Bundle Audit Committee (Open) 3 March 2022

1 13:00 - Chair's welcome; apologies and confirmation of quorum

2 13:01 - Declarations of interest

3 13:02 - Minutes of last meeting

ITEM 3 Audit Committee OPEN Minutes 2 December 2021. v3.doc

4 13:04 - Action Log

ITEM 4 AUDIT COMMITTEE Action and Decisions Log.xlsx

4.1 13:09 - Annex 1 to Action Log - Use of the Trust Seal

ITEM 4a Action Log Seal use.xlsx

5 13:10 - Committee Effectiveness Review

ITEM 5 Audit Committee SBAR on Committee Effectiveness v.2.docx

ITEM 6.1 Annex 2 Audit Committee TORs Marked up v4 130222.docx

ITEM 6.2 Annex 3 Audit Committee TORs Clean 160222.docx

ITEM 6.3 Annex 4 Audit Committee Participants Questionnaire.docx

ITEM 6.4 Annex 5 Audit Committee Handbook Questionnaire (January 2022) v4 9-02-22....docx

6 13:30 - Governance Practice Notes

ITEM 6 AC SBAR on Governance Practice Notes March 2022.docx

ITEM 6.1 Governance Practice Note 001 March 22 - Trust Seal.docx

ITEM 6.2 Governance Practice Note 002 March 22 - Private Board and Committee Business.docx

ITEM 6.3 Governance Practice Note 003 March 22 - Chair's Action.docx

7 13:45 - Internal Audit Reports

7.1 Internal Audit Progress report
7.2 Internal Audit Plan
7.3 Individual Audit Reports:
7.3a Information Management – Hear and Treat and See and Treat (Reasonable assurance)
7.3b Digital Governance (Reasonable assurance)
7.3c Recruitment Practices (Reasonable assurance)
7.3d Capital Projects: Cardiff Make Ready Depot (Reasonable assurance)
7.3e NEPTS – Transfer of Operations (Limited assurance) – TO FOLLOW

ITEM 7.1 WAST 2122 - Internal Audit Update Report - March 22.pdf

ITEM 7.2 WAST_2022-23_Draft Internal Audit Plan_for AC approval.pdf

ITEM 7.3a WAST_2122-011_Information Management_final Internal Audit Report client issue.pdf

ITEM 7.3b WAST_2122-13_Digital Governance_Final Internal Audit Report.pdf

ITEM 7.3c WAST_2122-20_Recruitment Practices_Final Internal Audit Report.pdf

ITEM 7.3d Final Report WAST Cardiff Make Ready Depot v1.0 (3).pdf

8 14:15 - Management response to Taking Care of the Carers Audit report

ITEM 8 Taking Care of the Carers - Management Response Feb 22.docx

9 14:25 - Audit Wales Update Report

ITEM 9 WAST Audit Committee update 03032022.pdf

9.1 14:35 - Audit Wales Annual Audit Report

ITEM 9.1 2798A2022-23_WAST_Annual_Audit_Report_2021_Final_Eng.pdf

10 14:45 - 2021-22 Annual Report Timeline

ITEM 10 SBAR to AC re Annual Report Timetable.docx

11 14:55 - Accounts Planning and Emerging Issues

ITEM 11 SBAR Finance Update Report March 2022.docx

ITEM 11A Annex a.pdf

ITEM 11b.pdf

ITEM 11C.pdf

12	15:15 - Audit Tracker ITEM 12 Executive Summary AC - Internal Audit Report 030322.docx
13	15:25 - Risk Management and Board Assurance Framework ITEM 13 Executive Summary Risk Management Report AC 030322.docx
14	15:35 - Losses and Special Payments – Payments for the Period ITEM 14 Executive Summary SBAR Losses and Special Payments.docx ITEM 14a Losses and special payments Annex A.pdf ITEM 14b Losses and Special payments Annex B.pdf ITEM 14c Losses and Special Payments Annex C.pdf
14.1	15:50 - Deep Dive on Personal Injury (special payments) Claims ITEM 14.1 Losses and Special Payments Deep Dive.docx
15	15:55 - Key messages for Board
16	15:58 - Any other business
17	Date and time of next meeting 7 June 2022 at 09:30

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN MEETING OF THE AUDIT COMMITTEE OF THE WELSH AMBULANCE SERVICES NHS TRUST HELD ON THURSDAY 2 December 2021 VIA TEAMS

PRESENT :

Martin Turner	Non Executive Director and Chair
Emrys Davies	Non Executive Director
Paul Hollard	Non Executive Director
Joga Singh	Non Executive Director

IN ATTENDANCE :

Julie Boalch	Head of Risk and Corporate Governance
Judith Bryce	Assistant Director of Operations
Andrew Doughton	Audit Wales
Helen Higgs	Head of Internal Audit NWSSP
Jill Gill	Financial Accountant
Navin Kalia	Deputy Director of Finance and Corporate Resources
Osian Lloyd	Deputy Head of Internal Audit NWSSP
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Duncan Robertson	Interim Assistant Director of Research, Audit and Service Improvement
Claire Roche	Executive Director of Quality Nursing (Minute 34/21 only)
Paul Seppman	Trade Union Partner
Dave Thomas	Audit Wales
Chris Turley	Executive Director of Finance and Corporate Resources
Carl Window	Counter Fraud Manager

APOLOGIES:

Brendan Lloyd	Medical Director

26/21 PROCEDURAL MATTERS

The Chair welcomed all to the meeting and advised that it was being audio recorded.

Declarations of Interest

The standing declaration of interest of Mr Emrys Davies as a former member of UNITE was recorded.

Minutes

The Minutes of the open and closed sessions of the Audit Committee meeting held on 16 September 2021 were confirmed as a correct record.

Action Log

The Committee considered the action log:

Action 19/21a - Internal Audit Reports: Fire safety Recommendations. Chris Turley referred the Committee to the report attached to the action log. The Committee agreed to close the action.

Action 19/21b - NEPTS Procurement. Was the process used by NEPTS sufficient for other providers and could it be adopted by other third party providers? Chris Turley verbally updated the Committee and explained that the process had been reviewed and would continue to provide updates on NEPTS contractor and control management. Action Closed.

RESOLVED: That

(1) the Minutes of the Audit Committee's open and closed sessions held on 16 September 2021 were confirmed as a correct record;

(2) the standing declaration of interest in respect of Mr Emrys Davies as a retired member of UNITE was recorded; and

(3) the actions referred to in the action log were considered and actioned as necessary.

27/21 INTERNAL AUDIT REPORTS

Helen Higgs presented an overview of the Internal Audit Progress report and advised the Committee of the following highlights:

Proposed changes to the approved plan; there was a request to defer the following reviews to next year:

a. Trade Union release time. Paul Hollard commented that the People and Culture Committee discussed the recommendations and advised it would be appropriate to defer the review
b. Health and safety. Judith Bryce explained that the Trust would benefit from some additional assurance and agreed to the deferment. This will be replaced by a review of Respiratory Protective Equipment.
c. Decarbonisation moves from the 2021/22 plan to quarter 1 of 2022/23. This is recognising that UHBs/Trusts are not required to publish their Decarbonisation Action Plans until March 2022 and the timing of expenditure of the initial capital allocations provided by Welsh Government. This will be replaced by a review of Waste Management.
d. Savings plan review. Chris Turley explained that emphasis on the savings delivery

had, during the last 12 months, not needed to be as focused as in previous years and that the Trust would gain more value by deferring the review. The Committee discussed whether the review should be deferred completely or a limited review be conducted and on the basis that a fuller report would be received if deferred, it was agreed to defer the review. It was noted that the Finance and Performance Committee met bi-monthly for oversight over the financial position and the Committee took this into consideration in their decision to defer.

The Committee, following a further discussion decided it was appropriate for these four reviews to be deferred to the following year and be replaced with reviews more suited to this year's audit programme.

Individual audit reports

Osian Lloyd gave an overview of the following reports:

Collaboration (Reasonable assurance) – The purpose of the review was to assess how the Trust collaborated with stakeholders to ensure commitment was included in the Integrated Medium Term Plan and the appropriate action was being taken.

The review considered a sample of the Trust's Service Development Initiatives (SDI) which illustrated how it engaged with partners.

The review was reasonable and was based on tow medium priority findings; these were in relation to, reviewing and updating the engagement framework and target setting with SDI's. The Executive Management Team had accepted the recommendations and Internal Audit were content with the actions in place to address them.

Comments:

Paul Hollard, Chair of the People and Culture Committee confirmed that work was ongoing to review and revise the Engagement Strategy

Asset Management (Real Asset Management (RAM) system) (Reasonable assurance) - The purpose of this review was to look at the extent to which benefits realised planned outcomes.

The review was based on one high priority finding and two medium priority findings. The high priority found that the Trust should implement a more proactive approach to the physical verification of assets; notwithstanding and recognising the challenges with locating the assets due to their mobile nature. The two medium priority findings related to ensuring there was adequate reporting of the benefits realised following implementation of the RAM system. The other finding was the need for the Trust to consider the requirement to use the proposed Radio Frequency ID system to validate assets.

Comments:

Chris Turley added that the recommendations were being worked through and further explained the challenges in managing mobile assets. He further added the outcomes of the recommendations were tracked through the Audit Tracker.

Medicines Management Controlled Drugs – (Reasonable assurance) – the purpose of this audit was to assess the effectiveness of the Abloy system (locking mechanism) for the Omnicell medical cabinets which was a follow up on a previous limited assurance.

There were still areas for improvement which were drawn out with three medium priority findings; to further analyse the cycle count results from Omnicell Cabinets, Vehicle medicine audits and to conduct a period review of the Abloy key system

Comments.

Members noted and recognised the significant improvement following the limited assurance review and acknowledged there was still further work to be undertaken. It was also noted that the introduction of the Omnicell cabinets had made a substantial and positive impact on the overall control of drugs.

The Committee discussed the process of audit reviews and how they were monitored and scrutinised by each particular Committee.

RESOLVED: That the reports were noted.

28/21 AUDIT WALES REPORTS

Audit Wales update report

Dave Thomas presented the report and gave an overview of the planned work which included the ongoing work on the unscheduled care system. It was anticipated that this ongoing work should be available for the next Audit Committee meeting.

Structured Assessment

1. Andrew Doughton explained the purpose of the structured assessment was to assist the Auditor General in being satisfied that NHS bodies had made appropriate arrangements to secure value for money.

2. The work had been conducted in two phases, the first had focused on operational and the Trust's planning arrangements and had been reported on earlier on in the year.

3. The second phase considered the corporate governance and financial arrangements and how they had performed over the last 12 months. It had been observed that both Board and Committees had been working well and had adapted to the virtual environment. It was also noted that the Trust continued to undertake self reviews of several aspects of governance arrangements; adopting a continuous improvement approach.

4. Chairs actions continued to be used frequently in the Trust, noting this method of making rapid decisions at Board level was widespread across the wider health sector in Wales.

5. The Trust had met its financial duties for the last five years and was currently on track to achieve break even for the current financial year. The Trust should

continue to focus on savings and efficiencies going forward.

Comments:

1. It was suggested that the Trust consider hybrid meetings for the Board going forward.

2. In terms of sickness absence, clarity was sought regarding the position. Andrew Doughton explained that the Trust continued to work on improving sickness absence whilst recognising it was still a challenge for the Trust. Paul Hollard added that as part of the work going forward, significant investment had been made in improving overall staff welfare.

3. Following a question regarding the performance management framework and the ongoing work in its development, Emrys Davies advised that considerable progress had been made.

4. The Committee discussed in further detail the wider governance responsibilities in terms of its oversight role.

Taking Care of the Carers Audit Review

Dave Thomas explained that the report described how NHS bodies had supported the wellbeing of staff during the pandemic.

The report also focused on the arrangements in place for safeguarding staff who were more at risk from Covid-19.

The key messages from the report were on the whole positive and included:

a. There was a broad set of activities available to support NHS staff wellbeing
b. The ability to signpost staff to the various issues could be challenging
c. Recommendations have been to health bodies and Welsh Government that staff welfare continues to be a main focus.

Comments:

1. Trish Mills advised the Committee that a draft management response had been drafted.

2. In terms of timing it was recognised that the action plan would be presented at the next People and Culture Committee and then to the Board.

RESOLVED: That the update was noted and the reports were received.

29/21 AUDIT RECOMMENDATION TRACKER

Julie Boalch presented the report to the Committee and drew their attention to the following areas:

1. All 99 recommendations on the tracker had been appropriately scrutinised at the

Executive Management Team (EMT), the Assistant Directors Leadership Team (ADLT) and all of the relevant Committees.

2. Of the 99 recommendations, 29 were overdue, 7 of which were considered as a high priority

3. In terms of the 7 high priority recommendations, 3 related to the Trade Union release time, 3 to the Clinical Contact Centre (CCC) performance management report and 1 to the ICT disaster recovery report.

4. With regards to the conclusion of the high priorities, it was expected that the CCC performance management report would be completed between April and June 2022, and the ICT disaster recovery review in April 2022. In terms of the Trade Union release time, the People and Culture (P & C) Committee had reviewed these in detail and had supported a slight amendment to one of the recommendations; this was in relation to a standardised process for requesting the recording of time off facilities.

5. Structured assessment report, in relation to the recommendation in terms of how the Trust was complying with new legislation, Julie Boalch provided assurance that this would be brought back on to the tracker. Trish Mills added that the legislative requirements would be added to the appropriate Committee's cycle of business going forward.

Comments:

Paul Hollard advised that a detailed discussion had taken place on the minor amendment to the recommendation in the Trade Union Release Time report at P&C and that the proposal includes a recommended proforma for staff to use to record their activities; however, this will not be mandated and it will be the individual's responsibility to record their activity. Paul Seppman updated the Committee from a Trade Union perspective and noted that this was seen as a positive step going forward.

RESOLVED: That the Audit Committee received and discussed the contents of the report and:

a) Agreed to change the proposal relating to Audit Recommendation 225 (Trade Union Release Time);
b) Noted the activity since the last Audit Committee in September 2021; and
c) Considered the overdue recommendations and the revised completion dates.

30/21 REVISED STANDING ORDERS

1. Trish Mills, in presenting the report reminded the Committee of the requirement for Standing Orders (SO) to be kept under review ensuring they remained correct and current. The SO's included the Scheme of Reservation and Delegation of Powers and the Standing Financial Instructions.

2. The Committee was asked to review the proposed changes which were illustrated in detail within the report and endorse those amendments for approval by the

Board.

3. In respect of SO's the main changes proposed were; adding the line under paragraph 1.1.8: Non Executive Directors should not normally serve on more than one NHS body in Wales and the requirement of the Annual Quality Statement was removed.

4. Scheme of Reservation and Delegation of Powers. There were several changes, and again these were highlighted in the report with the main ones relating to revisions to the Remuneration Committee under the Schedule of Matters reserved to the Board.

5. Scheme of Delegation of Executive Directors, Directors and Officers. The Committee noted this was an area where the most changes had been made. These included changes to Delegated Matters and Delegated Financial Limits. In respect of the former a change not included within the report was in respect of the Caldicott Guardian which replaces the Medical Director with the Director of Quality and Nursing, with effect form 1 January 2022. In terms of the Delegated Financial Limits, several changes had been made to overall layout; of note was the increase in the delegated limit of the Chief Executive from £250k to £500k.

6. Standing Financial Instructions – there were many changes to SFI's but they were not classed as material and not included within the report; they included expanding sections for more clarity in a particular area. Members were advised that should the table of changes be required they should contact Trish Mills.

Comments:

1. The Committee welcomed the change to the delegation of limits as these were more in line with inflation and also whilst not eliminating Chairs actions, would certainly reduce the requirement for them.

2. Chris Turley commented that the model version of SFI's had been refreshed through work led predominantly by Shared Services. He added that the Welsh NHS Finance Academy was developing user guides and tools on the new style of SFI's which would assist in implementing them.

RESOLVED: That the Committee:

(1) Reviewed and discussed the amendments to the SO, SoRD and SFI; and

(2) Endorsed the changes to the SO, SoRD and SFI for approval by the Trust Board on 27 January 2022.

31/21 STANDING ORDERS - TRUST SEAL USE

Trish Mills explained that the report advised the Committee on any non-compliance in respect of the provisions described in Standing Orders. The Committee were being informed that there had been non- compliance with regards to the use of the Trust Seal.

It had been noted that during a recent review of the process, the Trust seal had not been

affixed in the correct manner as prescribed in Standing Orders.

A process was being developed to ensure that the affixing of the seal was conducted correctly going forward.

Comments:

Following a query in respect of the seal being affixed to documents other than leases connected to land or property, Trish Mills advised that work was ongoing to ensure that they were all related to leases.

The Committee noted that the practise of affixing of the seal was prescribed in SO's and questioned if there was another option. Trish Mills advised that the Board Secretaries network would be considering the possibility of making any changes which would require escalation to Welsh Government.

RESOLVED: That the Committee;

(1) Noted the non-compliance with the Standing Orders with respect to the Trust Seal; and

(2) The non-compliance will be reported to the Trust Board at its meeting on 27 January 2022 and the developing guidance which would address gaps in process through the Committee highlight report.

32/21 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

1. Julie Boalch presented the report which drew out the corporate risk activity since the last meeting on 16 September 2021.

2. Work was continuing on the higher scoring risks to develop a process for them to be articulated with more clarity ensuring they were well described.

3. The Committee noted that Trust Board had recently agreed to close two risks and have them removed from the Corporate Risk Register (CRR). Risk 343 (seasonal planning) and 229 (Brexit).

4. Several new risks were being considered for inclusion on to the CRR and related to: Patient Safety/Putting Things Right Team, Leading Change Together – A Partnership Approach, Recurrent Funding and NHS Decarbonisation. The Committee noted that more detail on these risks would be provided at the next Audit Committee meeting on 3 March 2022.

Comments:

1. Highest scoring risks, should these be presented to Board as well as Committees? Trish Mills emphasised that the higher scoring risks should be considered at Board with the assurance that Committees were reviewing and scrutinising them.

2. Members were encouraged to see that other Committees were reviewing and managing more effectively the risks designated to them.

3. It was suggested that more narrative describing Executive Management Team ownership of risks and their involvement be included in future reports. Julie Boalch advised that this and how it was being reported at Board was part of the Corporate Governance's team risk improvement programme. Trish Mills added that once the Board Assurance Framework was aligned to the Integrated Medium Term Plan and illustrated the strategic risks; the Board would have sight of the higher risks through that mechanism.

4. The Committee discussed in further detail what the Board should consider in terms of ownership of risk, risk tolerance and appetite and what risks were in the Trust's control.

5. It was suggested that further consideration in terms of the risk reporting framework, i.e. how high risks were reported to the Board should be held at a future Board development session.

RESOLVED: That the Committee;

(1) Noted the closure of Risk ID 343 (Failure to undertake tactical seasonal planning) and Risk ID 229 (Impact of Brexit) approved by Trust Board; and

(2) Considered and commented on the risk management activity since the last Audit Committee meeting on 16 September 2021.

33/21 RISK MANAGEMENT IMPROVEMENT PROGRAMME

1. Trish Mills explained that the report detailed the future ambition of risk management and how it would be improved in the coming six months; the Committee were being asked to endorse the direction of travel and the focus over the next three to six months.

2. This work would include looking at how risks are expressed, escalation processes and the relevant training and education required across all levels of the Trust including the Board.

3. Members also noted that the Board Assurance Framework (BAF) would be improved as part of the programme given that the BAF is the mechanism by which the Board are made aware of the risks that might be detrimental to the Trust achieving its strategic objectives.

4. There were currently 365 risks on the risk register and with the migration to the Once for Wales Datix module, there was a need to focus on cleansing these risks and the resource required to undertake this work

RESOLVED: That the Committee considered and discussed the contents of the report and specifically:

(a) Endorsed the direction of travel of the longer term risk management strategy and framework; and

(b) Endorsed the focus over the next 3-6 months as set out in paragraph 13 of the report.

34/21 LOSSES AND SPECIAL PAYMENTS – PAYMENTS FOR THE PERIOD 1 April 2021 – 31 October 2021

1. Chris Turley presented the report which detailed the losses and payments for the period 1 April 2021 – 31 October 2021.

2. He added that the report was intended to be accompanied by a deep dive report on personal injury to staff; however the report was not available at this time. The deep dive on personal injury to staff would have been the last report in the cycle of deep dives over an 18 month period.

3. Deep dive reports had provided the Committee with comprehensive information in a particular area and highlighted any themes and trends and what were driving the costs and had any lessons been learned.

Comments

1. The Committee had found the deep dive reports to be very useful and informative and appreciated the significant work involved in producing them.

2. Following further discussion the Committee felt it would be appropriate that the current losses and special payments report be enhanced to include on a selective basis any particular theme, patterns or trends the Committee needed to be made aware of. Depending on the particular themes and trends emerging, these could then be referred to another Committee for further review.

3. Claire Roche confirmed that a deep dive report on personal injury would be presented at the next Audit Committee meeting on 3 March 2022. She suggested two options going forward; deep dives be conducted in a more agile or responsive away in that any trends emerging should be the focus of the report or, that a formal timetable of deep dives be implemented to report on a specific area and presented to the relevant Committee.

4. Members recognised there were several lessons to be learned from the deep dives and what was being changed a consequence of these lessons; the lessons learned were from several perspectives including; clinical, financial and personnel.

5. It was agreed that Chris Turley and Claire Roche would review the reporting process on deep dives and provide a recommendation to the Committee in terms of instigating these reports going forward.

RESOLVED: That

(1) the Losses and Special Payments Report for this period was received; and

(2) An update on the deep dive reporting process will be provided at the next meeting as agreed.

35/21 COVID-19 PUBLIC INQUIRY PREPARADNESS REPORT

1. Julie Boalch presented the report which was designed to update the Committee on the Trust's position in respect of its preparedness for the upcoming Covid-19 public inquiry.

2. The Committee noted that a Chair to the inquiry would be announced in due course and the proposed start date for the inquiry was spring 2022.

3. There were several governance processes already in place; however there were still some fundamentals that required further consideration and these included, ICT, e mail and recording of social media.

4. Further preparation for the inquiry included the attendance of the Assistant Directors Leadership Team and the Executive Management Team at events aimed specifically at staff who were likely to attend public inquiries.

5. The Committee would be advised further on the scope of the programme of work required in preparing for the inquiry at the next meeting.

RESOLVED: That Members:

a) **Noted the contents of the report and received assurances on the preparations for the inquiry to date.**
b) **Noted the next steps the Corporate Governance team would take to:**
   - **Consider the full programme of work identified in the report and outlined how this could be managed and,**
   - **Provide a further update report early in the new year once the programme of work has been explored.**

36/21 2022/2023 TIMETABLE FOR PRODUCTION OF ANNUAL FILINGS – VERBAL UPDATE

Trish Mills reminded the Committee that the Manual of Accounts was the document adhered to in respect of the annual filings, however the report had not yet been published; hence the verbal update.

A schedule had been developed and once the Manual of Accounts was published the dates would be populated; and once the dates were received, the Committee would be updated.

37/21 KEY MESSAGES FOR BOARD

Trish Mills would be providing this report for the Board.

RESOLVED: That Trish Mills would provide this update for the Board.

Date of Next Meeting: 3 March 2022

ACTION LOG

WELSH AMBULANCE SERVICES NHS TRUST - AUDIT COMMITTEE - December 2021

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
27/21	2 December 2021	Internal Audit reports	The four reviews - Trade Union Release Time - Health and Safety - Decarbonisation - Savings Plan be deferred to the following year and replaced with reviews more suited to this year's audit programme.	Osian Lloyd	3 March 2022	Update for 3 March 2022 Following discussions with management it has been agreed to replace the audit of Health and Safety with a review of Fit Testing; Decarbonisation is replaced with a review of Waste Management. A verbal update will be provided on the replacements for Trade Union Release Time and the Savings Plan.	Open
28/21	2 December 2021	Audit Wales reports	Taking Care of the Carers Audit Review - Management response to be provided at next meeting	Claire Vaughan	3 March 2022	Update for 3 March 2022. Report is on the Agenda at ITEM 8	Complete
31/21a	2 December 2021	Standing Orders - Use of the Trust Seal	A process to outline the use of the Trust Seal be developed	Trish Mills	3 March 2022	Update for 3 March 2022 On agenda at item 6.1	Open
31/21b	2 December 2021	Standing Orders - Use of the Trust Seal	Produce a list showing recent use of the Trust Seal	Steve Owen	3 March 2022	Update for 3 March 2022 Attached to action log at Item 4.1	Complete
34/21	2 December 2021	Losses and Special Payments - Deep Dives	Review the reporting process on deep dives and provide a recommendation to the Committee in terms of instigating these reports going forward.	Chris Turley and Claire Roche	3 March 2022	Update for 3 March 2022 Agenda includes the last deep dive to be presented to Audit Committee. It is proposed to expand future losses and special payments papers to highlight brief details of significant values, with subsequent deep dives undertaken if with emerging trends where areas of concern are raised by the Committee.	open
36/21	2 December 2021	2022/2023 Annual Filings Timetable	On publication of the Manual of Accounts, dates for annual filings to be populated and presented to Committee	Trish Mills	3 March 2022	Update for 3 March 2022 On agenda at item 10	open

DECISION LOG

WELSH AMBULANCE SERVICES NHS TRUST - AUDIT COMMITTEE

Ref	Date	Agenda Item	Decision/Approval

Open
Complete
Closed
Not Due

2	09-Mar-17
3	09-Mar-17
4	09-Mar-17
5	09-Mar-17
6	1 June 2017 and 14-Sep-17
7	01-Jun-17
8	01-Jun-17

9	14-Sep-17
10	14-Sep-17
11	14-Sep-17
15	14-Sep-17
16	14-Sep-17
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21	14-Sep-17
22	14-Sep-17
23	07-Dec-17
24	07-Dec-17
26	07-Dec-17
28	07-Dec-17

29	07-Dec-17
30	07-Dec-17
31	07-Dec-17
32	13-Mar-18
34	24-May-18

33	24-May-18
35	24-May-18
36	24/05/2018 and 13/09/18
37	24-May-18
13	14/09/2017 and 13 September 2018 and 6 December 2018
14	14 September 2017 and 7 December 2017 and 13 September 2018 and 6 December 2018
25	07-Dec-17

37	13/09/2018
38	06/12/2018
39	06/12/2018
40	06/12/2018
41	06/12/2018
42	07-Mar-19
43	07-Mar-19
46	07-Mar-19
44	07-Mar-19
45	07/03/2019 and 23/5/19
46	23-May-19
47	23-May-19
48	12-Sep-19
49	12-Sep-19
50	12-Sep-19

51	12-Sep-19
55	05-Mar-20
57	05-Mar-20
58	05-Mar-20
59	05-Mar-20
60	05-Mar-20
61	05-Mar-20
63	05-Mar-20
52	12/09/2019 and 18 Jun 2020

53	05 Dec 2019, 5 Mar 20 and 18 Jun 2020
54	05/03/2020 and 18 Jun 2020
56	05/03/2020 and 18 Jun 2020
64	05/03/2020 and 18 Jun 2020

66	17-Sep-20
65	18-Jun-20
67	17-Sep-20
68	04-Mar-21
62	05/03/2020 and 18 Jun 2020 and 3 June 2021
69	4 March 2021 and 3 June 2021
70	4 March 2021 and 3 June 2021

71	03-Jun-21
72	03-Jun-21
73	03-Jun-21

02/17 INTERNAL AUDIT PROGRESS REPORT and Internal Audit (IA) Plan 2017/18	**Controls over the use of NHS supplies** **RL** confirmed that the issues raised in the audit would be rectified by April 2017
02/17 Internal Audit (IA) Plan 2017/18	The comments regarding the plan be addressed by **HH** and an updated plan be circulated by the next Audit Committee meeting.
03/17 External Audit	Committee requested all completion dates were to be illustrated in subsequent reports
09/17 Reported Breach of Standing Orders	Updated report to be presented at next meeting
14/17 Audit of Financial Statements	The specific recommendations arising from the financial audit work would be reported in a separate report to the Audit Committee scheduled for September 2017. At 14 September meeting, this item was deferred by the WAO to December meeting.
17/17 Audit Recommendation Trackers	Members recognised the challenges involved in keeping the tracker up to date and in future would like to see the items earmarked for closure identified within the SBAR
13/17 External Audit Report	In terms of the Remuneration Report, following a detailed discussion into the process, it was agreed that the issue would be considered at the next Chairs Working Group meeting

Nov-17 DRAFT ANNUAL ACCOUNTS AND ACCOUNTABILITY REPORT 2016/17	Asset management - the Committee discussed the processes in terms of asset It was agreed that **PR** would arrange for this to be brought to the attention of the Finance and Resources Committee for their consideration
12/17 HEAD OF INTERNAL AUDIT OPINION AND ANNUAL REPORT	It was suggested that going forward, and as part of the process, Non Executive Directors would be made aware of specific IA reports which could be discussed through their respective Executive Director champions – This was to be actioned at the next meeting of the CWG.
Closed Session	Disseminate further information regarding Tenders and Waivers
21/17 External Audit Progress report	The charitable funds Financial Accounts Independent Examination was planned to be undertaken during October and once completed would be reported at the next Audit Committee meeting
22/17 Losses and Special Payments	Members were keen to understand how any lessons were being learned and were any themes or trends developing going forward? **LP** and **CT** agreed to consider this further and would provide the Committee with an analysis on any learning themes that were developing.
23/17 Corporate Risk Register (CRR) Quarterly Report Quarter One	Some of the target dates were in 2019 and if these applied to high risks, was this timely enough? **CB** explained that these had been timelines set by WG and would refer this back to the risk register advisory group for their consideration.
24/17 AUDIT RECOMMENDATION TRACKERS	**CB** was requested to conduct a review on the open health and safety items and provide comments for the tracker for the next Audit Committee meeting.

24/17 AUDIT RECOMMENDATION TRACKERS	Members asked for further detail in terms of progress with items on the tracker where completion dates had passed.
25/17 FoI report	The Committee requested that future FoI update reports include requests that had been refused with the specific reason why.
26/17 Items for Noting	**Auditor General for Wales - Audit of Cardiff and Vale University Health Board's** **KC** briefed the Committee on the developments being made following the audit and advised that a progress report should be forthcoming to the next Audit Committee.
Closed Session Nov-17	Members queried the process for the approval of the Counter Fraud Annual Report and it was agreed clarity would be provided.
Counter Fraud Annual Report 29/17 External Audit	To review and provide the Committee with an update on the finding included within the WAO Public Procurement in Wales report published in October 2017
29/17 External Audit	To provide Members of the Committee with a current update on the status of each of the items highlighted by WAO in their final accounts audit memorandum 2016/17
28/17 Internal Audit	Fleet Maintenance Costs – As part of the ongoing work it was agreed that a benchmarking exercise would be conducted.
28/17 Internal Audit	Personal Appraisal and Development Review (PADR) process, **LP** gave an overview of how these were being conducted and how any themes and trends identified were being mapped. A follow up review would be presented at the next meeting.

28/17 Internal Audit	Members discussed the issue of controlled drugs in further detail and it was suggested that a clinical notice to remind staff of the requirements would be circulated.
31/17 CRR	1. In terms of the Emergency Services Mobile Communications Programme (EMSCP) it was queried why the consequence/impact had been downgraded? 2. New committees had been identified; how would any duplication of work be avoided going forward?
36/17 Governance, Recruitment and Procurement	An update was to be provided on the actions as detailed in the attached:
Internal Audit Reports	IA Progress Report to include additional information to highlight turn-round times for reports
15/18	Annual Accounts, staff costs. Jill Gill, Financial Accountant agreed to circulate reconciliation paper to the Chair

15/18		Members sought clarity on the timescales involved regarding the asset register. **CT** advised that the Finances and Resources Committee were monitoring the situation and agreed to provide an update on progress to the Audit Committee on 13 September 2018
17/18	Internal Audit	Rest Breaks follow up review, it was agreed this be deferred to FRC to oversee and monitor progress
17/18	Internal Audit	Handovers at ED's. It was agreed that the Board Secretary arrange for the report to be circulated to Health Boards and that a log of discussion be kept to show outcomes going forward. An update would be provided at the next meeting
109/18 Audit Tracker		The Committee expressed concern that the rest break audit review did not appear on the tracker. KC advised that he would investigate this issue and update the Committee at its next meeting.
20/17 Internal Audit reports - Safeguarding		A review on DBS checks was being conducted; with a particular focus on Community First Responders.
20/17 Internal Audit reports – Weir report		Executive Management Team would formally close the report at its next meeting. Director of Operations to circulate report prior to next meeting.
28/17		The policy which managed the control of drugs was developed and effected as soon as possible.

28/18 Internal Audit	Volunteer Drivers - revised timeline of actions be circulated to Committee and assurance that the immediate gaps in compliance had been reviewed and addressed.
37/18	Management Actions, Travel and Subsistence review. Any issues in delivering the actions in a timely manner, Committee be advised in advance
39/18	Handover of Care at ED's - Actions
40/18	Committee asked to check whether the recommendation related to a compliance issue with the current Resourcing Policy or whether it referred to the delay with the new Policy.
41/18	In terms of risks being escalated and de-escalated, what was the value of the risk? Was it the likelihood or the impact? Julie Boalch advised that that any changes in scores will be included in the BAF report going forward.
02/19 Internal Audit progress report	A process to be in place for approval of changes to IA plan
02/19 Internal Audit Plan	Revised plan be sent to Members for approval, explaining the changes, and to state if the review was a follow up
03/19 CLOSED SESSION	Potential duplicate entry on the Tender register regarding Cisco Hardware ?
02/19 Internal Audit Plan	Health Board Areas/Station Follow up
03/19 CLOSED SESSION	Tender T.0914 why the difference between the budgeted and actual cost
15/19 Internal Audit reports	Chase up wording regarding Hospital arrival screens from WG
16/19 Internal audit update	Add original deadline to Tracker prior to new deadline agreed in the Follow Up report
Minute 19	Health Board/Station Audit outcomes. Quest Committee to be informed of outcomes
Minute 19	Action plan on Health Board/Station Audit review be presented at next meeting
Minute 20	Handover of Care at ED's. Cardiff and Vale UHB, escalate to Chairman and CEO COMPLETED

Minute 21	FPC to give consideration to benchmarking and predictions in terms of performance
Minute 1/20	To include TU Partners (not already doing so) as part of Board development training
Minute 2/20	Consider including a section on the Audit Tracker which would provide assurance of mitigating actions when a longer completion date has been agreed.
Minute 2/20	Additional filter to be added to Tracker to signify relevant Committee for IA reviews
Minute 2/20	Final and agreed IA plan for 2020/21 be circulated to AC Members
Minute 3/20	WHSSC thematic review to be circulated to Committee
Minute 5/20	Include additional narrative in the audit tracker report describing overdue recommendations against the assurance rating in future Audit Tracker reports
Minute 2/20 (Closed Session)	National Fraud Initiative report to be circulated to Members
Minute 22/19	Yearend assessment to be conducted to review completion times of management actions arising from audits

Minute 33/19	To identify External reports and how they will be handled re: governance and oversight.
Minute 1/20	Losses and Special payments - Trends and themes - consolidate report with Quest committee
Minute 2/20	Clarification on employment contract - was 52 hours a stated requirement. Matter to be considered at P and C Committee. Findings reported back to Audit Committee. This specific action on the contract hours has been completed and was reported to Audit at last meeting. The action needs to be changed now to be P&C Committee considering progress against IA recommendations.
Minute 3/20 (Closed Session)	FPC to conduct case study on tenders in which the costs differed substantially.

Minute 19/20	Explore and engage with workforce /learning teams with a view to making Counter Fraud awareness part of the mandatory e - learning process; and To present an overview of the Counter Fraud benchmarking platform
Minute 06/20 (Closed Session)	Counter Fraud Annual Report and Annual Plan. Redacted versions, which would highlight any themes and trends, to be presented in the open session
Minute 19/20	To develop a Counter Fraud Specific Risk assessment for WAST
Minute 04/21	Risk Management. Summary report to contain previous risk score
Minute 9/20	Risk Register Development guide and Risk Management Strategy. To contain details of new Digital Directorate and details of how project risks were managed
Minute 04/21	Risk Management. Narrative to include other Committee's scrutiny to give additional assurance. A system to provide a standardised approach to be implemented
Minute 05/21	Consider the process for closing down older recommendations with EMT

Minute 12/21	Limited assurance audit for ICT Disaster Recovery Update on progress against the actions.
Minute 14/21 Audit report	An in depth review of the long outstanding recommendations in conjunction with ADLT would be conducted with a report to the Committee in September
Minute 14/21 Audit report	In terms of the long term high priority recommendations, it would be beneficial to receive more narrative on the reason why there appears to be no progression in clearing

		CLOSED
COMPLETED **01-Jun-17** **Update provided at meeting.**	**Director of Operations**	
COMPLETED **01-Jun-17** **Revised plan and comments circulated to Members on 4 April 2017**	**Head of Internal Audit**	
COMPLETED **01-Jun-17**	**External Audit**	
COMPLETED **01-Jun-17** **Report is included in IA reports: Item 3.1g**	**Board Secretary**	
COMPLETED **07-Dec-17**	**Wales Audit Office**	
COMPLETED **14-Sep-17** **COMPLETED**	**Board Secretary**	
14-Sep-17	**Board Secretary**	
COMPLETED		

COMPLETED	**Executive Director of Finance and Deputy Chief Executive Officer**
03-Oct-17	Board Secretary
COMPLETED **Information e-mailed to Members of Committee on 18 September 2017**	Deputy Director of Finance
COMPLETED 07-Dec-17	Wales Audit Office
COMPLETED A full update on this area is being included within the December 2017 Losses and Special Payments Report. **On Agenda**	Deputy Director of Finance and Assistant Director of Operations
COMPLETED 07-Dec-17	Director of Quality, Safety and Patient Experience
COMPLETED 07-Dec-17	Director of Quality, Safety and Patient Experience
COMPLETED	

07-Dec-17	Corporate Governance Manager
COMPLETED 07-Dec-17	Board Secretary
COMPLETED 07-Dec-17 **COMPLETED**	Board Secretary
07-Dec-17	Board Secretary and Counter Fraud Manager
COMPLETED 08-Mar-18	Deputy Director of Finance
COMPLETED 31-Jan-18 **COMPLETED**	Deputy Director of Finance
Circulated to Committee on 1 March 2018 08-Mar-18	Deputy Director of Finance
COMPLETED 08-Mar-18	Assistant Director of Operations
To be monitored through FRC	

08-Mar-18	Assistant Director of Operations
COMPLETED 08-Mar-18 Note: Extract from CRR: 'Following further review by CEO and Director of Operations and consultation with blue light partners the consequence of risk has been adjusted to reflect consistent approach and assessment of risk by all partners'. **COMPLETED** Meeting arranged between Claire Bevan & Patsy Roseblade for 31 January 2018 to discuss/agree a way forward - **COMPLETED**	Assistant Director of Quality, Governance and Assurance
08-Mar-18 **COMPLETED** Verbal update will be provided	Board Secretary
COMPLETED 24-May-18	Head of Internal Audit
COMPLETED 13/09/2018 This action was completed with an e-mail to Pam Hall from Jill Gill on 29/05/18 **COMPLETED**	Financial Accountant

A Task and Finish group was created and met for the first time in July 2018. Since then a significant amount of work has been undertaken in this area and the group is on target to complete the implementation by the end of September 2018.	Interim Director of Finance and ICT
A paper was taken to FRC on 5th July outlining progress on the implementation of the new asset register system, as this item had been referred to FRC from AC. This confirmed implementation to due to completed by Sept / Oct 2018, well in advance of both the 2018/19 financial year end and any planned interim 2018/19 audit by WAO. **COMPLETED**	
13/09/2018 This related to the financial benefit likely to be seen following the significant increase in rest break compliance. This will be picked up by FRC as part of the overall scrutiny and monitoring of the 2018/19 financial position.	Interim Director of Finance and ICT
6 December 2018 Further update to be provided by KC regarding Audit Committee actions from Health Boards. Matter to be raised at the next JET meeting **COMPLETED - ON AGENDA**	Board Secretary
13/09/2018 Response will form part of the Audit Recommendation report on the Agenda. **COMPLETED**	Board Secretary
Ongoing until further information received **Note: Due for discussion at EMT on 5 December 2018 Update to be provided on 7 March 2019** **COMPLETED**	Director of Workforce and Organisational Development
Confirmation that all actions have been completed	Director of Operations
Update to be provided on 7 March 2019 **COMPLETED**	
The Corporate Governance Manager confirmed policy development was underway and would inform Committee of progress **Update to be provided on 7 March 2019**	Corporate Governance Manager and Clinical Directorate

The final draft Policy is being submitted to Medicines Management Group on the 25th February and then to Corporate Governance Manager to commence the process through to approval. **COMPLETED**	
Update to be provided on 7 March 2019 COMPLETED	Director of Workforce and OD
Ongoing **COMPLETED**	Director of Partnerships and Engagement
Formal update to be provided on 7 March 2019 - On Agenda On Agenda **COMPLETED**	Chief Executive
This has been picked up as part of the Health Board Areas/Station Review audit and the report is on the Agenda for the meeting on the 7th March. On Agenda **COMPLETED**	Corporate Governance Manager
On Agenda for 7th March 2019 ITEM ON AGENDA **COMPLETED**	Corporate Governance Manager
Update on progress: 23/05/2019 On Agenda under procedural matters	Board Secretary COMPLETED
Circulated to Members on 3 April 2019	Head of Internal Audit
23/05/2019 **COMPLETED**	Interim Director of Finance and ICT
Update report on progress 12 Sep 2019 - Detailed report at Item 1.3ci COMPLETED	Interim Director of Operations
Deferred to 12 Sep 2019 COMPLETED	Interim Director of Operations
Completed - superceded by Dual Pin roll out and new guidance circulated widely.	Corporate Governance Manager
Completed - on tracker	Corporate Governance Manager
26/11/2019 COMPLETED	Judith Bryce
05/12/2019 COMPLETED	Lee Brooks
COMPLETED	Pam Hall

05/12/2019 Formally handed over to the F and P Committee and discussed at its last meeting COMPLETED	Martin Turner
Understood that Martin Woodford has spoken to TU Board Reps and agreed that they will be included in some of the sessions planned as part of Board Development but that it would not be appropriate to include them in all. We are just at the point of awarding the contract to our preferred supplier now.	Claire Vaughan
Complete. New column included on the tracker	Julie Boalch
Complete. New column included on the tracker	Julie Boalch
Complete. The 20/21 Audit Plan was deferred by Trust Board until 30th June 2020. A revised plan is on the Agenda for approval.	Julie Boalch
I have spoken to the team undertaking the review of WHSSC to understand whether the scope of the review could have implications for WAST. The team have assured me that they have not identified any connection between the scope of the review and the services provided by WAST. The focus of the review is the governance of the WHSCC, and the team are not looking at individual commissioned services. However, if members have any further questions about this review the team will be more than happy to respond, so please feel free to get in touch. (Fflur Jones)	Fflur Jones
Complete.	Julie Boalch
21/05/2020 - On Agenda	Carl Window
Deferred to September 2020 Committee in agreement with the Chair. Complete and on Agenda	Julie Boalch

