committee agenda setting which involves the chair, committee lead director and secretariat. During 2022-23, all committees reviewed their terms of reference and 'cycles of business' to ensure full coverage of their remit* and to ensure their responsibilities are discharged.

8. Joint Escalation and Intervention Arrangements

8.1. Under the Joint Escalation and Intervention Arrangements, Welsh Government Health Inspectorate Wales and Audit Wales meet to discuss the overall assessment of the Trust.

8.2. Confirmation was received by the Trust in March 2024 that its escalation status remained unchanged at 'routine arrangements'.

9. Internal Audit

9.1. The 2023/24 Internal Audit Plan, and amended and approved by the Audit Committee, included 18 internal audits. The plan will be delivered in full ahead of the 7 June Audit Committee meeting.

9.2. From the opinions issued in 2023/24, 15 were allocated reasonable assurance and two were limited assurance (noting these were All Wales reviews on decarbonisation and estates condition, where all NHS Wales Health Bodies received limited assurance opinions). In addition, one advisory report was issued.

9.3. The Head of Internal Audit Opinion has been received by the Trust in draft form and it states that the overall opinion for 2023/24 is that the Board

can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively.

10. Governance Code 2017

10.1. An assessment was undertaken in March 2024 against the main principles of the Corporate Governance in Central Government Departments: Code of Good Practice 2017 ('Governance Code').

10.2. The Governance Code adopts a 'comply' or 'explain' approach. The Audit Committee reviewed the self-assessment on 30 April 2024 and were assured that the Trust complies with the principles of the Governance Code, is conducting its business in an open and transparent manner in line with the Code and has held true to good governance in the arrangements it has in place. The link to the full self-assessment can be found in the Audit Committee papers here at agenda item 8.

11. Transparency and Accessibility of Meetings

11.1. In accordance with the Public Bodies (Admissions to Meetings) Act 1960, the Trust is required to meet in public and has done so for the six scheduled meetings held in person at the Cardiff MRD in 2023/24. To ensure business is conducted in as open and transparent a manner as possible, members of the public, staff and stakeholders are able to join the public board and committee meetings via Zoom or Teams and have the opportunity to send questions to the board prior to those meetings. Board meetings are livestreamed on the Trust's Facebook page and retained on YouTube and the Trust website for future reference.

11.2. In addition to the public meetings, the board met nine times in private session in 2023/24, where matters of confidentiality and/or commercial sensitivity were discussed. Decisions made in private session are reported in the public session as soon as possible.

11.3. The Trust held its Annual General Meeting virtually on 27 September 2023, and this too was livestreamed.

11.4. Board and committee meetings in 2023/24 were appropriately constituted and quorate with excellent attendance. The Trust did not stand down any of the scheduled board or committee meetings.

11.5. The need for regular breaks including a lunch break in the longer committee meetings was introduced. Additionally, more hybrid meetings were introduced in 2023/24. The length of meetings and their mode continues to be factored into discussions with Chairs and Executive Leads when setting the agenda.

11.6. Agendas and papers for public sessions of the board and committees are published on the Trust's website seven days before a meeting.

12. Member Visibility

12.1. In May 2023 the board approved the Board Visibility and Engagement Standard Operating Procedure (SOP). The SOP supports the Chair and Chief Executive in their responsibility to provide strong, effective, and visible leadership in the Trust. It aims to provide a range of ways in which the board can be accessible, hear from our people, our patients, and our stakeholders and to triangulate the information received through more formal routes.

12.2. The dashboard, which is available on the WAST intranet site, can be accessed via this link. Once open the dashboard can be manipulated and filtered for date ranges and to enable the user to move between the sub-dashboards of 'Board Member Visits', 'Roadshows and Awards', and 'Hospital Visits'.

12.3. Whilst there are a number of opportunities for directors to visit our people and our patients due to the nature of their work, the time commitments of the Non-Executive Directors mean that this can be a challenge. Other than the Chair and Vice Chair who have minimum commitments of 14.5 and 8 days per month respectively, Non-Executive Directors are engaged for up to four days per month. It is recognised that this time commitment is often consumed by committee and board meetings and preparation for those meetings, leaving limited time for visits. Efforts will be made in 2024/25 to locate in-person board and

hybrid committee meetings in locations where Non-Executive Directors can have more ready access to our people and our patients. It is noted that each board and committee meeting (other than Audit, Remuneration and the Finance and Performance Committees) have a patient or staff story.

12.4. The heatmap illustrates a notable concentration of visits in the southern and northern regions of Wales, particularly around our headquarters in Cardiff, Cwmbran, Swansea, and St Asaph. Recognizing the need for broader geographic engagement, the board plans to utilise this heatmap strategically to promote a more equitable distribution of visits across Wales in the coming year. This effort will focus particularly on increasing the presence in rural areas, which were less frequently visited in 2023/24. By aligning board and committee meetings, as well as other events, to facilitate travel, board members will have more opportunities to conduct individual visits and engage more comprehensively with communities throughout the region.

13. Committee Effectiveness

13.1. Committees play an important role in supporting the board in fulfilling its responsibilities by providing advice on strategic development and specific aspects of business; gaining assurance and providing oversight on key aspects of activity in organisational performance, supporting achievement of the Trust's strategic goals; and carrying out specific responsibilities on the board's behalf.

13.2. The corporate governance framework at WAST places emphasis on its committees as fora where ideas can be explored in greater detail than board meetings are able to allow, providing time and space to consider issues to a greater depth.

13.3. In Q4 of 2023/24 each committee and the advisory group:

- Reviewed its terms of reference and operating arrangements
- Responded to and evaluated effectiveness surveys (Audit Committee used the National Audit Office Effectiveness Toolkit)

- Approved its Annual Committee reports
- Agreed its annual priorities

13.4. Responses to the surveys waned for those that were issued in December and January which is likely to be a result of the significant winter pressures the Trust experienced. Due to the spread of membership, some recipients received multiple surveys to complete. The Audit Committee considered the response rates at its 30 April 2024 meeting and agreed a change to the methodology for gathering feedback on effectiveness changes in 2024/25 and this is set out in more detail in the changes to operating arrangements section below.

13.5. In reviewing their terms of reference each committee was assured that the areas within their remit are appropriate and manageable. A comparison across all committees for duplications was also conducted. Annex 1 illustrates the breadth of business delegated to the committees by the board.

13.6. Each committee has a cycle of business which was developed to directly correlate to its responsibilities. This is used to set the agenda and is monitored at each meeting as a means of evaluating effectiveness on a continual basis.

13.7. Following each committee meeting a AAA report (alert, advise, assure) is prepared and circulated to the board by email. This provides timely communication to the board and the AAA report is formally presented at the next board meeting. The AAA reports are added to the board meeting packs and presented by the Chair of that committee. From January 2024 the AAA reports were also uploaded to the committee page of the Trust website within 14 days of the meeting to promote transparency.

13.8. The annual reports of the committees, together with an evaluation of their effectiveness and proposed changes to their terms of reference and membership are attached as Annex 2 - 8 for approval by the board. These were reviewed by the Audit Committee on 30 April 2024.

13.9. Changes to terms of reference for the committees are marked up in the annexures. All have included a provision for Chair's action (primarily aimed at approving policies between meetings), and a commitment to the duty of quality. Material changes include:

13.9.1. *Academic Partnerships Committee*: Change of purpose statement and a reduction in the Non-Executive Director membership of the committee from four to three (including the Chair). There is a potential change of name of this committee foreshadowed in 2024.

13.9.2. *Finance and Performance Committee*: The information governance and information security remit has been transferred from the Quality, Patient Experience and Safety Committee. Directorate specific plans aligned to the long term strategy 'Delivering Excellence' will be received by this committee rather than reviewed for alignment. Clarity that the Audit Committee will receive assurance on the implementation of the Quality and Performance Management Framework and that this committee will receive assurance on its effectiveness and the value of outcomes the framework produces.

13.9.3. *Remuneration Committee*: Addition of any interim appointments to the roles that are within the remit of the committee

13.10. There has been good progress on priorities set by committees for 2023/24 as set out in their annual reports. Priorities for 2024/25 are set out in **Annex 8** and quarterly reports will be presented to the committees on progress against each priority:

14. Trust Board Reflections and Changes to Operating Arrangements 2024/25

14.1. In concluding the reviews for 2023/24 and in demonstrating continued self-reflection and an appetite for continuous improvement, the board were asked to identify any areas of activity that are done well, or could be improved, with a summary of the response and themes set out below.

Question	Response
What is the board doing well?	*Meetings*: Good processes in place for agenda setting and commissioning; ongoing reflections and focus on continuous improvement; good balance between the frequency of board and Board Development activity; well chaired; meetings are productive. *Board Focus:* Greater focus on strategic development / transformation; managing oversight of risk – excellent understanding of and focus principal risks; focus on patient experience; clear objectives. *Committees*: escalation (AAA) reporting; confidence in reliance on committees; receiving robust feedback from committees; less discussion at board on matters reserved for committee as a result of effective committee operations and reporting. *Members*: Good visible engagement; engage in robust discussion and being open to challenge. *Information:* paper quality is good which allows open discussion; good data/performance reporting; effective governance function with focus on continuous improvement. *Culture*: positive support given to the Executive Directors; members demonstrate integrity and respect for others. *Composition:* Managing the changes with Non-Executive Director composition; good partnership approach between Non-Executive Directors and Executive Directors.
What could the board be doing better? (see changes to operating arrangements below for actions to address responses)	*Process/presentation*: better integrating insights from the Chairs with their committee AAAs into relevant agenda items through which it would enhance the flow and depth of board discussions, fostering a more holistic and informed governance process; guidance on writing and presenting of reports to the committees and board would be helpful. *Strategy*: increase/maintain focus on setting direction/strategy (and the realisation and challenges); scrutiny, support, and challenge on the longer-term objectives / milestones; include greater focus on the delivery of the long-term strategy versus the IMTP; focus on innovation and learning from other service providers; debate / discuss transformation priorities; strategic Board Assurance Framework is

Question	Response
	needed to be clear on each of the risks to each of the long-term strategy's strategic objectives. *Information:* Rationalising the volume of information used to monitor the Trust's activities; focus on few metrics to retain a high level view of performance (in turn reducing the burden on executives in terms of reporting requirements); discussing initiatives at concept stage. *Outcomes/impact*: As well as receiving good news stories from staff, be open and more actively report 'bad news' or where the outcome has not been positive; more open and honest discussions with TU Representatives. *Members*: There could be greater challenge of the executives in order to gain further assurance; arguably could be further challenge and scrutiny demonstrated by in doing so would repeat the good work of the committees; being more visible with staff.
What are the training and development needs of the board?	Finance (understanding the pressure points with the relevant Welsh Government legislation and the impact and consequences that has for the Trust). A session on the roles of the committees versus the board specifically regarding the MIQPR. A session on the different roles of the members of the board and their accountability. Longer-term development that supports the board in being high performing (preferably externally facilitated). Continue Board Development activities and continue to receive key areas of organisational activity being brought to the development sessions. TU Representatives board/committee training. How to monitor strategy (and how to do so efficiently and effectively). Understanding more about psychological safety.

14.2. Changes to operating arrangements and corporate governance practices have and will continue to be made to address the reflections from the board above, as well as those received during the committee effectiveness reviews (which are summarised in their annual reports). Some of these are replicated across the board and committees, and some are committee specific. A summary of the changes already in place and planned for 2024/25 are as follows:

	Changes to operating arrangements
Board and all committees	• Committee Chairs will receive the Board Chair and CEO's Brief which will include prompts for relevant parts of the agenda where the AAA report is relevant. • Where appropriate board meetings will be held in different WAST locations to enable more accessibility to the board. The same will be done where appropriate for hybrid committee meetings. • Board development sessions to be factored into the schedule for finance pressure points; MIQPR orientation refresher (interpretation and triangulation); roles and responsibilities of members of the board; psychological safety; monitoring strategy. • Development of scope and engagement of external facilitator for long term board development • Guidance on report writing and presentation to board and committees. • Trade Union Partner and Committee Chair induction session to be held (scheduled for June 2024). • Reflections targeted more on what went well/not so well rather than what was discussed during the meeting. • Revised monitoring report for the cycle of business.
Academic Partnerships Committee	• Drawing out the reporting and assurance with more particularity where possible, including elements of external reporting • Clarity of reporting of key metrics for Research and Innovation, and legislative compliance • Risk reporting where appropriate (an action carried over from the 2022/23 review) • University Trust Status remit of the committee clarified once granted • Arrange meetings to take place at education and training facilitates to develop understanding & improve visibility • Report from chair following research champion events • Continue work on research governance framework with a focus on its implementation at WAST • Clarity on the purpose and focus of the committee to be communicated to the wider organisation (an action carried over from the 2022/23 review)
Audit Committee	• The CEO will attend more frequent meetings in 2024/25 • Committee will cycle in a private meeting with Internal Audit and Audit Wales without any non-members present • Audit Committee Chair will establish quarterly meetings with Audit Committee NED members • Revised approach to effectiveness review surveys in 2024/25. This will see the committees receiving the simplified three questions of

Changes to operating arrangements	
	'what does the committee do well', 'what could it improve on', and 'what are the development needs', and the board receiving the more comprehensive 27 question survey. The Audit Committee will continue to use the National Audit Office Effectiveness Toolkit.
Charity Committee (included for completeness but reporting separately to the Corporate Trustee on 30 May)	• Ensure that all actions are closed off appropriately in meeting and on actions and decisions logs • Committee and Corporate Trustee development session to be arranged in 2024/25 when Head of Charity in post • The effectiveness survey questions for 2024/25 to be tailored to the Charity and relationship with Corporate Trustee • Separate Corporate Trustee meetings will be held at least twice a year, and the Charity Committee AAA report will be listed separately on board agenda in between these meetings • Consideration for member visibility to be increased through a bespoke list of areas/teams to visit and bringing back a short report on that in addition to the lived experience, as well as consideration for a spotlight on the Charity at future roadshows
People and Culture Committee	• WASPT approved minutes to be included in meeting bundle as well as the AAA report • Next iteration of the cycle of business would need to reflect any attempts to combine assurance reporting, particularly as it relates to the MIQPR and people and culture metrics which respondents felt were duplicative and needed to be more concise for the remit of the committee
WASPT	• Encouraging trade union partner members and management members to disburse themselves around the table during in person meetings • Provision of the minutes of WASPT as well as the AAA report to the People and Culture Committee in open session • In addition to the AAA report from WASPT being circulated to members, consideration will be given to a 'hot topics' newsflash that could be circulated by email and included on Siren. This will draw from the AAA and include a link • In addition to retaining the two hour bi-monthly in person meeting, an additional one hour slot will be included for a workshop on a single issue of importance. This will include a lunch break which will be a good opportunity for members to get to know each other better. This will be scheduled in as soon as possible in diaries • Issues raised in the survey such as the desire to walk in each other's shoes, strengthen links between Trade union partner and management members, and working on personal relationships will be addressed in different operating arrangements, but also from the

Changes to operating arrangements	
	partnership working development sessions that have taken place and are planned as part of the ACAS action plan • Where it is identified that the agenda may restrict timing of an item, whether that be in the agenda setting meeting with the joint chairs or the trade union partners pre-meet, the Board Secretary will review the overall timing and adjust where appropriate and with the agreement of the Joint Chairs • Specific sessions to include how to run effective meetings and financial reporting • Introduction for individual trade union partners and staff who wish to observe board and committee meetings

14.3. The changes proposed will be monitored in a variety of ways throughout 2024/25 including via the local directorate plan for the corporate governance team, the 2024/25 Board Development schedule, and by way of committee priorities.

15. Board Development

15.1. The Board Development Programme continued in 2023/24 with a focus on understanding, learning and reflection. The seven scheduled sessions were well attended and designed to stimulate discussion on strategic initiatives; shape culture and behaviours; strengthen system and partnership working; enhance knowledge of the regulatory environment and allow for more detailed briefing of complex issues ahead of formal meetings. Sessions included:

- Focus on the activities of the charity and charity requirements.
- A Non-Emergency Patient Transport Service (NEPTS) showcase.
- Organisational strategy and review of MIQPR metrics.
- Team building activities – dedicated Insights sessions.
- 2024/27 IMTP development.
- Llais (Citizens Voice Body) session.
- Conversations around culture.
- Equality, diversity & inclusion workshop and allyship programme.
- Working Safely Programme: A leading safely positive conversations awareness session.

- Structured Assessment and reflections on good governance in the NHS.

15.2. On 27 April 2023 Audit Wales attended the Board Development session in relation to their Structured Assessment and reflections on good governance in the NHS with a particular focus on the role of the Non-Executive Director and their role in relation to challenge and scrutiny. The further maturation of the risk management framework in 2023 naturally assists with this and, in the interim, guidance on the component parts of the Board Assurance Framework was developed and implemented in April 2023 to support closer scrutiny and challenge. The 2023 Structured Assessment indicated that feedback from the 2022 Structured Assessment had been carefully considered by the Trust and that board and committee meetings do demonstrate well-balanced and constructive challenge from the Non-Executive Directors.

16. Conclusion

16.1. Good governance consists of mechanics (structures and processes) and dynamics (strategy, behaviours, and culture). Effectiveness reviews seek to reflect on both these elements and ensure that the duty of quality applies to everything we do as a Trust Board.

16.2. On mechanics, the board has a well-established committee structure, with regular scheduled and quorate meetings. All committees have performed well during the year and have covered a significant portfolio of work as can be seen in Annex 1. Whilst volume of papers and length of the agenda remains a concern, the Audit Committee was assured that the remits were equitable and manageable.

16.3. Committee terms of reference are regularly refreshed, and they each have a cycle of business which provides for the appropriate frequency of reporting. Agendas are set well ahead of meetings and are built around the highest rated risks. Timeliness of papers improved in 2023/24 however there is work to do in 2024/25 to support report writers, board members and presenters with guidance and new templates, and to develop bespoke committee induction programmes.

16.4. Board and committees oversee key performance indicators at each meeting and regularly take deep dives into areas of concern. The board maintains a risk management framework and there is evidence of a strong risk culture at board and organisational level, notwithstanding the maturation of the strategic board assurance framework in 2024/25

16.5. With respect to dynamics, meetings are conducted respectfully and in line with the Nolan Principles. Presenters are well prepared, and attendance is excellent.

16.6. The public meetings are open to the public and decisions made in private session are reported openly and in a timely way. The lived experience heard at the board and many of the committees, together with new ways of conducting board visits allows members to triangulate assurance and connect with our people and our patients.

16.7. Committee Chairs escalate issues to the board transparently and provide timely assurance to the Board on matters within their committee's remit. There is good engagement with the Non-Executive Directors and the Directors through both buddying and Chair/Executive Lead arrangements. The Trust Board Chair and the Chief Executive meet regularly, as does the Trust Board Chair and the Board Secretary. Non-Executive Directors meet separately on a bi-monthly basis.

16.8. Each meeting seeks clarity on conflicts of interest in line with the Standards of Business Conduct policy, and the publicly available register of interests is linked to each agenda.

16.9. Board members are appointed based on a skill matrix, with campaigns for Non-Executive Directors tailored to meet any gaps in the matrix.

16.10. This year, the Board has intensified its emphasis on long-term strategic planning, a focus that extends across Board and committee meetings as well as Board development sessions. This strategic shift is evidenced in the Integrated Medium-Term Plan (IMTP) for 2024-2027, which elaborates on our long-term strategy in greater detail. This plan will serve as a foundation for the Board to more effectively monitor our progress towards strategic objectives alongside our annual goals."

16.11. Board development embeds the ethos that we are a learning board – continuously improving and striving for quality in the delivery of our long term strategy.

16.12. The changes to operating arrangements and corporate governance practices as set out in this paper will further strengthen mechanics and dynamics during 2024/25 and beyond.

RECOMMENDATION

17. The Board is requested to

(a) Review the external and internal sources of assurance to assure itself as to its effectiveness for 2023/24.

(b) Note the priorities set by committees for 2024/25.

(c) Approve changes to committee terms of reference.

(d) Note changes to operating arrangements for the Board and committees in 2023/24.

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

WAST BOARD COMMITTEE REMITS – 2024/25

Quality, Patient Experience and Safety Committee

- Duty of Quality and Duty of Candour
- KPIs in remit
- Clinical & quality plans
- Health and Care Quality Standards
- Quality Impact Assessment
- Mental health
- Infection prevention and control
- Safeguarding
- Continual quality improvements
- Learning
- Mortality reviews
- Putting Things Right
- Clinical negligence & personal injury
- Clinical effectiveness
- Clinical audit
- Citizens voice & patient experience
- Clinical and quality governance
- Risks, audits, policies in remit

People and Culture Committee

- People & Culture plan and metrics
- KPIs in remit
- Trust Behaviours
- Health and wellbeing
- Staff & volunteer experience
- Speaking up safely
- Equality, diversity, and inclusion
- Recruitment and retention
- Trade Union relationships
- Leadership & development
- Succession plans
- Welsh language
- Health and safety
- Health and Care Standards in remit
- Registration and revalidation
- Partnerships and engagement
- Risks, audits, policies in remit

Advisory Group (WASPT) reports to this Committee with onward reporting to Board via the AAA

Finance and Performance Committee

- Long term strategic direction
- Long term financial direction
- Capital and revenue monitoring
- Financial sustainability
- Business cases and PIRs
- Compliance with statutory duties
- IMTP endorsement and delivery
- Value based healthcare
- Performance against targets set by Commissioners and Welsh Gov.
- Quality &Performance Management Framework (QPMF) outcomes
- Trust wide KPIs (MIQPR)
- Recovery plans for performance
- Demand and capacity
- Estates
- Fleet
- Environment and sustainability
- Digital systems
- Digital plan direction
- Information governance
- Information security
- Major Incident Plan and Business Continuity Plan
- Cyber resilience & security
- Risks, audits, policies in remit

Audit, Risk and Assurance Committee

- Governance and assurance
- Effective systems of good governance, risk management and internal control
- Board Assurance Framework
- Annual Report
- Audited financial accounts
- Standing Orders and SFIs
- Accounting policies
- Assurance processes
- Policies for reg. compliance
- Schedule of losses & special payments
- Single tender actions
- Internal audit (inc annual plan; reports; HOIA Opinion)
- Audit Wales (inc annual plan; ISA260; structured assessment; reports;
- QPMF implementation
- Audit management responses
- Local Counter Fraud Service
- Standards of business conduct
- Whistleblowing processes
- Patient's property
- Policies in remit

Remuneration Committee

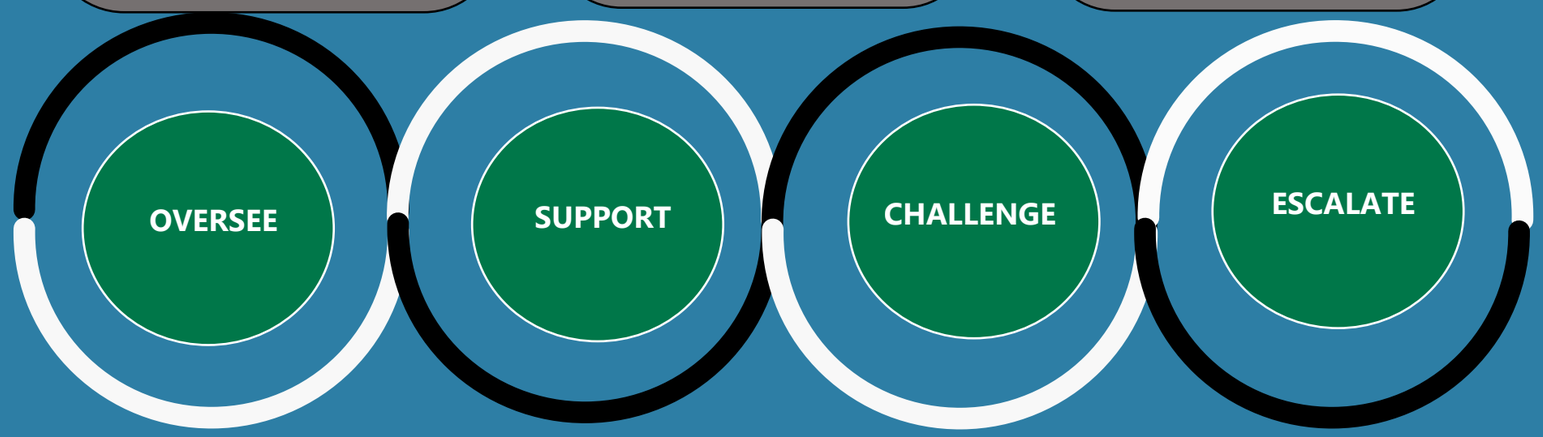
- Contractual arrangements for staff
- Appointment, termination, remuneration, terms of service and appraisal for Chief Executive; Executive Directors (including interim); Very Senior Managers
- Redundancy, VERs, Settlement settlements

Academic Partnerships Committee

- Strategic collaboration with education providers and commercial partners
- Collaboration with partners in health, social care, local authority and third sector
- Partnership arrangements
- University Trust Status
- Plans to build capacity of whole workforce
- Research governance framework
- Risks, audits, policies in remit

Charity Committee (Corporate Trustees)

- Charity strategic direction
- Charitable funds monitoring including systems and processes
- Review by Audit Wales of accounts
  Fundraising
- Bursary Panel
- Promote the charity
- Annual Report and Financial Accounts
- Approve expenditure over £5,000
- Bids Panel
- Risks, audits, policies in remit



AUDIT COMMITTEE
ANNUAL REPORT 2023/24

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The Committee met on 30 April 2024 and reviewed its terms of reference, responses to questionnaires completed by members and attendees, and its operating arrangements. Discussions were also held with the Committee Chair and Executive Lead ahead of that meeting. This Annual Report reflects on the effectiveness of the Committee in 2023/24 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The purpose of the Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's system of assurance - to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales. Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

MEMBERSHIP AND ATTENDANCE

6. The Committee met five times in public and four times in private session as scheduled in 2023/24 and was quorate on each occasion. Pre-meets with the Chair and auditors was reinstated in 2023.

7. In 2023/24 the Committee was supported by the Chair and three Non-Executive Directors (NEDs) as members, and several prescribed attendees with good attendance.

8. The chart below illustrates attendance of members and prescribed attendees as listed in the terms of reference for 2023/24. Audit Wales and Internal Audit were in attendance and the Committee welcomed non prescribed attendees at various meetings.

9. It is not intended to change the membership of the Committee other than to add the Deputy Board Secretary/Head of Risk to the prescribed attendees given the regular risk reporting.

COMMITTEE ATTENDANCE					
Name	**20 April 2023**	**25 July 2023**	**14 Sept 2023**	**30 Nov 2023**	**1 Mar 2024**
Martin Turner					
Peter Curran					
Paul Hollard					Kevin Davies
Joga Singh					
Ceri Jackson					
Chris Turley					
Lee Brooks		Judith Bryce	Judith Bryce		
Judith Bryce					
Liam Williams	Duncan Robertson				Part
Angie Lewis					
Osian Lloyd (IA rep)					
Audit Wales rep		Andrew Doughton	Fflur Jones	Fflur Jones	Fflur Jones
Paul Seppman					Christian Fox
Damon Turner					
Trish Mills					
Carl Window					

	Attended
	Deputy attended
	Apologies received
	No longer member

COMMITTEE VIEWS ON EFFECTIVENESS

10. The Committee's effectiveness was assessed through a review of its terms of reference, responses to a questionnaire, discussion with the Chair and Executive Leads, and at the 30 April Committee meeting. The questions differed from other

Committees in that the National Audit Office (NAO) Effectiveness Tool was used as it was in 2022/23.

11. The questionnaire provided an opportunity to rate essential and good practice areas based on ratings of 'room for improvement', 'meeting standards' and 'excelling'. Seventeen questionnaires were sent out with five responses being returned (a 29% return rate which was similar to 2023/24).

12. The responses were reviewed by the Committee on 30 April against the same questions from last year and most of the scores were an improvement from 2022/23.

13. The results highlighted the Committee's excellent performance across various areas including:

    - Financial reporting, where minimal areas for enhancement were identified.
    - Punctuality of submitted papers.
    - New practice of a recurring report from the Chair of the People and Culture Committee regarding the Trust's "speaking up safely" programme to assure the Committee on whistleblowing activity.
    - Membership was appropriate, with representation from Internal Audit and Audit Wales at meetings, and financial experience amongst the membership.
    - Members understand their role and what is expected of them when appointed.

14. Many of the areas raised as requiring improvement in the questionnaire were either already in train or were more relevant to government departments because of the nature of the NAO tool, however areas to strengthen include:

    - Committee level induction programme to be developed. This was planned for 2023/24 but was not progressed due to capacity in the Corporate Governance Team.
    - Lack of cyber and digital risk experience on the Board. The current NED campaign will seek to address this skills gap.
    - More of a focus on assurance mapping and assurance generally.
    - Reinstate NED and auditor only meetings of the Committee annually.
    - Committee Chair to meet quarterly with Audit Committee members.

15. The Committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the Committee and in this respect, it has discharged its responsibilities in providing assurance to

the Board aligned to its terms of reference. The Audit Wales annual audit plan and annual audit report have been carried over from Q4 into the April 2024 meeting as agreed.

16. The Committee's business in 2023/24 included the following, full details of which are in the Committee's AAA reports and minutes provided to the Board:

    16.1. In July 2023 the Committee **endorsed the 2022/23 Annual Accounts and the Annual Report** which were shortly after approved by the Board. The Audit Report was also reviewed at that meeting as was the Head of Internal Audit Annual Report and Opinion. The plan for development of the 2023/24 annual filings was received in March 2024 and endorsed.

    16.2. At each meeting other than in April, which is a meeting dedicated to the review of Committee effectiveness, members received an **update from Audit Wales and from Internal Audit** on their programmes of work and performance indicators (Internal Audit).

    16.3. The following **Internal Audit Reports** were presented by Internal Auditors and discussed by this Committee. They were also reviewed by the Committees with specific remits over the subject area. The list below includes a mix of 2022/23 and 2023/24 Internal Audits:

- Risk Management and Assurance
- Savings and efficiencies
- Trade Union Release Time
- Pain Management
- IM&T Infrastructure
- Follow UP Action Tracker Review
- Cyber Security
- Health and Safety
- Senior Paramedic Role
- Records Management
- Technical Resilience
- Estates Assurance: Estates Condition
- Decarbonisation
- Vehicle Replacement Programme
- ePCR Clinical Compliance
- Serious Adverse Incidents Joint Investigation Framework
- Strategy Development
- Retention of Staff
- 111 Commissioning

16.4. The **2024/25 Internal Audit Plan was approved** by the Committee in March 2024, as was the Internal Audit Charter and fee.

16.5. In November 2023 Audit Wales presented the **WAST Review of Workforce Planning Arrangements** and the NHS Workforce Data Briefing from the Auditor General for Wales. The report found overall that the Trust is taking effective steps to mitigate current workforce challenges and clarify its longer-term strategic vision, however medium to longer-term resourcing is a significant and ongoing barrier.

16.6. In March 2024 the Audit Wales Update presented the **WAST 2023 Structured Assessment**. Members noted the positive report and the improvements year on year, and thanked all teams involved. The four recommendations and management actions were noted, and this Committee will monitor progress.

16.7. Two areas of **non-compliance with the Standing Orders** were discussed and escalated to the Board. The Committee was assured that both areas were being appropriately addressed in a timely way:

- The first related to the availability of Board papers ten calendar days before a Board meeting. It was noted that whilst the Trust could make continued improvements on uploads to papers to ensure they are at least seven days ahead of Board meeting, the timeliness of data and information was key and a ten day period would potentially provide outdated information, particularly when factoring in governance processes ahead of that time. The Standing Orders were later amended to provide for a seven day timeframe.
- The second related to an issue raised in the vehicle replacement programme internal audit but had wider application. This centred on the approval of individual contracts by the Board. The Audit Committee received a verbal update on the plan to address this in March 2024 and will receive amendments to the Scheme of Reservation and Delegation and a Governance Practice Note to address this at its April 2024 meeting.

16.8. Amendments to **Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation** were reviewed and endorsed for the Board. Governance Practice Notes developed for interpretation and application of some parts of the Standing Orders were also approved.

16.9. The Committee reviewed the current state of play of **Policies** in July 2023 and agreed a prioritisation plan for 2023/24 and 2024/25. Members have been updated on progress at each meeting.

16.10. In April 2023 the Committee reviewed the **self-assessment against 2017 Governance Code** and noted that there were no areas where the Trust did not comply. A self-assessment against the Governance, Leadership and Accountability elements of the Health and Care Standards was also reviewed.

16.11. In September 2023 the **Audit Process and Reporting Handbook** was presented to the Committee. 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.

16.12. In September 2023 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.

16.13. In November an update was received regarding the **implementation of the Quality and Performance Management Framework** (QPMF), oversight of which transferred to this Committee from the Finance and Performance Committee in-year. Revised terms of reference are in place for the QPMF Steering Group (which reports to Executive Leadership Team), and a work plan is in place

16.14. Other than in April, the **losses and special payments** report is received at each meeting of the Committee. Likewise, **the Local Counter Fraud** update report and **tender and single tender waiver** reports are taken in private session.

16.15. The Committee received assurance from the Chair of Quest that the **clinical audit plan** had been approved and was being monitored quarterly by that Committee.

16.16. The Committee received assurance from the Chair of the People and Culture Committee that the **arrangements for whistleblowing** and speaking up safely were developing well with the All Wales Speaking Up Safety Framework in place, guardians operating at WAST, and the Work in Confidence platform operating for confidential reporting.

16.17. The **Register of Interests and the Register of Gifts and Hospitality** was received in April 2023 and the Standards of Business Conduct Policy approved in July 2023.

16.18. A **risk management and BAF** report was provided to each meeting. This Committee has oversight of the risk management transformation programme and noted delays in some deliverables given capacity in the team, however good progress against the principal risks was recognised as was the excellent risk culture at the Trust. Areas of focus for 2024/25 are to deliver a strategic BAF that reflects more closely the Trust's strategic objectives against its long-term strategy – Delivering Excellence: Vision 2030. Additionally, work will be undertaken to develop a series of strategic risks and risk appetite statements and will see the roll out of a programme of education and training across the Trust in support of the Risk Management Framework.

16.19. The **Risk Management Policy** was approved in March 2024, as was the **Local Counter Fraud Policy**.

16.20. Members **reflections** after each meeting included that papers were of good quality, concise and easy to read; presenters were clear; attendance and contributions at the meeting was excellent; focus on governance issues was welcomed; system of control was very good; good progress on risk and audit tracker; wider attendance of colleagues was welcomed; hybrid approach was considered to work well; and good focus on key audit points.

16.21. The 2023/24 Committee **cycle of business** was approved.

16.22. The **2022/23 annual effectiveness review** was conducted in the April 2023 meeting. At this meeting the Committee also reviewed the annual reports and changes to terms of reference for all Board Committee and Advisory Groups.

16.23. The **Committee's priorities for 2023/24** are reviewed at each meeting and a more detailed update appears later in this report. The Committee also reviews progress against its cycle of business at each meeting.

17. The Board received a highlight (AAA) report from this Committee by email circulation following each meeting which included alerts, advice, and areas of assurance. Where there was a shorter proximity of the meeting of this Committee and the Board meeting, that report was provided verbally by the Chair and captured in the Board's minutes. This AAA report included reporting at a high level of matters taken in private session.

18. The Committee is not serviced by any Sub-Committees or task and finish groups that this time.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

19. The Audit Committee's terms of reference were reviewed to ensure all matters within the remit of the Committee were clear and were articulated with the oversight and scrutiny role of the Committee in mind. The following changes are proposed for consideration by the Audit Committee:

    - Change of name from Audit Committee to Audit, Risk and Assurance Committee (ARAC). The National Audit Office recognises this as best practice nomenclature, and it describes more appropriately the wider remit of the Committee and the focus in 2024/25 and beyond on the strategic Board Assurance Framework and the programme of integrated governance and assurance.
    - The addition of the Deputy Board Secretary/Head of Risk to the prescribed attendees.
    - Addition of a Chair's Action provision. It is likely that this would be utilised primarily for policy approval where waiting a quarter for a scheduled meeting would cause undue delay.
    - Addition of the commitment of the Committee to continuous improvement and the duty of quality.

20. Changes in operating arrangements in 2024/25 to address issues raised in the survey will include those issues raised as areas requiring improvement at paragraph 14.

COMMITTEE PRIORITIES:

21. The Committee received an update on progress against its priorities at each meeting. The 2023/24 priorities were:

Priority	Progress
Review of the Board Member Induction Programme and Annex	The induction programme and annex documents were updated and reviewed by the Committee in September 2023.
Oversight of the development and effectiveness of the Quality & Performance Management Framework	The Committee received a verbal update regarding the implementation of the Quality and Performance Management Framework at its meeting in November.

Priority	Progress
	It was agreed that an update was not required for the March 2024 meeting however the reporting for this will be actively considered for early 2024/25.

22. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. Accordingly, the Committee has agreed the following priorities for 2024/25:

    (a) Monitor the development of the Committee specific induction programme.
    (b) Carry over the priority to monitor the implementation of the Quality and Performance Management Framework.

23. Progress on priorities will be reported to the Committee quarterly and to the Board through its highlight report.

NEXT STEPS

24. The next steps are to update the cycle of business with revised terms of reference

RECOMMENDATION

25. The Trust Board is requested to
    (a) Receive and note the contents of the Committee Annual Report for 2023/24 and analysis of its effectiveness; and
    (b) Approve the changes to the Terms of Reference and operating arrangements.

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

AUDIT, RISK AND ASSURANCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS ~~2023/24~~2024/25

1. ~~1.~~ INTRODUCTION

1.2 ~~1.1~~ The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government 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*".

1.2 In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Audit, Risk and Assurance Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3 The Board Committees play an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions by the Board.

2. PURPOSE

2.1 The purpose of the Audit, Risk and Assurance Committee ("the Committee") is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the

Trust's system of assurance - to support them in their decision taking, and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 ~~2.2~~ Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.3 The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

~~2.1~~2.4 The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

(a) the adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance process, including the Annual Governance Statement and the Annual Duty of Quality ~~Statement~~Report, providing reasonable assurance on:

(i) the organisation's ability to achieve its objectives.

(ii) compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others.

(iii) the efficiency, effectiveness, and economic use of resources; and

(iv) the extent to which the organisation safeguards and protects all its assets, including its people,

and to ensure the provision of high quality, safe healthcare for its citizens:

(b) the Board's Standing Orders and Standing Financial Instructions (including associated framework documents, as appropriate) and receive a report from the Board Secretary on any non-compliance.

(c) the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors; the Committee shall approve all financial procedures.

(d) the Schedule of Losses and Special Payments.

(e) the register of Single Tender Actions.

(f) the planned activity and results of internal audit, external audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports).

(g) the adequacy of executive and management's response to issues identified by audit, inspection, and other assurance activity.

(h) proposals for accessing Internal Audit services via Shared Services arrangements (where appropriate).

(i) anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

(j) any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

(k) the adequacy of the arrangements for Declarations of Interests, providing an annual report to the Board to this effect.

(l) arrangements for the discharge of the Trust's responsibility as bailee for patients' property.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by reviewing:

(a) all risk and control related disclosure statements (in particular the Annual Governance Statement and the Annual Duty of Quality ~~Statement~~Report) together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

(b) the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

(c) the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements.

(d) the policies and procedures for all work related to fraud and corruption as set out in National Assembly for Wales Directions and as required by the Counter Fraud and Security Management Service.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

(a) the comprehensiveness of assurances in meeting the Board and the Accountable Officers assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

(b) the reliability and integrity of these assurances.

3.5 To achieve this, the Committee's programme of work will be designed to provide assurance that:

(a) there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

(b) there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides

appropriate assurance to the Board and the Accountable Officer through the Committee and ensure all reported fraud concerns and ongoing investigations are notified to the Committee.

(c) there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees.

(d) the work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity.

(e) the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply.

(f) the systems for financial reporting to the Board, including those of budgetary control, are effective.

(g) the results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations' governance arrangements.

(h) monitor progress against the requirement of the Auditors' Management Letter.

(i) receive and review key Trust Annual Reports e.g., Trust Annual Report (including the Annual Governance Statement) and make recommendations to the Board for their adoption.

(j) review the content of the Corporate Risk Register and obtain assurance that control measures are in place to mitigate all identified risks.

Corporate Risks and Audit Recommendation Tracker

3.6 The Committee has overall responsibility for ensuring that corporate risks are identified and are being properly managed within the Trust and that there are processes in place to address and take forward audit recommendations. Nevertheless, each risk from the corporate risk register and Board Assurance Framework and each recommendation from the audit tracker, will be

presented to an appropriate Board Committee who will be responsible for ensuring that the Trust is managing and progressing each item as planned. In addition, these Committees will follow due process to escalate any issues to Audit, Risk and Assurance Committee for oversight, scrutiny and assurance. Regular reports will be provided to individual Committees on those items for which they have responsibility for oversight and overall Trust-wide progress reports will be presented to each Audit, Risk and Assurance Committee.

~~The Committee will consider the control and mitigation of each risk and provide assurance to the Board that such risks are being effectively managed and controlled.~~

Authority

3.7 The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

3.8 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.9 The Committee is authorised to approve Trust wide policies in accordance with the policy for the Review, Development and Approval of Policies.

Chair's Action

3.10 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

3.11 In these circumstances, the Chair and the Lead Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

3.12 The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Access

3.13~~0~~ The Head of Internal Audit and the Engagement Leads/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.1~~1~~4 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.1~~2~~5 The Chair of Committee shall have reasonable access to Directors and other relevant senior staff.

Sub Committees

3.1~~3~~6 The Committee may establish sub- committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-committees may only be established with the agreement of the Board.

4. MEMBERSHIP

Members

4.1 The membership of the Committee will comprise:

Chair	Non Executive Director
Members	Three further Non Executive Directors of the Board

4.2 The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise e.g. Wales Audit Office, Internal Audit.

4.3 The Chair of the Trust shall not be a member of the Committee.

Attendees

4.4 The core membership will be supported routinely by the attendance of the following:

- Executive Director of Finance and Corporate Resources (Committee Lead)
- Director of People and Culture
- Executive Director of Quality and Nursing
- Assistant Director of Operations, National Operations & Support
- Director of Corporate Governance/Board Secretary
- Deputy Board Secretary/Head of Risk
- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General
- Trade Union Partners (x2)
- Other Directors will attend as required by the Committee Chair

With the permission of the Chair, those in attendance may send a deputy in their place. This, however, does not affect the right of the Chair to require those listed above to attend.

By Invitation

4.5 The Committee Chair may invite the following to attend all or part of a meeting to assist it with its discussions on any particular matter:

- the Chair of the Trust
- any other Trust officials
- any others from within or outside the Trust
- the Chief Executive (Accountable Officer)

4.6 The Chief Executive (Accountable Officer) will be invited to attend meetings of the Committee and will attend ~~at least annually~~ to discuss ~~with the Committee~~ the process for assurance that supports the Annual Governance Statement and the Annual Duty of Quality ~~Statement~~Report.

4.7 The Committee Chair may extend invitations to attend committee meetings to other Directors and/or Senior Managers, and to officials from within or outside the organisation to attend all or part of the meeting to assist with its discussions on any particular matter.

4.8 Members may send deputies in their absence who will act with their full authority. 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.

Member Appointments

4.9 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

4.10 Non Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.11 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

Secretariat and Support to Committee Members

4.12 The Board Secretary, on behalf of the Committee Chair, shall:

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of People and Culture.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two of the four members of the Committee must be present to achieve a quorum. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.

Frequency of Meetings

5.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the

Committee deems necessary, consistent with the Trust's annual plan of Board business and calendar of meetings. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

5.3 The Chair of Committee, External Auditor or Head of Internal Audit may request a private meeting if they consider that one is necessary.

Withdrawal of individuals in attendance

5.4 The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/ GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other committees, including where appropriate joint (sub) committees and groups to provide advice and assurance to the Board through the:

(a) joint planning and co-ordination of Board and Committee business; and
(b) sharing of information;

in so doing, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.5 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

(a) report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports where appropriate throughout the year;

(b) bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, Annual Report to the Board and the Chief Executive (Accountable Officer) on its work in support of the Annual Governance Statement and the Annual Duty of Quality ~~Statement~~Report, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

7.3 The Board may also require the Committee Chair to report upon the committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.4 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit

Committee Handbook.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 5)

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

ACADEMIC PARTNERSHIP COMMITTEE
ANNUAL REPORT 2023/24

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The Committee met on 16 January 2024 and reviewed its terms of reference, responses to questionnaires completed by members and attendees, and its operating arrangements. Discussions were also held with the Committee Chair and Executive Lead ahead of that meeting. This Annual Report reflects on the effectiveness of the Committee in 2023/24 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The purpose of the Committee set out in its terms of reference reflects the maturing University Trust Status (UTS) journey and the fact that this is still a newly established committee that approaches its remit with 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 appropriate arrangements are 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).

MEMBERSHIP AND ATTENDANCE

6. The Committee met four times as scheduled in 2023/24 and was quorate on each occasion. The Committee met once in private session in January 2024.

7. The Committee has been supported by the Chair and three Non-Executive Directors as members, and a number of core attendees. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2023/24. The Committee welcomed non prescribed attendees at various meetings as well as external guests.

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		
Jonny Sammut				
Jonathan Turnbull-Ross				
Duncan Robertson				
Nigel Rees				
Chris Evans				
James Houston				
Jo Kelso		From item 5.4		
Trish Mills				
Mark Marsden				
Keith Rogers				
Academia Rep				

	Attended
	Deputy attended
	Apologies received
	No longer member

8. Attendance is steady with new members joining this year who have provided a positive and different lens on the work of the committee from a research, innovation, learning and strategic perspective. Leanne Smith was replaced as prescribed attendee when she completed her interim position when Jonny Sammut joined as Director of Digital. Hannah Rowan took the Chair for this Committee from 1 April 2023.

9. The Committee did not have a representative from academia in 2023/24, but a successful campaign saw the appointment of an academic Non-Executive Director in 2023.

10. No changes to membership are proposed at this stage other than the removal of the 'representatives from academia' as the original intent of that member has been fulfilled by the academic Non-Executive Director.

COMMITTEE'S VIEWS ON EFFECTIVENESS

11. The Committee's effectiveness was assessed through a review of its terms of reference, responses to a questionnaire, discussion with the Chair and Executive Lead, and at the 16 January Committee meeting.

12. The questionnaires provided an opportunity to gauge opinion on areas of good practice and areas that require improvement. Twenty questionnaires were sent out with 14 responses being returned (a 70% return rate which is similar to 2022/23).

13. Respondents were asked 27 questions and were encouraged to provide free text answers to explain or expand on their choices. The responses were reviewed by the Committee on 16 January against the same questions from last year. They discussed the need for clarity on the purpose of the Committee which was raised by a number of respondents and was a position that had not improved in the responses from 2023/24. These ranged from those proposing more of a focus on learning, on how to benefit from the existing partnerships, and the exploration of new partnerships with academia and industry, to a more focused application of academic research and innovation. This perhaps reflects new membership in 2023/24 and that this Committee is still finding its feet. It is anticipated that in 2024/25 the work of the Committee will benefit from a more certain understanding of our University Trust Status and the expertise of a Non-Executive Director from academia both on the Committee and the Board.

14. Good practice drawn out in responses included:
    - Engagement and participation overall rated good and Board engagement has improved
    - Overall good balance of key areas and appropriate remit for the Committee
    - Flexible and evolving nature of the committee appreciated
    - Behaviours reflected in meeting with supportive members
    - Work is reflective of the Trust's strategic priorities
    - Effective in implementing decisions and actions, closing off items, reporting to Board and reflecting on meeting

- Paper quality is good
- Excellent and collegiate chairing of meeting and reporting to the Board on key activities
- Definite feeling of progress in terms of the Committee's operations and effectiveness

15. The Committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the Committee and in this respect it has discharged its responsibilities in providing assurance to the Board. The Committee's business in 2023/24 included:

    (a) Establishment of a **task and finish group** which developed a strategic approach to the attraction of candidates to the Non-Executive Director position on the Board and this Committee, including role profile and candidate pack. The group also liaised with Welsh Government on the timing and process of the award of University Trust Status (UTS) and logistics related to the change of name and brand.

    (b) UTS was discussed extensively and the **priorities for the 2023-26 IMTP** related to UTS agreed. Additionally, the priorities for the 2024-27 IMTP were reviewed with a desire for the UTS priorities to better reflect the space the Committee is now moving into and the ambition to foster a culture of democratised learning and promote a more commercial lens.

    (c) The **Life Sciences Hub** presented on their current priorities and opportunities for strategic alignment, with the executive taking a collective focus on areas that will make the biggest difference to our patients and our people.

    (d) One of the Committee priorities this year was to focus on the adoption and implementation of the **new Health and Care Research Wales (HCRW) Research and Development Framework**. Colleagues showcased the significant amount of research and innovation underway at the Trust. 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.

    (e) A **self-assessment against the HCRW Framework** was reviewed and it was agreed that a key element of moving this forward will be the refreshing of the clinical strategy and a separate but linked research and innovation plan. Succession planning and capacity was a subject of some discussion with HCRW and members, and the need to build on the existing but small team and support the wider organisation getting involved in research and innovation - not as a separate role but embedded into job descriptions and

business as usual. The Committee will continue to monitor the maturity of the framework and support the refreshing of the research and innovation plan in 2024/25.