A new tab is being developed for inclusion on the tracker to describe external reports and which Committee they are assigned to for oversight. Due September 2020. Complete and on Agenda	Julie Boalch, Keith Cox
CT and CR discussed on 4 June. Agreed that current AC losses payments paper be enhanced to include some themes and lessons learnt from significant cases and spend. To be introduced from Sept 2020 with a consistent report to go to both QUEST and AC.Expected initial update of this, based on "deep dives" into certain areas of such spend, for September meetings. Actual finance report to remain similar to previous, to then be enhanced with deep dive themes, trends and lessons learnt in key areas as included.	Chris Turley, Claire Roche
CPD hours as part of paid contracted hours is not an express term of the employment contract (which is an all Wales) but is implied into the contracts of eligible staff as part of a collective agreement reached with Trade Union Partners back in 2014 during reviews of rostering arrangements. It has not explicitly been discussed at People and Culture Committee as yet, but P and C will consider progress against the actions in the IA plan as they relate to the CPD Audit at its next meeting. Due to timing of scheduled meetings, the People & Culture Committee will take a more detailed update on actions against the audit recommendations at its meeting in November 2020. However, a separate meeting between the Executive Director of Workforce & OD and People & Culture Committee NEDs is scheduled for 7 September 2020 to review the actions in advance of Audit Committee and receive an interim update of progress.	Claire Vaughan
To be included on agenda for July meeting of FPC - Approach confirmed at July FPC, report presented at FPC on 15th September	Chris Turley

03-Dec-20	Carl Window
Carl Updated the Committee adding that an update would be provided to the Committee prior to the next meeting scheduled for 3 June 2021	Carl Window
COMPLETED	Carl Window
26/05/21 Completed	Julie Boalch
16/08/21: This action can be closed from the log as the Risk Management Strategy review forms part of a larger programme of risk management work being undertaken. This will be presented to Audit Committee in due course. Project Risks will be considered as part of that programme of work.	Julie Boalch
16/08/21: Complete. Forms part of the Executive Summary report.	Julie Boalch
16/08/21: Complete. Deep dive has been undertaken to review all older recommendations. The process will be set down in an Internal Audit Handbook which is in development by the Corporate Governance Team.	Julie Boalch
NB. F and P Committee would now be monitoring this action	

Discussed at F&PC on 22nd July where Andy H, by way of a PowerPoint presentation, illustrated in more detail the reasons for the limited assurance audit review which was specifically around business continuity plans and the backup and recovery of data. The findings from the review included the requirement to have an effective audit trail and a formal policy/procedure for backup processes. A mapping exercise had started and the Committee noted that the key issues raised by the review from an operations perspective should be completed by September with the policy being drafted by October 2021. In terms of the other areas of concern these should be completed by April 2022. F&PC noted the mapping exercise and the dates of projected completion and it was agreed that Andy Haywood would provide the formal response to the Audit Committee	Andy Haywood
14/08/21: Complete and on Agenda as part of the Audit Recommendations Report	Julie Boalch
14/08/21: Complete and on Agenda as part of the Audit Recommendations Report	Julie Boalch

Register number	**Document Name**	**in Connection with**	**Between**	**and**	Date
192	Lease of Premises	Lease of premises, Wrexham, Gwynedd and Glan Clwyd hospitals to house Omnicell cabinets	BCUHB	Welsh Ambulance Services NHS Trust	Dec-18
193	Lease of Premises	Lease of Premises, University Hospitals of Llandough and Wales	Cardiff and Vale HB	Welsh Ambulance Services NHS Trust	Dec-18
194	lease	Omnicel Cabinets	Cwm Taf HB	Welsh Ambulance Services NHS Trust	Jan-19
195	Lease of Premises	Lease of Premises, Prince Phillip, Glangwilli, Withybush and Bronglais hospitals	Hywel Dda HB	Welsh Ambulance Services NHS Trust	Dec-18
196	Deeds of Appointment	Matrix one	Lawray and Mcanns	Welsh Ambulance Services NHS Trust	Feb-19
197	Lease	Lease of premises, Barry Fire Station	South wales Fire and rescue	Welsh Ambulance Services NHS Trust	Feb-19
198	Deed of Lease	Matrix one			Mar-19
199	Lease of Premises	Lease of Premises for Omnicell Cabinet	WAST	ABULHB	Mar-19
200	Lease of Premises	Morriston Hospital to house omnicell cabinets	Swansea Bay UHB	Welsh Ambulance Services NHS Trust	Apr-19
201	Lease of premises	Lease of premises at Prince Charles, Royal Glamorgan and Princess of Wales hospitals to house Omnicel cabinets	Cwm Taf HB	Welsh Ambulance Services NHS Trust	Apr-19
202	Alterations	Alterations and improvements carried out at Colwyn Bay Ambulance Station	WAST		Jul-19
203	Alterations	Alterations and works improvements to Bryn Tirion Control Centre	WAST		Jul-21
204	Land Registry	sale of Llanidloes station	WAST	Kevin Jones Cars	Jul-19
205	Lease of premises	Lease of Premises at Royal Gwent to house Omnicel cabinets	Aneurin Bevan Health Board	WAST	Aug-19
206	Contract for sale	Freehold Land sale of WAST HQ HM Stanley, St Asaph	WAST	Cartreffi Conwy	Sep-19
207	Lease of Land	Area B HM Stanley	Landlord: WAST	Tennant: St Kentigern	Sep-19
208	Warranty	Sub Contractors warranty work	WAST	Town and Country Electricals	Nov-19
209	Warranty	Sub Contractors warranty work	WAST	Kimpton energy Solutions	Nov-19
210	Counterpart Lease	Units 32 and 33 Gelli Industrial Estate	WAST	PROPCO 2 SARL	Nov-19
211	Transfer of Title	Disposal of Llantwit Major Ambulance Station	Transferor WAST	Transferee, Jane Forshaw Ltd	Feb-20
212	Building Contract	Works contract for Bangor workshops			Apr-20

213	Building Contract	Works contract for Welshpool			Apr-20
214	Building Contract	Works contract for Llanwrst			Apr-20
215	Lease Renewal	Unit 1 the Courtyard, D'arcy Business Park	Coed D'Arcy Ltd	Welsh Ambulance Services NHS Trust	Oct-20
216	Building Contract	For Cardiff Make Ready Depot	John Weavers - Contractors	Welsh Ambulance Services NHS Trust	
217	Lease	License for alterations relating to Unit B5, Porthmadog	Welsh Ministries	Welsh Ambulance Services NHS Trust	Nov-20
218	Transfer	Transfer of Title, Nelson Ambulance Station	Transferor, WAST	United Welsh Housing Housing Association Ltd	Dec-20
219	Lease Renewal	Lease renewal relating to Unit 1A Spring Meadow Business Park, Cardiff	Sunflower UK	Welsh Ambulance Services NHS Trust	Jan-21
220	Lease renewal	Lease renewal relating to Unit 43 Court Road Industrial Estate, Cwmbran	Pro Investments Ltd	Welsh Ambulance Services NHS Trust	Jan-21
221	Title	Transfer of Title relating to Bassaleg Mortuary	Transferor: Newport City Council	Transferee WAST	Feb-21
222	Lease	Refurbishment of works to Matrix	Jacrington Properties Ltd	Welsh Ambulance Services NHS Trust	May-21
223		Refurbishment to Aberaeron ambulance station	Welsh Ambulance Services NHS Trust	Mr Edmunds Webster	May-21
224	Lease	Lease agreement to Matrix House ground floor			Jul-21
225	Lease	License for alterations (Minor Works) relating to part of basement, ground floor and first floor in VPH, between Vantage Point Business Park and WAST	Vantage Point Business Park Limited	Welsh Ambulance Services NHS Trust	Nov-21
226	Lease	Lease Hywel Dda and WAST. Old garage site to Amb Station – Aberaeron			Nov-21
227	Lease	Lease – License for Alteration , part of Aberaeron site			Nov-21
228	Transfer of part of registered title	Disposal of land at Wrexham to BCUHB The disposal of land at Wrexham to BCU HB was agreed under the project which procured the Ambulance and Fire Services Resource Centre (AFSRC) in Wrexham. A public right of way passes in to the hospital car park adjacent to the land in question. The delay in completing this land transaction reflects the complicated nature of the title to the land. The Trust Board approved the Full Business Case for AFSRC Wrexham on 20 March 2014 and Welsh Government confirmed approval of the FBC in May 2014	BCUHB	Welsh Ambulance Services NHS Trust	Dec-21
229	Lease renewal	Aberdare Ambulance Station and Caernarfon Ambulance Station	Prudential Assurance Company	Welsh Ambulance Services NHS Trust	Dec-21
230	Resilience Works and Internal Alterations	Ty Elwy	WAST	Reed Construction	Jan-22
231	Transfer of Title	Units 2 and 3 Triangle Business Park, Merthyr Tydfil	WAST	Kascu Up Ltd	Feb-22

AGENDA ITEM No	**5**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**5**

COMMITTEE EFFECTIVENESS REVIEW 2021/22

MEETING	Audit Committee
DATE	3rd March 2022
EXECUTIVE	Martin Turner, Chair
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Trust's Standing Orders and Committee Terms of Reference require that Board Committees evaluate their effectiveness annually and prepare an annual report to the Trust Board.

2. The 2021/22 Committee effectiveness reviews provides for a number of stages before the Committee's annual report is presented to the Trust Board. The first two stages of evaluation design and process are complete, and the Committee will now review proposed amendments to the terms of reference and consider the responses to the NHS Wales Audit Committee Handbook self-assessment and the Audit Committee participants' questionnaire.

3. Amendments have been proposed to the terms of reference for the Committee's consideration, as well as changes to operating arrangements as a results of the review and the responses to the Audit Committee Handbook self-assessment and the questionnaire sent to members and core attendees.

RECOMMENDATION: The Committee is requested to:

(a) Review and approve changes to terms of reference
(b) Consider the issues raised in both the participants' questionnaire and the NHS Wales Audit Committee Handbook self-assessment
(c) Set priorities for the Committee for 2022/23

REPORT APPROVAL ROUTE

Executive Management Team – 16th February 2022

REPORT APPENDICES
1. Annex 1 – SBAR 2. Annex 2 – Proposed changes to terms of reference (marked up) 3. Annex 3 – Proposed changes to terms of reference (clean) 4. Annex 4 – Participants' questionnaire responses 5. Annex 5 – NHS Wales Audit Committee Handbook questionnaire self-assessment

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

Annex 1

COMMITTEE EFFECTIVENESS REVIEW 2021/22

SITUATION

1. The 2021/22 Committee effectiveness reviews provides for a number of stages before the Committee's annual report is presented to the Trust Board. The first two stages of evaluation design and process are complete, and the Committee will now review proposed amendments to the terms of reference and consider the responses to the evaluation questionnaire.

BACKGROUND

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 the Code of Governance provide that Boards should routinely assess the effectiveness of their governance arrangements, of which the Board's Committees form an integral part. Each Committee must submit an annual report to the Board through the Chair setting out its activities during the year and including the review of its performance.

4. The 2020/21 effectiveness review for the Committee includes a review of the terms of reference and general operating arrangements, completion of the NHS Wales Audit Committee Handbook self-assessment, as well as a questionnaire completed by members and core attendees. Any amendments to Terms of Reference as a result of this process is thereafter recommended to the Trust Board for approval.

ASSESSMENT

5. Committees play an important role in supporting the Board fulfilling its responsibilities by:

    - Providing advice on strategic development and specific aspects of business
    - Gaining assurance on key aspects of activity in organisational performance, supporting achievement of the Trust's strategic goals
    - Carrying out specific responsibilities on the Board's behalf

6. The Audit Committee is the primary Committee to provide assurance to the Board on the Trust's systems of risk, assurance, and internal controls. To ensure the Committee is in the best position possible to provide this support in a streamlined and integrated way, the approach for review of a Committee's operating arrangements is carried out annually in the following stages:

Stage	Process
Stage 1: Evaluation Design	• Questionnaires for the Board Committees are developed by the Board Secretary in consultation with the Committee Chairs and Executive Leads.
Stage 2: Evaluation Process	• Questionnaires are issued to Committee members and core attendees as set out in the Terms of Reference. • For Audit Committee, an additional self-assessment of how the Committee meets the requirements of the NHS Wales Audit Committee Handbook is undertaken by the Committee Chair, Executive Lead and Board Secretary. • Committee Chair, Executive Lead, Governance Officer and Board Secretary review questionnaires (participants' survey and Audit Committee Handbook self-assessment), review Terms of Reference and propose initial amendments. • Responses are collated and this report summarises the findings and includes proposed recommendations to address issues raised.
Stage 3: Discussion and actions	• The proposed amendments to the Terms of Reference and the responses to the questionnaires are discussed by the Committee.
Stage 4: Presentation to Trust Board	• Any changes to the Terms of Reference and operating arrangements are recommended to the Trust Board together with the Committee's annual report.

7. The Committee Chair, Executive Lead, Head of Risk and Corporate Governance (in the absence of the Board Secretary on annual leave), and Corporate Governance Officer met for stage 2 on 3rd February 2022. The Terms of Reference were reviewed to ensure all matters within the remit of the Committee were clear and that these were articulated with the strategic, oversight and scrutiny role of the Committee in mind. This was also an opportunity to begin building the cycles of business of the Committee aligned to the specific areas of delegated powers. The proposed amendments to the Terms of Reference are attached at Annex 2 in a tracked changes version, and Annex 3 as a clean version.

8. The majority of the proposed changes to the Terms of Reference are contained within sections 3 and 4, however key changes include:

8.1 The addition of oversight of declarations of interests, and the register of gifts and hospitality, as well as arrangement as the bailee for patients' property. These additions are also set out in the Standing Orders and Standing Financial Instructions.

8.2 The Quality, Patient Experience and Safety Committee (QuEST) includes oversight of clinical audit in their Terms of Reference, as follows:

Approve the annual 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.

QuEST also includes oversight of information governance and information security, with their amended Terms of Reference being expanded to provide they will:

(a) *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.*

(b) *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.*

(c) *Receive assurance on, and review effectiveness of the Trust's information security protocols.*

(d) *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.*

Oversight responsibility for both clinical audit and information governance and information security have been omitted from the Audit Committee's Terms of Reference. Given that both responsibilities are contained in the NHS Wales Audit Handbook model terms of reference for Audit Committees, the Committee is requested to approve the omission.

8.3 Proposed membership changes in paragraph 4.4 will strengthen Executive representation at the Committee. It is proposed to add the Executive Director of Workforce and Organisational Development and Executive Director of Workforce and Organisational Development as core attendees of the Committee.

9. Questionnaires were sent to members and core attendees, as well as a self-assessment checklist which was completed by the Chair and Executive Lead as recommended by the NHS Wales Audit Committee Handbook.

10. Eleven questionnaires were distributed to the members and core attendees of the Committee, and 4 responses were received (36% response rate), with 2 being completed by members and 2 by attendees. Thirteen questions were asked covering issues such as the effectiveness of the Committee, its boundaries with other Committees of the Trust, management and administration of meetings, and views on areas for improvement. The responses are set out at Annex 4, however key items are set out below together with proposed action to address them:

Issues raised	Commentary
Are boundaries between this Committee and others is well define?	• One responded raised the relationship of the Audit Committee to the Board and whether assurance from the Audit Committee to the Board is considered appropriate in all instances or whether the Board should require further assurance for itself rather than reliance on the Audit Committee view. **Action**: The Board is free to seek additional assurance at any point, however the revised BAF, amended Committee terms of reference and cycles of business will provide strengthened line of sight of assurance for the Audit committee.
Unnecessary duplication, overlap or gaps?	Respondents noted: • Further work around coordinating lessons learned throughout the Trust to provide assurance to the Non-Executive Directors. Evident following the number of discussions that have been held at Audit Committee on the losses and special payments item in particular **Action**: The terms of reference of all committees have been strengthened to include lessons learned and with a focus on continuous improvement; the board secretary attends all committee meetings and will assist in ensuring actions are appropriately transferred to other committees and fed back to the initiating committee, which should reduce duplication. • Should the Chair of Audit Committee attend each of the other committees on an annual basis to view how the committee operates and to seek assurance that their scrutiny is of an appropriate level **Action**: The Chair of Audit Committee can be provided with invitations to Committee meetings throughout the year.
Is the committee adequately supported by Executive Directors in terms of attendance, quality and length of papers and responses to challenges/questions?	• One respondent noted that attendance from Executive Directors is sometimes less that they would like, noting it did not feel like the committee is a priority for all Execs. In other organisations Audit Committee is the key committee for the Executive Team in terms of governance and probity. **Action**: The terms of reference for the Committee have been strengthened to increase Executives for WOD and clinical as core attendees.
Committee's effectiveness/ suggestions for improvement	Respondents noted: • Quality of papers support the effectiveness of the Committee. They can then be taken as read which leads to more focussed discussion on the key matters. • Consider seeking wider attendance at committee from others in teams to present, etc; If handled right this could be a good, positive experience for many. • As soon as possible, and safe to do so, to move back to meeting face to face meetings. • To be clear when the Trust is not pursuing audit recommendations and why. Understanding the risks associated with each audit

	recommendation and being clear of the level of risk the Trust is willing to bear. **Actions**: - As agreed at Board Development in October, presenters should take reports as read, leaving more time for discussion. - Whilst Executive attendance at Audit Committee is the standard, the shadow board programme could include provision for other members of the team to attend. - Face to face meetings will commence as soon as possible and the Board will be notified of arrangements for Board and Committees in that respect. - The audit tracker includes rationale for changes in audit recommendations which is agreed at the Audit Committee and approved by internal audit.

11. The self-assessment checklist was completed by the Chair, Executive Lead and the Head of Risk and Corporate Governance on 3rd February 2022 is attached as Annex 5.

12. Of the 85 questions, 51 are categorised as "must do" requirements, 25 as "should do", and nine questions as "could do". Of the 51 categorised as "must do", the Committee met this requirement on 45 occasions. The six occasions where the view was that the 'must do' requirement was not met are set out in the table below together with action to address them:

Question	Commentary
9. Are new members provided with induction?	• No current formal induction provided separately for Audit Committee. Informal discussions would be held with the Chair, other members and Executive Directors and other attendees. **Action**: This will be included in the overall new Board member induction programme which will be in place by mid March 2022.
19. Does the Committee review assurance and regulatory compliance reporting processes?	• This was answered no. **Action**: The new cycles of business which will be developed for each Committee will build a legislative and regulatory framework which will assist the Audit Committee to review assurance in this regard.
23. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?	• The Committee is assured with respect to standards compliance for finance, but not with respect to performance management. **Action**: The Finance and Performance Committee will monitor the Quality and Performance Management Framework and its implementation.
28. Has the Committee reviewed the robustness of the data behind reports and assurances received by itself and the Board?	• More work to be done in performance management and planning for e.g., regulatory frameworks around finance are excellent. **Action**: QuEST has strengthened assurances in its terms of reference regarding information governance and information security.

59. Does the Committee hold periodic private discussions with the Auditor General's representatives?	• Would if required. **Action**: Regular meetings will be incorporated into the cycle of business.
80. Does the Committee receive and review a draft of the organisation's Annual Governance Statement?	• **Action**: The timetable for the production of the annual report will provide for circulation of the draft AGS to the Board

13. 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 new issues it is adopting in its Terms of Reference; focus on areas it may not have addressed recently due to the pandemic; or review of the Committee's risks, both operational and strategic. It is recommended that such priorities are limited to two or three, and that they are tracked quarterly through a Chair's report to ensure they are on track. The Committee may wish to focus on the following priorities in 2022/23:

- Develop an induction programme for new Audit Committee Members; and
- The transformation of risk management and the Board Assurance Framework

RECOMMENDATION

14. The Committee is requested to:

(a) **Review and approve changes to Terms of Reference;**
(b) **Consider the issues raised in both the participants' questionnaire and the NHS Wales Audit Committee Handbook self-assessment; and**
(c) **Set priorities for the Committee for 2022/23.**

NEXT STEPS

15. Next steps includes the following:

15.1. A Committee Annual Report will be prepared for the July Trust Board setting out:

(a) Remit of the Committee
(b) Membership and attendance
(c) Effectiveness of the Committee (as a result of discussions from today's meeting)
(d) Proposed changes to the terms of reference and operating arrangements
(e) Priorities identified for the Committee for 2022/23

This report will be presented for approval at the 7th June 2022 meeting of the Committee and will also be considered in the round with all other Committee Annual Reports by the Chairs Working Group in May.

15.2. A key output of the discussions with the Chair, Executive Lead, Committee members and attendees, and the self-assessment questionnaire, is a cycle of committee business/programme of work for the Committee. This cycle of business will provide certainty on papers to be developed for upcoming Committees but will also clarify the assurance requirements aligned to the responsibilities of the Committee. The cycle of business will also provide a line of sight for the assurance journey of papers prior to their presentation at committees and will support the development of a legislative and regulatory framework where that is appropriate and applicable.

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

AUDIT COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

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 **Audit Committee**. 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 The purpose of the Audit 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 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.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- 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 Quality Statement, providing reasonable assurance on:

  - the organisation's ability to achieve its objectives.~~;~~
  - compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and

requirements set by the Welsh Government and others;.
- the efficiency, effectiveness and economic use of resources; and
- 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:;

- 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
- 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.;
- the Schedule of Losses and Special Payments
- the register of Single Tender Actions
- the planned activity and results of internal audit, external audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports).;
- the adequacy of executive and management's response to issues identified by audit, inspection and other assurance activity.;
- proposals for accessing Internal Audit services via Shared Services arrangements (where appropriate).;
- anti-fraud policies, whistle-blowing processes and arrangements for special investigations; ~~and~~
- any particular matter or issue upon which the Board or the Accountable Officer may seek advice.
- the adequacy of the arrangements for Declarations of Interests, providing an annual report to the Board to this effect.
- 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:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and the Annual Quality Statement) together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.;
- 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.;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

- 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:

- 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
- 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:

- 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;
- 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.;
- 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.;
- 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.;
- 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.;
- the systems for financial reporting to the Board, including those of budgetary control, are effective.;
- 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.~~;~~

- monitor progress against the requirement of the Auditors' Management Letter.~~;~~
- receive and review key Trust Annual Reports ~~e.g.~~e.g., Trust Annual Report, Infection Control Annual Quality Statement; Annual Governance Statement and make recommendations to the Board for their adoption; and
- 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 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~~ 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 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 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.

Access

3.10 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 Audit Committee.

3.11 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.

3.12 The Chair of Audit Committee shall have reasonable access to Directors and other relevant senior staff.

Sub Committees

3.13 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 Audit Committee.

Attendees

4.4 The core membership will be supported routinely by the attendance of the following:

- Executive Director of Finance and Corporate Resources
- Board Secretary
- Head of Internal Audit
- Director of Operations
- Executive Director of Workforce & Organisational Development
- Executive Director of Quality and Nursing
- 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) should be invited to attend at least annually to discuss with the Committee the process for assurance that supports the Annual Governance Statement and the Annual Quality Statement.

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.

4.12 The Board Secretary, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- 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 Workforce & Organisational Development.

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:

- joint planning and co-ordination of Board and Committee business; and
- 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:

- 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;
- bring to the Board and the Chief Executive (Accountable Officer's) specific attention any significant matter under consideration by the Committee; and
- 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 Quality Statement, 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.

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
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AUDIT COMMITTEE

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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.

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(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 Quality Statement, 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 Quality Statement) 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.

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(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; 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.

(b) 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.

(c) 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.

(d) 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.

(e) the systems for financial reporting to the Board, including those of budgetary control, are effective.

(f) 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.

(g) monitor progress against the requirement of the Auditors' Management Letter.

(h) receive and review key Trust Annual Reports e.g., Trust Annual Report, Infection Control Annual Quality Statement; Annual Governance Statement and make recommendations to the Board for their adoption.

(i) review the content of the Corporate Risk Register and obtain assurance that control measures are in place to mitigate all identified risks.

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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.

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4. MEMBERSHIP

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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 Audit Committee.

Attendees

4.4 The core membership will be supported routinely by the attendance of the following:

- Executive Director of Finance and Corporate Resources
- Executive Director of Workforce & Organisational Development
- Executive Director of Quality and Nursing
- Director of Operations
- Board Secretary
- 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) should be invited to attend at least annually to discuss with the Committee the process for assurance that supports the Annual Governance Statement and the Annual Quality Statement.

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:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- 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 Workforce & Organisational Development.

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:

- joint planning and co-ordination of Board and Committee business; and
- 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 Quality Statement, 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.

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AUDIT COMMITTEE - PARTICIPANTS' QUESTIONNAIRE

SITUATION

1. The Trust's Standing Orders require Committees to annually review their effectiveness. An agreed key strand of the 2021-22 work was for each Committee to undertake a survey of the views of its participants.

BACKGROUND

2. Anonymous self-assessment questionnaires were issued to the eleven members and attendees of the Audit Committee (as listed in the Board approved terms of reference) by the Corporate Governance team on 15 December 2021.

3. Colleagues were asked thirteen questions.

4. Four questionnaires were completed by the survey closure date of 14 January 2022 (36% response rate).

ASSESSMENT

5. Set out below are the responses to each of the thirteen questions.

   Do you believe this committee is effective in fulfilling its scrutiny and assurance role on behalf of the Board?

6. All four responders answered yes to the question. One responder added that this was achieved "through a variety of mechanisms supported by internal management, internal and external audit". A second responder added "the committee is chaired effectively and there is an appropriate depth of scrutiny on items presented to the committee."

   Are you satisfied that boundaries between this committee and other committees are clearly defined with adequate cross referral is required.

7. Three responders answered yes to the question with one adding that the Committee "is clear of its overall responsibility but also ensures it holds other committees to account when actions/scrutiny has been passed to them. The only grey area I feel is the relationship of the AC to the Board and whether assurance from the AC to the Board is considered appropriate in all instances or whether the Board should require further assurance for itself rather than reliance on the AC view."

8. One colleague commented that the position was "improving" and that "some good examples of cross committee referrals and feedback over the recent

past. Some areas (e.g. lessons learnt from losses and special payments) are still a bit mixed and cross over (in this example) QUEST."

Following the question above, are there any unnecessary duplication, overlap or gaps?

9. One responder stated that they were not able to comment as they were not familiar with other committee full remits, whilst a second referred back to their answer to the previous question.

10. Of the two remaining responses one colleague commented that "perhaps some further work around coordinating lessons learned throughout the Trust to provide assurance to the NEDs. Evident following the number of discussions that have been held at Audit Committee on the losses and special payments item in particular." The second area for comment was that "perhaps the Chair of AC should attend each of the other committees on an annual basis to view how the committee operates and to seek assurance that their scrutiny is of an appropriate level."

    Do you consider that where closed meetings are held that these have been used appropriately for items that should not be discussed in the public domain, i.e. commercially sensitive or identifiable?

11. All four responders answered yes to the question. One responder noted "that there are limited items than come to this committee in closed session, usually just 2 - the Counter Fraud update and details of tenders issued and awarded alongside STWs."

    Are meetings appropriate in length given the business it has to cover?

12. All four responders answered yes to the question. One responder added that "the agenda is well managed in my view".

    Is the atmosphere at committee meetings conducive to open and productive debate?

13. All four responders answered yes to the question. One responder added that the meetings were "well-structured and prepared, but with openness and support to open discussion", whilst a second colleague commented "supportive but challenging as appropriate".

    Is sufficient time allowed for questions, discussion and debate?

14. All four responders answered yes to the question. One responder added "usually".

    Is each item closed off with clarity on the decision and outcome of discussion?

15. All four responders answered yes to the question

Is the committee adequately supported by Executive Directors in terms of attendance, quality and length of papers and responses to challenges/questions?

16. Three colleagues answered yes to this question with one adding that the Committee was “well attended and the papers provided are of good quality.”

17. In contrast, one responder commented that “this can be a bit mixed. Attendance from EDs is sometimes less that I would like. It doesn't feel like the committee is actually seen as a priority for all Execs. In other orgs I have been in, AC is THE key committee for the Exec Team in terms of governance and probity.”

Are meetings chaired effectively with clarity and purpose and outcome?

18. All four responders answered yes to the question

Do you need additional training to fulfil your role as a member or attendee of the audit committee?

19. Three colleagues responded no to this question with one colleague adding that “I don't think so, but would always welcome such opportunities”.

Do you have any general comments about the committee's effectiveness that you wish to make?

20. Two colleagues stated that they had no additional comments to those already made. One responder stated that the “quality of papers support the effectiveness of the Committee. They can then be taken as read which leads to more focussed discussion on the key matters.” The second area for comment was that “we should consider seeking wider attendance at committee from others in teams to present, etc. I know previous attendees have not always been in favour of this (given the nature and connotations of this committee - to be "called to account to AC") etc but I think this would be helpful, for the committee and in many ways a good opportunity for those who are asked to do so. If handled right this could be a good, positive experience for many.”

If you have two suggestions for improvement what would they be?

21. Two comments were received on this question. The first was “as soon as possible, and safe to do so, to move back to meeting face to face meetings.” The second comment was to be “clear when the Trust is not pursuing audit recommendations and why. Understanding the risks associated with each audit recommendation and being clear of the level of risk the Trust is willing to bear.”

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NHS WALES AUDIT COMMITTEE SELF ASSESSEMENT CHECKLIST 2021/22

Ques No.	Status Key 1 = Must Do 2 = Should Do 3 = Could Do	Issue	Yes	No	N/A	Comments/Action
Section 1 - Composition, Establishment and Duties						
1	1	Does the Audit Committee have written terms of reference that adequately define the Committee's role in accordance with Welsh Government guidance?	☑			
2	1	Have the terms of reference been adopted by the Board?	☑			
3	1	Are the terms of reference reviewed annually to take into account governance developments (including good governance principles) and the remit of other committees within the organisation?	☑			
4	1	Has the Committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?	☑			
5	2	Are changes to the Committee's current and future workload discussed and approved at Board level?	☑			
6	1	Are Committee members independent of the management team?	☑			
7	1	Does the Committee report regularly to the Board?	☑			
8	1	Has the Chair of the Committee a prior understanding of, or received training in, finance and internal control or other relevant expertise?	☑			
9	1	Are new members provided with induction?		☑		No current formal induction provided separately for AC. Informal discussions would be held with the Chair, other members and Exec and other attendees.
10	1	Does the Board ensure that members have sufficient knowledge of the organisation's	☑			NEDS attendance at Board and BDD to get the breadth of the business

Ques No.	Status Key 1 = Must Do 2 = Should Do 3 = Could Do	Issue	Yes	No	N/A	Comments/Action
		business to identify key risk areas and to challenge both line management and the auditors on critical and sensitive matters?				
11	1	Does the Committee prepare an annual report on its work and performance in the preceding year for consideration by the Board?	☑			
12	1	Does the Committee assess its own effectiveness periodically?	☑			
Section 2 - Meetings						
13	1	Has the Committee established a plan of matters to be dealt with across the year?	☑			In line with contents of ToR and process in place A number of business matters externally prescribed, e.g MFA and AC also approves annual plans for IA, CF, etc The documented cycle of business is being developed
14	1	Does the Committee meet sufficiently frequently to deal with planned matters and is enough time allowed for questions and discussions?	☑			
15	1	Does the Committee's calendar meet the Board's requirements and financial and governance calendar?	☑			
16	2	Are Committee papers distributed in sufficient time for members to give them due consideration?	☑			
17	2	Are Committee meetings schedules prior to important decisions being made?	☑			
18	2	Is the timing of Committee meetings discussed with all the parties involved?	☑			
Section 3 - Compliance with the law and regulations governing the NHS						
19	1	Does the Committee review assurance and regulatory compliance reporting processes?		☑		
20	3	Has the Committee formally assessed whether there is a need for the support of a	☑			

Ques No.	Status Key 1 = Must Do 2 = Should Do 3 = Could Do	Issue	Yes	No	N/A	Comments/Action
		"Company Secretary" role or its equivalent?				
21	3	Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?	☑			Audit Wales highlights these in each meeting
Section 4 - Internal Control and Risk Management						
22	1	Has the Committee formally considered how it integrates with other committees that are reviewing risk e.g. risk management and clinical governance?	☑			
23	1	Has the Committee formally considered how its work integrates with wider performance management and standards compliance?	☑	☑		Performance management no Standards compliance yes
24	1	Has the Committee reviewed the robustness and effectiveness of the content of the organisation's system of assurance?	☑			
25	1	Has the Committee reviewed the robustness and content of the draft Annual Governance Statement before it is presented to the Board?	☑			Yes, Audit Committee considered the draft AGS on 3/6/21
26	1	Has the Committee reviewed the robustness and content of the draft Annual Quality Statement before it is presented to the Board?			☑	Quality Statement not required in 2021/22
27	2	Has the Committee reviewed whether the reports it receives are timely and have the right format and content to enable it to discharge its internal control and risk management responsibilities?	☑			
28	1	Has the Committee reviewed the robustness of the data behind reports and assurances received by itself and the Board?		☑		More work to be done in performance management and planning for eg. Regulatory frameworks around finance are excellent
29	1	Is the Committee satisfied that the Board has been advised that assurance reporting is in place to	☑			

Ques No.	Status Key 1 = Must Do 2 = Should Do 3 = Could Do	Issue	Yes	No	N/A	Comments/Action
		encompass all the organisation's responsibilities?				
30	1	Is the Committee's role in reviewing and recommending to the Board the Annual Report and Accounts clearly defined?	☑			
31	1	Does the Committee consider the Auditor General's report to those charged with governance including proposed adjustments to the accounts?	☑			
32	1	Is there clarity over the timing and content of the assurance statements received by the Committee from the Head of Internal Audit?	☑			
Section 5 - Internal Audit						
33	1	Is there a formal 'charter' or terms of reference, defining Internal Audit's objectives, responsibilities and reporting lines?	☑			
34	1	Is the Charter or terms of reference approved by the Committee and regularly reviewed?	☑			
35	2	Are the key principles of the terms of reference set out in the Standing Orders/Standing Financial Instructions?	☑			
36	1	Does the Committee review and approve the Internal Audit plan at the beginning of the financial year?	☑			
37	1	Does the Committee approve any material changes to the plan?	☑			
38	2	Are audit plans derived from clear processes based on risk assessment with clear links to the system of assurance?	☑			
39	1	Does the Audit Committee receive periodic reports from the Head of Internal Audit?	☑			
40	1	Do these reports inform the Audit Committee about progress or delays in completing the audit plan?	☑			
41	3	Has the Committee established a process whereby it reviews any	☑			

Ques No.	Status Key 1 = Must Do 2 = Should Do 3 = Could Do	Issue	Yes	No	N/A	Comments/Action
		material objection to the plans and associated assignments that cannot be resolved through negotiation?				
42	2	Does the Committee effectively monitor the implementation of management actions from audit reports?	☑			
43	1	Does the Head of Internal Audit have a direct line of reporting to the Committee and its chairman?	☑			
44	2	Is internal audit free of any scope restrictions and, if not, what are they and who establishes them?	☑			
45	2	Is Internal Audit free from any operating responsibilities or conflicts that could impair its objectivity?	☑			
46	2	Has the Committee determined the appropriate level of detail it wishes to receive from Internal Audit?	☑			
47	1	Does the Committee hold periodic private discussions with the Head of Internal Audit?	☑			As and when required.
48	2	Does the Committee review the effectiveness of Internal Audit and the adequacy of staffing and resources within Internal Audit?	☑			HoIA report includes staffing changes.
49	2	Has the Committee evaluated whether internal audit complies with the NHS Wales Internal Audit Standards?	☑			
50	3	Has the Committee agreed a range of Internal Audit performance measures to be reported on a routine basis?	☑			
51	1	Does the Committee receive and review the Head of Internal Audit's annual report and opinion?	☑			
52	2	Is there appropriate cooperation with the Auditor General's representatives and inspectorate bodies?	☑			
53	2	Are there any quality assurance procedures to confirm whether the work of the Internal Auditors	☑			

Ques No.	Status Key 1 = Must Do 2 = Should Do 3 = Could Do	Issue	Yes	No	N/A	Comments/Action
		is properly planned, completed, supervised and reviewed?				
Section 6 - External Audit						
54	1	Do the Auditor General's representatives present their audit plans and strategy to the Committee for consideration?	☑			
55	2	Has the Committee satisfied itself that audit work not relating to the financial statements work is adequate and appropriate?	☑			
56	2	Does the Committee receive and monitor actions taken in respect of prior years' reviews?	☑			
57	2	Does the Committee consider the Auditor General's annual audit letter?	☑			
58	1	Does the Committee consider the Auditor General's use of resources conclusion?	☑			
59	1	Does the Committee hold periodic private discussions with the Auditor General's representatives?		☑		Would if required
60	2	Does the Committee assess the quality and effectiveness of external audit work (both financial and non-financial audit)?	☑			
61	3	Does the Committee require assurance from the Auditor General about the policies for ensuring independence and compliance with staff rotation requirements?			☑	
62	3	Does the Committee review the nature and value of non-statutory work commissioned by the organisation from the Auditor General?	☑			Audit Wales update the Committee at each meeting
Section 7 - Annual accounts and disclosure statements						
63	1	Is the Committee clear about where clinical audit assurances are received and monitored?	☑			This sits with the Quality, Patient Experience and Safety Committee
64	2	When the Audit Committee receives and monitors clinical audit assurances does it: • Review the clinical audit plan at the beginning of each year?		☑		This activity is currently the responsibility of QuESt Committee. ToR agreed by Trust Board in March 2019.

Ques No.	Status Key 1 = Must Do 2 = Should Do 3 = Could Do	Issue	Yes	No	N/A	Comments/Action
		• Confirm that clinical audit plans are derived from clear processes based on risk assessment with clear links to the system of assurance? • Receive periodic reports from the person responsible for clinical audit? • Effectively monitor the implementation of management actions from clinical audit reports? • Ensure that person responsible for clinical audit has a direct line of access to the Committee and its Chair? • Hold periodic private discussions with the person responsible for clinical audit? • Review the effectiveness of clinical audit and the adequacy of staffing and resources available for clinical audit? • Evaluate clinical audit against the Annual Delivery Framework? • Confirm that there are quality and safety assurance procedures in place to confirm whether the work of clinical auditors is properly planned, completed, supervised and reviewed? • Confirm that there are terms of reference for clinical audit that define its objectives, responsibilities and reporting lines? • Review clinical audit's terms of reference regularly?				
Section 8 - Counter Fraud						
65	1	Does the Committee review approve the counter fraud work plan at the beginning of the financial year?	☑			
66	1	Does the Committee satisfy itself that the work plan adequately covers each of the seven generic areas defined in NHS counter fraud policy?	☑			

Ques No.	Status Key 1 = Must Do 2 = Should Do 3 = Could Do	Issue	Yes	No	N/A	Comments/Action
67	1	Does the Committee approve any material changes to the plan?	☑			
68	2	Are counter fraud plans derived from clear processes based on risk assessment?	☑			
69	1	Does the Audit Committee receive periodic reports from the Local Counter Fraud Specialist?	☑			
70	2	Does the Committee effectively monitor the implementation of management actions arising from counter fraud reports?	☑			
71	1	Does the Local Counter Fraud Specialist have a right of direct access to the Committee and its Chair?	☑			
72	1	Does the Committee review the effectiveness of the local counter fraud service and the adequacy of its staffing and resources?	☑			
73	1	Does the Committee receive and review the Local Counter Fraud Specialist's annual report of counter fraud activity and qualitative assessment?	☑			
74	1	Does the Committee receive and discuss reports arising from quality inspections by NHS Protect?	☑			Influencing factors of the annual plan
Section 9 - Annual accounts and disclosure statements						
75	1	Is the Committee's role in the approval of the annual accounts clearly defined?	☑			
76	2	Is a Committee meeting scheduled to discuss proposed adjustments to the accounts and issues arising from the audit?	☑			
77	1	Does the Committee specifically review: • Changes in accounting policies? • Changes in accounting practice due to changes in accounting standards? • Changes in estimation techniques? • Significant judgements made?	☑			In the accounts and presentation of accounts exploring disagreements on any judgements

Ques No.	Status Key 1 = Must Do 2 = Should Do 3 = Could Do	Issue	Yes	No	N/A	Comments/Action
78	3	Does the Committee review the draft accounts before the start of the audit?		☑		It was agreed in 2020/21 that a review of the accounts after the audit would allow the Committee to retain an independence view
79	1	Does the Committee ensure it receives explanations as to the reasons for any unadjusted errors in the accounts found by the Auditor General's representatives?	☑			
80	1	Does the Committee receive and review a draft of the organisation's Annual Governance Statement?		☑		The timetable will provide for circulation of the draft AGS to the Board
81	1	Does the Committee receive and review a draft of the organisation's Annual Quality Statement?			☑	Quality statement not required in 2021/22
82	2	Does the Committee receive and review a draft of the organisation's Annual Report?		☑		The timetable will provide for circulation of the draft AGS to the Board
	Section 10 - Other issues					
83	3	Has the Committee considered the costs that it incurs; and are the costs appropriate to the perceived risks and the benefits?		☑		Not necessarily in terms of the direct cost of the actions it agreed, however the audit plan and value itself is considered
84	2	Has the Committee reviewed its performance in the year for consistency with its: • Terms of reference? • Programme for the year?	☑			
85	3	Does the Annual Report and Accounts of the organisation include a description of the Committee's establishment and activities?	☑			

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

GOVERNANCE PRACTICE NOTES

MEETING	Audit Committee
DATE	3rd March 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Trust's Standing Orders (including the scheme of reservation and delegation and the standing financial instructions) were amended and approved by the Trust Board on 27th January 2022.

2. It is good practice to review governance processes on an ongoing basis to ensure compliance with Standing Orders, to introduce efficiencies and enhancements, and to adapt to new ways of working introduced during the pandemic.

3. Governance Practice Notes have been developed to capture these revised processes for elements of the Standing Orders.

RECOMMENDATION:

4. **The Audit Committee is requested to approve the Governance Practice Notes for the Trust Seal, Private Board and Committee Business, and Chair's Action.**

KEY ISSUES/IMPLICATIONS

5. The practice notes will be applied by the Corporate Governance Team and provide clarity to the Board and the organisation on particular elements of the Standing Orders.

REPORT APPROVAL ROUTE

24th February 2022 – Executive Management Team

REPORT APPENDICES
1. SBAR 2. Corporate Governance Practice Note – Trust Seal 3. Corporate Governance Practice Note – Private Board and Committee Business 4. Corporate Governance Practice Note – Chair's Action

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

ANNEX 1

SITUATION

6. The Trust's Standing Orders (including the scheme of reservation and delegation and the standing financial instructions) were amended and approved by the Trust Board on 27th January 2022.