(f) The Committee Chair, Hannah Rowan, was appointed as **research champion** and is active in this role.

(g) **The Research and Innovation Report 2022/23** was presented to the Committee and provided to the Board. The report included a range of policy developments, projects, and activities conducted and reported through the Research and Innovation Department.

(h) A further iteration on a **mapping exercise** that was commenced in 2022 was reviewed, 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.

(i) 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.

(j) The Committee **cycle of business** was approved.

(k) The Committee received a presentation on **inter-professional simulation-based education and training** which is a pan-Wales project based on collaboration with the NHS and social care. The project seeks to reduce variability across the system and takes a whole workforce approach which is aligned to WAST's desire to democratise learning and research. The Committee thanked all those who were involved in this project and will continue to follow its roll out to a wider audience following peer review and academic publication.

(l) Craig Brown Specialist Clinical Lead for 111 (North) shared his **personal and professional journey of pursuing a PhD in public health and leadership**, with the support of Bangor University and WAST (particularly Mike Brady, Consultant Clinician and Nigel Rees, Assistant Director of Research and Innovation). Craig highlighted the benefits of this pathway for his own development, the 111 service, and the wider research community within WAST.

(m) There are no formal **risks** on the corporate risk register for this Committee, however the risks related to capacity to take forward the research and innovation agenda were discussed

(n) The **annual effectiveness review** was conducted in the January 2024 meeting.

16. Audit Wales observed the Committee as part of their 2023 Structured Assessment work and did not identify any concerns either in that report or separately on the effectiveness of meetings.

17. The Board received a highlight report from this Committee by email circulation following each meeting which included alerts, advice, and areas of assurance. This was also presented to the next public Board meeting by the Chair of the Committee.

TASK AND FINISH GROUP

18. The Committee is not currently serviced by a Sub-Committee but has established the task and finish group noted in this report. That group met regularly, developed a work plan and reported against that work plan to this Committee. Members were assured that it was functioning effectively and its remaining tasks which related to the handling of conflicts of interest of the appointed Academic Non-Executive Director, and the timeframe and logistics around the change of name on conferring of UTS were completed in March 2024.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

19. Extensive changes to the Terms of Reference for this Committee were made during the effectiveness reviews held in 2022. The changes this year are therefore minimal and include feedback from the Committee following the survey and the meeting on 16 January. The changes in the Terms of Reference are marked up in [Annex 1] and include a change to the purpose statement and a reduction in the Non-Executive Director membership of the Committee from four to three (including the Committee Chair).

20. It was felt that there was potential to change the name of the Committee given its wider remit and that that would be considered during 2024/25 once the academic Non-Executive Director has joined the Board.

21. In addition there will be some changes to operating arrangements which include:

(a) Drawing out the reporting and assurance with more particularity where possible, including elements of external reporting
(b) Clarity of reporting of key metrics for Research and Innovation, and legislative compliance
(c) Risk reporting where appropriate (an action carried over from the 2022/23 review)
(d) UTS remit of the Committee clarified once granted
(e) Arrange meetings to take place at education and training facilitates to develop understanding & improve visibility
(f) Report from chair following research champion events
(g) Continue work on research governance framework with a focus on its implementation at WAST
(h) Clarity on the purpose and focus of the Committee to be communicated to the wider organisation (an action carried over from the 2022/23 review)

COMMITTEE PRIORITIES

22. The Committee received an update on progress against its priorities at each meeting and reviewed overall progress at the October meeting via the mid-year UTS review. The Director leading each UTS priority is an attendee at the meetings.

23. As can be seen below, progress on agreed priorities has been good:

Priority	Progress
Task and Finish Group to scope out the next 12 months to UTS (including partners, any reciprocal arrangements, conflicts, name change, legislative docket).	The Group has held five meetings and reported to the Committee on a AAA report. An update on UTS progress was provided to the October meeting. The academic NED role profile was endorsed by the Committee in August and the non-executive director recruitment activity has begun. The academic role is out to advert with a closing date of the 29 October 2023. The Group closed its work in March 2024 and provided a close out report in April 2024.
Focus on the research governance framework, which is a new area of oversight for the committee.	A paper was received by the Committee on the Research Governance Framework at their August meeting. The Framework was adopted, and it was asked that all departments within the Trust conduct a self-assessment against the Framework. An update on the Framework return to the Health Council Research Wales was before the Committee at the October and January meetings. Future research governance activity / business will be considered within the agenda setting for the Committee.

24. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. Accordingly, the Committee has agreed the following priorities for 2024/25:

    (a) Risk reporting where appropriate.
    (b) Review the name of the Committee during 2024/25.
    (c) Clarity on the purpose and focus of the Committee to be communicated to the wider organisation

25. Progress on priorities will be reported to the Committee quarterly and to the Board through its highlight report.

NEXT STEPS

26. The next steps are as follows:
    (a) Ensure changes to operating arrangements agreed at paragraph 21 are cycled into work programme for review in 2024/25
    (b) Update the cycle of business with revised terms of reference

RECOMMENDATION

27. The Trust Board is requested to
    (a) Receive and note the contents of the Committee Annual Report for 2023/24 and analysis of its effectiveness; and
    (b) Approve the changes to the Terms of Reference.

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

ACADEMIC PARTNERSHIP COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS ~~2023-24~~2024-25

1. INTRODUCTION

1.1 The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government 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*".

1.2 In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the Academic Partnership Committee.

1.3 The Board Committees play an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions by the Board.

1.4 The Trust has made a commitment to recognise the importance of partnership working with a full range of academic partners and has established an Academic Partnership Committee to facilitate and develop this work and its remit is~~are~~ hereby set out in these formal terms of reference and operating arrangements.

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2. PURPOSE

2.1 The delegated powers and authority set out in these terms of reference reflects the maturing University Trust Status (UTS) journey and the fact that this committee approaches its remit with 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 appropriate arrangements are 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).

~~2.1~~2.2 The Committee recognises the wealth of knowledge, expertise and skill within the Trust, as well as the need to ensure that ~~that~~ skill and expertise is maintained at the forefront of clinical and professional excellence. It will ensure that its work is not predicated just on the development and support of clinical staff but, rather, of everyone across the organisation, whether they be in a clinical, professional or corporate role. ~~In so doing the Committee is responsible for:~~

~~2.2 Overseeing strategic collaboration and partnership working with higher and further education, wider education providers and commercial partners across and beyond Wales. Through this partnership working, the Committee will look to ensure that the Trust provides and strengthens patient safety and quality, identifies, and implements best practice and gains an international reputation for excellence and innovation.~~

2.3 ~~Promoting collaboration with partners in efforts to improve the health and wellbeing of the general population in Wales, and where their strategic aims and objectives align, to optimise the benefits to patient care and health care service delivery through an inclusive and supportive approach.~~

~~2.3~~2.4 The Committee will Facilitat~~inge~~ a forward-looking organisational culture with partners which:

(a) promotes quality improvement across all activities;
(b) is rich in educational activities and staff development opportunities;
(c) helps attract and retain the very best staff, including internationally leading clinical academics;

(d) facilitates research, grant capture by clinicians and academics and the translation of evidence research findings into practice;
(e) encourages innovation and modernisation;
(f) encourages multi-disciplinary work and access to new and emergent fields of research and evidence based practice;
(g) builds capacity for translational research that allows all parties to compete at an international level;
(h) integrates education, research and practice that looks beyond targets and entrenched ways of working, fostering a culture of learning and innovation based on evidence and best practice;
(i) facilitates wealth and economic growth in the region and beyond;
(j) supports the capture and analysis of the service user experience;
(k) develops health informatics opportunities to achieve their potential;
(l) Supports strategic planned lines of enquiry enabling knowledge creation.
(m)use of digital technology to enhance our services.

2.5 The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

2.6 The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

3. DELEGATED POWERS AND AUTHORITY

With regard to its role in providing advice and assurance to the Board, the Committee will:

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3.1 Promote and support the exploration of opportunities with higher and further education, wider education providers and commercial partners across and beyond Wales to:

(a) develop collaborative activities in relation to clinical and non-clinical services, research, and development, teaching and education, innovation and improvement, and commercial opportunities; and
(b) influence programme design.

3.2 Promote and support collaboration with key partners in health, social care, local authorities, and the third sector, as well as patients and patient representative groups, developing opportunities for widening access and increasing participation in health and social care education amongst local communities.

3.3 Ensure appropriate arrangements are in place with partner organisations that establishes role, responsibilities, and expectations, and supports the achievement of the highest standards of health, clinical care, research, innovation and health care education. Depending on the nature of the projects the risk to the parties should be understood and the appropriate mitigated action taken.

3.4 Oversee and contribute to the development of submissions to Welsh Government for University Trust Status and ensure the ongoing maintenance of that status and compliance with any conditions from Welsh Government.

3.5 Review and agree programmes of work aligned to University Trust Status, ensuring that they:

(a) explore and identify opportunities for the development of the whole workforce;
(b) are appropriately resourced, and where possible maximise the benefits of shared resources and expertise, and availability of grants;
(c) are clear where Board level scrutiny will take place, whether that is at this Committee or another Board Committee, to avoid duplication and support coalescence of Board oversight.

3.6 Monitor plans to build capacity for the whole workforce whether they be in a clinical, professional, or corporate role, to participate in research; that

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opportunities to do so are being promoted; and that the workforce is encouraged to be professionally inquisitive.

3.7 ~~Approve the research governance framework and o~~Oversee ~~its~~ the implementation of the research governance framework in accordance with the Health and Care Research Wales ~~Welsh Government~~ Research Governance Framework ~~for Health and Social Care~~.

~~Corporate~~ Principal Risks and Audits ~~Recommendation Tracker~~

3.8 ~~The Audit Committee has overall responsibility for ensuring that corporate risks are identified and are being properly managed within the Trust. The Audit Committee also has responsibility for ensuring that there are processes in place to address and take forward audit recommendations.~~ The Committee will monitor the principal risks relevant to its remit. ~~Nevertheless, each risk from the corporate risk register and Board Assurance Framework, and each recommendation from the audit tracker, will be allocated to an appropriate Board Committee who will be responsible for ensuring that the Trust is managing and progressing each item as planned. Regular reports will be provided to individual Committees on those items for which they have responsibility and overall Trust-wide progress reports will be presented to each Audit Committee. The~~ It will~~Committee will~~ consider the controls and mitigations of ~~high level workforce~~ related risks and provide assurance to the Board that such risks are being effectively controlled and managed.

3.9 The Committee will receive and gain assurance from internal and external audits in their remit. It will also monitor management actions to address recommendations via the audit tracker and where appropriate scrutinise the impact of actions in response to audit recommendations.

Authority

~~3.8~~3.10 The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

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~~3.9~~3.11 The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

~~3.10~~3.12 The Committee is authorised to approve Trust wide policies in accordance with the policy for the Review, Development and Approval of Policies.

Chair's Action

3.13 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

3.14 In these circumstances, the Chair and the Lead Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

3.15 The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Sub-Committees

~~3.11~~3.16 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4 MEMBERSHIP

Members

4.1 The core membership is a minimum of three members comprising:-

Chair	Non-Executive Director
Members	~~At least~~ T~~t~~wo other Non-Executive Directors of the Board.

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Prescribed Attendees

4.2 The core membership will be supported ~~routinely~~ by the attendance of the following at each meeting:-

- Director of Partnerships and Engagement (Committee Lead)
- Director of People and Culture
- Executive Director of Paramedicine
- Director of Digital Services
- Assistant Director for Quality and Nursing (Quality Governance)
- Assistant Director of Clinical Development
- Assistant Director of Research and Innovation
- ~~Research, Innovation, and Improvement Lead~~
- Head of Strategy Development
- Head of Workforce Education & Development
- Director of Corporate Governance/Board Secretary
- ~~Representatives from Academia~~
- Up to two Trade Union Partners

Other Directors and staff members will be invited to attend, either by the Committee or to present individual reports.

With the permission of the Chair, those in attendance may send a deputy in their place. This, however, does not affect the right of the Chair to require those listed above to attend.

The Committee may also co-opt additional 'external' invitees from outside the organisation to provide specialist skills, knowledge and expertise.

Secretariat

4.3 Secretary as determined by the Board Secretary

Member Appointments

4.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

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4.5 Non Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board. The Board should consider rotating a proportion of the Committee's membership after three or four years service so as to ensure the Committee is continuously refreshed whilst maintaining continuity.

4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

4.7 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.

Support to Committee Members

4.8 The Board Secretary, on behalf of the Committee Chair shall arrange for the provision of advice and support to committee members on any aspect related to the conduct of their role.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two core members must be present to ensure the quorum of the committee, one of whom should be the committee Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board Business.

Withdrawal of individuals in attendance

5.3 The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/ GROUPS

6.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees and groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of appropriate information;

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework.

6.3 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

(a) report formally to each Board meeting (as appropriate) on the Committee's activities, in a manner agreed by the Board. This includes a

written highlight report ~~verbal updates on activity~~, the submission of approved Committee minutes ~~and referral of written reports where appropriate~~, ~~and~~

~~(a)~~ bring to the Board's specific attention any significant matter under consideration by the Committee; and

(b)

~~(b)~~ ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (a~~nd~~s Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the presentation of an annual report, ~~;~~
operation and/or reputation of the Trust.

7.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum – (as set out in section 5)

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

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FINANCE AND PERFORMANCE COMMITTEE
ANNUAL REPORT 2023/24

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The Committee met on 19 March 2024 and reviewed its terms of reference, responses to questionnaires completed by members and attendees, and its operating arrangements. Discussions were also held with the Committee Chair and Executive Leads ahead of that meeting. This Annual Report reflects on the effectiveness of the Committee in 2023/24 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The Committee is established to enable scrutiny and review of the Trust's arrangements in respect of the:

   - overall financial position (both capital and revenue) of the Trust and its compliance with statutory financial duties.

- ability of the Trust to deliver on its core objectives as set out in the Integrated Medium Term Plan (IMTP).
- monitoring of the IMTP and ensuring achievement of key milestones.
- robustness of any cost improvement measures and delivery of key strategies and plans.
- ensure development of the long term strategy and delivery of the Trust's strategic aims in relation to value and efficiency, including an increased focus on benchmarking.
- scrutinise business cases for capital and other investment.
- oversight of the development and implementation of the digital, estates, fleet, and environmental strategies.
- business continuity including emergency preparedness, resilience and response, cyber security, and cyber resilience.

MEMBERSHIP AND ATTENDANCE

6. The Committee met six times in private and in public as scheduled in 2023/24 and was quorate on each occasion.

7. The Committee is supported by the Chair and three Non-Executive Directors as members, and several prescribed attendees with good attendance.

8. The chart below illustrates attendance of members and prescribed attendees as listed in the terms of reference for 2023/24. The Committee welcomed non prescribed attendees at various meetings as well as external guests.

9. It is not intended to change the membership of the Committee other than the introduction of Peter Curran, Non-Executive Director, as a member. This was welcomed particularly as he has a strong finance background.

COMMITTEE ATTENDANCE						
Name	**15 May 2023**	**17 July 2023**	**18 Sep 2023**	**13 Nov 2023**	**15 Jan 2024**	**19 Mar 2024**
Joga Singh						
Kevin Davies	Until 11.30am	Chair				
Bethan Evans						
Ceri Jackson						
Martin Turner		Left at 11.30	Left at 12.00			
Peter Curran						
Chris Turley		Navin Kalia				
Rachel Marsh		Hugh Bennett			Left 11-12	Hugh Bennett[1]
Lee Brooks	Sonia Thompson	Judith Bryce[2]	Judith Bryce		Jon Edwards	
Liam Williams	Wendy Herbert			J Turnbull-Ross		Left 11.30[3]
Angie Lewis	Liz Rogers					Left 11.30
Jonny Sammut						
Leanne Smith			Aled Williams			
Hugh Parry						From 10.00am
Damon Turner						
Trish Mills				Julie Boalch		

	Attended
	Deputy attended
	Apologies received
	No longer member

COMMITTEE'S VIEWS ON EFFECTIVENESS

10. The Committee's effectiveness was assessed through a review of its terms of reference, responses to a questionnaire, discussion with the Chair and Executive Leads, and at the 19 March Committee meeting.

11. The questionnaires provided an opportunity to gauge opinion on areas of good practice and areas that require improvement. Sixteen questionnaires were sent out with seven responses being returned (a 43.75% return rate which is better than 2022/23).

12. Respondents were asked 27 questions and were encouraged to provide free text answers to explain or expand on their choices. It is often difficult to pinpoint the exact issue or example in mind when reviewing the free text, however all responses were discussed with the Chair and Executive Leads. The responses were also reviewed by the Committee on 19 March against the same questions from last year and the majority of the scores were an improvement from 2022/23.

13. With respect to the remit and volume work of the Committee, whilst it was felt that the agenda could be challenging at times, the remit is appropriate, balanced, and achievable. With respect to Trade Union Partner contributions, a more focused discussion with Committee Chairs and Trade Union colleagues is planned to ensure that they are supported in these meetings. With respect to team working, there

was a view that there was not a strong holding to account for late papers. This was discussed with the Chair and Executive Leads, and it was acknowledged that the MIQPR is often a late addition to ensure timeliness of data, but that it was important to ensure discipline for the majority of papers to be available seven days before the meeting to enable members plenty of time to read and digest them, and to seek any clarifications from Executives. This was usually achieved throughout the year.

14. Clarity on the role of this Committee regarding oversight of the Monthly Integrated Quality and Performance Report (MIQPR) was sought as opposed to the oversight of the People and Culture Committee and Quest Committee. A refresher on the MIQPR will be provided for the Board in 2024/25 to provide this.

15. Bringing in the full remit of the information governance and security was sought, which has been done for 2024/25. Other areas of focus included the need to ensure that agenda items and actions are closed off and that there is more time to offer up reflections at the end of the meeting. There were some mixed views on the Committee leadership, however there was no elaboration where respondents disagreed, noting however that Committee Chair encouraged free-flowing debate without asserting too strong a personal view on members.

16. As with other Board Committees, the question related to visibility of Committee members scored poorly. Given that there is a Board visits Standard Operating Procedure in place which illustrates members visibility, it is anticipated that this question will be omitted from the 2024/25 survey. The rationale being that it is unlikely, no matter how visible a Non-Executive or Executive Director may be, that that will always resonate with each Committee.

17. Good practice drawn out in responses included:

- The Chair allows free flowing debate and does not impose strong personal views.
- Feedback to the Board reflects challenge and scrutiny by members.
- Reports / information given to the Committee is of high quality.
- Clear reporting and escalations to the Board via AAA report.
- Strong focus on appropriate business, with balanced agenda and diverse topics.

18. Areas to strengthen include:

- Clarity on which areas of the MIQPR the Committee should be reviewing vs other Committees.
- Increase those with finance skills / experience within the membership.
- Holding the Executive to account for delays or missing assurances.
- Greater clarify on managing and closing off actions.
- Improving visibility – more visits / publication of visits to relevant stakeholders.
- Greater contributions from TU Partners

19. The Committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the Committee and in this respect, it has discharged its responsibilities in providing assurance to the Board. The Committee's business in 2023/24 included the following, full details of which are in the Committee's AAA reports and minutes provided to the Board:

    19.1. **Operational updates** are received at each meeting and often generate a good deal of discussion, particularly related to system pressures.

    19.2. The proposed **Board and Committee Level Key Performance Indicators for 2023/24** were presented to the Committee and endorsed at their July meeting. Additionally, the **MIQPR** is monitored at each meeting, with a particular focus on handover delays, lost hours and system pressures and the effect of this on performance. Notwithstanding this, good performance was noted throughout the year on ROSC (return of spontaneous circulation), Ambulance Care, and 111 performance.

    19.3. **Financial performance** was monitored at each meeting, including budget position on revenue and capital. In addition to reviewing risk 139 (*the failure to deliver our statutory financial duties in accordance with legislation)* at each meeting and following its change in scores in the latter part of the financial year. There was a deep dive conducted on the risk in Month 1. The Board was alerted in September and November with respect to the clarity of funding sources for the additional 100 WTE appointed in 2022/23.

    19.4. The Initial **2024/25 Revenue Budget** was received and endorsed by the Committee in February 2024.

19.5. The final 2022/23 **financial performance report for Month 12** was presented at the May 2023 meeting with a small revenue surplus reported of £62k, capital expenditure fully spent, and gross savings of £4.392m have been achieved against a target of £4.300m. In addition, the Public Sector Payment Policy was reported as on track with performance, against a target of 95%, of 97.4% for the number, and 97.8% of the value of non NHS invoices paid within 30 days. The Committee congratulated all directorates for achieving this end of year position.

19.6. The Committee received regular reporting on the **financial sustainability programme** and the identified initiatives including the support services review; service review; recruitment control panel; operations savings group; and income generation group.

19.7. The **Capital Assurance: Vehicle Replacement Programme Internal Audit** (reasonable assurance) was received at the March 2024 meeting.

19.8. The Committee received an update on the delivery of the **Integrated Medium Term Plan** (IMTP) 2023-26 at each meeting with issues of delivery escalated where necessary. In May 2023 it reviewed the end of year position with respect to the 2022-25 IMTP and congratulated the team for the significant amount of work that was achieved against the backdrop of a very difficult Winter in 2022/23 and prolonged industrial action. Updates on the development of the IMTP 2024-27 were received, as was the final version for endorsement to the Board in March 2024.

19.9. The **Strategy Development Internal Audit** (reasonable assurance) was received at the March 2024 meeting.

19.10. The **structure and governance for the Strategic Transformation Board** and its programmes was reviewed and the Committee was assured that these were appropriate and clear

19.11. The Committee received a number of reports on **Emergency Preparedness, Resilience and Response (EPRR)** and were assured as to EPRR arrangements and leadership. The **Welsh Government Annual Emergency Planning Report** was also reviewed regarding the Trust's compliance and readiness to meet its obligations under the Civil Contingencies Act 2004. Later in the year 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) increased in score from 15 to 20 and was escalated to the Board.

19.12. The Committee was assured that good progress was being made against the applicable actions for WAST from the **Manchester Arena Inquiry.** The Trust's **Incident Response Plan v.2.0** was presented in private session in November 2023. The updates to the plan include recommendations from the Manchester Arena Inquiry.

19.13. The **Business Continuity Annual Report** was received in November 2023 and also presented at Board. The Committee were assured that the necessary plans and business continuity arrangements are in place for the most significant risks. The Trust also holds plans for terror attacks, disruption of telecommunications, extremes of weather, flooding etc.

19.14. The Committee has the review of matters relating to **demand and capacity** plans in their remit and an update was received at this meeting. The EMS, NEPTS and 111 demand and capacity reviews were discussed as were current packages of work. Notwithstanding the absence of a formal framework, the Committee was reassured that the Trust's focus on forecasting and modelling, with both external and internal support, was strong and has led to significant transformation work programmes. At the March 2024 meeting a verbal update was received on the **strategic demand and capacity review**. A tactical **Winter forecasting and modelling report for 2023/24** was received in November 2023.

19.15. An update on the Decarbonisation Action Plan (DAP) was received by way of the **Environment, Decarbonisation and Sustainability Update** for April 2023, September 2023 and January 2024. The DAP has a range of actions which frame the Trust's decarbonisation response. Notwithstanding the very positive progress, the sheer volume of work, resource and capacity constraints remains of concern for WAST's delivery of the DAP – an issue which all NHS Wales organisations are experiencing, as set out in the limited assurance **internal audit on Decarbonisation**. The Committee noted that this review was conducted across all NHS Wales Health Bodies and that all have been given a limited assurance rated, therefore WAST is not an outlier. The significant work the Trust has been undertaking to address the requirements of the DAP were recognised in the report, however the overall rating reflects the complexity and range of risks associated with this area

which, along with the financial shortfalls, impacts on the Trust's ability to deliver on the wider decarbonisation agenda.

19.16. In September the Committee escalated to the Board the fact that the **Sustainability Report**, which they later approved, presented 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 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.

19.17. In September 2023 and March 2024 updates were received on progress against the April 2022 limited assurance **Waste Management Internal Audit** 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 the September meeting.

19.18. The annual **Fire Safety Compliance** report was received by the Committee in January 2024 with no issues to escalate to the Board. The limited assurance (All Wales) **Estates Condition Internal Audit Report** was received, and it was noted that this was limited across all NHS Wales Health Bodies, therefore WAST is not an outlier. The rating is based on the lack of a funded strategy to address the backlog of maintenance and the inconsistency of reporting across Wales.

19.19. The **Electronic Patient Care Record (ePCR) Benefits Realisation** report was received in May 2023 which had streamlined the benefits and included a five year plan to realize benefits for ePCR which will now be transitioned to business as usual, and owners identified to take these forward. Assurance on the decommissioning of the digital pen patient clinical report system following an extension to ensure patient information was also provided.

19.20. A Welsh Government gateway review of the WAST **Mobile Data Vehicle Solutions** was received in September 2023, 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.

19.21. In September 2023 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. The **111 Commissioning Advisory Report** from Internal Audit was received in January 2024 looking at 111 commissioning arrangements with the Committee noting that there are elements of that which are within the control of commissioners rather than WAST and that new national commissioning arrangements will be in place from 1 April 2024.

19.22. **Value based healthcare updates** were received in November 2023 and March 2024 which set out the progress of the key workstreams within its portfolio. The work programme includes the following seven workstreams – Patient Recorded Outcome Measures (PROMS), Patient Data Linkage, Patient Recorded Experience Measures (PREMS), Patient Level Information and Costing System (PLICS), Revenue Business Case Process, Evaluation Framework & Methodology, and Benchmarking. All workstreams are progressing well.

19.23. The Committee reviewed the reasonable assurance **IM&T Infrastructure Internal Audit Report** (reasonable assurance)**,** the overall objective of which was to provide assurance over the management and operation of the WAST Information Management and Technology (IM&T) Infrastructure. The reasonable assurance **ICT Capital Management Internal Audit** (reasonable assurance) was received at the March 2024 meeting.

19.24. A priority of the Committee for 2023/24 was the oversight and monitoring of the **digital strategy**. The Committee reviewed progress on the plan in

September 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.

19.25. The initial suite of **Digital KPIs** was received in September 2023 to provide assurance on the performance, work activities and contribution of the Digital Directorate to the Trust's Strategy and IMTP. These were monitored in subsequent meetings. In private session members were presented with the cyber highlight report for the period April to July 2023 and a detailed cyber activity report for July 2023.

19.26. The reasonable assurance **Cyber Security Internal Audit Report** was reviewed in private session due to confidentiality.

19.27. Members **reflections** after each meeting included:

- Diversity of the agenda which was supported by a more structured cycle of business.
- Flexibility from the Chair and members in taking some items out of order to allow the free flowing of discussion was effective.
- Due to the lateness of papers for the May 2023 meeting (predominantly the open agenda) it was difficult to allocate time with predictability in the week prior and members sought to see improvements in this.
- It was noted that the completion of cycles of business for all Committees will provide predictability and that a paper will be presented to ELT on 7 June setting out meeting timelines.
- Good focus on the impact of the financial challenges on our patients and our people.
- The financial position of the Trust has a direct impact on the ability of the Trust to deliver a safe service and acknowledged the direct relationship between organisational performance and patient safety and outcomes. The Members were assured that all actions within the Trust's control were being taken to mitigate the risks and issues observed but expressed concern over the continued challenges exacerbated by wider system pressures.

- 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.
- Welcomed scrutiny, challenge, and support on the financial position.
- Internal Auditors and Audit Wales were present which was appreciated.
- The quality of papers was good which allows members to scrutinise and question, and responses from management were clear.
- From a financial perspective the papers were clear and transparent, and the answers were well made, so members were assured that the outturn for this year and next year's budget have been fully thought out.
- Good to see a pragmatic approach to closing down audit actions when nothing further can be advanced by the Trust.
- The focus on our people was welcomed as being considered alongside the financial and performance aspects.

19.28. The **backlog of policies** – particularly those relevant to this Committee - was reviewed and escalated to the Board as an alert. A priority order of policies for review in 2023/24 was endorsed.

19.29. The Committee **cycle of business** was approved.

19.30. In the February 2024 closed session members received an update on the **CAS replacement programme** with the Committee receiving assurance that the programme is on track for go live on 30th April 2024. The level of commitment demonstrated by the team working on this was recognised by the members and they were thanked for their intense focus.

19.31. **Risks** relevant to this Committee are reviewed at each meeting and the agenda is driven by these risks. The highest rated risks, 139 (failure to deliver our statutory financial duties in accordance with legislation) and 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), were the focus and drive agenda setting. Other risks related to cyber security, loss of critical IT systems, and recurrent funding from commissioners were reviewed regularly.

19.32. The **annual effectiveness review** was conducted in the March 2024 meeting.

19.33. The revised **Audit** tracker and process was reviewed, and good progress is being made to close management recommendations.

19.34. The **Committee's priorities for 2023/24** are reviewed at each meeting and a more detailed update appears later in this report. The Committee also reviews progress against its cycle of business at each meeting.

20. In private session the Committee took matters that were commercially sensitive and confidential. Most matters made their way to the Trust Board private session and where appropriate were reported in open session in accordance with the Standing Orders. Other matters taken in private session included the capital programme and prioritisation.

21. The Board received a highlight (AAA) report from this Committee by email circulation following each meeting which included alerts, advice, and areas of assurance. Where there was a shorter proximity of the meeting of this Committee and the Board meeting, that report was provided verbally by the Chair and captured in the Board's minutes.

22. The Committee is not serviced by any Sub-Committees or task and finish groups that this time.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

23. Extensive changes to the Terms of Reference for this Committee were made during the effectiveness reviews held in 2022. The changes this year include feedback from the Committee following the survey and the meeting on 19 March. The changes in the Terms of Reference are marked up in [Annex 1] and include:

- The information governance and information security remit has been transferred from the Quality, Patient Experience and Safety Committee. This will allow all areas of digital to be within the remit of this Committee, including IT infrastructure and strategy, information governance and information security, and cyber security. The Director of Digital who is the Senior Information Risk Officer (SIRO) and the Executive Director of Quality and Nursing who is the Caldicott Guardian are both members of this Committee.

- Paragraph 3.18 has been amended to provide that directorate specific plans aligned to the long term strategy 'Delivering Excellence' will be *received* by this Committee rather than *reviewed for alignment*. It is a matter for the Committees who have specific remit over a plan to ensure alignment, for example when the People and Culture Plan was reviewed by the People and Culture Committee they were assured as to alignment to the long term strategy. The amendment will require new 'plans' to be received and shown on an organogram of aligned plans to the long term strategy.
- Clarity that the Audit Committee will receive assurance on the *implementation* of the Quality and Performance Management Framework and that this Committee will receive assurance on its *effectiveness and the value of outcomes* the framework produces.
- A change in the narrative on assurance to provide clarity on approach.
- Changes in the narrative on risk and audit to streamline responsibilities.
- Specific chair's action provision inserted, particularly given the significant number of policies which are due for approval in 2024/25.

24. Changes in operating arrangements in 2024/25 to address issues raised in the survey will include:
    - MIQPR orientation refresher: interpretation and triangulation – to be scheduled in 2024/25
    - Trade Union Partner and Committee Chair induction session to be held.

COMMITTEE PRIORITIES

25. The Committee received an update on progress against its priorities at each meeting. The 2023/24 priorities were:

Priority	Progress
Focused oversight on the implementation of the digital strategy.	• A Digital Strategy Plan update was given to the Committee at its meeting on the 18 September 2023 by the Interim Director of Digital Services. This report gave a snapshot of the current position and relevant data from the period 01 April 2023 – 31 July 2023. • At the September meeting the Committee also

Priority	Progress
	endorsed the related metrics as presented by the Interim Director of Digital Services. The metrics for digital systems infrastructure will be received (in line with the agreed reporting) on 13 November 2023. • In September, the Committee noted that the recent appointment of the new Director of Digital Services may affect the strategy implementation timeline. • In November, the Committee noted that an update on the progress against the Digital Strategy would likely be programmed for either the January or March 2024 meeting of the Committee. • Receipt of an update on the implementation of the Digital Strategy will be programmed for the May 2024 meeting of the Committee.
Focused oversight on the implementation of the Quality and Performance Management Framework (QPMF)	As of September 2023, oversight of this has moved to the Audit Committee. The Committee's ToR require that it "review the effectiveness of the Trust's Quality and Performance Management Framework and receive assurance on the value of outcomes produced by the framework". As above, the Committee will remain responsible for reviewing of the effectiveness of the QPMF once the Framework has been implemented. The Committee Cycle of Business will be updated to reflect the change in oversight of implementation of the Framework to Audit Committee.

26. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. Accordingly, the Committee has agreed the following priorities for 2024/25:

    (a) The development and approval of the Digital Plan.
    (b) Oversight of the potential commercialisation streams in the Financial Sustainability Programme.
    (c) Focus on the new elements of its terms of reference relating to Information Governance and Information Security.

27. Progress on priorities will be reported to the Committee quarterly and to the Board through its highlight report.

NEXT STEPS

28. The next steps are to update the cycle of business with revised terms of reference

RECOMMENDATION

29. The Trust Board is requested to
    (a) Receive and note the contents of the Committee Annual Report for 2023/24 and analysis of its effectiveness; and
    (b) Approve the changes to the Terms of Reference and operating arrangements.

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

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS ~~2023/24~~2024/25

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government 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*".

1.2. In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Finance and Performance Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3. The Board Committees play an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions by the Board.

2. PURPOSE

The purpose of the Finance and Performance Committee (the Committee) is to enable scrutiny and review of the Trust's arrangements in respect of the:

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2.1 overall financial position (both capital and revenue) of the Trust and its compliance with statutory financial duties;

2.2 ability of the Trust to deliver on its core objectives as set out in the Integrated Medium Term Plan (IMTP);

2.3 monitoring of the IMTP and ensuring achievement of key milestones;

2.4 robustness of any cost improvement measures and delivery of key strategies and plans;

2.5 ensure development of the long term strategy and delivery of the Trust's strategic aims in relation to value and efficiency, including an increased focus on benchmarking;

2.6 scrutinise business cases for capital and other investment;

2.7 oversight of the development and implementation of the digital, estates, fleet, and environmental strategies; ~~and~~

2.8 information governance and information security; and

~~2.8~~2.9 business continuity including emergency preparedness, resilience and response, cyber security, and cyber resilience.

~~2.9~~2.10 The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

2.11 The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

3. DELEGATED POWERS AND AUTHORITY

With regard to its role in providing advice and assurance to the Board, the Committee will specifically:

Finance

3.1 Oversee and contribute to the medium and long term financial strategy, in relation to both revenue and capital;

3.2 Monitor the Trust's in-year and forecast revenue financial position against budget and review and make appropriate recommendations for corrective action to address imbalances;

3.3 Review progress against the Trust's annual operating framework and make recommendations to the Board in relation to development of the annual financial plan and budget setting and long term financial strategy and financial sustainability programmes, efficiency review implementation and required savings targets;

3.4 Monitor progress against the Trust's capital programme, scrutinise, approve or recommend for approval (where appropriate) business cases for capital investment. This will include those then submitted to Welsh Government for approval via Trust Board;

3.5 Receive assurance that a business case post implementation review is in place and is effective; review post implementation reviews on specific business cases and capital investment schemes from time to time;

3.6 Receive, review and ensure mitigation of financial risks of delivery of plans;

3.7 Monitor progress against a range of key developments and capital schemes, either in development through the business case process or in implementation;

3.8 Review performance against the relevant Welsh Government financial requirements;

Value Based Healthcare

3.9 Receive assurance on ~~ensure~~ delivery of core aims in relation to delivering value and development of value based health care in an out of hospital setting;

Performance

3.10 Review performance against targets and standards set by Commissioners and/or Welsh Government for the Trust and, where appropriate, against national ambulance quality indicators;

3.11 Monitor and review progress against the Trust's Integrated Medium Term Plan and obtain assurance on the efficient management and delivery of corporate projects and those associated within the agreed strategic transformation programme and its associated work streams;

3.12 Review the effectiveness of the Trust's Quality and Performance Management Framework and receive assurance on the value of outcomes produced by the framework, noting that in 2024/25 the Audit Committee will receive assurance on the implementation of the framework;

3.13 ~~agree~~ Endorse and monitor progress against Trust wide key performance indicators and ensure the development of robust intelligent targets;

3.14 Monitor and review plans to recover areas of underperformance, reviewing where appropriate associated KPIs as part of any deep dives, and providing assurance to the Board and escalating as required;

Planning

3.15 oversee and contribute to the development of the Trust's long term strategy 'Delivering Excellence: Our vision for 2030', and make recommendations to the Board for its approval/amendment;

3.16 Oversee and contribute to the development of the Trust's Integrated Medium Term Plan (IMTP) and ensure alignment of that plan with Delivering Excellence: Our vision for 2030;

3.17 Monitor the effectiveness of commissioning arrangements with the Local Health Boards via the ~~Emergency Ambulance Services Committee~~appropriate commissioning forums;

3.18 ~~Review service or directorate specific long term plans and ensure they align to 'Delivering Excellence: Our vision for 2030', and are incorporated into the IMTP or, where relevant, local directorate plans. It is noted that other Board Committees will review specific long term plans in detail however this~~

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~~Committee will hold a central overview of all service or directorate specific long term plans. The Committee will not oversee local directorate plans; and~~Hold a central overview of all service or directorate specific long term plans that align to the long term strategy. These plans will be reviewed for alignment by the relevant Committee first and their implementation will be guided by the IMTP or relevant local directorate plans;

3.19 Review and consider matters relating to demand and capacity including proposals for reviews in this area and recommendations arising from such reviews.

Estates and Fleet

3.20 Oversee, contribute to, and receive assurance on ~~monitor~~ the implementation of, the Estate ~~Strategy~~Plan.

3.21 Oversee, contribute to, and ~~monitor~~ receive assurance on the implementation of, the Fleet ~~Strategy~~Plan.

3.22 Review proposals for acquisition, disposal, and change of use of land/buildings.

Environmental and Sustainability

3.23 Oversee, contribute to, and ~~monitor~~ receive assurance on the implementation of the Environmental Strategy

3.24 ~~ensure~~ Receive assurance on compliance with environmental regulations and national targets

Digital Systems and Strategy

3.25 Oversee, contribute to, and ~~monitor~~ receive assurance on the implementation of, the Digital ~~Strategy~~ Plan;

3.26 Review projects and monitor implementation and delivery of benefits of major digital and information/reporting projects.

Business Continuity and Cyber

3.27 Oversight and scrutiny of the Major Incident Plan and Business Continuity Plan and receive assurance that such plans are effective.

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3.28 Oversight and scrutiny of cyber resilience including assurance on awareness and training of WAST staff and volunteers; maintenance of upgrades/updates of systems, and replacement of legacy/high-risk systems; and

3.29 Oversight and scrutiny of cyber security including assurance of regular monitoring of risks and threats, business continuity planning and engagement with national cyber centres and stakeholders.

Information Governance and Information Security

3.30 Receive assurance the information governance and information security arrangements are appropriately designed and operating effectively to ensure the reliability, integrity, safety, and security of information to support the delivery of high quality, safe healthcare across the organisation.

3.31 Review progress of measures to improve information security and adherence to Caldicott principles against the Information Governance Toolkit, Network and Information Systems (NIS) Directive (2018), Data Protection Act (2018), and receive assurance on compliance with relevant standards, legislation and regulations.

3.32 Receive assurance on, and review effectiveness of the Trust's information security protocols.

3.33 Review performance of the Trust in relation to statutory and mandatory information requests and reporting requirements including but not limited to freedom of information requests, data breaches, police requests and subject access requests.

Policies

~~3.30~~3.34 ~~Oversight~~ Approval of policies within the remit of the Committee

Corporate Risks and Audit ~~Recommendation Tracker~~

3.35 The ~~Audit~~ Committee will monitor the principal risks relevant to its remit and ~~has overall responsibility for ensuring that corporate risks are identified and are being properly managed within the Trust. The Audit Committee also has responsibility for ensuring that there are processes in place to address and take forward audit recommendations. Nevertheless, each risk from the corporate risk register and Board Assurance Framework, and each recommendation from the audit tracker, will be allocated to an appropriate~~

~~Board Committee who will be responsible for ensuring that the Trust is managing and progressing each item as planned. Regular reports will be provided to individual Committees on those items for which they have responsibility and overall Trust-wide progress reports will be presented to each Audit Committee. The Committee will~~ consider the controls and mitigations of ~~high level~~ related risks and provide assurance to the Board that such risks are being effectively controlled and managed.

3.36 The Committee will receive and gain assurance from internal and external audits in their remit. It will also monitor management actions to address recommendations via the audit tracker and where appropriate scrutinise the impact of actions in response to audit recommendations.

Authority

~~3.31~~3.37 The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

~~3.32~~3.38 The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

~~3.33~~3.39 The Committee is authorised to approve Trust wide policies in accordance with the policy for the Review, Development and Approval of Policies.

Chair's Action

3.2 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

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3.3 In these circumstances, the Chair and the Lead Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

3.4 The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Sub-Committees

~~3.34~~3.40 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-committees may only be established with the agreement of the Board.

4. MEMBERSHIP

Members

4.1 The membership of the Committee should include at least one member of the Trust's Audit Committee and will comprise:

Chair	Non-Executive Director
Members	Three further Non Executive Directors of the Board.

Prescribed Attendees

4.2 The membership will be supported routinely by the following core attendees:

- Executive Director of Finance and Corporate Resources (Joint Committee Lead)
- Executive Director of Strategy, Planning and Performance (Joint Committee Lead)
- Executive Director of Operations
- Executive Director of Quality and Nursing
- Director of People and Culture
- Director of Digital
- Trade Union Partners (x 2)
- Board Secretary

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- Chairs of Sub-Committees (if any)

4.3 The Trust Board Chair and Chief Executive will have a permanent standing invite to attend the Committee.

4.4 The Committee Chair may extend invitations to attend committee meetings to other Directors and/or Senior Managers, and to officials from within or outside the organisation to attend all or part of the meeting to assist with its discussions on any particular matter.

4.5 Members may send deputies in their absence who will act with their full authority. 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.

Member Appointments

4.6 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

4.7 Non Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.8 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

Secretariat and Support to Committee Members

4.9 The Board Secretary, on behalf of the Committee Chair, shall:

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(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of People and Culture.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two of the four members of the Committee must be present to achieve a quorum. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.

Frequency of Meetings

5.2 Meetings shall be held bi-monthly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board Business. Meeting agendas, papers and minutes shall be circulated no less than seven days prior to each meeting.

Withdrawal of individuals in attendance

5.3 The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/ GROUPS

6.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and

- sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework.

6.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.4 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

(a) report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports where appropriate throughout the year;

(b) bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the

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following areas:

- Quorum (as set out in section 5)

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

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PEOPLE AND CULTURE COMMITTEE
ANNUAL REPORT 2023/24

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The Committee met on 20 February 2024 and reviewed its terms of reference, responses to questionnaires completed by members and attendees, and its operating arrangements. Discussions were also held with the Committee Chair and Executive Lead ahead of that meeting. This Annual Report reflects on the effectiveness of the Committee in 2023/24 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The Committee is established to enable scrutiny and review of the Trust's arrangements for all matters pertaining to its workforce, both paid and volunteer, and organisational culture and behaviour to a level of depth and detail not possible in Board meetings. The Committee will provide assurance to the Board of the Trust's leadership arrangements; behaviours and culture; training, education and development ; equality, diversity and inclusion; health, safety and welfare; people

and culture related partnerships and engagement; the Welsh Ambulance Services Partnership Team (advisory group); and Welsh Language, in accordance with its stated objectives and the requirements and standards determined by the Welsh Government, the NHS in Wales and other regulatory bodies.

MEMBERSHIP AND ATTENDANCE

6. The Committee met four times as scheduled in 2023/24 and was quorate on each occasion.

7. The Committee is supported by the Chair and three Non-Executive Directors as members, and several core attendees with good attendance.

8. The chart below illustrates attendance of members and prescribed attendees as listed in the terms of reference for 2023/24. The Committee welcomed non prescribed attendees at various meetings as well as external guests.

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			Hugh Parry
Ian James				
Tim Chalane				

	Attended
	Deputy attended
	Apologies received
	No longer member

9. The Chair of the Committee, Paul Hollard, completed his eight year tenure on the Board on 31 March 2024. This Chair of this Committee will be Ceri Jackson from 1 April 2024.

10. The survey results indicated that the Committee meetings were well led with the Chair coordinating meetings with exemplary style.

COMMITTEE'S VIEWS ON EFFECTIVENESS

11. The Committee's effectiveness was assessed through a review of its terms of reference, responses to a questionnaire, discussion with the Chair and Executive Lead, and at the 20 February Committee meeting.

12. The questionnaires provided an opportunity to gauge opinion on areas of good practice and areas that require improvement. Twenty questionnaires were sent out with seven responses being returned (a 35% return rate which is slightly lower than 2022/23). This survey was sent out in December which may have affected the return rate.

13. Respondents were asked 27 questions and were encouraged to provide free text answers to explain or expand on their choices. It is often difficult to pinpoint the exact issue or example in mind when reviewing the free text, however all responses were discussed with the Chair and Executive Lead. The responses were also reviewed by the Committee on 20 February against the same questions from last year.

14. On the themes of the Committee's focus and quality of information there were several comments on the length of the agenda, meetings and papers. These included that this felt unmanageable and impacted the ability of members to have appropriate discussion, and that more focus was required to address this at agenda setting. This was discussed with the Chair and Executive Lead and the terms of reference were reviewed to see where reductions in remit could be accommodated. It was felt this was not appropriate but that the next iteration of the cycle of business would need to reflect any attempts to combine assurance reporting, particularly as it relates to the MIQPR and people and culture metrics which respondents felt were duplicative and needed to be more concise for the remit of the Committee. Agenda setting meeting take place with the Chair and Executive Lead well in advance of the next meeting to ensure that papers are commissioned in a way that focuses the agenda on risks and priorities. The length of the meeting is reviewed at that time as well as a separate meeting with the Executive lead a week before papers close to revisit timing, focus and flow.

15. There was also a comment that not all members contribute to discussion or provide challenge. Whilst that could relate to the issue above on length of papers and agenda, the results relating to the leadership of the Committee indicates that those surveyed feel that Chair allows debate to flow freely without inhibiting contributions.

16. On the theme of Committee team working, whilst scores increased from last year, there was one comment that key risks are not discussed and that assurances providers are not necessarily held to account for late or missing assurances. Without understanding more about this comment, it is difficult to pinpoint the exact issue; however, the agenda is set with the highest rated risks set out on the draft agenda and the cycle of business prioritised around those risks, with relevant deep dives where required as can be seen from the work programme below. There is a risk management and BAF paper at each meeting with the detailed risk description, controls, assurances against controls, gaps, actions and progress against these. In that respect members and attendees have information before them to challenge progress and understand more fully the context of the risks and mitigations. Regular monitoring of the cycle of business, the action log and forward planner are in place to capture matters carried over. There is more work to be done on the monitoring report to make it clearer for 2024/25.

17. As with other Board Committees, the question related to visibility of Committee members scored poorly. Given that there is a Board visits Standard Operating Procedure in place which illustrates members visibility, it is anticipated that this question will be omitted from the 2024/25 survey. The rationale being that it is unlikely, no matter how visible a Non-Executive or Executive Director may be, that that will always resonate with each Committee.

18. Each meeting hears a lived experience of our people however there was a comment that these need to be more balanced on what went well and what did not go so well. A Trade Union Partner report was suggested to provide further context of partnership successes and challenges. The Director of People and Culture has recommended that a Trade Union 'spotlight' be included in her report to draw this out, and in addition to the WASPT AAA report, the approved minutes will also be part of the pack of papers for the Committee.

19. Good practice drawn out in responses included:

- Meetings are very well Chaired and run effectively.
- Chair is visible across the Trust.
- Reports / information given to the Committee are of high quality.
- Clear reporting and escalations to the Board via AAA report.
- Strong focus on appropriate business and activities which affect staff well-being, e.g. staff stories.

20. Areas to strengthen include:
    - Reduce the volume and length of papers to give more focused content.
    - Clarification for members ref role / expectations on Trade Union Partners.
    - Reporting on Trade Union successes and challenges.
    - Understanding and resolving duplicative reporting around performance metrics.
    - Greater balance for the Committee where things haven't gone well.
    - Improving visibility – more visits / publication of visits to relevant stakeholders.

21. The Committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the Committee and in this respect it has discharged its responsibilities in providing assurance to the Board. The Committee's business in 2023/24 included:

    21.1. The Committee welcomed the **change of name of the Workforce and Organisational Development Directorate** to the People and Culture Directorate, with Angie Lewis now known as the Director of People and Culture. This aligns to the Committee's remit and reflects the commitment of putting our people first and creating a positive workplace culture.

    21.2. The **People and Culture Plan** was presented in May and subsequently approved by the Board. The year one priorities and the communications strategy to accompany it was discussed. Metrics, both quantitative and qualitative, have been shared with the Committee throughout the year as have cultural themes and trends.

    21.3. The **culture review tool** was presented as a practical tool to deliver cultural change. It was thought to be particularly helpful for local managers.

    21.4. **The lived experiences of our people** were shared at the meetings:

- In May the Committee heard from **Fatehullah Tahir** as a follow-up from the experiences he shared in November 2022 of the challenges working at an organisation lacking in diversity in terms of ethnicity and faith. Members heard that Fatehullah, who is our Organisational Development Manager, felt that whilst it was helpful to share his story, fundamentally nothing had changed, although he recognised that culture change can be slow to take effect and that several initiatives were in place and are planned under the people and culture plan.

- In August **Ian Cross**, Voluntary 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.

- In November rather than hearing from individual, **feedback** was presented that had been collected from our people after recent CEO Roadshow.

- In February **Darren Anthony** joined the meeting to share his story. Darren is a newly qualified EMT 2 who joined WAST in September 2020 after working in various private and public sector jobs, including the leisure industry. Darren completed the Level 4 diploma for Associate Ambulance Practitioners, which is an accredited education program for EMT 2 roles. He was determined to excel on the course and achieved the highest marks. He also won the Skills for Health Apprentice of the Year Award for his achievement.

21.5. The February 2024 the meeting had a deliberate focus on equality, diversity and inclusion, with the first part of the meeting exclusively given over to this important topic. The Chair welcomed other Board members to the meeting for this spotlight which included the endorsement of the **Strategic Equality Plan 2024-28**, the **Annual Workforce Equality Monitoring Report for 2022/23** and the annual **Gender Pay Gap Report 2022/23.**

21.6. A deep dive was conducted regarding **recruitment outcomes for Black, Asian and Minority Ethnic communities** with a review undertaken of applications from April 2022 to March 2023. WAST receives a positive level of applications at circa 9% of all those received, against census data of 5%, but a significant number are not successful at shortlisting. There is recognition of the need to get upstream with some roles e.g. paramedics, and work with university partners on attracting a more diverse range of students or look at opportunities to link into other providers with a more diverse student population.

21.7. Members were assured on progress against the **Anti-Racist Wales Action Plan** in year, and were presented with the Welsh Government **LGPTQ+ Action Plan** published by Welsh Government in February 2023. The plan sets out an overarching vision to improve the lives of, and outcomes for, LGBTQ+ people. Whilst some elements await further direction from Welsh Government, the Committee was assured on progress.

21.8. The **Speaking Up Safely** Task and Finish Group completed its work, recommending the Trust adopt a speaking up safely guardian model and a confidential third-party platform to provide an alternative avenue to staff. This was a focus during the year with the All Wales speaking up safely framework adopted in November, and a self-assessment to Welsh Government demonstrating the work done in this area and links to wider culture work.

21.9. The **NHS Staff Survey** was released as was a **Pulse Survey** via the new tool Hive. A 'you said we did' will be collated to share with our people at CEO Roadshows.

21.10. The people and culture elements of the **IMTP 2024-27** were reviewed. Members welcomed the ambition of the people and culture team but sought to ensure that these were focused on key activities and priorities, align to our principal risks, financial envelope, and capacity.

21.11. 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.

21.12. **Health and Safety updates** were received with a focus on RIDDOR compliance, risk assessment compliance, manual handling, the effects of diesel fumes on our people (which was also the subject of the advisory group WASPT discussions), and violence and aggression. Risk 199 was able to be closed off the corporate risk register, with the Committee noting an improvement in the cultural journey of the organisation regarding health and safety.

21.13. The **draft Health and Well-being Plan 2025-2029** was received in February 2024 for comment.

21.14. The Committee noted that the **Engagement Framework Delivery Plan** was paused earlier in the year due to realignment of timescales. Notwithstanding this, the Trust continued extensive engagement externally including with Llais (the new Citizens Voice Body). A presentation was provided on the **Reputation Audit** conducted of our stakeholders in Q3 2022/23 and it was agreed that more time will be devoted to the responses and the next steps at a Board development session.

21.15. The August meeting had a spotlight on volunteers, celebrating the successes and illustrating the ambition of the **Volunteer Strategy.** 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 was showcased.

21.16. The **Seasonal Influenza Campaign 2023/23** report was received following the close of the flu vaccination programme in March 2023.

21.17. The Committee received assurance on the processes in place for 2023 **registration and revalidation** with respect to the Health and Care Professional Council and Nursing and Midwifery Council.

21.18. **Updates are received from the Director of People and Culture** at each Committee, and these were changed in year to reflect a new look and a balanced view on both successes and challenges.

21.19. **Operational updates** are received at each meeting and often generate a good deal of discussion, particularly related to system pressures.

21.20. An update was received on the **Welsh Language Framework** which is included in the Integrated Medium Term Plan 2023-26 (IMTP). Members were assured that it included a combination of compliance with Welsh language standards, centralisation of translation, and the Welsh Government mwy na geiriau/More than just words action plan. In September 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. In February 2024 the Welsh Government's annual report on the **More Than Just Words Action Plan for 2022/23** was presented to the Committee. Updates were also received on the Welsh Language plan for the IMTP 2024-27 and progress on initiatives in 2023/24. Members commended the work and the focus on Welsh language

21.21. The **MIQPR** and **Quarterly Workforce KPIs** were received at each meeting, with a particular focus on sickness absence levels, recruitment, PADRs, statutory and mandatory training, moving on interviews, and shift overruns.

21.22. A **deep dive into absences** due to anxiety, stress, depression/other mental health illness was presented. 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.

21.23. The **backlog of policies** – particularly those relevant to this Committee - was reviewed and escalated to the Board as an alert. A priority order of policies for review in 2023/24 was endorsed. The following policies were approved in 2023/24:

- Health and Safety Policy
- All Wales Speaking Up Safely Framework
- All Wales Flexible Working Policy
- Homeworking Policy

21.24. In private session the Committee looks at **suspensions** over four months and **Employment Tribunal** cases.

21.25. **Reflections** are taken at the end of meetings and included:

- The volume of papers and consequently the length meetings.
- The desire to better link and align performance reporting and deep dives on the agenda.
- Positive discussion on additional actions in response to the feedback on Fatehullah's experience.
- The hybrid meeting (November) was well managed and there was a desire to replicate this more often across all Committees.
- Post meeting review of the volume of papers with the continued intention to look at reducing these and consolidating, particularly performance reporting, wherever possible.
- In February [insert]

21.26. **Audit Wales** joined the November meeting to present the NHS Workforce Data Briefing and the Workforce Planning Audit, both of which were also presented to the Board also. Overall, this was a positive outcome with WAST demonstrating areas of good improvement and responding to some of the immediate operational challenges and diversity and recruitment challenges.

21.27. The Committee **cycle of business** was approved.

21.28. **Risks** relevant to this Committee are reviewed at each meeting and the agenda is driven by these risks. The highest rated risks, sickness absence (160), reputation (201) and latterly Trade Union relationships (163) were the focus and drive agenda setting

21.29. The **annual effectiveness review** was conducted in the February 2024 meeting.

21.30. The revised **Audit** tracker and process was reviewed, and good progress is being made to close management recommendations.

21.31. **The Senior Paramedic Role internal audit** (reasonable assurance) was presented.

21.32. 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.

21.33. 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.

21.34. The reasonable assurance **Retention of Staff Internal Audit** report was received.

21.35. The **Committee's priorities for 2023/24** are reviewed at each meeting and a more detailed update appears later in this report. The Committee also reviews progress against its cycle of business at each meeting.

22. The Board received a highlight (AAA) report from this Committee by email circulation following each meeting which included alerts, advice, and areas of assurance. In November that report was provided verbally due to the proximity of the meeting and the Board meeting.

23. The Committee is serviced by one Sub-Committees, which is the Welsh Ambulance Service Partnership Team (WASPT). WASPT held its first meeting in April 2023 and the AAA Highlight Reports provided to each meeting set out the work of this advisory forum in the year which included:

23.1. The operational and corporate sub-structures that feed into WASPT, including local partnership forums were formed in 2023. These forums will provide opportunities for resolution and escalation at a more local level, focusing WASPT on strategic issues.

23.2. Discussion regarding portering of patients and diesel fumes were the subject of several meetings. Both were also discussed by the Committee in that report but also in the Health and Safety updates.

23.3. Meetings were constructive.

23.4. The joint Executive and Trade Union Partner Insights Training Day was well received.

23.5. Despite industrial action there is a lot of good work to celebrate and capture.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

24. Extensive changes to the Terms of Reference for this Committee were made during the effectiveness reviews held in 2022. The changes this year are therefore minimal and include feedback from the Committee following the survey and the meeting on 20 February. The changes in the Terms of Reference are marked up in [Annex 1] and include:

    - A change in the narrative on assurance to provide clarity on approach.
    - Changes in the narrative on risk and audit to streamline responsibilities.
    - Specific chair's action provision inserted, particularly given the significant number of policies which are due for approval in 2024/25.

25. Changes in operating arrangements in 2024/25 will include:
    - Reflections targeted more on what went well/not so well rather than what was discussed during the meeting.
    - WASPT approved minutes to be included in meeting bundle as well as the AAA report.
    - Next iteration of the cycle of business would need to reflect any attempts to combine assurance reporting, particularly as it relates to the MIQPR and people and culture metrics which respondents felt were duplicative and needed to be more concise for the remit of the Committee.
    - Revised monitoring report for the cycle of business.
    - Trade Union Partner and Committee Chair induction session to be held.

COMMITTEE PRIORITIES

26. The Committee received an update on progress against its priorities at each meeting. The 2023/24 priorities were:

Priority	Progress
Carry over the Committee priority from 2022/23 to support the implementation and championing of the strategic equality objectives, including Welsh Language, to promote an inclusive organisation.	As set out above focus on this priority during the year has been good. Consideration of equality, diversity, and inclusion (EDI) matters are the golden thread throughout all discussions held at the Committee. Diversity metrics were included within the 'culture' theme of the 'People and Culture Plan Metrics and Success Factors', which the Committee received at its meeting in August. The Strategic Equality Objectives have been in development throughout the year and the final version was endorsed by the Committee in February. In August, the Committee received the Welsh Language Annual Report for 2022-23 (before its progression to Trust Board for approval in September), and they also received an update on the More Than Just Words action plan
Development and implementation of the Speaking Up Safely Framework.	The Cultural Trends and Themes Learning Report was received by the Committee at its meeting in August. This included an update on Speaking Up Safely and other cultural indicators identified. The revised Speaking Up Safely Framework, the All-Wales Speaking Up Safely Policy was received by the Committee in November for endorsement (subsequently ratified for adoption by the Trust Board).
Development and Progress of the People and Culture Plan	The People and Culture Plan was approved by the Trust Board at its meeting in May 2023, and the Committee received an update by way of 'metrics and success factors' at its meeting in August. The Committee are receive qualitative and quantitative updates against the Plan.

27. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. Accordingly, the Committee has agreed the following priorities for 2024/25:
    (a) Impact of wellbeing initiatives on our people.
    (b) Culture of conversations with a focus on communication and conversations with managers and their people.
    (c) A continued focus on equality, diversity and inclusion and the implementation of the strategic equality objectives.
    The Trust's approach to development of our people.

28. Progress on priorities will be reported to the Committee quarterly and to the Board through its highlight report.

NEXT STEPS

29. The next steps are as follows:
    (a) Ensure changes to operating arrangements are cycled into work programme for review in 2024/25
    (b) Update the cycle of business with revised terms of reference

RECOMMENDATION

30. The Trust Board is requested to
    (a) Receive and note the contents of the Committee Annual Report for 2023/24 and analysis of its effectiveness; and
    (b) Approve the changes to the Terms of Reference and operating arrangements.

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

PEOPLE AND CULTURE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS ~~2023/24~~2024/25

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government 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*".

1.2. In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the **People and Culture Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3. The Board Committees play an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions by the Board.

2. PURPOSE

2.1 The purpose of the People and Culture Committee ('the Committee') is to enable scrutiny and review of the Trust's arrangements for all matters pertaining to its workforce, both paid and volunteer, and organisational culture and behaviour to a level of depth and detail not possible in Board

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meetings. The Committee will provide assurance to the Board of the Trust's leadership arrangements; behaviours and culture; training, education and development; equality, diversity and inclusion; health, safety and welfare; people and culture related partnerships and engagement; the Welsh Ambulance Services Partnership Team (advisory group); and Welsh Language, in accordance with its stated objectives and the requirements and standards determined by the Welsh Government, the NHS in Wales and other regulatory bodies.

2.2 The Committee will provide evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to all matters relating to staff and staffing of the Trust.

2.4 The Committee will approve on behalf of the Board, relevant Directorate policies, procedures and other written control documents in accordance with the Trust's scheme of delegation.

2.5 The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

2.6 The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

3. DELEGATED POWERS AND AUTHORITY

The Committee will, in respect of its role in providing advice and assurance to the Board: -

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3.1 Oversee and contribute to the development of the Trust's ~~p~~People and ~~c~~Culture ~~p~~Plan aligned to the 2030 Delivering Excellence Long Term Plan.

3.2 Noting that the Finance and Performance Committee oversees delivery of the Integrated Medium Term Plan (IMTP), this Committee will conduct any required deep dives into aspects of the people and culture elements of the IMTP and monitor delivery of other strategic people and culture priorities which may not be included in the IMTP.

3.3 Receive and consider projects of major strategic organisational change where there is a significant impact on our people's health and wellbeing, and cultural change.

3.4 Monitor progress and seek assurance of arrangements in place to embed the Trust's behaviours, ensuring a continued journey of positive culture change.

3.5 ~~Ensure~~ Receive assurance that there is a robust plan in place for the health and wellbeing of our people and monitor the effectiveness of arrangements in place to support and protect the mental, physical, and financial wellbeing of staff.

3.6 Consider the experience of our people, including volunteers, and seek assurance of the effectiveness of mechanisms used for measuring, and for hearing and acting upon their experiences.

3.7 Receive assurance that ~~Ensure~~ arrangements are in place to allow staff to raise concerns in confidence, and that those processes allow any such concerns to be investigated proportionately and independently and that the learning from such concerns is considered and applied.

3.8 Oversee and contribute to the development of the Trust's equality, diversity and inclusion plan and be assured ~~monitor~~ its implementation is monitored; champion and support the plan and the work of the equality, diversity, and inclusion networks.

3.9 ~~Oversee~~ Receive assurance on the ~~the~~ development and implementation of the Trust's recruitment and retention plans.

3.10 ~~Ensure~~ Receive assurance that Trust management and ~~Staff Side/~~Trade Union Partners ~~representatives~~ continue to develop and build a shared understanding and common purpose through formal and informal consultative partnership working to ensure the efficiency and success of the Trust for the benefit of all.

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3.11 Receive assurance that ~~Ensure~~ the Trust has in place appropriate policies and procedures for its people; approve people and culture policies ~~and monitor compliance.~~.

3.12 Monitor the effectiveness of the Trust's leadership and management development and succession planning arrangements.

3.13 Monitor performance against key people and culture indicators ~~such~~ including but not limited to~~as~~ sickness absence, performance appraisal reviews, statutory and mandatory training, incidents of violence and aggression, disciplinaries and suspensions, turnover and recruitment; enabling deep dives to take place into specific areas of concern.

3.14 Monitor progress and seek assurance that arrangements are in place to meet the Welsh Language Standards and that the culture of Wales and the Welsh language is promoted within the Trust.

3.15 Ensure the Trust is discharging its statutory responsibilities, including but not limited to health and safety; equality, diversity, and inclusion; relevant Health and Care Quality Standards requirements; and that professional standards of registration and revalidation are maintained.

3.16 All matters relating to partnerships and engagement relevant to our people and cultural change.

3.17 any other matter in relation to the Committee's overall purpose and responsibilities

Corporate Risks and Audit Recommendation Tracker

3.18 The ~~Audit~~ Committee will monitor the principal risks relevant to its remit ~~has overall responsibility for ensuring that corporate risks are identified and are being properly managed within the Trust. The Audit Committee also has responsibility for ensuring that there are processes in place to address and take forward audit recommendations. Nevertheless, each risk from the corporate risk register and Board Assurance Framework, and each recommendation from the audit tracker, will be allocated to an appropriate Board Committee who will be responsible for ensuring that the Trust is managing and progressing each item as planned. Regular reports will be provided to individual Committees on those items for which they have responsibility and overall Trust-wide progress reports will be presented to each Audit Committee. The Committee will~~ and consider the controls and

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mitigations of ~~high-level workforce~~ related risks and provide assurance to the Board that such risks are being effectively controlled and managed.

3.19 The Committee will receive and gain assurance from internal and external audits in their remit. It will also monitor management actions to address recommendations via the audit tracker and where appropriate scrutinise the impact of actions in response to audit recommendations.

Authority

~~3.18~~3.20 The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

~~3.19~~3.21 The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

~~3.20~~3.22 The Committee is authorised to approve Trust wide policies in accordance with the policy for the Review, Development and Approval of Policies.

Chair's Action

3.23 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

3.24 In these circumstances, the Chair and the Lead Executive (Director of People and Culture), supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

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3.25 The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Sub-Committees

~~3.21~~3.26 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-committees may only be established with the agreement of the Board.

~~3.22~~3.27 The Welsh Ambulance Services Partnership Team (WASPT) is an advisory group of the Board and was re-constituted in November 2022 following the pandemic. The Board has agreed that WASPT is a sub-committee of this Committee and as such reports regularly by way of a AAA highlight report. Similarly, issues raised are reported, and where necessary escalated, to the Board by way of this Committee's AAA highlight report.

4. MEMBERSHIP

Members

4.1 The membership of the Committee will comprise:

Chair	Non Executive Director
Members	Three further Non Executive Directors of the Board.

Attendees

4.2 The membership will be supported routinely by the following core attendees:

- Director of People and Culture
- Executive Director of Finance and Corporate Resources
- Executive Director of Operations ~~(or Deputy/Assistant Director)~~
- Director of Partnerships and Engagement
- Executive Director of Paramedicine
- Assistant Director of Quality and Nursing (TBC)
- Assistant Director of Planning and Transformation
- Trade Union Partners (x4)
- Chairs of Sub-Committees (or their nominee)

Commented [AP1]: This needs to be updated to JTR but unsure if you or Angie has spoken to Liam about it yet. Wendy and Liam are in the invites, so JTR needs to be added if this is what's going to happen.

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- Board Secretary

4.3 The Trust Chair and Chief Executive will have a permanent standing invite to attend the Committee. Where the Executive Director of Operations nominates a Deputy/Assistant Director to attend meetings, that individual will be approved by the Chair and must be a regular and consistent attendee.

4.4 The Committee Chair may extend invitations to attend committee meetings to other Directors and/or Senior Managers, and to officials from within or outside the organisation to attend all or part of the meeting to assist with its discussions on any particular matter.

4.5 Members may send deputies in their absence who will act with their full authority. 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.

Member Appointments

4.6 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

4.7 Non Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.8 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

Secretariat and Support to Committee Members

4.9.1 The Board Secretary, on behalf of the Committee Chair, shall:

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(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of People and Culture.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two of the four members of the Committee must be present to achieve a quorum. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.

Frequency of Meetings

5.2 Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board Business. Meeting agendas, papers and minutes shall be circulated no less than seven days prior to each meeting.

Withdrawal of individuals in attendance

5.3 The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/ GROUPS

6.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees and groups to provide advice and assurance to the Board through the:

(a) joint planning and co-ordination of Board and Committee business; and

(b) sharing of appropriate information;

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in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework.

6.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.4 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

(a) report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports where appropriate throughout the year;
(b) bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and
(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 5)

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9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

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QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE (QUEST)
ANNUAL REPORT 2023/24

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The Committee met on 8 February 2024 and reviewed its terms of reference, responses to questionnaires completed by members and attendees, and its operating arrangements. Discussions were also held with the Committee Chair and Executive Lead ahead of that meeting. This Annual Report reflects on the effectiveness of the Committee in 2023/24 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The Committee is established to for scrutinise improvements in outcomes in quality, patient experience, effectiveness, and safety to reduce incidences of avoidable harm. It provides oversight of and seeks assurance on statutory and regulatory compliance, including but not limited to the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

MEMBERSHIP AND ATTENDANCE

6. The Committee met four times as scheduled in 2023/24 and was quorate on each occasion.

7. The Committee is supported by the Chair and three Non-Executive Directors as members, and a number of core attendees. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2023/24. The Committee welcomed non prescribed attendees at various meetings as well as external guests.

COMMITTEE ATTENDANCE				
NAME	**11 MAY 2023**	**10 AUGUST 2023**	**31 OCTOBER 2023**	**8 FEBRUARY 2024**
Bethan Evans				
Kevin Davies			In chair for meeting	
Paul Hollard				
Ceri Jackson				
Liam Williams				
Andy Swinburn		Duncan Robertson		Duncan Robertson*
Lee Brooks	Steve Clinton		Sonia Thompson	Mark Harris
Leanne Smith	Jon Hopkins			
Jonny Sammut				Leanne Smith
Rachel Marsh			Hugh Bennett	Mark Thomas
Trish Mills				
Mark Marsden				
Hugh Parry				
Ian James				

Andy Swinburn in meeting between 11am and 1pm

	Attended
	Deputy attended
	Apologies received
	No longer member

8. Attendance is excellent. Leanne Smith was replaced as prescribed attendee when she completed her interim position, and Jonny Sammut joined the Committee when he commenced as Director of Digital.

9. No changes to membership are proposed at this stage.

COMMITTEE'S VIEWS ON EFFECTIVENESS

10. The Committee's effectiveness was assessed through a review of its terms of reference, responses to a questionnaire, discussion with the Chair and Executive Lead, and at the 8 February Committee meeting.

11. The questionnaires provided an opportunity to gauge opinion on areas of good practice and areas that require improvement. Sixteen questionnaires were sent out with eight responses being returned (a 50% return rate which is slightly better than 2022/23).

12. Respondents were asked 27 questions and were encouraged to provide free text answers to explain or expand on their choices. The responses were reviewed by the Committee on 8 February against the same questions from last year. There were a number of comments on the length of the agenda, meetings and papers. These ranged from these impacting the ability of members to undertake their role effectively, to them being appropriate given the frequency of meetings and the crucial scrutiny and oversight of patient safety, quality and patient experience. In 2024/25 meeting invitations will be extended to provide an appropriate amount of time for the meetings where that is deemed necessary at agenda setting meetings and in conjunction with the Chair.

13. Whilst the was a sense the committee needed to strengthen its timely close off of actions/holding to account for late or missing papers, it is recognised that operational pressures may mean some items are prioritised. Regular monitoring of the cycle of business, the action log and forward planner are in place to capture matters carried over.

14. There is a desire to seek to extrapolate only sections of the MIQPR which are relevant for the Committee however it was recognising this could lead to additional work and reporting. An alternative approach is the focus of members on the relevant quality, clinical, patient safety and experience indicators (in the MIQPR and the PTR report) as opposed to the full balanced scorecard (which is scrutinised at Finance and Performance Committee and Board), and the impact of that performance and improvements on patients.

15. As with other Board Committees, the question related to visibility of Committee members scored poorly. Given that there is a Board visits Standard Operating Procedure in place which illustrates members visibility, it is anticipated that this question will be omitted from the 2024/25 survey. The rationale being that it is unlikely, no matter how visible a Non-Executive or Executive Director may be, that that will always resonate with each Committee.

16. Good practice drawn out in responses included:

- The focus in 2023/24 on clinical indicators;

- Key risks are discussed and drive the agenda, with more deep dives on risks welcomes;
- Relevant information is shared clearly and robustly with the Board;
- The meetings are well chaired; and
- There is a positive and transparent culture.

17. The Committee has a cycle of business that is aligned to its terms of reference. All matters scheduled for oversight and review have been brought to the Committee and in this respect it has discharged its responsibilities in providing assurance to the Board. The Committee's business in 2023/24 included:

    17.1. **The Putting Things Right** (PTR) (previously the Patient Safety Highlight Report) and **MIQPR reports** are received at each meeting. Throughout the year the focus was on:

    - Pressures in the teams to respond to concerns in a timely way;
    - Concerns response time improvement plans;
    - Continuing number of immediate release requests refused;
    - Incidents being reviewed at the Serious Case Incident Forum;
    - Joint investigations being passed to Health Boards;
    - National Reportable Incidents;
    - The continued upward trend in Coroner's requests for information;
    - Regulation 28 are brought to the attention of the Committee;
    - Improvement actions under review to ensure the Electronic Patient Record (ePCR) data is correctly inputted to ensure accurate reporting on the various clinical bundles;
    - Good call back time for 111 Wales calls.

    17.2. A **focus on clinical indicators** was agreed at the 2022/24 effectiveness review and the first report was presented at the August 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 hypoglycaemia, 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). In October the Committee focused on the clinical indicator of **Return of Spontaneous Circulation (ROSC)**, acknowledging substantial enhancements in ROSC rates since April 2022. In February the Committee focused on **stroke indicators** with discussion of the time-based metrics.

17.3. Each meeting heard a **patient story**:

- In May the Committee heard from **Keith Jones** who is a long-standing CFR at WAST and attended a patient at their home in November 2022. Keith was with the patient and their partner for over four hours awaiting an ambulance and during that time the patient went into cardiac arrest. Despite attempts to resuscitate him, the patient unfortunately died. Members heard about the effect of this on Keith and the patient's partner who was present, and discussed the support which is available to CFRs following such an event.

- In August 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.

- In October **Steven Parsons** recounted his distressing experience of being unable to get an ambulance for his grandfather, who he thought was suffering a stroke. Steven called 999 but was told there were no ambulances available at that time because of the system pressures. Believing it was a stroke, Steven decided to transport his grandfather to the hospital himself. Upon arrival, his grandfather collapsed but was resuscitated in the Emergency Department.

- In February **Alison Cassidy** recounted the experience of her daughter Emma, who has a rare genetic disorder, severe learning disabilities and epilepsy. She needed urgent dental care requiring general anesthetic at Glan Clwyd Hospital and was advised by Health Care Professionals in the Health Board to access the Non-Emergency Patient Transport Service (NEPTS) to take Emma to her appointment.

17.4. The **IMTP 2024-27** elements that related to this Committee were reviewed ahead of the IMTP's approval by Board in March.

17.5. The **Quality strategy implementation plan** was reviewed in May 2023 and February 2024. The plan was developed to support delivery of the Quality Strategy 2021-2024. Whilst progress against the plan has been slow due to resourcing challenges, there was progress in the latter half of 2022/23 in preparation for the Health and Care (Quality and Engagement) (Wales) Act 2020. The planning and engagement for a new Quality

Plan will be developed during 2024/25 with the 2023/24 Quality Report informing some of this.

17.6. The Patient Experience and Community Involvement (**PECI**) reports were received providing positive assurance we are meeting with and consulting with the public and out stakeholders, including with Llais (the Citizens Voice Body). Reports from PECI are now provided bi-annually.

17.7. The Trust's **annual Clinical Audit Plan**, which allows the planning and prioritisation of clinical audits across the financial year, was approved. It is not always possible to predict all of the topics that require evaluation and therefore this is a dynamic document which is updated quarterly with oversight by this Committee. This supports recommendations in the Audit Wales Clinical Governance Review 2022.

17.8. A **deep dive on red rural performance** was presented in August. 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.

17.9. 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 reporting provides an overview of information governance in terms of accountability, assurance and compliance and the Committee agreed a set of metrics. The Board will note that this area of oversight will transfer to the Finance and Performance Committee from 1 April 2024 so there is alignment and avoidance of duplication.

17.10. The **backlog of policies** – particularly those relevant to this Committee - was reviewed and concerns escalated to the Board. A priority order of policies for review in 2023/24 was endorsed. The following policies were approved in 2023/24:

- National Policy on Patient Safety Incident Reporting and Management;
- Aseptic Non-Touch Technique Policy;
- Medicines Management Policy;
- Information Governance Policy;
- Infection Prevention and Control Policy (by Chair's Actions);
- Clinical Supervisions Policy; and
- Data Protection Policy.

17.11. The **Welsh Risk Pool Concerns Assessment** was received and themes such as the PTR capacity and Datix Cymru were discussed.

17.12. **Operational updates** are received at each meeting and often generate a good deal of discussion, particularly related to system pressures.

17.13. **Reflections** are taken at the end of each meeting and included:

- In May: noted the different approach with an afternoon start; supportive challenge and identification of further actions as a result; lived experience was important to continue to hear; papers were improved, succinct and clear and picked up on the threads of the duties of quality and candour.

- In August: 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.

- In October: clear and succinct papers and tangible progress on some longstanding issues.

- In February: more time and a lunch break meant the meeting did not feel rushed; the patient story provoked both challenging and constructive discussion and it is important to continue to hear these and to allow time to do so.

17.14. 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. The Committee noted:

- In May: The Quality and Performance Management Steering Group incorporates senior oversight and responsibility for the duty of quality and duty of candour to ensure the Quality and Performance Management Framework has an integrated approach to improving the quality of services and outcomes for patients. A quality management system digital dashboard is in progress and Trust intranet pages are available to staff to cascade messaging and enhance knowledge in this area. There was positive progress of the Trust position against the Welsh Government road map for the Act implementation, including exemplar content and ideas produced by Trust staff now being adopted at NHS Wales level. Concern was raised as to impact on teams and resources with the increased requirements under the duty of candour as raised in the alert section.

- In August: 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 set of Performance and Quality Standards are currently being developed for the duty of candour 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.

- In October: The Welsh Government roadmap for August 2023 rated the Trust's progress as having identified that 'delivery is at risk but manageable' or is 'behind schedule but within tolerance'. This is in line with other NHS organisations across Wales and includes a further nine deliverables recently added to the roadmap. The appointment of the Senior Quality Governance Lead and bespoke implementation plan has increased capability and capacity to support full implementation. The current impact of this has been a review of arrangements which has led to some previously reported good progress being revised on the current WG report.

17.15. The duty of quality requires each organisation to provide demonstrable 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 are **Quality Impact Assessments** (QIA). The Committee were assured that the framework for QIAs was appropriate and noted that the template developed by the Trust has since been adopted by the NHS Wales Executive for use across Wales. Two QIAs were subsequently reviewed by the Committee, including the Implementation of a revised approach to the application of the Non-Emergency Patient Transport Service (NEPTS) eligibility criteria and a revised Capacity Management Plan, and The Mid and West Wales Fire and Rescue Services (M&WWF&RS) support to the Trust's emergency responses.

17.16. The Health and Care Standards (2015) have now changed to the **Health and Care Quality Standards (2023)** with six domains and five enablers. The domains are Safe, Effective, Timely, Efficient, Equitable and Person Centred. The enablers include Leadership, Culture and Valuing People, Data to Knowledge, Learning Improvement & Research, and Whole System Perspective. Work is progressing to define quality outcome measures aligned to the Standards.

17.17. The Committee **cycle of business** was approved.

17.18. The following **annual reports** were received for assurance and discussion:

- Infection Prevention and Control Annual Report 2022/23
- Safeguarding Annual Report 2022/23
- Mental Health and Dementia Annual Report 2023

17.19. The Audit Wales Quality Governance Review 2022 raised the issue of the backlog of **mortality reviews** and the need to develop an action plan to reduce this backlog. The Committee saw there is evolving work to embed and strengthen the mortality review process. Learning will be shared and triangulated with information produced from other sources e.g. coroners, incidents, clinical audit programmes, and this Committee will see this in the Patient Safety Report.

17.20. **Risks** relevant to this Committee – 223 and 224 – are reviewed at each meeting and the agenda is driven by these risks. Risks to the Trust's ability to implement the duty of quality and duty of candour were also discussed with relevant mitigations, as were challenges and risks in achieving, maintaining and assurance compliance of data protection.

17.21. The **annual effectiveness review** was conducted in the January 2024 meeting.

17.22. The **Medicines Management Assurance Report** was reviewed by the Committee. This is the first report of its kind and content on future reports was discussed. Assurance was taken on this report, and it was good to see that the previous internal audit on medicines management was a good lever for change.

17.23. The revised **Audit** tracker and process was reviewed and good progress is being made to close down management recommendations.

17.24. 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 latter part of 2023/24.

17.25. The **HIW national review of patient flow – a journey through the stroke pathway** and the **HIW Annual Report** were reviewed in February 2024.

17.26. The **Healthcare Inspectorate Wales (HIW) Annual Report 2022-23** was reviewed in February 2024 and the Committee noted that the issues raised, including system pressures and safeguarding, are frequent areas of discussion and oversight at QUEST.

17.27. **The Infection Prevention and Control (IPC) internal audit** (reasonable assurance) was presented with the Committee being assured that whilst recommendations for improvements were being made, the response and the ways we seek to support our patients with respect to IPC i.e., guidance, advice and support is appropriate.

17.28. The **Immediate Release Directions internal audit** (reasonable assurance) was presented and the need for a collaborative approach to these was apparent.

17.29. The **Data Analysis internal audit** (reasonable assurance) was also reviewed.

17.30. The **Records Management Internal Audit** (reasonable assurance) was received in February 2024.

17.31. 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.

17.32. The **Committee's priorities for 2023/24** (implementation of the quality strategy, and the duty of quality and duty of candour) are reviewed at each meeting and a more detailed update appears later in this report. The Committee also reviews progress against its cycle of business at each meeting.

18. The Board received a highlight (AAA) report from this Committee by email circulation following each meeting which included alerts, advice, and areas of assurance. This was also presented to the next public Board meeting by the Chair of the Committee. Each of the AAA report escalated the issue of handover delays and the impact of this on our patients and our people; the highest rated risks 223 and 224; concerns over PTR response times and over the backlog of policies.

19. The Committee is not currently serviced by any Sub-Committees.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

20. Extensive changes to the Terms of Reference for this Committee were made during the effectiveness reviews held in 2022. The changes this year are therefore minimal and include feedback from the Committee following the survey and the meeting on 8 February. The changes in the Terms of Reference are marked up in [Annex 1] and include:

- A change in the narrative on assurance to provide clarity on approach;
- The information governance and information security elements are proposed to transfer to the Finance and Performance Committee from 1 April. That Committee has the digital infrastructure, systems and strategy in their remit as well as cyber security and it was felt by the Caldicott Guardian (Liam Williams) and Senior Information Risk Officers (Jonny Sammut) that this move was

appropriate to reduce duplication and align the approach. The Caldicott Guardian will alert the Committee to any relevant issues of patient information concerns; and

- Changes in the narrative on risk and audit to streamline responsibilities.

COMMITTEE PRIORITIES

21. The Committee received an update on progress against its priorities at each meeting. The 2023/24 priorities were:

Priority	Progress
Committee will monitor implementation of the Duty of Quality and Duty of Candour following the Health and Social Care (Quality and Engagement) (Wales) Act ('Act') coming in to force in the Spring of 2023	As set out above, progress against this priority has been good throughout the year.
Implementation plan for the quality strategy.	As set out above, progress against this priority has been monitored throughout the year, noting that focus has been on the implementation of the duty of quality and duty of candour.

22. It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. Accordingly, the Committee has agreed the following priorities for 2024/25:

(a) Continue to monitor the duty of quality and duty of candour i.e. Committee will monitor implementation of the Duty of Quality and Duty of Candour following the Health and Social Care (Quality and Engagement) (Wales) Act.
(b) Monitor the delivery of the Quality Strategy (plan)
(c) Monitor the organisation's compliance with the Health and Care Quality Standards 2024

23. Progress on priorities will be reported to the Committee quarterly and to the Board through its highlight report.

NEXT STEPS

24. The next steps are to update the cycle of business with revised terms of reference

RECOMMENDATION

25. The Trust Board is requested to
    (a) Receive and note the contents of the Committee Annual Report for 2023/24 and analysis of its effectiveness; and
    (b) Approve the changes to the Terms of Reference.

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

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

~~2023/24~~2024/25

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government 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*".

1.2. In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the Quality, Patient Experience and Safety Committee. This Committee has a key assurance role on behalf of the Board in relation to the Trust compliance with the Commissioning Core Quality Requirements, the NHS Wales Health & Care Standards 2015 and the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3. The Board Committees play an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions by the Board.

2. PURPOSE

2.1. The Committee is responsible for scrutinising improvements in outcomes in quality, patient experience, effectiveness, and safety to reduce incidences of avoidable harm.

2.2. During the ~~2023/24~~ 2024/25 financial year the Committee will continue to oversee the systems and process developed to ensure compliance with the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020, and ensure compliance with the Act to improve the quality of healthcare provided by the Trust.

2.3. The Committee will provide oversight of, and seek assurance on, statutory and regulatory compliance on areas within its remit.

2.4. ~~Oversee the quality and integrity, safety and security, and appropriate access and use of information (including patient and personal information) to support the provision of high quality healthcare.~~

2.5. The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

2.6. The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

~~2.6.~~2.7.

3. DELEGATED POWERS AND AUTHORITY

The Committee will:

3.1. ~~Ensure~~ Receive assurance that the organisation has the right systems and processes in place to deliver services consistent with the six domains of quality (~~patient~~ person centred; safe; equitable; timely; effective; and efficient).

3.2. Advise the Board on a set of key indicators for quality, patient experience and clinical safety, and monitor performance against those indicators.

3.3. ~~Ensure~~ Receive assurance on compliance with the Duty of Quality and the Duty of Candour as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to improve the quality of healthcare provided by the Trust and to support the delivery of an open and honest reporting and continuous learning culture.

Strategy

3.4. Oversee and contribute to the development of the Trust's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.

3.5. Monitor the implementation of strategies and plans within the remit of the Committee where that is not already done by the Finance and Performance Committee.

3.6. Receive assurance that ~~Ensure~~ there is clear, consistent strategic direction, strong leadership, transparent lines of accountability.

Safe Care

3.7. Receive assurance that ~~Ensure~~ the Health and Care Quality Standards 2023, and Commissioning Quality Core Requirements are embedded Trust wide with actions taken in relation to any identified non-compliance.

3.8. ~~Ensure~~ Receive assurance that there is a process in place for quality impact assessments, and consider the implications for quality and safety and equitable care arising from the development of the Trust's corporate strategies and plans, or those of its stakeholders and partners, including those arising from any Committees of the Board.

3.9. Consider the implications for the Trust's quality and safety arrangements from

review/investigation reports, external guidance and national reports and actions arising from the work of external regulators.

3.10. Receive assurance that ~~Monitor~~ the Trust is compliance~~cte~~ with the Mental Health Act 1983, Code of Practice, and the Mental Capacity Act 2005.

3.11. Review the annual infection prevention and control plan and monitor its implementation.

3.12. Receive assurance that ~~Ensure~~ the Trust is meeting its obligations with respect to safeguarding of children and vulnerable adults.

3.13. Review the impact of professional standards and staffing issues on patient care, noting the People and Culture Committee has oversight of the selection, training, registration, and revalidation for staff.

3.14. Receive assurance that ~~Oversee~~ improvements and changes applied as a result of reviews of mortality, clinical incidents, complaints, litigation, external regulator reports etc., and their impact on minimising patient harm and maximising patient experience.

Effective Care

3.15. Receive assurance that ~~Ensure~~ the care planned and provided across the breadth of the organisation's functions is clinically effective and quality driven and where this falls beneath expected standards, the impact is reviewed to support continuous improvement.

3.16. Approve the ~~annual~~ Trust's clinical audit plan that meets the standards set for the NHS in Wales; review the outcomes of clinical audits in line with the clinical audit plan and provide assurance to the Audit Committee in this respect;

3.17. Receive assurance that there ~~There~~ is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation.

Citizen Voice and Patient Experience

3.18. Approve the patient experience/engagement plan and monitor its implementation.

3.19. Receive assurance that ~~Ensure~~ the organisation has a citizen centred approach, putting patients, patient safety, quality of care and safeguarding above all other considerations.

3.20. Receive assurance that ~~Ensure~~ the Patient Experience & Community

Involvement (PECI) continuous engagement model is taken into account in the design and delivery of services, ensuring the full implementation of lessons learnt.

3.21. ~~Seek assurance~~ Receive assurance that that lessons are learned from patient experience information and patient safety and workforce related incidents, complaints and claims, and that learning from reports and incidents is embedded in the Trust's practices, policies and procedures.

3.22. Receive assurance that ~~Ensure~~ there is good collaborative team and partnership working to provide the best possible outcomes for its citizens.

3.23. Ensure any matters raised by the ~~Medical Director,~~Executive Director of Quality & Nursing (including in their role as Caldicott Guardian), Executive Director of Paramedicine, or other Directors in relation to patient safety and clinical risk are considered and addressed promptly and fully.

~~**Information Governance and Information Security**~~

~~3.24. Receive assurance the information governance and information security arrangements are appropriately designed and operating effectively to ensure the reliability, integrity, safety, and security of information to support the delivery of high quality, safe healthcare across the organisation.~~

~~3.25. Review progress of measures to improve information security and adherence to Caldicott principles against the Information Governance Toolkit, Network and Information Systems (NIS) Directive (2018), Data Protection Act (2018), and receive assurance on compliance with relevant standards, legislation and regulations.~~

~~3.26. Receive assurance on, and review effectiveness of the Trust's information security protocols.~~

~~3.27. Review performance of the Trust in relation to statutory and mandatory information requests and reporting requirements including but not limited to freedom of information requests, data breaches, police requests and subject access requests.~~

Governance

~~3.28.~~3.24. Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities, and that these are compliant with relevant legislation.

3.25. Receive and gain assurance from internal and external audits in their remit. It will also monitor management actions to address recommendations via the audit tracker and where appropriate scrutinise the impact of actions in response to audit recommendations.

~~3.29. Recommendations made by internal audit and external reviewers are considered and acted upon on a timely basis;~~

~~3.30.~~3.26. Review and recommend to the Board the Trust's annual Duty of Candor and ~~q~~Quality ~~statement~~ Report(s) ~~(as relevant)~~ and quality improvement priorities for the coming year, monitoring progress against these priorities and their impact on patient safety.

~~3.31.~~3.27. Review policies in its remit and endorse policies for Board approval that relate to complaints and incidents in line with Putting Things Right.

~~Corporate Risks and Audit Recommendation Tracker~~

~~3.32.~~3.28. Monitor the key risks relevant to its remit. ~~The Audit Committee has overall responsibility for ensuring that corporate risks are identified and are being properly managed within the Trust. The Audit Committee also has responsibility for ensuring that there are processes in place to address and take forward audit recommendations. Nevertheless, each risk from the corporate risk register and Board Assurance Framework, and each recommendation from the audit tracker, will be allocated to an appropriate Board Committee who will be responsible for ensuring that the Trust is managing and progressing each item as planned. Regular reports will be provided to individual Committees on those items for which they have responsibility and overall Trust-wide progress reports will be presented to each Audit Committee. The Committee~~ It will consider the controls and mitigations of ~~high level workforce~~ related risks and provide assurance to the Board that such risks are being effectively controlled and managed.

Authority

~~3.33.~~3.29. The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

~~3.34.~~3.30. The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

~~3.35.~~3.31. The Committee is authorised to approve Trust wide policies in accordance with the policy for the Review, Development and Approval of Policies.

Chair's Action

3.32. There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

3.33. In these circumstances, the Chair and the Lead Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

3.34. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Sub-Committees

~~3.36.~~3.35. The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-committees may only be established with the agreement of the Board.

4. MEMBERSHIP

Members

4.1. The membership of the Committee should include at least one member of the Trust's Audit Committee and will comprise:

Chair	Non Executive Director
Members	Three further Non Executive Directors of the Board.

Prescribed Attendees

4.2. The core membership will be supported ~~routinely~~ by the attendance of the following at each meeting:

- Executive Director of Quality and Nursing (Committee Lead)
- Executive Director of Paramedicine
- Executive Director of Operations
- Executive Director of Strategy, Planning and Performance
- Director of Digital Services ~~(SIRO)~~
- Trade Union Partners (x 3)
- Chairs of Sub-committees (where established)
- Board Secretary

4.3. The Committee Chair may extend invitations to attend committee meetings to other Directors and/or Senior Managers, and to officials from within or outside the organisation to attend all or part of the meeting to assist with its discussions on any particular matter.

4.4. Members may send deputies in their absence who will act with their full authority. 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.

Member Appointments

4.5. The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of

skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

4.6. Non-Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7. Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

Secretariat and Support to Committee Members

4.8. The Board Secretary, on behalf of the Committee Chair, shall:

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of People and Culture.

Quorum

4.9. At least two members must be present to ensure the quorum of the Committee. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.

Frequency of Meetings

4.10. Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board Business. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

Withdrawal of individuals in attendance

4.11. The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

5. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/ GROUPS

5.1. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

5.2. The Committee, through its Chair and members, shall work closely with the Board's other committees and groups to provide advice and assurance to the Board through the:

(a) joint planning and co-ordination of Board and Committee business; and
(b) sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework.

5.3. The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

5.4. The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

6. REPORTING AND ASSURANCE ARRANGEMENTS

6.1. The Committee Chair shall:

(a) report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes

a written highlight report~~verbal updates on activity~~, the submission of Committee minutes and written reports where appropriate throughout the year;

(b) bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and

(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

6.2. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In so doing, account will be taken of the requirements set out in the NHS Wales Quality & Safety Committee Handbook and national guidance.

7. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

7.1. The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 5)

8. REVIEW

8.1. These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

REMUNERATION COMMITTEE
ANNUAL REPORT 2023/24

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change, for example as people leave, organisations restructure, or strategy shifts, regular reviews of Board Committees ensure governance remains fit for purpose.

3. Standing Orders, Committee terms of reference, and Codes of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part.

4. The Committee met on 8 March 2024 and reviewed its terms of reference, responses to questionnaires completed by members and attendees, and its operating arrangements. Discussions were also held with the Committee Chair and Executive Lead ahead of that meeting. This Annual Report reflects on the effectiveness of the Committee in 2023/24 and proposes changes to terms of reference.

PURPOSE OF THE COMMITTEE

5. The Purpose of the Committee is to:
   (a) Approve on behalf of the Board matters relating to the appointment, termination, remuneration, terms of service and appraisal for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government and in accordance with the Standing Orders; and

(b) Approve proposals regarding termination arrangements, including those under the Voluntary Early Release Scheme, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.

(c) Provide assurance to the Board in relation to the Trust's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales.

MEMBERSHIP AND ATTENDANCE

6. The Committee has meetings scheduled four times a year, however given the nature of the work of this Committee, they can sometimes be moved because there are limited issues to review. At other times additional meetings are required depending on demand.

7. The Committee met three times in 2023/24 and was quorate on each occasion.

8. The Committee's membership is not proposed to change but the attendance of the Executive Director of Finance and Corporate Resources is now specified in the terms of reference where Voluntary Early Release Scheme (VERS) applications are before the Committee. The chart below illustrates attendance of members and attendees as listed in the terms of reference for 2023/24.

COMMITTEE ATTENDANCE			
Name	**5 June 2023**	**July 2023**	**8 March 2024**
Colin Dennis			
Prof. Kevin Davies			
Bethan Evans			
Paul Hollard			
Ceri Jackson			
Hannah Rowan			
Joga Singh			
Martin Turner			
Peter Curran			
Hugh Parry			
Damon Turner			
Jason Killens	*		
Trish Mills			
Angie Lewis			

*Recused from discussions on relevant agenda items

	Attended
	Sent Deputy
	Apologies
	No longer a member.

COMMITTEE'S VIEWS ON EFFECTIVENESS

9. The Committee's effectiveness was assessed through a review of its terms of reference, responses to a questionnaire, discussion with the Chair and Executive Lead, and at the 8 March 2024 Committee meeting.

10. The questionnaires provided an opportunity to gauge opinion on areas of good practice and areas that require improvement. Fourteen questionnaires were sent out with 4 responses being returned (a 28.5% return rate which is better than 2022/23).

11. Respondents were asked 27 questions and were encouraged to provide free text answers to explain or expand on their choices. The responses were reviewed by the Committee on 8 March against the same questions from last year.

12. Good practice drawn out includes:
    - Increased awareness of key sources of assurance and a conscious decision made on information it receives.
    - Committee has the right balance of skills and experience, and members contribute regularly to the issues discussed.
    - Clarity on its role and equal prominence given to all key areas in the remit of the Committee.
    - Agenda items are appropriately closed off.
    - Reporting and challenge of reporting by Board is appropriate.
    - There is a period of reflection at the end of each meeting.
    - There are good and effective relationships amongst members.
    - The Committee is well led.

13. As with other Board Committees, the question related to visibility of Committee members scored poorly again this year. Given that there is a Board visits Standard Operating Procedure in place which illustrates members visibility, it is anticipated that this question will be omitted from the 2024/25 survey. The rationale being that it is unlikely, no matter how visible a Non-Executive or Executive Director may be, that that will always resonate with each Committee.

14. Responses included a desire to increase focus on the long-term strategy, the impact on staffing requirements, and implications of working from home on our people. Whilst alignment of annual objectives and progress thereon for the Chief Executive Officer and their direct reports must align with the long-term strategy, these areas are within the remit of the Finance and Performance Committee, the People and Culture Committee and the Board, rather than this

Committee. Similarly, the Board Assurance Framework and risk registers are not routinely brought to this Committee due to its remit, however risks related to issues of settlement agreements including VERS and executive level appointments are highlighted.

15. A Trade Union Partners and Committee Chairs development session has been scoped to support inductions into Board Committees and will be held in 2024/25.