7. Governance Practice Notes have been developed to provide clarity of process for elements of the Standing Orders.

BACKGROUND

8. It is good practice to review governance processes on an ongoing basis to ensure compliance with Standing Orders, and to introduce efficiencies and enhancements. The challenges as a result of WAST being a national service with its workforce located throughout the country, and practices adopted during the pandemic and as a result of virtual and hybrid meetings becoming the norm have also driven these practice notes.

9. Governance Practice Notes provide clarity on the application by the Corporate Governance Team and the Board of some elements of the Sanding Orders.

10. Future Governance Practice Notes may be internal to the Corporate Governance Team, and others will more appropriately be approved by the Audit Committee or the Executive Management Team depending on their wider application and impact.

ASSESSMENT

11. The following Governance Practice Notes are presented for consideration by the Audit Committee.

    11.1. Trust Seal Governance Practice Note 001 at Annex 2: On 2nd December 2021 the Audit Committee were informed of non-compliance with respect to the use of the Trust Seal. This has driven the development of a revised process. A proforma is proposed when requests for the use of the seal are made and this is included in the practice note. The Governance Team are working with the Estates Team to develop a forward view of the leases and other land related documents that may require the Trust Seal so that approvals can be scheduled in advance to take place in person where possible.

    11.2. Private Board and Committee Business Governance Practice Note 002 at Annex 3: This practice note provides clarity on the business that is appropriately taken into a private session of the Trust Board or its Committees and sets out the ways in which decisions made in private session are communicated in public session.

    11.3. Chair's Action Governance Practice Note 003 at Annex 4: Whilst the increased delegated limits of the Chief Executive approved with the revised Standing Orders will reduce the instances of urgent approvals being

required between scheduled meetings, this practice note provides for a streamlined approach to Chair's Actions by way of email in the majority of cases. It also provides for the ways in which they are ratified in public session of the Board thereafter.

12. It is proposed that these Governance Practice Notes are approved by the Audit Committee and appended to the Committee's highlight report to March Board for information.

RECOMMENDATION

13. The Audit Committee is requested to approve the Governance Practice Notes for the Trust Seal, Private Board and Committee Business, and Chair's Action.

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GOVERNANCE PRACTICE NOTE 001
MARCH 2022

TRUST SEAL

1. The Trust's Standing Orders at para 9.0 (see below) provides that the common seal of the Trust is only applied to documents where the Board has approved a transaction to which the document relates, or separately approves the common seal being applied. This practice note introduces a revised process to ensure that this information is provided at the time a request to apply the common seal to a document is made, and to reiterate the signing and witnessing process.

2. The common seal is often required to be applied to deeds and legal documents such as transfers of land or lease agreements. The common seal is not always required for a document to be signed as a deed, and the instructions from the Trust's solicitors or NWSSP legal and risk team should be followed in all circumstances. Where there is doubt the Board Secretary should be consulted on the correct process.

3. The following process should be followed where a document requires the Trust common seal:

   3.1. The requester completes the common seal proforma at Annex 1 and sends to the Board Secretary and the relevant Director with a copy of the document to be signed and sealed.

   3.2. Where the requester indicates the transaction to which the document relates has not been approved by the Board, the Board's approval to applying the common seal must be sought. It should be noted that such approval is not to approve the transaction – only the application of the seal to the document in accordance with standing order 9.0.1.

   3.3. Where Board approval to the application of the common seal is required the Board Secretary will advise the requester and the relevant Director of the next scheduled opportunity to do so. Where the document is required to be sealed before the next scheduled meeting of the Board, the Board Secretary will seek approval of the Chair and Chief Executive for a Chair's Action. However, all attempts must be made to provide notice to the Board Secretary of the forward plan for leases and/or land related documents in particular to be sealed in accordance with the estates strategy and renewal programme.

   3.4. The common seal is applied to the document by the Board Secretary or a member of the Corporate Governance Team in the presence of the Chair and the Chief Executive (or their formal deputy). This may be done virtually where all parties are unable to meet in person.

   3.5. The application of the common seal is noted in the register of seals and reported to the public Trust Board at the next opportunity. The Board Secretary will ensure this note is provided as part of the Chair's Report to Trust Board.

4. Documents, whether they be leases, deeds or contracts, are signed in accordance with the Scheme of Reservation and Delegation that forms part of the Standing Orders. The Standing Orders v.5 provides as follows:

Delegated Matter		Responsible Officer/Committee	Delegated To
32.1.	Legal Proceedings/Advice		
(a)	Engage Trust's solicitors/legal advisor	Chief Executive	Executive Director or Board Secretary
(b)	Documents connected with legal proceedings[3]	Chief Executive	Executive Director or Board Secretary
32.2.	Documents which are required to be executed as a Deed[4]	Chief Executive	Executive Director and Board Secretary
32.3.	Other Agreements not required to be executed as a Deed	Chief Executive	Relevant Director
32.4.	Lease Agreements[5]	Chief Executive	Director of Finance and Corporate Resources and Board Secretary

5. Recognising that WAST is a national service and that hybrid and flexible ways of working have embedded since the Covid-19 pandemic, signatories to documents may not always be present in the same location. Accordingly, where a document requires a wet signature, all attempts will be made to have both the relevant Director and the Board Secretary present in person to sign the document, however where that is not possible, the Board Secretary will witness the Director's signature virtually (via Microsoft Teams or other medium) and will sign the document separately. A record of such virtual signings will be kept by the Board Secretary.

6. The Board Secretary will keep a record of all sealings in the Register of Sealings. The Register is currently in hard copy form and kept securely with the common seal by the Board Secretary. From 1 April 2022 the Register of Sealings will be recorded on an excel sheet and retained in the Corporate Governance Directorate shared drive.

Extract from Standing Orders:

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.

ANNEX 1

REQUEST FOR THE COMMON SEAL TO BE APLIED TO A DOCUMENT		
Name of Requester		
Name of Director		
Date of request		
Date by which document is required to be sealed		
Type of document (e.g., land transfer, lease agreement, deed) Please provide a copy of the document to be sealed		
Parties to the document		
Please Note: The Trust's Standing Orders provide that 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.		
Has the transaction to which the document relates been approved by the Board	Yes	Provide the date of Board approval:
	No	If no, Board approval will be required. Refer to Board Secretary for advice

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Welsh Ambulance Services
NHS Trust

GOVERNANCE PRACTICE NOTE 002
MARCH 2022

PRIVATE BOARD AND COMMITTEE MEETIINGS

1. The Trust Board and its Committees, other than its Remuneration Committee, conduct as much of its formal business in public as possible to promote openness and transparency. However, some of the business conducted at these meetings may more appropriately need to be considered in private session.

2. Matters relating to the award of contracts, disciplinary matters and matters concerning staff or any identifiable patient information will usually be considered as unsuitable for discussion in public. Other issues are harder to identify in advance. In determining which matters should be reserved for private session, consideration is given to whether the information to be discussed would be exempt from disclosure under the Freedom of Information Act 2000 (FOI Act). If information would be exempt then it is likely that it should be considered during the private session.

3. This practice note outlines the situations most likely to apply to matters considered by the Board and Committees in private session, and the manner in which decisions made in private session are reported in the public session of the Board.

Matters considered appropriate for consideration in private session

4. The matters below relate to exemptions from the FOI Act, however those marked with an * are subject to the public interest test. This means they will only apply if the public interest in withholding the information is stronger than the public interest in releasing it.

   4.1. **Investigations into conduct of employees or Board systems that aim at identifying any improper conduct on behalf of staff and/or protecting patients**[1]*.
   Examples may include disciplinary or legal investigations into members of staff, and personal data including patient identifiable information.

   4.2. **Drafts of documents, not in final form, which will be published in the future**[2]*.
   Examples may include the draft annual report (which can only be made public once it has been laid before Parliament), or draft consultation documents.

   4.3. **Issues, the discussion of which in public would be likely to inhibit the free and frank provision of advice**[3]*.
   Examples may include matters in the initial stages of enquiry; early stages of strategic thinking; sensitive 'live' issues addressed or discussed in recommendations/advice from external organisations.

   4.4. **Issues, the discussion of which in public would be likely to prejudice the effective conduct of public affairs**[4]*.
   Examples may include issues the Board is 'working through', where discussion in

[1] FOI s.31(1)(g)
[2] FOI s.22
[3] FOI s.36(2)(b)
[4] FOI s.36(2)(c)

public may cause concern/alarm, or discussions about future public consultations where the Board wants to manage the timing and manner in which disclosures are made.

4.5. **Information containing the personal data of any living patient, staff member or any other person if disclosure would not be fair to that person**[5].
Examples may include reports relating to the conduct of a particular employee, or serious Incident reports relating to a particular (living) patient.

4.6. **Information provided in confidence from another person or organisation, if releasing that information would lead to a successful claim for breach of confidence**[6].
Examples may include patient records (including of patients who are no longer living), and some technical information from suppliers.

4.7. **Legal professional privilege**[7]*.
Examples may include communications with solicitors and barristers and information created in order to seek legal advice or to help prepare for a legal claim.

4.8. **Disclosure of the information would be likely to damage an organisation's commercial interests**[8]*.
Those interests may be those of the Board, one of its suppliers or one of its customers. Examples may include current pricing information contained in contracts or tenders Information that would damage the Board's negotiating position if disclosed.

4.9. **Information, disclosure of which is prohibited by law**[9].
An example may be information prohibited from disclosure by Court Order.

5. Special regulations apply to requests for environmental information (the Environmental Information Regulations 2004). Similar exemptions to those outlined above are found in the Environmental Information Regulations. If the information to be discussed by the Board or Committee relates to the Board's estate, emissions, or decisions/policies likely to affect the environment, Directors should seek further guidance from the Board Secretary.

6. The final decision on whether material shall be discussed in private or public session shall be made by the Chair and Chief Executive, having taken advice from the Board Secretary and in accordance with this practice note.

7. The Board Secretary will keep under review the nature and volume of business considered in private to maintain openness and transparency.

Recording and Reporting Matters Considered in Private Session

8. Minutes of public meetings will be approved at the next public session, and minutes of private meetings will be approved at the next private session. Copies of approved

[5] FOI s.40(2)
[6] FOI s.41
[7] FOI s.42
[8] FOI s.43(2)
[9] FOI s.44

Committee minutes are provided to the Board for information, with private minutes in private session of the Board and public minutes in the public session of the Board.

9. When the Board or a Committee meets in private session it must formally report any decisions taken to the next meeting of the Board in public session. With respect to the Board, such decisions will be reported by the Chair in the Chair's report in public session. For Committees, these will ordinarily be reported through the Committee Chair's highlight report to the Board.

10. The Remuneration Committee meets exclusively in private session given the sensitive and confidential nature of its deliberations. Approved minutes of the Committee will be provided to the Board for information in private session, unless in the opinion of the Chair, they contain highly sensitive information. Notwithstanding this, the Remuneration Committee will report on its work through the Chair's Committee Highlight Report, which, depending upon issues of sensitivity and confidentiality, may be presented in public and/or private session of the Board.

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

GOVERNANCE PRACTICE NOTE 003
MARCH 2022

CHAIR'S ACTION

1. The Trust Board meets on a bi-monthly basis, however there will be times when urgent issues arise that require the approval of the Board between these scheduled meeting.

2. The Trust's Standing Orders at para 2.1 (see below) provides that such urgent approvals may be made by the Chair and the Chief Executive on behalf of the Board, after first consulting with at least two other Non-Executive Directors. Where the Chair and the Chief Executive are satisfied that a decision cannot wait until the next scheduled meeting and the Director of Finance and Corporate Resources has reviewed the request where financial approvals are sought, the following process will ordinarily be followed:

   2.1. An SBAR will be prepared by the relevant Director in the same way as if the matter was to be decided at a scheduled Board meeting. Reasons for urgency must be included in the SBAR.

   2.2. Whilst the Standing Orders calls for consultation with at least two Non-Executive Directors, the Board Secretary will circulate the SBAR and the request for Chair's Action to the full Board by email (including Non-Executive Directors, voting and non-voting Directors, and Trade Union partners) to promote transparency.

   2.3. The email will include the recommendation(s) for approval and a request for responses within a particular time period. Where possible, that should be at least three working days, however in cases of extreme urgency that may be truncated with the approval of the Chair and Chief Executive.

   2.4. Once the deadline has been reached, the Board Secretary will confirm the outcome to the full Board.

   2.5. A note of the Chair's Action, together with copies of the email request and responses will be prepared by the Board Secretary and stored on the shared drive for audit purposes.

   2.6. The Board Secretary will ensure that a record of the Chair's Action is formally captured in the Chair's Report at the next meeting of the Trust Board for ratification, with such ratification captured in the minutes of that meeting.

3. There may be occasions when the Chair and Chief Executive wish to convene a meeting to consider a Chair's Action request. On such occasions there shall be at least two Non-Executive Directors present, together with the Director of Finance and Corporate Resources, the Board Secretary, and relevant Director.

<u>Extract from Standing Orders:</u>

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.*

Internal Audit Progress Report

Audit Committee

March 2022

Welsh Ambulance Service NHS Trust

NWSSP Audit and Assurance Services

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

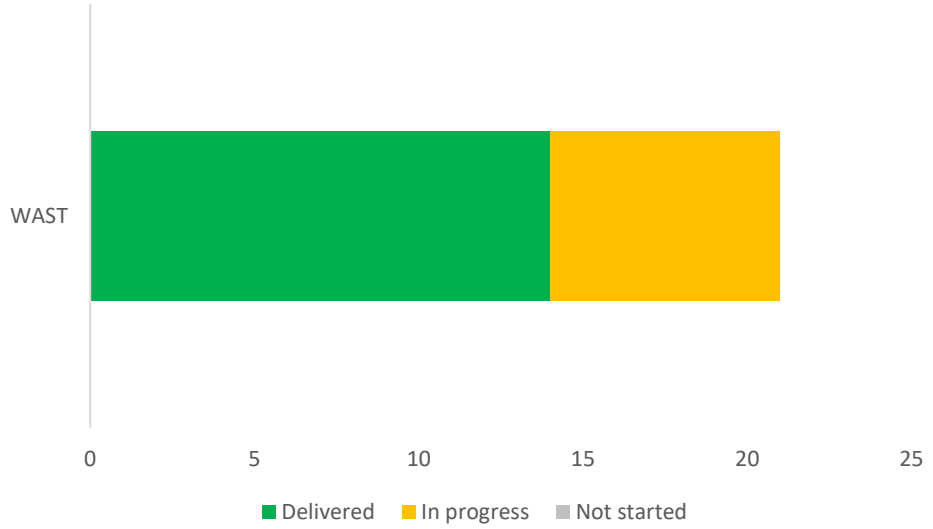
1. Introduction

The purpose of this report is to:

- highlight progress of the 2021/22 Internal Audit Plan to the Audit Committee; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2021/22 Internal Audit Plan

There are 21 reviews in the 2021/22 Internal Audit Plan, and overall progress is shown below.



Detailed progress in respect of each of the reviews in the 2021/22 Internal Audit Plan is summarised in Appendix A.

3. Proposed changes to approved plan

- At the request of management, we are proposing to defer the review of Savings Plans to 2022/23.

4. Planning 2022/23

The draft plan has been discussed by the Executive Team and issued to Non-Executive Directors for comment. The final version is included in papers for the Committee to consider for approval.

The plan will remain flexible throughout 2022/23 in response to new and emerging risks. We will re-visit the approved plan on a regular basis to allow discussion of priorities.

5. Engagement

The following meetings have been held/attended during the reporting period:

- observation of Board and Committee meetings;
- audit scoping and debrief meetings;
- liaison with senior management; and
- liaison with external regulators.

6. Key Performance Indicators

Correct on 31 January 2022

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2021/22		March	By 30 June
Audits reported over planned		11	12
Work in progress		10	
Report turnaround: time from fieldwork completion to draft reporting [10 days]		11 out of 11	80%
Report turnaround: time taken for management response to draft report [15 days]		6 out of 10	80%
Report turnaround: time from management response to issue of final report [10 days]		8 out of 9	80%

Key:

- v>20%
- 10%<v<20%
- v<10%

7. Recommendation

- The Audit Committee is invited to note the above; and
- Approve the proposed changes at section 3.

Appendix A: Progress against 2021/22 Internal Audit Plan

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Risk management and BAF	In progress			June 2022
Financial planning and budgetary control	Final report	Reasonable	Budget meeting regularity varies and there is a low level of minutes or notes to evidence the monitoring of meetings between budget holders and finance business partners Review and approval of the Oracle user hierarchy set-up documentation was not evidenced.	September 2021
Savings plans	N/A		To be deferred to 2022/23	N/A
IMTP approach	Final report	Reasonable	Areas for refinement and further development	September 2021
Network & Information Systems (NIS) directive	In progress			June 2022
FIT Testing *Replacing Health & safety*	In progress			June 2022
Collaboration	Final report	Reasonable	Engagement delivery action plan actions were overdue before the pandemic intervened to halt and now need re-scheduling; low instance of activity performance target setting in the service development initiatives examined.	December 2021
Service reconfiguration	In progress			June 2022
Asset management – RAM system	Final report	Reasonable	A more proactive approach to physical verification of assets including auditing a sample of assets and requesting returns from departmental managers in line with procedures; a link between RFID and the RAM system to reconcile and validate the assets that will be tracked on RFID; and reporting of benefits realised.	December 2021

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Medicines management-controlled drugs	Final report	Reasonable	Analysing the results of both the Omnicell cycle counts and vehicle medicines audits; review of the Abloy keys listing	December 2021
Information management (hear & treat and see & treat)	Final report	Reasonable	We recommend that greater use is made of referral data to inform further developments of current and future referral pathways. Current analysis and sample examination of the 'Can't Send' call responses should be extended to include other incident responses and should be routinely analysed and reported.	March 2022
Service management	Final report	Reasonable	The provision of services and the level of support have not been agreed with user departments There is no process operation for problem management.	September 2021
Digital governance	Final report	Reasonable	Developing a Strategic Outline Programme that sets out how the Digital Strategy will be implemented and the required resourcing; Defining the timescales for delivery of the Digital Strategy; Establishing the structures for linking Digital with the operational part of the organisation.	March 2022
NEPTS – transfer of operations	Final report	Limited	Our overall assurance rating relates to the capturing, reporting and monitoring of benefits realised. Whilst we acknowledge that many of the benefits may have been realised now that the transfer has completed, the Trust needs to undertake an exercise to support and demonstrate this.	March / June 2022
NEPTS procurement	Final report	Reasonable	The Trust is not obtaining assurances from 365 that all monthly repository updates have been received. Implementation of the advisories tracker.	September 2021
Mobile Testing Unit	Final report	Substantial	Areas for refinement and further development.	September 2021

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Role of Advanced Paramedic Practitioner (APP)	Final report	Reasonable	There has been a lack of formal oversight of the APP programme. A lessons learned exercise has not been undertaken. Interviews with APPs highlighted a lack of support was available to them.	September 2021
Trade union release time	Deferred to 2022/23	N/A	N/A	N/A
Organisational culture (a learning organisation)	In progress			June 2022
Recruitment practices	Final report	Reasonable	Improved links required between work undertaken by the Patient Experience and Community Involvement (PECI) team and the Strategic Equality Objectives; Limited analysis of the effectiveness of initiatives to attract new staff; There is no regular analysis of candidate progress to establish and assess barriers to applicants from minority backgrounds; Equality, Diversity and Inclusion Steering Group was not quorate and the Terms of Reference requires updating.	March 2022
Recommendations tracker	In progress			June 2022
Capital & Estates				
Estates assurance – Waste Management *Replacing Decarbonisation*	In progress			June 2022
Capital Projects: Cardiff MRD	Final report	Reasonable	The need to conclude on the assessment of delays at the project and instruct appropriately in accordance with the contractual requirements; To formally review the project team's performance to determine whether it has had any impact on the project objectives and whether any further action is required; Noting that the project is due to complete shortly, the remaining recommendations are primarily for the benefit of future	March 2022

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			projects and should be considered as part of a formal Post Project Evaluation.	

[1] May be subject to change

Annual Internal Audit Plan: Draft Internal Audit Charter

February 2022

Welsh Ambulance Services NHS Trust

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Welsh Ambulance Services NHS Trust

Contents

1. Introduction

This document sets out the Internal Audit Plan for 2022/23 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Trust Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Trust management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2022/23. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by DHCW, NWSSP, WHSSC and EASC on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for WHSSC and EASC) but the results, as in previous years, are reported to the relevant Health Boards and Trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place, in particular the ongoing impact of COVID-19 and the significant backlog in NHS treatment. In addition, the plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with

management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Board Secretaries and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance and Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up: this is follow-up work on previous limited and no assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Trust, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), WHSSC and EASC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed

for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Trust's systems of assurance

The risk based internal audit planning approach integrates with the Trust's systems of assurance; therefore, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Trust's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and the Quality, Patient Experience and Safety Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW, WHSSC and EASC;
- work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Trust Executives and Non-Executive Directors to discuss current areas of risk and related

assurance needs. Meetings have been held, and planning information shared, with the Trust's Executive team, the Chair of the Audit Committee and the Chair of the Board.

The draft Plan has been provided to the Trust's Executive Management Team to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and Corporate Risk Register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2022/23

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the corporate risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. We are particularly mindful of the level of uncertainty that currently exists with regards to the ongoing impact of and recovery from the COVID-19 pandemic. At this stage, it is not clear how the pandemic will affect the delivery of the Plan over the coming year. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Trust, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

Under the approach we have adopted for a number of years, the top slice provided to us to undertake the internal audit programme is supplemented by an additional charge for work undertaken over and above the 'top slice' arrangements. To this end the Trust has agreed to pay an additional £39,760 to cover this additional audit work.

Also, under the approach we have adopted since the formation of NWSSP we charge for the specialist Capital & Estates work delivered as a part of the agreed plan. For 2022/23, this additional charge is £17,510.

Therefore, the Trust will be charged an additional amount of £57,270 which is over and above the 'top slice' recharge agreed as part of NWSSP's overall funding for 2022/23.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2022/23 and:

- approve the Internal Audit Plan for 2022/23;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Simon Cookson

Director of Audit & Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2022/2023

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Chief Executive / Board Secretary	Q4
Risk Management & Assurance	1		To review the framework of organisational assurances in place and report on risk management.	Board Secretary	Q4
Health and Safety (*Deferred from 2021/22*)	2	199	A review of the Trust's structures and arrangements for complying with the Health & Safety legislation.	Director of Quality and Nursing	Q4
Infection Prevention and Control	3		To assess adherence to organisational policies and the Standards for Health Services in Wales. To include review of progress made to implement recommendations raised in the 2019/20 'limited' assurance Cleaning Standard report.	Director of Quality and Nursing	Q2

Savings and Efficiencies (*Deferred from 2021/22*)	4	139	An assurance that savings plans are specific, realistic and measurable and that monitoring arrangements are effective.	Director of Finance and Corporate Resources	Q3
Fleet Maintenance	5		The review will assess the application of the fleet management system and its impact in improving the coordination of fleet maintenance and cost control.	Director of Finance and Corporate Resources	Q1
Major incidents	6		To assess the Trust's approach to prepare for major incidents and how it ensures it learns from such events.	Director of Operations	Q1
Hazardous Area Response Team (HART)	7		To review how the Trust ensures the team is appropriately trained and equipped to respond to high-risk and complex emergency situations.	Director of Operations	Q2
Immediate Release Request	8	223	A review of the effectiveness of the mechanisms in place to request the immediate release of ambulances outside hospitals to respond to patient needs in the community.	Director of Paramedicine / Director of Operations	Q2
Trade Union Release Time	9		To provide assurance on the deployment of the refreshed Trade Union facilities agreement. To include review of progress made to implement recommendations raised in the 2018/19 'limited' assurance report.	Director of Workforce & OD	Q2

Sickness Absence Management	10	160	To assess the effectiveness of the early intervention mechanisms the Trust has put in place.	Director of Workforce & OD	Q1
Clinical Handover	11	224	To review the operational deployment of the standardised handover tool being developed and assess compliance.	Director of Paramedicine / Director of Quality and Nursing / Director of Operations	Q3
Pain Management	12		A review of the application of pain relief methods and their effect on patient outcomes in terms of pain relief and patient satisfaction.	Director of Paramedicine	Q3
Strategy Development	13	100	A review of the arrangements in place to support the development of the Trust's strategic ambitions. To include a review of the process in place to manage strategic decision making and how these are communicated throughout the organisation.	Director of Planning and Performance	Q4
IMTP Delivery	14	109, 424	To assess the effectiveness of the Transformation Programme structures as a mechanism to support delivery of the Trust's strategic ambitions.	Director of Planning and Performance	Q3
Cyber Security	15		Specific focus to be agreed in discussion with the Trust and the cyber resilience unit.	Director of Digital	Q3

IM&T Infrastructure	16		Review of the management of the IM&T infrastructure and network.	Director of Digital	Q4
Data Analysis	17		Review of the foundations for data analysis. Consideration of the storage, aggregation, sharing and access of data together with the processes to ensure quality of information.	Director of Digital	Q2
Standards of Business Conduct: Declarations	18		To review compliance with the Standards of Business Conduct, including arrangements in place to manage declarations.	Board Secretary	Q2
Estates Assurance - Decarbonisation	19		To determine the adequacy of management arrangements to ensure compliance with the Welsh Government decarbonisation strategy, and to provide assurance on decarbonisation capital allocations provided by Welsh Government to address decarbonisation issues across the estate during 2021/22.	Director of Finance and Corporate Resources	Q1
Electronic Patient Clinical Record	20		To obtain assurance on the arrangements being applied by the Trust to manage the successful delivery of the ECPR project. The review may include an assessment of: • Governance & decision-making arrangements;	Medical Director	Q1

			• Value for Money / benchmarking & procurement; • Project and risk management arrangements: • Delivery to time, cost & quality; • Stakeholder interface; • Other (to be determined through risk assessment and discussions).		
Follow Up Action Tracker	21		To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	Board Secretary / Executive Team	Q4
NHS Wales national audit work	N/A	N/A	To collate the assurances derived from the review of NHS Wales bodies that provide services to this organisation and contribute to its overall system of control. This will cover some of our work at Health Education & Improvement Wales, Public Health Wales, NHS Wales Shared Services Partnership, Digital Health and Care Wales, Welsh Health Specialised Services Committee and Emergency Ambulance Services Committee.	Board Secretary	Q4

Please note: The national audits undertaken at DHCW, NWSSP, WHSSC and EASC will be added later.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2022/23
Audit plan 2022/23 agreed/in draft by 30 April	✓	100%
Audit opinion 2021/22 delivered by 31 May	✓	100%
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	80%
Report turnaround management response to draft report [15 working days minimum]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	80%

Appendix C: Internal Audit Charter

1 Introduction

1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Welsh Ambulance Services NHS Trust with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Welsh Ambulance Services NHS Trust. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Welsh Ambulance Services NHS Trust. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular

private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, WHSSC and EASC.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;

- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the

assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the

relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational

managers to confirm understanding and shape the reporting stage through issue of a discussion draft report;

- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the closure of fieldwork. Operational management will be required to respond to the discussion draft report within 5 working days of issue.
- The discussion draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The discussion draft report will also indicate priority ratings for individual report findings and recommendations;
- Following the receipt of comments on the discussion draft (for factual accuracy etc), operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- Reminder correspondence will be issued to the Executive Director and the Board Secretary 5 working days prior to the set response date.
- Where management responses are still awaited after the 20 working days deadline, or are of poor quality, the matter will be immediately escalated to the Executive Director and copied to the Board Secretary and Chair of the Audit Committee.
- If non-compliance continues, the Board Secretary and the Chair of the Audit Committee will decide on the course of action to take. This may involve the draft report being submitted to the Audit Committee, with the Executive Director being called to the meeting to explain the situation and why no responses/poor responses have been received;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.

- The relevant Executive Director, Board Secretary and the Chair of the Audit Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
February 2022

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Information Management Internal Audit Report

February 2022

Welsh Ambulance Services NHS Trust

NWSSP Audit and Assurance

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

EXTERNAL • QUALITY • ASSESSMENT

Contents

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Fieldwork commencement:	9th November 2021
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Final report issued:	15th February 2022
Auditors:	Simon Cookson, Director of Audit & Assurance Osian Lloyd, Deputy Head of Internal Audit Chris Scott, Audit Manager
Executive sign-off:	Claire Roche, Executive Director of Quality & Nursing Dr Brendan Lloyd, Executive Medical Director
Distribution:	Lee Brooks, Director of Operations Jonathan Edwards, Assistant Director of Operations, Resourcing & EMS Coordination Jonathan Turnbull Ross, Assistant Director of Quality Governance Stephen Clinton, Assistant Director of Operations, Integrated Care
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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

Executive Summary

Purpose

To assess, in respect of 999 calls, the availability of information on patient discharges through 'Consult and Close' ('Hear and Treat'), 'See and Treat' and 'Can't Send' emergency responses and how this is analysed to inform patient safety and quality improvement.

Overview of findings

Key matters arising concerned:

- Low level of incident 'See and Treat' and 'Consult and Close' pathway referral reporting.
- Low level of scrutiny of 'See and Treat' and 'Consult and Close' incident cases.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	Not previously audited

Assurance summary[1]

Assurance objectives		Assurance
1	Information capture	Reasonable
2	Communication of incident response models	Reasonable
3	Information analysis and solution evaluation	Limited
4	Management oversight	Reasonable

Matters arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Analysis, review and oversight of 'See and Treat, 'Consult and Close' and 'Can't Send' incident stop codes	3	Design	Medium
2	Management review of incident responses and patient outcomes	3	Design	Medium

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

1. Introduction

1.1 The Welsh Ambulance Services NHS Trust ('the Trust') operates Clinical Contact Centre call handling and clinical triage/assessment services nationally for both 111 and 999. Patients ringing 999 either receive advice over the phone ('Consult and Close', formerly known as 'Hear and Treat') or a response to scene from the Emergency Medical Service (EMS) ('See and Treat', 'See and Refer', 'See and Transport', collectively termed, and referred to in this report as 'See and Treat'). In periods of extreme demand, patients may be told an ambulance is not available ('Can't Send') and advised to contact their GP or the 111 service.

1.2 'Hear and Treat' and 'See and Treat' was a feature of Welsh Government's New Clinical Response Model which was piloted in 2016 and fully implemented in February 2017.

1.3 Enhancing the clinical response model for ambulance services to 'Consult and Close' people by providing clinically safe alternatives to transport to Emergency Departments and enable better management of people's health needs in the community has been an objective of Welsh Government for some years and appear in the healthcare plan 'A Healthier Wales: Plan for Health and Social Care' launched in 2018.

1.4 The terms 'Hear and Treat' (now referred to as 'Consult and Close') and 'See and Treat' were first introduced by the Trust in their Integrated Medium Term Plan (IMTP) 2017/18. Since then the 'See and Treat' and 'Consult and Close' patient treatment models have been introduced to their operation.

1.5 These models, which incorporate a series of clinical assessment steps that are used by call handlers to identify cases where they can be used, provide alternative emergency call responses to the despatch of an ambulance and subsequent conveyance to ED and through this reduce the number of these conveyances.

1.6 Volumes of patients using these pathways and their outcomes are monitored and reported internally and externally.

1.7 The Trust's Demand Management Plan has for many years provided a framework of tactical options to support them in responding to situations where the demand for services are greater than capacity. In 2020, the Demand Management Plan was expanded with the introduction of 'No Send' (also termed 'Can't Send') outcomes for callers at the point of contact. It has more recently been revised to be consistent with agreed UK naming and is now known as the Trust Clinical Safety Plan (CSP). This was approved by the Executive Management Team in September 2021.

1.8 The CSP provides a revised response matrix covering higher levels of excess demand, so that the Trust can dynamically react to situations to ensure those patients with the most serious conditions or in greatest need according to their presentation remain prioritised to receive services.

1.9 The overall objective of the audit was to assess, in respect of 999 calls, the availability of information on patient discharges through 'Consult and Close', 'See and Treat' and 'Can't Send' treatment pathways and how this is analysed to inform patient safety and quality improvement. This included an assessment of the effectiveness of patient communication, clinical handover and follow up arrangements.

1.10 The key risk considered in this review was that patient outcomes are adversely impacted through inappropriate or delayed clinical response.

1.11 The audit included in its scope only the calls that are received and processed by the 999 clinical support desk.

2. Detailed Audit Findings

Objective 1: patient volumes that use the 'Consult and Close', 'See and Treat' and 'Can't Send' treatment pathways are accurately captured

2.1 We examined the processes involved in 999 call handling and either the despatch of an EMS responder or referral to other services, with an emphasis under this objective on the means by which incident responses are captured by systems for subsequent oversight reporting. We sought to establish whether data is generated to distinguish between the different types of incident response and whether systems are reliable and consistent in the capture of this.

2.2 All 999 calls are received in one of the three Wales Emergency Medical Services Clinical Contact Centres (EMS CCC). Within each EMS CCC, there is a team of operational staff who are responsible for triaging calls received and coordinating the appropriate response. A triage process is undertaken for each call and is completed through the Medical Priority Dispatch System (MPDS).

2.3 The MPDS is used internationally, including by half of the UK ambulance Trusts, to triage emergency calls. The responses provided by the caller to the call handlers questions allow the MPDS system to generate a number-letter-number format code to each type of incident. The Dispatch Cross Reference (DCR) table allocates MPDS codes to one of the Red, Amber 1, Amber 2, Green 2 and Green 3 priority classifications, in order to determine the response required.

2.4 According to the Trust escalation level and the CSP response matrix, higher priority calls receive an ambulance despatch. Calls requiring secondary triage are passed to the 111 service (not in the scope of this audit) and all other calls go to the Computer Aided Despatch (CAD) ambulance despatch system's call queue or 'stack'. Those that may be dealt with by telephone ('Consult and Close') are then picked up by the clinical staff of the Clinical Support Desk (CSD) and addressed according to the incident type.

2.5 The CSD is a virtual function spread across three CCCs and comprises of nurses and paramedics, who undertake secondary telephone assessment of patients calling or being referred to 999.

2.6 Nurses and paramedics triage patients remotely using Computer Decision Support Software (CDSS) to achieve the best outcome for them, within the general principles of providing *the Right Care, at the Right Time, in the Right Place*.

2.7 The CSD clinician picking up a call may conduct further assessment with the caller using the Manchester Triage System (to be replaced by the Emergency Communication Nurse System (ECNS) in March 2022), which could result in the case priority code being amended up or down (e.g. an Amber 1 may be raised to a Red or vice versa).

2.8 Calls which have undergone secondary triage by the 111 service are generally automatically closed in the CSD system but can be passed back in the event that an ambulance despatch is necessary.

2.9 Systems used in the CCC typically operate with a combination of defined entry and free form fields. The following data protection measures operate within the systems:

- user entry fields are controlled through the use of drop-down value lists.
- date and timestamps are automatically applied and can only exceptionally be overwritten / amended.
- other fields are auto populated - e.g. caller phone number, caller address.
- triage tools run on predefined workflows constructed around key questions that callers are asked in order to determine the nature of the incident. Caller responses determine the workflow pathways taken which direct call handlers with appropriate prompts.
- call designation codes, which are the output of the workflow, cannot be amended by the operator (but note that clinicians on the CSD picking up these calls can re-assess and amend the incident code and / or priority).
- audit logs operate within the systems to capture and report changes that are made to values e.g. time or date stamps.

2.10 The 'See and Treat' model is one which provides focused clinical assessment at the patient's location, followed by appropriate immediate treatment, discharge and / or referral. 'Consult and Close' describes the scenario where 999 calls are successfully completed ('stopped') without despatching an ambulance vehicle response. This may include advice, self-care or a referral to other urgent care services. In periods of high escalation, and in line with the Trust's CSP, lower priority calls will be 'stopped' after the caller is told the Trust cannot send an ambulance ('Can't Send'). In all three scenarios calls are assigned a 'stop' code which denote the call outcome.

2.11 A data warehouse combines the data collected in several related systems from which analysis and reporting is available, although we have not examined the parameters used to generate the reports.

2.12 'See and Treat' and 'Consult and Close' 999 caller outcome volumes are regularly reported internally and externally based on flags assigned to incident records in the database and volumes of incidents with a 'Can't Send' response 'stop' code are monitored by operational teams (these areas are examined further under Objective 3 and are the subject of **Matters Arising 1**).

2.13 We noted too there is a dedicated audit team within the EMS CCC who are responsible for auditing calls and providing feedback and support to call handlers. Quality Assurance reports are produced monthly which outline compliance against the Academy of Emergency Dispatch performance standards, including data on whether responses were ideal or if there was an over or under response.

2.14 It was noted within the Executive Director of Quality and Nursing Patient Safety Highlight Report presented to the Trust's Quality, Patient Experience and Safety Committee (QuEST) at its September 2021 meeting that between January 2021 - June 2021, 2,328 calls were randomly audited. Of these 155 were non-compliant. Further review identified that 72 of the non-compliance achieved the incorrect MPDS categorisation; 15 were over-coded, 32 were under-coded and for the remainder there was not enough information to determine

what the final code should have been. In a worst-case scenario assuming all the remainder of the calls were under-coded, this would mean 2% were under-coded against MPDS hierarchy.

2.15 Issues that emerge from this audit cycle that impact patient safety are also captured as Datix incidents and managed through the regular Datix review processes. Each CCC has individually been re-accredited by the International Academy of Emergency Dispatch as a Centre of Excellence (ACE).

Conclusion:

2.16 The Trust's triage systems automatically generate the priority codes for incidents and further assessments are made during the triage process by clinicians at the clinical service desk. Incidents are designated 'See and Treat', 'Consult and Close' or 'Can't Send' for monitoring and evaluation purposes. We have raised no findings in this section of the audit and consequently have provided **Reasonable** assurance for this objective.

Objective 2: the alternative response pathways are communicated and explained to users of the emergency medical system, including patients and clinicians

2.17 The Trust communicates with service users and liaises and shares with health care partners through a variety of different channels. We sought to establish whether the Trust communicates the different incident responses with patients and partners to assist delivery and flow.

2.18 Callers to the 999 number are taken through a series of questions by call handlers to determine the severity of the incident. The Ambulance Service' response is determined by a combination of the incident severity and the Trust's level of escalation as set out in a response matrix in the Trust's CSP.

2.19 For consistency, call handlers use a series of scripts to advise callers how they will respond and to provide other key information, for example, where an ambulance is being despatched, it's estimated time of arrival.

2.20 In periods of higher escalation, scripts are also used to advise callers that an ambulance is not available and what action they should take. Callers with incidents which in the models are designated for 'Consult and Close' response will be advised they'll receive a call back from a clinician.

2.21 The CCC call handling supervisor monitors the waiting patients in the call 'stack' and directs welfare telephone calls to patients accordingly. Vulnerable patients who are waiting may receive these calls to ensure they remain stable and are aware of the delay to receiving assistance.

2.22 Patients who receive an ambulance response but are then assessed at scene for referral to other services are advised accordingly by the attending paramedic.

2.23 Regarding liaising with health care partners, the Trust chair the National Risk Huddles which take place daily, during which the Trust's CSP escalation level is shared. The National Risk Huddles are attended by the Strategic leads of all Health Boards and Welsh Government (these are the nominated System Leads responsible for service delivery in their respective

areas). If there is significant pressure in the system, additional ad hoc National Risk Huddles are also scheduled. The Trust's community demand and CSP level are discussed routinely during these huddles.

2.24 As well as the National Risk Huddles, local site huddles take place daily and these are attended by the Trust's Operational Delivery Unit National Delivery Managers or local Operations Managers. Again, the Trust's community demand and CSP level are routinely discussed during these local huddles to inform local planning assumptions, although we recommend later under objective 3 that the Trust provide health boards with more detailed incident response data to assist them with their service provision planning (see **Matters Arising 1**).

2.25 The Trust's unscheduled care partners across the system also have access to a live Power BI dashboard through which they can monitor the live CSP position (but not incident response data). The Trust is also in the process of providing Primary Care colleagues with access to the Power BI dashboard and it is anticipated that this will be in place by March 2022.

2.26 As the Trust escalate and de-escalate through the CSP levels, its Operational Delivery Unit make a number of recommendations cascaded to the relevant Strategic leads informing them of the escalation and potential impacts to service delivery in their respective areas. The Strategic leads are then responsible for cascading further the message within their own organisations. Again, we recommend under objective 3 that the Trust provide health boards with more detailed data to assist them with their service provision planning (see **Matters Arising 1**).

2.27 In terms of a more general approach to raising awareness as to purpose, scope and associated impacts of the CSP on the wider system, we were advised that representatives from the Trust have supported a number of meetings with relevant stakeholders across the system. This includes information sharing with health boards at regular peer to peer collaborative meetings.

2.28 The Trust use multiple channels to capture feedback from service users with all engagement and experience data being brought together and presented quarterly at the Trust's QuEST Committee in the Patient Experience Community Involvement (PECI) highlight report.

Conclusion:

2.29 We noted a detailed level of communication planning with both 999 callers in respect of individual incidents and health care partners regarding the fluctuating demand and response for emergency services and the changing response models being deployed by the Trust. We have raised no findings in this section of the audit (although Matters Arising 1 under objective 3 considers the provision of further information to health boards) and consequently have provided Reasonable assurance for this objective.

Objective 3: assessments are made of the impact and effectiveness of the pathways on patient outcomes to inform patient safety and quality improvement

2.30 The Trust has a role as part of the broader urgent and emergency care system to develop services to influence a shift of patient demand towards scheduled care as far as possible.

2.31 The Trust has undertaken a clinical review of the CCC and, with funding agreed to recruit paramedics into the clinical service desk to further develop the service model, is currently implementing its findings.

2.32 To further the service's ambition to 'shift left' in the patient pathway, a range of initiatives are in progress to increase the volumes of incidents that are dealt with by either referral to alternative services through the CSD ('Consult and Close'), or at the scene ('See and Treat').

Active monitoring of alternative pathways

2.33 We sought to establish whether there is active monitoring of these volumes using the data captured which is then used to inform changes to the models for further improvement.

2.34 Analysis of the incident volumes that are dealt with via these routes are reported at a summary level to a number of operational review groups.

2.35 EMS CCC reports are seen by the weekly Senior Operations Team (although this group still meets as the Senior Pandemic Team (SPT) during the continuing pandemic response). We note the 'Consult and Close' volumes ('See and Treat' not reported to this group) are only one item in a very extensive performance report deck and are largely for information only, as the SPT have a broader responsibility to prioritise personnel resources and services to protect core activities. Incident outcomes and conveyance rates are also reported in the daily operational report of CCC activity. This records at summary level incident volumes dealt with through 'See and Treat' and 'Consult and Close' which inform and may contribute to operational decision making.

2.36 We noted that the Trust does not report on referrals activity by type. Although 'stop' codes, which include the suite of referral pathways, are assigned all incidents where there is no conveyance to an emergency department (ED), we did not encounter any regular incident reporting at this more detailed level (**see Matters Arising 1**). We note a link here to the Emergency Ambulance Services Committee (EASC) commissioning intentions 2022-23 (CI1) that call for the development of this area.

2.37 Other groups receive reports of activity volumes of the 'See and Treat' and 'Consult and Close' pathways to assess the impact on 999 verified incidents as initiatives launch and develop to increase their use and where uptake of these pathways is a project objective. For example, service development initiatives of the Care Closer to Home group (CCHG) linked to the EMS Demand & Capacity Review are aimed at providing safe alternatives at scene ('See and Treat') to Emergency Department (ED) conveyance and these include:

- developing a range of dedicated pathways that can be delivered by EMS responders e.g. COPD pathway.
- increasing the number and range of incident types that can be dealt with at scene by Advanced Paramedic Practitioners (APP).
- increasing the numbers of prescribing paramedics.

2.38 We noted the CCHG report the impact of these initiatives to the Clinical Transformation Board (CTB) and saw material illustrating the reduction in ED conveyances being achieved through the increasing number of APP attendances at 999 incidents.

Monitoring and maintaining the Trust's incident response model

2.39 We sought to establish whether there is active monitoring of the suitability of the Trust's current incident response model and to identify further opportunities where 'See and Treat' and 'Consult and Close' pathways can be expanded.

2.40 We note the role of the Clinical Prioritisation Assessment Software (CPAS) Group in managing the Trust's Despatch Cross Reference (DCR) table. This allocates the Medical Priority Despatch System (MPDS) incident codes to one of the Red, Amber 1, Amber 2, Green 2 and Green 3 priority classifications and gives the clinical contact centre advice on the ideal ambulance asset to send, including crew composition and vehicle type.

2.41 The DCR table, which is common to all 3 CCCs, is a critical look-up resource which is embedded in the Despatcher's workflow and is referenced to direct the call-handlers response to the 999 call.

2.42 CPAS meet quarterly to consider opportunities for changes to the DCR table arising from their own review work, as well as requests for change from the EMS CCC.

2.43 Requests for change which we saw to have emerged from recent review initiatives were:

- Shift left proposals from 'stop' code studies e.g. the MPDS protocol (code) 17 Falls case study (linking to the development of the Falls framework).
- Requests for incident code re-designation to 'Consult and Close' response where there has been a recent pattern of good outcomes with that approach. (e.g. some 021 MPDS incident codes relating to Haemorrhage / Lacerations).
- Focussed reviews on individual MPDS protocol usage e.g. Protocol 36, Pandemic response.
- Benchmarking exercises with other Ambulance Services (England, Scotland) who have had success with 'Consult and Close' and 'See and Treat' response to other incident types and where that response might prove effective for the Trust.

2.44 Changes to the individual incident response codes in the DCR table are made only after careful consideration and modelling to assess the impact on the service areas that would receive higher volumes of incidents to ensure patient safety would not be impacted.

2.45 We noted a total of 10 DCR table Request for Change (RFC) papers had been submitted to CPAS in 2021/22, although not all of these were 'Consult and Close' and/or 'See and Treat' related.

Monitoring patient safety impacts of non-conveyance

2.46 Regarding patient safety we sought to establish whether information is available and used to ensure that patients are not put at increased risk by increasing non-conveyance to an ED.

2.47 We found that monitoring of patient re-contact rates takes place to ensure that patients are not calling 999 soon after a 'Consult and Close' discharge because they still require emergency services.

2.48 The percentage of re-contacts within 24 hours of telephone 'Consult and Close' has fluctuated over the last two years, peaking in June 2020 at 15.7%. Re-contact rates in October 2021 were 13.8%, an increase compared to 8.8% in September 2021 and when compared to 5.5% in October 2020.

2.49 Re-contact rates are not monitored to the same extent for patients who are treated at scene ('See and Treat') but we note that these did not exceed 1.2% in January to July 2021 (more recent analysis packs do not record re-contact rates for 'See and Treat' incidents).

2.50 The Datix reporting system will capture any reports of concern relating to 'See and Treat', 'Consult and Close' and 'Can't Send' incident responses, which are subsequently reported to the quarterly QuEST sub-committee in the PECI Patient Safety Highlight report.

2.51 Any cases that are considered as potentially causing significant harm are identified and examined by the Trust Serious Case Incident Forum (SCIF) which meets twice a week. The cases are discussed and if necessary, reported as Nationally Reportable Incidents (NRI's) to the Delivery Unit and investigated accordingly, or for cases where the root cause of a potential NRI is hospital handover delays, shared with the relevant health board. These cases are reported in a regular Patient Safety report to the CEO and in a CEO brief presented to EMT monthly.

2.52 We were unable to confirm with analysis but were advised that there is no observed increase in cases attributed to the rise in 999 incident numbers being handled through the 'See and Treat' and 'Consult and Close' responses. Review of summary level reporting by the Patient Safety function confirmed no correlation is currently being reported or inferred between patient incidents and 'See and Treat', 'Consult and Close' and 'Can't Send' case volumes.

2.53 The revised response matrix of the recently adopted Clinical Safety Plan, which replaced the earlier Demand Management Plan, has led to a greater incidence of 'Can't Send' EMS CCC responses to 999 incidents.

2.54 We were advised that during periods of escalation when the Trust are not sending ambulances to Amber 1 priority incidents, analysis work is carried out of 'Can't Send' incident responses by the CCC to provide assurance that no obvious risks are being identified. Whilst we understand the results of this, and more detailed audits of a sample of these incidents, are shared with operational review teams, we were not able to confirm this information was regularly reported to the QuEST committee or other oversight body. We also noted the review work that is being done is limited currently to the 'Can't Send' cases and that there could be benefit in extending this to cover other 'See and Treat' and 'Consult and Close' incident responses (see **Matters Arising 2**).

Monitoring alternative pathway incident response against targets

2.55 We sought to establish whether information is available and used to assess the effectiveness of the incident response model against incident volume targets.

2.56 We noted that a quantitative target is set for 'Consult and Close' responses but not for 'See and Treat' volumes where, for the latter, the Trust's ambition, by design, is described in broader terms reflecting the commissioning intention of 'optimising conveyance'.

2.57 For the former, 'Consult and Close' volumes are recorded in the monthly reports as a percentage of verified incidents against a target of 10.2%. Latest reported data (October 2021) at the time of the audit indicated the service achieved a combined 9.7% performance

(CSD 5.8%, NHSDW/111 3.9%). Target volumes are not set for 'See and Treat' incident responses.

Alternative pathways and patient outcome

2.58 We sought to establish whether information is available and used to establish the effectiveness of the incident response in terms of patient outcomes.

2.59 Clinical guidelines for pre-hospital care are provided by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and Paramedics are able to access these and the available referral pathways at scene using tablet or other electronic devices. We understand that referral to a pathway involves contacting the referee, making arrangements for follow-up, e.g. speaking to a clinician through the 'Consultant Connect' technology, arranging a patient appointment with the patient's GP, and advising the patient accordingly. The most common instance of 'See and Treat' referral is to the patient's GP in which case the paramedic will make contact with the practice and make arrangements for the patient to be seen, although we were not able to establish what arrangements are made out of hours or with other referrals pathways e.g. palliative care, midwife, diabetic, falls, cardiac care etc. Notes are made on the incident record of what's been arranged and patients are advised accordingly.

2.60 Clinicians on the CSD taking calls from the 'stack' suitable for 'Consult and Close' use a Directory of Services (DoS) to determine what referral pathways are available in the area of the incident in question. The DoS is maintained by an internal team but is reliant on the information coming from the wider NHS Wales. We were advised that CSD clinicians make contact with pathway providers e.g., through the 'Consultant Connect' technology, and arrange for follow-up of these cases, although we didn't conduct any testing to verify this.

2.61 We were advised that there is no practical method at present to enable the Trust to trace 999 callers they've referred to other services to establish the effectiveness of this referral process. We note a lack of integration of Trust and health board systems prevents the Trust from understanding individual patient journey and outcomes. However, we were advised that the recent launch of the Electronic Patient Care Record (ePCR) solution will bring improved capability to achieve better data and better access to information to improve patient care, including enabling secure sharing of information with other NHS Wales bodies to improve learning and continuity of an individual's patient care.

2.62 We were advised that the linking of the health board Emergency Department Data Set (EDDS) and other partner systems to the Trust's data warehouse is currently being developed and will increase opportunities for further analysis of the broader patient journey in the near future.

Conclusion:

2.63 We noted incident volumes that are dealt with by 'See and Treat' and 'Consult and Close' responses are regularly reported to a number of operational review groups which monitor these against expectations and targets but that this is limited at summary level. Measurement of caller re-contact rates are analysed to gauge impact on Patient safety of increasing 'See and Treat' and 'Consult and Close' responses and decision makers observe levels of reported patient incidents to ensure these are not being impacted by rising levels of non-conveyance to ED. We have raised a number of findings in this section and have therefore provided **Limited** assurance for this objective.

Objective 4: appropriate oversight arrangements are in place within the Trust to manage and monitor the delivery of the 'Consult and Close', 'See and Treat' and 'Can't Send' treatment pathways

2.64 We record in the previous section of this report the operational monitoring that takes place over 999 incident response within the CCC to assure process efficiency, effectiveness and the preservation of patient safety. This is as increasing numbers of cases are dealt with through telephone advice ('Consult and Close') and at scene by an EMS responder without ED conveyance ('See and Treat'). This section considers broader Trust management, commissioner and other stakeholder oversight.

2.65 We sought to establish whether information is available to senior decision makers in the Trust to assess the efficiency, effectiveness and safety of current response models and if so, whether this is used to inform future pathway developments.

2.66 We noted Trust Board and sub-committees receive only summary level information about 'See and Treat' and 'Consult and Close' volumes, targets, trends, re-contact rates etc. through the monthly integrated performance reports (MIQPR), indicators 22 ('Hear and Treat') and 23 (Conveyance to ED) which present the information in a graphical form. These mirror similar graphics as those provided to the operational teams, outlined under Objective 3 above and referred to in **Matters Arising 1**.

2.67 Information is provided to senior planning teams and Executives on the progress and success of service development initiatives on which decisions are then made for their future direction. Reports of the progress of 'shift left' service development initiatives linked to the EMS Demand & Capacity Review (examples of these were given under objective 3 above) are provided via the Strategic Transformation Board, to which programme boards managing these provide regular updates.

2.68 Future plans are formed drawing on the experience of earlier initiatives, and in the EMS context, from the impacts seen on the reduction in ED conveyances through the successful use of 'See and Treat' and 'Consult and Close' alternative incident responses.

2.69 Examples of this are the second phases now launching of the falls response team (development of Level 2 following the success of Level 1) and recruitment of CSD Mental Health practitioners to provide the resources to extend the Mental Health referral pathway 'See and Treat' offer.

2.70 Also monitored is the patient safety aspect, through the continuous incident capture in Datix and regular analysis, investigation and reporting of these to the Patient Safety groups and the Quality and Patient Safety & Experience sub-committee.

2.71 We looked at what the Trust are doing to share their EMS response information with commissioners and other stakeholders.

2.72 We note that the Ambulance Quality Indicators (AQIs) published by EASC quarterly include metrics relating to 'See and Treat' and 'Consult and Close', but at present none relating to the 'Can't Send' incident response which is applied when the Trust is at levels of high escalation.

2.73 We are advised that commissioners also have access to the Trust's data warehouse and through this, material is available to the National Collaborative Commissioning Unit (NCCU) at any time through the self-service Qliksense dashboards where users can configure their own enquiries.

2.74 The Trust reports bi-monthly to EASC in the EASC Provider Report, covering key issues affecting quality and performance for EMS and NEPTS and providing an update on commissioning and planning. The latest report of November 2021 refers to the award of new resources for the CSD and the further modelling work currently being undertaken on shift left options ('See and Treat', 'Consult and Close'), following the re-opening of the EMS Demand and Capacity Review.

2.75 We saw materials in which performance against a broad variety of different targets including 'See and Treat' and 'Consult and Close' are reported in the regular Joint Executive Team (JET) meeting held every six months with Welsh Government.

Conclusion:

2.76 The Trust uses incident response information available from its systems to assess the models being used and to further its ambition to shift more patient demand left, where it is clinically safe to do so (although we recommend in **Matters Arising 1** under objective 3 that the analysis is extended to further inform incident response model development). We have raised no findings in this section of the audit and consequently have provided **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matters arising 1: Analysis, review and oversight of 'See and Treat, 'Consult and Close' and 'Can't Send' incident stop codes (Design)	Impact
We noted that the Trust do not routinely analyse and report the detail of 999 incident volumes by stop codes, including those dealt with by referral to the different health care partners and pathways, and as a result may miss opportunities to optimise case handling in using the 'See and Treat' and 'Consult and Close' options. Data is captured from a long list of values of different referral pathway types including palliative care, midwife, diabetic, falls and cardiac care, but we did not encounter any analysis of case volumes of these so were unable to determine how usage of the respective pathways is being monitored and interpreted (although project groups who own the service development initiatives will be conducting monitoring and data may be available through the Power BI reporting tools). There have been examples of development in some of these pathways, e.g. falls framework and mental health pathway, but more coordinated analysis and scrutiny of all referral pathways usage could identify further improvement opportunities. This information could be used internally by the Trust to inform incident response development as well as being shared with health boards (who currently receive only records of incidents where the outcome was a conveyance to a hospital in their area) to assist in their service provision planning, and to do so would deliver against one of the current commissioning intentions.	Potential risk that opportunities for further 'See and Treat' and 'Consult and Close' incident responses are missed.

Recommendations	Priority
1.1 We recommend that greater use is made of referral data in the incident records to inform further developments of current and future referral pathways, including; 1) production of reports showing more detailed analysis by stop code. 2) coordinated analysis, review and scrutiny of these internally to inform quality improvement. 3) reporting referral volumes at health board level to assist with their service provision planning.	**Medium**

	Management response	Target Date	Responsible Officer
1.1	1.1.1 A new report is available with data back to January 2021 which shows the referral pathway presented to the patient once the consultation with CSD is complete. This will be able to be broken down by health board area given the nature of the patient's location information. The Ops team is also reviewing in more detail the calls into CSD and their outcome. A review of this is likely late Q4 2022.	Q4 2021-22	Assistant Director of Operations (Integrated Care) S Clinton
	1.1.2. The review can be shared to inform quality improvement.	Q1 2022-23	Assistant Director of Operations (Integrated Care) S Clinton
	1.1.3. The detail in the new stop codes will allow for the reporting referral volumes through Consult and Close in CSD.	Q1 2022-23	Assistant Director of Operations (Integrated Care) S Clinton

Matters arising 2: Management review of incident responses and patient outcomes (Design)	Impact
We noted that, because of the heightened harm risk where ambulances are not sent to callers, the CCC are monitoring volumes of 'Can't Send' responses and examining sample cases to ensure there has been no patient harm resulting, but that this information is not routinely reported to an oversight group within the Trust's governance structure. Other 'See and Treat' and 'Consult and Close' incident responses are not currently being similarly examined. As the Trust is expected to increase 'Consult and Close' and 'See and Treat' activity going forward, to shift left along the five-step clinical response model, this should present opportunities to expand this review process to assess these stop codes. We note a lack of integration of Trust and health board systems prevents the Trust from understanding individual patient journey and outcomes. However, we were advised that the recent launch of the Electronic Patient Care Record solution will bring improved capability to achieve better data and better access to information to improve patient care.	Potential risk of patient harm

Recommendations		Priority
2.1	We recommend that current analysis and sample examination of the 'Can't Send' call responses is extended to include other 'See and Treat' and 'Consult and Close' incident responses. This could be coordinated by theme and pathway type, to inform patient safety and quality improvement and should be routinely analysed and reported into the agenda of an appropriate group in the Trust's governance structure.	Medium

Management response		Target Date	Responsible Officer
2.1	With the introduction of a dedicated training and audit team within the CSD more opportunity to analyse and sample Consult and close outcome will be possible. We will ensure it is part of normal audit of the activity in the CSD. Findings can be shared with other groups to ensure quality and enhanced clinical review similar to Can't Send outcomes.	Q2 2022-23	Assistant Director of Operations (Integrated Care) S Clinton

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Digital Governance
Final Internal Audit Report

February 2022

Welsh Ambulance Services NHS Trust

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

EXTERNAL • QUALITY • ASSESSMENT

Contents

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Executive sign-off:	Andy Haywood, Director of Digital
Distribution:	Trish Mills, Board Secretary
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

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

Executive Summary

Purpose

To provide assurance to the Audit Committee that the Trust's governance of digital services is appropriate to provide oversight and deliver the organisations digital strategic objectives.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Developing a Strategic Outline Programme that sets out how the Digital Strategy will be implemented and the required resourcing;
- Defining the timescales for delivery of the Digital Strategy; and
- Establishing the structures for linking Digital with the operational part of the organisation.

Other recommendations / advisory points are within the detail of the report.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives		Assurance
1	Digital Strategy	Reasonable
2	Requirements for Implementation	Reasonable
3	Governance Structure	Reasonable
4	Digital Knowledge	Reasonable
5	Steering and Management	Reasonable
6	Policies	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Delivery Timescales	1	Operation	Medium
3	Roadmap / SOP	2	Operation	Medium
5	Steering Level	5	Operation	Medium
7	Policies and Guides	6	Operation	Medium

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

1. Introduction

1.1 In line with the 2021/22 Internal Audit Plan for Welsh Ambulance Services NHS Trust (the Trust) a review of the arrangements in place for Digital Governance has been undertaken.

1.2 The aim of the review was to provide assurance to the Audit Committee that the Trust's governance of digital services is appropriate to provide oversight and deliver the organisation's digital strategic objectives.

1.3 The potential risks considered in this review were as follows:

- the Trust does not maximise the benefits from its investments in digital technologies;
- the Trust has not planned effectively to deliver the digital strategy; and
- the governance structure does not enable effective oversight of digital.

2. Detailed Audit Findings

Objective 1: A digital strategy is in place which is aligned to organisational strategies and is being implemented.

2.1 The Digital Strategy covers all the key relevant items expected, including a consideration of the environment, of stakeholders and of digital maturity. It sets out high level objectives within 4 themed "digital missions" each of which has key objectives and makes clear how success will be measured. The missions are defined as: Digital Patient; Digital Workforce; Intelligence through Data; and Digital Foundations.

2.2 The Digital Strategy underpins and enables the delivery of the overall Trust Strategy and vision (Delivering Excellence).

2.3 The Digital Strategy is very clear about the other Trust strategies it aligns to, with each mission identifying the relevant Trust strategy to which it aligns or references.

2.4 The timing of the delivery of the Digital Strategy is split into 3 phases which show how it will move forward, these are: Stabilise; Optimise; and Sustain. However, we note that there are no timings defined for when each phase will be complete and as such the Digital Strategy does not include an indication of when the organisation intends to deliver its aims. (Matter Arising 1)

2.5 The embedding of the Digital Strategy into the Trust business and thus ensuring alignment is via the IMTP. The IMTP references the Digital Strategy and includes key digital aims and actions to take forward for the next 3 years, together with more specific detail for year 1.

2.6 The Strategic Transformation Board (STB) monitors delivery of the IMTP and as such monitors the delivery of the Digital Strategy items included within this. Our review of STB business confirmed that the implementation of the Digital Strategy is monitored by the STB.

2.7 The Digital Strategy is being implemented, and there are processes in place to monitor the component parts of this. The monitoring framework comprises multiple parts including individual programmes, STB and the Finance and Performance Committee.

2.8 Our review of progress against the Digital Strategy showed that overall, in terms of implementation of the digital strategy, it is moving forward and the specific items defined under it are generally being implemented appropriately.

2.9 The Digital Strategy includes an objective to "expand the use of digital champion". We note that a group was originally set up, however there has been a lack of capacity to take this forward and the development of a network of digital champions has not occurred. The lack of this network of champions may adversely impact in the traction of the Digital Strategy and of key items within it. (Matter Arising 2)

Conclusion:

2.10 There is a Digital Strategy in place which is clearly aligned to, and supportive of the delivery of the Trusts organisational objectives. The Digital Strategy is embedded into the IMTP and there are processes to monitor the implementation of this. In general, the Digital Strategy is being implemented, although we note there a lack of clarity over the timescale for delivery of the Digital Strategy. Accordingly, we have provided reasonable assurance over this objective.

Objective 2: Requirements for implementing the strategy are clearly defined in the IMTP.

2.11 As noted above, the Digital Strategy is referenced in the IMTP and key targets for the delivery of this are included. However, the level of staff resource and funding required to deliver the Digital Strategy is not included within the Digital Strategy or the IMTP as the position with these is complex. There has been a number of staff funded through different programmes e.g., EPCR and 111, however not all the funded posts have been recruited to due to difficulties in recruitment which means the residual gap in resource was not fully known at the time of drafting the Digital Strategy.

2.12 The Trust commissioned Channel 3 to review the Digital Strategy and has received a report with a suggested Target Operating Model (TOM). This has been accepted and work is ongoing to develop a Strategic Outline Programme (SOP) which sets out how the Digital Strategy will be delivered and what roles and skills are required.

2.13 In the interim, work has been ongoing using the ongoing recruitment programme and natural wastage to restructure the Digital Directorate to better align with strategic need by re-writing the job descriptions for vacant posts to take into account the required skills.

2.14 The Channel 3 report noted that there has been a lack of investment in digital, and this has led to resource and capability gaps. The risks relating to lack of digital staff and digital skills to support the current position and roll out further digital

initiatives is included on the ICT risk register, as is a risk relating to lack of funding for projects overall.

2.15 The current position therefore is that there has not been a full assessment of the funding required, or the skills and capacity required in order to deliver the digital strategy and the risks associated with under provision. As such the resource, capacity and delivery model is not fully defined. We do note that work has commenced to develop an SOP for digital which would cover these aspects along with the delivery structures. (Matter Arising 3)

Conclusion:

2.16 The Digital Strategy is included within the IMTP with defined actions stated, however there is no identification of the funding or staff resource needed to implement the Digital Strategy. This has been acknowledged and work is ongoing to move the Digital Directorate structure to better align with the organisational needs and to develop a SOP that sets out the resources needed for the Digital Strategy. Accordingly, we have provided reasonable assurance over this objective.

Audit objective 3: A governance structure is in place with an appropriate committee and a monitoring and reporting framework.

2.17 There is no single Board sub-committee that oversees digital. Currently the governance of digital is split with various groups being involved, including:

- Quality, Patient Experience and Safety Committee, oversees Information Governance related items;
- Finance and Performance Committee oversees the progress of Digital projects and Programme related items, the Committee also tracks relevant audit actions;
- Audit Committee oversees internal and external audit reports and recommendations; and
- Strategic Transformation Board (STB) oversees delivery of the IMTP and programmes.

2.18 Our review of the business of the different governance groups confirmed that the relevant digital governance items were included within these, together with relevant reporting and discussion.

2.19 The Trust has considered establishing a specific, dedicated sub-committee for digital, however there is a lack of capacity at the Board level for this. The decision has been made however to move the information governance oversight into the Finance and Performance Committee in order to ensure that all digital items are within the same Committee.

2.20 We note however, that although there is regular discussion of digital items at this committee, digital is not defined as a specific agenda item for each meeting. Without this specific inclusion there is a risk that sufficient time may not be allocated for digital and the visibility of digital issues may drop. (Matter Arising 4)

Conclusion:

2.21 There is an appropriate governance structure in place for digital, with digital issues discussed at the relevant sub committees. We note that there is no capacity for a dedicated committee for digital, with the current structure splitting digital issues across two board Sub committees. There is an intent to move all digital issues into one sub committee, however digital is not currently a standing agenda item. Accordingly, we have provided reasonable assurance over this objective.

Audit objective 4: Members within the digital governance structure understand their responsibilities and the thematic area over which they preside and can ensure that the organisation understands and uses digital technologies fully.

2.22 The Channel 3 work included interviews with Executives to ascertain their level of understanding of digital and their role, the outcome of which was that the work noted that the understanding was good.

2.23 This work also highlighted the need to improve the knowledge base for non -officer members, accordingly two sessions were conducted as part of the Digital Strategy development process in order to ensure that all Board members fully understand Digital and their role.

2.24 We also note that further Board development work is planned, with a session on cyber security and data protection planned to take place in January.

2.25 As noted above the staffing requirements are being worked through as part of the development of the SOP, and in the interim, there is tactical restructuring of the directorate using attrition and vacancies.

2.26 There is an awareness of the need to ensure up to date modern digital skills, and work is ongoing to develop these, including joining the British Computer Society in order to access training and development. We note however that this process isn't fully structured and doesn't match needed, and anticipated future required skills with the current in place resource to define a plan. (see Matter Arising 3)

Conclusion:

2.27 An assessment of the digital knowledge of the members of the governance structure has been undertaken and where gaps were identified development work has been undertaken. Management within the Digital Directorate are appropriately skilled and aware of their responsibilities. There is an acknowledgement that the Trust needs to ensure the Digital Directorate has sufficient appropriately skilled staff, and work is ongoing to develop in this area, although we note that the final requirements are not yet known. Accordingly, we have provided reasonable assurance over this objective.

Audit objective 5: An appropriate steering and management framework is in place to deliver operational requirements and enable reporting into the governance structure.

2.28 The Strategic Transformation Board is comprised of executives and other relevant leads and so acts as a steering group at a high level. However, the Channel 3 report noted that there was lack of an operational steering level for digital with a disconnect between business activities and digital planning being highlighted.

2.29 The Channel 3 report recommended the establishment of a set of business channels to link digital to the business operations and to enable steering and engagement. We note from our discussion that the intent is to move towards the channel structure to enable the steering aspect of the Digital Strategy. (Matter Arising 5)

2.30 Within the Digital Directorate there is an appropriate management framework which enables oversight. There is a Digital Leadership Group which comprises senior management from Digital and which meets on a weekly basis. Our review of the operation of this noted that it is well attended and the business of the meetings enables tracking of projects and significant actions. We also note that a review of the digital risk register is included in the meetings and there is evidence of upward reporting of significant risks to the committee level.

2.31 Below this level within the Digital Directorate, there are regular Senior Leadership Team meetings, one for ICT and one for Informatics which enable further management.

2.32 We do note that there are some inconsistencies in the detail of reporting into the governance structure against some of the Digital Strategy components. (Matter Arising 6)

- The delays to the delivery of SALUS has impacts that are wider than the digital strategy component, however the risk to the wider organisational strategy has not been reported on the corporate risk register. We do note that is work in progress with the risk currently being developed
- Reporting against the 111 / 999 call platform resilience is combined and currently flagged as Green. However, the 999 aspect is not on target and is sufficiently delayed to call into question the need for the specific item.
- Reporting on the data portal does not use the standard highlight report format and is not so clearly defined.

Conclusion:

2.33 There is a high level group in place to track the delivery of the IMTP, and so relevant digital items, with reporting from project and programme groups, although we note some inconsistencies in reporting. There is management structure in the Digital Directorate, with a Digital Leadership Group meeting regularly and regular and senior leadership team meetings. The steering level where digital interfaces with the operational business is not fully defined. This is acknowledged and the intent

is to move to a model with business channels to enable this. Accordingly, we have provided reasonable assurance over this objective.

Audit objective 6: Policies and procedures have been defined for key areas which are regularly updated / reviewed.

2.34 There is a suite of digital related policies in place for the Trust. These cover both ICT and Informatics themes. The spread of polices is reasonable and cover most of the expected items.

2.35 We note that it is clear that some of the polices have been updated recently. The Policies are maintained by corporate and there is a process for contacting policy leads to request updating if required.

2.36 We further note however, that there has not been any structured review of additional digital policies or guidelines that may be required by the organisation that take into account up to date technology, e.g., cloud services.

2.37 In addition, some of the currently available digital related policies are out of date and have not been reviewed:

- Social Media Policy dates from 2018;
- Asset Management Policy dates from 2011; and
- Data Protection Policy dates from 2016. We note that this doesn't reference GDPR.

Conclusion:

2.38 There are policies in place for key digital related themes, although these may not be fully complete for all modern technology areas, and we note that some are out of date. Accordingly, we have provided reasonable assurance over this objective.

Appendix A: Management Action Plan

Matter arising 1: Delivery Timescales (Operation)	Impact
The Digital Strategy clearly splits the timing of the delivery into 3 phases which show how it will move forward. However, there are no actual timings for when each phase will be complete, and as such the Digital Strategy does not include an indication of when the organisation intends to deliver its aims.	Potential risk that the Trust has not planned effectively to deliver the digital strategy.

Recommendations		Priority
1.1	The Trust should be explicit and define the intended timescales for the delivery of the Digital Strategy phases.	Medium

Management response		Target Date	Responsible Officer
1.1	WAST is producing a Digital Strategic Outline Case (SOC) for Digital Services that will make these timelines clear.	September '22	Director of Digital Services

Matter arising 2: Digital Champions (Operation)	Impact
The Digital Strategy includes an objective to "expand the use of digital champion". We note that a group was originally set up, however there has been a lack of capacity to take this forward and the development of a network of digital champions has not occurred. The lack of this network of champions may adversely impact in the traction of the Digital Strategy and of key items within it.	Potential risk that the Trust does not maximise the benefits from its investments in digital technologies

Recommendations		Priority
2.1	The process of developing a network of digital champions and expanding the role of these should be re-instated.	Medium

Management response		Target Date	Responsible Officer
2.1	Fully support this recommendation. Both EPCR and OCP have user groups with nearly 150 members combined. This was required due to the Trust being at REAP 4, however, as this is de-escalated and capacity increases within the workforce, the role will be broadened and publicised more widely.	Q4 22/23	Director of Digital

Matter arising 3: Roadmap / SOP (Operation)	Impact
The Digital Strategy makes no reference to the resources required for delivery of it, either in terms of finance or staff capacity and skills. There has not been a full assessment of the funding required, the skills and capacity required in order to deliver the digital strategy and the risks associated with under provision. And so the resource, capacity and delivery model are not fully defined. We do note that work has commenced to develop an SOP for digital which would cover these aspects along with the delivery structures.	Potential risk that the Trust has not planned effectively to deliver the digital strategy.

Recommendations		Priority
3.1	A SOP should be developed that provides a roadmap to delivery of the Digital Strategy and defines the resources required together with a delivery and monitoring structure.	Medium

Management response		Target Date	Responsible Officer
3.1	In progress. Third party support has been engaged and the SOP / SOC is planned in the IMTP for delivery at the end of September ’22.	End of Sep ‘22	Director of Digital

Matter arising 4: Digital within Committee Agenda (Operation)	Impact
The governing committee for all of the digital aspects is to be the Finance and Performance Committee, with the addition of the IG aspects into this committee. Although we note regular discussion on digital items at this committee, digital is not defined as a specific agenda item for each meeting. Without this specific inclusion there is a risk that time may not be allocated sufficiently and the visibility of digital issues may drop.	Potential risk that the governance structure does not enable effective oversight of digital.

Recommendations		Priority
4.1	Digital should be included as a standing agenda item within the Finance and Performance Committee.	Low

Management response		Target Date	Responsible Officer
4.1	Under discussion with the Board Secretary and in the revised terms of reference being considered as part of a wider effectiveness review.	Q2 22/23	Director of Digital / Board Secretary

Matter arising 5: Steering Level (Operation)	Impact
Although there are high level governance groups for the Digital Strategy and delivery there is a gap at the steering level where digital interfaces with the business units. This was also identified within the C3 report which recommended a set of business channels to enable engagement and steering. We note that the intent is to move towards this structure.	Potential risk that the governance structure does not enable effective oversight of digital.

Recommendations		Priority
5.1	The steering level should be established as noted.	Medium

Management response		Target Date	Responsible Officer
5.1	This will be handled by clarifying the oversight of Digital in the relevant board sub committees, as WAST is not scaled for a further sub-committee for Digital alone. The Information Governance Steering Group has now recommenced as a formal sub-committee of QUEST and consideration will be given to a further steering group for F&P.	Q3 22/23	Director of Digital

Matter arising 6: Reported Detail (Operation)	Impact
We do note that there are some inconsistencies in the detail of reporting into the governance structure against some of the Digital Strategy components. • The delays to the delivery of SALUS has impacts that are wider than the digital strategy component, however the risk to the wider organisational strategy have not been reported on the corporate risk register. We do note that is work in progress with the risk currently being developed • Reporting against the 111 / 999 call platform resilience is combined and currently flagged as Green. However, the 999 aspect is not on target and is sufficiently delayed to call into question the need for the specific item. • Reporting on the data portal does not use the standard highlight report format and is not so clearly defined.	Potential risk that the governance structure does not enable effective oversight of digital.

Recommendations	Priority
6.1 The SALUS risk should be articulated on the corporate risk register. Reporting on the 999 call platform should be separated from the 111 aspect. The impact of the delay on the current suitability of the project should be assesses. Reporting on the data portal should follow the same format as other aspects of the Digital Strategy.	Medium

Management response	Target Date	Responsible Officer
6.1 Risk is in draft, ready to be added to the corporate register. Discussion planned for early March ’22 to confirm.	Q1 22/23	Director of Digital

Matter arising 7: Policies and Guidelines (Operation)	Impact
There has not been any structured review of what additional digital policies or guidelines may be required by the organisation. in addition, some of the currently available digital related policies are out of date and have not been reviewed: • Social Media Policy from 2018; • Asset Management Policy from 2011; and • Data Protection Policy from 2016. We note that this doesn't reference GDPR.	Potential risk that the governance structure does not enable effective oversight of digital.

Recommendations	Priority
7.1 An assessment of the current, and future need for digital related policies should be undertaken. The existing policies should be reviewed to ensure that they are all within date and valid.	Medium

Management response	Target Date	Responsible Officer
7.1 Agree, although it should be noted that in many cases these are corporate policies for all staff that relate to digital technology.	Q4 22/23	Director of Digital

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

Priority level	Explanation	Management action
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Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
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Recruitment Practices – Equality, Diversity and Inclusion

Final Internal Audit Report

February 2022

Welsh Ambulance Services NHS Trust

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Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

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

Executive Summary

Purpose

To provide the Trust with assurance that there are adequate arrangements in place to ensure that applicants from a diverse range of backgrounds are encouraged, supported and able to apply and be successful.

Overview

We have issued reasonable assurance on this area. The matters requiring management attention include:

- Improved links required between work undertaken by the PECI team and the Strategic Equality Objectives
- Limited analysis of the effectiveness of initiatives to attract new staff
- There is no regular analysis of candidate progress to establish and assess barriers to applicants from minority backgrounds
- EDI Steering Group was not quorate, and the Terms of Reference requires updating

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved	N/A

Assurance summary[1]

Assurance objectives		Assurance
1	Strategy in place	Reasonable
2	Initiatives to attract	Reasonable
3	Analysis	Limited
4	Initiatives to retain	Substantial
5	Reporting	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Link PECI work to the Strategic Equality Plan	1	Operation	Medium
2	Analysis of initiatives to attract and recruit	2	Design	Medium
3	Analysis of candidate progress	3	Design	Medium
4	EDI Steering Group ToR and attendance	5	Operation	Medium

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

1. Introduction

1.1 The Welsh Ambulance Service Trust ('the Trust') has a Strategic Equality Plan in place: *Treating People Fairly 2020-2024*. The strategy sets out a number of Strategic Equality objectives, including for the Trust to take positive action to increase representation and create a positive experience of work for individuals from diverse backgrounds, cultures and identities to ensure the Trust is seen as a great place to work, volunteer, develop and grow for all. This, in turn, should assist the service to understand and be responsive to the needs of the communities it serves.

1.2 The key risk considered in this review is the inability to attract, recruit, retain and develop a diverse workforce with a culture that accepts, recognises and respects diversity and that can effectively represent the communities the Trust serves.

2. Detailed Audit Findings

Audit objective 1: there is a strategy in place that focuses on initiatives to attract and retain a skilled workforce from diverse backgrounds, cultures, and identities across the organisation.

2.1 The Trust's Strategic Equality Plan 2020-2024 outlines four objectives that aim to ensure it maintains and contributes to a fair and equitable society, and creates a diverse and inclusive culture, both inward and outward facing.

2.2 Alongside each of the objectives are several actions that the Trust intends to complete. These include:

- *Promote a culture of inclusivity and develop leaders who understand and value the benefits of a diverse and inclusive culture.*
- *Work in partnership to strengthen the voice of all citizens and improve access to information and services in a variety of different formats and languages, including meeting our Welsh language commitments.*
- *Improve the quality, understanding, accessibility and reporting of our equalities monitoring data, information and stories to show how we are doing in progressing towards delivery of our strategic equality objectives, and inform future action planning.*
- *Review our recruitment strategy and approach to ensure that applicants from a diverse range of backgrounds are encouraged, supported and able to apply and be successful.*

2.3 Our review has shown that there are several mechanisms in place that contribute towards the achievement of these objectives, but that due to the impact of Covid-19, monitoring progress against the actions has been challenging and development work is ongoing to demonstrate outcomes.

2.4 Examples of the mechanisms in place is the Allyship programme, alignment of Trust events with the NHS Employers calendar and the refresh of the Trust's behaviours and cultures (refer to objective 4 below for further detail).

2.5 In addition, the Patient Experience and Community Involvement (PECI) team prepare quarterly reports for the Quality, Safety & Patient Experience Committee. These summarise the work that has been undertaken by the team to engage with communities across Wales. However, there is an opportunity to strengthen the link between the PECI work and how it feeds in and contributes to the objectives set out within the Strategic Equality Plan. **See matter arising 1 in Appendix A**

Conclusion:

2.6 The Trust's Strategic Equality Plan establishes four objectives that lay the groundwork for ensuring the Trust is able to attract and retain a skilled workforce from diverse backgrounds. Further work is needed to link the Trust's activities back to the plan. As such, a **Reasonable** assurance rating is determined for this objective.

Audit objective 2: effective initiatives are in place to promote the service to potential employees from diverse backgrounds, cultures, and identities.

2.7 The Trust is currently developing a 'Recruitment Outreach Programme' which seeks to ensure recruitment processes reach all societal groups. In particular, this includes working with third sector organisations to ensure that recruitment processes are inclusive and that the net for all recruitment drives is cast as widely as possible. We note that this project is in its infancy and awaiting the appointment of a recruitment advisor to support this work.

2.8 Training workshops are available to all recruitment managers to ensure that the recruitment process is inclusive and consistently applied across directorates. This includes a session on unconscious bias with tips and guidance to overcome this in recruitment. In addition, information on recruiting for diversity is included within the recruitment learning launchpad channel within Microsoft Teams. We note that applications are anonymised to help prevent short listers from being able to identify protected characteristics when shortlisting.

2.9 The Trust regularly uses social media platforms to promote and advertise roles and there is an intention to increase candidate reach going forward by advertising roles across more diverse networks and job platforms. A specific careers discovery event for individuals from the Black, Asian and Minority Ethnic backgrounds was held in July 2021.

2.10 As a result of Covid-19, the Trust has only been able to hold a limited number of career events. However, moving these to online events has provided the opportunity to make them accessible to a more diverse range of candidates and there are plans to undertake more of these. We note that there is currently limited analysis undertaken to establish the effectiveness of these online initiatives. **See Finding 2 in Appendix A**

Conclusion:

2.11 Work is ongoing to develop initiatives to ensure recruitment reach is as wide as possible. A **Reasonable** assurance rating has been determined for this objective.

Audit objective 3: the Trust undertakes analysis of its applicants and how far they progress into the recruitment process, in order to understand and address any inherent barriers.

2.12 There is currently no analysis being undertaken to enable the Trust to identify the number of applicants by background, culture, identity and how far candidates progress through the recruitment process. We understand from discussion with the recruitment team that the trac.jobs recruitment system, which covers all health sector jobs, has the capability to generate reports to provide this analysis. This could help the Trust identify any inherent barriers in the process that need to be addressed. **See matter arising 3 in Appendix A**

2.13 We note that NHS Wales Shared Services Partnership (NWSSP) Recruitment Team issue surveys to all applicants and that the results of these surveys are shared with the Trust. However, themes raised tend to be experience driven and do not therefore provide the relevant level of intelligence required.

Conclusion:

2.14 Limited analysis is currently undertaken of applicants and how far candidates progress through the recruitment process, although the trac.jobs system has the capability to provide this. A **Limited** assurance rating is given for this objective.

Audit objective 4: the Trust have initiatives in place to support and retain its staff.

2.15 The Warm WAST Welcome is an induction programme available to all new starters and existing employees moving into new roles. It provides a broad induction into the organisation's culture, behaviours and values while raising awareness of the importance of equality, diversity and inclusion. 12 weeks after completing the induction, staff are invited to 'check-in' with the team, providing an opportunity for staff to raise any issues or concerns.

2.16 The aim of the Allyship programme, referred to in objective 1 above, is to create a more inclusive and mindful workforce based on continued education and learning around equality, diversity and inclusion, with a clear focus on protected characteristics. We note that this programme is currently in its infancy but that several introductory sessions have been arranged throughout February 2022 to drive the programme forward.

2.17 As part of wellbeing week in November 2021, the Trust issued a pulse survey to staff to gauge how they were feeling. This survey has allowed the Trust to take stock after an unprecedented and challenging period and to assess people's

wellbeing. While the above is not directly an initiative to retain staff, it serves as a mechanism to capture staff satisfaction.

2.18 The Trust is a member of several national ambulance forums. These include the National Ambulance Diversity and Inclusion Forum (NADIF), National Ambulance LGBT+ Network, National Ambulance BME Forum (NABMEF), National Ambulance Disability Network (NADN) and the Equality Leadership Group. Representatives from the Trust attend the forums and feed back to the Equality, Diversity and Inclusion (EDI) Steering Group. This helps ensure that that the Trust stays up to date with developments within minority communities and any impact had on Ambulance Trusts across the UK.

2.19 The Trust has also established support for two internal staff networks, Inclusion and LGBT+, which also feed into the EDI Steering Group. These offer a safe space for colleagues to come together and share experiences.

2.20 One of the initiatives the Trust has in place is to align the events calendar with that of the NHS employers' national campaigns which includes Pride and National Inclusion Week. Awareness for such events is raised via the Siren Trust wide announcements and posters are also issued to Directorates to provide information and promote and encourage staff to get involved. The most recent National Inclusion Week saw a take up from a wide range of staff across the Trust.

Conclusion:

2.21 The Trust has several mechanisms in place to support staff. A **substantial** assurance rating is determined for this objective.

Audit objective 5: adequate reporting mechanisms are in place to monitor the diversity of the workforce through the Trust, both locally and at Board level.

2.22 The EDI Steering Group is responsible for ensuring that the Trust '*embeds equality, diversity and human rights considerations, while carrying out its respective functions and responsibilities as a service provider and employer.'* The Group meets quarterly and is also committed to meeting the objectives the Trust has set out in the Strategic Equality Plan 2020-2024.