16. The Committee has a cycle of business that is aligned to its terms of reference, albeit there are limited opportunities to proactively plan the work of this Committee. All matters scheduled for oversight and review have been brought to the Committee other than the annual settlement agreement which was introduced in 2023/24. This will be presented in Q2 of each year going forward. In all other respects the Committee has discharged its responsibilities in providing assurance to the Board. The Committee's business in 2023/24 included:

    (a) Approval of **settlement agreements** (two in 2023/24).

    (b) Approved the process and timeline for the **appointment of the Digital Director**.

    (c) Following on from the AACE independent **benchmarking review of Director salary levels** in the UK ambulance sector, the Committee has been overseeing the process of review of Executive Leadership Team job descriptions by Welsh Government. This process continues into 2024/25.

    (d) The Committee noted that the **5% ESP pay award for 2023/24** which was delayed following the pay award for Agenda for Change colleagues earlier in the year, has now been approved by Welsh Government

    (e) The Committee reviewed the **CEO's outturn position for 2022/23 and his objectives for 2023/24** noting they had been cascaded to his direct reports and appraisals completed. The Committee noted the outturn position for 2022/23 was consistent with discussions throughout the year and showed some great progress despite many challenges throughout the year

    (f) On the retirement of Dr Brendan Lloyd on 31 December 2023, the Committee considered the removal of the Medical Director role, and the change in **designation of voting rights** at the Board from the Medical Director to the Director of Paramedicine effective 1 January 2024. This was endorsed by the Board. RemCom also supported the revised senior leadership structure for the Clinical Directorate.

(g) The Committee **cycle of business** was approved.

(h) The **annual effectiveness review** was conducted.

17. One Chair's Action was held for an urgent settlement agreement in March 2023 which was ratified at the 5 June meeting.

18. The Board received a highlight report from this Committee following each meeting which included alerts, advice, and areas of assurance. This was also presented to the next public Board meeting by the Chair of the Committee.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

19. Extensive changes to the Terms of Reference for this Committee were made during the effectiveness reviews held in 2022. The changes this year are therefore minimal and are marked up in [Annex 1] and include the addition of any interim appointments to the roles that are within the remit of the Committee. These will usually come forward at the time the process and timelines for a new appointment is reviewed and will include the remuneration and any handover period remuneration for interim roles, which has been an issue raised recently by auditors on the annual Remuneration Report.

20. Additionally, a provision for Chair's Action has been included in the authority section.

21. Given the somewhat reactive nature of the Committee it does not set annual priorities.

NEXT STEPS

22. The next steps are to ensure changes to the terms of reference are cycled into the work programme for review in 2024/25

RECOMMENDATION

23. The Trust Board is requested to
    (a) Receive and note the contents of the Committee Annual Report for 2023/24 and analysis of its effectiveness; and
    (b) Approve the changes to the Terms of Reference.

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

REMUNERATION COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS ~~2023/24~~2024/25

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government 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*".

1.2. In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Remuneration Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3. The Board Committees play an important role in supporting the Board in fulfilling its responsibilities by:

- providing advice on strategic development and performance within the terms of reference;
- undertaking scrutiny and gaining assurance on key aspects of organisational performance, and supporting achievement of the Trust's strategic goals;
- carrying out specific responsibilities on the Board's behalf; and
- providing a forum where ideas can be explored in greater detail than Board meetings are able to allow, providing time and space to consider issues in greater depth.

Regular and timely reporting and escalations to the Board on the issues within the Committee's remit allow for more focused discussions by the Board.

2. PURPOSE

The purpose of the Remuneration Committee (the Committee) is to:

2.1. Approve on behalf of the Board matters relating to the appointment, termination, remuneration, terms of service and appraisal for the Chief Executive, Executive Directors and other senior staff (including Interim Director

roles) within the framework set by the Welsh Government and in accordance with the Standing Orders; and

2.2. Approve proposals regarding termination arrangements, including those under the Voluntary Early Release Scheme, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.

2.3. Provide assurance to the Board in relation to the Trust's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales.

2.4. The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

2.5. The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

3. DELEGATED POWERS AND AUTHORITY

The Committee will support the Board with regard to its responsibilities for remuneration and terms of service and will:

3.1. Provide assurance to the Board in relation to the Trust's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales. The Committee will review the annual Remuneration Report and approve its contents, by way of email circulation where necessary.

3.2. Approve the remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change, ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government, are applied consistently.

3.3. Approve the appointment of the Chief Executive and Executive Directors (officer members of the Board) and where applicable, interim appointments to those roles.

3.4. Terminate appointments and suspend officer members in accordance with the provision of regulations.

3.5. Consider the appraisal of officer members of the Board.

3.6. Approve the appointment, appraisal, discipline and dismissal of any other board level appointments (including where applicable, interim appointments to these roles) and other senior employees, in accordance with Welsh Government Ministerial instructions, e.g., the Board Secretary.

3.7. Consider and approve redundancy and Voluntary Early Release (VERs) applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.

3.8. Approve proposals for novel employment and pay cases, such as settlement agreements, overtime payments, and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered.

Corporate Risks and Audit Recommendation Tracker

3.9. The ~~Audit~~ Committee will monitor the principal risks relevant to its remit ~~has overall responsibility for ensuring that corporate risks are identified and are being properly managed within the Trust. The Audit Committee also has responsibility for ensuring that there are processes in place to address and take forward audit recommendations. Nevertheless, each risk from the corporate risk register and Board Assurance Framework, and each recommendation from the audit tracker, will be allocated to an appropriate Board Committee who will be responsible for ensuring that the Trust is managing and progressing each item as planned. Regular reports will be provided to individual Committees on those items for which they have responsibility and overall Trust-wide progress reports will be presented to each Audit Committee. The Committee will~~ and consider the control and mitigation of high level related risks and provide assurance to the Board that such risks are being effectively controlled and managed. It will also review any audits relevant to its remit.

Authority

3.10. The Committee is authorised to approve those matters listed above.

3.11. The Committee is authorised by the Trust Board to investigate, or have investigated, any activity within its terms of reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records, or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable request made by the Committee.

3.12. The Committee is authorised by the Board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Trust's procurement, budgetary and other requirements.

3.13. There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. This is most likely, but not exclusively, to arise with respect to approval of policies particularly given the current backlog.

3.14. In these circumstances, the Chair, and the Lead Executive (Director of People and Culture), supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee after first consulting with at least two other Members (Non-Executive Directors).

3.15. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Sub-Committees

~~3.13.~~3.16. The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. Formal sub-committees may only be established with the agreement of the Board.

4. MEMBERSHIP

Members

4.1. The membership of the Committee will comprise:

Chair	Trust Board Chair
Members	All Non-Executive Directors of the Board, including the Audit Committee Chair.

Prescribed Attendees

4.2. The membership will be supported routinely by the following core attendance:

- Chief Executive
- Director of People and Culture (Committee Lead)
- Board Secretary
- Trade Union Partner (x2)

Depending upon the sensitivities being discussed, the Chair may request that core attendees are not in attendance.

4.3. The Committee Chair may extend invitations to attend committee meetings to other Directors and/or Senior Managers, and to officials from within or outside the organisation to attend all or part of the meeting to assist with its discussions on any particular matter. In particular, the Executive Director of Finance and Corporate Resources may be asked to attend where VERS or other settlement applications are being considered.

4.4. Members may send deputies in their absence who will act with their full authority. 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.

Member Appointments

4.5. The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the committee's remit, and, subject to any specific requirements or directions made by the Welsh Government.

4.6. Non Executive Members shall be appointed to hold office for a period of one year at a time, (Membership being reviewed by the Chairman of the Board on an annual basis) up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7. Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Trust Chair and, where appropriate, on the basis of advice from the Trust's Remuneration Committee.

Secretariat and Support to Committee Members

4.8. The Board Secretary, on behalf of the Committee Chair, shall:

(a) arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
(b) ensure the provision of a programme of organisational development for committee members, as part of the Trust's overall board development programme developed by the Director of People and Culture

5. COMMITTEE MEETINGS

Quorum

5.1. At least three members of the Committee must be present to achieve a quorum. In the absence of the Committee Chair, one of those in attendance must be designated as Chair of the meeting.

Frequency of Meetings

5.2. Meetings shall be held no less than quarterly or otherwise as the Chair of the Committee deems necessary, consistent with the Trust's annual plan of Board Business. Meeting agendas, papers and minutes shall be circulated no less seven days prior to each meeting.

Withdrawal of individuals in attendance

5.3. The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/ GROUPS

6.1. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2. The Committee, through its Chair and members, shall work closely with the Board's other committees and groups to provide advice and assurance to the Board through the:

(a) Joint planning and co-ordination of Board and Committee business; and
(b) Sharing of appropriate information;

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework.

6.3. The Committee will consider the assurance provided through the work of the Board's other committees and subgroups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.4. The Committee shall embed the Trust's corporate standards, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1. The Committee Chair shall:

(a) report formally, regularly and on a timely basis to the Board and the Chief Executive (Accountable Officer) on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports where appropriate throughout the year;
(b) bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and
(c) ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1. The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum (as set out in section 5)
- The Committee meets in private due to the sensitivity of its deliberations.

9. REVIEW

9.1. These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

WELSH AMBULANCE SERVICES PARTNERSHIP TEAM (WASPT) ADVISORY GROUP ANNUAL REPORT 2023/24

INTRODUCTION

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees and Advisory Groups (of which WASPT is the sole group) evaluate their effectiveness annually and present an annual report to the Trust Board.

2. As the factors underpinning effective governance can change regular reviews of ensure governance remains fit for purpose. WASPT members agreed that with the reinstatement of the group in 2023 that an effectiveness review would be welcomed to review operating arrangements.

3. The Committee met on 19 February 2024 and reviewed its terms of reference, responses to questionnaires completed by members, and its operating arrangements. Discussions were also held with the Joint Chairs ahead of that meeting to inform proposed changes.

4. This Annual Report reflects on the effectiveness of WASPT in 2023/24 and proposes changes to terms of reference.

PURPOSE OF WASPT

5. WASPT is the forum where senior leaders, trade union partners and professional organisations work together to improve the Trust's services for the people of Wales. It is the principal partnership forum for the discussion of national priorities and strategies and where key stakeholders will engage with each other to inform, debate, and seek to agree priorities on workforce and health service issues.

6. WASPT provides the formal mechanism for consultation, negotiation and communication between the staff organisations and management. The TUC principles of partnership apply.

MEMBERSHIP AND ATTENDANCE

7. WASPT met six times as scheduled in 2023/24 and was quorate on each occasion.

8. WASPT membership consists of eight management members and twelve trade union partner members. Meetings are Chaired on rotation between the management and trade union partner members.

9. Trade union membership includes three seats for each of the four recognised trade unions (GMB, RCN, Unison and Unite). The chart below illustrates attendance of members as listed in the terms of reference for 2023/24. The Committee welcomed non prescribed attendees at various meetings.

COMMITTEE ATTENDANCE						
Name	**13 April 2023**	**14 June 2023**	**30 August 2023**	**12 October 2023**	**15 December 2023**	**19 February 2023**
Joint Chairs						
Jason Killens	Chair	Part meeting	Chair	Until 11am	Chair	
Mark Marsden (Unison)		Chair		Chair		Chair
Management Representatives						
Angela Lewis						
Lee Brooks				Mark Harris		Jon Edwards
Rachel Marsh	Alex Crawford					
Chris Turley						
Andy Swinburn			Part meeting			
Estelle Hitchon						
Trish Mills						
Trade Union Representatives						
Unite representative	Paul Seppman	Paul Seppman	Paul Seppman		Paul Seppman	
Unite representative	Hugh Parry		Hugh Parry	Hugh Parry		Hugh Parry
Unite representative	Christian Fox Carl Jones	Christian Fox	Christian Fox		Christian Fox	Christian Fox
GMB representative	Sharon Thorpe	Sharon Thorpe		Ian James		
GMB representative	Maldwyn Jones	John Phillips	Maldwyn Jones		Maldwyn Jones	Maldwyn Jones
GMB representative	Marcus Viggers	Marcus Viggers		Marcus Viggers	Marcus Viggers	
Unison representative	Rob Morgan	Henry Garrard	Henry Garrard	Henry Garrard	Henry Garrard	Henry Garrard
Unison representative	Bethan Williams	Bethan Williams		Bethan Williams	Bethan Williams	Bethan Williams
Unison representative	Damon Turner	Damon Turner	Damon Turner	Damon Turner	Keith Rodgers	Damon Turner
RCN representative						
RCN representative						
RCN representative						

	Attended
	Deputy attended
	Apologies received
	No longer member/Not member

10. Attendance is steady and the group recognises the importance of consistent membership across the trade unions wherever possible to aid in the flow of information, but also acknowledges that this can be difficult to achieve with shifts

etc., and that there is a need for some flexibility. One RCN member has now been identified to join WASPT.

11. No changes to membership are proposed at this stage.

VIEWS ON EFFECTIVENESS

12. WASPT's effectiveness was assessed through a review of its terms of reference, responses to a questionnaire, discussion with the Joint Chairs, and at the 19 February meeting.

13. The questionnaires provided an opportunity to gauge opinion on areas of good practice and areas that require improvement. Twenty six questionnaires were sent out with 12 responses being returned (a 46% return rate with an equal split between management and Trade union partner members).

14. Respondents were asked three questions:

14.1. <u>What is WASPT doing well:</u>

Responses indicated that WASPT:

- Allows for organisational issues to be discussed.
- Provides a vehicle for relationships to grow.
- Is a good demonstration of partnership working.
- Allows for free flowing discussions.
- Is effective in covering some challenging issues.
- Covers issues in a timely way.
- Has a meeting structure that flows well and frequency and timing is appropriate.
- Reports via the People and Culture Committee which enables the Board to be engaged.
- Is well chaired.
- Gives everyone the opportunity to engage.

14.2. <u>What improvement could be made to the meeting or arrangements:</u>
Responses indicated that improvements could be made in decision-making arrangements, time allocation, agenda management, and communication – specifically:

- More time needs to be allocated to meetings (feels rushed).
- Ensure agenda is relevant.
- Factor in a break.

- Focus on the item on agenda and not conflate items.
- Review meeting frequency
- Review how things are moved on outside the meeting.
- Ensure AAA appropriate for trade union partners to communicate to their members.
- Decision making with a strong link between WAST management and senior trade union representatives has not been happening.
- Keep meeting in person; alternate between in person and online.
- Mix up seating of members and not talk about 'sides' – more unification.
- Personal relationship issues should be resolved outside of WASPT to aid effective working.

14.3. <u>What training and development needs are there for WASPT/members</u>:
Training and development needs for WASPT members include committee effectiveness, relationship building, and understanding of finances and reports – specifically:

- Trade union/management training to start.
- Trade union and management relationship.
- Committee and meeting effectiveness.
- Finances and interpreting various reports.
- Understanding of roles.
- Communication skills.
- NED membership and reporting to Board.
- Separate governance inductions.
- Programme of development specific to WASPT.
- Executives need to be more visible to the shop floor and the lived experience.
- Be less defensive when hearing from staff and take views seriously.
- Need to hear more feedback from corporate forums – very ops focused.

15. Whilst some matters can be timed into the meetings for the year, the nature of WASPT is that it can be difficult to develop a predictable cycle of business. Having said that, the agenda is set with the Joint Chairs and the Board Secretary in advance with reference to the action log, escalations and reporting from the local partnership forum structures approved in 2023, and any issues that would benefit from a partnership discussion. WASPT's discussed the following in 2023/24:

(a) Establishment of the **WASPT sub-structures** to ensure local issues are discussed at local levels was discussed. Governance forums include local partnership forums feeding into established operations forums with Trade

Union Partners. This structure includes an 'Operations Stream' and a 'Corporate Stream'. Reporting on both sub-structure streams was provided throughout the year and issues escalated where necessary.

(b) In April 2023 the **IMTP 2023-26** was discussed as was the challenging revenue and capital financial plan for 2023/24 and the knock on effect of the reduced fleet replacement programme.

(c) In February 2024 the **IMTP 2024-27** was discussed with members engaged on the developing plan for approval by the Board in March 2024.

(d) Several **issues were discussed** in detail, some over multiple meetings, and were subsequently reported to the People and Culture Committee on the AAA report. These included:

- Portering of patients
- Diesel engine exhaust emissions
- Six week relief
- Revised pay offer and WAST specific annex
- EMS establishment
- Overtime restrictions
- Study leave
- Hive survey
- Infection Prevention and Control Policy

(e) Updates were provided on progress against the **actions agreed in partnership with ACAS** in 2022 and developing work with agreed target dates ranging with completion from September 2023 to June 2024. Those agreed actions are as follows:

- Complete move to WASPT and substructure, noting that is now complete and operational.
- Workshop session on best practice (will inform partnership principles).
- Develop partnership principles to support partnership statement.
- Redevelopment partnership statement.
- Develop trade union session for WAST warm welcome.
- Rolling programme of Working Together sessions for managers and Trade Union partners.
- Develop mentoring, coaching, and shadowing programme to share perspectives and experiences.
- Post-meeting reviews.
- Develop consultation sheet for managers/TUPs.

Actions are being progressed through a series of workshops with local representatives and local managers, with representation from the Chief Executive, Director of People and Culture, Trade Union Chair and Secretary. WASPT will continue to monitor progress.

(f) The **annual effectiveness review** was conducted at the February 2024 meeting.

16. The People and Culture Committee receive a highlight report from WASPT following each meeting. The Committee includes reference to this in their report to the Board. The Joint Chairs are invited to the People and Culture Committee and some of the WASPT trade union partner and management members are prescribed attendees. From February 2024 the approved minutes of WASPT will also be included in the Committee's open meeting pack.

17. The Trust Board Chair and Joint Chairs meet quarterly to discuss any issues that may arise and to keep the Trust Board Chair informed.

18. In addition to the regular bi-monthly meetings of WASPT, the following has taken place because of issues raised/matters discussed in WASPT:

(a) Insights Preferences session.
(b) EMS Establishment information session.
(c) Financial Sustainability Programme quarterly updates.
(d) Partnership Development Meeting.

SUB-STRUCTURES

19. WASPT is serviced by the operational and corporate sub-structures established in 2023. Those groups are meeting regularly and reporting in to WASPT by way of a AAA report, escalating issues where they are unable to resolve them at a local level.

PROPOSED CHANGES TO THE TERMS OF REFERENCE

20. The WASPT Terms of Reference were revised in March 2023 shortly after the group was reconstituted. Therefore, changes are minor and include:
    - 4.2 – removal of reference to review of trade union partner numbers in membership. However, trade union partner Chair will review membership to ensure that it is representative as far as possible of all major work groups and professional bodies at WAST as per the Terms of Reference.
    - 5.2 – it had been anticipated that meetings might change to quarterly following the establishment of the local partnership forums, however following feedback

from the survey it is agreed that meetings will be retained on a bi-monthly cycle.

- 7.3 – codifies the position with respect to minute taking and aligns to the timetable for Board and Committee drafts.

21. The changes in the Terms of Reference are marked up in Annex 1.

22. In response to the issues raised in the survey there will be some changes to operating arrangements which include:
    - Encouraging trade union partner members and management members to disburse themselves around the table during in person meetings.
    - Provision of the minutes of WASPT as well as the AAA report to the People and Culture Committee in open session.
    - In addition to the AAA report from WASPT being circulated to members, consideration will be given to a 'hot topics' newsflash that could be circulated by email and included on Siren. This will draw from the AAA and include a link.
    - In addition to retaining the two hour bi-monthly in person meeting, an additional one hour slot will be included for a workshop on a single issue of importance. This will include a lunch break which will be a good opportunity for members to get to know each other better. This will be scheduled in as soon as possible in diaries.
    - Issues raised in the survey such as the desire to walk in each other's shoes, strengthen links between Trade union partner and management members, and working on personal relationships will be addressed in different operating arrangements, but also from the partnership working development sessions that have taken place and are planned as part of the ACAS action plan.
    - There is a Board Visits Standard Operating Procedure in place where Executive and Non-Executive Director visits to our people are shown. This is available for all staff at this Link (Board Member Visits Dashboard (sharepoint.com)) and is reviewed quarterly by the Executive Leadership Team and Trust Chair, and reported in open Board session annually.
    - Where it is identified that the agenda may restrict timing of an item, whether that be in the agenda setting meeting with the joint chairs or the trade union partners pre-meet, the Board Secretary will review the overall timing and adjust where appropriate and with the agreement of the Joint Chairs.
    - On training and development needs identified, there is a trade union partners and Board and Committee Chairs joint session agreed. Additional sessions will include:
        - How to run effective meetings.

- Committee specific induction programmes on roles and responsibilities.
- Financial reporting session.
- Introduction for individual trade union partners and staff who wish to observe Board and Committee meetings for succession or other reasons.

PRIORITIES

23. Given the nature of the issues before WASPT, which are usually topical and emerging, it was felt that it would not be appropriate to set priorities for WASPT for 2024/25. However, the focused agenda setting meetings and agile nature of preparation for meetings will continue as standard practice.

RECOMMENDATION

24. The Trust Board is requested to
    (a) Receive and note the contents of the WASPT Annual Report for 2023/24 and analysis of its effectiveness; and
    (b) Approve the changes to the Terms of Reference.

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

WELSH AMBULANCE SERVICES PARTNERSHIP TEAM (ADVISORY GROUP)

~~V2.1~~

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS 2024-25

1. INTRODUCTION

1.1. The Trust's Standing Orders provide that "*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. 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*".

1.2. In line with Standing Orders the Board shall nominate annually a committee to be known as the Local Partnership Forum, herein referred to as the **Welsh Ambulance Services Partnership Team (WASPT)**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

2. PURPOSE

2.1. WASPT is the forum where the senior leaders, trade union partners~~s~~ and professional organisations work together to improve the Trust's services for the people of Wales. It is the principal partnership forum for the discussion of national priorities and strategies and where key stakeholders will engage with each other to inform, debate and seek to agree priorities on workforce and health service issues.

2.2. WASPT will provide the formal mechanism for consultation, negotiation and communication between the staff organisations and management. The TUC principles of partnership will apply.

2.3. Members will work in partnership, including:

- Showing joint commitment to the success of the organisation with a positive and constructive approach
- Recognising the legitimacy of other partners and their interests and treat all parties with trust and mutual respect
- Demonstrating commitment to employment security for workers and flexible ways of working
- Sharing success – rewards must be felt to be fair
- Practising open and transparent communication – sharing information widely with openness, honesty and transparency
- Bringing effective representation of the views and interests of the workforce
- Demonstrating a commitment to work with and learn from each other

2.4. The committee shall, in carrying out its functions and responsibilities, consider how their decisions secure an improvement in the quality of health services (the duty of quality) as outlined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes but is not limited to ensuring the provision of high-quality, safe, and effective healthcare services that meet the needs of patients, service users, and their families.

2.5. The committee shall demonstrate the duty of quality through its own operating arrangements, ensuring that its processes, procedures, and decision-making mechanisms uphold the highest standards of transparency, accountability, and governance. It shall regularly review and refine its operating procedures to align with best practices and legal requirements, fostering an environment of continuous improvement. Furthermore, the committee shall monitor, assess, and report on the implementation of Health and Care Quality Standards, outcomes, and performance indicators where relevant within their remit.

3. DELEGATED POWERS AND AUTHORITY

WASPT will:

3.1 Establish a regular and formal dialogue between WAST management and trade union partners ~~the staff representatives~~ on strategic issues affecting the workforce and provide opportunities to input into organisational strategy and service development plans at an early stage.

3.2 Consider the implications on staff of service reviews and identify and agree new ways of working where required to deliver the service effectively.

3.3 Consider the implications for staff of NHS organisational change at a national level and to work in partnership to achieve mutually successful implementation.

3.4 Consider and discuss the Trust's services, activity and financial performance and the role of WASPT in improving performance and value for money.

3.5 Take account of, consider and communicate key decisions taken by the Board and senior management.

3.6 Develop and maintain in partnership appropriate facilities arrangements using Agenda for Change Facilities Agreement as a minimum standard.

3.7 Discuss and resolve escalations from sub-groups

Authority

3.8 WASPT as an advisory group supports, advises and challenges on matters of partnership working at a strategic level. Whilst decisions on a range of issues will be made by WASPT relating to consultation, negotiation, next steps and communication, all decisions that have financial, performance, and workforce consequences must be made with reference to the authorities set out in the Standing Orders and its annexures, in particular the Scheme of Reservation and Delegation ('SoRD') which details where decisions are reserved to the Board and where they may be delegated to Executives. Table A of the SoRD details the non-financial delegations and Table B details the financial delegations to Directors and Officers. The SoRD can be found on the Trust website.

Sub-Committees

3.9 WASPT may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of its business. Formal sub-committees may only be established with the agreement of the Board.

3.10 Sub-committees shall report regularly to WASPT by way of a highlight report clearly indicating areas of escalation.

4. MEMBERSHIP

Members

Membership of WASPT is proposed to be kept as small as possible to ensure its focus on strategic issues. A clear sub-structure for resolving issues at a local level and escalations will be put in place to support this. Membership is proposed as follows:

4.1 Management membership will be as follows:

- Chief Executive (management Chair)
- Director of Workforce and Organisational Development
- Executive Director of Operations
- Executive Director of Strategy, Planning and Performance
- Executive Director of Finance and Corporate Resources
- Director of Paramedicine
- Director of Partnerships and Engagement
- Board Secretary

4.2 ~~Staff~~ Trade Union Partner ~~representative~~ membership shall consist of 12 members, representing the four recognised Trade Unions (GMB, RCN, Unison and Unite). ~~However, once the sub-committee structure is established the numbers of staff representative membership will be reviewed~~. ~~Staff representation~~Trade Union Partner membership will collectively represent all major work groups and professional bodies at WAST.

4.3 WASPT shall have joint Chairs who will work in partnership and rotate the role each meeting. Joint Chairs shall ensure that key and appropriate issues are discussed by members in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

4.4 The joint Chairs may extend invitations to other staff representatives, Directors and/or Senior Managers, and to officials (including full time officers) from within or outside the organisation to attend all or part of the meeting to assist with its discussions on any particular matter.

4.5 All members must:

- Engage with and fully contribute to WASPT's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- Prepare fully for the meeting by reviewing any papers provided;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes;
- Promote the work of WASPT within the directorate, Trade Union and/or professional discipline they represent.

4.6 Members may send deputies in their absence who will act with their full authority. To instigate a substitution arrangement members must notify the Board Secretary before the day of the meeting that they are unable to attend and the name of the member who will attend as the substitute.

4.7 The arrangements under which staff are allowed time off to attend meetings of the group and reimbursed expenses incurred in attending such meetings are set out in the agreed Policy on Recognition of and Facilities for Trade Unions.

Member Appointments

4.8 WASPT membership shall be determined by the Board, based on the recommendation of the Trust Chair, taking account of the balance of skills and expertise necessary to deliver the group's remit, and, subject to any specific requirements or directions made by the Welsh Government. Membership will be reviewed by the Trust Chair annually.

4.9 ~~Staff representative~~Trade Union Partner membership (including the Chair) will be drawn from the elected staff side.

4.10 It is intended that the majority of membership will be consistent to allow for continuity of discussions and ease of communication, other than when a deputy is required under the provisions in paragraph 4.6. Where a member does not attend for three consecutive meetings the joint Chairs may seek an explanation from the member and where necessary the replacement of the member.

Secretariat and Support to WASPT

4.11 The Board Secretary, on behalf of the joint Chairs, shall:

(a) Arrange the provision of advice and support to members on any aspect related to the conduct of their role;
(b) Facilitate the effective conduct of Trust business through meetings
(c) Provide the secretariat function to WASPT;
(d) Ensure members have the right information to enable them to make informed decisions and fulfil their responsibilities;
(e) Ensure that in all its dealings, WASPT acts fairly, with integrity, and without prejudice or discrimination;
(f) Monitor the group's compliance with its terms of reference

4.12 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub-committees established.

5. COMMITTEE MEETINGS

Quorum

5.1 At least 50% of the management members and 50% of the ~~staff representative~~ Trade Union Partner members must be present to achieve a quorum.

Frequency of Meetings

5.2 Meetings shall be held no less than ~~than quarterly or otherwise as the joint Chairs deems necessary. However, for the first four meetings of WASPT these shall be~~ bi-monthly or as the joint Chairs deem necessary~~to allow the group to re-establish~~.

5.3 Due to the sensitivity of the issues being discussed, meetings shall be held in private session with the public and press excluded.

Withdrawal of individuals in attendance

5.4 The Chair may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of particular matters.

Conflicts of Interest

5.5 Members must disclose all conflicts of interest in line with the Standing Orders and the Trust's standards of business conduct policy. Members may be asked to recuse themselves from all or part of discussions where a conflict is deemed to exist.

6. OPERATING ARRANGEMENTS

Agenda Setting

6.1 The joint Chairs shall meet with the Board Secretary at least 5 weeks before a meeting to set the agenda which will be circulated to members within 5 working days of that meeting.

6.2 Changes to agenda shall only be made with the agreement of both joint Chairs.

6.3 Any items of 'other business' must be notified to the joint Chairs ahead of each meeting so that appropriate time can be provided for in the meeting for discussion.

Papers and timetables

6.4 The presentation of items on the agenda should be accompanied by sufficient information for WASPT to make a determination on that item. Where an SBAR is not possible due to operational pressures, a shortened template will be developed.

6.5 Best endeavours will be made to ~~Papers will be~~ circulate~~d~~ the agenda and sufficient papers to enable Trade Union Partners to consider these at any pre-meeting discussions. However ~~with~~ the final agenda and meeting papers will formally be distributed ~~14~~seven calendar days before the meeting unless otherwise agreed with the joint Chairs.

7. REPORTING AND COMMUNICATION

Reporting

7.1 WASPT shall report into the People and Culture Committee of the Board as that Committee has the responsibility to provide advice and assurance to the Board on all matters relating to partnerships and engagement relevant to the remit of the Committee, including but not limited to trade unions, external organisations and staff communications.

7.2 Notwithstanding that the Standing Orders provide that WASPT's main link with the Board is through the executive members of the group, the joint Chairs shall prepare a AAA (alert, advise, assure) highlight report to the People and Culture Committee ~~following~~ within 14 days of each WASPT meeting setting out any areas of escalation and key issues discussed. In turn, the People and Culture Committee will report such work in their highlight report to the Board. A copy of the AAA report will be distributed to the WASPT membership once approved by the Joint Chairs.

Minutes

7.3 Minutes will be prepared of each meeting in addition to the AAA report and presented to the Joint Chairs within 14 days of a meeting for review and approval.

Annual Report

~~7.3~~7.4 WASPT shall submit an annual report to the Board through the Chair of the People and Culture Committee within three months 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-Committee it has established.

Communication

~~7.4~~7.5 The WASPT AAA highlight report will be used to communicate the work of the group to the organisation more widely. This is in keeping with the Standing Orders that requires advisory groups to report regularly on its activities to those whose interest they represent.

~~7.5~~7.6 The Chair of the Trust Board shall meet with the Joint Chairs on a regular basis to discuss the WASPT activities and operation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of WASPT, except in the following areas:

- Quorum
- Meeting in private session
- Reporting to the People and Culture Committee

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed at least annually but more frequently if required.

9. VERSION CONTROL TABLE

Version Number	Change	Author/ Reviewer/ Approver	Date
1.0	Terms of Reference and Operating Arrangements for Welsh Ambulance Partnership Forum (WASPF)	WASPF	TBD
1.1	Terms of Reference for reconstituted Welsh Ambulance Services Partnership Team (WASPT). Revised format and wording review approved	WASPT	15 November 2022
2.0	Terms of Reference for reconstituted Welsh Ambulance Services Partnership Team (WASPT) – amendment sought to para 3.4	People and Culture Committee –	29 November 2022
2.1	Terms of Reference amendment to par 3.4 approved	WASPT	20 January 2023

2.1	Terms of Reference for reconstituted Welsh Ambulance Services Partnership Team (WASPT)	Trust Board – Approval	30 March 2023
3.0	• 4.2 – removal of reference to review of trade union partner numbers in membership. However, trade union partner Chair will review membership to ensure that it is representative as far as possible of all major work groups and professional bodies at WAST as per the Terms of Reference. • 5.2 – it had been anticipated that meetings might change to quarterly following the establishment of the local partnership forums, however following feedback from the survey it is agreed that meetings will be retained on a bi-monthly cycle. • 7.3 – codifies the position with respect to minute taking and aligns to the timetable for Board and Committee drafts.	WASPT	19 February 2024
3.0	As above	Trust Board – Approval	May 2024

ANNEX 8
COMMITTEE PRIORITIES 2024/25

Committee	Priorities for 2024/25
Academic Partnership Committee	• Risk reporting where appropriate. • Review the name of the Committee during 2024/25. • Clarity on the purpose and focus of the Committee to be communicated to the wider organisation.
Audit Committee	• Monitor the development of the Committee specific induction programme. • Carry over the priority to monitor the implementation of the Quality and Performance Management Framework.
Charitable Funds Committee	• Monitoring the recruitment of the Head of Charity and Fundraising Officer and their objectives. • Ensure a development session is held at an agreed time with respect to duties and responsibilities of Trustees. • Ensure that the work of the Charity and its governance arrangements and those involved in the Charity's leadership and decision-making, are more visible internally and externally.
Finance and Performance Committee	• The development and approval of the Digital Plan. • Oversight of the potential commercialisation streams in the Financial Sustainability Programme. • Focus on the new elements of its terms of reference relating to Information Governance and Information Security.
People and Culture Committee	• Impact of wellbeing initiatives on our people. • Culture of conversations with a focus on communication and conversations with managers and their people. • A continued focus on equality, diversity and inclusion and the implementation of the strategic equality objectives. • The Trust's approach to development of our people.
Quality, Patient Experience and Safety Committee	• Continue to monitor the duty of quality and duty of candour i.e. Committee will monitor implementation of the Duty of Quality and Duty of Candour following the Health and Social Care (Quality and Engagement) (Wales) Act. • Monitor the delivery of the Quality Strategy (plan) • Monitor the organisation's compliance with the Health and Care Quality Standards 2024
Remuneration Committee	Given the nature of this Committee no specific priorities were set
WASPT	Given the nature of this Advisory Group no specific priorities were set

Archwilio Cymru
Audit Wales

Annual Audit Report 2023 – Welsh Ambulance Services NHS Trust

Audit year: 2022-23

Date issued: February 2024

Document reference: 4056A2024

This document has been prepared as part of work performed in accordance with statutory functions.

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

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

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Summary report

About this report

1 This report summarises the findings from my 2023 audit work at Welsh Ambulance Services NHS Trust (the Trust) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by Trust, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts
- Arrangements for securing economy, efficiency, and effectiveness in the use of resources

3 This year's audit work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.

4 I aimed to ensure my work did not hamper public bodies in tackling the post-pandemic challenges they face, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 The delivery of my audit of accounts work has continued mostly remotely. Auditing standards were updated for 2022-23 audits which resulted in some significant changes in our approach. The specific changes were discussed in detail in my 2023 Audit Plan. The audited accounts submission deadline was extended to 31 July 2023. The financial statements were certified on 28 July 2023, meaning the deadline was met. This reflects a great collective effort by both my staff and the Trust's officers.

6 I also adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the post-pandemic challenges facing the NHS in Wales. I have published an NHS Workforce Data Briefing that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally

and nationally. The data briefing complements my assessments of how the workforce planning arrangements of individual NHS bodies are helping them to effectively address current and future workforce challenges. My local audit teams have commented on the governance arrangements of individual bodies, as well as how they are responding to specific local challenges and risks. My performance audit work is conducted in line with INTOSAI auditing standards[1].

7 This report is a summary of the issues presented in more detailed reports to the Trust this year (see **Appendix 1)**. I also include a summary of the status of work still underway, but not yet completed.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2023 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2023 Audit Plan and how they were addressed through the audit.

10 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We presented it to the Audit Committee on 30 April 2024. The Board will receive the report at a later Board meeting and every member will receive a copy. I strongly encourage the Trust to arrange its wider publication. I will make the report available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Trust's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit), however, I brought some issues to the attention of officers and the Audit Committee in my closing Audit of Accounts Report.

13 I identified no material financial transactions within the Trust's 2022-23 accounts that were not in accordance with authorities or not used for the purpose intended, and so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2022-23 accounts.

[1] INTOSAI (International Organisation of Supreme Audit Institutions) is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

14 I placed no substantive report alongside my opinion this year as there were no issues to report.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

15 My programme of Performance Audit work has led me to draw the following conclusions:

- my national workforce data briefing identified challenges at an all-Wales level including that despite an increasing NHS workforce, there remain vacancies in key areas, high sickness and staff turnover resulting in over-reliance on agency staffing[2]. More positively, NHS Wales is becoming a more flexible and equal employer.
- the Trust is taking effective steps to mitigate current workforce challenges and clarify its longer-term strategic vision, however, medium to longer-term resourcing is a significant and ongoing barrier.
- the Trust demonstrates a focus on improving its arrangements for governance, planning and finance. However, significant operational pressures, inefficiencies caused by handover delays, reliance on non-recurrent savings and lack of available funding are limiting its ability to transform services.

16 These findings are considered further in the following sections.

[2] For the Trust specifically, increased agency costs in 2021-22 were noted as due to pandemic and system pressure-related factors, such as staffing to cohort patients outside of some Emergency Departments, and usage has subsequently decreased.

Detailed report

Audit of accounts

17 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

18 My 2023 Audit Plan set out the key risks for audit of the accounts for 2022-23 and these are detailed along with how they were addressed in **Exhibit 4**, **Appendix 3**.

19 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2022-23 accounts

20 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit), however, I brought some issues to the attention of officers and the Audit Committee.

21 The unaudited accounts were produced for audit in line with agreed timescales, the quality of working papers was judged to be generally strong.

22 I must report issues arising from my work to those charged with governance (the Audit Committee) for consideration before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues on 25 July 2023. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit Committee

Issue	Auditors' comments
Uncorrected misstatements	No such misstatements identified.
Corrected misstatements	A number of misstatements were identified which were corrected by management in the final accounts. None of the corrections raised affected the disclosed year-end surplus of £62,000.

Issue	Auditors' comments
Other significant issues	We reported two issues for the attention of the Audit Committee: • confirmation that there would be no qualified audit opinion for 2022-23 in relation to the Ministerial direction relating to senior NHS staff's pension tax liabilities; and • identification of two expenditure transactions worth £110,000 which had been recorded incorrectly in 2022-23 instead of 2023-24.

23 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Trust's financial position on 31 March 2023, and the return was prepared in accordance with the Treasury's instructions.

24 My separate independent examination of the charitable funds accounts is complete with the closing findings reported to the Charitable Funds Committee on 18 January 2024. The Auditor General certified the final accounts on 29 January, allowing the accounts to be filed before the Charity Commission's statutory deadline of 31 January.

Regularity of financial transactions

25 The Trust's financial transactions must be in accordance with the authorities that govern them. It must have the powers to receive income and incur expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Trust does not have the powers to receive or incur.

26 I identified no material financial transactions within the Trust's 2022-23 accounts that were not in accordance with authorities or not used for the purpose intended, and so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2022-23 accounts.

27 I placed no substantive report on the accounts alongside my opinion this year as there were no issues to report.

28 I have the power to place a substantive report on the Trust's accounts alongside my opinions where I want to highlight issues. Where the Trust fails one of its financial duties – to break even over a three-year period and to have an approved three-year plan in place – or my opinion is qualified, I will issue a substantive report.

29 The Trust met both of its financial duties set out the financial position in more detail including in-year surplus/deficit and the three-year position, and my opinions were unqualified, so I did not issue a such a report.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

30 I have a statutory requirement to satisfy myself that the Trust has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Trust over the last 12 months to help me discharge that responsibility. This work has involved:

- publishing an NHS Workforce Data Briefing that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally and nationally;
- reviewing the effectiveness of the Trust's workforce planning arrangements; and
- undertaking a structured assessment of the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

31 My conclusions based on this work are set out below.

NHS workforce data briefing

32 In September 2023, I published a data briefing which set out key workforce data for NHS Wales. My briefing highlighted continued growth of NHS Wales, and reflected that in some instances, the growth in staff levels, particularly in nursing and some medical specialties has not kept up with increasing demand.

33 The pandemic clearly had an impact on staff and the workforce remains under significant pressure. The recent key trends show increased staff turnover, sickness absence and vacancies. This has resulted in greater reliance on external agency staffing and notably increased agency costs to £325 million in 2022-23.[3] Wales is growing its own workforce, with increased nurses and doctors in training, yet despite this, there is still a heavy reliance on medical staff from outside of Wales, demonstrating a need to both ensure that education commissioning is aligned to demand, but also that health bodies are able to recruit sufficient graduates, once

[3] For the Trust specifically, increased agency costs in 2021-22 were noted as due to pandemic and system pressure-related factors, such as staffing to cohort patients outside of some Emergency Departments, and usage has subsequently decreased.

they have completed their training. My report also highlights some positive trends that show that the NHS is becoming a more flexible and equal employer.

Workforce planning arrangements

34 My review examined whether the Trust has effective arrangements to support workforce planning. It focussed on the strategic and operational workforce planning, how it uses workforce information and how it works with its stakeholders to develop solutions. The work also considered the organisation's capacity and capability to identify and address key short and long-term workforce challenges and how it monitors whether its approach is making a difference.

35 My work found that **the Trust is taking effective steps to mitigate current workforce challenges and clarify its longer-term strategic vision, however, medium to longer-term resourcing is a significant and ongoing barrier**.

36 The Trust is strengthening its strategic workforce approach and is developing its strategic workforce plan which it expects to complete by April 2024. It is appropriately using workforce data to inform key workforce decisions, however, the Trust needs to better integrate IT systems to enable workforce data analysis. While the relationship between the Trust and its trade union partners is sometimes challenging, the Trust effectively engages with its staff, wider stakeholders and commissioners to develop workforce solutions.

37 The Trust is investing in workforce planning capacity and capability and providing training for managers, but it will need to ensure that its efforts are delivering the intended benefits. While the Trust has costed its workforce plan through the development of its Integrated Medium Term Plan (IMTP), it is likely to require significant additional resources to fully achieve the degree of service transformation set out in its strategic vision. At the time of fieldwork, the Trust was working to identify the specific workforce requirements to achieve its vision and the accompanying funding which it will need to source. Sourcing this funding is likely to be a significant challenge.

38 The People and Culture Committee receive regular and comprehensive workforce reports. While these reports are often operational there is an improving focus on progress of the Trust's strategic aims within the People and Culture Plan. External oversight by the Emergency Ambulance Services Committee (EASC)[4] ensures the commissioners understand the Trust's service workforce pressures. This helps to align commissioners' expectations with available finance and workforce resource.

[4] The Emergency Ambulance Services Committee (EASC) is a Joint Committee of the seven health boards in Wales, with the responsibility for planning and securing sufficient ambulance services for the population.

Structured assessment

39 My 2023 structured assessment work took place at a time when NHS bodies were continuing to deal with the legacy of the COVID-19 pandemic in terms of recovering and transforming services and responding to the additional demand in the system that built up during the pandemic. Furthermore, they were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate.

40 My team focussed on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency, effectiveness, and cohesion; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. Auditors also paid attention to progress made to address previous recommendations.

41 Overall, I found that **the Trust demonstrates a focus on improving its arrangements for governance, planning and finance. However, significant operational pressures, inefficiencies caused by handover delays, reliance on non-recurrent savings and lack of additional funding are limiting its ability to transform services**.

Board transparency, effectiveness, and cohesion

42 My work considered whether the Trust's Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:

- Public transparency of Board business
- Arrangements to support the conduct of Board business
- Board and committee structure, business, meetings, and flows of assurance
- Board commitment to hearing from staff, users, other stakeholders
- Board skills, experiences, cohesiveness, and commitment to improvement

43 My work found **that Board and Committee arrangements are effective, however, the Trust has a significant backlog of policies due for review, and there is scope to make some improvements to other areas of administrative governance**.

44 The Board remains committed to public transparency. Meetings are livestreamed, there are opportunities for the public to ask questions in advance of meetings, and private/closed meeting actions are reported in public Board papers. The Trust publishes most meeting papers in advance of meetings. However, to further increase the transparency of Board business, the Trust should publish unconfirmed Board and committee minutes sooner, and a written version of the Chair's Report should be provided. Whilst the Trust has a significant backlog of policies that are overdue, it has developed a realistic and prioritised plan to address this issue.

45 The Board and its committees operate well, supported by up-to-date terms of reference and an outline of the agenda for the year ahead. Meetings are well-chaired, and members provide meaningful contribution to support, scrutinise, and seek assurance. There will be some changes to the membership of the Board over coming months and the Trust has taken reasonable and well-considered action to manage these changes. Papers are generally of a good standard although there is ongoing work to encourage more succinct presentations of key risks and issues.

Corporate systems of assurance

46 My work considered whether the Trust has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:

- overseeing strategic and corporate risks;
- overseeing organisational performance;
- overseeing the quality and safety of services; and
- tracking recommendations.

47 My work found that **the Trust is strengthening its corporate systems of assurance, however, there is more to do in key areas including the Board Assurance Framework (BAF) and handling concerns and incidents. Arrangements for oversight and management of performance are reasonable in the context of an extremely challenging operational position due to increased demand and wider system pressures**.

48 The Trust has reasonable arrangements for updating, managing and overseeing its risks. The Trust demonstrates a commitment to collaborating with partners to establish a shared understanding and response to some if its highest rated risks as these are often outside of the Trust's direct control. The Trust maintains reasonable performance management arrangements, however, operational performance remains extremely challenging due to increased demand and wider system pressures that are resulting in continued and significant handover delays at many Emergency Departments and the consequential inefficiencies created by time lost to handover delays.

49 The Trust has taken positive steps to improve its quality governance arrangements, including work to prepare for the requirements under the new Health and Social Care (Quality and Engagement) Act (2020). However, timeliness of response to concerns has deteriorated due to increased demand and capacity issues. Arrangements for tracking audit recommendations are strengthening, with greater clarity on the closure of actions and the impact achieved.

Corporate approach to planning

50 My work considered whether the Trust has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:

- producing and overseeing the development of strategies and corporate plans, including the Integrated Medium Term Plan; and
- overseeing the delivery of corporate strategies and plans.

51 My work found that **the Trust has a good corporate approach to developing strategies and plans, but plans do not include SMART[5] milestones, and delivery reports do not provide enough clarity on whether intended outcomes are being achieved**.

52 The Trust's arrangements for producing and overseeing the development of strategies and plans are reasonable. Its 2023-2026 Integrated Medium Term Plan aligns well to its long-term vision and again received approval from the Welsh Government. However, the Trust needs to strengthen its approach for Integrated Medium Term Plan progress reporting by increasing the focus on outcomes and impact achieved, rather than focussing solely on activity/actions delivered. It should also ensure that all actions set out in the IMTP are SMART with measurable outcomes and clear delivery milestones.

Corporate approach to managing financial resources

53 My work considered whether the Trust has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:

- achieving its financial objectives;
- overseeing financial planning;
- overseeing financial management; and
- overseeing financial performance.

54 My work found that **the Trust demonstrates strong financial performance, a good approach to financial planning and appropriate Board and committee oversight. However, the reliance on non-recurrent savings schemes, operational inefficiencies caused by handover delays and lack of available additional funding may limit the Trust's ability to support its service modernisation plans**.

55 The Trust continued its good track-record of meeting its financial objectives and duties both for 2022-23 and the rolling three-year period of 2020-21 to 2022-23. The Trust is on track to achieve its financial duties in 2023-24.

56 The Trust has robust arrangements for financial planning, which clearly identifies key risks and issues. The Trust had a savings gap at the time of approving its financial plan but was able to identify the necessary savings to meet this gap by month four. However, the level of non-recurrent savings within the Trust's plan is a cause of concern, which, along with ongoing inefficiencies caused by ambulance

[5] Specific, measurable, achievable, relevant, and time-bound.

handover delays and difficulties accessing additional funding limit the Trust's ability to fund the transformational change it is seeking.

57 There is regular financial oversight at both executive and board level. Financial reports contain the most up-to-date information, although we note that savings reports could provide further clarity on whether savings are recurrent or non-recurrent. The Trust must also maintain a focus on ensuring that verbal updates to the Finance and Performance Committee provide sufficient clarity given that members are not able to prepare questions in advance of meetings.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Trust since our previous report.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	July 2023
Opinion on the Financial Statements	July 2023
Audit of the Charitable Funds' Financial Statements	January 2024
Performance audit reports	
NHS Workforce Data Briefing	September 2023
Review of Workforce Planning Arrangements	October 2023
Structured Assessment 2023	November 2023
Other	
2023 Outline Audit Plan	March 2023

My wider programme of national value for money studies in 2023 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts

Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are several performance audits that are still underway at the Trust. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Review of Financial Efficiencies	April 2024
Quality Governance arrangements – follow-up	June 2024
Review of Unscheduled Care	July 2024

Appendix 2

Audit fee

The 2023 Audit Plan set out the proposed audit fee of £188,424 (excluding VAT). My latest estimate of the actual fee is in keeping with the fee set out in the outline.