2.23 The Group feeds through to the People and Culture Committee (PCC) via the Workforce and Organisational Development (WOD) update and subsequently through to the Board within the PCC update, ensuring that the Board is aware of any issues effecting equality, diversity and recruitment. The minutes for the previous EDI meetings are included within the papers for the Committee and a recent paper taken to the PCC outlined the progress made in relation to the organisational behaviours and cultures reset. In addition, a recruitment update paper was presented to the Committee in May 2021, outlining the recruitment challenges facing the Trust.

2.24 A review of the EDI Group Terms of Reference and minutes has shown that of the three meetings reviewed, only one was quorate. Our review also notes that the

terms of reference state that the Group reports to the WOD Business meeting, but this was confirmed as being incorrect. **See matter arising 4 in Appendix A**

Conclusion:

2.25 There are mechanisms in place to monitor the diversity of the workforce however the Terms of Reference for the EDI Steering Group require updating and some meetings have not been quorate. As such a **Reasonable** assurance rating is determined for this objective.

Appendix A: Management Action Plan

Matter arising 1: Link PECI work to the Strategic Equality Plan (Operation)	Impact
The PECI team prepare quarterly reports for the Quality, Safety & Patient Experience Committee. These summarise the work that has been undertaken by the team to engage with communities across Wales. However, it has been acknowledged by the team that there is an opportunity to strengthen the link between the PECI work and how it feeds in and contributes to the objectives set out within the Strategic Equality Plan (SEP).	Potential risk of: • Activity undertaken by the Trust is not aligned to the SEP

	Recommendations	Priority
1.1	Work is undertaken to link the PECI work directly to the Strategic Equality Plan	Medium

	Management response	Target Date	Responsible Officers

1.1	WAST accepts this finding and will increase links between PECI and the EDI team.
	• Set up monthly meetings between EDI team and PECI team:
	  ○ To review progress against SEO objectives
	  ○ To plan joint events
	  ○ To share data/ reports
		April 2022	Keithley Wilkinson, Head of Equality and Engagement
			Gareth Thomas, PECI Manager

Matter arising 2: Analysis of initiatives to attract and recruit (Design)	Impact
The Trust has a number of initiatives in place that help promote the service as an attractive place to work, including membership to a number of National Ambulance Networks, targeted career events and training for staff that helps ensure the recruitment process is inclusive. However, there is currently limited analysis undertaken to establish the effectiveness of these initiatives.	Potential risk of: • Initiatives are not effective or as successful as intended

Recommendations		Priority
2.1	Establish mechanisms to allow the Trust to analyse and capture the effectiveness of initiatives	Medium

Management response		Target Date	Responsible Officer
2.1	WAST accepts this finding and will explore and establish mechanisms to capture effectiveness.		Keithley Wilkinson, Head of Equality and Engagement
	a) Survey new starters about where they heard about working for WAST.	April 2022	
	b) Routinely conduct pulse surveys following a careers event.	May 2022	
	c) Ask the inclusion network to participate in a focus group to provide qualitative feedback on the effectiveness of initiatives.	June 2022	

Matter arising 3: Analysis of candidate progress (Design)	Impact
The trac.jobs system provides a data report that breaks down groups of applicants against their progress through the recruitment process. However, this report is not run as a matter of course and as such there is currently no regular analysis undertaken.	Potential risk of: • Potential inherent barriers are not identified or addressed

Recommendations	Priority
3.1 a. The Trust should consider undertaking regular analysis of reports from Tracjobs and address any inherent barriers potentially impacting candidate progression.	Medium

Management response	Target Date	Responsible Officer
3.1 a. The trust accepts this finding. • Meet with Tracjobs and set up a reporting system for monthly updates	April 2022	Keithley Wilkinson, Head of Equality and Engagement

Matter arising 4: EDI Steering Group Terms of Reference and attendance (Design)	Impact
The Equality, Diversity and Inclusion Steering group terms of reference state that the group feeds through to the WOD Business Meeting. However, while establishing the reporting structure we were advised the EDI Steering Group reports to People and Culture Committee. Our review of the meeting minutes for the last three meetings (noting that there was no April 2021 meeting due to the Covid-19 response) identified that only one was quorate. We note that there were no significant decisions made during either of these meetings.	Potential risk of: • EDI Group is not compliant with its Terms of Reference

Recommendations	Priority
4.1 a. The Terms of Reference for the EDI Steering Group should be updated to reflect the correct reporting structure. b. The Terms of Reference should be reviewed in order to ensure that the membership is appropriate.	Medium

Management response	Target Date	Responsible Officer
4.1 a. The Trust accepts this finding and will update the Terms of Reference with support from the Deputy Corporate Board Secretary.	June 2022	Keithley Wilkinson, Head of Equality and Engagement
b. The Trust accepts this finding and will review the memberships of the EDI Steering Group.	May 2022	Keithley Wilkinson, Head of Equality and Engagement

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Cardiff Make Ready Depot
Final Internal Audit Report

February 2022

Welsh Ambulance Services NHS Trust

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

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Executive sign-off:	Executive Director of Finance and Corporate Resources
Distribution:	Assistant Director of Capital and Estates Project Manager
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

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

Executive Summary

Purpose

The review was undertaken to evaluate the processes and procedures put in place by the Trust to support the management and delivery of the Cardiff Make Ready Depot (MRD) scheme.

Overview

Whilst the works cost at the project has increased significantly (19%), the overall project will be delivered within the overall funding envelope – primarily attributed to WG agreement to retain savings on VAT and non-works costs.

The project has been subject to 18 weeks of delay in total, which has yet to be formally instructed under the contract. Noting Trust concerns on cost/progress reporting, further independent advice has been sought to provide assurance on the current assumptions on the likely time/cost implications – and these are reflected within the current programme and cost reporting.

The key priorities for management attention are:

- The need to conclude on the assessment of delays at the project and instruct appropriately in accordance with the contractual requirements.
- To formally review the project team's performance to determine whether it has had any impact on the project objectives; and whether any further action is required. This may be restricted given that the original adviser contracts cannot currently be located.
- Noting that the project is due to complete shortly, the remaining recommendations are primarily for the benefit of future projects and should be considered as part of a formal Post Project Evaluation.

There are some issues that require immediate management attention. However, in the context of overall project objectives, particularly the cost position and impact on the overall service resulting from this investment, an overall **reasonable assurance** has been determined.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance, having **Low to moderate impact** on residual risk exposure until resolved.	 2020/21

Assurance summary [1]

Assurance objectives		Assurance
1	Follow-up	Reasonable
2	Governance Arrangements	Reasonable
3	Project Management	Reasonable
4	Monitoring and Reporting	Reasonable
5	Change Management	Limited
6	Covid-19	Substantial

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1	The need to strengthen governance arrangements where competing pressures impact individuals' availability.	2	Design	Medium
2.1	To ensure that project risks are quantified and monitored against available contingencies	3	Operation	Medium
3.1	Reporting should be consistent for month-to-month to allow active monitoring/ benchmarking	4	Operation	Medium
4.1	Delays to date should be administered in accordance with contract requirements.	5	Operation	High
5.1-2	A post project evaluation is required to identify any recourse at this project and lessons for future projects.	5	Operation	Medium

1. Introduction

1.1 The project brings together the Emergency Medical Services (EMS) currently delivered from Blackweir Ambulance Station, with Non-Emergency Transport Services (NEPTS) teams, to provide a sustainable solution for the continued delivery of clinical services in the Cardiff area. The solution will implement a 'Make Ready' approach to vehicle washing and stocking, which reduces infection risks and enables frontline workforce to concentrate on service delivery.

1.2 The scheme has been in gestation in one form or another for over 10 years, with the agreed proposal being approved by Welsh Government in January 2020 in the sum of £7.958m, with construction works commencing in July 2020. The project is currently reported to be within its overall funding envelope; however, a delay has been reported, with a forecast completion date of 21st February 2022 (from an original completion date of October 2021).

1.3 This was the second audit of the project, with the first undertaken pre-construction, determining reasonable assurance.

1.4 Noting the ongoing impact of Covid-19, the delivery of this assignment has included an increased element of remote working.

1.5 The potential risks considered in the review were as follows:

- the potential failure to achieve key project objectives (e.g. delivery to time cost and quality);
- the governance arrangements were inadequate to provide assurance;
- the project management arrangements were not sufficiently robust to control key project objectives;
- adequate monitoring and reporting were not demonstrated; and
- the time and costs implications of changes were not adequately managed.

2. Detailed Audit Findings

Project Performance: Summary of the achievement of the project's key delivery objectives (time, cost and quality) for the period from the date of the previous audit report.

2.1 At a project audit, levels of assurance are determined on whether the project achieves its original key delivery objectives and that governance, risk management and internal control within the area under review are suitably designed and applied effectively.

2.2 The performance against time, cost and quality are summarised as:

- Time: The February 2022 Project Manager Dashboard report provides for an anticipated completion date of 21st February 2022. This represents an

eighteen week delay against the original completion date of 18th October 2021.

As noted in the detailed findings, the delays and the reasons behind them are the subject of ongoing scrutiny/ challenge but were attributed to factors such as the impact of the Covid pandemic and associated supplier delays and availability of subcontractor staffing, together with additional client instructions etc.

During this period of delay, the service has continued to operate out of the existing premises without disruption.

- Cost: The reported project cost position at the time of the review was:

Item	WG Approved	PM Report Jan 2022
Works Cost	£3,800,000	£4,527,087
Non-works costs	£1,900,000	£1,747,284
Fees	£554,355	£569,394
Contingency	£320,218	£25,000
Equipment Costs	£150,000	£158,543
VAT	£1,234,044	£703,986
Total	£7,958,617	£7,731,294

Whilst the works cost have increased c.19%, Welsh Government has agreed that this can be offset by utilising client contingency, non-works savings and VAT recovery. The project was therefore forecast to be managed within the overall funding allocation.

The forecast out-turn above includes a cost provision for the combined delays at the programme to date – including the impact of Covid on working methodology and staffing/ supplies. Due to Trust concerns, further independent advice has been obtained to provide further assurance on key assumptions made within the forecast.

- Quality: There have been no issues noted with the quality of the build. The solution will significantly improve on the existing buildings and working arrangements. However, there have been issues in regards of the project team performance, and these are addressed within the appropriate sections below.

2.3 The following sections of the report further outline the key observations that have contributed to the above.

Follow-up: Assurance was sought on the status of previously agreed management actions (as agreed in the September 2020 audit of the Cardiff Make Ready Depot - see **Appendix B**).

2.4 An audit of the program was previously undertaken in September 2020 providing reasonable assurance. The current position as determined by follow-up at this audit can be summarised as:

Priority	High	Medium	Low	**Total**
Number of recommendations	1	6	2	**9**
Actioned	-	4	1	**5**
Outstanding	1	2	1	**4**

They remaining outstanding recommendations can be summarised as:

- the inability to locate contract documentation for the Project Manager and Cost Advisor (high priority);
- The need to define terms of reference for the Design Team (medium priority);
- The need to ensure that the Post Project Evaluation reflects on any assessment/reporting of contract awards (medium priority)
- To avoid the future use of letters of intent (medium priority).

The remaining outstanding actions are unlikely to be addressed at this project noting the project is due for completion shortly. Accordingly, it is recommended that each recommendation is considered in full at the Post Project Evaluation to determine the appropriate action required to inform future projects.

2.5 Noting the above, a **reasonable** assurance is therefore determined (see **Appendix B**).

Governance Arrangements: Assurance that appropriate governance arrangements were in place for the current project phase, including operation of effective reporting and accountability lines, and that appropriate approvals were in place.

2.6 The governance of the project was defined via a current Project Initiation Document (PID), which included the project objectives, structures, roles and responsibilities, and terms of reference of project groups. An active Project Board operated, attended by the Project Director (Assistant Director of Capital and Estates) and the Trust's Internal Project Manager. The Project Accountant and Project Delivery lead along with other Senior Trust Leads were also in attendance. These members of the senior management team provided strong corporate linkage to the Executive and enabled effective decision making.

2.7 Whilst it was noted that attendance at Project Board meetings was very good overall with several of the lead officers regularly attending, there were four other Senior Managers that failed to attend sufficiently regularly during the period reviewed. It is inevitable that the unprecedented prioritisation of the Covid-19 response had an impact on attendance. Nonetheless, to ensure sound governance arrangements are maintained, alternative arrangements should be determined in the event that similar competing resource pressures arise at future projects (see **recommendation 1.1**).

2.8 The Project Board did not meet for a period of four months between October 2020 and February 2021. It is advised that the meetings were cancelled due to the Trust being in the highest level of response (REAP 4) due to the pandemic. The meeting

in February 2021 took place at the earliest possible convenient time for Board members. Oversight of the scheme was maintained however with the monthly site meetings still taking place during this period.

2.9 Two meetings of the Project Board were noted as non-quorate in accordance with the Project Board's Terms of Reference. The Project Director was in attendance as Chair and has assured that the meeting was conducted as non-quorate and no actions were agreed (see **recommendation 1.1**).

2.10 As regards Project Team Meetings, the situation remains as was reported at the last audit, with no formal Project Management Team Meetings taking place. It was explained that due to the pressures on all teams within WAST over the pandemic, the decision was taken to meet individually and to manually record the outcomes/ decisions. It is understood however that with a de-escalation of the Covid situation that Project Team meetings are resuming week commencing 31st January 2022. Management advised that this was only utilised due the exceptional circumstances at the time, and was in agreement that this arrangement would not usually be utilised at projects and would not be used at future projects.

2.11 **Reasonable** assurance has therefore been determined in relation to project governance.

Project Management: Assurance that appropriate project management controls were applied, including the management of contractor and adviser performance, project risks and change control.

2.12 As noted above, a Project Initiation Document had been prepared by the internal Project Manager outlining the project scope, management, and overall success criteria for reference during the project progression. The document was last updated prior to commencement of the construction phase in July 2020 and was assessed as adequate.

2.13 In conjunction with the contractor, a programme of work had been developed in the form of a Gantt chart highlighting critical path items. This had been updated at key stages and included within the Highlight Report and presented to Project Board meetings.

2.14 The Trust advised that the risk contingency budget was developed by the Cost Advisor and was based on previous experience of similar projects and was calculated as a percentage of the construction envelope of the project. Whilst there is evidence that the risk register was regularly reviewed, it remained uncosted, contrary to NHS Wales Infrastructure Investment Guidance (**recommendation 2.1**).

2.15 **Reasonable** assurance has therefore been determined in relation to project management.

Monitoring & Reporting: Assurance was sought that appropriate monitoring and reporting arrangements are in place, including arrangements to monitor, review and control the financial performance of the project.

2.16 The Highlight reports are utilised as a means of distributing key reporting documents to Project Board Members, and they in turn are attached to the Project Agenda for months when the Project Board is sitting.

2.17 The consistency of key documents appended to these reports varied significantly in the period of review. Management advised that this was primarily attributed to the timely provision of information by the external advisors and has required significant input from Trust Finance staff and independent advice (see ***Change Management*** section*)* to provide assurance on the outturn cost position at the project.(**recommendation 3.1)** Other concerns around project team performance have also been observed and are detailed within the ***Change Management*** section below and **recommendation 5.2**.

2.18 Noting the Trust was able to gain its own independent assurances on the out-turn cost position, a **reasonable** assurance has been determined. However, as is noted below, it is important that the project team performance is reviewed upon completion (see below).

Change Management - to ensure compliance with agreed change management processes

2.19 The change management process was managed by the external advisers. The latest version of the change control register identifies 267 changes over the course of the project – all of which was funded from within the client contingency.

2.20 Management confirmed that, at key junctures during the project, the External Advisers were unwilling to share the change control register (alongside other key project documentation).

2.21 The current anticipated completion date of the 21st^{h} February 2022 represents an eighteen week delay against the original completion date of 18th October 2021. At the time of review, whilst an initial delay of 8 weeks had been assessed by the advisers, no element of the delays had been formally administered in accordance with the contract (see **recommendation 4.1**). Given the extent of delays to date, the Trust has sought its own independent advice on the provision to be made for these delays and associated costs, to affirm the position to be reported at the project.

2.22 The Trust has sought to manage the project team performance issues using Key Performance Indicators and regular dialogue, however the concerns remained at the time of audit. Given the current phase of the project, and other performance related issues noted at this report, it is suggested that a Post Project Evaluation is completed – to identify not only lessons for future project, but also whether any further actions are required (**recommendation 5.1**). Please note that the options available to the Trust may be limited, as the original contractual agreements for the advisers cannot be located (see **Appendix B Ref. 14**).

2.23 A **limited** assurance has been determined in this area due to the need to fully assess delays (and associated costs) in accordance with contract.

Covid-19 - assurance was sought that financial and delivery implications, including contractual issues, are appropriately managed, and that safe working practices were established and monitored

2.24 The programme of work was extended to take account of the risks Covid-19 presented in terms of delivery. The minutes of the Project Board Meeting held on the 24th July 2020 report "*It was noted that an additional 10 weeks had been agreed to be programmed into the project taking into consideration the current pandemic. RD stated that after speaking to the Cost Advisors the additional budget required could be absorbed within the contingency monies set aside".*

2.25 A monthly independent Health & Safety Inspection/audit is undertaken which includes within its scope issues presented by Covid-19. The Trust's Project Manager reports back to the Project Board levels of Covid-19 within the contractor workforce where this is identified along with the repercussions for the scheme if any.

2.26 A **substantial** assurance has been determined in this area.

Appendix A: Management Action Plan

Matter Arising 1: Project Board Attendance		Impact
The latest Project Initiation Document sets out the requirements for the Project Board and Project Team: **Project Board:** Whilst it is noted that attendance at Project Board meetings was very good overall with several of the lead officers being almost ever present, there were four other Senior Managers who individually attended less than 3 meetings out of the 10 held between July 2020 and November 2021. Project Board meetings were quorate with the exception of those held on the 08/03/21 and 02/11/21 at which there was no Project Assurance attendance as in keeping with the quoracy specified within the Project Board's Terms of Reference. **Project Team:** As was reported at the last audit, no formal Project Management Team Meetings were taking place. It was explained that due to the pressures on all teams within WAST during the pandemic response, the decision was taken to meet individually and to manually record the outcomes/ decisions. It is understood however that with a de-escalation of the Covid situation that Project Team meetings are resuming week commencing 31st January 2022. There is an opportunity to define the requirements for future project in respect of attendance, frequency and undertaking of meetings, in the event of similar competing pressure arising.		The governance arrangements may be inadequate to effectively manage the project.
Recommendations		**Priority**
1.1 Email all Project Directors to remind them of expected governance arrangements to ensure they are appropriate during periods of significant competing pressures.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**

1.1 Agreed. Going forward it will be emphasised to the Capital Project Team the importance of the meetings being quorate and deputies being present if the Project Board member is not available to attend. Terms of Reference (ToR)for future projects will also be reviewed to ensure this.	30th March 2022	Project Director

Matter Arising 2: Risk Register	**Impact**
NHS Wales Infrastructure Investment Guidance states: "Risk registers for each individual project/programme must be completed, shared and monitored, with reference not only to time, cost and quality." Management advised that the risk contingency budget was developed by the Cost Advisor and was based on previous experience of similar projects and was calculated as a percentage of the construction envelope of the project. At future projects, the expectation should be that risk registers within business cases should be fully costed and reconciled with the contingency requirement specified. The Risk Register is intended to act as a key project management tool. Risks should progressively be managed down as the project progresses and compared to residual contingency. The risk register was reviewed as part of the monthly Highlight Report, it is also noted that a risk register workshop was held in June 2021. The risks remained uncosted - merely stating whether they had a capital or revenue implication. The monitoring of a costed risk register is fundamental in determining the ongoing sufficiency of remaining contingency – to assist management in prioritising/ implementing a risk mitigation strategy.	Potential risk that: • the cost impact of risks is not fully appreciated.

Recommendation	**Priority**
2.1 In accordance with NHS Wales Infrastructure Investment Guidance, project contingencies should be developed from costed risk registers – both of which should be monitored for the duration of the project, this should be communicated to all pertinent Trust staff to ensure compliance for future projects.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 Actioned. It has been confirmed to the Capital Team in an email from the Head of Capital Development Planning dated 25th January 2022, that for future schemes - each risk needs to be valued rather than a contingency fund worked out as a percentage of the project.	Actioned and complete	Project Director

Matter Arising 3: Reporting		**Impact**
The Highlight reports were utilised as a means of distributing key reporting documents to Project Board Members, and they in turn were attached to the Project Agenda for months when the Project Board was sitting. The following was noted with regards to consistency of key documents being distributed through this medium: • External Project Manager Dashboard Reports, none included post December 2020 (No 5 30/11/20). • Cost reports included with 5 of the 13 highlight reports produced in the period under review. • Cashflow forecasts included with 3 of the 13 highlight reports produced in the period under review. • Issues and decision logs attached up till July 2021 and then omitted going forward. Management highlighted significant concerns with the timing and accuracy of the reporting from external advisers. It was determined necessary for Trust finance staff to provide additional assurance in respect of managing project cost and cashflow – over and above that which would normally be expected. It is important that the Trust review the performance of the advisers and determine any associated further actions are required (see **recommendation 5.2**).		The variations impact the ability of the Trust to effectively manage the key project objectives.
Recommendation		**Priority**
3.1 Assess adviser performance as part of the Post Project Review, and for future projects, ensure reporting is consistent to allow reasonable comparison and benchmarking of information.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 Agreed. The issues with the reporting process would form part of the project review process and this has also been addressed by ensuring such essential reporting criteria is included within the invitation to tender documentation for professional services, to include architectural design, cost advisors and project managers.	6 months post completion 30th Sept 2022	Project Director

Matter Arising 4: Delays		**Impact**
As noted in the executive summary, the anticipated completion date of the 11th February 2022 represents a four-month delay against the original completion date of 18th October 2021. The project has been subject to the following delays: • In March 2021, the contractor highlighted issues in the supply of the cladding required for the building, an industry wide issue. • At the Project Board meeting of 19th August 2021, the contractor confirmed an eight-week delay in the programme of works taking the completion date to December 2021. The Trust report that a site meeting took place on 21st October 2021, and the contractor confirmed this date remains the date they are working to currently. • The contractor formally outlined their claim on the 31st August 2021 associated with 26 formal instructions, delays due to awaiting critical design information and/or clarification of ambiguity and delays awaiting receipt of cladding system. At the time of audit, whilst a financial provision had been made within the cost reporting based on the cost adviser assessment of delays, the same had not been formally assessed or processed in accordance with the contract. Given management concerns, an independent external adviser was engaged that confirmed that the time/cost provisions made to date were adequate. Subsequent to the conclusion of audit fieldwork, the contractor has advised of further delay due to *"Covid-19 affecting Sub- Contractors, a general shortage of labourers, and the sub-contractor working on the cladding also left the site".*		Delays to the project impact both the time and cost objectives of the project.
Recommendation		**Priority**
4.1 The assessment of delays to date should be formally processed in accordance with contractual requirements (e.g issue of extension of time certificates, non-completion certificates etc.).		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**

4.1 Agreed. The scrutiny of application for an extension of time will impact on the potential of issuing a non-completion certificate, this piece of work is under review by the contract administrator. The collation of further documentation to substantiate extensions of time and non- completion has also commenced, further advice has also been sought to review all documentation and the administrative process in line with the adopted JCT form of contract.	March 30th 2022	Project Director

Matter Arising 5: Post Project Evaluation		**Impact**
A number of issues have been identified during the current and prior audits that should be considered post completion to determine appropriate action at this and/or future projects. For example: • Late provision of information from external advisors; • Late provision of cost reports by external advisors; • An unwillingness to share information held on externally held drives, including change management details. • Protracted assessment of delays to date; and • Contract completion/ documentation retention.		The Trust fails to learn from experiences to improve future delivery of projects.
Recommendation		**Priority**
5.1 A Post Project Evaluation should be completed to ensure that lessons are learnt from this project. 5.2 As appropriate, the Trust should determine whether there are any further actions required noting project team performance issues at this project.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
5.1. Agreed 5.2 Agreed	6 months post completion 30th Sept 2022	Project Director

Cardiff Make Ready Depot issued November 2020	Previously providing 

Ref	Recommendation	Responsibility & Timescale	Current Status	Updated responsibility, timescale & rating
2	Terms of Reference should be produced to clarify the role of the Design Team.	Project Director At future projects & at the PPE	**Outstanding** To be considered at the Post Project Evaluation with appropriate action to be determined to inform future projects.	**Medium**
3	Project discussions / decisions outside a formal project team meeting should be clearly documented to provide a robust audit trail of project progression and decisions made.	Project Director Immediately / ongoing	**Closed.** A log of key decisions was maintained for discussion held	**Low**
4	Progress updates for all major projects (including Cardiff MRD) should be included as a standing agenda item at the Capital Management Board.	Project Director November 2020 onwards	**Closed** – minutes agendas of Capital Management Board meetings provided demonstrated that the Project Director provided adequate update. Accordingly, this has been actioned.	**Medium**
5	The Welsh Government Project Progress Reports (PPR) should be received and scrutinised by an appropriate forum, ensuring timely submission to Welsh Government	Project Director November 2020 onwards	**Closed Subsequent to Audit Fieldwork** The Head of Capital Planning issued an email on the 25th January 2022 requiring that "WG status reports need to be approved by Project Board. Going forward PB/site meetings need to be rearranged to ensure the status report is approved prior to sending to WG. Due on the	**Medium**

Ref	Recommendation	Responsibility & Timescale	Current Status	Updated responsibility, timescale & rating
	(e.g. Project Board / Capital Management Board).		12th working day of each month. This is applicable to fleet projects also".	
8	Key performance indicators should be maintained for relevant parties (advisers, contractor) throughout the project.	Project Director December 2020	**Closed** Project Director provided copies of KPIs completed for the project.	**Medium**
9	A central project repository should be maintained by the internal project team, containing all relevant project information (including that prepared/managed by external advisers).	Project Director December 2020	**Closed** This was not implemented at this project. Going forward, the Project Director demonstrated that the tender for professional services now includes the requirement for successful tenderers to maintain a central repository for future commissions.	**Medium**
11	Contract award reports should document and assess potential reasons for reduced numbers of tender returns. Such assessment should also be considered at the post project evaluation, to ensure lessons can be learned for future projects.	Project Director, in liaison with NWSSP Procurement Services At future projects & at the PPE	**Outstanding** To be considered at the Post Project Evaluation with appropriate action to be determined to inform future projects.	**Low**
12	The use of the letter of intent at this project should be retrospectively reported to the Board.	Project Director	**Outstanding** The LoI was signed by the Assistant Director of Capital and Estates having sought advice prior to this as this	**Medium**

Ref	Recommendation	Responsibility & Timescale	Current Status	Updated responsibility, timescale & rating
		To be addressed as part of the PPE for this Project	project had previously been approved by Trust Board due to the value of the project. In future it will be noted this will be taken back to Trust Board for additional sanctioning. To be addressed as part of the PPE for this Project.	
14	Framework call-off contractual documentation should be completed by all parties and retained by the Trust.	Project Director To be addressed as part of the PPE for this Project	**Outstanding** Whilst a contractual agreement has been provided in respect of appointment of Architects, Management advised that they were unable to locate the contracts for the project manager and cost adviser due to the amount of time that has passed. To be addressed as part of the PPE for this Project.	**High**

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
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Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

AGENDA ITEM No	**8**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

Response to Audit Wales Report and Checklist: Taking Care of the Carers

MEETING	Audit Committee
DATE	3 March 2022
EXECUTIVE	Executive Director of Workforce and OD
AUTHOR	Ceri Bryant, Eleri Griffith, Lynda Bogunovic
CONTACT	Ceri.Bryant@wales.nhs.uk

EXECUTIVE SUMMARY

Audit Wales produced a report entitled 'Taking Care of the Carers' in October 2021 which was accompanied by a checklist of questions that they felt all board members should be ask their Trusts to ensure the ongoing and long-term wellbeing of staff following the pandemic.

This paper summarises the WAST response to those questions and the management response on the Audit Wales template in Appendix 4.

We hope that the committee agree that we have taken significant steps to look after our staff during the pandemic and in the future.

KEY ISSUES/IMPLICATIONS

Audit Wales have produced a report entitled *'Taking Care of the Carers? How NHS bodies supported staff wellbeing during the Covid-19 pandemic'* (October 2021) acknowledging that all NHS bodies enhanced their staff wellbeing offer during this time, but now need to ensure ongoing support is provided and made easily accessible for all.

The COVID-19 pandemic has undeniably had an impact on staff wellbeing. Surveys and research carried out by professional bodies highlight the increased stress and burnout experienced by staff. With a more emotionally and physically exhausted NHS workforce than ever, NHS bodies in Wales must maintain a focus on staff wellbeing to navigate through the longer-term impacts of the crisis, possibly redesigning the approach to staff wellbeing in order to ensure they are able to continue to provide high-quality, effective, and efficient health and care services. The report is accompanied by a checklist which sets out some of the questions NHS Board members should be asking to ensure their health bodies have good arrangements in place to support staff wellbeing.

This paper provides information to the Audit Committee in response to these questions for current and planned Wellbeing provision within WAST.

REPORT APPROVAL ROUTE

REPORT APPENDICES
Appendix 1: Audit Wales Report 'Taking Care of the Carers? How NHS bodies supported staff wellbeing during the Covid-19 pandemic' (October 2021) link https://audit.wales/sites/default/files/2021-10/Taking-Care-of-the-Carers-October-2021-English.pdf **Appendix 2: Recommendations for the Board https://audit.wales/sites/default/files/2021-10/Taking-Care-of-the-Carers-A-Checklist-for-NHS-Board-Members-English.pdf** **Appendix 3: WAST detailed response** **Appendix 4: Management Response for Audit Wales**

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

Appendix 3: WAST Detailed Response

Checklist of responses to press release: NHS bodies in Wales prioritised staff wellbeing during the pandemic, but longer-term challenges remain

1. What wellbeing services does the health body currently offer to staff?

The Occupational Health (OH) and Wellbeing Team currently provide the following services to ensure that the health and wellbeing of staff is regularly monitored:
There is an in-house Wellbeing service that staff can contact Mon – Fri 8am – 4pm for advice and support and also signpost to external services. The Occupational Health and Wellbeing team work closely with other departments within WAST and with external partner organisations to provide the most effective, holistic service for staff including TASC (The ambulance Staff Charity), MIND Blue Light, Women's Aid, HHP (Health for Health Professionals), SilverCloud, Samaritans, Able Futures, Remploy.

There is an internal nurse led Occupational Health Department with access to an external Occupational Health Physician if required.

The team have been working with managers throughout WAST to promote the OH and Wellbeing service, to update managers on the importance and benefits of early intervention for staff who present with emotional and physical health issues.

Presentations on the OH and Wellbeing service have been provided for managers to understand the processes for referral to the service, also webinars made available on the new EAP provision and the TRiM service.

Regular updates are provided for managers and staff to ensure that all are aware of what help is available and information is provided for new starters through the Warm WAST Welcome days.

A Health Surveillance programme is in the process of being developed in line with risk assessment through Health and Safety and skin surveillance has begun.

A programme of health diagnostics is being developed looking at reducing risk of cardiac ill health in our older workforce, by implementing a screening programme. The programme is dependent on securing funding and is currently being scoped and if agreed it will be implemented initially as a pilot.

A new Employee Assistance Programme for staff, and their immediate families, has been in place since March 2021. The service provides; advice, information, and guidance from legal aspects to financial advice, there is also a counselling service available and a 24-hour helpline. The helpline is also available for managers seeking advice and support in relation to their team members.

We offer an effective Trauma counselling service for staff who present more complex issues and for those staff who present with longstanding, complex issues we have external providers and in-house psychological support when this is related to work. We also offer TRiM (Trauma Risk Incident Management) as a protective factor initially and as a screen for early intervention at the four week follow up.

A Fast-Track physiotherapy service is offered to all staff which ensures individuals referred are contacted within 24 hours. An appointment for clinical assessment is made within 2 working days.

A programme of Health Promotion has been implemented, including a series of Roadshows, events/workshops on nutrition, alcohol awareness, exercise advice, stress management.

The Wellbeing Team run various workshops including anxiety, sleep, stress, a programme, 'Living Life to the Full' where trained facilitators offer practical educational life skills based on Cognitive Behavioural Therapy (CBT) principles.

There are also Drop-in sessions available for staff in Clinical Contact Centres, where staff have the opportunity to discuss any presenting issues with a Wellbeing Facilitator on a one-to-one basis.

The Thrive App was introduced in May this year; the programme includes support for staff in several areas. Thrive helps to prevent and manage stress, anxiety, and related conditions. The game-based app can be used to relax before a stressful situation or on a more regular basis to assist toward increased coping skills to more effectively manage the stresses that can life bring.

A Women's Health Group was set up in June 2021, these sessions are run fortnightly and once a month have an invited guest speaker.

A Road to Recovery Group is also in place offering support to staff who have had Covid19 infection and have developed Long Covid, as well as those with long term health conditions.

An immunisation programme is in place for all staff which ensures that staff are protected carrying out their role. The service offers all required immunisations including, Hepatitis B, MMR, Pertussis, Typhoid, Varicella and BCG.

Eye Care plan in line with DSE regulations for screen users to access free eye tests and spectacles if required for working.

We are establishing a peer- support network and increasing the Chaplaincy provision.

2. How much do they cost 21/22?

Total cost of OH&W staff establishment = £621,391
Cost of External Services = £77,000

3. How accessible is the health body's current staff wellbeing offer?

The offers are as accessible as possible, through communications via Team WAST – now YAMMER – and Siren, Posters, meetings, Teams Groups, Roadshows. Information about TRiM is automatically sent to all staff involved in potentially difficult jobs in contact centres and road crews. All new starters, or those changing roles, are made aware of the offer, OH representatives partner with people teams and H&S teams. Information about wellbeing support is provided at PADRs.

The Culture and Behaviours reset will incorporate information about wellbeing support and the role of the managers in supporting their teams in maintaining their physical

and emotional wellbeing. The peer support network will also provide ad hoc support and increase awareness of the range of offers available for our people to be proactive in self-care.

4. How effective is the health body's current staff wellbeing offer?

It has been noticeable in the past 20 months, that the OHW service has become extremely busy offering increasing support to both staff and managers and this has resulted in WAST investing heavily in increasing the size of the OH&W establishment to meet demand. Access to the service has increased and new providers have been sourced to reflect need. Communications remain challenging in some areas of the service but increased engagement in proactive health and wellbeing initiatives should increase access.

As we are in REAP 4, staff cannot always access webinars and roadshows but we are looking at making webinars available post recording via link so staff can look at this in their own time. Access to physiotherapy and the EAP is increasing. TRiM is proactive and reaching more people with an increased uptake. The Wellbeing service is busy and continues to receive positive feedback.

5. Which wellbeing services should the health body offer to staff in the short-, medium-, and long-term?

We hope to continue to offer all that we do for the long term and expansion should be in proactive, preventative initiatives that promote self-care and self-management of physical and emotional health.

We would hope to introduce Health Checks for over 45-year-olds particularly in relation to cardiac health. There are many groups and clubs within WAST that have formed over the years, including a football team, walking, and cycling groups and we hope to support the further expansion of these and other societies and clubs. It would beneficial to be able to support staff in accessing NHS treatment quicker, this could be through developing a late cancellation or standby queue to attend following a late cancellation. This may help to reduce long term sickness levels which is negatively impacting psychological and physical health, and therefore increases pressure and stresses on the remaining workforce and service.

Support and training for managers will include the continuing roll out of 'Leading on Wellbeing Workshops' in supporting both their Wellbeing and their teams.

In the short term, staff have been consistent in their requests for mobile tea trucks as rolled out successfully in London Ambulance Service and planned for other ambulance services in England. The benefits of having 24 access to a hot drink and someone to speak to, particularly a volunteer from within the service has been highly valued by LAS.

6. How should the health body deliver its wellbeing offer to staff?

A robust communication strategy needs to be in place which accesses all staff areas to ensure everyone can be included. There also needs to be a clear commitment to staff wellbeing by managers and leaders at all levels of the service and a budget for OH&W services that accurately reflects the ask.

Collaboration with Health Boards could establish quicker treatment times for staff. Ongoing commitment from senior managers to reducing work related stress,

particularly in terms of chronic excessive workload, which is integral to the Working Safely Programme will also support this.

Providing training for managers and staff in improving their Wellbeing, what wellbeing is, how to be resilient in the workplace and policies, practices and processes to support this will also benefit the service.

7. How should the health body continue to engage with staff?

Through various mediums including digital platforms, training sessions, health promotion events, face to face sessions, regular dialogue and actions from relevant teams.

8. What assurance does the Board require going forward?

Commitment of senior management that staff wellbeing is at the forefront of everything that the service undertakes and moves in line with the Health and Wellbeing Strategy, People and Culture Strategy and Working Safely Programme.

Appendix 4: Management Response for Audit Wales

Management Response – Taking Care of the Carers?

Health Body: Welsh Ambulance Service NHS Trust (WAST)

Completion Date: 17th November 2021

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
R1	**Retaining a strong focus on staff wellbeing** NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified	WAST accepts these recommendations and will ensure this focus is maintained by: • Staff wellbeing monitored and reported quarterly to People and Culture Committee. • Implement the health and wellbeing strategy • External Employee Assistance Programme • In House Occupational Health Team established and activity reported quarterly to People and Culture Committee.	• 10 May 2022 • November 24 • Reviewed annually – next review January 2023 • 10 May 2022	• C Goodwin • C Goodwin • C Goodwin Assistant Director Inclusion Culture and Wellbeing • C Bryant

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
	as being at higher risk from COVID-19.	• Workforce Risk Assessment Tool implemented and reported to People and Culture Committee annually. • Long covid support group established and now participant led so no longer formally reported.	• To be reviewed June 2022	• C Bryant Occupational Health and Wellbeing Lead
R2	**Considering workforce issues in recovery plans** NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.	WAST accepts these recommendations and will ensure these issues are considered by: • Continuing to increase OH&W capacity in relation to growth in workforce. • Joint meetings with managers, people services and OHW regarding sickness absence reported to People and Culture Committee quarterly. • Recruit an additional wellbeing practitioner.	• Review in September 22 • 10 May 2022	• C Goodwin / L Rogers Ast. Dir and Deputy Director or WOD • C Goodwin / J Stokes Ast Dir and Head of

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
		• Launch of Peer Support Network	• January 22 • January 22	• People Serivces • L Bogunovic Occupational Health and Wellbeing Business Manager • E Griffith Clinical Psychologist
R3	**Evaluating the effectiveness and impact of the staff wellbeing offer** NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and	WAST accept this recommendation and will ensure effectiveness is measured by: • WAST Wellbeing Survey in conjunction with Swansea University. • NHS Staff Survey	• February 22 • Q3 (TBC)	• C Goodwin Ast.Dir

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
	impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	• Feedback questionnaires following access to OH and Wellbeing and analysis reported to WOD team. • Regular meetings with all external providers to ensure KPIs are maintained. • Health and Wellbeing Steering Group was paused to make way for the Health, Quality and Welfare Cell during the pandemic. It will be reinstated in Quarter 1.	• June 2022 • April 2022 • April 2022	• K Wilkinson Head of Equality and Engagement • L Bogunovic OHW Bus Mgr. • L Bogunovic • C Goodwin
R4	**Enhancing collaborative approaches to supporting staff wellbeing** NHS bodies should, through the National Health and Wellbeing	WAST accepts this recommendation: • Attend and participate in the National Health and Wellbeing Network Meetings both in Wales and within the Ambulance Sector.	• Complete	• C Goodwin Asst. Dir Inclusion,

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
	Network and/or other relevant national groups and fora, continue to collaborate to ensure there is adequate capacity and expertise to support specific staff wellbeing requirements in specialist areas, such as psychotherapy, as well as to maximise opportunities to share learning and resources in respect of more general approaches to staff wellbeing.	.		Culture and Wellbeing
R5	**Providing continued assurance to boards and committees** NHS bodies should continue to provide regular and ongoing assurance to their Boards and relevant committees on all applicable matters relating to staff wellbeing. In doing so, NHS bodies should avoid only providing a general description of the programmes, services, initiatives, and approaches they have in place to support staff wellbeing. They should also provide assurance that these programmes, services, initiatives, and approaches are having the desired effect on staff	WAST accepts this recommendation and continues to provide assurance through quarterly reports at each meeting: • People and Culture Committee • EMT	• 10 May 2022 • 4 May 2022	• C Goodwin • C Goodwin Asst Dir or Inclusion Culture and Wellbeing

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
	wellbeing and deliver value for money. Furthermore, all NHS bodies should ensure their Boards maintain effective oversight of key workforce performance indicators – this does not happen in all organisations at present.			
R6	**Building on local and national staff engagement arrangements** NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	WAST accepts this recommendation and has the following arrangements in place: • Inclusion network and Allyship programme • WIIN portal for welfare and wellbeing ideas. • Staff report concerns via Datix. • EDI Steering Group	• Complete • Complete • Complete • Complete	• K Wilkinson • C Goodwin • C Goodwin • K Wilkinson

Please indicate below how the Board Members Checklist will be used to inform debate within your organisation
The board members checklist will be reviewed by EMT and will be regularly reviewed alongside the Health and Wellbeing Strategy Implementation.

Archwilio Cymru
Audit Wales

Audit Committee Update – Welsh Ambulance Service NHS Trust

Date issued: February 2022

Document reference: 2843A2022

This document has been prepared for the internal use of the **Welsh Ambulance Service Trust** as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

Audit Committee update:

Audit Committee Update

About this document

1 This document provides the Audit Committee with an update on current and planned Audit Wales work. Our 2021 audit plan was presented to the Audit Committee in March 2021.

2 Accounts and performance audit work are set out in this update, and information is also provided on the Auditor General's wider programme of national value for money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

Exhibit 1 summarises the status of our key accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of 2020-21 Financial Statements	The Auditor General certified the Performance Report, Accountability Report and Financial Statements on 15 June. The next day they were laid by the Senedd, with a published statement by the Welsh Government.
Independent Examination of the 2020-21 Charitable Funds' Financial Statements	Complete – Presented to Charitable Funds Committee on 17 January 2022. Trust Board approved the Trust Charity Annual Report and Accounts Committee on 27 January 2022.
2021-22 Audit of the Financial Statements	Interim audit commenced and ongoing

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- work that is currently underway or completed (**Exhibit 2**); and
- planned work not yet started or revised (**Exhibit 3**).

Exhibit 2 – Work currently underway

Topic	Focus of the work	Current status and Audit Committee consideration
Quality Governance	As an extension to structured assessment, this work will consider the structures, information and assurance flows that support quality governance.	Fieldwork in progress – draft report anticipated in May 2022
Annual Audit Report 2021	This report summarises the findings from audit work undertaken at the Welsh Ambulance Services NHS Trust in 2021	Complete – Presented to Audit Committee in March 2022
NHS Structured Assessment	Phase 2 - examines how well NHS bodies are embedding sound arrangements for corporate governance and financial management, as well as drawing on lessons learnt from the initial response to the pandemic.	Complete – Presented to Audit Committee in December 2021
	Phase 1 - examines the effectiveness of operational planning arrangements when NHS bodies continue to respond to the pandemic and to recover and restart services.	Complete – presented to Audit Committee in June 2021

Exhibit 3 – Planned work not yet started or revised

Topic	Focus of the work	Current status
Review of Unscheduled Care	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	Whole system commentary and data analysis currently being completed Phase 2 scope and timescales to be confirmed.

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

5 There have been no Good Practice Exchange (GPX) events since we last reported to the Committee in December 2021. Details of future events are available on the GPX website.

6 In response to the Covid-19 pandemic, we have established a **Covid-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here.

NHS-related national studies and related products

7 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus 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. **Exhibit 4** provides information on the NHS-

related or relevant national studies published during the past six months. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 4 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
Joint working between Emergency Services	January 2022
Care Home Commissioning for Older People	December 2021
Taking Care of the Carers?	October 2021
A Picture of Healthcare	October 2021
Picture of Public Services	September 2021
Infographic on the NHS (Wales) summarised accounts for 2020-21	September 2021
Picture of Public Services 2021	September 2021

8 **Exhibit 5** provides information on NHS-related or relevant national studies work in progress with indicative publication dates.

Exhibit 5 – NHS-related or relevant studies and all-Wales summary work currently in progress

Title	Indicative publication date
Orthopaedic services	2022

Title	Indicative publication date
Unscheduled care – a whole system view	2022
NHS waiting times tool	2022

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We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Annual Audit Report 2021 – Welsh Ambulance Services NHS Trust

Audit year: 2020-21

Date issued: January 2022

Document reference: 2798A2022-23

This document has been prepared for the internal use of the Welsh Ambulance Services NHS Trust as part of work performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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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.

Contents

Summary report

About this report

1 This report summarises the findings from my 2021 audit work at the 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 the 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 public bodies continued responding to the unprecedented challenges presented by the COVID-19 pandemic, whilst at the same time recovering services. My work programme was designed to best assure the people of Wales that public funds are well managed. I have considered the impact of the current crisis on both resilience and the future shape of public services. I aimed to ensure my work did not hamper public bodies in tackling the crisis, whilst ensuring it continued to support both scrutiny and learning. On-site audit work continues to be restricted, and we continued to work and engage remotely where possible through the use of technology. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

4 As was the case in 2020, the delivery of my audit of accounts work was not without its challenges, not only in how and where we undertook the work, but also in taking account of considerations for financial statements arising directly from the pandemic. The success in delivering it reflects a great collective effort by both my staff and the Trust's officers to embrace and enable new ways of working and remain flexible to and considerate of the many issues arising.

5 I have adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the crisis and to enable remote working. My programme of work has provided focus on themes, lessons and opportunities relating to NHS governance and NHS staff wellbeing. I have reviewed the Test, Trace, Protect programme and the rollout of the COVID-19 vaccine. My local audit teams have commented on how governance arrangements have adapted to respond to the pandemic, and the impact the crisis has had on service delivery.

6 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 planned work currently being re-scoped.

7 **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 2021 Audit Plan.

8 **Appendix 3** sets out the financial audit risks set out in my 2021 Audit Plan and how they were addressed through the audit.

9 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We are presenting it formally to the Audit Committee at its meeting on 3 March 2022 and it will later be received by the Trust Board at its meeting on 24 March 2022. We strongly encourage the Trust to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

10 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

11 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 the Trust's internal controls (as relevant to my audit). However, I placed an Emphasis of Matter paragraph in my report to draw attention to disclosures in the accounts in note 24 relating to the impact of a Ministerial Direction issued on 18 December 2019 to the Permanent Secretary of the Welsh Government.

12 I brought several issues to the attention of officers and the Audit Committee, which I will review and monitor as part of my audit of the 2021-22 accounts.

13 I identified no material financial transactions within the Trust's 2020-21 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 2020-21 accounts.

14 The Trust achieved financial balance for the three-year period ending 31 March 2021. The Trust has an approved three-year plan in place. I placed a substantive report on the Trust's financial statements to set out further detail on the Emphasis of Matter paragraph that I included in my audit opinion. While I did not modify my audit opinion in respect of this matter, I did place a substantive report on the Trust's financial statements.

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:

- the Test, Trace, Protect programme is making an important contribution to the management of COVID-19 in Wales. Whilst the programme struggled to cope with earlier peaks in virus transmission, it has demonstrated an ability to rapidly learn and evolve in response to the challenges it has faced.
- the COVID-19 vaccination programme in Wales has been delivered at significant pace with local, national and UK partners working together to vaccinate a significant proportion of the Welsh population. A clear plan is now needed for the challenges which lie ahead.
- all NHS bodies have maintained a clear focus on staff wellbeing throughout the pandemic and implemented a wide range of measures to support the physical health and mental wellbeing of their staff during the crisis. It is vital that these activities are built upon, and that staff wellbeing remains a central priority for NHS bodies as they deal with the combined challenges of recovering services, continuing to respond to the COVID-19 pandemic, and also managing seasonal pressures.
- the Trust has continued to adapt and refine its planning approach to respond to new requirements, the challenges of the COVID-19 pandemic and maintain oversight of its long-term ambitions. However, as a result of operational pressures some aspects of monitoring and reporting of plan progress were paused or altered during the year and there is scope to clarify these arrangements going forward.
- the Trust continues to improve governance and risk management arrangements. However, internal and external factors are putting services under severe pressure which presents risks to patient safety and delivery of agreed plans for service transformation.
- the Trust continues to meet its financial duties and has appropriate arrangements for monitoring and reporting its finances.

16 These findings are considered further in the following sections.

Detailed report

Audit of accounts

17 This section of the report summarises the findings from my audit of the Trust's financial statements for 2020-21. These statements are how the organisation shows its financial performance and sets out its net assets, net operating costs, recognised gains and losses, and cash flows. Preparing the statements is an essential element in demonstrating the appropriate stewardship of public money.

18 My 2021 Audit Plan set out the financial audit risks for the audit of the Trust's 2020-21 financial statements. **Exhibit 4** in **Appendix 3** lists these risks and sets out how they were addressed as part of the audit.

19 My responsibilities in auditing the Trust's financial statements are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2020-21 financial statements

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 the Trust's internal controls (as relevant to my audit). However, I placed an Emphasis of Matter paragraph in my report to draw attention to disclosures in the accounts relating to note 24 of the financial statements which describes the impact of a Ministerial Direction issued on 18 December 2019 to the Permanent Secretary of the Welsh Government, instructing her to fund NHS Clinicians' pension tax liabilities incurred by NHS Wales bodies in respect of the 2019-20 financial year. I did not qualify my audit opinion in respect of this matter.

21 I brought several issues to the attention of officers and the Audit Committee which are summarised in **Exhibit 1** below.

22 I must report issues arising from my work to those charged with governance before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues to the Trust's Audit Committee on 3 June 2021. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues identified in the Audit of Financial Statements Report

Issue	Auditors' comments
Uncorrected misstatements	There is one misstatement identified within the accounts, which remains uncorrected. Note 23 provisions 'other provisions' is overstated by £134,000. Our review determined that the conditions of the provision, for potential staff exit packages, does not comply with those required by International Accounting Standard (IAS) 37 'Provisions Contingent Liabilities and Contingent Assets' and therefore should not have been included within the financial statements.
Corrected misstatements	There were initially misstatements in the accounts that were corrected by management.
Other issues	• Assets under construction: we reported the need for the Trust continue to review and strengthen their processes to record and monitor assets under construction. • Defibrillators: we reported the need for the Trust to be able to easily identify the existence and location of all defibrillators held on the fixed asset register. • Inventories: we recommended that the Trust prepare clear and accurate working papers to support the value of inventories within the financial statements.

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 at 31 March 2021 and the return was prepared in accordance with the Treasury's instructions.

24 My separate independent examination of the charitable funds financial statements is complete with no issues arising.

Regularity of financial transactions

25 I identified no material financial transactions within the Trust's 2020-21 accounts that were not in accordance with authorities or not used for the purpose intended,

and so I issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2020-21 accounts.

26 The Trust's financial transactions must be in accordance with the authorities that govern them. It must have the powers to receive the income and incur the 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.

27 The Trust achieved financial balance for the three-year period ending 31 March 2021. The Trust has an approved three-year plan in place. I have the power to place a substantive report on the Trust's accounts alongside my opinions where I want to highlight issues. I placed a substantive report on the Trust's 2020-21 accounts to set out more detail on the Emphasis of Matter paragraph in my audit opinion.

Arrangements for securing efficiency, effectiveness and economy in the use of resources

28 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:

- examining how NHS bodies have responded to the challenges of delivering the Test, Trace, Protect programme;
- reviewing how well the rollout of the COVID-19 vaccination programme was progressing;
- reviewing how NHS bodies supported staff wellbeing during the COVID-19 pandemic; and
- undertaking a phased structured assessment of the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively and economically.

29 My conclusions based on this work are set out below.

Test, Trace, Protect programme

30 My work examined how public services responded to the challenges of delivering the Welsh Government's Test, Trace, Protect Programme (TTP). As well as commenting on the delivery of TTP up to and including December 2020, my report set out some key challenges and opportunities that will present themselves as part of the ongoing battle to control COVID-19.

31 I found that the different parts of the Welsh public and third sector had worked together well together to rapidly build the TTP programme. The configuration of the system blended national oversight and technical expertise with local and regional ownership of the programme, and the ability to use local intelligence and knowledge to shape responses.

32 Arrangements for testing and contact tracing have evolved as the pandemic has progressed. But maintaining the required performance in these arrangements proved challenging in the face of increasing demand.

33 Despite increased testing and tracing activity, the virus continued to spread, and as in other parts of the UK and internationally, testing and tracing have needed to be supplemented with local and national lockdown restrictions in an attempt to reduce transmission rates.

34 While a range of support mechanisms exist, it remains difficult to know how well the 'protect' element of TTP has been working in supporting people to self-isolate.

Vaccination programme

35 My audit focused on the rollout of the COVID-19 programme in Wales up to June 2021, the factors that affected the rollout and future challenges and opportunities.

36 The vaccine programme has delivered at significant pace. At the time of reporting, vaccination rates in Wales were the highest of the four UK nations, and some of the highest in the world. The milestones in the Welsh Government's vaccination strategy provided a strong impetus to drive the programme and up to the time of reporting, the key milestones had been met.

37 The UK's Joint Committee on Vaccination and Immunisation guidance on priority groups was adopted but the process of identifying people within some of those groups has been challenging.

38 The organisations involved in the rollout have worked well to set up a range of vaccination models which make the best use of the vaccines available, while also providing opportunities to deliver vaccines close to the communities they serve.

39 Overall vaccine uptake to the time of reporting was high, but there was a lower uptake for some ethnic groups and in the most deprived communities. At the time of the audit, vaccine wastage was minimal, but concerns were emerging about non-attendance at booked appointments.

40 The international supply chain is the most significant factor affecting the rollout, with limited vaccine stock held in Wales. However, increasing awareness of future supply levels was allowing health boards to manage the vaccine rollout effectively.

41 As the programme moved into the second half of 2021, challenges presented themselves around encouraging take-up amongst some groups, vaccine workforce resilience and venue availability. A longer-term plan is needed to address these and other elements of the ongoing vaccination programme.

How NHS bodies supported staff wellbeing during the COVID-19 pandemic

42 My review considered how NHS bodies have supported the wellbeing of their staff during the pandemic, with a particular focus on their arrangements for safeguarding staff at higher risk from COVID-19.

43 NHS staff have shown tremendous resilience and dedication throughout the pandemic, despite facing huge strains to their mental and physical health.

44 The NHS in Wales was already facing a number of challenges relating to staff wellbeing prior to the pandemic, and the crisis has highlighted the importance of supporting the mental and physical health of the NHS workforce. Through my Structured Assessment work, I found that NHS bodies moved quickly at the beginning of the pandemic to enhance wellbeing initiatives to support staff through unprecedented times. As the pandemic unfolded, I found that NHS bodies in Wales implemented a range of measures to improve staff wellbeing, such as creating dedicated rest spaces, increasing mental health and psychological wellbeing provision, enhancing infection and prevention control measures, and enabling remote working.

45 My work also looked at how NHS bodies in Wales protected staff at higher risk from COVID-19. Amongst other safeguarding initiatives, I found that all bodies rolled out the All-Wales COVID-19 Workforce Risk Assessment Tool which identifies those at a higher risk and encourages a conversation about additional measures to be put in place to ensure staff are adequately protected. Although NHS bodies promoted and encouraged staff to complete the assessment tool, completion rates varied between NHS bodies.

46 While the crisis has undoubtedly had a considerable impact on the wellbeing of staff in the short term, the longer-term impacts cannot be underestimated.

47 With a more emotionally and physically exhausted workforce than ever, NHS bodies in Wales must maintain a focus on staff wellbeing and staff engagement to navigate through the longer-term impacts of the crisis. My report, therefore, is accompanied by a checklist which sets out some of the questions NHS Board members should be asking to ensure their health bodies have good arrangements in place to support staff wellbeing.

Structured assessment

48 My structured assessment work was designed in the context of the ongoing response to the pandemic. I ensured a suitably pragmatic and relevant approach to help me discharge my statutory responsibilities, whilst minimising the impact on NHS bodies as they continue to respond to the pandemic. My team undertook the work into two phases this year:

- phase 1 considered the planning arrangements underpinning the development and delivery of the operational plan for quarters three and four of 2020-21.
- phase 2 considered how corporate governance and financial management arrangements adapted over the year. Auditors also paid attention to progress made to address previous recommendations.

Operational planning arrangements

49 My work considered the Trust's operational planning arrangements underpinning the operational plan for quarters three and four of 2020-21. The planning framework covered the maintenance of effective and efficient operational planning arrangements in health bodies to guide their response to the pandemic as well as responding to winter pressures and laying the foundations for effective recovery of services.

50 My work found that the Trust has continued to adapt and refine its planning approach to respond to new requirements, the challenges of the COVID-19 pandemic and maintain oversight of its long-term ambitions. However, as a result of operational pressures, some aspects of monitoring and reporting of plan progress were paused or altered during the year and there is scope to clarify these arrangements going forward.

51 The Trust made a number of changes to the way it has planned during the pandemic to be able to react and respond to the challenges it faces. These included teams ('cells') that focussed on specific challenges, supported rapid decision making and informed the shorter-term planning cycles used during the year. The Trust's planning approach:

- responded to external challenges of responding to rapidly changing need for services;
- supported internal factors such as the need to support staff-wellbeing; and
- maintained focus on the longer-term need to transform services.

52 Since my initial phase 1 work, the Trust has developed its Integrated Medium Term Plan (IMTP) for 2021-2024 and is in the process of delivering it. However, pressures on ambulance services are resulting in a need to prioritise some aspects of this year's element of the plan, leaving other areas potentially delayed into next year.

53 During the early stages of the pandemic, some of the routine arrangements to monitor and track progress against delivery of plans, such as the Strategic Transformation Board were stood down. When I reported the phase 1 work, the Trust started to strengthen those arrangements again, with plans to bolster them supported by a Transformation Support Office, and in September 2021 revised the Terms of Reference for the Strategic Transformation Board to clarify roles and accountabilities. Progress is now reported to the Finance and Performance Committee in an IMTP Tracker and Delivery Assurance Report.

Governance arrangements

54 My work considered the Trust's ability to maintain sound governance arrangements while having to respond to the unprecedented challenges presented by the pandemic. The key focus of the work has been the corporate arrangements for ensuring that resources are used efficiently, effectively, and economically. We also considered how business deferred in 2020 was reinstated and how learning from the pandemic is shaping future arrangements for ensuring continued good governance and recovery.

55 I found that the Trust continues to improve governance and risk management arrangements. However, internal and external factors are putting services under severe pressure, which presents risks to patient safety and delivery of agreed plans for service transformation.

56 My work found that, overall, the Trust has continued to operate its governance arrangements appropriately, with the Board and its committees discharging their requirements. A range of activities are helping the Trust refine and improve arrangements further, including use of a committee self-assessment and board development programme. The Trust is also taking further steps to strengthen its risk management arrangements and its Board Assurance Framework.

57 While the governance arrangements are continuing to develop and refine, the Trust is finding itself under extreme service pressures. High levels of demand, including increased demand for 'red' calls are combined with increased pressure in wider hospital and social care settings, which is affecting hospital patient flow and resulting in prolonged handover delays. These external pressures alongside internal challenges relating to staff sickness absence, capacity planning and current working practices present higher risks of service users coming to harm.

Managing financial resources

58 I considered the Trust's financial performance, financial controls and arrangements for monitoring and reporting financial performance. I found that the Trust continues to meet its financial duties and has appropriate arrangements for monitoring and reporting its finances.

59 The Trust met its financial duties for 2020-21 and whilst it is reporting it is on track to achieve breakeven in 2021-22, it will need to closely monitor achievement of savings plans. The Trust made a small surplus of £0.07 million in 2020-21 against operating expenditure of £241.8 million. It delivered £4.3 million in savings during that financial year and the £13.8 million of COVID-19 costs were covered by the Welsh Government.

60 For the current year, the Trust is forecasting a balanced position between revenue and expenditure. The Trust is continuing to make the assumption that this year's COVID-19 costs will again be covered by the Welsh Government and is in regular dialogue on the latest financial position and forecasts. The year-to-date savings

performance is currently exceeding expectations, but there will be a need to maintain focus on this for the remainder of the year.

I also found that the Trust has effective financial controls, suitable arrangements for preventing and detecting fraud, and improved processes for signing off COVID-19 expenditure.

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 in 2021.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	June 2021
Opinion on the Financial Statements	June 2021
Performance audit reports	
Doing it Differently, Doing it Right? (Structured Assessment 2020 All-Wales themes, lessons and opportunities relating to NHS governance during COVID-19)	January 2021
Test, Trace, Protect in Wales: An Overview of Progress to Date	March 2021
Rollout of the COVID-19 vaccination programme in Wales	June 2021
Taking care of the carers? (Structured Assessment 2020 All-Wales themes, lessons and opportunities relating to NHS staff wellbeing during COVID-19)	October 2021
Structured Assessment 2021: Phase 1 Operational Planning Arrangements	May 2021
Structured Assessment 2021: Phase 2 Corporate Governance and Financial Management Arrangements	November 2021

Report	Date
Other	
2021 Audit Plan	March 2021

My wider programme of national value for money studies in 2021 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: audit work still underway

There are a number of 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
Unscheduled care	Phase 1 – February 2022 Timing of further work included as part of the 2022 plan still to be confirmed.
Independent Examination of the Charitable Funds Financial Statements	Completed January 2022
Quality Governance	March 2022

Appendix 2

Audit fee

The 2021 Audit Plan set out the proposed audit fee which was to be confirmed due to ongoing discussions on the audit of the Charitable Funds accounts. An independent examination of the charitable funds accounts was agreed with the Trustees, so the overall fee is in line with the prior year of £151,618, (excluding VAT). My latest estimate of the actual fee is in keeping with this fee.

Appendix 3

Financial audit risks

Exhibit 4: financial audit risks

My 2021 Audit Plan set out the financial audit risks for the audit of the Trust's 2020-21 financial statements. The table below lists these risks and sets out how they were addressed as part of the audit.

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 [ISA 240.31-33].	I will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business; and • add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.	The work was carried out as proposed. We did not identify any issues.

Audit risk	Proposed audit response	Work done and outcome
NHS Trusts have a financial duty to break even over a three-year rolling period. Although the Trust is forecasting a break-even position for the year-end, this duty increases the risk that management judgements, and estimates included in the financial statements, could be biased in an effort to achieve the financial duty. If the Trust fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2020-21 financial statements. I may also place a substantive report on the financial statements to explain the basis of the qualification and the circumstances under which it had arisen.	My audit team will focus its testing on areas of the financial statements which could contain reporting bias such as judgements and estimates.	The work was carried out as proposed. We did not identify any issues.

Audit risk	Proposed audit response	Work done and outcome
The COVID-19 national emergency continues and the pressures on staff resources and of remote working may impact on the preparation and audit of accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.	I will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and monitor the accounts preparation process. I will help to identify areas where there may be gaps in arrangements.	The work was carried out as proposed. We did not identify any issues.
The increased funding streams and expenditure in 2020-21 to deal with the COVID-19 pandemic will have a significant impact on the risks of material misstatement and the shape and approach to our audit. Examples of issues include fraud, error, and regularity risks of additional spending; valuation of year-end inventory, including Property, Plant and Equipment (PPE); and estimation of annual leave balances.	I will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.	The work was carried out as proposed. We did not identify any issues.

Audit risk	Proposed audit response	Work done and outcome
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year I included an 'Emphasis of Matter' paragraph in my audit opinion drawing attention to your disclosure of the contingent liability. However, if any expenditure is made in-year, I would consider it to be irregular as it contravenes the requirements of 'Managing Welsh Public Money'.	I will review the evidence one year on in respect of the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.	The work was carried out as proposed. No expenditure was incurred by the Trust. The Trust included the contingent liability in line with the prior year and we drew the reader's attention to this disclosure in an Emphasis of Matter paragraph in the audit report.

Audit risk	Proposed audit response	Work done and outcome
Relevant auditing standards require auditors to attend and validate year-end stock balances where these balances are deemed material to the financial statements. Due to the impact of the COVID-19 pandemic and the statutory lockdown arrangements, we will be unable to observe and re-perform parts of the Trust's count of its inventories on 31 March 2021. Unless I can obtain the required audit assurance by alternative means, I would therefore be unable to determine whether the Trust's reported year-end inventory balance is materially true and fair, ie I would need to qualify my opinion.	We will assess the Trust's year-end stock balances, particularly from a materiality context. If we need to qualify our opinion, it is important to emphasise that qualification would not be due to shortcomings in the Trust's systems or actions, but because of the impact of COVID-19 on one of our key audit procedures.	The work was carried out as proposed. The Trust's year-end stock values were below the materiality set on the financial statements. We did identify some issues regarding the documentation and working papers supporting the values in the financial statements and reported these within our Audit of Accounts report.

Audit risk	Proposed audit response	Work done and outcome
I reported within my Audit of Accounts Report 2019-20 my concerns over the level of Assets Under Construction (AUC) brought forward on 1 April 2019 that remained as AUC on 31 March 2020. We issued a recommendation within our Final Accounts Action Plan around the monitoring and recording of such expenditure to ensure assets are operationalised as soon as possible and to minimise the risk of obsolescence of the expenditure.	We have agreed a planned approach with officers in terms of how supporting documentation and evidence will be provided by the Trust to support the year-end AUC balances. We will review the audit evidence provided to gain assurance on the expenditure classified as AUC on 31 March 2021.	The work was carried out as proposed. We did identify some issues regarding the documentation provided to audit to support capital accruals and also difficulties in identifying the existence and location of some defibrillators held on the fixed asset register. We reported these matters within our Audit of Accounts report.

Audit risk	Proposed audit response	Work done and outcome
I audit some of the disclosures in the Remuneration Report, such as the remuneration of senior officers and independent members, to a lower level of materiality. The disclosures are therefore inherently more prone to material misstatement. A number of changes have taken place to the senior management team and non-executive directors during the financial year. There is a risk that these changes are not correctly disclosed within the Trust's Remuneration Report.	I will review all entries in the Remuneration Report to verify that the Trust has reflected all known changes to senior positions, and that the disclosures are complete and accurate. I will also seek appropriate assurances from the Trust's Remuneration Committee which intends to review the Trust's draft Remuneration Report before it is presented to us for audit.	The work was carried out as proposed. Amendments were agreed with the Trust to ensure the final remuneration report was accurate and disclosures complied with the requirements of the NHS Manual for Accounts.

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

2021-22 ANNUAL REPORT TIMELINE

MEETING	Audit Committee
DATE	3rd March 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Assistant Corporate Secretary (Interim)
CONTACT	Email: Trish.Mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. A Task and Finish Group ('Group') has been established to ensure that the Trust meets the Annual Report 2021-22 reporting requirements as set out in the Manual for Accounts published by Welsh Government. The Annual Report includes the performance report and the accountability report. In previous years a separate public facing annual report has been developed, however the intention is to include this in the front end of the Annual Report for 2021/22. The Group at their next meeting will look at how that flows and ensure duplication is reduced in the complete document.

2. A timetable for the production of the Annual Report has been developed and is attached set out in the SBAR at Annex 1. A supplementary timetable is in place for contributions to the various sections of the Annual Report which will be managed by the Group.

RECOMMENDATION

3. The Audit Committee is requested to approve:

3.1 The Annual Report 2021-22 Timetable
3.2 Circulation of the reports set out at paragraph 9.3 by email circulation for review

KEY ISSUES/IMPLICATIONS

Given the tight timeframes within which the annual report must be prepared, and the contributions from multiple sources, a structured approach will be adopted to allow for oversight and escalation.

REPORT APPROVAL ROUTE
Executive Management Team – 16th February (Task and Finish Group established) and 24th February (timetable reviewed)

REPORT APPENDICES
1. Annex 1 – SBAR

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

ANNEX 1

SITUATION

1. A Task and Finish Group ('Group') has been established to take a structured approach to the 2021-22 Annual Report requirements as set out in the Manual for Accounts published by Welsh Government.

BACKGROUND

2. The Welsh Government Manual for Accounts 2021-22 requires the Trust to submit as a single PDF document a three part Annual Report and Accounts. The Annual Report includes the performance report and accountability report.

3. In addition to this statutory Annual Report and Accounts, the Trust has in the past produced a separate public facing annual report in English and Welsh. This document draws from the Statutory Annual Report and Accounts and provides an easy to read and contextual view of the Statutory Annual Report and the Accounts, a look back to the year in review and a forward look at the next year.

4. The aim for the 2021/22 Annual Report is to incorporate the public facing annual report in the 'front end' of the statutory Annual Report for 2021/22. The Group at their next meeting will look at how that flows and ensure duplication is reduced in the complete document.

ASSESSMENT

5. The Annual Report requires contributions from a number of individuals including performance and planning, partnerships and engagement, corporate governance, finance, workforce and organisational development and others.

6. Whilst the performance report is drafted by the performance team there is close coordination with those drafting the accountability report and the front end. Where governance information that would otherwise appear in the accountability report would flow better appearing in the performance report, cross-referencing is required to ensure duplication is reduced and messaging is consistent.

7. The development of the Financial Accounts has an established timetable which appears on the agenda for this meeting, and whilst it is not intended that the Group will manage this work, finance colleagues are part of the Group to ensure a coordinated approach, synchronicity of dates, management of contributions to the accountability report, and the publishing of the final single PDF Annual Report and Accounts.

8. The timetable below has been developed to include key submission dates to Welsh Government, Audit Wales, Trust Board and this Committee.

No.	Who	What	When
1.	EMT	Sign off of Draft Annual Report Lead: Board Secretary	27 April 2022
2.	RemCom (Email circulation)	Sign off Draft Remuneration Report Lead: Board Secretary	28 April 2022
3.	Audit Committee (Email circulation)	Sign off of Draft Annual Report Lead: Board Secretary	28 April 2022
4.	Submission to Welsh Gov. and Audit Wales of draft Annual Accounts Lead: Executive Director Finance and Corporate Resources		29 April 2022
5.	Submission to Welsh Gov. and Audit Wales of draft Annual Report Lead: Board Secretary		6 May 2022
6.	EMT	Updates/escalations from WG and AW Lead: Executive Director Finance and Corporate Resources and Board Secretary.	11 May 2022 – 1 June 2022
7.	Audit Committee	Scrutiny and approval of audited Annual Report and Accounts Lead: Executive Director Finance and Corporate Resources and Board Secretary	7 June 2022
8.	Trust Board	Approval and signing of audited Annual Report and Accounts Lead: Executive Director Finance and Corporate Resources and Board Secretary	13 June 2022.
9.	Audit Wales submission of approved and signed audited Annual Report and Accounts to Welsh Government.		15 June 2022
10.	Annual Meeting	Presentation and publication of audited Annual Report and Accounts Lead: Director of Partnerships and Engagement.	14 July 2022

9. The Audit Committee is requested to note the following with respect to the timetable:

   9.1 A supplementary timetable will be developed by the Group to manage contributions to the various sections of the Annual Report, its layout and Welsh translation.

   9.2 The draft Annual Report signed off at numbers 2-3 above may not include the full 'front end' of the document. This will not delay any review of the draft by Welsh Government or Audit Wales as it is not a statutory requirement. In any event it cannot be fully completed until the performance and accountability reports drafts are finalised. The Board Secretary and Director of Partnerships and Engagement will liaise with Audit Wales on the timing of this to ensure if receives the auditor's review.

   9.3 Due to the scheduling of Trust Board and Committee meetings, it is proposed that some draft documents are provided to members by email circulation for review: those being numbers 2 and 3 above.

RECOMMENDATION

10. **The Audit Committee is requested to approve:**

   10.1 **The Annual Report 2021-22 Timetable**
   10.2 **The circulation of the reports set out at paragraph 9.3 by email circulation for review**

AGENDA ITEM No	**10**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**3**

2021/22 Annual Accounts Update

MEETING	**Audit Committee**
DATE	**3rd March 2022**
EXECUTIVE	**Chris Turley (Executive Director of Finance & Corporate Resources)**
AUTHORS	**Navin Kalia (Deputy Director of Finance & Corporate Resources) and Jill Gill (Head of Financial Accounting)**
CONTACT	**Chris.Turley2@wales.nhs.uk**

EXECUTIVE SUMMARY

This report provides to the Committee an update on planning undertaken, progress made and any issues arising with both the preparation and external audit of the 2021/22 Annual Accounts.

KEY ISSUES/IMPLICATIONS

- A routine response to the Audit Wales (AW) '*Audit Enquiries to those charged with governance and management*' is required and is shown at Annex 2.
- An update is provided on the 'Scheme pays' arrangements for NHS Pensions and the potential qualification implications for NHS Wales' accounts in 2021/22.
- As part of the planning arrangements a detailed timetable for the accounts and audit process is included at Annex 3.

REPORT APPROVAL ROUTE

- Audit Committee – 3rd March 2022

REPORT APPENDICES
Annex 1 – AW Audit Enquiries Letter 21/22 Annex 2 – WAST Responses to AW Enquiries 21/22 Annex 3 – 2021/22 Year end Timetable Draft

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
AUDIT COMMITTEE

2021/22 Annual Accounts Update

INTRODUCTION

1. In preparation for year-end an interim Audit took is taking place virtually by the AW (Audit Wales) team during February and March 2022. Early issues and systems are being examined and a review of the Trust's Month 10 Financial Statements is being undertaken.

2. As part of the initial routine planning work, the AW team have issued the attached letter at ***Annex 1*** '*Audit Enquiries to those charged with governance and management'*. This is requested every year and is formally seeking documented consideration and understanding on a number of governance areas that impact on the year-end audit of the Trust's financial statements.

BACKGROUND/ASSESSMENT

Audit Enquiries to those charged with governance and management

3. The Trust's planned responses to the enquiries mentioned above are attached at ***Annex 2***.

Scheme Pays – NHS Pension scheme

4. You may recall that following a Government Ministerial Direction issued on 18 December 2019, a scheme was arranged which allowed members of the NHS Pension scheme to request that the NHS pay their annual allowance charge to HMRC. In return, the member's NHS Pension benefits will be permanently reduced when it becomes payable or if they leave and transfer out of the scheme.
5. This scheme was intended to support clinical staff who wished to work additional hours who were facing the impact of onerous pension tax rules.
6. At the time that the 2020/21 accounts were being approved, there was insufficient data of take-up of the scheme by Welsh clinical staff to enable a reasonable assessment of future take up, and resulting cost, to be made. As a result of this at 31 March 2021, the existence of an unquantified contingent liability was instead disclosed by all NHS Wales bodies, alongside a "narrative view" of this placed on all accounts by Audit Wales.
7. Data recently extracted for the Trust indicated that there had been no applications made by any staff member for this scheme to date.
8. Discussions are currently taking place between the Welsh Government (WG) and Audit Wales (AW) teams in connection with this issue and the potential requirement for a qualification of some or all of NHS Wales' 2021/22 statutory accounts. There is a potential that an unquantified contingent liability may again have to be disclosed for 2021/22. In terms of materiality, although this matter is unlikely to be technically material, it could be considered material due to its nature and due to the use of the public purse.
9. Discussions on this continue, including via the All Wales Technical Accounting Group

(TAG) with views recently further shared with WG. This includes a general consensus that if a qualification of the 2021/22 accounts was required then this should sit at WG level rather than with the individual Health Boards and Trusts as the decision to fund this scheme was made at Government level and in addition no costs sit with the Health Boards or Trusts (and if and when they do, they will be backed by WG funding). Consistency with approaches to this across the UK are also being argued.

10. In addition to this, as stated above, for this Trust no applications have currently been identified for any of our staff.

11. The risk of qualification for this Trust's 2021/22 accounts in respect of this area is therefore deemed to be low.

Year End Timetable

10. A copy of the detailed 2021/22 Year End Accounts timetable is attached at ***Annex 3*** for the Committee's information. This is based presently on the draft timetable issued by the Welsh Government. The final timetable is not anticipated to be significantly different.

11. Key dates are shown below:-

Key Dates	
EMT to review draft Remuneration report	27-Apr-22
Review of Remuneration report by Remuneration Committee (virtually)	28-Apr-22
Submit Unaudited accounts, Pooled Budgets and TFR/LFRs including LFR6, (except FR10) TMS A to C and F-H inclusive	29-Apr-22 (12 Noon)
NHS Bodies to submit (from Corporate Team) Accountability Report (Statement of Accountable Officer Responsibilities, Statement of Directors responsibilities in respect of the accounts, Annual Governance Statement) (At this stage the statements are not signed and the AGS is in draft).	06-May-22 (12 Noon)
NHS Bodies to submit (from Finance) Remuneration Report TMS/LMS2 and FR10	06-May-22 (12 Noon)
Audit commences	03-May-2022 (Tuesday)
Closure Meeting with External Auditors	30/05/2022 (Monday)
Audit Committee Meeting initial accounts approval	07-June-2022 (Tuesday)
Trust Board Meeting to formally approve and sign accounts	13-June-2022 (Monday)
The WAO to submit final audited accounts to the Welsh Government including:-	15-June-2022 (Wednesday) (12 Noon)
Audited accounts	
All TFR/LFRs	
TMS 1 A to C and F-H inclusive	
TMS 2	
Audited accounts, Annual Report Sections including;	
Accountability Report (Statement of Accountable Officer Responsibilities, Statement of Directors responsibilities in respect of the accounts AGW Report and Certificate, Performance Report, Annual Governance Statement, Remuneration Report) and Financial Statements (audited accounts)	

RECOMMENDED that the Committee:

a) Note the contents of this report.
b) Consider and approve the response points within Annex 2.

Annex 1, Annex 2, Annex 3 ATTACHED

24 Cathedral Road / 24 Heol y Gadeirlan
Cardiff / Caerdydd
CF11 9LJ
Tel / Ffôn: 029 2032 0500
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Textphone / Ffôn testun: 029 2032 0660
info@audit.wales / post@archwilio.cymru
www.audit.wales / www.archwilio.cymru

Martin Turner, Chair of the Audit Committee
Chris Turley, Director of Finance and ICT
Welsh Ambulance Services NHS Trust
Vantage Point House
Vantage Point Business Park
Ty Coch Way
Cwmbran
NP44 7HF

Reference: AW/WAST/MJP

Date issued: 17 January 2022

Dear Martin and Chris

Welsh Ambulance Services NHS Trust 2021-22 - Audit enquiries to those charged with governance and management

The Auditor General for Wales is responsible for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error.

This letter formally seeks documented consideration and understanding on a number of governance areas that impact on our audit of your financial statements. These considerations are relevant to both the management of the Welsh Ambulance Services Trust (the Trust) and 'those charged with governance' (the Audit Committee).

I have set out below the areas of governance on which I am seeking views.

1. Processes in relation to:
   - undertaking an assessment of the risk that the financial statements may be materially misstated due to fraud;
   - identifying and responding to risks of fraud in the organisation;

- communication to those charged with governance the processes for identifying and responding to fraud; and
- communication to employees of views on business practice and ethical behaviour.

2. Awareness of any actual or alleged instances of fraud.

3. How assurances are gained that all relevant laws and regulations have been complied with.

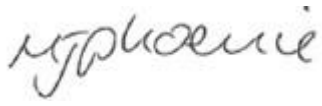
4. Whether there is any potential litigation or claims that would affect the financial statements.

5. Processes to identify, authorise, approve, account for and disclose related party transactions and relationships.

The information you provide will inform our understanding of the Trust and its business processes and support our work in providing an audit opinion on your 2021-22 financial statements.

I would be grateful if you could complete the attached tables in Appendices 1-3, which should be formally considered and communicated to us on behalf of both management and those charged with governance by 3 March 2022. For information purposes this table also includes the responses provided in 2020-21. In the meantime, if you have queries, please do not hesitate to contact me.

Yours sincerely



Michelle Phoenix
Audit Manager

CC: Jill Gill, Financial Accountant

Appendix 1

Matters in relation to fraud

International Standard for Auditing (UK and Ireland) 240 covers auditors responsibilities relating to fraud in an audit of financial statements.

The primary responsibility to prevent and detect fraud rests with both management and 'those charged with governance', which for the Trust is the Audit Committee. Management, with the oversight of the Audit Committee, should ensure there is a strong emphasis on fraud prevention and deterrence and create a culture of honest and ethical behaviour, reinforced by active oversight by those charged with governance.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error. We are required to maintain professional scepticism throughout the audit, considering the potential for management override of controls.

What are we required to do?

As part of our risk assessment procedures we are required to consider the risks of material misstatement due to fraud. This includes understanding the arrangements management has put in place in respect of fraud risks. The ISA views fraud as either:

- the intentional misappropriation of assets (cash, property, etc); or
- the intentional manipulation or misstatement of the financial statements.

We also need to understand how Audit Committee exercises oversight of management's processes. We are also required to make enquiries of both management and the Audit Committee as to their knowledge of any actual, suspected or alleged fraud and to understand the processes for identifying and responding to the risks of fraud and the internal controls established to mitigate them.

Enquiries of management - in relation to fraud		
Question	**2020-21 Response**	**2021-22 Response**
1. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud and what are the principal reasons?	The risk of the financial statements being misstated due to fraud is considered to be low. The Trust is not aware of any occurrences of fraud that would materially impact on our financial statements. Management controls, counter fraud and internal audit activity has not identified any significant incidence of fraud or suspected fraud during 2020-21. As this has been identified as a low risk area and the Internal Audit Plan is risk based, there are no scheduled audits of this area within the Plan for 2020-21.	The risk of the financial statements being misstated due to fraud is considered to be low. The Trust is not aware of any occurrences of fraud that would materially impact on our financial statements. Management controls, counter fraud and internal audit activity has not identified any significant incidence of fraud or suspected fraud during 2021-22. As this has been identified as a low risk area and the Internal Audit Plan is risk based, there are no scheduled audits of this area within the Plan for 2021-22.
2. What processes are employed to identify and respond to the risks of fraud more generally and specific risks of misstatement in the financial statements?	Internal and external audit reviews are undertaken each year on key financial systems and statements. An accounts review is undertaken by the Director of Finance and other senior financial managers to ensure significant changes from previous years accounts can be explained. There are internal and external audit and counter fraud plans in place. Regular reports are provided to Audit Committee on all of the above. The risk of the financial records being misstated due to fraud is considered to be low.	Internal and external audit reviews are undertaken each year on key financial systems and statements. An accounts review is undertaken by the Director of Finance and other senior financial managers to ensure significant changes from previous years accounts can be explained. There are internal and external audit and counter fraud plans in place. Regular reports are provided to Audit Committee on all of the above. The risk of the financial records being misstated due to fraud is considered to be low.

Enquiries of management - in relation to fraud		
Question	**2020-21 Response**	**2021-22 Response**
3. What arrangements are in place to report fraud issues and risks to the Audit Committee?	Counter fraud is a standing item on the Audit Committee agenda and update reports are presented at each Audit Committee. An annual work plan and an annual report are also presented to the Audit Committee. No incidences of significant fraud or suspected fraud were identified during 2020-21.	Counter fraud is a standing item on the Audit Committee agenda and update reports are presented at each Audit Committee. An annual work plan and an annual report are also presented to the Audit Committee. No incidences of significant fraud or suspected fraud were identified during 2021-22, that specifically related to financial statements.
4. How has management communicated expectations of ethical governance and standards of conduct and behaviour to all relevant parties, and when?	Staff are informed on how to report fraud and are encouraged to report all concerns. The fraud policy is available to all staff and provides guidance on what to do if fraud is suspected. The Trust are communicating more real examples of fraud to staff to raise awareness of real life cases and their outcomes. Over the last few years the Trust has further enhanced and developed its core set of behaviours that it expects all employees to adhere to. These include being honest and open with individuals and each other, and each employee owning their own decisions. The Trust is also fully committed to upholding the 7 principles of public life first encaptured within the Nolan Report.	Staff are informed on how to report fraud and are encouraged to report all concerns. The Counter Fraud Policy is available to all staff and provides guidance on what to do if fraud is suspected. The Trust are communicating more real examples of fraud to staff to raise awareness of real life cases and their outcomes. Over the last few years the Trust has further enhanced and developed its core set of behaviours that it expects all employees to adhere to. These include being honest and open with individuals and each other, and each employee owning their own decisions. The Trust is fully committed to upholding the 7 principles of public life first encaptured within the Nolan Report, this is in addition to the abiding by the principles of good governance.