Appendix 3

Audit of accounts risks

My 2023 Audit Plan set out the risks of material misstatement and/or irregularity for the audit of the Trust's 2022-23 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Exhibit 4: audit of accounts – significant risks

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk.	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; and • evaluate the rationale for any significant transactions outside the normal course of business.	Audit work over journal entries and accounting estimates found no evidence of management override of controls, and provided assurance that the accounts were free from material error.
There is a risk that you will fail to meet your first financial duty to break even over a three-year period. You have reported a year-end surplus of £62,000. This, combined with the outturns for 2020-21 and 2021-22, shows a three-year surplus of £207,000. Your current financial pressures increase the risk that management judgements and estimates could be biased in an effort to achieve the financial duty. There is also a risk of material misstatement due to fraud in expenditure recognition and as such is treated as a significant risk. This risk is focused on transactions before and after the year end, and key year-end	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; • perform detailed testing on a sample of key transactions before and after the year end to ensure they are accounted for in the correct accounting period; and • perform detailed testing on a sample of key year-end balances to ensure they are appropriate and complete.	Audit work provided assurance that the accounts were free from material error and that the year-end surplus position for 2022-23 was appropriate.

Audit risk	Proposed audit response	Work done and outcome
balances, relating to non-pay expenditure with bodies outside of NHS Wales and the Welsh Government.		

Exhibit 5: audit of accounts – other areas of focus

Audit risk	Proposed audit response	Work done and outcome
A new accounting standard, IFRS16 Leases, has been adopted by the FReM for 2022-23. IFRS16 will significantly change how most leased assets are accounted for, as leased assets will need to be recognised as assets and liabilities in the Statement of Financial Position. There are also significant additional disclosure requirements specific to leased assets that will need to be reflected in the financial statements.	My audit team will: • consider the completeness of the lease portfolios identified by the Trust needing to be included in IFRS16 calculations; • review a sample of calculated asset and liability values and ensure that these have been accounted for and disclosed in accordance with the Manual for Accounts; and • ensure that all material disclosures have been made.	Audit work confirmed that the disclosures in this area of the accounts were materially complete and accurate, with no significant issues arising.
The quinquennial valuation of the NHS estate took place as at 1 April 2022. There is a risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date.	My audit team will: • consider the appropriateness of the work of the Valuation Office Agency as a management expert; • test the appropriateness of asset valuation bases; • review a sample of movements in carrying values to ensure that movements have been correctly accounted for and disclosed, in accordance	Audit work provided assurance that accounting entries arising from the quinquennial valuation had been appropriately disclosed in the 2022-23 accounts.

Audit risk	Proposed audit response	Work done and outcome
	with the Manual for Accounts; and • consider whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.	
There is significant investment in capital projects and a risk that capital expenditure classified as Assets Under Construction is materially mis-stated: • capital expenditure up to month 11 was reported at £12.5 million, increasing to £29.1 million up to month 12; • at the year end, there are balances of £25.5 million classified as Assets Under Construction, with vehicles under construction held by third parties; and • there is an element of judgement needed when determining the amount of costs to be capitalised on each project and the valuation of these assets at the end of the year.	My audit team will: • understand the reasons for the peak in capital expenditure in month 12 and assess impact on audit approach; • detailed testing on a sample of additions and capital accruals; • for vehicles under construction by third parties, review the contractual terms and assess whether the criteria for recognising the assets have been met; and • review and challenge whether any assets under construction require impairment.	Audit work provided assurance that capital expenditure was appropriately recorded and disclosed in the 2022-23 accounts.
Last year there were issues with the completeness of asset disposals within the financial statements. Assets no longer in use were removed from Property, Plant and Equipment and Intangibles.	My audit team will: • review your arrangements for capturing disposals; and • perform detailed testing to ensure asset disposals are complete.	Audit work provided assurance that asset disposals in the accounts were accurate and complete in the 2022-23 accounts.
A key source of estimation uncertainty relates to the provision for clinical negligence and personal injury claims.	My audit team will: • perform detailed testing on a sample of claims;	Audit work provided assurance over the reasonableness and

Audit risk	Proposed audit response	Work done and outcome
The subjective nature of these provisions and associated judgments gives rise to increased risk.	• evaluate the reasonableness of key assumptions and judgments; and • consider the work of Legal and Risk Services and the NHS Business Services Authority as a management expert.	disclosure of such liabilities in the 2022-23 accounts.

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
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Archwilio Cymru
Audit Wales

Welsh Ambulance Services University NHS Trust - Audit Plan 2024

Date issued: April 2024

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This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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

About Audit Wales

Our aims and ambitions

Assure

the people of Wales that public money is well managed

Explain

how public money is being used to meet people's needs

Inspire

and empower the Welsh public sector to improve

Fully exploit our unique perspective, expertise and depth of insight

Strengthen our position as an authoritative, trusted and independent voice

Increase our visibility, influence and relevance

Be a model organisation for the public sector in Wales and beyond

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Introduction

I have now largely completed my planning work.

This Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

It sets out the work my team intends undertaking to address the audit risks identified and other key areas of focus during 2024.

It also sets out my estimated audit fee, details of my audit team and key dates for delivering my audit team's activities and planned outputs.

Adrian Crompton
Auditor General for Wales

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material is set out later in this plan.

I am also required to certify a return to the Welsh Government which provides information about the Trust to support preparation of the Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

Performance audit work

I must satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Trust and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

My performance audit work is designed to comply with auditing standards set out by the International Organisation of Supreme Audit Institutions (INTOSAI). This is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations

Your audit at a glance

My financial statements audit will concentrate on your risks and other areas of focus

My audit planning has identified the following risks:

Significant audit risks

- Management override of controls

Other areas of audit focus

- Achieving the financial duty to break even
- Recognition of expenditure
- Estimation of provisions and contingent liabilities
- IFRS 16 leases
- Recognition and measurement of capital expenditure
- Senior officer remuneration
- Related party disclosures

My performance audit will include:

- Structured Assessment – core
- Structured Assessment – deep dive review of investment in digital systems to support service resilience and transformation
- All-Wales Thematic Review – managing demand for urgent and emergency care

Materiality

Materiality	£2.963m
Reporting threshold	£148,000

Financial statements audit materiality

Planning Materiality £2.963m

My aim is to identify and correct material misstatements, that is, those that might other cause the user of the accounts into being misled.

Materiality is calculated using:

- 2022-23 gross expenditure of £296.3 million
- Materiality percentage of 1%

I report to those charged with governance any misstatements above a trivial level (set at 5% of materiality).

Areas of specific interest

There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

- Remuneration of senior officers and non-executive directors as per the banding category within the Remuneration Report (excluding technically calculated pension entries which are not material by nature): £5,000
- Related party disclosures with senior officers and non-executive directors: £10,000

Significant audit risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other ISAs. The ISAs require us to focus more attention on these significant risks.

Exhibit 1: significant financial statement risks

Significant risk	Our planned response
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; and evaluate the rationale for any significant transactions outside the normal course of business.

Other areas of audit focus

I set out other identified risks of material misstatement which, whilst not determined to be significant risks as above, I would like to bring to your attention.

Exhibit 2: other areas of focus

Audit risk	Our planned response
There is an inherent risk that you will fail to meet your first financial duty to break even over a rolling three-year period. However, your reported position at month 11 shows a year-to-date surplus of £108,000 and a forecast of break-even which is consistent with the Minister's published control total. This, combined with the outturns for 2021-22 and 2022-23, would result in a rolling three-year surplus of £137,000. While the financial position of the Trust is robust, the existence of such a financial duty increases the risk that management judgements and estimates could be biased in response.	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; • perform detailed testing on a sample of key transactions before and after year end to ensure they are accounted for in the correct accounting period; and • perform detailed testing on a sample of key year end balances to ensure they are appropriate and complete.
Our 2022-23 audit identified £110,000 of transactions that had been recorded in the 2022-23 accounts, despite reflecting transactions arising from 2023-24. There is therefore an inherent risk that we could uncover similar transactions in our 2023-24 audit, which could be material in value and require amendment.	My audit team will perform detailed testing on a sample of key transactions before and after year end to ensure they are accounted for in the correct accounting period.
From 1 December 2023, the Losses and Special Payments Register (LaSPaR) used to calculate the losses and many of the provisions balances in the accounts has been decommissioned. For the remainder of 2023-24, a model Excel spreadsheet has been used to	My audit team will: • test the completeness and accuracy of data transfer from the LaSPaR system to the excel based spreadsheets; • review the year-end Excel spreadsheet to ensure that there are no significant errors or issues;

record losses and special payments and calculate year-end balances. There is a risk that transactions and balances related to losses and special payments are misstated due to: • the data transfer between LaSPaR and the Excel model not being complete and accurate; and/or • the Excel model miscalculating balances, due to formula errors and/or incorrect data entry. Furthermore, the subjective nature of estimating provisions for clinical negligence and personal injury claims (and the need for expert external input) gives rise to increased audit risk.	• confirm Excel entries back to supporting evidence (e.g. Quantum reports) on a sample basis; and • Confirm the competence and objectivity of expert opinion informing the value of such estimates.
The revised accounting standard for leases (IFRS 16) was adopted by the Financial Reporting Manual (FreM) from 2022-23 onwards. IFRS 16 significantly changes how most leased assets are accounted for and there are also significant additional disclosure requirements arising. As 2023-24 is the second year of adoption, there is a risk that the accounting and disclosure requirements will be incomplete as it will take time for IFRS 16 requirements to be fully embedded.	My audit team will: • consider the completeness of the lease portfolios identified by the Trust needing to be included in IFRS 16 calculations; • review a sample of calculated asset and liability values and ensure that these have been accounted for and disclosed in accordance with the Manual for Accounts and FReM; and • ensure that all material disclosures have been made appropriately.
There is significant investment in capital projects and a risk that capital classified as Assets Under Construction is materially mis-stated: • Capital expenditure up to month 11 was reported at £10m, with a forecast of £23m at year end. • There is an element of judgement needed when determining the amount of costs to be capitalised on each project and the valuation of these assets at the end of the year.	My audit team will: • understand the reasons for the peak in capital expenditure predicted in month 12 and assess impact on audit approach; • perform detailed testing on a sample of additions and capital accruals; • for vehicles under construction by third parties, review the contractual terms and assess whether the criteria for

	recognising the assets have been met; and • review and challenge whether any assets under construction require impairment.
Senior Officer Remuneration is an area of complexity and significant interest in the accounts each year. As an area of specific interest for the audit, we apply a lower materiality level in our review of this area.	My audit team will review these disclosures in detail to ensure that they are reasonable and in line with legislative requirements.
Related Party Disclosures is an area with a lower materiality level in our review of this area as there are risks of incorrect or incomplete disclosures being made.	My audit team will review these disclosures in detail to ensure that they are reasonable, complete and in line with the FReM.

Financial statements audit timetable

I set out below key dates for delivery of my accounts audit work and planned outputs.

Exhibit 3: key dates for delivery of planned outputs

Planned output	Work undertaken	Report finalised
2024 Audit Plan	March - April 2024	April 2024
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements	May - June 2024	July 2024

Planned performance audit work

I set out below details of my performance audit work and key dates for delivery of planned outputs.

Exhibit 4: key dates for delivery of planned outputs

Area of work	Scope of the work	Planned timescales
Structured Assessment - core	Structured assessment will continue to form the basis of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My core 2024 structured assessment work will review the following areas: • Board and committee cohesion and effectiveness. • Corporate systems of assurance. • Corporate planning arrangements; and • Corporate financial planning and management arrangements. My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.	Fieldwork to commence between June and August 2024 with reporting by the end of October 2024.
Structured Assessment - deep dive review of investment in digital systems to support service resilience and transformation	In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth. This year, my audit teams will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency. This work was deferred from	Fieldwork to commence during the spring of 2024 and reporting by the end of December 2024.

Area of work	Scope of the work	Planned timescales
	2023, following my decision to replace the work with a review of the Trust's approach to financial efficiencies.	
All Wales thematic review of urgent and emergency care – managing demand for urgent and emergency care	In my 2020 audit plan for the Trust, I set out my intention to undertake work to examine arrangements to manage demand for urgent and emergency care services, as part of my wider work focused on these services. Due to the COVID-19 pandemic, I deferred this work to allow NHS bodies to respond to the pandemic, with a plan to bring the work back online once the impact of the pandemic had subsided and my work on patient flow out of hospital was completed. I am now able to take forward my work on managing demand for urgent and emergency care. The work will be undertaken during 2024 and will be funded from this year's audit fee. Consequently, I have decided to refund the Trust the fee paid for this work as part of my 2020 audit plan. My 2024 urgent and emergency care work will focus on: • The robustness of plans to manage the demand on urgent and emergency care services; • The effectiveness of arrangements to encourage and enable people to access the right care, in the right place, at the first time; and • The effectiveness of arrangements to monitor the performance of urgent and emergency care services and apply lessons learnt to improve the services further.	Fieldwork commenced in February 2024 and reporting by the end of September 2024.

Fee and audit team

In January 2024 we published our Fee Scheme for the 2024-25 year as approved by the Senedd Finance Committee. My fee rates for 2024-25 have increased by an average of 6.4% as a result of unavoidable inflationary pressures and the ongoing need to invest in audit quality.

I estimate your total audit fee will be £200,483.

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without first discussing them with the Director of Finance and Corporate Resources.

Our financial audit fee is based on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and includes timescales and responsibilities.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 5: breakdown of audit fee

Audit area	Proposed fee for 2024 (£)[1]	Actual fee for 2023 (£)
Audit of Financial Statements	114,496	107,609
Performance audit work:		
• Structured Assessment	62,896	62,811
• All-Wales thematic review	23,091	-
• Local projects	-	18,004
Performance work total	**85,987**	**80,815**
Total fee	**200,483**	**188,424**

[1] The fees shown in this document are exclusive of VAT, which is not charged to you.

The main members of my team, together with their contact details, are summarised in **Exhibit 6**.

Exhibit 6: my local audit team

Name	Role	Contact details
Dave Thomas	Engagement Director/Audit Director (Performance Audit)	Dave.Thomas@audit.wales
Gareth Lucey	Audit Director (Financial Audit)	Gareth.Lucey@audit.wales
Yvonne Thomas	Audit Manager (Financial Audit)	Yvonne.Thomas@audit.wales
Darren Griffiths	Audit Manager (Performance Audit)	Darren.Griffiths@audit.wales
Amy Lord	Audit Lead (Financial Audit)	Amy.Lord@audit.wales
Fflur Jones	Audit Lead (Performance Audit)	Fflur.Jones@audit.wales

I can confirm that my team members are all independent of Trust and your officers.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD* and our Chair, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2023.

Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

* QAD is the quality monitoring arm of ICAEW.

Supporting you

Audit Wales has developed a range of resources to support the scrutiny of Welsh public bodies and to support those bodies in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

	our **Good Practice** work where we share emerging practice and insights from our audit work in support of our objectives to assure, to explain and to inspire.
	our **newsletter** which provides you with regular updates on our public service audit work, good practice, and events.
	our **publications** which cover our audit work completed at public bodies.
	information on our **forward performance audit work programme 2023-2026** which is shaped by stakeholder engagement activity and our picture of public services analysis.
	various **data tools** and **infographics** to help you better understand public spending trends including a range of other insights into the scrutiny of public service delivery.

You can find out more about Audit Wales in our Annual Plan 2024-25 and Our Strategy 2022-27.

Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff CF10 4BZ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

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

AGENDA ITEM No	17
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	1

INTERIM AMENDMENT OF STANDING ORDERS

MEETING	Trust Board
DATE	30 May 2024
EXECUTIVE	Trish Mills, Director of Corporate Governance/Board Secretary
AUTHOR	Trish Mills, Director of Corporate Governance/Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. Interim changes were made to the Model Standing Orders by Welsh Government in March 2024 to reflect the new commissioning arrangements following the introduction of the Joint Commissioning Committee and the change of the Trust's name following its award of University Trust Status, both of which took effect from 1 April 2024. The changes also clarify our status as a Public Body under the Wellbeing of Future Generations Act 2015.

2. The marked-up changes to the Standing Orders are at **Annex 1** and have been made in line with the Welsh Health Circular numbered 2024/019. It is anticipated that a full review of the Standing Orders, Scheme of Matters Reserved to the Board, and the Standing Financial Instructions will be undertaken by Welsh Government in or around Q3 2024/25.

3. The Audit Committee reviewed the changes to the Standing Orders at their meeting on 30 April 2024 and recommend them to the Board for approval.

4. The Standing Orders at 7.2.5 provides for our Annual General Meeting (AGM) to be held by 31 July each year. Welsh Government have advised in the Manual for Accounts that for the 2023/24 annual report and accounts the AGM may be held before 30 September 2024. This ensures alignment with the external audit scheme. The Trust Board is asked for formally approve this temporary change to the Standing Orders.

RECOMMENDATION

5. **The Board is requested to:**

(a) Approve the interim amendments to the Standing Orders at Annex 1.
(b) Approve the change to the deadline to hold the 2023/24 AGM by the 30 September 2024.

KEY ISSUES/IMPLICATIONS
6. The Audit Committee also reviewed amendments to the (non-prescribed) Scheme of Delegation at its 30 April 2024 meeting, however a further clarifying amendment is to be made and presented to the 7 June meeting. It will thereafter come back to the Board for formal approval.

REPORT APPROVAL ROUTE
Audit Committee – 30 April 2024

REPORT APPENDICES
Annex 1 – Interim amendments to Standing Orders

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

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

Welsh Ambulance Services University NHS Trust

STANDING ORDERS

Approved by Trust Board

30 May 2024

~~23 November 2023~~

Adopted from the Model Standing Orders, Schedule of Reservation and Delegation of Powers, and Standing Financial Instructions issued by Welsh Government in ~~July~~ April~~2023~~ 2024 (WHC/2024/019)

Date approved:	**~~23 November 2023~~ 30 May 2024**
Approved by:	**Trust Board**
Review date:	**Annual**

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/.

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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 University 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.

iii) All business shall be conducted in the name of Welsh Ambulance Services University 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

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.

ix) In exercising their powers NHS Trusts must be clear about the statutory basis for exercising such powers.

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.

~~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.~~

~~**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 arrangemen~~

~~**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.~~

xi) The **National Health Service Joint Commissioning Committee (Wales) Directions 2024 (WG24-06)** provide that the seven Health Boards in Wales

will establish a joint committee to exercise the functions of planning, securing and commissioning:

(a) specialised services for –
(i) cancer and blood disorders,
(ii) cardiac conditions,
(iii) mental health and vulnerable groups
(iv) neurosciences, and
(v) women and children,

(b) services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis,

(c) emergency medical services,

(d) non-emergency patient transport services,

(e) emergency medical retrieval and transfer services,

(f) NHS 111 services,

(g) sexual assault referral centres, and

(h) other services as directed by the Welsh Ministers.

Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made the **National Health Service Wales Joint Commissioning Committee (Wales) Regulations 2024 (2024 No. 135 (W29)),** which make provision for the constitution and membership of the Joint Commissioning Committee, including its procedures and administrative arrangements.

~~xi)~~xii) **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.

~~xii)~~xiii) **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.**

~~xiii)~~xiv) 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.

~~xiv)~~xv) 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.

~~xv)~~xvi) 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.

~~xvi)~~xvii) 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.

~~xvii)~~xviii) 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

~~xviii)~~xix) 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.

~~xix)~~xx) 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.

~~xx)~~xxi) 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 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/

~~xxi)~~xxii) 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 Services University NHS Trust will be considered a public body under the Act from 24 June 2024. ~~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.~~

~~xxii)~~xxiii) 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

~~xxiii)~~xxiv) 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.

~~xxiv)~~xxv) 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 University 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.*

~~xxv)~~xxvi) 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).

~~xxvi)~~xxvii) 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

~~xxvii)~~xxviii) 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.*

~~xxviii)~~xxix) 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.

~~xxix)~~xxx) **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

~~xxx)~~xxxi) 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

~~xxxi)~~xxxii) 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).

~~xxxii)~~xxxiii) 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

~~xxxiii)~~xxxiv) 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 University NHS Trust, including details on how to contact them, is available at ~~Welsh Ambulance Service NHS Trust - Trust Board (wales.nhs.uk)~~Welsh Ambulance Service University NHS Trust - Trust Board (wales.nhs.uk).

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
(ii) Vantage Point House, Ty Coch Way, Cwmbran, NP44 7HF
(iii) Ty Elwy, St Asaph Business Park, St Asaph, LL17 0LJ,
(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 non-executive directors and 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 six, appointed by the relevant committee, and consisting of the Chief Executive, the Director of Finance and Corporate Resources and 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 (excluding the Chair and Vice Chair) appointed by the Minister for Health and Social Services, which will include:.

- A person who holds a health related post in a university.

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 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, 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 The Citizen Voice Body for Health and Social Care Wales (known as Llais)

6.1.1 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 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)

6.1.4 In discharging these duties, and given the all-Wales nature of the Trust's functions, the Board shall work constructively with the Board of Llais, to ensure that regional offices of Llais are involved, as appropriate, in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for service change and 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, formally consulting and working jointly with the Board of Llais 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.

6.1.5 The Board shall ensure that Llais is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

6.1.6 The Board may determine that a designated Llais representative shall be invited to attend Board meetings.

6.1.7 The Board shall ensure arrangements are in place for regular meetings between Trust officers and representatives of Llais.

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 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 Llais.

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 28 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 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 seven 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 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 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 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.

[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.

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 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

[2] The term gift refers also to any reward or benefit.

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,

[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.

- 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

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~~10.0.4 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 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 Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

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	30 May 2024
Committee Meeting Date	23 April 2024
Chair	Hannah Rowan

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. As the Board will be aware, the appointed **Academic Non-Executive Director** who was due to start on 1 April 2024 was not able to join the Trust. A fresh campaign has commenced with a closing date of 10 May.

ADVISE

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

2. As was announced at the March Board meeting, the Trust's application for **University Trust Status** has now been approved and the Trust's name has changed to the Welsh Ambulance Services University NHS Trust.

3. Hannah Rowan, the **Research Champion Non-Executive Director** and Chair, recently attended a research workshop in Wrexham hosted by WAST. The morning session was enriching, offering diverse viewpoints from attendees. The previous evening, discussions at the Emergency Department at Wrexham Maelor Hospital revolved around the insights of various colleagues on ongoing projects and potential improvements. Key discussions at the workshop emphasised the need to elevate our research visibility within the organisation. There was also a focus on identifying and addressing barriers to participation, e.g. discussing the reasons behind the discrepancy between the number of colleagues signed up and trained to participate in the PARAMEDIC-3 trial and the much lower number of patients recruited to it. The workshop was marked by a strong sense of enthusiasm and highlighted the opportunities available for involvement at all levels in research initiatives.

4. **Reflections** from members on the meeting were positive, highlighting the effective sharing and celebration of research within the Trust. Members appreciated the maturity and collegial atmosphere

of the committee, noting the open and supportive environment that encourages dialogue. There was an acknowledgment that more efforts are needed to ensure colleagues are given the necessary time and support for their research endeavours, particularly noting the challenge of releasing PhD students to pursue their studies. The meeting was characterised by a curious and dynamic atmosphere. The achievement of University Trust Status was celebrated, recognising the significant contributions of many colleagues. Members expressed pride in working for an organisation that has attained such a prestigious status and extended thanks to those who have guided this achievement.

ASSURE

(Detail here any areas of assurance the Committee has received)

5. A **research update** was provided with highlights including:
   - The committee was informed that the drone project had received a prestigious award from the UKRI Future Flight SBRI funding call, highlighting its potential to enhance the supply chain in Wales. The project has garnered significant media attention, and a paper has been submitted to the Journal of Paramedicine.
   - The organisation has begun participating in the HCRW Communications Alliance. This involvement is seen as a positive step towards promoting and sharing research and innovation initiatives across Wales, enhancing our collaborative efforts and visibility in the field.
   - Three regional WAST research and innovation workshops have been completed.
   - A secondment appointment has been made for the Research & Innovation Officer (Clinical) and the job description for new Head of Research and Innovation is in the evaluation stage.

   The update on the Health and Care Research Wales (HCRW) Research and Development Framework showed an increased focus on this and the Committee noted a group has been established, reporting to the Executive Leadership Team, that will ensure buy-in for research and innovation across the Trust. The committee noted the need to ensure that our resourcing decisions keep up with our broadening ambitions, and that these are aligned with the IMTP.

6. The original University Trust Status priorities i.e. digitisation to enable better outcomes, advanced practice, and decarbonisation, remain central to the **Integrated Medium Term Plan (IMTP) 2024-27.** However, it was noted that they are primarily monitored by other Committees, with the IMTP oversight overall coming under the Finance and Performance Committee, which will escalate issues to this Committee where necessary. The IMTP focus therefore for this Committee for 2024-25 will be those related to reporting and assurance in relation to the NHS Wales Research Governance Framework and those linked to the embedding and realisation of the benefits of University Trust Status. Our relationship with stakeholders was seen as key to linking these initiatives to the wider NHS system.

7. The **Academic Partnerships Committee Task and Finish Group closure report** was received and the Committee was assured that it completed its work plan which included developing an approach to attract Academic Non-Executive Director candidates; proactively plan for the management of conflicts of interest; consider logistics for the change of name once University Trust Status was conferred; and align the work to the legislative docket at Welsh Government for a change to the

Trust's establishment order. The Chair thanked the members of the group for their contributions and recommendations.

8. The Committee approved its **cycle of business** which aligns with its revised terms of reference.

RISKS

Risks Discussed: There are no formal risks on the corporate risk register for this Committee. However, risks related to resourcing were discussed as well as broadening access to research and innovation.

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		
Research Governance Framework (update and approach to assurance on framework implementation	Research champion update	IMTP 2024-27 priorities
APC Task and Finish Group closure report	Cycle of business and monitoring report	

COMMITTEE ATTENDANCE				
Name	**23 April 2024**	**July 2024**	**22 October 2024**	**23 January 2025**
Hannah Rowan				
Prof Kevin Davies				
Academic NED				
Estelle Hitchon				
Angela Lewis				
Andy Swinburn				
Jonny Sammut	Aled Williams			
Jonathan Turnbull-Ross				
Duncan Robertson				
Prof Nigel Rees				
James Houston				
Jo Kelso				
Trish Mills				
Mark Marsden				
Keith Rogers				

	Attended
	Deputy attended
	Apologies received
	No longer member

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

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.

The papers for this meeting can be found by following this link to the Committee page on the Trust website.

Trust Board Meeting Date	30 May 2024
Committee Meeting Date	30 April 2024
Chair	Peter Curran

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. The Committee reviewed interim **changes to the model Standing Orders** to reflect the Trust's change of name following approval of its university trust status, and the introduction of the Joint Commissioning Committee. The **Scheme of Reservation and Delegation (SoRD) was also revised** to provide more clarity on the approval of awards of contracts by the Board. This was following the escalation from the Committee's last meeting on the non-compliance with Standing Orders raised in the Vehicle Replacement Programme Internal Audit. The Committee also **approved Governance Practice Note No. 005** to provide further clarity to Directors on this issue. Changes to the Standing Orders and the SoRD are before the Board for approval at this meeting.

2. This meeting was primarily a **governance focused meeting** and therefore did not receive the usual standing items.

ADVISE

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

3. A **pre-meet** was held with Audit Wales, Internal Audit and the Committee Chair ahead of the meeting.

4. Members **reflected** that the reports were succinct and recognised the collective effort of all members of the teams that supported the chairs in their review of the effectiveness of their committees. The hybrid nature of the meeting was not as effective for those in the room given the configuration of the IT, however an action was agreed to review instructions for their use in all meeting rooms. The meeting was well chaired.

ASSURE

(Detail here any areas of assurance the Committee has received)

5. The **2023/24 annual effectiveness review** was conducted for the Audit Committee. The National Audit Office tool was used for the survey questions and Members reviewed their effectiveness based on this, the work of the Committee during the year and discussions at today's meeting. Changes to the terms of reference will be proposed to the Board at its May meeting.

6. The Committee reviewed the 2023/24 annual reports for the Academic Partnerships Committee, Charity Committee, Finance and Performance Committee, People and Culture Committee, Quality Patient Experience and Safety Committee, Remuneration Committee, and Welsh Ambulance Partnership Team (WASPT). This is in line with the Committee's duty to advise and assure the Board on whether effective arrangements are in place to support them in their decision taking. Members were assured that effective arrangements are in place across all Committees and WASPT and represented the maturity of our corporate governance arrangements. A revised and streamlined approach to surveys for the 2024/25 reviews was agreed and all **annual reports and changes to terms of reference were endorsed for approval by the Board and the Committee**. The Board has before it at its 30 May meeting a separate paper with the results of these reviews.

7. The Board is required to confirm adherence with **corporate governance code for central government departments 2017** in the annual governance statement. The Committee reviewed the self-assessment against the code and were assured that the Trust complies with all elements.

8. Progress against the **2023/24 Internal Audit Plan** was received. There are five remaining audits for the 2023/24 audit plan which will be completed in time for the June meeting. The following **Internal Audits** reviews were completed during the quarter and presented to the Committee:

    - Seatbelt Action Plan – reasonable assurance. The purpose of this audit was to review the deployment of the seatbelt action plan, to ensure the safety of crews and patients on board Trust vehicles, and to assess compliance. The Quality, Patient Experience and Safety Committee will review this in more detail in May as will the People and Culture Committee given that this spans patient safety and health and safety.

    - ICT Contract Management – reasonable assurance. The purpose of this audit was to assess whether the Trust has appropriate contract management arrangements in place, ensuring achievement of value for money. The Finance and Performance Committee reviewed this audit at its March meeting.

9. The **2023 Audit Wales Annual Report for WAST** was received and is at Annex 1 for the Board's review. The report summarised the findings from the 2023 audit work which includes the audit of the 2022/23 accounts, 2023 structured assessment, national workforce review and the Trust's workforce planning arrangements. These reports have been reviewed by this Committee and the Board.

    The audit fee proposed for this work in 2023 was £188,424 and latest estimated by Audit Wales confirm the fee is in keeping with this. The **audit fee for the 2024/25** year was noted at £200,483. This is in line with the Fee Scheme as approved by the Senedd Finance Committee and represents a 6.4% increase.

The **2024 Audit Plan** was also received and is at Annex 2 for Board endorsement. Work includes the audit of the 2023/24 accounts, completing the national deep dive into financial efficiencies and a follow up of the Review of Quality Governance Arrangements which will begin in May 2024. A deep dive review will also start in Spring 2024 on investment in digital systems to support service resilience and transformation.

The **Review of Unscheduled Care** Part Two (accessing urgent and emergency care) has commenced and WAST will be formally engaged in this part of the overall review. The review encompasses Part One (flow out of hospital) which has been completed and is currently in clearance with the Regional Partnership Boards, and Part Three (national arrangements and leadership structures) which will begin over the coming months.

10. The Committee received the **register of members interests** as of 30 March 2024 and noted the next stage is for the interests of a cohort of decision makers in the Trust (in excess of 200 pax) to be centrally held and published during 2024. The **register of gifts, hospitality and sponsorship** was also received and is published on the Trust website.

11. The **Committee's cycle of business** was approved.

RISK MANAGEMENT

This was a governance focused meeting therefore risk report was not cycled.

COMMITTEE AGENDA FOR MEETING		
Internal audit update and related audits	Audit Wales progress report, annual report and annual audit plan	Audit Committee effectiveness review and annual board and committee effectiveness reviews 2023/24
Self-assessment against the Corporate Governance Code 2017	Changes to Model Standing Orders and Scheme of Reservation and Delegation	Committee cycle of business 2024/25
Register of members interests and register of gifts, hospitality and sponsorship		

COMMITTEE ATTENDANCE						
Name	**30 April 2024**	**7 June 2024**	**10 July 2024**	**12 Sep 2024**	**21 Nov 2024**	**6 Mar 2024**
Peter Curran						
Kevin Davies						
Joga Singh						
Ceri Jackson						
Chris Turley						
Angie Lewis						
Liam Williams						
Judith Bryce						
Trish Mills						
Julie Boalch						
Osian Lloyd						

COMMITTEE ATTENDANCE						
Name	**30 April 2024**	**7 June 2024**	**10 July 2024**	**12 Sep 2024**	**21 Nov 2024**	**6 Mar 2024**
Carl Window						
Audit Wales	Fflur Jones[1]					
Damon Turner						
Christian Fox						

	Attended
	Deputy attended
	Apologies received
	No longer member

[1] Darren Griffiths and Amy Lord also attended

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

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	30 May 2024
Committee Meeting Date	7 May 2024
Chair	Ceri Jackson

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Lost hours due to handover delays remained significant in January at just under 27,000 hours with a slightly improving picture in February and March at around 24,000 hours. **Handover delays continue to present patient safety risks and extended waits in the community** with a deteriorating Red performance being outside of what is acceptable to deliver a safe emergency service. 2,137 patients waited over 12 hours to receive a response in Quarter 4, with one patient waiting almost 47 hours. 220 of these patients were elderly frail who are likely to experience additional harm due to protracted delays and the first Regulation 28 report was issued in March which raised concerns about patients developing pressure damage.

2. The Trust continues to work across the system with partners to influence system change, the Committee demonstrated through the discussions throughout the agenda and the Trust Board has before it today, an update on the system actions to mitigate avoidable harm. Whilst risks 223 and 224 have not changed their risk rating, the Committee was assured that they are dynamically reviewed and updated with new mitigations wherever possible. Acknowledgement of the work underway internally on the approach to articulating these risks both from system and internal perspectives

3. The **111 CAS (Clinical Assessment Software) Replacement Project** went live on 30th April 2024 as planned.

4. Members noted the continued challenge in the team to deliver the **Putting Things Right Recovery Plan** with two key members of staff off long term and the additional time constraints in recruiting to the posts.

5. Members specifically requested escalation updates on the Trust's ability to provide a Civil Contingency Response.

ADVISE

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

6. Fiona Maclean, PECI (Patient Experience Community Involvement) Manager, and Julie Starling, Save a Life Cymru, attended to present their **Staff Story** and recounted how the team actively promote the learning of life saving skills throughout the year, with particular emphasis during its annual campaigns 'Shoctober', 'Restart a Heart' and 'Defibuary'. Through research and engagement, it became apparent that not everyone can perform CPR and for some, they were left with symptoms of Post Traumatic Stress Disorder (PTSD); particularly those who may have performed CPR on a loved one. Recognising our duty of care to support both cardiac arrest survivors and family members or laypersons who have performed CPR, the team explored the potential of adopting a post CPR leaflet as developed by Yorkshire Ambulance Service. The PECI team reached out to Save a Life Cymru (SaLC) to explore how this could be progressed in collaboration utilising a digital solution and a QI (Quality Improvement) methodology.

7. Further, a proposal was put forward to the Resuscitation Council UK (RCUK), who have agreed to host a Link Tree on behalf of Wales that will serve as a guide to appropriate support services for individuals and their families in need of support following CPR and cardiac arrest survivor support. This concept will include the WAST, the Health Boards and partners such as GPs, EMRTS (Emergency Medical Retrieval and Transfer Service), Police and the Fire Service. There will be an opportunity to share good practice with other nations adopting this repository of resources and the project could support other RCUK survivor projects.

8. An initial pilot of bilingual business cards titled, 'Support for cardiac arrest survivors and CPR providers is planned, it will feature a QR code is planned, with engagement through the Trust's People & Community Network, that will signpost users to the RCUK website and provide information on available support services in Wales for both cardiac arrest survivors and bystanders. The cards will be easy to use particularly in time sensitive situations. Funding options are being explored to print the cards and an evaluation of the pilot will inform the plans to expand distribution across Wales and provide cards to all designated touchpoints. Considerations were explored at Committee on digital solutions including automated SMS, linking to the NHS App and community outreach programmes.

9. Members expressed thanks to Fiona and Julie for sharing this initiative and the recognition and support of bystanders through their often once in a lifetime experience of providing CPR.

10. The Committee received a patient story update following **Alison Cassidy's patient story** at the last meeting and commented on the tracker as an important paper on a difficult story and to capture the learning captured from the discussion.

11. The Committee received the **Operational Update**, highlighting key areas including workshops on the Trust's capacity and capability to respond following the Manchester Arena Inquiry to recommend what additional resources are required to effectively plan. The Trust's accredited centre of excellence standard for MPDS (999 call handling) has fallen below the required standards set by the International Academy of Emergency Dispatch in the last quarter; however, demonstrable improvements have already been made to return to compliance in April. Resilience in teams is improving with the planned launch of the

Work Management Portal in Q3, recruitment into the EMD function and the EMSC Leadership, Operations Quality and Ambulance Care OCPs (Organisational Change Process) all in progress. Q2 will see the 111 service return to full establishment with digital solutions in the pipeline to enable progress on patient flow which is key due to demand levels increasing. Quality and Support days have been delivered to operational managers promoting culture and behaviours in key areas such as seat belt and safety harness use, Dress Code Policy, and IP&C (Infection & Prevention Control).

12. A **suite of policies** was presented to Committee and approved. EqIAs (Equality Impact Assessment) had been undertaken for each policy and there were no issues to escalate. The extensive activity was commended by the Committee in ensuring our policies remain up to date.
    - Consent to Examination and Treatment
    - Management of Controlled Drugs
    - Non-Medical Prescribing
    - Premises and Vehicle Cleaning
    - Clinical Supervision
    - Dispatch Cross Reference Table Policy.

13. Members' **reflections** on the meeting were that good assurance had been received and an appropriate level of discussion had taken place on each of the reports. An appreciation of the staff story was highlighted as an important element of the meeting along with recognition of the social responsibility on the action plan. Members thanked the Chair for stepping in at short notice and for excellent chairing.

ASSURE

(Detail here any areas of assurance the Committee has received)

14. The Committee received assurance by way of the **Monthly Integrated Performance Report** (MIQPR (Monthly Integrated Quality and Performance Report)) for February and March 2024 along with the **Quarter 4 Putting Things Right (PTR) Report**. The Committee noted that:

    - 999 calls answered have declined to 34 seconds in March not achieving the 6 second target. The 65th and 95th percentile performance is strong.
    - Red 8-minute response times remain of concern at 48.9%; however, these are consistent across a sustained period.
    - Amber 1 median is 1 hour 22 minutes.
    - Abstraction levels in EMS (Emergency Medical Service) hit 30% as a benchmark level.
    - 111 Abandonment rates increased in March to 11.8%.
    - 111 demand continues to increase, and a Demand & Capacity review is required.
    - Re-rostering of NEPTS (Non Emergency Patient Transport Services) will be reviewed this year as a key efficiency.
    - 7.67% sickness absence slightly above target in March 2024 compared to 8.50% in February 2024. The 2023/24 target is 6%.
    - The Trust received two Regulation 28 Reports from the Coroners during the period, one joint with Swansea Bay University Health Board resulting from a protracted wait. The Trust is working with the All-Wales Tissue Viability Network to determine next steps in identifying avoidable harm across the

system in respect of pressure damage and provide assurance to the coroner. The CQGG continue to give focus on this and a workstream is taking place on AACE (Ambulance Chief Executives) and Qi Guard to understand the level of challenge across UK ambulance services. The desire to understand true system risk and how it is managed by the system has led to a workshop later in May.

- 1,094 patient safety incidents were reported in Q4 with themes continuing to be timeliness to respond and handover of care delays. Whilst these are lower than the previous quarter, they remain extreme.
- 336 concerns were received in Q4, and the acknowledgement target has been amended nationally to 5 days. Performance during the period was at 99%, 95% and 99% for January to March respectively (100% target). The 30-day target achieved 53%, 35% and 56% respectively (75% target) which overall was a slight reduction from the previous quarter. The themes and trends through most of the concerns remains timeliness to responding to calls in the community and access to Ambulance Care.
- There continues to be a backlog of concerns relating to Ambulance Care relating to appointments and work is underway with the Patient and Family Relations Team to provide advice and expedite early resolution concerns.
- Over 100 incidents were reviewed at the Serious Case Incident Forum (SCIF) and Joint Investigations passed to Health Boards. Key themes of these continue to be over-crowded Emergency Departments and wider system pressures resulting in high levels of escalation, lack of end-of-life care or ceilings of care planning and discharge delays.
- From September 2024, the Medical Examiner Service will become a statutory body and all non-coronial deaths and community deaths will be included in their reviews.

15. The Committee discussed measurement systems, data reporting and the maturity journey, the plan to incorporate population outcomes, in line with progress of the new clinical response model, and which will form part of the workshops to progress this in the coming period.

16. **The Putting Things Right Recovery Plan** linked to the recent Joint Investigation Framework Internal Audit, outlines the key improvement actions for the team over the next 12 months to help the Trust meet its targets and ensure patients and families receive the best service from the team.

17. Members received the **Patient Experience Community Involvement Bi-Annual Report** detailing the work of the team to capture feedback and experiences, ensuring voices are heard that contribute to improvement in the quality of services and patients' use of them. The impact of the work is supporting discussions on progressing the new clinical model. The work is mapped against the Quality Standards to provide assurance against the Duty of Quality. The level of ambition and commitment was recognised, drawing through focus on continuous improvement and the value of patient experience reporting.

18. The draft **Annual Quality Report 2023/24** was positively received ahead of presentation to the Trust Board for approval. A comprehensive appraisal focused on improving quality and the level of harm experienced by our patients. Collaboration across respective leads and NHS bodies undertaken to prepare the report in lieu of firm guidance and strong edicts from Welsh Government are predicted for the 2024/25 report. Members were complimentary of an excellent report, the cohesiveness across disciplines, the lived experience context and the framing of the report.

19. Members received a presentation on the revision of the **Clinical Plan**, previously the Delivering Clinical

Excellence in Wales Clinical Strategy, noting the progress made in the Trust since the original strategy was implemented. The content will be significantly revised with a changing emphasis on how clinical data is used in terms of our ambitions, transforming our service and how patients are managed differently to prevent avoidable harm. The next steps include joint Directorate planning events to devise delivery mechanisms that ensure alignment across teams and formulating reporting routes.

20. The **Clinical Audit Plan and Action Tracker update for Q4 2023/24** was received with no escalations. 10 audits completed during the period. 39 out of 46 actions completed. Results are cascaded to the Trust linking with the Quality Management Group and the Quality Improvement work. Internal Audit have reviewed the Clinical Audit processes to support forward travel.

21. The Committee focused on the **clinical indicators on Fractured Neck of Femur (#NoF)** and the ability to manage pain, linked to the Internal Audit report on Medicines Management. Testing of the ePCR user interface will be completed and the establishment of a minimum clinical data set. Work continues with the supplier to complete the required changes which are aimed and improving the usability for clinicians to input data and to improve clinical indicator (CI) compliance. A CI recovery plan has been implemented which includes focussed communication, clinical workshops, implementing the Clinical Supervision Policy, and improvements in technology (AI (Artificial Intelligence)). Whilst Committee received assurance there are challenges for clinicians using the tools to evidence the quality of care on ePCR (Electronic Patient Clinical Record) based on the Ambulance Quality Indicators (AQI), there is a need for clinicians to understand the importance of secondary uses of this data with our partners and how the public perceive it without the context provided today. There are innovation opportunities within the revised Digital Plan and education on data interpretation.

22. The Committee was presented with a suite of **internal audit reports:**
    - Serious Adverse Incidents – Joint Investigation Framework
    - Electronic Patient Clinical Record: Clinical Compliance
    - Seatbelt Action Plan

23. An update was received on the **Audit tracker** with 76% of QuEST related internal audit actions (due in quarter) closed in quarter, with 33% of external audit actions closed this period. Several historical actions have been revisited with a view to closing these down or revising them acknowledging the passage of time.

24. Members received the **Committee Cycle of Business (CoB) and Monitoring Report** updated following the effectiveness review conducted in Q4. Focus will be given to including the Trust's compliance against the Health & Care Quality Standards in the CoB in the coming period. The CoB for 2024/25 was approved.

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. Both risks have been reviewed in accordance with their schedules and the scores remain static. The theme of these risks ran throughout the agenda items discussed at this meeting and are part of the alert section of this report.

Members were assured that these risks, whilst not moving in score, are dynamically reviewed regularly, and closely monitored at many of the Board's Committees as well as at internal forums. Additionally, the approach to these risks is being considered given that their score has remained catastrophic for a significant period.

New Risks Identified: No new risks were identified.

The papers for this meeting can be found by following this link to the Committee page on our website.

COMMITTEE AGENDA FOR MEETING		
Operations Directorate Quarterly Report for Q4 2023/24	Staff story – Fiona Maclean, PECI and Julie Starling, Save a Life Cymru Patient Story update – Alison Cassidy	Putting Things Right Report Q4 and Putting Things Right Recovery Plan
Patient Experience Community Involvement Bi-Annual Report	Monthly Integrated Quality and Performance Report	Annual Quality Report 20234/24
Clinical Plan update	Clinical Audit Plan and Action Tracker Q4 2023/24	Spotlight on Clinical Indicators: Fractured Neck of Femur
Audit tracker and audit reports: • Joint Investigation Framework • EPCR Clinical Compliance • Seatbelt Action Plan	Risk Management and Board Assurance Framework Report	Policies for approval: • Consent to Examination and Treatment, Management of Controlled Drugs, • Non-Medical Prescribing, • Premises and Vehicle Cleaning, • Clinical Supervision, • Dispatch Cross Reference Table
Committee Cycle of Business and Monitoring Report		

COMMITTEE ATTENDANCE				
NAME	**07 MAY 2024**	**13 AUGUST 2024**	**05 NOVEMBER 2024**	**04 FEBRUARY 2024**
Bethan Evans				
Kevin Davies				
Ceri Jackson	Chair			
Liam Williams				
Andy Swinburn				
Lee Brooks	Jonathan Edwards			
Rachel Marsh	Hugh Bennett			
Jonny Sammut				
Trish Mills	Julie Boalch			
Mark Marsden				
Hugh Parry				

	Attended
	Deputy attended
	Apologies received
	No longer member

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

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.

The papers for this meeting can be found by following this link to the Committee page on the Trust website.

Trust Board Meeting Date	30 May 2024
Committee Meeting Date	09 May 2024
Chair	Ceri Jackson

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. N/A

ADVISE

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

2. Key progress was noted as part of the **Director of People and Culture** update including:

- Continued progress of the Culture Champions Network and the positive impact on shaping Trust culture; an increased focus on visibility, programme of support and opportunities to empower CCs in their roles.
- Positive engagement and interactions across the Trust.
- Attended the CIPD Awards with the Voices Advocates.
- Time with TU colleagues and a road trip to North Wales for the partnership sessions "walking in each other's shoes".
- Executive Leadership Team 360 process undertaken demonstrating to continuous learning and development.
- Clinical transformation workshops with focus on change management and building the change management capability.
- Commitment and endorsement on investigation team to move forward – ready to go to advert for those posts.
- Assurance given on Occupational Health work plan.
- Members assured about the roadshows as well as the positive engagement balanced with realism in relation to the level of change taking place across the Trust.
- Counselling sessions being offered by the EAP providers has increased to 8 sessions.

- Appointed to full time, dedicated guardian role from next month.
- Implementation of a dedicated investigation team.

3. The Committee received the **Operational Update**, highlighting key areas including:

   - Relief planning has been extended following a successful first stage pilot from 5 to 6 weeks' notice. The move is expected to improve the working experience of our people.
   - The EMSC restructure has been agreed in principle to increase management, leadership support capacity and career development opportunities.
   - Quality and Support days have been held promoting culture and behaviours in key areas such as seat belt and safety harness use, process, and policy; all providing opportunities to have conversations with operational managers. Themes and trends data gathered from these sessions.
   - End of Shift Overruns (EoS) – Good progress noted with a reduced average EoS overrun length reducing to a lower level than the last 15 months. The holding area has been lost at the Grange University Hospital which was highlighted as an issue. New premises are being sought.
   - Operations staff encouraged to drop into culture workshops which utilise the CEWS tools to facilitate feedback from staff on their experiences and expectations.
   - CAS replacement project for NHS 111 went live successfully on 30 April 2024 and a major achievement for the Trust and all involved.

4. **Staff Story - A View of Front Line Leadership** – Matthew T Jones, Locality Manager in Pembrokeshire, attended the meeting to share his learning on the work he has undertaken on attendance and sickness absence. Matt started as a student paramedic in 2010 and worked in Surrey for a year before returning to WAST in Pembrokeshire in 2013. He became a clinical team leader in 2019 and then acted up as a locality manager during the pandemic. He was appointed permanently in May 2020 and transitioned into the Duty Operations Manager (DOM) role and then substantively as a Locality Manager.

5. Matt has faced some challenges in leading a team that he used to work within as a colleague, in dealing with high sickness rates and outdated stations and had concerns regarding the support available to colleagues off long term. 'Chat with Matt' sessions were set up to discuss key issues such as sexual safety, sickness, handover delays, overruns, and an opportunity to explain things to staff. For example, the national Managing Attendance at Work Policy and delivering it local, making the most of the People and Culture Plan as a guide to support staff and to have open and honest conversations with them. There was a clear need for change with abstraction rates.

6. Matt adopted a new system on O365 Microsoft planner to track and manage staff absences and other operational matters. He said it was very intuitive and visual and helped him and the DOMs to provide timely and appropriate support to staff, linking in with Information Governance and ensuring confidentiality. A year on from using the system, it is clear when staff have received welfare calls, occupational health referrals etc and it intuitively tracks staff to enable customisation in the way absence is managed. The capability to attach long term sick records, e-files, staff information, time and date stamp of actions, letters to be sent out or supportive actions due, is invaluable. The results and benefits have been realised as a whole system change building a team back from 25% sickness to 7% and PADR rates. Angie Lewis and Jason Killens visited Pembrokeshire station and saw this in action, acknowledging that a lot has been achieved in a short space of time and most of it done in house by Matt and his team Station facilities were improved by creating quiet rooms for staff to reflect and relax. He said he did this with very little money and with the help of the estates team and the staff themselves.