Enquiries of management - in relation to fraud		
Question	**2020-21 Response**	**2021-22 Response**
5. Are you aware of any instances of actual, suspected or alleged fraud within the audited body since 1 April 2021?	Counter fraud update reports are provided at each meeting highlighting any referrals made and actions taken, including progress on any investigations taking place. There were no instances of significant actual, suspected or alleged frauds reported during 2020-21. Any referral of suspected fraud is reported to the Audit Committee and investigated through agreed processes, with the Committee receiving updates on the status of each such referral at each meeting.	Counter fraud update reports are provided at each Closed Session of the Audit Committee meeting highlighting any referrals made and actions taken, including progress on any investigations taking place. There were no instances of significant actual, suspected or alleged frauds reported during 2021-22, that specifically related to financial statements. Any referral of suspected fraud is reported to the Audit Committee and investigated through agreed processes, with the Committee receiving updates on the status of each such referral at each meeting.
6. Are you aware of any instances of actual, suspected or alleged fraud within NWSSP or BCULHB since 1 April 2021, given these are service organisations that you use?	The Trust or the Audit Committee is not aware of any significant actual frauds. The Trust is a full member of the NWSSP standing committee. The Trust also regularly links in with the NHS Wales Regional Counter Fraud service where such concerns could also be raised. All counter fraud teams within Wales share intelligence and alerts around fraud investigations that impact upon their health boards or Trust. Local Counter fraud specialists, in conjunction with the NHS Counter Fraud Wales team, have access to quarterly reports that highlight received fraud reports, and also actively engage in direct communications with linked Trusts should an occurrence of fraud be reported	The Trust or the Audit Committee is not aware of any significant actual frauds. The Trust is a full member of the NWSSP standing committee. The Trust also regularly links in with the NHS Wales Regional Counter Fraud service where such concerns could also be raised. All counter fraud teams within Wales share intelligence and alerts around fraud investigations that impact upon their health boards or Trust. Local Counter fraud specialists, in conjunction with the NHS Counter Fraud Wales team, have access to quarterly reports that highlight received fraud reports, and also actively engage in direct communications with linked Trusts should an occurrence of fraud be reported

Enquiries of management - in relation to fraud		
Question	**2020-21 Response**	**2021-22 Response**
	that has an impact on our Trust. In the light of this, WAST has not been notified of any such fraud concerns that relate to services provided by NHWSSP, and should there have been any, notification and referral information would have been presented by the host Counter Fraud team, or the regional CFS wales team.	that has an impact on our Trust. In the light of this, WAST has not been notified of any such fraud concerns that relate to services provided by NHWSSP, and should there have been any, notification and referral information would have been presented by the host Counter Fraud team, or the regional CFS Wales team

Enquiries of those charged with governance – in relation to fraud		
Question	**2020-21 Response**	**2021-22 Response**
1. How does the Audit Committee, exercise oversight of management's processes for identifying and responding to the risks of fraud within the audited body and the internal control that management has established to mitigate those risks?	Declarations of interest are sought annually from all senior staff, and at the outset of each meeting of the Board and its various formal sub committees Details of related party transactions of Board Members are included within the Annual Accounts. The Audit Committee also routinely receives details of all tenders let and Single Tender Waivers applied for. The Audit Committee is not aware of any related party relationships or transactions that could give rise to instances of fraud.	Declarations of Interest are sought annually from all senior staff. Standing Declarations from Board Members are noted at the outset of each meeting of the Board and its various formal Board Committees. Details of related party transactions of Board Members are included within the Annual Accounts. The Audit Committee routinely receives assurances on tenders let and Single Tender Waivers applied for. The Audit Committee is not aware of any related party relationships or transactions that could give rise to instances of fraud. The Audit Committee, in conjunction with the Director of Finance and corporate resources, and the Local Counter Fraud Manager acknowledge an annual work plan for Counter Fraud activities, and monitors its progress providing assurance to the Audit Committee through regular update reports.
2. Are you aware of any instances of actual, suspected or alleged fraud with the audited body since 1 April 2021?	The Audit Committee has no suspicion of any significant actual, suspected or alleged frauds.	The Audit Committee has no suspicion of any significant actual, suspected or alleged frauds, specifically related to financial statements of the Trust.

Appendix 2

Matters in relation to laws and regulations

International Standard for Auditing (UK and Ireland) 250 covers auditors responsibilities to consider the impact of laws and regulations in an audit of financial statements.

Management, with the oversight of those charged with governance, which for the Trust is the Audit Committee, is responsible for ensuring that the Council's operations are conducted in accordance with laws and regulations, including compliance with those that determine the reported amounts and disclosures in the financial statements.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error, taking into account the appropriate legal and regulatory framework. The ISA distinguishes two different categories of laws and regulations:

- laws and regulations that have a direct effect on determining material amounts and disclosures in the financial statements;
- other laws and regulations where compliance may be fundamental to the continuance of operations, or to avoid material penalties.

What are we required to do?

As part of our risk assessment procedures we are required to make inquiries of management and the Audit Committee to whether the Trust is in compliance with relevant laws and regulations. Where we become aware of information of non-compliance or suspected non-compliance we need to gain an understanding of the non-compliance and the possible effect on the financial statements.

Enquiries of management – in relation to laws and regulations		
Question	**2020-21 Response**	**2021-22 Response**
1. How have you gained assurance that all relevant laws and regulations have been complied with?	External regulators and commissioners report on legal requirements and compliance. The Internal Audit programme includes legal and statutory compliance. Legal implications are considered as necessary in papers to the Board or Board Committees.	External regulators and commissioners report on legal requirements and compliance. The Internal Audit programme includes legal and statutory compliance. Legal implications are considered as necessary in papers to the Board or Board Committees.
2. Have there been any instances of non-compliance or suspected non-compliance with relevant laws and regulations since 1 April 2021, or earlier with an ongoing impact on the 2021-22 financial statements?	The Audit Committee is not aware of any significant non-compliance issues.	The Audit Committee is not aware of any significant non-compliance issues.
3. Are there any potential litigations or claims that would affect the financial statements?	All known litigations/claims are either provided for within the financial statements or disclosed as a contingent liability. All claims under consideration and potential claims are reviewed by the Quality and Safety Committee.	All known litigations/claims are either provided for within the financial statements or disclosed as a contingent liability. All claims under consideration and potential claims are presented to the Quality and Safety Committee for scrutiny.
4. Have there been any reports from other regulatory bodies, such as HM Revenues and Customs which indicate non-compliance?	The Trust has not received any reports from such bodies and as such the Audit Committee is not aware of any significant non-compliance issues.	The Trust has not received any reports from such bodies and as such the Audit Committee is not aware of any significant non-compliance issues.
5. Are you aware of any non-compliance with laws and regulations within NWSSP or BCULHB since 1 April	The Audit Committee is not aware of any significant non-compliance issues. The Trust regularly meets with its service providers in order to gain assurance on	The Audit Committee is not aware of any significant non-compliance issues. The Trust regularly meets with its service providers in order to gain assurance on

2021, given these are service organisations that you use?	several different levels. In addition regular KPI performance reports are shared with the Trust. Within these forums there is an expectation that incidences of noncompliance with laws and regulations that would impact on the service provided to the Trust would be formally reported.	several different levels. In addition regular KPI performance reports are shared with the Trust. Within these forums there is an expectation that incidences of noncompliance with laws and regulations that would impact on the service provided to the Trust would be formally reported.

Enquiries of those charged with governance – in relation to laws and regulations		
Question	**2020-21 Response**	**2021-22 Response**
1. How does the Audit Committee, in its role as those charged with governance, obtain assurance that all relevant laws and regulations have been complied with?	External regulators and commissions report directly and independently and reports are reviewed by the Board and Committees. All internal and external audit reports are considered by the Audit Committee. Other legal implications where appropriate are considered in papers to the Board and Board Committees.	External regulators and commissioners report directly and independently and reports are received by the Board and Committees for assurance. All internal and external audit reports are received by the Audit Committee. Other legal implications, where appropriate, are detailed in reports submitted to the Board and Board Committees.
2. Are you aware of any instances of non-compliance with relevant laws and regulations?	There are no known instances of noncompliance with relevant laws. On 30 May 2019 the Trust moved from implementing its Welsh Language Scheme under the Welsh Language Act 1993 to implementing Welsh Language Standards as part of the Welsh Language (Wales) Measure 2011. As a result the Trust has implemented actions in order to comply with its Statutory Welsh Language Standards Compliance Notice that was received from the Welsh Language Commissioner.	There are no known instances of noncompliance with relevant laws. On 30 May 2019 the Trust moved from implementing its Welsh Language Scheme under the Welsh Language Act 1993 to implementing Welsh Language Standards as part of the Welsh Language (Wales) Measure 2011. As a result the Trust has implemented actions in order to comply with its Statutory Welsh Language Standards Compliance Notice that was received from the Welsh Language Commissioner.

Appendix 3

Matters in relation to related parties

International Standard for Auditing (UK and Ireland) 550 covers auditors responsibilities relating to related party relationships and transactions.

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the entity's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

What are we required to do?

As part of our risk assessment procedures, we are required to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the entity's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework.

Enquiries of management – in relation to related parties		
Question	**2020-21 Response**	**2021-22 Response**
1. Confirm that you have disclosed to the auditor: • the identity of any related parties, including changes from the prior period; • the nature of the relationships with these related parties; • details of any transactions with these related parties entered into during the period, including the type and purpose of the transactions.	Confirmed. Declarations have been received and are available for audit scrutiny.	Declarations are available for internal and external audit scrutiny. An Internal Audit review is planned for 2022-23 to review the internal process for these declarations.
2. What controls are in place to identify, authorise, approve, account for and disclose related party transactions and relationships?	Declarations of interest are sought annually from all senior staff. and at the outset of each meeting of the Board and its various formal sub committees Details of related party transactions of Board Members are included within the Annual Accounts which are approved by Audit Committee and Board.	Declarations of Interest are sought annually from all senior staff. Standing Declarations from Board Members are noted at the outset of each meeting of the Board and its various formal Board Committees. Details of related interests and transactions of Board Members are included within the Annual Accounts.

Enquiries of the those charged with governance – in relation to related parties		
Question	**2020-21 Response**	**2021-22 Response**
1. How does the Audit Committee, in its role as those charged with governance, exercise oversight of management's processes to identify, authorise, approve, account for and disclose related party transactions and relationships?	There is a central Declarations of Interest Register and Central Register of Gifts & Hospitality. These are reported to the Board at least annually.	There is a central Declarations of Interest Register and Central Register of Gifts & Hospitality. These are reported to the Board at least annually.

ANNUAL ACCOUNTS - END OF YEAR TIMETABLE 2021/22

Key dates

Key Dates	
EMT to review draft Remuneration report	27-Apr-22
Review of Remuneration report by Remuneration Committee (virtually)	28-Apr-22
Submit Unaudited accounts, Pooled Budgets and TFR/LFRs including LFR6, (except FR10) TMS A to C and F-H inclusive	29-Apr-22 (12 Noon)
NHS Bodies to submit (from Corporate Team) Accountability Report (Statement of Accountable Officer Responsibilities, Statement of Directors responsibilities in respect of the accounts, Annual Governance Statement) (At this stage the statements are not signed and the AGS is in draft).	06-May-22 (12 Noon)
NHS Bodies to submit (from Finance) Remuneration Report TMS/LMS2 and FR10	06-May-22 (12 Noon)
Audit commences	03-May-2022 (Tuesday)
Closure Meeting with External Auditors	30/05/2022 (Monday)
Audit Committee Meeting initial accounts approval	07-June-2022 (Tuesday)
Trust Board Meeting to formally approve and sign accounts	13-June-2022 (Monday)
The WAO to submit final audited accounts to the Welsh Government including:- Audited accounts All TFR/LFRs TMS 1 A to C and F-H inclusive TMS 2 Audited accounts, Annual Report Sections including; Accountability Report (Statement of Accountable Officer Responsibilities, Statement of Directors responsibilities in respect of the accounts AGW Report and Certificate, Performance Report, Annual Governance Statement, Remuneration Report) and Financial Statements (audited accounts)	15-June-2022 (Wednesday) (12 Noon)

ANNUAL ACCOUNTS - END OF YEAR TIMETABLE 2021/22

Key staff

Name	Initials
Abigail Gregory	AG
Angela Evans	AE
Beverly Davies	BD
Chris Turley	CT
Claire Vaughan	CV
Dawn Butterworth	DB
Edward Roberts	ER
Jason Collins	JC
Jessica Price	JP
Jillian Gill	JG
Lee McAlea	LMc
Megan Marsden	MM
Michelle Jones	MJ
Mike Armstrong	MA
Navin Kalia	NK
Nick Roberts	NR
Nicola Parsons	NP
Shannon Owen	SO
Steph Taylor	ST
Tracey Thomas	TT

Teams	Abbrev	Lead
Accounts Payable	AP	Noel Williamson
Audit Wales	AW	Michelle Phoenix
Financial Accounts	FA	Jill Gill
Financial Management	FM	Jason Collins
Systems (led by Steve Harper)	Syst	Steve Harper

ANNUAL ACCOUNTS - END OF YEAR TIMETABLE 2021/22

TMS

SECTION	TASK	Resp.	16/03	17/03	18/03	21/03	22/03	23/03	24/03	25/03	28/03	29/03	30/03	31/03	01/04	WD1	WD2	WD3	WD4	WD5	WD6	WD7	WD8	WD9	WD10	15/04 18/04	WD11	WD12	WD13	WD14	WD15	WD16	WD17	WD18	WD19	03/05	15/06	20/06
			W	Th	Fr	M	Tu	W	Th	Fr	M	Tu	W	Th	Fr		M	Tu	W	Th	Fr	M	Tu	W	Th	Easter	Tu	W	Th	Fr	M	Tu	W	Th	Fr	Tu	W	M
TMS WHSSC	Issue Debtor balances with WHSSC	MM																																				
	Sign off Debtor/ Creditor with WHSSC	BD																																				
	Issue Income transactions to WHSSC	TT																																				
	All NHS bodies to agree Income balances with WHSSC	BD																																				
TMS All	Estimated NHS Wales Income accruals to be accrued and reported to Tracey Thomas for TMS feed	FM											Noon																									
	Income accruals to be added to Balances	TT																																				
	Circulate details of agreed balances to FM for comment and information	BD/TT																																				
Prep	Month 12 Income Statements	TT																																				
	Month 12 Debtor Statements	MM																																				
TMS All	Issue - Debtor statements to other NHS Wales bodies	MM																																				
	Circulate individual e-mails received (ASAP) with debtor statements to FM to enable accruals to be confirmed and disputes to be raised formally	BD																																				
	FM to agree accruals in GL to NHS Wales Debtor statements and raise any disputes formally with Bev Davies and Dawn Butterworth in AP	FM																																				
	Disputed invoices to be recorded on TMS	BD/DB																																				
	Sign-off date for agreement of NHS Wales creditors	BD																																				
	Sign-off date for agreement of NHS Wales Debtors	MM																																				
	Reconcile agreed position to ledger for NHS Wales creditors	BD																																				
	Reconcile agreed position to ledger for NHS Wales Debtors	TT																																				
	Issue - Income transactions statement to other NHS Wales bodies	TT																																				
	Sign-off date for agreement of NHS Wales expenditure	BD																																				
	Sign-off date for agreement of NHS Wales income	TT																																				

First I and E Mon Rtn
Agree final dr/cr bals NHS
M13 Open
Stat accts drafted
Mon Rtn prov deadline
Submit draft accts
Audit commences
Submit audited accounts

ANNUAL ACCOUNTS - END OF YEAR TIMETABLE 2021/22

TMS

SECTION	TASK	Resp.	16/03	17/03	18/03	21/03	22/03	23/03	24/03	25/03	28/03	29/03	30/03	31/03	01/04	WD1	WD2	WD3	WD4	WD5	WD6	First I and E Mon Rtn	WD7	Agree final dr/cr bals NHS	WD8	M13 Open	WD9	WD10	15/04 18/04	WD11	WD12	WD13	WD14	Stat accts drafted	WD15	Mon Rtn prov deadline	WD16	WD17	WD18	WD19	Submit draft accts	03/05	Audit commences	15/06	Submit audited accounts	20/06
			W	Th	Fr	M	Tu	W	Th	Fr	M	Tu	W	Th	Fr		M	Tu	W	Th	Fr		M		Tu		W	Th	Easter	Tu	W	Th	Fr		M		Tu	W	Th	Fr		Tu		W		M
TMS All	Submit TMS A to C to WG	TT																															Noon													
	WG to issue - Debtor and Creditor matrix and Income and expenditure matrix	WG																															PM													
	Submit Unaudited Accounts, TFR's (incl TFR6) and TMS	JG																																						Noon						
	Matrix based on unaudited accounts TMS Debtor and Creditor, Income and Expenditure	WG																																												
	The WAO to submit final audited accounts to the Welsh Government including:-	AW																																										Noon		
	Audited accounts all TFRs TMS 1 A to C and F-H inclusive and TMS 2																																													
	Annual Report sections:																																													
	Accountability Report (Statement of Accountable Officer Responsibilities, Statement of Directors Responsibilities in respect of the accounts, AGW Report and Certificate, Annual Governance Statement, Remuneration Report) and Financial statements (audited accounts)																																													
	• Single pdf document • Typed names of all signatories (not signatures) • Typed full dates of signing • The hard copy version to be provided for certification by WAO must be as the single PDF document for laying but excludes the typed in names that must be physically signed.																																												
	Matrix based on audited accounts TMS Debtor and Creditor, Income and Expenditure	WG																																												

ANNUAL ACCOUNTS - END OF YEAR TIMETABLE 2021/22

Draft Trust Accounts

SECTION	TASK	Resp.		25/02 Fr	03/03 Th	04/03 Fr	07/03 M	08/03 Tu	09/03 W	10/03 Th	11/03 Fr	14/03 M	15/03 Tu	16/03 W	17/03 Th	18/03 Fr	21/03 M	22/03 Tu	23/03 W	24/03 Th	25/03 Fr	28/03 M	29/03 Tu	30/03 W	31/03 Th	01/04 Fr	WD1	04/04 M	05/04 Tu	06/04 W	07/04 Th	08/04 Fr	11/04 M	12/04 Tu	13/04 W	14/04 Th	15/04 Easter	18/04	WD2	19/04 Tu	20/04 W	21/04 Th	22/04 Fr	25/04 M	26/04 Tu	27/04 W	28/04 Th	29/04 Fr	02/05 BH	WD3	03/05 Tu	04/05 W	05/05 Th	WD4	06/05 Fr
Year end Cash	Daily Notification of Bankings to HQ	TT																																																			
	Localities notified to top up Petty Cash	MM																																																			
	All Petty Cash Accounts topped up or confirmed that already at full imprest	MM																																																		
	Advise National Loan Fund to expect deposit	TT																																																		
	Place National Loan Fund Short term Deposits	TT																																																		
FA	Financial Accounts early feeds Depreciation and Prepayments inc Lease cars	BD																																																		
	Contact Pensions Agency to expedite year end PIBS information in connection with any changes or additions to individual cases	JG																																																	
	Finalise year end position for PIBS and Early Retirement provisions	JG																																																	
	Calculate final year end CRU position including bad debt element	MM																																																	
	Losses & Compensation	BD																																																	
	Charitable Funds Oracle purchases transferred	TT																																																	
	Fixed Assets	JP																																																	
	Bad Debt Provision	JG/TT																																																	
AR	Last NOI date notified to Managers	TT																																																	
	With the aim of reducing the number of NHS Wales invoices outstanding with Welsh Government prior to year end, NHS Wales organisations must submit the majority of their Welsh Government year-end invoices and backing documents electronically to HSSE2EMailbox@gov.wales by close of play on 3rd March 2022. Every effort will be made to process these invoices for payment prior to year-end. Please ensure if there are any invoices that require cash payment post 31 March 2022 that this requirement is clearly identified in the invoice narrative. NHS organisations should continue to inform Welsh Government of any invoices raised after this date to reduce the number of "new" invoices appearing on the debtor statements issued on the 6 April 2022 as part of the year-end formal agreement process. There will still be a need for accruals; however, they should be limited in number. Any invoices raised based on estimates to cover March, need to be clearly marked that they are Estimates.	All																																																					
	Deadline for remotely raised invoices and invoice requests to be sent to HQ team	Requisitioners and invoice requesters																						Noon																														
	Receipting to be completed by 3pm	MJ																							3pm																												
	AR posted to GL & AR closed	TT/MM																							6 pm																												
	Write offs/cancellations actioned	TT																							6 pm																												

ANNUAL ACCOUNTS - END OF YEAR TIMETABLE 2021/22

Draft Trust Accounts

SECTION	TASK	Resp.		25/02 Fr	03/03 Th	04/03 Fr	07/03 M	08/03 Tu	09/03 W	10/03 Th	11/03 Fr	14/03 M	15/03 Tu	16/03 W	17/03 Th	18/03 Fr	21/03 M	22/03 Tu	23/03 W	24/03 Th	25/03 Fr	28/03 M	29/03 Tu	30/03 W	31/03 Th	WD1 01/04 Fr	WD2 04/04 M	WD3 05/04 Tu	WD4 06/04 W	WD5 07/04 Th	WD6 08/04 Fr	WD7 11/04 M	WD8 12/04 Tu	WD9 13/04 W	WD10 14/04 Th	15/04 Easter	18/04	WD11 19/04 Tu	WD12 20/04 W	WD13 21/04 Th	WD14 22/04 Fr	WD15 25/04 M	WD16 26/04 Tu	WD17 27/04 W	WD18 28/04 Th	WD19 29/04 Fr	02/05 BH	M1 WD1 03/05 Tu	M1 WD2 04/05 W	M1 WD3 05/05 Th	M1 WD4 06/05 Fr
																														First I and E Mon Rtn	Agree final dr/cr bals NHS	M13 Open												Stat accts drafted	Mon Rtn prov deadline			Submit draft accts		Audit commences			Residual draft submission	
AP team /Systems/Financial Accounts	Holdback and don't register 40-80 invoices of varying values that don't need to be paid before 31/3 (as fallback plan)	DB/AP																																														
	Final BACS NHS Creditors run (to pay 24th Mar last day for NHS)	TT/AP																	PAY																																
	Final BACS Non NHS Creditors run	TT/AP																					PAY																												
	Final manual Cheque Run	TT/AP																						Noon																												
	Upload manual cheques	TT/MM																						5pm																												
	AP Closedown	TT/AP																						3pm																												
	AP posted to GL	Syst																						5pm																												
	PSPP prompt payment policy report	ST																																																	
	GL M12 Closedown/M13 opened	Syst																																																	
POs	Last PO receipt date notified to Managers	JP																																																	
	Last PO receipt date	AP / Syst																						Noon																												
	PO accruals	AP / Syst																						5pm																												
	PO Closedown	AP / Syst																						5pm																												
Stock	Stock Takes planned	NR/SO																																																	
	Central valuations for standard M and S stock, cleaning stock and diesel stock produced including full audit trail	NR/SO																																																
	Central valuation information re Fleet workshop stock obtained from Fleet with full audit trail	LMc																																																
	Physical Stock taking/workaround	NR/FM																																																
	Completion of stock proforma files using agreed central valuation information	NR/SO																																															
	Ledger adjusted re stock figures by FM	NR/SO																																															
	Stock Taking results submitted to Abigail Gregory within agreed Trust proforma files for collation	NR/SO																																															
	Final collated stock files (agreed to ledger) reported to Jill Gill	AG																																															
Up to M12 Monitoring Return	Annual Leave accruals to be prepared and ledger adjusted by FM. Reports to be submitted to Abigail Gregory for collation.	FM																																															
	Collation of Annual Leave accruals and agree to ledger	AG																																															
	Final M12 position	FM																																															
	Review of Key Final Accounts issues	NK/JC/ER/JG																																															
	Balance Sheet for M12 reconciled	TT																																															
	Management Accounts to adjust in M13 where necessary mismatches between GL and TMS agreed balances	FM																																															
	Mon. Rtn to WG	NK/ER																																															

ANNUAL ACCOUNTS - END OF YEAR TIMETABLE 2021/22

Draft Trust Accounts

SECTION	TASK	Resp.		25/02 Fr	03/03 Th	04/03 Fr	07/03 M	08/03 Tu	09/03 W	10/03 Th	11/03 Fr	14/03 M	15/03 Tu	16/03 W	17/03 Th	18/03 Fr	21/03 M	22/03 Tu	23/03 W	24/03 Th	25/03 Fr	28/03 M	29/03 Tu	30/03 W	31/03 Th	WD1 01/04 Fr	WD2 04/04 M	WD3 05/04 Tu	WD4 06/04 W	WD5 07/04 Th	WD6 08/04 Fr	WD7 11/04 M	WD8 12/04 Tu	WD9 13/04 W	WD10 14/04 Th	15/04 18/04 Easter	WD11 19/04 Tu	WD12 20/04 W	WD13 21/04 Th	WD14 22/04 Fr	WD15 25/04 M	WD16 26/04 Tu	WD17 27/04 W	WD18 28/04 Th	WD19 29/04 Fr	02/05 BH	M1 WD1 03/05 Tu	M1 WD2 04/05 W	M1 WD3 05/05 Th	M1 WD4 06/05 Fr
Unaudited Accounts Prep	Summary of Consultancy costs	ST																																													
	Notes to Accounts - Revenue from Patient Care and Other Operating Revenue	ST																																													
	Notes to Accounts - Operating Expenses	ST																																													
	Income and Expenditure variance analysis	JC/ST																																													
	Notes to Accounts - Investment Revenue	TT																																												
	Notes to Accounts - Other Gains and Losses	JP																																												
	Notes to Accounts - Finance costs	JG																																												
	Notes to Accounts - Operating Leases	NP																																												
	Notes to Accounts - Employee costs and exit packages	ST																																												
	Notes to Accounts - Employee numbers	FM TBC																																												
	Notes to Accounts - Remuneration relationship (Hutton Report)	ST																																												
	Notes to Accounts - Public Sector Pay Policy	JG																																												
	Notes to Accounts - Property, plant and equipment	JP																														1st cut				Final											
	Notes to Accounts - Intangible fixed assets	JP																																												
	Notes to Accounts - Revaluation reserve	JP																																												
	Notes to Accounts - Impairments	JP																																												
	Notes to Accounts - Capital Commitments	JP																																												
	Notes to Accounts - Other Financial assets	JG																																												
	Notes to Accounts - Other assets	JG																																												
	Notes to Accounts - Inventories (stock)	AG																																												
	Notes to Accounts - Trade and other receivables (debtors) and reconcile to TMS	TT																																												
	Notes to Accounts - Cash and Cash equivalents	TT																																												
	Notes to Accounts - Trade and other payables (creditors) and reconcile to TMS	BD																																												
	Notes to Accounts - Borrowings	JG																																												
	Notes to Accounts - Other financial liabilities	JP																																												
	Notes to Accounts - Other liabilities	JP																																												
	Notes to Accounts - Provisions	JP																																												
	Notes to Accounts - Finance Leases	JP																																												
	Notes to Accounts - Finance Lease Commitments	JP																																												
	Notes to Accounts 29 Other/Private finance transactions	JG																																												
	Notes to Accounts - Financial Instruments	JG																																												
	Notes to Accounts - Contingencies	JP																																												
	Notes to Accounts - Third Party assets	JG																																												
	Notes to Accounts - Events after the reporting period	CT/NK/JG																																												
	Notes to Accounts - Related party transactions	TT																																												
	Notes to Accounts - Intra Government Balances	TT																																												
	Notes to Accounts - Losses and Special Payments	JP																																												
	Notes to Accounts - Pooled budgets	JG																																												
	TFR 3 Pay and Non Pay	ST																																												
	TFR's 4&5 Losses	JP																																												
	TFR 6 Income and Debtors	TT																																												
	TFR 6 Expenditure and Creditors	BD																																												
	TFR 7 Impairments	JP																																												
	TFR 8 Analysis of Accruals	JP																																												
	TFR 9 Funds Held on Trust Extract for WG (Charitable Funds)	TT																																												

First I and E Mon Rtn
Agree final dr/cr bals NHS
M13 Open
Stat accts drafted
Mon Rtn prov deadline
Submit draft accts
Audit commences
Residual draft submission

ANNUAL ACCOUNTS - END OF YEAR TIMETABLE 2021/22

Draft Trust Accounts

SECTION	TASK	Resp.		25/02 Fr	03/03 Th	04/03 Fr	07/03 M	08/03 Tu	09/03 W	10/03 Th	11/03 Fr	14/03 M	15/03 Tu	16/03 W	17/03 Th	18/03 Fr	21/03 M	22/03 Tu	23/03 W	24/03 Th	25/03 Fr	28/03 M	29/03 Tu	30/03 W	31/03 Th	WD1 01/04 Fr	WD2 04/04 M	WD3 05/04 Tu	WD4 06/04 W	WD5 07/04 Th	WD6 08/04 Fr	WD7 11/04 M	WD8 12/04 Tu	WD9 13/04 W	WD10 14/04 Th	15/04 Easter	18/04	WD11 19/04 Tu	WD12 20/04 W	WD13 21/04 Th	WD14 22/04 Fr	WD15 25/04 M	WD16 26/04 Tu	WD17 27/04 W	WD18 28/04 Th	WD19 29/04 Fr	02/05 BH	M1 WD1 03/05 Tu	M1 WD2 04/05 W	M1 WD3 05/05 Th	M1 WD4 06/05 Fr
																									First l and E Mon Rtn						Agree final dr/cr bals NHS	M13 Open									Stat accts drafted	Mon Rtn prov deadline			Submit draft accts		Audit commences			Residual draft submission
Unaudited Accounts Prep	Payroll M12 l and E rec plus consolidation of all monthly recs	BD (prov)																																														
	Payroll proof in total reconciliation.Reconciliation of payroll to the general ledger (total pay costs recorded in the financial ledger to be reconciled to pay costs recorded in the payroll system per the Blue Book).	TT																																														
	Remuneration Report for Annual Return/Accountability Report to be presented to RemCom and submitted with Draft Accounts and provided for Auditors to report on	ST																																														
	Financial performance Notes	JG																																														
	Working paper review and Unaudited Financial Accounts Drafted	JG																																														
	Review of Unaudited Accounts by DDoF	NP/JG																																														
	Review of Unaudited Accounts by DoF	CT/JG																																														
	Draft Annual Report (Financial Statements section) provided to Jill Gill for first review	TT																																													
	Annual Report to DDoF for review	JG/NK																																														
	Annual Report to DoF for review	JG/CT																																														
	Reconciliation and collation of Period 12 to Period 13 position/journals	TT																																														
	Submit Unaudited Accounts, TFR's incl TFR6 (except FR10) and TMS A-C and F-H inclusive	JG																																												Noon				
	Residual submission - Submit to WG Accountability Report (Statement of Accountable Officer Responsibilities, Statement of Directors Responsibilities in respect of the accounts, Annual Governance Statement) . (At this stage the statements are not signed and the AGS is in draft)	MA																																													Noon	
	Residual submission- Submit to WG Remuneration Report, TMS 2 and FR10	JG																																														Noon
	Arbitration cases prepared for Disputed Invoices	TT																																														
	Arbitration cases submitted for Disputed Invoices	TT																																														
	Submit Draft Annual Report to Corporate Team (Mike Armstrong) for consolidation ahead of residual submission on 6 May 2022	JG																																														
Remuneration Report	Upload figures to Pension Agency	ST																																														
	Pension Agency figures received																																															
	P11D figures to Steph Taylor	AE																																														
	Note re Hutton Report drafted	ST																																														
	Secondment figures if applicable received																																															
	Quality review	ER/JG																																														
	Sent to DoW&OD & DoF for review	ER																																														
	Reviewed by DoW&OD and DoF	CT/CV																																														
	Papers to EMT (to Jonathan Jones)	ER/CT																																														
	EMT																																															

ANNUAL ACCOUNTS - END OF YEAR TIMETABLE 2021/22

MR M01- 22-23

SECTION	TASK	Resp.	21/04 Th	29/04 Fr	02/05 BH	03/05 Tu (M1 WD1)	04/05 W (M1 WD2)	05/05 Th (M1 WD3)	06/05 Fr (M1 WD4)	09/05 M (M1 WD5)	10/05 Tu (M1 WD6)	11/05 W (M1 WD7)	12/05 Th (M1 WD8)	13/05 Fr (M1 WD9)
					Audit commences									
M1 Monitoring Return	Depreciation and prepayments FA Early Feeds for April 22/23 M1	BD												
	AP M1 Closedown (last working day)	AP team												
	PO Feeds M1	Systems												
	Stores feed M1	Systems												
	AR close receipting done	TT												
	Review of M1 position	CT/NK/JC/ER/JG												
	Day 5 Return to WG	JC												
	FA Closedown	TT/JP/BD/MM												
	M1 Monitoring return to WG (to be confirmed) Day 9	NK/ER												

ANNUAL ACCOUNTS - END OF YEAR TIMETABLE 2021/22

WAO Audit

SECTION	TASK	Resp.		29/04 Fr	02/05 BH	03/05 Tu	04/05 W	05/05 Th	06/05 Fr	09/05 M	10/05 Tu	11/05 W	12/05 Th	13/05 Fr	16/05 M	17/05 Tu	18/05 W	19/05 Th	20/05 Fr	23/05 M	24/05 Tu	25/05 W	26/05 Th	27/05 Fr	30/05 M	31/05 Tu	01/06 W	02/06 BH	03/06 BH	06/06 M	07/06 Tu	08/06 W	09/06 Th	10/06 Fr	13/06 M	14/06 Tu	15/06 W	16/06 Th	17/06 Fr
AUDIT PROCESS	Submit Unaudited Accounts, TFR's (incl TFR6) and TMS	JG		Noon																																		
	Review file for all M13 journals to ensure all paper copies are located within Financial Accounts folder. Chase any missing journals with preparer.	AG																																				
	Residual submission - Submit to WG Accountability Report (Statement of Accountable Officer Responsibilities, Statement of Directors Responsibilities in respect of the accounts, Annual Governance Statement) . (At this stage the statements are not signed and the AGS is in draft)	MA							Noon																													
	Residual submission- Submit to WG Remuneration Report, TMS 2 and FR10	JG							Noon																													
	Audit Commences																																					
	Working papers, full and summarised accounts available	JG																																				
	Final Accounts meeting - (Face to Face)																																					
	Papers for Audit Committee																																					
	Review PDFcombination of submissions file for errors	JG																																				
	Audit Committee Meeting initial accounts approval																																					
	Trust Board Meeting to formally approve and sign accounts																																					
	Electronically (by e-mail) submission of signed Audited Accounts, Annual Governance Statement and Accountability Report (inc Remuneration Report, Directors Certificates and AGW Report and Certificate) and all TFRs and TMS A to D to WAO with letters of representation	JG																																PM				
	The WAO to submit final audited accounts to the Welsh Government including:- Audited accounts All TFR/LFRs TMS 1 A to C and F-H inclusive TMS 2	AW																																		Noon		
	GL Month 13 Closedown	Syst																																				

ANNUAL ACCOUNTS - END OF YEAR TIMETABLE 2021/22

WoGA

Submit draft accts | Audit commences | Closure Meeting with AW | Audit Committee | Trust Board | Submit audited accts

SECTION	TASK	Resp.		29/04 Fr	02/05 BH	03/05 Tu	04/05 W	05/05 Th	06/05 Fr	09/05 M	10/05 Tu	11/05 W	12/05 Th	13/05 Fr	16/05 M	17/05 Tu	18/05 W	19/05 Th	20/05 Fr	23/05 M	24/05 Tu	25/05 W	26/05 Th	27/05 Fr	30/05 M	31/05 Tu	01/06 W	02/06 BH	03/06 BH	06/06 M	07/06 Tu	08/06 W	09/06 Th	10/06 Fr	13/06 M	14/06 Tu	15/06 W	16/06 Th
WOGA	WOGA -feeds into accounting model and TFR (process to be confirmed)	JP																																			

AGENDA ITEM No	**12**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	1

AUDIT REPORT

MEETING	Audit Committee
DATE	3rd March 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk and Corporate Governance
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide the Audit Committee with an up to date position in relation to recommendations resulting from Internal Audit and external reviews.

2. **Members are asked to receive and discuss the contents of the report and:**
   a) **Note the activity since the last Audit Committee in December 2021.**
   b) **Consider the Trust's proposals to address each recommendation.**

KEY ISSUES/IMPLICATIONS

3. Relevant sections of the audit tracker assigned to the following Committees were considered during this period for scrutiny and strategic oversight as follows:

   a. **Finance & Performance Committee** (20th January 2022)
   b. **Quality, Safety & Patient Experience Committee** (17th February 2022)
   c. **People & Culture Committee** (22nd February 2022)

4. The paper was discussed by the Executive management Team (EMT) and particular consideration was given to the overdue recommendations and any outliers to agree the proposals to address them.

5. Each of the 83 recommendations were subject to a monthly review by the Assistant Directors Leadership Team since the last Audit Committee in December 2021 to ensure that realistic timescales were proposed where necessary and any new completion dates assigned with a strong narrative and rationale to support this.

REPORT APPROVAL ROUTE
6. The report has been submitted to: • ADLT – 21st February 2022 • EMT – 23rd February 2022

REPORT APPENDICIES
7. The Audit Tracker has been circulated as a separate appendix.

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

WELSH AMBULANCE SERVICES NHS TRUST
AUDIT COMMITTEE
INTERNAL AUDIT TRACKER

SITUATION

1. The purpose of this paper is to provide the Audit Committee with a position statement in respect of recommendations made resulting from internal and external audit reviews.

BACKGROUND

2. The audit recommendation tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports were actioned and in a timely manner.

3. This tracker provides Senior Managers with a workable tool that allows for closer scrutiny of audit recommendations and is designed to provide a more detailed focus as to the reasons why recommendations are overdue or have not progressed within the agreed timeframes. This will highlight areas that may require additional support and ensures there are clear mechanisms in place to escalate any issues.

ASSESSMENT

Internal Audit Highlights

4. The Trust continued to face significant operational pressures resulting from the pandemic and REAP level 4 during the period and as such expects to be carrying a slightly higher number of overdue recommendations.

5. 32 recommendations were marked as complete at the December 2021 Audit Committee and removed from the tracker.

6. At the time of issuing the paper, there were a total of 83 current internal audit recommendations. 15 of these were added to the tracker resulting from 3 Internal Audit Reports which were presented to the Audit Committee in December 2021.

7. The status of each of the current internal audit recommendations is described in the table below.

Status	Total Number of Recommendations on the tracker	High Priority	Medium Priority	Low Priority
Overdue	31	4	17	10
Not yet due*	31	6	17	8
Complete	21	5	7	9
Total	83	15	41	27

* accepting extensions have been applied in line with the agreed pandemic arrangements.

8. Of the 4 high priority recommendations showing as overdue these relate to the 20/21 Clinical Contact Centres Performance Management Reasonable Assurance review. These are due to be completed between April and June.

9. The total number of recommendations, separated by financial year, and status this period is described below.

Financial Year	Total No. of Recommendations on the tracker	Complete	Overdue	Not Yet Due
2018/19	4	4	0	0
2019/20	4	0	4	0
2020/21	32	3	24	5
2021/22	43	14	3	26
Total	83	21	31	31

8. There are 4 recommendations showing as overdue from 19/20 reports, all of which are of medium priority. One relates to the Raising Concerns Report and changes to the new Once for Wales Datix system. Whilst significant progress has been made, the decision has been taken to postpone the implementation of this system and the completion date has therefore been amended to April 2022; however, it is likely that this may be further extended.

9. A further recommendation relates to the Trust's Risk Appetite Statement from the Risk Management and Assurance review which forms part of the Risk Transformation programme currently underway. This will not be completed until approximately March 2023.

10. The remaining two recommendations outstanding from 2019/20 relate to the Information Systems Security Leavers Reasonable Assurance Follow Up Review, both of which are expected to be completed by the end of March 2022.

10. The number of recommendations by assurance rating and level of priority are described below.

Assurance Ratings	Total No. of Recommendations on the tracker	High Priority	Medium Priority	Low Priority
Limited	10	5	4	1
Reasonable	60	10	37	13
Substantial	1	0	0	1
Not Rated	12	0	0	12
Total	83	15	41	27

11. Each of the 83 recommendations were subject to a monthly review by the Assistant Directors Leadership Team since the last Audit Committee in December 2021 to ensure that realistic timescales were proposed where necessary and any new completion dates assigned with a strong narrative and rationale to support this.

12. A summary of recommendations relating to the 2018/19 financial year is described in the table below:

Number	Description
0	Overdue
0	Not yet due
4	Complete during this period
0	No progress
0	Partially complete
3	High priority overdue
1	Medium priority overdue
0	Low priority overdue
0	Limited report recommendations overdue
0	Reasonable report recommendations overdue
0	Not Rated report recommendations overdue
4	Total Recommendations

13. A summary of recommendations relating to the 2019/20 financial year is described in the table below:

Number	Description
4	Overdue
0	Not yet due
0	Complete during this period
2	No progress
0	Partially complete
0	High priority overdue
4	Medium priority overdue
0	Low priority overdue
0	Limited report recommendations overdue
0	Reasonable report recommendations overdue
0	Not Rated report recommendations overdue
4	Total Recommendations

14. A summary of recommendations relating to the 2020/21 financial year is described in the table below:

Number	Description
24	Overdue
5	Not yet due
3	Complete during this period
0	No progress
2	Partially complete
4	High priority overdue
10	Medium priority overdue
10	Low priority overdue
0	Limited report recommendations overdue
15	Reasonable report recommendations overdue
1	Substantial report recommendations overdue
8	Not Rated report recommendations overdue
32	Total Recommendations

15. A summary of recommendations relating to the 2021/22 financial year is described in the table below:

Number	Description
3	Overdue
26	Not yet due
14	Complete during this period
0	No progress
2	Partially complete
0	High priority overdue
3	Medium priority overdue
0	Low priority overdue
0	Limited report recommendations overdue
3	Reasonable report recommendations overdue
0	Substantial report recommendations overdue
0	Not Rated report recommendations overdue
43	Total Recommendations

16. The Governance team continue to seek assurance from Executives to ensure that:

- Recommendations have been considered and completed within agreed timeframes and,
- All is being done to ensure that the follow up of recommendations will not result in further *Limited* or *No Assurance* rated reports.

External Audit Reviews

17. Section 2 on the tracker describes 3 recommendations made following the 2018 and 2019 Structured Assessments and the Effectiveness of Counter Fraud Arrangements Report.

18. No new recommendations were made as part of the 2020 Structured Assessment work; however, improvement opportunities were made throughout the report and these form part of the CoVID-19 tab described on the Audit Tracker. In addition, this section includes considerations made within the Internal Audit Governance Arrangements During CoVID-19 Pandemic Advisory Review 20/21.

19. The table below describes the status of current external audit recommendations:

Status	Number of Recommendations
Overdue	3
Not yet due	0
Complete during this period	0
Total	3
Overdue from 2019/20 reports	1
Overdue from 2019/20 reports	1
Overdue from 2020/21 reports	1
Total	3

RECOMMENDED:

20. Members are asked to receive and discuss the contents of the report and:

a) Note the activity since the last Audit Committee in December 2021.

b) Consider the Trust's proposals to address each recommendation.

AGENDA ITEM No	**13**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**3**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit Committee
DATE	3rd March 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk and Corporate Governance
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide an update to the Audit Committee in respect of the Trust's Corporate Risks.

RECOMMENDATION:

2. **Members are asked to receive assurances on the contents of the report and consider and approve:**
   - **a. The request to suspend reporting of the Board Assurance Framework for 3 months.**
   - **b. The change in title of Risk 139.**
   - **c. The closure of Risk 109 from the Corporate Register.**
   - **d. The escalation of Risk 163 to the Corporate Register.**
   - **e. The inclusion of Risk 458 on the Corporate Register**

KEY ISSUES/IMPLICATIONS

3. Audit Committee are asked to approve the Governance Team's request to suspend reporting of the BAF for a period of 3 months.

4. This will provide the Governance Team with time to invest in developing a transitional BAF which clearly sets out the work that is currently underway to rearticulate the corporate risks as well as the relevant and current controls, assurances and actions that will mitigate these risks to their target.