7. Matt's reflections included: having a safe space to learn from mistakes in the beginning of the project, linking into the People & Culture (P&C) Plan, an excellent example of how a whole team in EMS has been involved in supporting staff back into work following a period of absence, the work that has been done to support staff in complex cases and the innovation and creative thinking.

8. Committee reflected how impressed they were with the progress, Matt's innovation and creative thinking resulting in whole scale support for staff and managing absence and how this approach could impact staff nationally. Matt could provide a podcast on this topic and forge connections with the north to roll the concept out across the whole service and delve into the issues with moving from buddy to boss and supporting that transition, considering the WAST way and experience for future leadership development sessions. One point is to ensure that staff records on the planner are linked back centrally to main personnel files.

9. Angie commended Matt for his great leadership from the front line, noting that the system and tools are great; however, it is the passion, commitment, and desire to help staff have a positive working experience which came through. Being keen to keep shining a light where we see great practice happening, learning, and evolving, failing fast and moving on and scaling up of successful projects.

10. The Committee received insights from **NHS Staff Survey** focussing on stress and burnout in the workplace and discussed the links between addressing these issues with our overarching People & Culture ambitions and the Health and Wellbeing Plan. The results will increase awareness of these issues and develop meaningful actions against the cultural transformation work.

11. **The Staff Development Outline Plan** was presented acknowledging it is a deliverable of the P&C plan aiming to provide equity in development opportunities for our people to undertake their roles and benefit from progression opportunities. Mapping is underway on professions and roles and will define skills and competencies and create a progression diagram tapping into external best practice in this area.

12. The Committee were pleased to approve the **Homeworking Policy** and acknowledged that the **Exit Interview Policy** has been reclassified as a Standard Operating Procedure.

13. **Reflections** on the meeting were that it worked positively as a hybrid meeting; however, there is a structural challenge in considering all the items on the agenda ensuring energy and full input towards the end of the meeting. More breaks and consent items will be considered. Attendees thanked Ceri Jackson as her first time in the Chair and commended Angie Lewis on winning the International Culture Award.

ASSURE

(Detail here any areas of assurance the Committee has received)

14. The Committee received a paper on the **People and Culture plan Metrics**, including quantitative data that highlighted achievements and challenges related to the plan, such as the international award for culture, the work on change management, and the dedicated investigation team. She also mentioned positive trends, such as reduced turnover, sick absence, and missed compliance capability, as well as areas of concern, such as stress and burnout. More detailed information will be shared in the next

meeting.

15. A deep dive on the disciplinary processes and the compassionate practices approach was presented to Committee. The highlights included the increase in workload due to the rise in cases related to sexual safety and inappropriate behaviour, and the efforts to reduce the duration and harm of disciplinary cases. The introduction of three independent investigators and the importance of decision making officers having the capacity and pace to deal with cases. Concern was raised regarding the harm caused by suspensions and the need to improve in that area.

16. The **Monthly Integrated Quality and Performance Report** ("MIQPR") and the **Q4 Workforce Scorecard** show that continued system pressures including handover delays remain a significant pressure on our people. Demand in NHS 111 coupled with the decrease in the number of call handlers commissioned will have an impact on staff wellbeing. There was acknowledgement on the sustained improvement made on sickness absence; however, there is work to do. Committee were assured that there is a dynamic plan in place on areas such as Muscular Skeletal issues, Manual Handling and Mental Health that remain a priority given the challenging 6% sickness absence target.

17. **Committee were assured on the Health & Safety (H&S) Report** which several positive aspects such as high compliance rates for RIDDOR reporting which demonstrates a grip of control and flows of work in the Trust. A low number of RIDDOR incidents were reported in Quarter 4. There remain areas of concern in relation to mandatory training and increasing instances of violence and aggression. There is ongoing work and initiatives to address these issues such as the Right Care Right Person with the Police in the coming 12-24 months on the association of Mental Health with incidents of violence and aggression. Several highlights included:
    - An IOSH article on H&S in December 2023 on the Trust's efforts.
    - The Head of H&S has been invited to join an editorial board.
    - The CEO has been invited to discuss learning with Blue Light partners across the UK.
    - The H&S Annual report will be presented to the next meeting.

18. The Health & Safety Committee (H&SC) will continue discussions in relation to diesel fumes and key monitoring within the next quarter as a priority area for the Trust. This will continue to be monitor at Committee through the H&SC AAA report. New fleet solutions are being explored.

19. **WASPT highlight report** was received following their meeting on 19 February 2024, with no specific issues escalated. A verbal update noted from the 2 May 2024 meeting was provided acknowledging that whilst there were open and constructive discussions it was a challenging meeting. Focus on the nature of the issued being raised and ensuring this is done in the right forum was a key issue with a resolution to meet and progress this. The committee members praised the work of the WASPT team, expressed their support for the partnership approach, and asked questions about the data quality, the feedback mechanisms, and the future plans for the WASPT.

20. In private session the Committee reviewed progress against four **suspensions over four months** which is the same number as reported in the last quarter. Each of these cases have police involvement which increases the time taken to close the investigations noting the impact on individuals. Four cases were lodged with the **Employment Tribunal** (an increase of two from the previous quarter). Members were assured on actions in place to manage these cases.

21. The **Audit Tracker** was reviewed, and the Committee noted the update with 14 internal audit actions related to Committee were closed in quarter.

22. The reasonable assurance **Retention of Staff Internal Audit** report was received, with key matters arising including finalisation and ratification of the 'Moving on Interview' process, with a clear timetable for its roll out; and evaluation of the effectiveness of the initiatives that have recently been introduced to improve staff retention. The roll out of moving on interviews was welcomed. The **Seatbelt Action Plan**

23. Members received the **Committee Cycle of Business (CoB)** updated following the effectiveness review conducted in Q4 along with the Q1 **Monitoring Report**. The CoB for 2024/25 was approved.

RISKS

Risks Discussed: The four risks within the remit of this Committee were reviewed as 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). Committee acknowledged that elements of the risk had been discussed throughout the Agenda including controls, mitigations and additional actions being taken.

201 – Committee received a deep dive on this risk - Damage to the Trust's reputation following a loss of stakeholder confidence which remains at a score of 20 (4x5). The risk is inextricably linked to several of the metrics measured at PCC and is not solely related to performance and will include key issues such as the impact of diesel fumes, for example, that was discussed at length during the meeting. The latest reputation audit closed in May 2024 and evidence there is more work to do to understand our service offer. The qualitative feedback is being thematically reviewed and triangulated against intelligence from the ELT 360 and stakeholder engagement. This will inform the revised influencing plan. To continue to mitigate the risk is to position and promote WAST as a credible 'system voice', shape the media narrative and political engagement; formal and informal engagement with key stakeholders, internal communications in light of the strategy, engaging the Board, senior leaders and TUPs on their influencing role. Building confidence, improving performance and patient experience will lead to enhanced morale and improved cultural climate.

163 – Maintaining effective and strong Trade Union partnerships remains at a score of 16 (4x4). The risk was presented in detail to the Welsh Ambulance Services Partnership Forum for the first time in May 2024 recognising this is a dynamic risk.

Risk **558** (deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences) remains unchanged at a score of 15 (3x5).

The Committee acknowledged risks **223 and 224** overseen by the Quality, Safety & Patient Experience Committee; however, considered at each of the Board Committees given they impact every area of the Trust.

New Risks Identified: No new risks identified at this meeting.

Director of People and Culture Update	Operations Quarterly Report Q4	Staff Story – A View of Front Line Leadership
NHS Staff Survey	People and Culture Plan metrics update	Workforce scorecard and MIQPR
Health & Safety Report	Staff Development Outline Plan	Risk management and BAF
Deep Dive on Risk 201	Audit tracker and Retention of staff and Seatbelt Action Plan internal audit	Policies for Approval • Homeworking Policy • Exit Interview Policy - reclassified SOP
Cycle of business 2024/25 and monitoring report	WASPT Highlight report	

COMMITTEE ATTENDANCE				
Name	**9 MAY 2024**	**8 AUGUST 2023**	**16 NOVEMBER 2023**	**20 FEBRUARY 2024**
Ceri Jackson				
Bethan Evans				
Joga Singh				
Hannah Rowan				
Angela Lewis				
Chris Turley				
Lee Brooks	Sonia Thompson			
Liam Williams	Jonathan Turnbull-Ross			
Estelle Hitchon				
Andy Swinburn				
Rachel Marsh	Alex Crawford			
Trish Mills	Julie Boalch			
Damon Turner				
Mark Marsden				
Christian Fox	Hugh Parry			

	Attended
	Deputy attended
	Apologies received
	No longer member

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

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	30 May 2024
Committee Meeting Date	14 May 2024
Chair	Joga Singh

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. No alerts for the Board from this meeting.

ADVISE

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

1. The Committee received the **Digital Plan Refresh 2024-29** and considered options, approving an option which balances addressing essential resource gaps in our day-to-day digital services provision and advancing key digital transformation initiatives that support our IMTP and broader organisational strategy. There was good engagement of committee members ahead of the presentation. Building on the current digital strategy, the Digital Plan prioritises a comprehensive, forward looking approach aligned to the Trust's commitment to serve the people of Wales and is aligned to the Long Term Strategy Delivering Excellence 2030. Members acknowledged the necessary investment in the plan to ensure that digital, cybersecurity, and operational vulnerabilities and inefficiencies are addressed, and that the Trust's digital innovation aligns to our strategic ambitions in the IMTP and long term strategy to meet the advancements in healthcare and the evolving complexities delivery. The funding for this plan is included in the digital revenue allocation of £1.376m and was approved by the Executive Finance Group in the budget setting meeting and included in the financial plan and IMTP for 2024/25. The capital costs of £196k are captured in the capital programme for this financial year.

2. The plan sets out the digital transformation journey to date and how proactive utilisation of digital and technological advancements will enhance our service delivery, provide exceptional patient care, and maximise patient experience. Members discussed key areas including:

   - The rationale for the refresh which centres around three pivotal themes: compliance with regulatory and strategic frameworks, enhancement of patient outcomes, and the optimisation of

resources.
- The key pillars that enable delivery of key work programmes.
- The five digital tranches approach to track and supporting delivery of objectives and evolution over the next 5-10 years.
- The Digital Transformation function and Chief Clinical Information Officer (CCIO) role which will be implemented to drive forward innovation and operational efficiency.
- The four options for balancing operational integrity and digital growth, endorsing option two as the preferred option for the team.
- The costs attached to approved option are included in the digital financial envelope for 2024/25.
- The development of new KPIs to track progress, identify areas for improvement and accountability reporting through Board, FPC and internal forums as well as in the wider community.
- The risks on adequate investment and the maturity and realistic timeliness of implementing the significant work programmes underpinning the plan at a balanced pace was discussed.

3. Members were updated on the Trust's **Information Governance Toolkit** undertaken to test the secure handling of patient data and compliance against legal and regulatory requirements. The preliminary report shows good compliance; however, there are 6 areas that require improvement to meet the minimum standards. An improvement plan is in development and will be reported to Committee in due course.

4. An update on the **Clinical Assessment Software** (CAS) replacement system went live on 30th April 2024 successfully. Call handling time has extended with peak activity on the Bank Holiday meaning some callers had had to wait longer than expected; however, this is returning to normal. Positive initial feedback from Health Boards on referral activity to GP OOH that is a biproduct of new algorithms. Chair expressed thanks and congratulations to the team in meeting the challenging deadlines of this project.

5. Members **Reflections** on the meeting included:
   - The Chair thanked Executives and their teams for the effort in preparing well written papers supporting good opportunities for scrutiny, challenge, and support. Members felt it is easy to ask questions given the openness and transparency of the papers and agreed that the time went by quickly despite the lengthy Agenda. The hybrid meeting model will be given consideration after the success of this in other Committees. Thanks was given particularly for the time on the Cyber discussions and to the Chair for steering the meeting.

ASSURE

(Detail here assurance items the Committee receives)

6. The Committee received the **Operations Quarterly update** and noted key areas including:

   - The publication of the Manchester Arena Inquiry report in future closed sessions.
   - The AACE centre of excellence demonstrating a return to the required accreditation standards during April.
   - The relief planning pilot is underway on 6 weeks' notice period.
   - Call handling recruitment successful and a formal consultation on career plan is in development in

EMSC.

- Reaping the benefit of overtime controls learning from last year.
- Month 1 shows a favourable financial position for the directorate.
- 111 demand is up; however, demand and capacity modelling required to understand required establishment needed.

7. The Committee received assurance on the draft yearend presentation on the **financial position for Month 12 2023/24**. The Board has a detailed paper on the financial position before it for its May meeting. The revenue position reports a small surplus of £85k and the capital expenditure of £22m being fully spent, all subject to audit. Gross savings of £6.546m have been achieved against a target of £6.000m and the Public Sector Payment Policy is on track with performance, against a target of 95%, of 96.4% for the number, and 98.5% of the value of non-NHS invoices paid within 30 days. Audited accounts will be presented to Audit Committee and Trust Board in July 2024 ahead of final submission to Welsh Government.

8. An update was provided on the draft **financial position for Month 1 2024/25** in advance of the submission to Welsh Government with the cumulative year to date (end of April 2024) revenue financial position against budget of a small surplus of £0.019m with capital planned expenditure of £21.672m forecast to be fully spent. This now includes the c£12.828m against the 2024/25 Fleet Business Justification Case, recently confirmed by WG. Savings are reported of £0.663m against the target of £0.569m. Public Sector Payment Policy is on track against the 95% target of 97.3% for non NHS invoices paid in 30 days.

9. An update was provided on the **Financial Sustainability Programme** (FSP) celebrating the overperformance of £546,000 against our planned total for the year. This accomplishment underscores our commitment to Achieving Efficiency and Income Generation, showcasing substantial progress in key schemes. Moreover, our targeted savings opportunities, earmarked at £6.4m, position us strongly for the future and keep this at the forefront of the agenda.

10. The **2023-24 IMTP year-end report** captured a positive summary despite continuing financial challenges in NHS Wales last year. Exceptions reported on the Ambulance Care Programme NET Centre re-roster for operational hours and relief and Consult and Close rates for the Gateway to Care Programme marked in red and the independent prescribing element of the Clinical Transformation Programme which is amber; all of which remain a priority for the 2024/25. The **Forward Assurance Plan for 2024/25** was noted and a key assurance was in relation to apprentices and the diminishing pool of talent, workforce planning and on the redesign of our Clinical Service Model which showcases our opportunities to manage large scale transformation and service wide improvements.

11. **The Digital KPIs** relating to data and analytics, ICT systems, service provision and projects within the IMTP for the period 1 April 2023 to 31 March 2024 were reviewed by exception. The Committee noted:
    - The average turnaround for non-trivial data requests spiked at 37 days due to the ''operational pause and improve" work to focus on the 111 CAS replacement.
    - A high level of records requests received show an increase of 45% on 2021/23 and 2022/23.
    - Full year system availability metrics will be available for the July meeting.
    - The 111 CAS system replacement went live successfully as planned on 30 April.
    - The Data Linkage project continues to progress focusing on the Out-of-Hospital Cardiac Arrest dataset. A join controller agreement is in development with DHCW and the Trust to meet the

Information Governance requirements.

- The 111 Website project is underway with a strategy report supporting the development of a longer term business case for this service.
- The QPMF reporting project has increased to a 100% compliance on 75% reported in the last period with version 1 of the MIQPR successfully delivered.

- The Digital Experience and Digital Champions initiatives have not progressed at pace, yet supporting activities such as automation of processes, engagement with colleagues internally and digital suppliers are underway which will support the delivery of the People & Culture plan in the coming years.
- The Mobile Data Vehicle Solutions installation project has been concluded and plans are in place for the project wrap up. The NEPTS installs have commenced and on target for June 2024 completion. Operational teams are engaging staff to complete training and the dashboard is on Siren.

12. Members received an update on the work undertaken in relation to **Environment, Decarbonisation and Sustainability** work programmes and noting specifically the continuing progress against that within the Trust's Decarbonisation Action Plan (DAP) in response to the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan (NHSW- DSDP) which is overseen by the Decarbonisation Programme Board. Members were assured that an escalation plan is in development to ensure the Trust is undertaking all possible actions against identified risks and wider environmental considerations. An application was submitted for an NHS Sustainability Awards early in May and will be shared with Committee as a summary of what has been achieved over the last two years.

13. The **Monthly Integrated Quality and Performance Report (MIQPR) for March and April 2024** was presented. The report is before the Trust Board in May 2024 along with a separate patient harm report. Key highlights included: Red performance at 48% in April acknowledging that red activity continues at rates higher than previous years with the highest red activity week of the year last week which is impacting capacity due to higher attendance rates, Amber one median was one hour and 8 minutes, Abandonment rate for 111 was 5.5%, Sickness rate was 7.67% in March, Abstraction rate was 32.5% in March, and Handover delays were 23,620 hours lost in April.

14. Committee were assured that the **commissioning intention arrangements for EMS and NEPTS** are built into the planning cycles, quarterly assurance cycles and support the work towards our strategic ambitions and transformational plans and monitoring of that will be included in the IMTP delivery reports.

15. A **suite of policies** was presented to Committee and approved. EqIAs had been undertaken for each policy and there were no issues to escalate to Members.
    - Purchase Card Policy
    - Waste Management Policy
    - Data Quality Policy

16. The **Audit Tracker** was received, and the Committee noted the update with 60% of FPC related internal audit actions (which were due in quarter) closed in quarter, with 50% of external audit actions due closed this period.

17. Members received the **Committee Cycle of Business (CoB)** updated following the effectiveness review conducted in Q4 along with the Q1 **Monitoring Report**. The CoB for 2024/25 was approved noting that there are areas that will be dynamically developed throughout the year in relation to Cyber and Commissioning reporting and the Annual Sustainability Report.

18. In **closed session** members received an update on Cyber Reporting and an alert, the initial Capital Programme for 2024/25, the GUH Transfer Service SLA, an updated Business Case for the new Dolgellau Ambulance Station and recommendations relating to the cyber security actions.

RISKS

Risks Discussed: Whilst the report provides that there are no material changes to the eight principal risks within the remit of this Committee as at 7 February 2024, the Committee were assured that there are several changes foreshadowed to these risks in readiness for presentation to Trust Board in May 2024 including:

a) Two new risks will be included on the Corporate Risk Register – **Risk 623** (Data Protection Legislation) scoring 15 (3x5) and **Risk 542** (Decarbonisation) at a score of 16 (4x4).

b) **Risk 458** (A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning) will be closed from the CRR on the basis that this was specifically in relation to the 100wte and the overlap with **Risks 424** and **139**.

c) Two risks will be de-escalated from the CRR to the Directorate Risk Registers as the actions have been completed and mitigated to target score. **Risk 283** (Failure to implement the EMS Operational Transformation Programmes) has reached target of 8 (2x4) from 12 (3x4) and **Risk 543** (major disruptive incident resulting in a loss of critical IT systems) has reached target of 10 (2x5) from 15 (3x5).

d) **Risk 424** (prioritisation or availability of resources to deliver the Trust's IMTP) will reduce in score from 16 (4x4) to 12 (3x4) given the funding allocated within the IMTP financial plan to support key areas of work agreed with Commissioners.

Further, **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 static at 20 (4x5) reflecting continued challenges across the unscheduled care system.

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) remains at a score of 15 (3x5).

Risks 100 (Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience) and **Risk 139** (Failure to Deliver our Statutory Financial Duties in accordance with legislation) remain unchanged at this time.

COMMITTEE AGENDA FOR MEETING		
Operations Quarterly Update	IMTP 2023-24 End of Year Position and Forward Assurance Plan for 2024/25	Digital Reporting
Digital Plan Refresh 2024-2029	Information Governance Toolkit	Commissioning Intentions EMS and NEPTS
Clinical Assessment Software update	Financial Position for Month 12	Financial Position for Month 1 2024/25
Financial Sustainability Programme report	Policies for approval: • Purchase Card Policy • Waste Management Policy • Data Quality Policy	Environment, Decarbonisation and Sustainability Update May 2024
MIQPR and review of metrics	Risk Management and BAF	Audit Tracker
Cycle of Business 2024/25 and Monitoring Report		

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

	Attended
	Deputy attended
	Apologies received
	No longer member

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

WELSH AMBULANCE SERVICES NHS TRUST

CONFIRMED MINUTES OF THE OPEN SESSION OF THE MEETING OF THE QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE HELD ON 8 FEBRUARY 2024 VIA TEAMS

Meeting started at 09:30

PRESENT:

Bethan Evans	Non-Executive Director and Chair
Professor Kevin Davies	Vice Chair of the Board and Non-Executive Director
Paul Hollard	Non-Executive Director
Ceri Jackson	Non-Executive Director

IN ATTENDANCE:

Julie Boalch	Head of Risk/Deputy Board Secretary
Louise Colson	Head of Infection Prevention and Control
Mark Harris	Assistant Director of Operations (Deputy for Lee Brooks)
Leanne Hawker	Head of Patient Experience and Community Involvement
Fflur Jones	Audit Wales, Performance Auditor (left after Minute11/24)
Alison Kelly	Business and Quality Manager
Osian Lloyd	Head of Internal Audit, NWSSP
Mark Marsden	Trade Union Partner
Trish Mills	Board Secretary
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Duncan Robertson	Assistant Director of Clinical Development (Left after Minute 16/24)
Leanne Smith	Assistant Director of Digital (Data) (Deputy for Jonny Sammut)
Andy Swinburn	Director of Paramedicine (Joined at Minute 05/24 and left after Minute 11/24)
Mark Thomas	Commissioning and Performance Manager
Jonathan Turnbull-Ross	Assistant Director of Quality Governance (left after Minute 11/24)
Liam Williams	Executive Director of Quality and Nursing
Debbie Young	Executive Assistant to the Executive Director of Quality and Nursing

Apologies:

Lee Brooks	Executive Director of Operations
Ian James	Trade Union Partner
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Jonny Sammut	Director of Digital Services

01/24 PROCEDURAL MATTERS

The Chair extended a warm welcome to everyone advising that the meeting was being recorded. Apologies were noted from Lee Brooks, Ian James, Rachel Marsh and Jonny Sammut.

Declarations of Interest

There were no further declarations of interest to those already listed in the Register.

Minutes

The Minutes of the meeting held on 31 October 2023 were confirmed as a correct record.

Ratification of Chair's Action

The QuEST Committee ratified the Chair's Action made on 30 January 2024 to approve the Infection, Prevention and Control Policy (v.2.4) which was presented to the Committee for the formal record.

Action Log

The action log and the Committee Highlight AAA report from the last Quest meeting was considered:

Action Number: 50/23: Update on EMS CSD reconfiguration. Action to remain open, final paper will be shared with colleagues once ready.

Action Number 50/23a: NEPTS Eligibility matrix update. Mark Harris advised the Committee that no formal challenge had been received from Local Authorities or Welsh Government in respect of the changes made. There may be occasions when the Trust was unable to offer transport to those patients who were ineligible but would try their utmost to arrange it, however all eligible patients who required transport would receive it. Action Closed.

Action Number 51/23: It was highlighted that the Operational Delivery Unit have informed the Stroke Association that they are conducting an Audit on self-presentation to A&E. Liam Williams agreed this would be reported through to Quest if there was a material consideration. Liam Williams was engaging with Ceri Jackson to obtain further information on Lead within Operational Delivery Unit. Action Closed.

Action Number 52/23: In terms of the longest waiting patient (39 hours and 59 Minutes) it was requested that context be provided. The context was included in the Quarter 3 Putting Things Right report. Action Closed.

Action Number 54/23: Clarity on utilisation rates of Cymru High Acuity Response Unit (CHARU) activated at call centres. Work continues to define this action. It is recognised that CHARU dispatch requires further development to ensure an appropriate balance between clinical performance/ clinical outcomes/ response time performance and old despatching multi-resources when clinically appropriate. To this end, the CHARU Task and Finish Group will now be converted in a CHARU Delivery Group which will work with several teams across the organisation to continue to hone the delivery of the CHARU service. Action Closed.

Committee AAA report dated 31 October 2023

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 31 October 2023.

RESOLVED: That

(1) Apologies were recorded for Lee Brooks, Ian James, Rachel Marsh and Jonny Sammut;

(2) The Minutes of the Open meeting held on 31 October 2023 were confirmed as a correct record;

(3) The Committee ratified the decision made by Chair's Action dated 30 January 2024 to approve the Infection Control Policy v.24; and

(4) Consideration was given to the Action Log and the AAA report as described above.

02/24 OPERATIONS DIRECTORATE QUARTERLY REPORT – 2023/24 Q3

Mark Harris introduced the Operations Quarterly Report as read, and drew attention to the following pertinent elements within it:

The work on the Manchester Arena Inquiry (MAI) recommendations has now been ongoing for 6 months, and a mid-year review was completed in December. An update on the 68 recommendations that the Trust was working on was given. One of the recommendations from the MAI is the introduction of two new triage tools for mass casualty incidents. Ten Second Triage (TST) is designed to be used by anyone responding to a major incident to provide care to casualties prior to the arrival of clinicians on scene, and the Major Incident Triage Tool (MITT) is for use by NHS Responders at scene. Work has been ongoing to introduce this new tool within the Trust with the UK Ambulance Services go-live date set for 1 April 2024.

The outstanding tasks sitting with the Operations Quality (OQ) Concerns Team is at 168. This is down from 209 in Q2. The OQ Team continues to work closely with the Putting Things Right (PTR) Team to prioritise work to meet deadlines and requests.

In terms of NEPTS, the team has reviewed the current Capacity Management Plan, which sets out how the service applies the Welsh Government WHC 2007(005) eligibility criteria for non-emergency transport and the process for managing scenarios where demand for transport exceeds available capacity. The revised plan, which has been through an Equality Impact Assessment (EQIA) and Quality Impact Assessment (QIA) process, modifies the approach to a position where the service will only take bookings from patients that meet the criteria as per the Welsh Health Circular. Patients who do not meet the eligibility criteria will not be entitled to Non-Emergency Patient Transport and will be signposted to alternative transport solutions only. This plan has been shared with the Chief Ambulance Services Commissioner (CASC) and supported at the Delivery Assurance Group (DAG) meeting.

The 111 Operations Team have deployed an action plan designed to improve Welsh call answer performance, specifically the percentage of callers answered in Welsh where this is their chosen language. Performance has been consistently improving and throughout Q3 has remained stable.

Comments:

Members were keen to understand if there had been any business continuity incidents (BCI) for 111 in the last 12 months. Mark Harris was not aware of any however agreed to confirm the position and report back to the Committee. He added there were a number of different scenarios that would trigger a BCI, and in terms of 111, there may be times when it is out of the Trust's control; for example, the issue with the Adastra system which was a Health Board system issue which occurred in 2022.

With respect to the Joint Emergency Services Interoperability Programme (JESIP) assurance visit noted in the report, the Committee asked what the position was with the report reference. Mark Harris advised that he would ascertain if there were any further details in respect of the visit and report back to the Committee.

RESOLVED: That the report was received.

03/24 PATIENT STORY

Liam Williams introduced the patient story in relation to Alison Cassidy and what has been a challenging family life for both mother and daughter. Whilst the Trust's response was compliant and in line with policies and procedures, it might not have been as sensitive or supportive as desired given the personal nature of the circumstances.

Leanne Hawker provided assurance to the Committee that the Trust was collaborating with colleagues at the Betsi Cadwaladr University Health Board (BCUHB) to extract

shared insights and plans of action from this story. Additionally, the story was being shared with BCUHB and any decisions regarding the next steps will be made collaboratively.

Alison Cassidy recounted the experience of her daughter Emma, who has a rare genetic disorder, Angelman Syndrome. Most people with this syndrome will have limited speech and will need support throughout their life and have severe learning disabilities and epilepsy.

In August 2021 Emma needed urgent dental care which required her to attend Ysbyty Glan Clwyd Hospital for treatment under general anesthetic and was advised by Health Care Professionals in the Health Board to access the Non-Emergency Patient Transport Service (NEPTS) to take Emma to her appointment (as she was unable to be transported safely due to seizure risk being elevated by the dental pain). NEPTS advised that at least 24 hours' notice was needed, and Alison was advised to ring 999; however, due to system pressures at that time a 999 response was unavailable. A further six 999 calls were made during the next 24 hours in an attempt to secure an emergency ambulance response.

After 28 hours Emma was sedated by Learning Disability Liaison nurses in the garden at her home, supervised by two North Wales Police officers, who arranged a taxi to take Emma with her siblings to hospital.

In Emma's escalating distress, she began exhibiting self-harming behaviour, this triggered an "attempted suicide" script from the Clinical Contact Centre call-taker. Alison believes it was entirely inappropriate and indicative of how the Advanced Medical Priority Dispatch System (AMPDS) scripts do not have capacity to effectively assess people with learning disabilities.

Comment:

Leanne Hawker advised that this story has been shared with BCUHB colleagues who identified the need for further education on staff protocols for ordering ambulances and their appropriate utilisation. They are eager to engage with Alison Cassidy to discuss her experience and collaborate on enhancing existing initiatives for individuals with specific needs. A patient story tracker specific to this case will be presented at the May 2024 Quest Committee meeting to ensure ongoing monitoring and improvement.

The Committee agreed there was learning required across the Health Board, but also within the ambulance service. Whilst the AMPDS was a robust system there were occasions when it did not work for every patient, and situations like this need to be challenged going forward.

Liam Williams explained that under most circumstances the Clinical Support Desk (CSD) clinicians would normally be reviewing the call stack would be able to intervene directly. It is not necessarily clear from the Story that this was a period of high demand and the Trust faced challenges in responding to Amber calls.

Due to a lack of available resources the CSD was under considerable pressure, meaning that focus would be on Red calls in addition to reducing the number of Ambers. The challenge was to ensure that people with long term complex needs have the appropriate care plan escalations in place; with these plans documented and digitally accessible across the system given to the patients and their carers. Furthermore, the CSD must be informed of these plans on a case-by-case basis. The Committee noted that since this incident recruitment into the CSD had increased and were interested to see if improvements will be made going forward.

Liam Wiliams added that Digital Health and Care Wales (DHCW) were working on increasing accessibility for flagged patients allowing clinicians in CSD to access this through the Welsh clinical portal to indent where a flag exists. Using this portal clinicians can inform the correct response. Leanne Hawker added that the Trust does have a flagging policy and has recently completed a consultation with the public for people with learning disabilities and learning difficulties around the priorities for the Trust with regards to quality improvement. Overwhelmingly the feedback was that a system where they can be assured that the Trust was using flags against individual patients (as currently the system flags addresses), was desired.

The Committee recognised that joint working would include that the relevant care plan was in place. Health Boards will be accountable to ensure the equity of access to services for an individual with complex healthcare needs.

Mark Harris added that whilst NEPTS was a planned routine service there was some flexibility in the system. He welcomed the ongoing work particularly with BCUHB to try and prevent similar incidents occurring in the future. Liam Williams added that the Trust's priortisation system was built for a response model which has timelines far more than what can be achieved. It is acknowledged that a cohort priortisation system is not designed to and does not meet the needs of some people. The system was designed for a whole system response in a timely manner and was not a priortisation system for long term care. He added that the collaborative work highlighted by Leanne Hawker was critical going forward.

Members held a discussion in which they acknowledged it was an overall system issue and that services should be working hard to ensure this does not happen again. In this particular case the Trust was unable to meet Emma's needs. The Committee also asked that going forward, progress with patient stories (patient story diagram) be included as a substantive item on agendas.

The Committee recognised that whilst the video was being shared at the Health Board it was felt that wider distribution to staff would be of great benefit. Liam Williams explained that when the service was under considerable pressure the Trust and other partners will always want to do better.

Leanne Hawker emphasised the extensive sharing and dissemination of patient stories across various platforms and stakeholders in Wales, including through networks, forums, podcasts, and organisational channels. This also included the development of

a national repository for patient stories to enable wider access and the ability to learn lessons.

The Chair expressed gratitude to Liam Wiliams and Leanne Hawker for bringing this story to the Committee's attention. Sharing the story with BCUHB and collaborating on implementing actions was crucial in preventing similar incidents. The comment made by Alison about the system not working for everyone, especially for those with complex needs, was very prominent to the Committee. The Trust must take control and improve itself, focusing on what it can control and collaborating with partners to do the same. The Chair stated that the system wide pressures and risks are readily discussed at every Committee meeting. There must be a commitment to learning from these experiences to ensure prompt support for individuals with complex needs in the future.

RESOLVED: The Committee noted the update.

04/24 PUTTING THINGS RIGHT (PTR) REPORT QUARTER 3, OCTOBER – DECEMBER 2023

Liam Williams presented the report to the Committee focusing on the specific points below for their attention which should be taken into context against the backdrop of ongoing pressures and challenges within the system being experienced:

1. There continues to be a high volume of incidents being reviewed at the Serious Case Incident Forum (SCIF).

2. The PTR Organisational Change Process has concluded and recruitment to posts is in progress. The new structure is expected to be fully established by April 2024.

3. There continues to be progress in the two and five day acknowledgement in respect of concerns; however, the acknowledgement of the 30 days responses remains a challenge to meet.

Patient waiting times in the community continue to impact on patient safety and during December 2022, 1.180 patients waited over 12 hours. During this period 231 of the patients waiting over 12 hours had experienced a fall, with the longest waiting patient being 45 hours and 04 minutes. A review of this case has been requested following an initial screen of the sequence of events. Liam Wiliams planned to conduct roundtable discussions with colleagues across the Trust to explore additional improvements in this area. Liam Williams also raised the question of whether there were additional measures that could be implemented through the clinical support desk for patients who had fallen and been assessed, and to explore alternatives to help alleviate system pressures.

Six incidents have been reported as National Reportable Incidents (NRIs) to the NHS Wales Executive and included clinical practice issues, delayed diagnosis and patient injury whilst being conveyed. The Trust currently has a total of 59 open NRI investigations with 56 of them overdue.

The Duty of Quality (DoQ) and Duty of Candour (DoC) Welsh Government Roadmap is updated monthly with oversight from the Clinical and Quality Governance Group. Progress in respect of DoC is also monitored locally through the PTR Work Plan.

Following the detailed update to the Committee at the last meeting on Learning from Deaths (Mortality reviews and the Medical Examiner Service) a plan is in place to fully review the backlog of cases (800 cases) forwarded by the Medical Examiner Service, map the cases to incidents and complaints as relevant, and update the Datix Cymru Mortality Module.

All referrals have been screened on receipt by a member of the Patient Safety Team and escalated as required. Following collaboration with various teams within the Trust there has been an improvement in clearing the backlog.

During the reporting period the Trust received one Prevention of Future Deaths Report (Regulation 28) from a Coroner in South Wales Central. The Report was also sent to the Chief Executive of Cardiff & Vale University Health Board and the Minister for Health & Social Services.

Between 1 October 2022 and 30 September 2023, 1055 concerns were received by the Trust. During the same period 50 approaches were made to the Public Services Ombudsman for Wales (PSOW). This equates to less than 4% of Trust concerns being escalated to the PSOW.

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 stem from delayed responses to patients at a time of escalation.

Comments:

It was observed that the data captured for those patients waiting for a response after a fall varied across Wales. The Committee acknowledged that ensuring a representative boundary for data capture was crucial for accurate analysis.

Following a query regarding the public service ombudsman work in terms of collecting data across the system regarding investigations which was clearly very pertinent to patient outcomes, Members sought an update and any timelines. Liam Williams advised that the Trust's aspiration was to look at these cases beyond the ambulance/hospital interface.

Liam Williams added that that future PTR reports will include presentation of the data from a population point of view per Health Board area, as opposed to simply by Health Board - to put the numbers in context across Health Board. The Trust was also working with colleagues to have a better understanding of how we can present this more clearly.

The Committee recognised there had been issues with Residential and Nursing Homes; and queried if the Trust could do more, particularly around remote and/or video assessment of patients. Especially in cases where patients are lying on the floor for a lengthy period to await a paramedic to make the assessment. Jonathan Turnbull-Ross advised that the Trust continues to consider more and more remote consultation but would require the appropriate infrastructure, investment and resource going forward to develop it. In terms of falls cases, he added that work was ongoing to ascertain the correct model and the scale of resource required.

Members discussed what initiatives could be done to support Care Homes more widely going forward and were very supportive.

In terms of clinical reviews, and particularly the concern raised by a patient regarding the attitude of a crew member, the Committee sought whether the Trust had an update on any learning from this. Liam Williams acknowledged there was more work to do in terms of the guidance regarding compassion moving forward.

RESOLVED: The Quality, Patient Experience & Safety Committee received the report for discussion and were satisfied with the assurance given regarding the Trust's Putting Things Right function.

05/24 MONTHLY INTEGRATED QUALITY PERFORMANCE REPORT – DECEMBER 2023

Mark Thomas presented the report and highlighted the following areas for the Committee's attention:

999 call answering times achieved the 6 second answering target during the early part of 2023; however, in the second half of the year the 95th percentile began to worsen. In November 2023 it was 18 seconds, with an improvement to 12 seconds in December 2023. The 65th percentile and median performance remain very good.

111 call answering decreased, as expected over the holiday period, with the call abandonment target of <5% not being achieved in December 2023 for the first time in seven months (13.1%).

111 Clinical response saw the highest priority 111 calls (P1CT) remain stable and above target at 98.3%. Priority 2 and Priority 3 fell further below the 90% performance target in December 2023, with the respective figures being 63.2% and 62.3%.

Red 8-minute performance was 48.9% (target 65%) in December 2023 and Amber 1 median one hour and 36 minutes. Clearly, these levels of performance remain concerning, but they are a material improvement on the levels seen in December 2022 of 39.5% and three hours and 30 minutes respectively. The actual number of Red incidents responded to in 8 minutes has improved throughout the year.

One of the key factors in relation to response times is the capacity lost to handover outside Emergency Departments. 22,756 hours were lost during December 2023, which is a material improvement on the 32,098 hours lost in December 2022.

Ambulance Care (formally NEPTS) (Patient Experience): Oncology performance dropped below the 70% target in December 2023 to 68.16%. Renal performance increased in December 2023, and remained above target at 74.08%. Advanced discharge & transfer journey booked in advance performance decreased compared to the previous month to 78%; remaining below the 95% target. Overall demand for NEPTS continues to increase, but remains below pre-pandemic levels.

The percentage of suspected stroke patients who are documented as receiving an appropriate stroke care bundle was 75.3% in December 2023, a slight decrease from the 77.9% seen in November 2023, and remaining below the 95% performance target.

The return to spontaneous circulation (ROSC) compliance rate decreased to 17.6% in December compared to 22.2% in November 2023.

National Reportable Incidents (NRIs) / Concerns Response: the Trust reported one NRI to the NHS Executive in December 2023, a slight decrease from the three reported in November 2023; and 16 serious patient safety incidents were referred to health boards under the Joint Investigation Framework, which has now been adopted NHS Wales wide.

In December 2023 complaint response times increased to 58%, a significant improvement on November 2023's 38%, but remains below the 75% target, with cases remaining complex.

The Trust produced 123,727 Ambulance Response unit hours in December 2023, an increase from the 121,349 produced in November 2023.

Good progress has been made through the year in increasing Consult and Close rates after 999 calls; and the Trust achieved 14.1% in December 2023, a slight increase from the 14% seen in November 2023, but below the Trust's 2023/24 IMTP ambition of 17%.

The indicators used highlighted that even though demand, and subsequently, system pressures increased during December 2023, performance remained relatively stable, across all areas, and significantly exceeded the levels achieved during December 2022.

Comments:

It was noted by the Committee there had been significant improvement in performance in some areas since December 2022; however, current performance in some areas was still below target.

In terms of the issues in meeting the targets regarding staff sickness and Personal Appraisal Development Reviews (PADRs), it was agreed this would be discussed at the next People and Culture Committee (PCC). The Chair of the PCC, Paul Hollard, agreed that the Committee would consider the action plan for reducing sickness and would look at the areas where PADR rates were low.

In respect of the presentation of the MIQPR and the phrase '*holding in the community*' particularly around immediate release, it was suggested that it could be prudent for the Trust to re-consider the use of language to ensure transparency of this term.

The Committee acknowledged that around 9900 patients cancelled their ambulance and that we were unable to respond to 793 calls. From a presentation perspective it was queried whether the placement of this data under 'Partnership & System Contribution' was correct. It was agreed that Mark Thomas would feed this back to his Directorate for clarification.

In terms of Immediate Release Directives, the Committee sought clarity at what level such Directives are made. Andy Swinburn explained that the request was made from the Operational Delivery Unit who would ask the nurse in charge of the department.

In respect of those patients that were delayed at handover, it was queried if it was possible to identify what type of cases they were. Andy Swinburn advised that the majority were likely to be frail older people who had a mixture of presentations. Liam Wiliams advised there was further work required in terms of clinical audits for the Trust to understand further the presentation and the clinical decision making that inform the decision to convey. Prior to conveyance, the ambulance crew will consider the presentation of the patient, their existing identified clinical need, and any potential clinical need. It was important that the Trust should build the clinical pathway in collaboration with Health Boards to understand what could be done differently.

Liam Williams assured the Committee that the Executive Leadership Team were well sighted on the pending political changes that may affect the Trust going forward.

RESOLVED: The Committee received the Monthly Integrated Quality and Performance report for December 2023 and actions being taken and determined that the report provided sufficient assurance

06/24 INTEGRATED MEDIUM TERM PLAN (IMTP) – QUEST COMMITTEE ELEMENTS

Trish Mills gave a verbal update in which she advised at this stage there was no written update due to the IMTP development timeline, but that the Board would have an opportunity to review the document so far as its Development Day on 22 February 2024. Going forward this item will need to be considered in the terms of the Committee's cycle of business.

RESOLVED: The Committee noted the update.

07/24 QUALITY STRATEGY IMPLEMENTATION PLAN UPDATE

Jonathan Turnbull-Ross presented the report and updated the Committee on the following points:

Following the internal Organuisational Change Process (OCP), the Senior Quality Leads have been appointed and took post as of September 2023. An Engagement Plan has been developed with delivery continuing in Quarter 4. This will ensure regular engagement with clinical, operational, and corporate functions to support quality improvement and provide specialist advice.

The first stage of development for the quality hub is due to be completed by the end of December 2023 with a proposed launch in early 2024. The first phase will focus on the Welsh Ambulance Services NHS Trust Improvement and Innovation Network (WIIN) portal and tracking of improvement data across Wales. The second stage will focus on development of training, information, and resources.

Careful consideration has been taken with the Operations Directorate in assessing the alignment of operational governance structures. Continued collaborative working through the two Directorates has allowed the Quality Management Group (QMG) to establish a growingly effective forum, embedding patient safety and learning into this agenda with a revised TOR tabled for CQGG on 24 January 2024.

Engagement with communities has continued with recruitment of citizens into the Trust's people and community network, and as previously reported this will be a continuous exercise to ensure appropriate representation.

Comments:

Members noted the ongoing work in engaging with communities especially with the Citizen's Voice and the challenges in managing their expectations; and it will be interesting to understand how this develops.

The Committee asked that for the next update it would be useful have some timelines, in respect of the actions being undertaken, particularly in the red areas.

The Committee were keen to understand how the Senior Quality Lead was settling into their roles. Jonathan Turnbull-Ross assured the Committee they were settling in well, however the Trust still required further resource to ensure the full effectiveness of implementing the strategy.

Members queried if the Duty of Quality report for 2024 would be presented in a consistent format across all Health Boards. Jonathan Turnbull-Ross commented that following guidance, that was the intention going forward, however there may be slight nuances with every Health Board.

The Committee sought an update on any future engagement events following the implementation of the strategy. There has been some extensive engagement already and agreed to update the Committee on future timelines. Liam Williams updated the Committee on the work in terms of how the Trust was engaging at Health Board level. He added that he was keen for the Trust to have an approach that aligned quality improvement and quality and safety into a single operating environment with a defined set of metrics.

Members thanked all those involved in the progress they had made despite the ongoing challenges.

RESOLVED: The Quality, Patient Experience & Safety Committee noted the progress against the Implementation Action Plan.

08/24 SPOTLIGHT ON CLINICAL INDICATORS (CI) - STROKE

Duncan Robertson gave the Committee a PowerPoint presentation which outlined the following details:

An ePCR technical specification was created to enable reporting and since the implementation of ePCR all Clinical Indicators (Cis) are reported on using 'raw' data inputted by clinicians (*no manual auditing prior to reporting*)

Due to staff being unfamiliar with a new system, a reduction in CI compliance was anticipated (as in other UK Trusts), risk 535 (monitored by CIAG) was created to highlight three elements: User behaviour, User interface and Scripting.

A Clinical Indicator dashboard has been developed to include Stroke (*Version 2 released December 2023 includes time-based metrics*). A deep dive audit had been conducted by the Clinical Intelligence and Assurance Team to:

- Provide a more accurate clinical picture of the care delivered
- Highlight the variation between automated and audited data
- Help inform future reporting and caveats
- Help inform an improvement plan and changes to the ePCR User Interface

By and large through March of 2023 the Trust performed better than it did in March 2022, in terms of getting the resource to the to the patient. There have been several improvements to date following the ePCR Clinical Data Assurance clinical audit which included:

- A more accurate clinical picture of the care delivered is provided
- The variation between automated and audited data is highlighted
- It has helped to inform future reporting and caveats and inform an improvement plan and changes to the ePCR User Interface

The User Interface changes were being implemented in December 2023 and the

improvement plan was progressing with further engagement and support from Senior Paramedics for ePCR completion and CI compliance. Furthermore, the development of a revised CI 'Jigsaw Poster' following requests from staff to use as an *aide memoire*.

Future Changes to Stroke Call Timing:

In line with most UK ambulance services, the Trust prioritises MPDS protocol 28 (Stroke) calls, in accordance with the timing of symptom onset ('t' value)
Currently the 't' value priority assigned to Strokes is:
Onset of symptoms < 5 hours or unknown time = amber-1 priority
Onset of symptoms > 5 hours = amber-2 priority

Recent discussions with senior clinicians from the Wales Stroke Network have indicated that:
New treatment opportunities exist for patients who have Stroke symptoms with an unknown onset time (often known as a 'wake up' Stroke)
The time window for specific therapy is now much greater – up to 12 hours.
The Trust is now working to support the clinical recommendation to change the 't' value in protocols 28 and 18, from five hours to ten hours. A paper is to be submitted to the Executive Leadership Team (ELT) in January 2024.

Comments:

The Committee welcomed the presentation and recorded a note of thanks for those involved in its production, notably Kevin Webb. The Committee expressed their concern about potential variations in access to treatment across Health Boards, especially with the extended therapeutic window switching from five hours to ten hours. Data collection will be crucial for providing feedback and addressing any disparities in access to treatment within this context.

Duncan Robertson commented that Patients who wake up with stroke symptoms but with a very narrow therapeutic window are missing opportunities. It may be that they had their stroke an hour before they woke up or 10 minutes before they woke up and are being disadvantaged through this approach. There has been a lot of work done in the background in terms of modelling the numbers through this as well and working with colleagues within Operations in relation to making sure they're not being inundated with a lot of what might be false positives in terms of stroke. The other piece of work involves the Clinical Prioritisation Assessment Software (CPAS) team who look after the tables that indicate how the Trust responds to each of the codes that it goes to. There was also some work involved moving amber one into amber two calls so from an organisational perspective it is not increasing the number of amber one calls because of the strokes but what that does mean is there is space there for the additional amber one stroke coding to go through that way and doesn't have any additional burden.

Andy Swinburn explained in terms of the CI there was only one element that fundamentally contributes to the outcome of the patient and that was recognising that the person is having a stroke through a Face, Arms, Speech, Time(FAST) test. While

assessing blood pressure and using the Glasgow Coma Scale were important and useful, they don't directly alter patient outcomes. Instead, factors like pre alerts, shorter time on scene and call to door time are more impactful in improving patient outcomes.

Following further discussion, it was noted that a deep dive audit was scheduled to be conducted on the Stroke CI, and once this had completed the Committee would be updated.

The Committee were keen to understand more detail around when the FAST assessment was completed, unless there was a justified exception and how is the justified exception being documented and then evaluated. Duncan Robertson explained this was being updated with the user interface changes in ePCR, as some of the justified exceptions were not as clear as they were with the documentation to support the digital pen and paper-based Patient Clinical Record (PCR)s. Every CI has its own separate section on the ePCR, and these sections have been streamlined so that the indications for doing something are included and what they've done and if medication is involved this can be updated accordingly.

Liam Williams added it was important to note that the changes that are being made were made by the stroke network on behalf of Wales.

RESOLVED: The Committee noted the PowerPoint update for the Stroke Clinical Indicator.

09/24 HEALTHCARE INSPECTORATE WALES (HIW) NATIONAL REVIEW OF PATIENT FLOW – A JOURNEY THROUGH THE STROKE PATHWAY (AND TRUST ACTIONS) & IMPROVEMENT PLAN

Andy Swinburn presented the report advising the Committee that a review from Health Care Inspectorate Wales (HIW) had identified 50 recommendations to improve patient flow for patients who have suffered a stroke in Wales.

Of the 50 recommendations, seven were specific to the Trust, with the remaining recommendations sitting with other healthcare services such as the Health Boards and Public Health Wales.

The Trust has devised management actions in response to the review recommendations and these alongside actions for Health Boards and Public Health Wales have been included in the Patient Flow Review Improvement Plan. A copy of the Trust's management actions has also been lifted to the Trust's audit tracker to hold Directorates to account and to monitor progress the actions relevant to the Trust.

Comments:

In terms of the Immediate Release Directives protocol and how the process worked in Emergency Departments, it was asked whether this was being reviewed and whether it

would be appropriate for the Committee to have sight of this work. Andy Swinburn explained that this was not within the Trust's control.

As part of addressing the actions the Committee asked whether the increase of Advanced Paramedic Practitioners (APP) played an important part. Andy Swinburn explained the ultimate goal was to create the capacity to reduce the usage of ambulances to ensure there was always one available to respond to patient who present as a stroke.

2022/23HIW Annual Report

Liam Williams presented the report as read and highlighted the key areas as follows:

Outlined the work undertaken by HIW in relation to the Stroke pathway.

The work carried forward from 2021/22 and into 2022/23 in relation to systems pressures and understanding the pathway issues for offering care, particularly around handover delays and the consequences this had on the Trust's ability to provide care.

Safeguarding, the Committee had previously received the annual report which set out all the work the Trust had undertaken to highlight safeguarding as a critical part of practice.

Comments:

The Chair advised there had been an increase in the number of safeguarding alerts raised in the Trust, whilst the report states a significant drop, Liam Williams explained that some of the alerts are coded to the Health Boards and were picked up at Local Authority level. He agreed to clarify this point and update the Committee.

RESOLVED: The Committee

(1) Received the 'HIW National Review of Patient Flow (a journey through the Stroke pathway)' report and were assured that the improvement plan actions relevant to the Trust were being progressed accordingly; and

(2) Noted the 2022/23 HIW Annual Report.

10/24 CLINICAL AUDIT PLAN AND ACTION TRACKER QUARTER 3 UPDATE AND CLINICAL AUDIT PLAN Q1 2024/25

Duncan Robertson presented the report highlighting for the Committee's attention:

During Q3 2023-24, a further four of the 15 clinical audits included in the Clinical Audit Plan for 2023-24 have been completed. These audits and associated action plans have been approved by the Clinical Intelligence & Assurance Group. The audits that have been completed are:

- ePCR Clinical Data Assurance – $EtCO_2$ Compliance
- Non-conveyance form images in ePCR
- ROLE form images in ePCR
- Levetiracetam (Keppra) Potential use in convulsions

Since the last update (October 2023), a further 16 actions have been completed that were aligned to eight of the audits.

Clinical Audit Plan Q1 2024/25

The plan was presented by Duncan Roberston who advised that its development had been in consultation with eh Clinical Intelligence and Assurance Team (CIAT).

The development of this Annual Plan takes into consideration several aspects including the resources available both in terms of funding and skills.

This plan and the subsequent action tracker to monitor learning from each of the audits is monitored by the Clinical Intelligence & Assurance Group (CIAG), and an update noted at Clinical Directorate Business meetings.

Comments:

The Committee welcomed the reports, noting the good progress and recorded a note of thanks for those involved in its production, notably Kevin Webb.

It was also noted that the Chair of the Committee would prepare a report to advise the Audit Committee that the Quest Committee had received the plan, in accordance with the Audit Committee's Terms of Reference.

RESOLVED: The Committee

(1) Noted the Q3 2023-24 Clinical Audit Pan and Action Tracker Update; and

(2) Approved the Clinical Audit Plan Q1 2024/25 as set out with the caveat that additional items may be added as the year progressed.

11/24 MEDICINES MANAGEMENT ASSURANCE REPORT FOR 2023

Duncan Robertson presented the report adding it was the first time a Medicines Management Annual Report had been provided. Areas within the report included the following:

Vehicle medicines Audit
Omnicell Monthly Cycle Count
Unresolved Controlled Drug Discrepancies on the Omnicell System
Patient Group Directions (PGD) – Evidence of Signed Authorisations
Expired PGDs
Abloy (controlled drug key) System

Notification Alerts
Controlled Drug Quarterly Occurrence Reports
Medication Errors

The report had identified that in terms of any controlled drug discrepancies within the Omnicell system, this had improved with less discrepancies being reported.

The Committee were given assurance that additional work was ongoing with the Patient Group Directions as directed via an Internal Audit report.

Medication Errors were currently based in table form and was based on reports received from Datix administrators; the Trust was looking to expand and include more information.

Comments:

The Committee noted that a plan was being worked on to expand capacity and resource within the Medicines Management Team.

Members recognised this report had been subject to an Internal Audit and the progress has been significant and positive, demonstrating the actions being taken.

Members discussed whether this report should be appended to the Committee Highlight report being presented to the Board next month. It was agreed that the report should be presented in the Closed session of the Board.

RESOLVED: The Committee:

(1) Agreed that future reports for QuEST are synchronised to be delivered following closure of a financial year, therefore next report to be delivered at the May 2025 meeting covering the 2024/25 financial year; and

(2) Noted and discussed the content of the appended report as required.

12/24 COMMITTEE ANNUAL EFFECTIVENESS REVIEW 2023/24

Trish Mills explained that the Annual Effectiveness Reviews are designed to evaluate the effectiveness of the Board and its Committees, review its operating arrangements, and propose changes to improve its support, challenge, scrutiny, and oversight responsibilities.

Questionnaires were sent to members and attendees provided an opportunity to gauge opinion on areas of good practice and areas that require improvement. Sixteen questionnaires were sent out with eight responses being returned (a 50% return rate which was slightly higher than 2022/23).

It is good practice for Committees to set priorities for the forthcoming year when they review their effectiveness. Such priorities may include a particular focus throughout the year, or in particular quarters. For example, the Committee may wish to prioritise more agenda time to any new issues it may be adopting in its terms of reference; focus on areas it may not have addressed as strongly last year or which are developing; or review of the Committee's risks, both operational and strategic.

It was noted that due to operational pressures, this has sometimes meant that information was presented at different times. However, the cycle of business and monitoring report presented at each meeting indicates the reasons for this.

The Committee noted from the Annual Report the significant amount and varied issues of business discussed during the year. There were several proposed minor changes to the Committee's terms of reference. The main change was moving the Information Governance, and the Information Security sections over to the Finance and Performance Committee.

In terms of membership there will be a change to the Members with a new NED arriving and one leaving, with no changes to the Prescribed Attendees list.

Comments:

The Committee discussed the issues around clinical indicators and the data aligned to that and how that along with the Duty of Quality and Candour would develop going forward.

Trish Mills commented that Committee would focus on the quality strategy or quality plan the development of it as it comes through next year and maybe also with the new health and care quality standards being introduced with the new act is how the Trust was moving towards providing assurance to the Board on those standards. Liam Williams added that the Quality Management Group was addressing the standards with updates, through the Clinical Quality and Governance Group (CQGG) coming to the Committee.

Liam Williams added that the Chief Nursing Officer will have a focus on Infection Prevention and Safeguarding.

The Committee must continue to focus on the two main 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), and their impact. Liam Wiliams added that the Committee could weave its agenda items into these risks and align the work of the Committee to support the mitigation of these risks.

Members appreciated that the focus of the Trust was on those areas of high risk and queried if there was enough focus on the other services, i.e. NEPTS. It was

suggested if there were ways in which the Committee could have more visibility on some of the lower risk areas.

In setting its priorities for 2024/25, the Chair emphasised the importance of recognising the duty of quality and duty of candour as a priority highlighting the role of the quality strategy in fulfilling this duty additionally as a sub section of this priority. Addressing risks 223 to 224 too should be noted as another priority alongside innovations in care. The many comments made during this discussion have aligned with these three overarching priorities. Members were content and agreed with these priorities.

RESOLVED: The Committee:

(1) Reviewed and approved the draft Annual Report.
(2) Reviewed and endorsed any further changes to the terms of reference;
(3) Confirmed the proposed changes to operating arrangements in response to issues raised in questionnaires as set out in the draft Annual Report; and
(4) Set its priorities for the Committee for 2024/5.

13/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK (BAF)

Trish Mills presented the report advising that the same information was presented to the Board last month.

The Trust's highest rated Risks 223 and Risk 224 scoring 25, remain unchanged because of sustained and extreme pressure across the Welsh NHS urgent and emergency care system which is negatively impacting on patient flow leading to avoidable patient harm and death. These risks continue to be closely monitored by management, Board Committees, and at the Trust Board meetings.

Several updates have been made to the controls and assurances in relation to Risk 223 and 224 during this period and these are highlighted on the BAF to address gaps in assurance. These two risks will be reviewed closely in conjunction with each other to ensure the synergy between them both and that they reflect the actions from the avoidable harm paper in the same way.

Comments:

Members welcomed the reviewing of the two highest scoring risks, noting that the Trust continued to do everything it could to reduce the score.

RESOLVED: The Committee noted the report.

14/24 POLICIES FOR APPROVAL/ADOPTION

Leanne Smith explained that the Data Protection Policy has been fully revised, redrafted and brought into alignment with the requirements of the Data Protection Act 2018 and UK General Data Protection Regulations, which are key pieces of legislation covering the handling, security, and confidentiality of personal information.

This policy has been through the relevant stages of the policy review process, including the Information Governance Steering Group with invites for comments, followed by Trust-wide consultation. It was approved by the Policy Group on 19 December 2023.

The Committee were advised that the Trust employed Kelly Holding as the data protection expert who's responsible for helping ensure the Trust's legal obligations as a collective were met. Her work and others involved in the Trust who have developed the policy should be recognised.

RESOLVED: The Data Protection Policy was approved.

15/24 AUDIT TRACKER AND AUDIT REPORTS

Trish Mills advised the Committee that the Audit Tracker has been updated in Quarter three following its complete revision in Quarter two; again, there has been excellent engagement from Directorates. Around12.5% of internal audit recommendations are presented as closed in quarter in this report and there are actions with a change in date proposed, many of which are due to be closed in Quarter four or Quarter one of 2024/25.

The current version of the tracker is now open for Directorate review for actions due in January, February, and March. These updates will then be reported to the Committee at its meeting in May 2024.

Discussions have taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these, and discussions will continue into Q4 with a view to closing or revising as many as possible.

Records Management Internal Audit Report – Reasonable Assurance

Leanne Smith presented the report and thanked the Internal Auditors for their assistance in developing this report.

Leanne Smith clarified that the records team comprises only three permanent members who covered two essential services; handling requests for personal and Trust records and managing Trust records which was the focus of the audit.

The Trust has experienced a notable rise in records requests over the past decade with a 40% increase in 2022-2023 compared to the previous year. This year the increase is projected to be around 7% however the capacity to focus on records management as highlighted in the audit is diminishing. The team has prioritised not breaching any individual rights and subject access requests, but this focus has led to challenges in implementing records management improvement plans.

Progress was being made on the action listed in the report which is illustrated in the Audit Tracker.

Comments:

Members queried whether the storage of physical records, which were currently being held in a premises owned by Denbighshire County Council, as the Trust moved towards digitisation, would decrease over time. Leanne Smith commented that the risk of paper records being held outside Trust premises and the cost would decrease over time. She added that the Trust was looking to see if there was unused space on Trust premises that could be used as storage in the meantime.

Osin Lloyd added that some of the high priority findings in the audit related to the paper records and storage.

Given the resources in the Team, the Committee queried whether the timelines reflected in completing the actions were realistic. Leanne Smith accepted there would be challenges but plans were currently on track to meet the timelines for the current quarter.

RESOLVED: The Committee:

(1) Received and reviewed any Internal Audits and Audit Wales reviews within their remit where relevant. For this meeting these were: -

(2) Records Management (received by Audit Committee on 30 November); and

(3) Monitored management actions to address recommendations in the Tracker, noting any revised dates for actions and were assured by the update received.

16/24 INFORMATION GOVERNANCE REPORT AND INFORMATION SECURITY KEY PERFORMANCE INDICATORS (KPI) REPORTING

Leanne Smith presented the report and highlighted the following areas for the Committee's attention:

Data Protection Impact Assessments (DPIA): DPIAs are required when new systems, processes or projects, or changes to existing ones, may result in a risk to the rights and freedoms of individuals and their personal information. Although progress has been steady over the year, many DPIAs are still awaiting review or have not yet been started due to lack of engagement from teams around the organisation, and limited capacity in the IG team to support the completion and approval of DPIAs. The Information Governance Steering Group was now assisting in the prioritisation of reducing the current backlog.

Records Requests: despite a significant increasing trend requests for records received annually, the small team have managed to increase compliance rates since the October reporting where compliance was at 86%. This is through improved processes and support from individuals performing alternative duties within the Trust.

Information Governance Toolkit – This is the top section of the dashboard and has seen a significant change from the 2022/23 set of minimum expectation requirements. The questions set in the categories for this year have changed which means that some of the evidence to be collected will be different. In terms of progress against the 2023/24 IG Toolkit submission, there was still around 28% of requirements with outstanding evidence against them.

Work was ongoing to improve the strength of passwords within the Trust; the challenge being for front line staff.

Comments:

Freedom of Information Requests: There has been an increase in the volume and complexity of FOI requests compared to 2022/23 which has led to months in 2023/24 seeing poor performance against the target (of responding to 90% of requests within 20 working days). Trish Mills explained the challenges in resources which has been the cause of this issue; adding that the Trust was looking at ways to improve the situation which included automation.

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

17/24 WELSH RISK POOL CONCERNS ASSESSMENT

Liam Williams advised the Committee that the report outlined the progress against the Welsh risk Pool (WRP) Concerns Assessment as of December 2023.

The Report identified several recommendations. Each organisation in Wales has been asked to develop an Improvement Plan which addresses the findings and supports the prioritisation of improvement activity in this area. There were 10 areas earmarked for improvement, one of the recommendations (WRP01) required Committee support to be extended to 31 March 2024, the remaining nine actions were on target to be completed by then.

The Committee noted and supported the extension of the action WRP01 to 31 March 2024.

RESOLVED: The Committee noted the report and agreed that WRP01 completion date be extended to 31 March 2024:

18/24 CYCLE OF BUSINESS MONITORING REPORT

The report was presented for information.

RESOLVED: The Committee noted the report.

19/24 PATIENT STORY UPDATES

The report was presented for noting.

RESOLVED: The update was noted.

20/24 KEY MESSAGES FOR BOARD

Trish Mills would draft the update which will be presented to the Board via the Committee's AAA highlight report.

21/24 REFLECTIONS & SUMMARY OF DECISIONS & ACTIONS

The following actions were captured during the meeting:

The driver diagram now will be a substantive item on the next meeting agenda rather than in the consent items.

The PTR report discussed how data could be presented differently and considered how to have different approaches to remote consultation and involve care homes.

MIQPR, PCC would consider more closely the staff sickness and PADR. There were also questions raised on the content regarding the number of patients where ambulances were cancelled or where it was not possible to provide a response, it was queried whether the placement of this under 'Partnership & System Contribution' was correct.

The Committee asked that a timeline/timetable of how the revised Quality Strategy would be delivered.

Healthcare Inspectorate Wales Annual Report 22-23, it was agreed this would be appended to the AAA report going to the Board.

Medicines Management Assurance report, it was agreed this would be added to the Trust Board closed meeting.

In respect of the Committee's effectiveness, Members reviewed and approved the draft Annual Report. Reviewed and approved any further changes to the terms of reference. Confirmed the proposed changes to operating arrangements in response to issues raised in questionnaires as set out in the draft Annual Report and set its priorities for the Committee for 2024/5.

Agreed to review Risks 223 and 224 noting the position has been the same for several years.

The Committee approved the new Data protection policy.

Welsh Risk Pool Concerns, the Committee noted and supported the extension of the action WRP01 to 31 March 2024.

The patient story was challenging and led to a very constructive discussion, but it was important to continue to hear from patients.

It was recognised that the lack of capacity in some areas of the workforce added to the already significant and challenging workloads of staff.

The meeting, with a lunch break did not feel rushed and each item was afforded the appropriate time allowing for effective discussion.

22/24 ANY OTHER BUSINESS

The Chair of the Committee, recognising this was Paul Hollard's last meeting thanked him for his support and valued contribution over the past several years.

Paul Hollard thanked the Chair adding that he had seen over the years how the Quest Committee had grown positively and improved.

Date of Next meeting: 7 May 2024

Meeting concluded at 14:30

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

CONFIRMED MINUTES OF THE PEOPLE AND CULTURE COMMITTEE MEETING (OPEN SESSION) HELD REMOTELY VIA MICROSOFT TEAMS ON 20 FEBRUARY 2024

Chair: Paul Hollard

Member:	Non-Executive Director and Chair
Paul Hollard	Non-Executive Director
Bethan Evans	Non-Executive Director
Hannah Rowan	
Prescribed Attendee:	
Lee Brooks	Executive Director of Operations
Alex Crawford	Assistant Director of Planning and Transformation (left after 11/24)
Christian Fox	Trade Union Partner
Estelle Hitchon	Director of Partnerships and Engagement
Angie Lewis	Director of People and Culture
Trish Mills	Board Secretary
Andy Swinburn	Executive Director of Paramedicine
Chris Turley	Executive Director of Finance and Corporate Resources
Jonathan Turnbull-Ross	Assistant Director of Quality
Damon Turner	Trade Union Partner
Attendee:	
Darren Anthony	EMT2 Staff Member (left after 02/24)
Julie Boalch	Head of Risk/Deputy Board Secretary
Sarah Davies	People and Culture Directorate Business Manager
Colin Dennis	Trust Chair
Dr Catherine Goodwin	Assistant Director Inclusion, Culture and Wellbeing
Melfyn Hughes	Welsh Language Services Manager
Ceri Jackson	Non-Executive Director (only for 07/24)
Alison Kelly	Business and Quality Manager
Osian Lloyd	NWSSP Internal Audit
Caroline Jones	Corporate Governance Officer
Kathryn Cobley	Head of Inclusion and Engagement
Sara Mills	Head of Culture and OD
Alex Payne	Corporate Governance Manager
Liz Rogers	Deputy Director of People and Culture

Apologies:

Joga Singh	Non-Executive Director
Tim Cahalane	Trade Union Partner
Ian James	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

01/24 WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the hybrid meeting of the People and Culture Committee noting that some members, including the Trust Chair and the Executive Lead were in the room, with others attending via Teams.

Apologies were recorded from Joga Singh, Tim Cahalane, Ian James, and Liam Williams.

02/24 STAFF STORY

Angie Lewis welcomed Darren Anthony to the meeting and thanked the Management Team for allowing him time to join the meeting whilst on shift.

Darren Anthony had completed the Level 4 Diploma for Associate Ambulance Practitioners, which is the accredited education programme for EMT2 roles, and went on to win the Skills for Health Apprentice of the Year award in recognition of his achievement. This showed the importance of continued learning.

Darren Anthony shared his background prior to starting work with the Welsh Ambulance Services NHS Trust (WAST). He worked for Gwynedd Council in the local leisure centres starting out as a young apprentice before becoming a lifeguard and teaching swimming to both adults and children. He then moved to senior management and qualified as a personal trainer, although his passion remained with teaching children, which he recognised was a transferable skill and helped him during his training with WAST.

Having previously applied to WAST 13 years earlier and being successful, it came at a difficult time in his personal life, and he declined the offer at that time. He applied again and was once again successful and became part of EMT 7 in September 2022. He praised the IT, resources and tutors although did say that some additional practical training would have been beneficial, together with issuing the workbooks earlier. Recognising he didn’t want to just pass the course he wanted to excel, he was determined to prove himself. He then became the student of the course followed by 'Apprentice of the Year’, which was a huge achievement.

Darren Anthony was proud to work for WAST and everything it offered and was hoping to gain an opportunity to progress to become a Paramedic. He appreciated the policies, procedures, development, and support that the organisation offers.

Members congratulated Darren Anthony on his achievement and thanked him for sharing his inspirational story, determination, commitment, and enthusiasm. They also wished him well in his application to become a paramedic.

RESOLVED: That

1) **The suggested improvements to the training be taken back to the team; and**
2) **the inspirational story was welcomed by members.**

03/24 DECLARATIONS OF INTEREST

No new declarations were made in addition to the standing declarations which were already noted on the Trust Register of interests.

RESOLVED: That no new declarations were received.

04/24 MINUTES OF PREVIOUS MEETING, ACTION LOG AND HIGHLIGHT REPORT

The Minutes of the Open meeting held on 16 November 2023 were considered and agreed as a correct record.

Lee Brooks confirmed that action 57/23 was part of Connected Support Cymru and in terms of meeting the grant requirements, it was positive. Recruitment was underway for Community Welfare Responders in Cardiff and Swansea. He also confirmed that a webinar to build third party relationships was encouraging. He advised Committee that more detail would be included within the quarterly report in future. The action was closed due to the progress being reported via the quarterly report in future.

Committee confirmed that action reference 60/23 around the Welsh Language Speakers could be closed as the detail would be contained within the Annual Report.

The final action reference 63/23, a deep dive into disciplinary themes and trends was reference on within the People and Culture Metrics report programmed for this meeting. Members also noted that the disciplinary case management audit would be shared soon, therefore agreed to close the action on that basis.

RESOLVED: That the

1) **minutes of the meeting held on 16 November 2023 were approved; and**
2) **Actions 57/23, 60/23 and 63/23 as set out above were closed.**

05/24 DIRECTOR OF PEOPLE AND CULTURE DIRECORATE UPDATE

The Director of People and Culture highlighted the successful joint sexual safety workshop given to 140 colleagues on 9 January 2024. The workshop aimed to share the knowledge and learning around dealing with sexual safety issues and creating a safe environment in the workplace. Working closely with legal and risk also raised understanding and knowledge within WAST.

Colleagues were aware of the recent publication of the ambulance services in England Cultural Review, with the emphasis now for the Trust to focus on its culture and psychological safety. Additional engagement on the Freedom to Speak Up raising concerns would be focused on.

The Trust was delighted to have been shortlisted for the CIPD Wales Award for Equality and Diversity with a meeting to be held with judges on 21 February, and results announced on 15 March. The Trust had been open around the ongoing progress, with more work still to do.

Angie Lewis had also attended a CPD day for year one and year two students at Glyndwr University, along with Andy Swinburn. Their feedback was positive and particularly highlighted the support of their practice educators.

Training had been ongoing around workforce planning with a significant number of managers. A further iteration of the Strategic Workforce Plan would be presented at the next meeting, as a key requirement for the organisation. Angie Lewis also referenced an online event which would be held on 8 March for International Women's Day.

Damon Turner confirmed the workshop in February was both challenging and positive, and queried if information on leavers would be shared with managers. Angie Lewis confirmed that some data was provided within the culture metrics report and that an audit had recently taken place which would be shared. She agreed to share information with Trade Union Partners around upcoming themes relating to leavers. She also noted that funding has been made available by Health Education and Improvement Wales (HEIW) for two years for a retention lead for all Health Boards and Trusts, a role to which Paola Spiteri had been appointed for WAST.

RESOLVED: That the update from the Director of People & Culture was noted.

06/24 OPERATIONS QUARTERLY REPORT

Lee Brooks drew out pertinent aspects for Members, which included the more detailed update in relation to the Manchester Arena Inquiry within the report with good progress made on the recommendations with action 27/68 now complete.

The ten second triage and major incident triage tool was set to go live on 1 April which was not without a significant undertaking in promoting Mandatory in-Service Training (MIST). The Senior Operations Team were comfortable that sufficient staff would have been through MIST by that time.

Lee Brooks was pleased to inform members that recruitment to the Resourcing, Rostering Systems Manager post had been successful which would allow the Trust to further review the benefits of GPRS and allow the movement of timesheets onto an electronic system working with the Electronic Staff Record (ESR) interface the GRS Everbridge interface and the GRS CAD interface.

The Executive Leadership Team had committed additional budget for the next financial year for EMS Coordination, which would see the design of a career structure from a Band 3 Call Handler to the Executive Director of Operations post. The Organisational Change Policy (OCP) for this change was hoped to get underway soon. Members welcomed the career development model for operational staff.

A considerable number of Emergency Medical Staff Coordination employees were recognised through the Emergency Medical Dispatcher of the year process, with many shortlisted and some winners too.

RESOLVED: That the Operations Quarterly Report was noted.

07/24 STRATEGIC EQUALITY PLAN, ANNUAL WORKFORCE EQUALITY MONITORING REPORT 2022/23, ANNUAL GENDER PAY GAP REPORT 2022/23 AND ANTI-RACIST WALES ACTION PLAN

A presentation by Kat Cobley was delivered to Members which covered several Equality Diversity and Inclusion (EDI) related papers, their purpose and progress to date, and their relevance to the People and Culture Plan.

It was recognised that Equality, Diversion, and Inclusion was evident in everything the Trust does. With improvements in the use of Equality Impact Assessment, policy development and digital forms being developed, the re-establishment of the EDI Steering Group to monitor the Strategic Equality Plan (SEP) objectives, there was much work ongoing.

Kat Cobley wished to update Members on progress to date and focus on the future plans, with a discussion on the role of the People and Culture Committee and the Non-Executive Directors in the overall EDI agenda.

Trust staff were leading on sexual safety work and worked closely with national staff networks in this regard. A number of conferences that Kat Cobley had attended were well presented in terms of raising issues around EDI and challenges faced by those who were disadvantaged in our society.

Work was ongoing to develop the carers passport scheme and the staff disability network was working to support neurodiverse staff in the workplace as well as being aware of service users too. Finally, warm WAST welcome sessions had been introduced for staff, to emphasise the positive aspects of being a member of WAST.

SEP

Under the requirements of the Equality Act 2010: The Public Sector Equality Duty (PSED), the Trust was required to publish a Strategic Equality Plan (SEP) and a set of objectives by 31 March 2024 which would demonstrate how the Trust would:;

- eliminate discrimination, harassment and victimisation and other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and those who do not;
- foster good relations between people who share a protected characteristic and those who do not.

This work involved a review of the previous SEP and the progress made against the objectives. The new four-year plan and objectives must be informed by the relevant information that is already held, followed by consultation and engagement with staff, service users and stakeholders, in particular, those with a protected characteristic, Welsh speakers and other minority groups or those who are vulnerable. The SEP should also consider the findings published in the Equality Human Rights Commissions' 2024 Report 'Is Wales Fairer?'. The responsibility for meeting the requirements and giving due regard to the PSED lies with all employees, senior leaders, and board members.

Based on the information the Trust has and the feedback received during consultation and engagement, a SEP for 2024-2028 has been drafted with the following overarching strategic equality objectives:

- Designing Equitable Services
- Leading by Example
- Being an Employer of Choice
- Creating Allyship

During the consultation period no further comments were received which required changes to the draft SEP and objectives. However, feedback had suggested that there was a need for the Trust to produce an easy read version alongside the plan for people whose first language wasn't English or Welsh. Plans were in place to explore options to create an easy read version and a video animation to provide an overview of the SEP.

Gender Pay Gap Report and Workforce Equality Monitoring Report 2022/23

The gender pay gap reporting requirements and equality monitoring data requirements are outlined in The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017.

As an organisation that employs more than 250 people the Welsh Ambulance Services NHS Trust must publish and report specific information about our gender pay gap both on our own website, and the Government's website.

As a public sector body, the Trust is required to publish workforce data and assess the diversity of the workforce in relation to the population we serve. This information is pulled from our Electronic Staff Record system and the TRAC system.

In 2022-2023 our gender pay gap was 5.4%. This compared favourably to other NHS Wales organisations with some of these between 20-25%. It also sits in the middle of the table comparison between UK Ambulance Trusts, whose gender pay gap reports range from 0.85% (North East Ambulance Service) to 10.77% (North West Ambulance Service).

In 2022-2023, there was a small increase in the diversity of our workforce in relation to the number of staff with a disability, those who identify as LGBTQ+, and those from a Black, Asian, and Minority Ethnic background.

Both the Annual Workforce Equality Monitoring Report 2022-2023 and the Annual Gender Pay Gap Report 2022-23 will be published on the Trust website prior to the deadline on 31 March 2024 and would sit alongside the Strategic Equality Plan Annual Report for 2022-2023, which had already been approved and published.

When assessing whether our workforce is reflective of the population we serve, there were some shortfalls in the following areas:

Non-White population in Wales 6.2% (Census data 2021)	WAST Staff from BAME background 1.83%
People with a disability in Wales 21.1% (Census data 2021)	WAST Staff with a disability 5.93%

The non-White population figures and the people with a disability in Wales figures include children and people over the age of 65 and is not reflective of the general working age population. The data above is Wales-wide. The population percentages for the non-White category are much higher in urban areas of Wales, in particular Cardiff, Newport and Swansea.

Work was already ongoing to increase diversity in the workforce via a number of initiatives such as the inclusive recruitment programme and the implementation of the actions set out in the Anti-Racist Wales Action Plan. The inclusive recruitment programme should also focus on attracting higher numbers of staff with a protected characteristic in our urban areas to be more reflective of the local populations. Funding had been made available to introduce Retention Leads within NHS Wales organisations who will be contributing to the development of inclusive recruitment and retention initiatives in 2024-2025.

Whilst the gender pay gap has not worsened over the past six years, the gender pay gaps still exists within the Trust despite the actions taken to improve our female staff experience in the workplace. The Trust will continue to implement initiatives which focus on encouraging career progression amongst our female staff and are continuing to support women's health in the workplace via staff networks and policy development, e.g. All Wales Menopause Policy, Shared Parental Leave Policy, Flexible Working Policy, etc. Actions will focus on engagement with our female staff to understand the reasons behind the gender pay gap. This work would also link to our actions around increasing psychological and sexual safety in the workplace.

Anti-Racist Wales Action Plan

Much discussion around the development of the action plan had taken place and an update was provided on where the Trust was with the actions set out within that plan for NHS Wales organisations.

An intense active bystander and allyship training module was developed and delivered to staff as part of the actions set out in the Anti-Racist Action Plan (ARWAP). This training covered discrimination and allyship for all of the protected characteristics, not just race and ethnicity. The Trust is passionate about this and believes that educator education and raising awareness of the challenges faced by some of those people with a protected characteristic is paramount to helping people change their behaviours and really display the behaviours that the Trust would want to see being displayed.

In March 2022, following a lengthy planning and consultation period, Welsh Government published its vision to achieve an Anti-Racist Wales by 2030. A

detailed action plan sets out the actions needed to improve the experiences of Black, Asian, and Minority Ethnic individuals.

In the health section of the plan, there are five specific goals with nine specific actions for NHS Wales Boards and organisations with agreed timelines for implementation between July 2022 and December 2023.

Welsh Government have requested that progress against the ARWAP actions be included in the bi-annual SEP update, which is presented as part of the NHS Wales Performance Framework Policy Assurance. It is also recommended that NHS Wales organisations include a progress update in their annual Strategic Equality Annual Reports which are published on our website.

The Equality Leadership Group (ELG) which consists of EDI Managers across NHS Wales continue to share best practice and discuss the implementation of the ARWAP at its bi-monthly meetings. The ELG has maintained links with Welsh Government and engaged in discussions around some of the challenges in implementing the actions. The Report included highlights, further actions together with risks.

Annual progress updates on the Trust's progress against the ARWAP actions will be included in the Annual Strategic Equality Plan Report which will be approved by the People and Culture Committee and the Board prior to publication.

Members endorsed the plan and reiterated the need to ensure implementation includes SMART actions and is outcome-focused to demonstrate the impact of the initiatives to the lives of our people. It was noted that the performance reporting on cultural themes and workforce KPIs would draw out that impact and the themes, but that work was required to ensure they are connected in a way that the Committee and the Board can see progress of these important initiatives. The role of Non-Executive Directors (NEDs) as champions was also discussed and Hannah Rowan, EDI NED champion sought to have more guidance on how she and other NEDs might most appropriately support initiatives throughout the year, over and above monitoring the plan.

RESOLVED: That

1) **the Committee received and endorsed the SEP 2024-2028;**
2) **the Committee received and endorsed the 2022-23 Gender Pay Gap Report & 2022-23 Workforce Equality Monitoring Report; and**
3) **the Committee noted the ARWAP report.**

08/24 WELSH GOVERNMENT MORE THAN JUST WORDS ANNUAL REPORT

The new More Than Just Words plan 2022-27 was launched by the Minister for Health and Social Services in August 2022. The five-year plan was developed following an independent evaluation of the first More Than Just Words five-year plan.

Welsh language featured in the IMTP for 2024-27 and Members will have an opportunity to review the full IMTP at a Board development session later this month and at Trust Board in March, however the intention for 2024/25 is to build an environment in which the Welsh language can flourish. This will ensure focus is on cultural change as well as standards compliance.

Trish Mills explained about the great work that was ongoing across the organisation with Welsh language, including significant activity in 111 regarding improving the trajectory for answering calls in Welsh, with some raising confidence tutors planned to spending time in this area. An improving trajectory on the answering of calls in NEPTS could also be seen.

Details of the mandatory Welsh Language Awareness Course was going to be promoted more in quarter four to improve the uptake.

The in-house Welsh language translation service had started with a soft launch which was well received, with more to do on moving away from using external providers.

The annual meeting with the Welsh Language Commissioner's Office had been held recently and Melfyn Hughes, Welsh Language Manager and Trish Mills were able to report that WAST was one of the only organisations in Wales that had reached 100% on recruitment, bilingual recruitment, and job descriptions.

It was recognised that within the report there are many quotes from patients and their families which justified the importance of Welsh language being built into what we do at WAST. Members commended the work and focus on the Welsh language and noted the update and the More Than Just Words 2022-23 Annual Report

RESOLVED: That the

1) **Welsh Government's More Than Just Words Annual Report 2022-23 was noted; and**
2) **Committee received assurance against the Trust's progress in delivering its commitments to the plan.**

09/24 WORKFORCE PRIORITIES RELATED TO IMTP

Angie Lewis reminded Members of the proposed priorities presented to the Committee in November and how the People and Culture Directorate had been challenged to manage aspirations and ambitions in a more realistic way.

The report presented today was more deliverable and allowed space for business-as-usual activity and unforeseen issues.

The number of objectives for inclusion within the IMTP had been significantly reduced. The remaining items would be managed in an alternative way whilst the three headings of Culture, Capacity and Capability had been maintained.

Members were challenged on what good looked like and what the Trust was aiming for; an example, of which was leadership development. How would people know what good would look like.

It was noted that most of the metrics were quantitative rather than qualitative measures and Members requested a focus on evaluating the impact of initiatives and the markers of success.

RESOLVED: That the IMTP 2024-27 objectives and metrics for the People and Culture Directorate were approved, subject to ongoing conversations relevant to the wider Plan.

10/24 PEOPLE AND CULTURE PLAN METRICS UPDATE TO INCLUDE CULTURAL THEMES- PRIORITIES FOR 2024/25

The agreed metrics 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 optimising the capabilities of our people. The themes reflected the Plan's goals of improving organisational culture, creating a sense of belonging and developing the skills of our people.

Members commended the approach and noted that whilst what our people were telling us was sometimes difficult to hear, it was important to show we are listening and responding. Members highlighted the progress made in the last 18 months, such as:

- Having richer and more frequent feedback from staff and students through surveys and roadshows.
- Increasing the awareness and reporting of employee relations issues, such as culture reviews and grievances, and supporting people to come forward and

raise concerns.

- Engaging the executive leaders in regular discussions and actions on people and culture metrics and challenges.
- Applying compassionate practices for individuals affected by organisational changes or employee relations processes.
- Reducing sickness absence rates in some regions and learning from their best practices.
- Promoting proactive health surveillance and addressing the main causes of absence, such as mental health and musculoskeletal problems.

The report also acknowledged the areas where more work was needed, such as:

- Building trust and confidence among staff and students to speak up and share their views.
- Ensuring that all colleagues feel safe and respected in the workplace.
- Achieving the target of 6% sickness absence by April and maintaining it.
- Continuing to monitor and improve the impact of the People and Culture Plan on organisational performance and wellbeing.

RESOLVED: That the

1) **Insights shared were commented on;**
2) **Content of the report was noted; and**
3) **Alternating reporting of quantitative and qualitative data approach was agreed.**

11/24 WORKFORCE SCORECARD & MONTHLY INTEGRATED QUALITY AND PERFOMANCE REPORT

The Monthly Integrated Quality and Performance Report ("MIQPR") and the Q3 Quarterly Workforce scorecard showed that continued system pressures including handover delays remained a significant pressure on our people.

The Committee noted a welcomed increase in Personal Annual Development Reviews (PADR) and the focus of the senior leaders on improving statutory and mandatory training compliance.

<u>MIQPR</u>

It was noted that sickness absence in 111 was high and that a cultural review was underway to look at this. Angie Lewis agreed to bring a paper to the next meeting which would look at the ongoing cultural reviews and identify the actions taken.

Low vaccination rates among patient-facing staff were a concern.

Members noted good performance on unit hours produced and abstraction rates.

Andy Swinburn agreed to take a paper to the Quality, Patient Experience and Safety Committee around the continued deployment of Cymru High Acuity Response Unit (CHARU), aiming to illustrate progress, activity, and deployment.

RESOLVED: That

1) **the People and Culture Performance Scorecard report was received and commented on; and**
2) **the MIQPR was considered by the Committee.**

12/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK REPORT

The aim of the report was to provide assurance to Members in respect of the management of the Trust's principal risks, particularly the risks relevant to the Committee's remit. Controls in place against each principal risk could be viewed in the Board Assurance Framework.

The risks were presented to Trust Board in January 2024 with 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* being dynamically reviewed as system pressures continued. With respect to the risks for this Committee, members noted:

Risk 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). Whilst good progress is being made to reduce sickness absence, a decision has been made to keep the risk rating under review. The controls and assurances have been strengthened and a suite of new mitigating actions have been identified during the last review.

Risk 201 – Damage to the Trust's reputation following a loss of stakeholder confidence remains at 20 (4x5). Whilst the score remains unchanged and remains high, the risk has been strengthened to describe the difficulties in progressing the Trust's long term strategic ambition because of lack of stakeholder confidence and support. Additional controls and mitigations have been articulated to support this change.

Risk 163 – Maintaining effective and strong Trade Union partnerships increased score to 20. Additional mitigating actions reflecting the WASPT effectiveness review, the new ToR and operating arrangements for the group were discussed and it was noted that the actions detailed in the ACAS action plan will be aligned to this risk in the next review.

Risk 558 deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences remains

unchanged and scores 15 (3x5).

Risk 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 as reported to the November 2023 Trust Board, this had achieved its target risk score of 10 (2x5). This was due to the demonstrable work undertaken across the Trust in relation to the Working Safely Programme and Health & Safety. The risk had therefore been de-escalated to the directorate register and will be monitored by the Executive Director and team on a quarterly basis.

RESOLVED: That

1) **Members considered and discussed the report;**
2) **the increase in risk score of Risk 163 from 16 to 20 was noted;**
3) **the de-escalation of Risk 199 from the Corporate Risk Register to the Directorate Risk Register as this has reached its target score of 10 (2x5) was noted; and**
4) **the ratings and mitigating actions for each principal risk was noted.**

13/24 HEALTH AND WELLBEING PLAN

The draft Health and Well-being Plan 2025-2029 was received for comment. The draft plan set out the principles for the approach to improving the health and well-being of our people and to provide strategic leadership to the Trust's health and well-being activities.

The Committee noted that a consultation process with various stakeholders was planned to inform its development, and that a holistic approach to the plan would be taken as opposed to focusing just on individual well-being support initiatives. The Committee asked that the Well-being Team consider the accessibility of the document to ensure it's easy to understand and apply.

RESOLVED: That the Committee commented on the draft plan.

14/24 ANNUAL EFFECTIVENESS REVIEW

The Trust’s Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and prepare an annual report which will be presented to Audit Committee in April, and then to the Trust Board in May.

Annual effectiveness reviews are designed to evaluate the effectiveness of the Board and its Committees, review operating arrangements, and proposing changes to improve Committee’s support, challenge, scrutiny, and oversight responsibilities.

Whilst the Duty of Quality is demonstrated by adopting a continuous improvement methodology to the Board and its Committees throughout the year, the annual effectiveness review was an opportunity to formally review membership, review the work of the Committee during the year, and set the Committee's priorities for the coming year.

A review of the Terms of Reference provided an opportunity for the Committee to ensure it was comfortable with the focus and direction.

The report included responses to the questionnaires completed by members, a draft Annual Report from the Committee to the Board and proposed marked up changes to the Terms of Reference. As a result of the response to a questionnaire completed by Members and attendees, changes had been proposed to the Committee's operating arrangements and its Terms of Reference, one of which was to formalise the procedure for Chair's Actions.

Members agreed that the Committee effectively discharged its responsibilities under its terms of reference and that the annual report was a true reflection of its operating arrangements in 2023/24. Areas of good practice and improvement were noted and these will be rolled up into a schedule for the Board of cross-Committee improvements.

Priorities for the Committee for 2024/25 were agreed as follows:

(a) Impact of wellbeing initiatives on our people;
(b) Culture of conversations with a focus on communication and conversations with managers and their people;
(c) A continued focus on equality, diversity and inclusion and the implementation of the strategic equality objectives;
(d) The Trust's approach to development of our people.

Paul Hollard and Bethan Evans reflected on the journey of the Committee over the past four years which had seen focus in more essential areas.

RESOLVED; That the

1) **the draft Annual Report was reviewed and endorsed;**
2) **changes to the terms of reference as set out in the annex were endorsed;**
3) **the proposed changes to operating arrangements in response to issues raised in questionnaires as set out in the draft Annual Report were confirmed; and**
4) **priorities for the Committee for 2024/25 were set.**

15/24 AUDIT TRACKER AND INTERNAL AUDIT REPORT

The Audit Tracker was reviewed, and the Committee noted the good progress in closing recommendations, with approximately 11% closed or due to close in Quarter four.

Retention of Staff Internal Audit
The reasonable assurance 'Retention of Staff' Internal Audit report was received, with key matters arising including finalisation and ratification of the 'Moving on Interview' process, with a clear timetable for its roll out; and evaluation of the effectiveness of the initiatives that have recently been introduced to improve staff retention. The roll out of moving on interviews was welcomed.

RESOLVED: That

1) **the good progress made in closing recommendations was noted; and**
2) **the Retention of Staff Internal Audit Report was received.**

16/24 ALL WALES FLEXIBLE WORKING POLICY AND HOMEWORKING POLICY

The Committee approved two policies**;** those being the All-Wales Flexible Working Policy and the Homeworking Policy. The were no comments or issues raised.

RESOLVED: That the All-Wales Flexible Working Policy and Homeworking Policy were approved.

17/24 WASPT HIGHLIGHT REPORT

The WASPT highlight report was presented following their meeting on 15 December 2023, with members noting discussions related to:

- The EMS establishment with an agreement that emergency ambulance lines would not be taken down but that a one-off relief gap created.
- Detailed discussion following a report with the results of air monitoring for diesel exhaust emissions at seven emergency departments in Wales and the actions taken to reduce exposure and the risk to staff.
- Agreement on an approach to the Infection Prevention & Control Policy with regard to carrying snacks, as well as other IPC related issues.
- The actions agreed in partnership with Advisory, Conciliation and Arbitration Service in 2022 are on track.
- The sub-structures established to report into WASPT are doing so with escalations making their way through where appropriate.

Damon Turner confirmed the positive nature of the discussions and the direction of travel, whilst recognising there was still some fragility.

RESOLVED: That the WASPT highlight report was received.

18/24 CYCLE OF BUSINESS MONITORING REPORT

The priorities and cycle of business monitoring report was noted. The Committee's cycle of business was on track with no escalations required.

RESOLVED: That the update was noted.

19/24 KEY MESSAGES FOR BOARD

Any messages for Trust Board would be included inn the highlight report from the Committee.

20/24 ANY OTHER BUSINESS

As this would be Paul Hollard's final meeting as Chair of the Committee and as a Non-Executive Director for the Trust. Members thanked him for his contribution, support, curiosity and challenge of the work of the Committee and wished him well.

Estelle Hitchon also confirmed that she would be joining the Academy Wales Expert Panel on Public Sector Leadership.

21/24 DATE OF NEXT MEETING

The next meeting is scheduled for the 9 May 2024.

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

WELSH AMBULANCE SERVICES NHS TRUST

CONFIRMED MINUTES OF THE OPEN MEETING OF THE AUDIT COMMITTEE OF THE WELSH AMBULANCE SERVICES NHS TRUST HELD ON FRIDAY 1 MARCH 2024 IN CARDIFF AND VIA TEAMS

Meeting Commenced at 09:30

PRESENT:

Peter Curran	Non-Executive Director and Committee Chair
Ceri Jackson	Non-Executive Director and Vice Chair of the Trust Board
Kevin Davies	Non-Executive Director
Joga Singh	Non-Executive Director

IN ATTENDANCE:

Hugh Bennett	Assistant Director, Commissioning and Performance (Item 04/24 only)
Julie Boalch	Head of Risk/Deputy Board Secretary
Judith Bryce	Assistant Director of Operations
David Butler	Internal Audit, NWSSP
Christian Fox	Trade Union Partner
Jill Gill	Head of Financial Accounting
James Houston	Head of Strategy Development (left after Item 04/24)
Fflur Jones	Audit Wales
Navin Kalia	Deputy Director of Finance and Corporate Resources
Olaide Kazeem	Project Accountant Financial Services
Alison Kelly	Business Manager
Angela Lewis	Director of People and Culture
Martyn Lewis	Internal Audit, NWSSP
Osian Lloyd	Head of Internal Audit, NWSSP
Amy Lord	Audit Wales
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Madrun Parry-Jones	Finance Graduate
Alex Payne	Corporate Governance Manager
Felicity Quance	Deputy Head of Internal Audit, NWSSP

Duncan Robertson	Assistant Director for Clinical Development
Jonny Sammut	Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources
Carl Window	Counter Fraud Manager
Liam Williams	Executive Director of Quality and Nursing (Joined meeting at 11:20 for Item 4/24)

APOLOGIES:

Paul Hollard	Non-Executive Director
Damon Turner	Trade Union Partner

01/24 PROCEDURAL MATTERS

The Chair welcomed all to the meeting, introduced himself and then each participant introduced themselves.

Members noted that any declarations of interest were contained within the Trust's Register of Interests. It was noted that Peter Curran's declarations were not yet entered on the register, and it was confirmed by Alex Payne that he had no interests which conflicted with any of the items on the agenda.

Minutes:

The Minutes of the Audit Committee meeting held on 30 November 2024 were approved subject to amending Lee Brooks' attendance to an apology.

Action Log

Action Number 48/23: To liaise with Paul Seppman to consider retrospective induction particularly for Trade Union partners who are members of the Board and its sub-Committees. Trish Mills has developed the scope for a session with Chairs and TU members on their role and mutual expectations and will be delivered in Q4 or Q1 (2024/25) subject to stakeholder availability. Trish Mills advised that the scope had now been agreed adding it was now the time to secure dates in the diary. Action Closed.

Action Number 56/23: Workforce Planning Report. Ceri Jackson, a Non-Executive Director, asked Fflur Jones about the audit approach in relation to mental health and wellbeing, and Fflur Jones explained that they did not look in depth at that aspect because of a previous review on taking care of the carers, but said that they were scoping work on mental health. It was requested that the work around mental health be provided in a future update report. The Forward Work Programme includes a review of adult mental health and is due to be scoped shortly. Updates on that work will be brought via the audit committee update in due course. Action Closed.

RESOLVED: The Committee;

(1) Noted the apologies received from Paul Hollard and Damon Turner;

(2) Approved the Minutes of 30 November 2023 subject to adding Lee Brooks as an apology; and

(3) Considered the action log and closed the actions as described.

02/24 2023/24 ACCOUNTS PLANNING AND ANY EMERGING ISSUES

Chris Turley presented the report as read noting the following key points:
An update has been provided on the proposed audit timetable for the 2023/24 year end audit by Audit Wales. The proposed audit certification deadline is 15 July 2024 which is 16 days shorter compared to 31 July last year.

Audit Wales (AW) have signified their intention to increase the audit fee by an average of 6.4% for the audit of 2023/24 accounts. The proposed increase in audit fees is driven mainly by regulatory pressures from new auditing standards (including ISA 315) and the attendant increasing quality, recruitment challenges and rising costs of audit staff required to continue to carry out the audit work in line with the new regulatory standards. This uplift will be applied to all NHS Wales organisations.

Chris Turley drew attention to a potential issue which had emerged over the last week or so and was across NHS Wales and concerned senior managers pay and the pay award for the 2023/24 financial year, which has been awarded but not yet paid. This could impact on the values included in the 2023/24 Remuneration Report. As previously mentioned, it was an all- Wales issue and was being managed by a subcommittee of Finance Directors. Chris Turley was confident that once the accounts were presented this should not be an issue.

Comments:

Members commented that given that NHS Wales is mandated to use the same auditor, they could not see the risk as alluded to and expect it to be seen as normal business. Chris Turley explained that it had been flagged as a potential issue suggesting that it could materialise into a risk.

The committee expressed concern about the increased costs from audit Wales and whether they aligned with those of the wider health sector. Fflur Jones mentioned that the fees had not risen in recent years, but due to this and ongoing cost pressures it was felt they had to be raised. She agreed to provide more comparisons and details on the fee increase for the next meeting.

RESOLVED: The Committee noted the report.

03/24 2023-24 ANNUAL FILINGS SCHEDULE

Trish Mills presented the report and drew the Committee's attention to the following areas: The Annual Filings Task and Finish Group (the "Group") was re-established in November 2023 to ensure that the Trust meets the Annual Report and Accounts 2023-24 disclosure and reporting requirements as set out in the Manual for Accounts (MfA) published by Welsh Government (WG).

A timetable has been drafted based on the draft MfA, and the schedule is subject to change as confirmation from WG is yet to be received. The Committee is asked to note that Audit Wales have issued correspondence dated 05 February 2024 indicating that they are proposing a certification of the accounts deadline of 15 July 2024. It has been proposed to add two extraordinary meetings in July; Audit Committee on 8 July and Trust Board on 9 July. Chris Turley added that there may be a need to potentially adjust these dates to avoid disruptions to paperwork and other committee schedules.

It was noted that there is a requirement for the Trust to publish the Duty of Quality and the Duty of Candour reports this year. Guidance on these was expected shortly.

No formal confirmation of the Annual General Meeting timing has been received yet but informal indications suggest it will likely be the same as last year which is the end of September. Once the formal confirmation is received the committee will be informed accordingly.

To ensure ample review time before presentations to the Audit Committee and the Trust Board, draft reports such as the Remuneration Report will be circulated via e-mail as will the annual report for initial feedback. This will allow for early input before formal consideration by the relevant committees.

It was requested that the Committee approve this approach in the timetable and also the proposal to hold those extraordinary meetings as described subject to timings.

Comments:

Chris Turley explained, following a query in terms of when the accounts were seen, that the draft accounts were not routinely seen by the Audit Committee, but they would see the draft audited accounts prior to them being presented to the Trust Board. Trish Mills advised that the Committee would have sight of the draft Annual Report. The Chair offered his support in reviewing the draft accounts.

RESOLVED: The Committee:

(1) Approved the Annual Filings 2023-24 schedule subject to the placement of the extraordinary dates; and

(2) Approved the circulation of the draft reports for review and comment via e mail.

04/24 INTERNAL AUDIT ITEMS

The Head of Internal Audit (HoIA), Osian Lloyd presented the reports which consisted of his update, the Audit Plan for 2024/24 and seven Internal Audit (IA) Reports.

Internal Audit Progress Report

Good progress was being made with the 18 reviews (originally 20) in the 2023/24 Internal Audit Plan with the team remaining on track to deliver the plan.

There were two reviews that were being proposed to be deferred: Delivery of Major Change Programmes and the Integrated Quality and Performance Management Framework.

The Committee were updated on the current position of the Key Performance Indicators (KPI) as detailed in the report.

Comments:

Members sought clarity on one of the KPIs; Report turnaround time taken for management response which should be 15 days, and the reason for its status being red. Osian Lloyd explained there was nothing of significant concern and it may have been due to a resource issue. Trish Mills explained there were sometimes a few nuances in when reports come through and are returned from management. It has been agreed for 2024/25 to have a closer monitoring of reports with clarity on timelines. There is also a commitment to address any delays and offer support where needed for all involved parties.

2024/25 Internal Audit Plan

Osian explained that the report sets out the planed Internal Audits for the next year, prepared in accordance with Audit Standards. The work was focussed on risk, noting there had been regular liaison with Audit Wales, Health Inspectorates Wales (HIW), and other colleagues, to ensure that the work aligned with their programmes. A prioritisation process has been conducted and this will be kept under review going forward. Osian Lloyd expressed his thanks and acknowledged the positive engagement with teams within the Trust who had supported in the coordination of the plan.

The Committee considered and approved the Internal Audit plan for 2024/25 and also approved the Internal Audit Charter.

The following Internal Audit reports were received:

Decarbonisation – The Internal Audit (IA) opinion was Limited.
Felicity Quance explained that the purpose of the review was to consider the progress against the NHS Wales Decarbonisation Strategic Delivery Plan and the Trust's Decarbonisation Action Plan. The work had built on the advisory review which had been prepared in 2022/233 which provided an overview of the overarching position across NHS Wales. This year the review has been undertaken as an assurance report and has been given limited assurance; this was based on two high priority rating recommendations and four medium. In reaching this assurance rating the audit had considered the complexity and range of risks associated with this particular area; and also noting the challenges faced by the Trust with available funding.

Key points from the audit included:

1. The appropriate governance arrangements have been established in relation to decarbonisation to enable the Trust to progress with the decarbonisation target.

2. Consistent with all NHS organisations the carbon footprint has increased in value since the initial baseline assessment.

3. Current reporting indicates there remains a real risk that the Trust may not be able to contribute effectively to the NHS carbon reduction target.

4. The ten year capital cost estimate submitted to Welsh Government with some elements not being able to be accurately costed.

5. The primary source of funding has been EFAB allocating £2.1m for the period April 2023 to March 2025, of which the Trust contributes 30%.

6. There were appropriate monitoring and reporting arrangements in place to provide assurance on the implementation of the strategy and action plan. It was noted that many of the governance structures were recent and will take time to fully mature.

7. It was appreciated that the key officers were disappointed with the assurance rating; noting that management actions have been provided for the recommendations raised.

Comments:

Chris Turley expressed the disappointment felt by the whole team involved in this assurance rating. This was further recognised by the Committee acknowledging the limitations of the Trust's funding and resources and abilities in improving the decarbonisation process under the current circumstances.

Osian Lloyd recognised the disappointment noting there were things outside of the Trust's control and recognising the strength of feeling across the NHS. He added that a summary report will be issued and shared with WG considering feedback from organisations.

The Committee recorded a note of thanks to the team involved in their sterling efforts, albeit under challenging circumstances to work towards decarbonisation.

In respect of the Decarbonisation Programme Board, it was noted that it was reported that attendance was below expectations, and the impact of effectiveness was questioned. Chris Turley advised the programme board was one of the better attended meetings when compared to other sub-Boards. He added that all matters for the Board had been successfully conducted without hindering any decisions with those in attendance and would review the terms of reference to consider membership going forward.

The Chair proposed a future strategy to distinguish between issues within the Trust's control and those beyond its influence. This approach would involve identifying issues for independent assessment to determine management's effectiveness within their control while separating out external factors like funding for example. This would help clarify the Trust's areas of influence for clearer decision making going forward.

Serious Adverse Incidents Joint Investigation Framework – The IA opinion was Reasonable. Felicity Quance explained that the audit's purpose was to review the Trust's compliance with the joint investigation framework for serious patient safety incidents. The reasonable assurance was based on three matters arising which gave rise to two medium and four low recommendations.

Key areas to note:

1. There were incident management procedures and a policy aligned to the NHS Wales policy, but some enhancements were recommended to ensure they fully aligned the NHS Wales national policy. There were timelines on the national policy that required adherence to for the initial capture and escalation of incidents.

2. There was appropriate training and supervision arrangements in place for staff undertaking investigations into patient safety incidents.

3. Patient safety incidents were captured on Datix Cymru and were reviewed by the Patient Safety Team. Those incidents requiring a joint investigation were recorded on the Serious Case Incident Forum action log.

4. In relation to internal reporting, the appropriate reporting framework was in place.

5. Organisational wide learning from investigations was captured within the Putting Things Right (PTR) team and reported to the Quality, Patient Experience and Safety Committee (Quest)

6. Liam Wiliams reminded the Committee that the PTR team has been under significant challenge for a period. Investment to increase resources has been agreed and this was made available in quarter three of last year with several appointments being made.

7. In terms of joint investigations, effective communication and collaboration between the Trust and Health Boards is crucial. While progress has been made, there are still challenges with some Health Boards requiring more effort and diligence from the Trust to acquire a consistent approach.

Comments

Members were reminded of the focus applied at the Quest Committee in discussing the issues raised in the review.

Liam Williams emphasised that while many incidents involve factors beyond the Trust's control it is crucial for the organisation to identify and learn from those within its influence. Transparency across the workforce alongside collaboration with the learning development team ensures that lessons are applied effectively to improve learning opportunities for colleagues.

Strategy Development – The Internal Audit opinion was Reasonable.
Felicity Quance explained that the purpose of the audit was to review the arrangements in place to support the development of the Trust's strategic ambitions. The opinion was reasonable based on three medium rated recommendations and one low.
The key points from the review were as follows:

The Trust's long term strategic framework, IMTP and associated objectives are aligned to the requirements of the Welsh Government and the Commissioners.

The long term strategy has been subject to regular review and has recently been reconfirmed by the Trust Board.

In terms of the current juncture of the strategy, consideration should be given to refresh it to account for the Trust's developments post approval and also following the pandemic.

Consultation for the development and the strategic case for change, including inverting the triangle and wider integrated service model proposes was ongoing.

Engagement with stakeholders was clear, noting that a number of workshops have been planned to assist in the development of the work required.

A robust method of monitoring and reporting was in place, however integrating a benefits realisation plan could bolster these capabilities.

James Houston added that the opportunity now was for the Trust to expand and integrate its services, building on existing efforts to advance the concept of inverting the triangle. Finalising the delivery plan was crucial, especially considering the extensive discussions with executive management. Regarding consultation, it was essential to confirm whether formal consultation with Llais Wales (an independent statutory body set up by WG to give the people of Wales a say on the planning and delivery of health and social care services) or other stakeholders will be necessary.

Comments

Following a question in terms of the Trust's commitment to engage with the public, James Houston outlined core pillars of the engagement delivery plan starting with senior stakeholders who hold considerable influence over the Trust's future service model. Additionally, it encompasses various external stakeholder Health Board partners and the public making it a comprehensive engagement strategy spanning both external stakeholders and the public.

It was recognised that Commissioning will be taking a dynamic change in the not too distant future, confirmation was sought whether the Trust was alive to this in terms of the audit process. James Houston, in terms of the performance metrics, work was being undertaken in terms of the handling plan. The system metrics were being reviewed which will be shared with key partners with further work to fully understanding those system metrics. from a commissioning perspective recognising the Trust will be moving into new commissioning arrangements, there is continued regular dialogue with key leads and potential commissioners going forward. The Trust will need to undertake an assessment in the first quarter to see if there is any shift in terms of the strategic commissioning position.

Retention of Staff – The Internal Audit opinion was reasonable.
Felicity Quance explained that the purpose of the review was to evaluate and determine the adequacy of the systems and controls in place within the Trust in relation to staff retention. The opinion was based on two matters arising which gave rise to four medium rated recommendations.

The key points from the review were:

1. It has been recognised that the retention of staff within the Trust was a challenge and the people and culture plan has included the commitment to create an environment that attracts, retains, and develops talent and expertise.

2. The pre-exit policy has surpassed its review period, but it was recognised that the Trust has been undertaking work to replace this with through the moving on interview process.

3. there are several initiatives in place to improve the retention of staff and this was reviewed both at corporate level at those in place within 111 noting the attrition rate in this area has been of concern previously.

4. There was regular reporting in relation to turnover rates within the Trust at operational and Board level including the recently introduced people and culture plan metrics report.

5. The Audit Wales recommendation regarding more regular benchmarking of workforce performance metrics was noted.

6. Appropriate management actions were provided for each of the recommendations raised with reasonable timeframes for implementation.

7. In respect of the target date for recommendation 1.3 (Guidance for managers on using the process developed and signed off) it had been agreed to extend the target date to 30 June 2024 from 30 April 2024. This was due to delays in the development of the training package.

Comments:

Angela Lewis recognised there was still further work to be undertaken to refine the final process when staff leave the Trust. It was anticipated the new digital solution would improve this process. She added that the review would be presented at the next People and Culture Committee meeting for fuller scrutiny.

The Committee acknowledged the positive aspects in the report noting the exit interview process was on track with the pilot scheme appearing to be working well.

111 Service Commissioning Arrangements (Advisory).
Felicity Quance explained that the objective of this advisory review was to assess the effectiveness of the new arrangements and structures for the NHS 111 Wales service, to ensure sustainable and improved patient quality experience provision with appropriate resourcing and finance mechanisms.

Key points from the review included:

1. The arrangements put in place were still evolving and improvements had been identified as part of the review will assist in strengthening the current framework.

2. The roles and accountabilities of partners was currently unclear within the lates draft version of the National Collaboration Agreement.

3. A governance structure for NHS 111 Wales has been established; however, two enhancements had been identified to further strengthen the current arrangements.

4. There was frequent performance reporting on the NHS 111 Wales service delivery to Welsh Government.

5. The review further identified it would be beneficial to have a designated strategy to assist with developing sustainable service provision.

6. It was noted that any risks associated with Commissioning arrangements was recorded on the Trust's risk register.

7. Eleven recommendations were raised against five matters arising with no priority ratings due to the nature of the report. It was encouraging to note all the recommendations had been accepted by management with appropriate timescales for completion.

8. Hugh Bennet advised the Committee that the current commissioning arrangements effectively ends on the 1 April 2024 with it then transferring over to the Joint Commissioning Committee. The national collaboration agreement needs to be updated with 111 commissioners by the end of March 2024 as well as the terms of reference.

9. Each of the recommendations were referred to by Hugh Bennett who outlined details of each one and explained further in respect of the timelines for completion.

Comments:

The Chair queried post April how it was intended to review the effectiveness. Osian Loyd advised it was not currently in the IA plan but expected it would be part of Audit Wales's unscheduled care review.

Capital Assurance: Vehicle Replacement Programme – The Audit opinion was reasonable. David Butler advised that the purpose of the review was to evaluate the processes and procedures in place to support the management and control of the ongoing procurement of replacement vehicles. The Trust undertakes a cyclical refresh of its vehicles with an annual funding targeted at £94m over the next six years.

Key points from the review included:

1. Positive assurance was obtained in the areas of strategic planning and approvals, programme management and financial monitoring and reporting. however, an issue was raised around procurement relating to the need to ensure compliance to standing orders for the Trust approval of contracts where the Trust has undertaken to review the process.

2. Other matters raised included the need to enhance reporting and review of the procurement strategy; with the need to demonstrate optimal procurement numbers.

3. Overall, the refresh was found to be a mature process with a good understanding of the key factors determining the refresh frequency and accordingly a reasonable assurance was determined.

Comments:

Chris Turley recognised the useful suggestions in the report especially in respect of the contract award approval process.

Trish Mills explained it had been an ideal opportunity to reconsider the scheme of delegation and the scheme of reservation under the standing orders. A governance practice note has been developed regarding the interpretation of standing orders particularly internally because as it aids in providing clarity on such matters. The practice note gives clarity on the approval of awards by the Trust Board and what details are required in business cases. It has been circulated to Audit colleagues for their consideration and feedback. It will come through to the April Audit committee meeting for approval and the endorsement of some changes to the scheme of reservation and delegation to address this.

The Chair added he had seen the proposed changes and was content with them.

ePCR (Electronic Patient Clinical Record) Clinical Compliance – The opinion was reasonable. Felicity Quance explained that the purpose of the audit was to review the operational deployment of the ePCR being developed and assess compliance.

Some of the key points to highlight included:

1. There were sufficient resources available to all staff in respect of how to use and how to complete ePCR.

2. Training compliance is reported at 94.8% and it was noted that staff self-certify their completion on the Electronic Staff Register (ESR).

3. It was not that some of the training modules appeared from the auditor perspective to be quite lengthy, with a recommendation to see if they could be streamlined.

4. In relation to an ePCR being completed for every patient contact it was noted there were some exemptions applicable for 3rd party responders who would complete paper records.

5. Management information relating to the completion of ePCRs was regularly reported and monitored, with any issues investigated and escalated where necessary. It was noted there had been some issues with data quality and data limitations to reporting. Work was ongoing to upgrade the software to facilitate this process more efficiently.

6. One of the aims of ePCR was to try and identify the improved performance against the clinical indicators; it was not yet showing improvement expected at this point in time for the clinical indicators being presented to the Emergency Ambulance Services Committee (EASC) but clinical data assurance audits were being undertaken to measure compliance to help inform the information required in relation to subsequent software updates.

Duncan Robertson acknowledged there were several actions in the review which were being progressed to completion. He added that in terms of the data quality and the compliance dashboards this was being looked at and how all that fed into the Trust's approach to clinical indicators from the perspective of the user interface on an ePCR.

The Committee queried connectivity for Paramedics in areas where on occasion this was non-existent. Jonny Sammut explained there had been some connectivity issues with EE who had recently replaced some of their core infrastructure which had caused some intermittent issues, particularly in west Wales. A formal escalation has been sent to the EE

account director. Overall, connectivity in Wales was, compared to the rest of UK, relatively poor due to the vast difference in the number of masts. From a longer-term perspective, the ambulance radio programme solution will be replacing terminals in ambulances which will in effect create a rolling Wi-Fi spot. The Trust was also working with Health Boards around improving Wi-Fi coverage in hospitals.

RESOLVED: The Committee:

(1) Approved the Internal Audit Plan for 2024/25;

(2) Approved the Internal Audit Charter;

(3) Approved the following changes to the approved 2023/24 IA plan, the deferment of the Delivery of Major Change Programmes and deferment of the Integrated Quality and Performance Management Framework IA reviews.

(4) Noted the associated Internal Audit resource requirements and Key Performance Indicators; and

(5) Received the following IA reports: Decarbonisation, Serious Adverse Incidents Joint Investigation Framework, Strategy Development, Retention of Staff, 111 Service Commissioning Arrangements (Advisory), Capital Assurance: Vehicle Replacement Programme and ePCR (Electronic Patient Clinical Record) Clinical Compliance.

05/24 AUDIT WALES REPORTS

Audit Committee Update Report

Fflur Jones presented the report outlining details of work currently underway or planned. This included the review of unscheduled care, workforce planning and the structured assessment and the deep dive into financial efficiencies. Furthermore, there will be a follow up review of quality governance arrangements which the field work will be commencing soon.

The Committee queried if there were any issues regarding resourcing. Fflur Jones explained there were no current issues; there have been two changes in the team but there were no gaps in terms of resources.

Structured Assessment

Fflur Jones explained that the structured assessment was conducted annually at all NHS bodies, and it focused on governance, planning and financial resource usage. This year's report was mostly positive highlighting well run meetings and oversight of key risk areas.

Areas for improvement included the reviewing of outdated policies and enhancing the effectiveness of the Board Assurance Framework (BAF) to make it more strategic. It was found that the Trust has reasonable and well considered plans for addressing these issues.

The Trust maintains robust arrangements for developing and obtaining approval for the IMTP from Welsh Government. However, there is room for improvement in ensuring that actions are specific, measurable, achievable, realistic and time bound. Emphasising reporting on the delivery of intended outcomes rather than just on the actions taken could enhance effectiveness even further.

In relation to finances the Trust continues to demonstrate strong financial performance both annually and over a three-year period. Financial planning is robust considering the unique and ongoing risks related to the system pressures and limited additional funding. Suggestions were made to enhance financial reporting and oversight to clarify recurrent versus non recurrent funding levels for further consideration.

Fflur Jones expressed her gratitude to everyone involved in engaging with the work. Positive discussions have ensued regarding the recommendations made and there is optimism about how the Trust can utilise these to progress positively.

Chris Turley explained there was general contentment with the report and advised that work on the recommendations would be progressed.

Trish Mills highlighted the close collaboration between Audit Wales and the Trust particularly regarding the joint approach to the BAF which has proven beneficial. The Trust is continually refining the BAF and utilising it for the development of its strategic objectives. Additionally, the report has reflected the implementation of recommendations from effectiveness reviews which are incorporated either into this year's IMTP or a local directorate plan.

The Committee acknowledged the excellent work of the governance team and the progress being made.

RESOLVED: The Committee received the Audit Wales update report and the SA,

06/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Julie Boach explained that the purpose of the report was to provide assurance in respect of the management of the Trust's principal risks and an update on the risk management transformation programme. There were 14 principal risks which are outlined in more detail in the Board Assurance Framework (BAF).

Key areas for the Committee's attention:

1. As reported at the last Board meeting; Risk 139 (Failure to Deliver our Statutory Financial Duties in accordance with legislation) has achieved its target risk score of 8 (2x4). The risk has reduced in score from 16 (4x4) and will remain on the Corporate Risk Register (CRR) and continue to be monitored in month and it is expected that the risk score will increase in the next financial year due to the challenging financial climate.

2. 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) was increased in score from 15 (3x5) to 20 (4x5) along with Risk 163 (Maintaining Effective and Strong Trade Union Partnerships) from 16 (4x4) to 20 (5x4). In terms of risk 594, since the increase in score Health Boards have agreed to implement policies to ensure the release of ambulances; noting that the score will be reviewed in the next reporting period.

3. The title of Risk 424 was amended to include a reference to revenue, capital and staff capacity and now reads Resource availability (revenue, capital, and staff capacity) to deliver the organisation's Integrated Medium-Term Plan (IMTP).

4. Risk 201(A loss of stakeholder confidence that damages the Trust's reputation), work was ongoing to strengthen the description of the risk to align it more closely to the Trust achieving its strategic objectives.

Comments:

The Chair referred to 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) as risks mainly outside of the Trust's control and queried whether it was possible to articulate such risks differently to delineate what was in the Trust's control. Julie Boalch advised this has been a regular discussion at Committees adding that external support has been commissioned to provide advice and guidance to manage these more effectively.

The Chair noted that the risk to capital rather than revenue was more of an issue and queried if this needed to be drawn out more explicitly at this moment in time given the implications on a delayed, in particular fleet replacement policy. Chris Turley explained there was a differential potentially in terms of the revenue uplift compared to the expected capital funding. He added that work was ongoing to address this potential issue.

Angela Lewis referred to Risk 163 (Maintaining Effective and Strong Trade Union Partnerships) adding there had been significant progress in this area and anticipated the score would be reduced further by the next Audit Committee meeting.

Progress against the Risk Management Transformation Programme

The Risk Transformation Programme enters its third and final year as set out in the 2024/25 IMTP. External support has been commissioned to support the team to progress the programme advising on best practice in areas such as the strategic BAF, risk appetite and exploring options for digitising the BAF. The programme will see the delivery risk management training for the Board and across the organisation building on bespoke sessions already on offer to staff groups, risk leads and directorates. As previously mentioned, external support will also provide guidance in this area; a report will be coming to the Committee to update on best practice going forward.

Risk Management Policy

The Risk Management Policy is before the Audit Committee for approval ahead of endorsement at Trust Board. Risk Management guidelines are available for staff, and procedures will be finalised for publication along with the Policy following Board endorsement on 28 March 2024. A set of guidelines are already available for colleagues across the Trust, and these will be procedures to support the delivery of the policy. The policy has followed due policy process from the drafting, and it has been shared with internal auditors as well for the comments and any queries.
Comments:

The Chair raised the possibility of strengthening the effectiveness of the third line of defence and how that collaborative way of working can provide good assurance for this committee.

Trish Mills informed the committee about the development of a document that would elaborate on the BAF and would detail how the lines of defence collaborated and functioned independently. This document along with changes to the risk policy will be presented to the Audit Committee in the future.

The Committee asked if the policy could be more explicit in terms of incorporating volunteers. Julie Boalch agreed for this to incorporated.

RESOLVED: The Committee:

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

(2) Noted the reduction in risk score of Risk 139 to the target score of 8;

(3) Noted the increase in risk score of Risk 594 from 15 to 20;

(4) Noted the increase in risk score of Risk 163 from 16 to 20;

(5) Noted the amendment to the summary description of Risk 201;

(6) Noted the amendment to the title of Risk 424;

(7) Noted the update on the Risk Management Transformation Programme; and

(8) Approved the Risk Management Policy.

07/24 AUDIT TRACKER 2.0 - DECEMBER 2023

Trish Mills advised that the update provided the Committee with the current position with respect to management actions for overall and within the purview of the Committee.

Good progress has been made on the development of the SharePoint solution for Tracker 3.0 with colleagues in Digital Health and Care Wales Centre of Excellence. It is intended that this solution will be ready to implement / use early in the 2024/25 financial year.

The Audit Tracker has been updated in Quarter three following its complete revision in Quarter two and again there has been excellent engagement from Directorates. Across the Tracker as a whole, 18.2% of the internal audit recommendations were closed in quarter and there are actions with a change in date proposed, many of which are due to be closed in Quarter four or Quarter one of 2024/25.

As well as monitoring management actions for audits in their purview, the Audit Committee has the responsibility to scrutinise the progress of audits overall, escalating to the Board any issues or concerns.
Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these, and discussions will continue into Q4 with a view to closing down or revising as many as possible.

Comment:

The Committee welcomed the progress and agreed that less was more in terms of the information being provided.

RESOLVED: The Committee received assurance that the management actions for the audits within the purview of this Committee and overall are being effectively and appropriately managed and closed off in quarter.

08/24 QUEST COMMITTEE HIGHLIGHT REPORT DATED 8 FEBRUARY 2024

Trish Mills explained this was to give assurance to the Audit Committee that the Clinical Audit Plan for 2024/25 which was under the remit of the Quality, Patient Experience and Safety Committee Quest), has been reviewed and approved. It is cycled on each committee

meeting for them to monitor the plan and approve any adjustments to it so this will be an annual assurance report that comes from the Chair of the Quest Committee.

RESOLVED: The Committee noted the approval of the Clinical Audit Plan 2024/25 at the QuEST Committee meeting on 8 February 2024.

09/24 LOSSES AND SPECIAL PAYMENTS

Chris Turley presented the report to the Committee which set out a summary and full details of all Losses and Special Payments made during the ten months from 1 April 2023 to 31 January 2024.

This relates to actual payments made less reimbursements received from the Welsh Risk Pool and does not relate to any adjustments made to the provision. During the ten months to 31 January 2024 payments made exceeded the reimbursements received by £522.94k.

He added that a series deep dives looking at the key themes had been conducted two/three years ago to discover any themes and trends and what learning had been implemented. From a benchmarking perspective following these deep dives there had been no real areas of significance. He wondered, especially from a learning perspective if this should be reinstated going forward.

Following a query as to why these reports were received in this format, Chris Turley advised that the detail in the report were as a consequence when ordinarily the Trust should not have incurred costs.

The Committee suggested it would be useful to have more context in terms of the losses and special payments going forward. They also noted there had been some value in the deep dives.

RESOLVED: The Losses and Special Payments Report for the period 1 April 2023 to 31 December 2023 were received and noted.

10/24 POLICY REPORT

Julie Boalch explained that the purpose of the report is to provide an update to the Committee on the status of the Trust's policy work programme to bring key policies up to date.

The work plans are progressing well, with good levels of activity taking place to refresh existing policies and develop new ones. A reasonable number of policies are navigating the Trust's policy governance process through to approval.

As a result of the work undertaken to date, 33% of Trust owned policies will be within their review date after the next round of approvals compared to 14% overall reported to Committee in July 2023. This figure does not include those policies developed by NHS Wales or the NHS Employers Unit which are adopted by the Trust.

Counter Fraud, Bribery and Corruption Policy

Carl Window advised the policy provides a framework for responding to suspicions of fraud, providing advice and information on various aspects of fraud and implications of an investigation.

This policy had no significant changes since the last review, other than to replace old references and make use of the new WAST policy template.

Comments:

In terms of shared learning Carl Window added that other Health Boards and Trust's follow the same guidance on a national level which complies with Welsh government standards to ensure consistency.

Members asked if the policy could make specific reference to volunteers. Carl Window agreed to ensure this was included.

RESOLVED: The Committee:

(1) Noted the update and next steps; and

(2) Approved the Counter Fraud, Bribery and Corruption Policy, subject to the inclusion of a reference to volunteers.

11/24 COMMITTEE PRIORITIES AND CYCLE OF BUSINESS MONITORING REPORT

The report updated the Committee on progress against the priorities it set for 2023/24 and progress against the agreed cycle of business for the Committee. There are no matters to escalate with respect to the Priorities.

RESOLVED: The Committee Priorities and Cycle of Business Monitoring Report for 2023/24 was noted.

12/24 AUDIT COMMITTEE HIGHLIGHT REPORT – 30 NOVEMBER 2023

The Audit Committee Highlight report from the meeting of 30 November 2023 was presented for noting.

RESOLVED: The Audit Committee Highlight report from the meeting of 30 November 2023 was noted.

13/24 ALL WALES AUDIT COMMITTEE CHAIRS REPORT (NOVEMBER 2023)

The report was presented for information.

It was noted that Swansea Bay Health Board had taken over the secretariat for all Wales Audit Committee Chairs meetings.

RESOLVED: The all Wales Chairs report from November 2023 was noted.

14/24 REFLECTIONS & SUMMARY OF DECISIONS AND ACTIONS

The excellent standard and presentation of papers was noted.

The system of internal control assurances was very good. A key theme was to try and delineate against risk and issues about things outside to the Trust's control.

It was good to see several people who are not prescribed attendees on the terms of reference both coming to observe but also to present reports.

The hybrid approach to the meeting was welcomed.

It was helpful to have the transparent conversations on items, significantly around decarbonisation and serious adverse incidents and the increased scrutiny was welcomed.

The efficient and effective chairing of the meeting was welcomed.

It was good to see the positive conversations mature, develop and challenge which was a vital piece of work for Non-Executive Directors.

Key messages for the Board would be captured in the AAA report.

RESOLVED: The above was noted.

Meeting concluded at: 12:30

Date of Next Meeting: 30 April 2024

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 19 MARCH 2024 VIA TEAMS

Meeting started at 09:30

PRESENT:

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

IN ATTENDANCE:

Hugh Bennett	Assistant Director Commissioning and Performance
Julie Boalch	Head of Risk/Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Alexander Crawford	Assistant Director of Planning and Performance (Item 19/24 only)
Paul Hollard	Non-Executive Director (Item19/24 only)
Fflur Jones	Audit Wales
Navin Kalia	Assistant Director of Finance and Corporate Resources
Angela Lewis	Director of People and Culture (left after item 22/24)
Rachel Marsh	Executive Director of Strategy, Planning and Performance (Joined for item19/24 only)
Trish Mills	Director of Corporate Governance/Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Alex Payne	Corporate Governance Manager
Jonny Sammut	Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources
Damon Turner	Trade Union Partner
Liam Williams	Executive Director of Quality and Nursing

16/24 PROCEDURAL MATTERS

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

Apologies

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

Minutes

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

Action Log

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

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

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

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

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

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

RESOLVED: The

(1) Minutes of the meeting held on 15 January 2024 were confirmed as a correct record; and

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

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

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

RESOLVED: The update was noted.

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

Hugh Bennett provided an update as follows:

1. Emergency Medical Services (EMS) Operations Programme: This is due to close soon and was largely complete with further Human Resources data being awaited.

2. The Ambulance Care Programme was progressing well, however there was one red rated deliverable which related to the Non-Emergency Transport (NET) Centre re-roster as current funding does not provide a new roster within current operating hours.

3. The Non Emergency Patient Transfer Services (NEPTS) roster has been paused due to funding issues.

4. Urgent Care Service, this was making positive progress in terms of tightening scope of practice.

5. Gateway to Care Programme: The main focus was on the CAS replacement, and this was currently on track.

6. The 111 booking and pathway work is currently showing as an amber status due to interim technology led delays.

7. Clinical Transformation Programme: This was mostly on track, there were some issues with independent prescribing caused by the lack of supervisory support for trainee Advanced Paramedic Practitioners (APP).

8. Financial Sustainability Programme and income generation, this continues to progress well and budget balancing was on track.

9. The Administrative Review Action Plan continues to progress well.

10. Enabling Programmes: There is ongoing work with Equality Impact Assessment (EQIA) training, TU partnership, and employee offer development.

11. All planned activities with the National Data resource programme was complete.

12. The upgrade to the 999 telephony platform was due to go live mid-April 2024.

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

Comments:

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

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

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

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

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

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

RESOLVED: That the Finance & Performance Committee

(1) Noted the overall delivery of the IMTP detailed in the report.

(2) Noted the update against the ministerial priorities that are relevant to the Trust in Appendix 1 of the report.

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

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

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

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

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

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

Financial Plan

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

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

Comments:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESOLVED: The Committee:

(1) NOTED the progress made in developing this year's IMTP;

(2) ADVISED of any further assurance required during the final stages of the planning cycle.

(3) ENDORSED the IMTP 2024-27 for submission to Trust Board at its meeting on 28 March 2024 for approval, subject to any final editing.

20/24 WAST INITIAL 2024-25 REVENUE BUDGET

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

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

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

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

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

Comments:

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

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

budget management.

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

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

21/24 FINANCIAL POSITION FOR MONTH ELEVEN 2023/24

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

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

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

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

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

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

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

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

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

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

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

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

Comments:

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

RESOLVED: The month eleven financial update was noted.

22/24 FINANCIAL SUSTAINABILITY PROGRAMME

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

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

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

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

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

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

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

Comments:

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

RESOLVED: That the Committee noted the update.

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

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

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

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

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

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

Comments:

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

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

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

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

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

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

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

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

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

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

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

24/24 STRATEGIC DEMAND AND CAPACITY REVIEW – VERBAL

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

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

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

25/24 VALUE BASED HEALTHCARE REPORT

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

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

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

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

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

Comments:

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

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

26/24 COMMITTEE EFFECTIVENESS REVIEW AND ANNUAL RETURN 2023-24

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

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

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

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

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

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

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

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

1. The development and approval of the Digital Plan.

2. Oversight of the potential commercialisation streams in the Financial Sustainability Programme.

3. Focus on the new elements of its terms of reference relating to Information Governance and Information Security.

RESOLVED: The Committee

(1) Reviewed and approved the draft Annual Report.

(2) Reviewed and endorsed any further changes to the terms of reference;

(3) Confirmed the proposed changes to operating arrangements in response to issues raised in questionnaires as set out in the draft Annual Report; and

(4) Set priorities for the Committee for 2024/25.

27/24 WASTE MANAGEMENT UPDATE

Chris Turley drew out the following points:

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

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

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

1. Recommendation 501 – Writing of a Waste Policy

2. Recommendation 505a – Waste transfer to hospital sites

3. Recommendation 505(b)- Clinical waste transfer

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

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

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

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

Comments:

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

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

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

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

RESOLVED: The Committee

(1) NOTED this update, in relation to waste management changes and infrastructure put in place to manage change.

(2) NOTED the internal audit recommendations and any remaining challenges in terms of some of their closure.; and

(3) SUPPORTED the closure of the two actions. Recommendation 505a – Waste transfer to hospital sites and Recommendation 505(b)- Clinical waste transfer.

28/24 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

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

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

Comments:

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

RESOLVED: The Committee considered the contents of the report.

29/24 INTERNAL AUDITS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31/24 CYCLE OF BUSINESS MONITORING REPORT

The report was noted for information.

RESOLVED: The Committee noted the report.

32/24 REFLECTION: SUMMARY OF DECISIONS AND ACTIONS

Reflections of the meeting were given.

Meeting concluded at 13:02.

Date of Next Meeting: 14 May 2024.

GIG CYMRU NHS WALES | Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC) | Welsh Health Specialised Services Committee (WHSSC)

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) JOINT COMMITTEE MEETING BRIEFING – 19 MARCH 2024

The Welsh Health Specialised Services Committee held its latest public meeting on 19 March 2024. 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 30 January 2024 and 27 February 2024 were **approved** as a true and accurate record of the meetings.

2. Action log & matters arising

Members **noted** the progress on the actions outlined on the action log.

3. Integrated Commissioning Plan (ICP)

Members received a report and a presentation presenting the 2024-2025 Integrated Commissioning Plan (ICP) for approval prior to its submission to Welsh Government in line with NHS Wales planning requirements.

Members noted the planning and engagement undertaken to develop the ICP over the last 12 months, and the additional work undertaken since the JC meetings on 30 January 2024 and 27 February 2024 to refine the plan.

Members discussed the plan presented that included an average 4.45% uplift across Health Boards providing an allocation to fund activity demand and unavoidable growth as well as a 3.2% uplift for NHS Wales on non pay contracts. 6 of the 7 Health Boards (HBs) agreed to approve the plan subject to:

- An agile and flexible approach to delivery of the plan over the next 12 months,
- Recognition that they were carrying a degree of risk in the system,
- The need for the JCC team to undertake further interrogative work on medicines management and optimisation,
- A finance working group being set up to ensure HBs were closer to the recurrent spend across the year,

- Work being undertaken in parallel with HBs on policy and looking at sustainability of specialised services across Wales, including consideration of what is feasible for NHS Wales and what needs to be commissioned from NHS England to manage the volatility and instability for the next 12 months; and
- That the new JCC has strategic discussions on the delivery of the Specialised Strategy for Wales.

Members (1) **Noted** the report and presentation; and (2) **Approved** the Integrated Commissioning Plan 2024-2025 prior to its submission to Welsh Government.

4. Chair's Report

Members received the Chair's Report and **noted**:

- **Chair's Action** –a Chair's Action was taken on 12 March 2024 to approve expenditure for Advanced Medicinal Therapeutic Products (ATMPs) through the Blueteq High Cost Drugs (HCD) software programme, and a letter was issued JC members on the 12 March 2024 confirming the action taken,
- **Chair's Appraisal with the Minister** - On the 26 February 2024 the Chair met with the Minister for Health & Social Services for her annual appraisal on the objectives set for the remit of the JC, in line with ministerial priorities, and areas where the Minister expected the JC, and the Chair, to demonstrate leadership and strategic direction. Members noted that the Chairs tenure comes to an end on 31 March 2024,
- **Dr Sian Lewis, Managing Director, WHSSC -** Dr Sian Lewis will be stepping down from her role as Managing Director on 28 March 2024. The Chair advised it had been a privilege and a pleasure working with Sian. Her energy, commitment and openness underpinned a strong and effective JC. On behalf of the JC, the Senior Corporate Team and all staff, the Chair expressed her sincerest gratitude to Sian for everything she has achieved, with and for our staff, patients, their families and carers, and our local communities,
- **Appointment of IPFR Lay Members -** The appointment process for the appointment of lay members on to the WHSSC Individual Patient Funding Request (IPFR) panel has been delayed and will commence under the new NHS Wales JCC in Quarter 1 2024-2025; and
- **Key Meetings.**

Members (1) **Noted** the report; and (2). **Ratified** the Chairs action taken on 12 March 2024 to approve expenditure for Advanced Medicinal Therapeutic Products (ATMPs) through the Blueteq High Cost Drugs (HCD) software programme.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates:

- **WHC/2024/005 - Welsh Health Circular - Private Obesity Surgery and the Welsh NHS** - In February 2024, Welsh Government published the Welsh Health Circular (WHC) - Private Obesity Surgery and the Welsh NHS. Currently, reliable estimates of the number of patients who are likely to request a follow-up are not available, however we know that approximately one third of surgical procedures carried out in the Welsh Institute of Metabolic and Obesity Surgery (WIMOS) for patients in South Wales are emergency band removal procedures for patients who have previously undergone treatment in the private sector. Therefore, it is possible that this could have a significant impact on NHS pre-operative and post-operative service capacity,
- **Gender Identity Development Services (GIDS)** - An update on developments in Gender Identity Development Services (GIDS) in NHS England (NHSE), including the approach to the prescribing of Puberty Supressing Hormones was given,
- **South Wales Major Trauma Network Gateway Review** - The South Wales Trauma Network (SWTN) was launched on 14 September 2020 to care for adults and children across South and West Wales and South Powys who had suffered a major trauma. On 7 March 2024, the Stage Gate Assessment of the South Wales Trauma Network was reported to the SRO for the programme and was given a green assessment rating which is a significant achievement which should not be underestimated for such a young network. The report will be shared at the SWTN Governance Group scheduled in March 2024 for information, with a view to developing an action plan to address the recommendations in readiness for the SWTN Clinical & Operational Board (COB) in April 2024,
- **Cardiac interventions in Wales: A comparison of benefits between NHS Wales' specialties - Published Article (PLOS ONE)** - WHSSC in collaboration with the cardiac network and the Secure Anonymised Information Linkage (SAIL) databank in Swansea have undertaken a study aimed at assessing if specialised healthcare service interventions in Wales was benefitting the population equitably in work commissioned by the WHSSC. The findings of the study were published on PLOS ONE in February 2024; and
- **NHS Wales Joint Commissioning Committee Implementation -** Further to the report presented to the Joint Committee on 30 January 2024 concerning the business continuity risks for specialised services commissioning associated with the establishment of the new NHS Wales Joint Commissioning Committee (JCC) on 1 April 2024, the recent appointment of an interim Tier 1 Chief Commissioner was a positive step forward, however concern remained regarding the Mental Health portfolio of

the new JCC concerning the ICP and quality issues which will be factored into the risk register.

6. Any Other Business

- **Annual Committee Effectiveness Survey** – members noted that the annul committee effectiveness survey would be issued to all members after the meeting and would focus on the work of the Joint Committee only, and not the sub-committees. The feedback will support developing the new JCC; and
- **Farewell from the Chair of WHSSC –** members noted that it was Kate Eden's last meeting as Chair of WHSSC and she advised that it had been a privilege to work for WHSSC for the last 4 years, working with experts and dedicated professionals to deliver high quality specialised services for Wales and also gave a thanks to the Independent Members (IMs) for supporting the work of WHSSC.

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

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	21 March 2024

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 activities since the last meeting. This includes attending the Chairs' Peer Group and meeting with the Minister. The Welsh Risk Pool Committee was held the previous week with a full agenda and the Staff Awards Ceremony at the end of February was a very positive experience. The Chair also advised Committee members that there may be a need for an urgent Chair's Action before the May Committee. This is in respect of Radiopharmacy Isolators where approval is likely to be required in April to progress this urgent procurement.

The Committee **NOTED** the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- Following the approval of the IMTP by the Committee in January, the two keeping in touch meetings, with the Finance Delivery Unit and the Planning Director at Welsh Government, produced no significant issues and the plan, has now been formally submitted;
- Work to finalise the Business Justification Case for the Radiopharmacy service to be located in IP5 is progressing well with all necessary appointments to relevant contractors having been made;
- The NWSSP People & OD Team have recently supported a further visit to Kerala in India which included attendance by the Minister for Health and Social Care from Welsh Government, who signed a formal agreement with the Kerala Government to continue the current co-operation arrangements which provides for a further 250 qualified healthcare professionals to be recruited into NHS Wales;

- The closure of the Laundry in Carmarthen is well underway and is on track for the end of March, with the new hub coming into operation in April. All affected staff have been given the opportunity to continue to work in the service at the Swansea Laundry or working in a suitable alternative role within Hywel Dda UHB;
- The recruitment process to replace the Director of Finance & Corporate Services has concluded and Alison Ramsey, the current Director of Planning, Performance, and Informatics was successful in being appointed to this post;
- Similarly, Nicola Phillips the current Deputy Director of Primary Care Services was successful in being appointed to the role of Director of Primary Care Services.

The Committee **NOTED** the update.

Items Requiring SSPC Approval/Endorsement

Decarbonisation Action Plan

The original Action Plan covered the period 2021-23 and there is now a need to update it. The plan is both externally and internally focused. External achievements to date include setting up a reporting template for all NHS Wales organisations to measure their progress against the 46 initiatives contained in the Welsh Government Plan and providing advice on achieving net zero in future construction projects. Internally we have invested in LED lighting across the estate, solar panels, and electric vehicles in our fleet. Going forward the plan continues to provide support to NHS Wales organisations and to take forward projects within NWSSP subject to the availability of capital. The plan is ambitious but is equally pragmatic, given the financial context to the years ahead. In the light of these challenges, a coordinated approach across NHS Wales is essential. Monitoring of progress against the plan at Committee is via the quarterly IMTP updates, albeit this is by exception, and it was agreed that a more detailed half-yearly report would be helpful.

The Committee **APPROVED** the Decarbonisation Action Plan.

NHS Building for Wales 2 Framework

The framework provides a number of specialist advisors to support major capital schemes across NHS Wales. The current framework expires in April and work has been undertaken over the last two years to prepare for a new framework, which will commence in May for a period of four years, with the option to extend for a further two years. There has been extensive consultation with Health Boards throughout the development of the new framework, and there has been proactive initiatives to support the Welsh economy wherever possible,

The Committee **ENDORSED** the Framework for formal approval by the Welsh Government.

Nantgarw 2 Lease

Due to low occupancy rates at both Companies House and the current Nantgarw HQ, NWSSP is taking the opportunity to consolidate staff into one new building on the Nantgarw estate. This will provide a better working environment and will release revenue savings The previous plan to move into Cathays Park was discounted due to increasing costs and restrictions on access, and it would also not have allowed the exit from the current HQ. The Committee was therefore asked to approve NWSSP entering into a 10-year lease for the new building.

The Committee **APPROVED** the signing of the lease for Nantgarw 2.

Items for Noting

All-Wales Energy Arrangements

The Committee were updated on developments with the implementation of new governance and contracting arrangements, and also the proposals for the supply of energy in the next few years.

The Welsh Energy Group, supported by the Welsh Energy Operating Group, were both established in March 2023, replacing the Energy Price Risk Management Group. Both of the new groups have performed well, with regular and well attended meetings, which has led to informed strategic decisions on energy supply. The governance arrangements were recently reviewed by Internal Audit and their report was rated as providing substantial assurance. NHS Trusts in England are considering the benefits of centralising their purchase of energy requirements and the Welsh Energy Group is similarly considering the benefit of joining this arrangement.

The Committee **NOTED** the update.

Flu Vaccination Proposal

The Central Procurement of Influenza project brief was approved by the Vaccination Programme Wales Transformation Board last July. The aim was to deploy centrally procured adult Influenza vaccine during the autumn of 2025. NWSSP have formed part of the Project Group to establish feasibility and design of a centrally procured Influenza model.

The next phase of implementation requires the Minister to direct General Practice to not purchase Influenza vaccine for Autumn 2025, which they would normally commence in September of this year. For this direction to be given, assurance needs to be provided that NHS Wales will be ready to provide GPs, Health Boards and Trusts with centrally procured adult Influenza vaccine. An Influenza vaccine tender process would run over the summer of 2024 to enable vaccine delivery commencing in September 2025.

NWSSP will procure the vaccines but there is the option of these being directly

delivered by the supplier or being held and distributed centrally via NWSSP. The paper provided to Committee focused in the latter option, but it is for Welsh Government to decide the preferred approach.

The Committee **NOTED** the proposal.

Staff Benefits Update

NWSSP currently provide administration services for several Staff Benefit Schemes for multiple NHS Wales organisations covering Salary Sacrifice Cars, Bicycles and Home Electronics. These services ensure that a fully procured supplier has been sourced, providing quality and value for money.

The Salary Sacrifice Car Scheme current fleet of vehicles stands at 3,736 at February 2024 which represents a 23% increase over the last 12 months. Additionally 94% of live fleet are electric/hybrid vehicles and 87% of cars on order are electric/hybrid vehicles. The car scheme deliver savings estimated at £750 per car per annum, resulting in a total annual saving of £2.8m across NHS Wales.

The Home Electronic scheme provides employees access to over 5000 items from Currys taken via salary sacrifice, allowing the employees to make savings through their salary.

The Cycle to Work scheme is supplied in conjunction with Halfords. The scheme provides employees access to bikes and accessories from Halfords and Tredz taken via salary sacrifice, allowing the employees to make savings on the cost of new bicycles.

The Committee **NOTED** the update.

Finance, Performance, People, Programme and Governance Updates

Finance – NWSSP reported a break-even Month 11 financial position with a year-to-date additional non-recurring savings of £2.277m. The 2023/24 distribution to NHS Wales is now finalised at £2m. In addition NWSSP anticipate being able to return £1m of funding to Welsh Government so that the total additional savings generated and distributed for 2023/24 is £3m.

People & OD Update – The sickness absence rate remains very low with the average for the last 12 months being 2.98%. Statutory and Mandatory training compliance is good at over 93% but PADR compliance needs to improve from the current level of 83%.

Performance – The in-month January performance was generally good with 38 KPIs achieving the target against the total of 41 KPIs. The three that missed the target were Recruitment, where performance has improved and the target was only marginally missed, and two for Audit & Assurance in respect of the issue of draft audit reports and the subsequent timeliness of management responses.

Project Management Office Update – Two projects are currently rated as red. These are the Primary Care Workforce Intelligence System and Transforming Access to Medicine (TrAMS). On the former there are issues with increasing costs and extremely tight implementation timescales and on the latter the lack of capital is the major issue although good progress is being made on the development of the Radiopharmacy Service. **Corporate Risk Register –** There remain three red risks relating to the impact of industrial action and also of responding to the UK COVID Public Inquiry, and the development of the TrAMs project. The Committee **NOTED** the above Reports.	
Papers for Information	
The following items were provided for information only: • Finance Monitoring Returns (Months 10 and 11). • Final Version of IMTP. • PPE Dashboard • Audit Committee Assurance Report.	
AOB	
N/a	
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	16 May 2024

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

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
CAMHS	Child and Adolescent Mental Health Services
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
CPSS	Call Priority Streaming System
CHARU	Cymru High Acuity Response Unit
D&C	Demand and Capacity

Abbreviation	Term
DOM	Duty Operations Manager
DOS	Directory of Services
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
IAED	International Academies of Emergency Despatch
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

Abbreviation	Term
MTU	Mobile Testing Unit
NCCU	National Collaborative Commissioning Unit
NEPTS	Non-Emergency Patient Transfer Service
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

Abbreviation	Term
SPCT	Specialist Palliative Care Team
SOC	Strategic Outline Case
SOP	Strategic Outline Programme
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