5. Furthermore, principal risks assigned to the following Committees were considered during this period for scrutiny and strategic oversight as follows:

   a) **Finance & Performance Committee** (20th January 2022)
   b) **Quality, Safety & Patient Experience Committee** (17th February 2022)
   c) **People & Culture Committee** (22nd February 2022.)

REPORT APPROVAL ROUTE
6. The report has been considered by: • ADLT – 21st February 2022 • EMT – 23rd February 2022

REPORT ANNEXES
7. SBAR report. 8. Schedule of Risk reviews. 9. Summary table describing each of the 16 Corporate Risks. 10. The BAF Report.

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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The purpose of this report is to provide an update in relation to the Trust's Corporate Risks and Board Assurance Framework. A particular focus is on the work that is underway to rearticulate and strengthen the Trust's highest scoring risks. The schedule for which is detailed in Annex 1.

2. An extract from the Corporate Risk Register (CRR) is detailed in Annex 2 as a short summary report.

3. A further extract from the Board Assurance Framework (BAF) report is included in the paper in Annex 3.

BACKGROUND

4. The Risk Management and Board Assurance Framework Transformation Programme was supported as the direction of travel at the Audit Committee in December 2021 and has been included in the IMTP. A full progress report will be submitted to the Audit Committee meeting in June 2022 as agreed.

5. The immediate priority was for a detailed review of the Trust's 5 highest scoring risks with the remaining 11 Corporate Risks to follow.

6. A programme of work has commenced to strengthen the articulation of the corporate risks and any new risks including title, summary descriptions, controls, assurances and any gaps or additional actions required.

7. The ADLT continue to review the risk assessments on all new risks in addition to reviewing changes to existing risks and mitigating actions, reporting activity to the Executive Management Team (EMT), each of the Committees and Trust Board.

ASSESSMENT

8. There are currently 16 Corporate Risks on the register which are described in the summary table in Annex 2 as at 5th February 2022; these have been extracted from the Datix E-Risk module.

<u>Highest Scoring Risks</u>

9. Sessions have taken place during February to undertake a full review of the Trust's highest scoring risks: Risks 223, 224, 199, 316 and 160. Firstly, to determine new titles and to clearly articulate the risks, descriptions and map controls and assurances. Secondly, to identify any gaps and articulate further actions to mitigate the risks in addition to reviewing the scores and controls rating assurances. A schedule is detailed in annex 1.

Board Assurance Framework

10. Members are asked to consider and approve a request to suspend reporting of the BAF for a period of 3 months to enable the Governance team to develop a transitional BAF that will be presented at the Audit Committee in June 2022 and the Trust Board in July 2022.

11. The purpose of the request is to provide the Governance Team with a period of time to invest in developing a transitional BAF which clearly sets out the work that is currently underway to rearticulate the corporate risks as well as the relevant and current controls, assurances and actions that will mitigate the risks to their target.

12. By way of assurance, the team will provide a high level report to the Trust Board and each scrutiny Committee during May 2022 on each of the corporate risks with a particular focus on the developing controls and assurances of the Trust's 5 highest scoring risks.

13. The current BAF, included in annex 3, does not reflect or capture the breadth of work underway to rearticulate and strengthen the current corporate risks.

14. The longer term ambition for the BAF over the next 12 months is included in the Risk Transformation programme.

New Corporate Risks

15. Work is ongoing to consider and develop potential new Risks for inclusion on the CRR and consideration will be given during the coming weeks to the following:

- *Patient Safety/Putting Things Right Team*
- *NHS Decarbonisation*
- *Supply Chain Issues – Digital Equipment*
- *Securing Stakeholder Support to Deliver the Strategy and IMTP*
- *Ongoing Impact of CoVID or potential future waves*
- *Health and wellbeing of the workforce*
- *Capacity to deliver change (IMTP)*
- *Demand for our Services increasing (IMTP)*

16. Risk 458 – *A confirmed commitment from EASC and/or Welsh Government required regarding funding for recurrent costs of commissioning*. This is scored at a 12 (3x4). The risk was reviewed by ADLT on the 7th February 2022 and EMT approved the inclusion of this risk on to the CRR. The summary description for this risk is as follows:

***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** 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.*

17. In terms of next steps, the Governance Team will continue to work with the Finance Team to clearly articulate current and relevant controls, assurances and any gaps and actions that will mitigate the risk.

Review of other Corporate Risks

18. Risk 100 - *Failure to collaborate and engage with EASC on developing ambitions and plans for WAST* is undergoing a full review following discussions at the Finance & Performance Committee and ADLT on 21st February 2022.

19. Risk 139 is under review; however, the new title is described as the *Failure to deliver our Statutory Financial Duties in accordance with legislation.* This is scored at a 16 (4x4). The previous title was *Non Delivery of Financial Balance.* The summary description and full risk review will be reported to the Trust Board report in March 2022.

20. Risk 201 - A further working group has been established for the review and rearticulation of the *Trust's Reputation* Risk and is due to take place on 28th February 2022.

21. Work has commenced on all other corporate risks to strengthen and rearticulate these in accordance with the transformation programme.

22. The outcome of the work described in paragraphs 19 to 22 will be reported during the May 2022 Committee and Board reporting cycles.

Escalation of Risks

23. Risk 163 – It is recommended that the *Maintaining Effective and Strong Trade Union Partnerships* risk be escalated to the Corporate Register. This has been considered by the Trade Union Partners Cell and ADLT and it was agreed to escalate the risk which has increased in score from 9 (3x3) to 12 (4x3). The summary description for this risk is as follows:

***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 will 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.*

24. Risk 260 – Work has continued on the *Cyber Risk* with a view to potentially escalating this risk to the CRR in the next reporting cycle.

Closure and De-Escalation of Risks

25. Risk 109 - *Resource availability (revenue) to deliver the organisation's IMTP* is recommend for closure given that this element is included in Risk 458 described in paragraph 17.

RECOMMENDED:

26. **Members are asked to receive assurances on the contents of the report and consider and approve:**
    a. **The request to suspend reporting of the Board Assurance Framework for 3 months.**
    b. **The change in title of Risk 139.**
    c. **The closure of Risk 109 from the Corporate Register.**
    d. **The escalation of Risk 163 to the Corporate Register.**
    e. **The inclusion of Risk 458 on to the Corporate Register.**

Annex 1 – Schedule of review for the Trust's 5 highest scoring risks

Risk ID	Session Dates	Notes
223	20/09/21	Rearticulation of title and descriptions
	26/11/21	Controls and assurances refreshed for the BAF
	20/12/21	Cancelled due to REAP 4
	17/02/22	Director of Paramedicine review
	18/02/22	Cancelled due to the storm response
	21/02/22	ADLT meeting to review title and summary description
	25/02/22	*Due to finalise controls, assurances, gaps and actions*
	09/03/22	*EMT review of the risk*
	24/03/22	*Trust Board*
224	26/11/21	No action as 223 Agenda overran
	20/12/21	Cancelled due to REAP 4
	17/02/22	Director of Paramedicine review
	18/02/22	Cancelled due to the storm response
	21/02/22	ADLT meeting to review title and summary description
	25/02/22	*Due to finalise controls, assurances, gaps and actions*
	09/03/22	*EMT review of the risk*
	24/03/22	*Trust Board*
199	04/02/22	Rearticulation of risk
	11/02/22	Strengthening title, summary, controls and gaps
	18/02/22	Title and summary description
	21/02/22	ADLT meeting to review title and summary description
	22/02/22	*Due to finalise controls, assurances, gaps and actions*
	01/03/22	*Due to finalise controls, assurances, gaps and actions*
	09/03/22	*EMT review of the risk*
	24/03/22	*Trust Board*
316	02/02/22	Title and summary description
	18/02/22	Strengthening title, summary, controls and gaps
	21/02/22	ADLT meeting to review title and summary description
	22/02/22	*Due to finalise controls, assurances, gaps and actions*
	01/03/22	*Due to finalise controls, assurances, gaps and actions*
	09/03/22	*EMT review of the risk*
	24/03/22	*Trust Board*
160	09/02/22	Rearticulation of risk
	21/02/22	Strengthening title, summary, controls and gaps
	21/02/22	ADLT meeting to review title and summary description
	28/02/22	*Due to finalise controls, assurances, gaps and actions*
	09/03/22	*EMT review of the risk*
	24/03/22	*Trust Board*

Annex 2 – Corporate Risk Register Summary

CORPORATE RISK REGISTER: Summary					
RISK ID	**RISK**	**RISK CATEGORY**	**DIRECTORATE**	**CURRENT RISK SCORE**	**COMMITTEEE**
223	Unable to attend patients in community who require See & Treat	Service Delivery	Operations Directorate	**25 (5x5)**	Quality, Patient Experience and Safety Committee
224	Patients delayed on ambulances outside A&E Departments	Quality & Safety	Operations Directorate	**25 (5x5)**	Quality, Patient Experience and Safety Committee
199	Compliance with Health and Safety legislation	Statutory Duties	Quality, Safety & Patient Experience	**20 (4x5)**	Audit Committee; Quality, Patient Experience and Safety Committee
316	Increased risk of personal injury claims citing COVID exposure	Statutory Duties	Quality, Safety & Patient Experience	**20 (5x4)**	Quality, Patient Experience and Safety Committee
160	High Sickness Absence Rates	Resource Availability	Workforce & Organisational Development	**16 (4x4)**	People and Culture Committee
139	Failure to Delivery our Statutory Financial Duties in accordance with legislation	Statutory Duties	Finance and Corporate Resources	**16 (4x4)**	Finance and Performance Committee
244	Impact on EMS CCC service delivery due to estates constraints	Service Delivery	Operations Directorate	**16 (4x4)**	Finance and Performance Committee
311	Failure to manage the cumulative impact on estate of the EMS Demand & Capacity Review, the NEPTS Review and GUH	Resource Availability	Finance & Corporate Resources	**16 (4x4)**	Finance and Performance

CORPORATE RISK REGISTER: Summary					
RISK ID	**RISK**	**RISK CATEGORY**	**DIRECTORATE**	**CURRENT RISK SCORE**	**COMMITTEEE**
201	Trust Reputation	Stakeholder Relationships	Partnerships and Engagement	**15 (3x5)**	People & Culture Committee
245	Inability to maintain safe & effective services during a disruptive challenge due to insufficient capacity in EMS CCCs.	Service Delivery	Operations Directorate	**15 (3x5)**	Finance & Performance Committee
100	Failure to collaborate and engage with EASC on developing ambitions and plans for WAST.	Service Developments	Planning and Performance	**12 (3x4)**	Finance and Performance Committee
283	EMS Demand and Capacity Review Implementation Programme	Service Delivery	Planning and Performance	**12 (3x4)**	Finance and Performance Committee
424	Resource Availability (capital) to deliver the organisation's IMTP	Service Developments	Planning & Performance	**12 (3x4)**	Finance and Performance Committee
NEW 458	A confirmed commitment from EASC and/or Welsh Government required regarding funding for recurrent costs of commissioning	Service Delivery	Finance and Corporate Resources	**12**	Finance and Performance Committee
303	Delayed initiation of chest compressions (resuscitation)	Quality and Safety	Medical & Clinical	**10 (2x5)**	Quality, Patient Experience and Safety Committee
109	Resource availability (revenue) to deliver the organisations IMTP	Service Developments	Planning and Performance	**8 (2x4)**	Audit Committee; Finance and Performance Committee

Annex 3 – Board Assurance Framework begins at the top of the next page 11. (**This has not been updated since the last Audit Committee in December 2022 and does not reflect the work underway to strengthen and rearticulate the corporate risks including relevant and current controls, assurances, gaps and actions**).

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			*What measures are already in place to mitigate the risk?*	*What evidence is available to show that the controls are effective?*	*What additional actions need to be or can be taken to mitigate this risk*
	Title and Description	**Initial**	**Current**	**Target**			
223	Unable to attend patients in community who require See & Treat **ASSIGNED TO:** **EXECUTIVE OWNER:** LEE BROOKS **COMMITTEE:** QUEST **DIRECTORATE:** OPERATIONS	20 4x5 QTR 2 19/20	25 5x5 ⟷ QTR 4 21/22	10 2x5 QTR 2 21/22	Last reviewed on Datix: 07/01/22 1. Welsh Government have set a target that ambulance handovers at ED will be no longer than 15 minutes. 2. Commissioning intention to reduce total lost hours at Welsh Hospitals do not exceed 150 hours per day.	• 2016 Welsh Health Circular • 2021/22 Commissioning Intentions • Deep Dive x2 Risks - QUEST Presentation. ADLT and EMT review. • Ambulance Taskforce • Red immediate release request refusals now being recorded on Datix. • Datix recording all handover delays over 6 hours. • Weekly review of the impact of hospital waits data shared with the Chief Operating Officers group. • Weekly report to CEO and EMT and ADLT. • Return to response – monitor phase of Pandemic Plan • Re-establishment of the Pandemic Structures • Health Board to Health Board Executive reports. • Directors Peer Group meetings	• Continue to engage in improvement work at Health Board level and as part of the EDQDF. • Leading Service Change Together programme of work is being developed in partnership. No outputs as yet as the programme is underway but the expectation is that modernisation proposals will be agreed to achieve internal, improved staff wellbeing and welfare, patient safety and organisational improvements by Q3 of 2022. • Schedule of workshops to be agreed by the working group. • ADLT to report outcome of the programme to Executive Management Team in Q1 of 2022.
					3. Regional Escalation Protocol agreed between each Health Board and utilised by ODU to dynamically divert between Health Boards and manage system flow. The implementation of a risk based RES to incorporate an ambulance distribution framework that is intelligence led to help to improve the safe delivery of services to all patients requiring unscheduled care.	• Daily 11am conference calls to agree RES levels in conjunction with HBs which is published in the On-call structure daily. It is used to determine delays in the system.	• Development and pilot of a Rural Model (p18 of IMTP) Paper has been submitted to Commissioner on pilot for consideration by Director of Planning & Performance. The pilot is managed by Ben Collins, Interim Ambulance Operations Manager for Powys.
					4. REAP (Resource Escalation Action Plan – hyperlink the document?)	• REAP level is reviewed on a weekly basis by Senior Operations Team and can be dynamically reviewed by the Strategic Commander at any point.	• Exercise scheduled for 13/10/21 to test REAP as part of winter planning exercise linked to demand forecasts. • The plan is subject to annual review and the current review commencing September 2021.

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			*What measures are already in place to mitigate the risk?*	*What evidence is available to show that the controls are effective?*	*What additional actions need to be or can be taken to mitigate this risk*
	Title and Description	**Initial**	**Current**	**Target**			
					5. The Operational Delivery Unit is the first point of contact for all escalation issues and work is underway in October 2021 to become a 24/7 service. Escalation by the on-call system as and when required. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.	• The On Call OOH rota is bolstered by clinical and some corporate services. Duty Operations Manager appointed. • Shift reports received by Exec, SOT and On-Call team from ODU at start/end as well as ODU Dashboard.	
					6. Alternative care pathways in place to provide safe clinical admission avoidance and available through the Consultant Connect App. This in addition to the Clinical Support Desk and Operational Advanced Paramedic Practitioners.	• Reports from Health Informatics on use of national pathways. • Care Closer to Home Group developed and implemented alternative pathways providing consistency across the organisation. • Monitored through programme of work and conveyance • APP dashboard monitors collective and individual patient disposition. • Senior Paramedics in place and conducting operational contact shifts with their teams and encouraging use of alternative care pathways. • Consultant Connect provide regular reports on the use of the app.	
					7. Maximising the services across the 5 Step model: Hear and Treat Services (CCC, NHSDW and 111). Enhanced the 111 services through the 111 initiative.	• CSD rates monitored through AQIs and number unique visits to the 111 Wales website as described in the performance report. The EASC AQI report is an output.	• 111 element to be reflected in the performance report.
					8. Developing community resilience in line with the 5 year Volunteering Strategy to reach patients sooner who require help when we can't get a resource to them.	• Operations Manager Community Support – CFRs and Operations Manager Community Support – Alternative Responders. Volunteering Team is focussed on community resilience. MOU with St John Ambulance and Fire Services. Volunteer Strategy signed off.	• The action plan to support implementation of the volunteer Strategy is awaiting sign off by Trust Board on 30th October 2021 and will be monitored by People & Culture Committee.
					9. Clinical Safety Plan replaces the Demand Management Plan brining WAST in line with other UK Ambulance Trusts. Introduction of ETA scripting enables patients to make an informed choice.	• Optima modelling. Clinical agreement to escalate into higher levels. Live reporting through the ODU dashboard. Calls received Vs attended calls attributed to alternatives to dispositions and DMP. AACE paper through National Director of Operations group.	

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			*What measures are already in place to mitigate the risk?*	*What evidence is available to show that the controls are effective?*	*What additional actions need to be or can be taken to mitigate this risk*
	Title and Description	**Initial**	**Current**	**Target**			
					10. Increasing capacity in our EMS Service through internal reconfiguration and recruitment (p18 of IMTP). Work with external partners and agencies.	• Monitored through the EMS Transformation Board. Seasonal planning approach incorporated into Senior Pandemic Team. Tactical Approach to Production. Winter modelling and forecasting through Optima. Performance Improvement Plan.	• Considering additional actions through the Trust's Tactical plan and the Performance Improvement Plan which are both reported and considered by the Senior Pandemic Team and reported to the Executive Pandemic Team. Monitoring those plans on a weekly basis. • Expansion of numbers of clinicians (paramedics) into CSD to increase ability to triage greater number of calls having benefits for patients • Additional Military Support request made for 250 personnel.
					11. Bi-Weekly SCIF meetings	• Outcomes reported to the Patient Safety Learning and Monitoring Group and then to the Clinical Quality Governance Group. Quarterly Scrutiny Panels are held led by NEDs. Patient Safety Highlight report for Trust Board and Committee and Chief Executive Report to EMT. By Claire Roche weekly. • Monthly meeting to discuss the information shared through SCIFs at the WAST and Health Board Patient Safety Meetings. • Identified Learning is cascaded to the appropriate department or Directorate.	
224	Patients delayed on ambulances outside A&E Depts (CRR57) **ASSIGNED TO:** **EXECUTIVE OWNER:** LEE BROOKS **COMMITTEE:** QUEST **DIRECTORATE:** OPERATIONS	20 4x5 QTR 2 19/20	25 5x5 ⟷ QTR 4 21/22	10 2x5 QTR 4 20/21	Last reviewed on Datix: 07/01/22 1. Welsh Government target that ambulance handover at ED will be no longer than 15 minutes 2. Piloted a HALO (hospital ambulance liaison officer) at major Emergency Departments 3. REAP (Resource Escalation Action Plan) and Demand Management Plan in place 4. Gold/Strategic, Silver/tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans 5. Alternative pathways in place 6. Maximising the services across the 5 Step model: Hear and Treat Services (CCC, NHSDW and 111)	1. CEO letters to Health Boards. 2. CEO to CEO meetings. 3. Ambulance Task Force. 4. Medical Director/ COO/Nurse Directors meetings. 5. Visits to HB Quality Committees. 6. Joint Investigation Framework. 7. Deep Dive x2 Risks - QUEST Presentation (Feb20). 8. Regional Escalation Protocols - Establishment of Operational Delivery Unit (ODU) in WAST. 9. Demand Management Plan (DMP) and clinical review of no sends (DMP 4 and above) 10. Significant incident declared on 03/12/20 as a result of whole system pressure and escalation to REAP 4	1. WAST exploring the possibility of cohorting patients delayed outside EDs on agency vehicles managed by agency paramedics 2. Transforming and modernising our service offer, including Mobile Urgent Care (p19-20 IMTP) 3. Working with the system to consider how we can support the Welsh Access Model and implementation of Contact First across Wales (p16 & 18 IMTP)

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			*What measures are already in place to mitigate the risk?*	*What evidence is available to show that the controls are effective?*	*What additional actions need to be or can be taken to mitigate this risk*
	Title and Description	Initial	Current	Target			
					7. Working to the Well-being and Future Generations Act in co-production with various partners and volunteers to build community resilience (Prudent care principles) 8. SAIs identified as being directly due to hospital handover delays are reassigned (in the form of an Appendix B) to the respective Health Board to investigate 9. SOP for managing patients on the back of ambulances 10. Lost hours due to Hospital Handover Delays are reviewed routinely by senior operational management team 11. Operational Delivery Unit (ODU) having oversight of the Regional and National positions, enabling live review of demands and delays, and arranging redirection of crews and resources as appropriate	for a sustained period throughout Dec20 into mid Jan21. 11. Extended hours of opening in ODU and recruitment to commence imminently. 12. Tactical Approach to Production (TAP) 13. One additional UCS capacity in place by SJC through existing MOU agreed by EMT for 6mths Apr-Sept21. 14. Duty Operations Managers (DOMs) appointed and induction commencing May 2021. Senior Paramedics recruitment & induction also underway. 15. Weekly review of the impact of hospital waits data shared with COO group 16. Red immediate release request refusals now being recorded on Datix 17. Datix of all handover delays over 6hrs 18. HIW undertaking a review of patient experience as a result of handover delays 19. The role of the Operational Delivery Unit 20. Transforming and modernising our service offer, including Mobile Urgent Care 21. Working with the system to consider how we can support the Welsh Access Model and implementation of Contact First across Wales	

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			*What measures are already in place to mitigate the risk?*	*What evidence is available to show that the controls are effective?*	*What additional actions need to be or can be taken to mitigate this risk*
	Title and Description	Initial	Current	Target			
199	Compliance with Health & Safety legislation ASSIGNED TO: **EXECUTIVE OWNER:** CLAIRE ROCHE **COMMITTEE:** QUEST **DIRECTORATE:** QUALITY, SAFETY & PATIENT EXPERIENCE	20 4x5 QTR 2 19/20	20 4x5 ⟷ QTR 4 21/22	10 2x5 QTR 4 21/22	Last reviewed on Datix: 23/12/21 1. Leadership and direction set by Executive Management Team and Head of risk and H&S. 2. Health and Safety Governance structure (National Health and Safety Committee Meeting and Regional Meeting held in Q3& Q4 2020/2021. 3. Structure and arrangements reviewed with view of implementation Q2 2021/22. 4. Health and safety Policy and topic specific policies and procedures. 5. Health and Safety mandatory training 6. IOSH health and Safety training for Managers and Leaders. 7. IOSH Managing Safely re-established March 2021. 8. Programme for IOSH Leading Safely training for SMT and Execs under development view of implementation Q1 2021/22. 9. Local H&S Inspections (COVID secure inspections undertaken) 10. Rolling programme of H&S Review visits -(temp suspended to COVID). 11. Rolling programme of inspections to be developed for 2021/22. 12. Health and Safety improvement plan actions incorporated into draft H&S Transformation Plan. Plan presented at TU Cell, National HS Committee, 13. Local risk assessments (COVID) 14. Workplace Risk assessments prioritised rolling programme in place, monitored at SPT meetings. 15. RA facilitation workshops held in May & June to assess scope of Ra/SOPS required for EMS and NEPTS activities. 16. Two H&S Coordinators fixed term contracts cease on 31 August 2021. 17. Serious incident investigation template developed. 18. Working Safely paper presented at EMT on 16.06.21 19. Head of H&S appointed 18.06.21	1. Internal Audit Reports – *dates to be included* 2. External Audit Reports 3. HSE Visits / Inspections 4. Local Authority Inspections 5. HSE Covid Learnings Report / Trust Position Report 6. Working Safely Report presented to EMT on 16/06/21 7. Local H&S Inspections – scope of inspections strengthened 8. Rolling programme of H&S Review visits 9. Health and Safety improvement plan 10. Monitored through Health & Safety Committee, QuEST, EMT and ADLT. 11. Health & Safety Committee received a draft review of the Health & Safety Improvement Plan for initial approval. Due to be presented to EMT for final approval. 12. HSE CoVID Learning Report / Trust position report. 13. Local Risk Assessments 14. Health & Safety mandatory training 15. IOSH Health & Safety Training for managers and Leaders 16. Draft transformation plan 17. Working safely action group established 18. Local Risk Assessments Health & Safety Governance Structure reviewed to strengthen existing arrangements for implementation Q2 21/22	

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			*What measures are already in place to mitigate the risk?*	*What evidence is available to show that the controls are effective?*	*What additional actions need to be or can be taken to mitigate this risk*
	Title and Description	Initial	Current	Target			
					20. Funding agreed to resource Working Safely Programme 02.08.21 21. Working Safely Programme board established 03.08.21 22. Working Safely Dynamic Delivery Action Group established 10.08.21 23. Working Safely Programme Manager Appointed 17.08.21. 24. IOSH Leading Safely Training piloted 13.08.21 25. WAST Leading Safely Behavioural audits training piloted 13.08.21		
316	Increased risk of personal injury claims citing COVID exposure ASSIGNED TO: **EXECUTIVE OWNER:** CLAIRE ROCHE **COMMITTEE**: QUEST **DIRECTORATE:** QUALITY, SAFETY & PATIENT EXPERIENCE	20 5x4 QTR 2 20/21	20 5X4 ⟷ QTR 4 21/22	12 3x4 QTR 4 20/21	Last reviewed on Datix: 24/12/21 1. RIDDOR Investigation Tool trailed with developments undertaken to undertake amendments to accommodate 111 and strengthen Corporate investigation criteria. 2. Amendments made to tool January 2021 to incorporate MRD, MTU and include vaccination information. 3. Group established to investigate backlog of cases. 4. Central coordinator assigned to manage retrospective cases. 5. Operational staff members appointed to assist with completion of COVID Investigation tools. 6. Shielded staff member appointed and trained to review COVID investigations 7. Volume of cases challenging for staff to undertake a thorough investigation during periods of high operational demands. 8. Operational central coordinator appointed in Jan 2021 to coordinate backlog of retrospective cases. 9. Several changes in designated coordinators and support teams throughout Q4 20.21 - Q2 2021/22	1. Outbreak Management SOP 2. SBAR Trust Cleaning Provision Options V5 Oct 30 19 3. IPC Policy reviewed and updated 4. Competencies for Fit Testing on ESR 5. IPC Group feeds into QUEST 6. IPC Improvement Plan and monitoring 7. Pandemic Plan 8. HSE - RIDDOR Regulations 2013. 9. Local Authority local inspections 10. Regional Groups previously established to review and RA suitability and integrity of donated PPE. 11. Pan Wales group established to discuss RA's and information share	

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			*What measures are already in place to mitigate the risk?*	*What evidence is available to show that the controls are effective?*	*What additional actions need to be or can be taken to mitigate this risk*
	Title and Description	**Initial**	**Current**	**Target**			
160	High Sickness Absence Rates ASSIGNED TO: **EXECUTIVE OWNER:** CLAIRE VAUGHAN **COMMITTEE**: PEOPLE & CULTURE COMMITTEE **DIRECTORATE:** WORKFORCE & OD	16 4x4 QTR 1 19/20	16 4x4 ⟷ QTR 4 21/22	12 3x4 QTR 4 19/20	Last reviewed on Datix: 01/01/22 1. Sickness Absence Policy. 2. Sickness Action plan. 3. Health and Wellbeing Strategy. 4. Operational Workforce Recruitment Plans. 5. Roster Review & Implementation. 6. Monthly performance review meetings. 7. Reported at ET, FRC, Board.	Under Review	
244	Impact on EMS CCC service delivery due to estates constraints ASSIGNED TO: **EXECUTIVE OWNER:** CHRIS TURLEY **COMMITTEE:** FINANCE & PERFORMANCE **DIRECTORATE:** OPERATIONS	20 5x4 QTR 3 19/20	16 4x4 ⟷ QTR 4 21/22	8 2x4 QTR 4 21/22	Last reviewed on Datix: 19/07/21 1. Full review of CCC room configuration completed. 2. CCC Management team prioritise how the space is used on each shift to align it to priorities associated with safe service delivery.	1. Risk Assessments have been undertaken on all three sites. 2. VPH Reconfiguration plans in progress - action 3. Temporary capacity 2nd floor Llangunnor 4. Logistics cell review 5. Use of the major incident room to facilitate social distancing in Bryn Tyrion 6. Use of Ty Elwy in North Wales for 111	
311	Failure to manage the cumulative impact on estate of the EMS Demand & Capacity Review, the NEPTS Review and GUH. ASSIGNED TO: **EXECUTIVE OWNER:** CHRIS TURLEY **COMMITTEE:** FINANCE & PERFORMANCE **DIRECTORATE:** FINANCE & CORPORATE RESOURCES	16 4x4 QTR 2 20/21	16 4x4 ⟷ QTR 4 21/22	8 2x4 QTR 2 20/21	Last reviewed on Datix: 17/02/21 1. Estates SOP Delivery Group. 2. EMS D&C Programme Board. 3. NEPTS D&C Review. 4. GUH Programme Team and development of a "mega" s/sheet that is combining all the information into the total cumulative impact on estate (and fleet), led by AD Commissioning & Performance.	1. Development of the refreshed Estates SOP is progressing, good engagement with Operational colleagues. Further engagement with EMT planned in March and onward to F&P and Trust Board for approval and onward to WG. 2. A detailed programme has been developed by the Estates team for the staff increases identified within the D&C data and subsequent megasheet. 3. Further resources have been agreed to commence the delivery of the programme as part of the Capital and Estates team.	

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			*What measures are already in place to mitigate the risk?*	*What evidence is available to show that the controls are effective?*	*What additional actions need to be or can be taken to mitigate this risk*
	Title and Description	**Initial**	**Current**	**Target**			
201	Trust Reputation ASSIGNED TO: **EXECUTIVE OWNER:** ESTELLE HITCHON **COMMITTTEE:** PEOPLE & CULTURE COMMITTEE **DIRECTORATE:** PARTNERSHIPS & ENGAGEMENT	15 3x5 QTR 2 19/20	15 3x5 ⟷ QTR 4 21/22	10 2x5 QTR 4 20/21	Last reviewed on Datix: 29/11/21 1. Regular engagement with senior stakeholders, namely, Minister, senior Welsh Government officials, commissioners, elected politicians, and NHS Wales organisational system leaders. 2. Programme of media engagement including challenging of reporting to ensure accuracy and media liaison to ensure relationships developed with key media. 3. Appointment of Head of External Communications in October 2019 supports efforts to engage media and stakeholders. 4. Board approved Engagement Framework (July 19) focuses on a range of actions to manage reputation. 5. Engagement Framework delivery plan developed to specify discrete actions and forms basis of monitoring.	1. Quarterly reports to Trust Board 2. EMT discusses "reputational forward" look fortnightly at formal EMT 3. Horizon scanning 4. Engagement Delivery Plan Framework (qtrly to Board) 5. Ad hoc board updates to reflect incidents 6. Board updates - comms in real time to inform members - daily updates 7. Quarterly Board reports monitoring progress against Engagement Framework deliver plan from November 19 (identified as good practice by internal audit and believed to be unique in Wales) 8. Risk register reviewed by Heads of Comms, Assistant Corporate Secretary and Director at directorate business meeting	
245	Inability to maintain safe & effective services during a disruptive challenge due to insufficient capacity in EMS CCCs ASSIGNED TO: **EXECUTIVE OWNER:** CHRIS TURLEY **COMMITTEE:** FINANCE & PERFORMANCE **DIRECTORATE:** OPERATIONS	15 3x5 QTR 3 19/20	15 3X5 ⟷ QTR 4 21/22	6 2X3 QTR 3 19/20	Last reviewed on Datix: 20/10/21 1. National EMS CCC Business Continuity Plan. 2. Clinical remote working. 3. Single instance CAD allowing virtualisation 4. ITK (Interoperability Toolkit) technology in place which provides connectivity with other UK ambulance Trusts	1. Senior manager on duty capacity increased through the ODU 2. Business continuity plans and outbreak management SOP activated during recent Covid-19 outbreaks in North Wales (EMS and 111); resilience and Trust's ability to maintain service upheld. 3. Increased cleaning provision has been provided as a result of recent outbreaks especially within the CCC environment although not solely at CCC buildings. 4. Management teams are also reinforcing the principals social distancing, cleanliness, temperature testing and masking	

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			*What measures are already in place to mitigate the risk?*	*What evidence is available to show that the controls are effective?*	*What additional actions need to be or can be taken to mitigate this risk*
	Title and Description	**Initial**	**Current**	**Target**			
100	Failure to collaborate and engage with EASC on developing ambitions and plans for WAST ASSIGNED TO: **EXECUTIVE OWNER:** RACHEL MARSH **COMMITTEE:** FINANCE & PERFORMANCE **DIRECTORATE:** PLANNING & PERFORMANCE	12 3x4 QTR 1 19/20	12 3x4 ⟷ QTR 4 21/22	8 2x4 QTR 3 20/21	Last reviewed on Datix: 13/01/22 1. EASC/WAST Forward Plan. 2. EASC Management Group (replacement for PDEG/JMAG/ NEPTS DAG, 111 engagement and Mental Health engagement - with NCCU and HBs). 3. Monthly catch up between CASC/CEO. 4. Collaboration on specific projects e.g. Amber Review, EMS D&C Programme Board. 5. There is also now a monthly Quality & Delivery meeting. 6. There are strong committee mechanisms in place and NCCU have also appointed an officer to support with their governance.	1. EASC Management Group agendas and minutes. 2. CASC Assurance Q&D agendas and minutes. 3. EMS D&C PB agenda and minutes. 4. Ambulance Care (NEPTS) programme governance map 5. NEPTS DAG agenda and minutes 6. 111 First Programme docs 7. Correspondence with the IMTP on 111 roll out 8. Cases for investment.	
139	Failure to Delivery our Statutory Financial Duties in accordance with legislation ASSIGNED TO: **EXECUTIVE OWNER:** CHRIS TURLEY **COMMITTEE:** FINANCE & PERFORMANCE AND AUDIT COMMITTEE **DIRECTORATE:** FINANCE & CORPORATE RESOURCES	12 3x4 QTR 1 19/20	12 3x4 ⟷ QTR 4 21/22	8 2x4 QTR 4 21/22	Last reviewed on Datix: 06/01/22 1. Financial reporting to EFG & FPC, policies in respect of financial management. 2. Ensuring good governance and compliance with Trust Standing Orders. 3. Welsh Government Reporting. 4. Regular review of savings targets via ADLT. 5. Regular review monitoring and challenge via WAST and CASC quality and delivery meeting with commissioners. 6. Monthly ICMG meetings to monitor and review progress against capital programme and engagement with WG and capital leads. 7. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications.	1. Diarised dates for EFG and FPC and monthly reports. 2. Budget management meetings. Approval of hierarchies. 3. Monthly Monitoring Returns to WG. 4. ADLT review and communication. 5.EASC management meetings. Fortnightly meetings with EASC. DAG meetings for NEPTS. 6. Diarised dates for ICMG meetings with regular reports. Regular Capital CRL meetings with Trust and WG capital leads. 7. Periodic PSPP communications and Regular P2P meetings diarised	
283	EMS Demand and Capacity Review Implementation Programme ASSIGNED TO: **EXECUTIVE OWNER:** RACHEL MARSH **COMMITTEE:** FINANCE & PERFORMANCE **DIRECTORATE:** PLANNING & PERFORMANCE	16 4x4 QTR 4 20/21	12 3x4 ⟷ QTR 4 21/22	8 2x4 QTR 2 20/21	Last reviewed on Datix: 13/01/22 1. Implementation Programme Board firmly established. 2. Executive SRO in place. 3. Programme Manager and programme support office functioning. 4. Programme documentation in place and developing. 5. Clear links to EASC Management Group and EASC. 6. Ambulance Availability Taskforce restarted. 7. Programme budget.		

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			*What measures are already in place to mitigate the risk?*	*What evidence is available to show that the controls are effective?*	*What additional actions need to be or can be taken to mitigate this risk*
	Title and Description	Initial	Current	Target			
424	Resource availability (capital) to deliver the organisation's IMTP ASSIGNED TO: **EXECUTIVE OWNER:** CHRIS TURLEY **COMMITTEE:** FINANCE & PERFORMANCE **DIRECTORATE:** PLANNING & PERFORMANCE	12 3x4 QTR 1 21/22	12 3x4 ⟷ QTR 4 21/22	4 1x4 QTR 4 23/24	Last reviewed on Datix: 13/01/22 1. Regular Capital Management Board meetings 2. Prioritisation process 3. Regular CRM meetings with WG 4. Capital Business case process through ADLT for small discretionary 5. Finance & Performance Committee scrutiny 6. Standing Financial Instructions for levels of sign off 7. WG processes are strong to ensure full scrutiny across the 5 step model		
303	Delayed initiation of chest compressions (resuscitation) ASSIGNED TO: **EXECUTIVE OWNER:** ANDY SWINBURN **COMMITTEE:** QUEST **DIRECTORATE:** MEDICAL & CLINICAL	15 3x5 QTR 1 20/21	10 2x5 ⟷ QTR 4 21/22	10 2X5 QTR 3 21/22	Last reviewed on Datix: 25/10/21 1. Ready available PPE: ease of access. 2. Repeated and regular communication to staff via written and broadcasts/ videos/ podcasts. 3. Clarity of guidance to staff (infographic). 4. Communication to caller via CCC call handler regarding BLS. 5. Clinical Cell will review frequently and amend guidance if required. 6. Patient safety incidents will be monitored and reported via EPT/TPT. 7. Dissemination of a process for rapidly donning PPE disseminated.	1. Operational performance appears to be improving in recent weeks, mitigating the impact of donning PPE. 2. Switching back on of GoodSam App which will increase the number of provider available to respond in a timely manner (albeit L3 PPE still required) 3. Existing guidance from RCUK still current and not been amended. 4. Now rapid donning process has been disseminated this now has the potential to improve the speed at which PPE can be donned. 5. The evidence of performance is reported through to Senior Pandemic Team.	

Risk ID	Risk Details	Risk Score			Existing Controls	Assurances	Actions
		Likelihood v consequence			*What measures are already in place to mitigate the risk?*	*What evidence is available to show that the controls are effective?*	*What additional actions need to be or can be taken to mitigate this risk*
	Title and Description	**Initial**	**Current**	**Target**			
109	Resource availability (revenue) to deliver the organisations IMTP ASSIGNED TO: EXECUTIVE OWNER: RACHEL MARSH COMMITTEE: FINANCE & PERFORMANCE DIRECTORATE: PLANNING & PERFORMANCE	12 3x4 QTR 1 19/20	8 2x4 ⟷ QTR 4 21/22	4 1x4 QTR 2 21/22	Last reviewed on Datix: 13/01/22 1. EASC governance structure whereby the performance and wider scrutiny of the organisations IMTP delivery and proposed funding requirements are discussed and agreed. 2. Strategic Transformation Board oversight of delivery 3. Finance and Performance sub committee.	1. Process by which internal revenue business cases are produced and submitted for scrutiny and approval and monitoring whilst in existence needs to be more robust, as well as a more robust benefits realisation process (value based approach) could be improved. 2. ASC management group has been established as a substructure to the main EASC committee. The intention is to bring planning and performance issues through EASC Management Group for detailed discussion. An example being the detailed discussions regarding the EMS Demand and Capacity Review, ODU etc. 3. NEPTS DAG provides a forum for detailed operational and service planning discussions for NEPTS. 4. A commissioning framework for transfer and discharge (not just NEPTS) services has yet to be established by a commissioning intention for EASC in 2021/22. 5. For 2021/22 planning cycle - there were two weekly touch point meetings with CASC and his team, to include WAST DOP, DOF and DOO. This will have a focus on recurrent funding issues, particularly the EMS D&C Review implementation. 6. EASC endorsed year 1 of the IMTP in March 2021 with a letter of support from CASC to set out how funding assumptions can be achieved.	

Strategic Aim Key

1	Help Patients and Staff to Stay Healthy
2	Help Patients More Easily Access our Services at the Right Time
3	Provide the Right Care in the Right Place, Wherever and Whenever it is Needed
4	Continue to Provide the Best Possible Care, Outcomes and Experience to Our Patients
5	Enable Our People to Be the Best They Can Be
6	Whole System Partnership and Engagement
7	Ensure the Design and Infrastructure of the Organisation are at the Forefront of Innovation and Technology
8	Quality at the Heart of Everything We Do
9	Value and Efficiency in Everything We Do

AGENDA ITEM No	**14**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**3**

LOSSES AND SPECIAL PAYMENTS REPORT

MEETING	**Audit Committee**
DATE	**3rd March 2022**
EXECUTIVE	**Chris Turley (Executive Director of Finance & Corporate Resources)**
AUTHOR	**Navin Kalia (Deputy Director of Finance & Corporate Resources) and Jill Gill (Head of Financial Accounting)**
CONTACT	**Chris.Turley2@wales.nhs.uk**

EXECUTIVE SUMMARY

In accordance with SFI's this report presents to the Committee details of Losses and Special Payments made during the ten months from 1st April 2021 to 31st January 2022, (**Annex 1**).
Details are also included of losses written-off during the financial year to 31st December 2021, (**Annexes 2 & 3**).

KEY ISSUES/IMPLICATIONS

Total net Losses and Special Payments made were as follows:-

- period 1st April 2021 to 31st January 2022 £1.385m

Total of losses written-off were as follows:-

- period 1st April 2021 to 31st December 2021 £0.005m
  (now also provided to ensure complete compliance with SFI's)

REPORT APPROVAL ROUTE

Audit Committee 3rd March 2022 – no action required for information under SFI's only

REPORT APPENDICES
Annex 1 – Summary and details of payments made for the ten months to 31st January 2022 Annex 2 – Details of losses written-off for the six month from 1st April 2021 to 30th September 2021 Annex 3 – Details of losses written-off for the three months from 1st October 2021 to 31st December 2021

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)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

WELSH AMBULANCE SERVICES NHS TRUST
AUDIT COMMITTEE
LOSSES AND SPECIAL PAYMENTS REPORT

SITUATION

1. In accordance with SFI's all losses and special payments made are to be reported to the Audit Committee on a regular basis.

BACKGROUND

2. This report presents to the Committee details of Losses and Special Payments made during the ten months from 1st April 2021 to 31st January 2022 (**Annex 1**).

3. Details of losses written-off during the nine months from 1st April 2021 to 31st December 2021 (**Annexes 2 & 3**) are also included.

ASSESSMENT

4. Total net Losses and Special Payments made during the period 1st April 2021 to 31st January 2022 amounted to £1.385 million (**Annex 1**).

5. This relates to actual payments made less reimbursements received from the Welsh Risk Pool and does not relate to any adjustments made to the balance sheet provision. During the ten months to 31st January 2022 payments made exceeded reimbursements received by £1.385m.

6. During November you will note that payments in relation to Damages amounted to £0.495m. These costs relate to the finalisation and settlement of a medical negligence case against the Trust following the death of a patient as a result of failure to identify the severity of the patients' symptoms.

7. During January you will note that payments in relation to Damages amounted to £0.408m. The majority of the Damages payments incurred in January, £0.402m, related to the finalisation and settlement of a medical negligence case against the Trust following the death of a patient following an ambulance delay.

8. Total losses written-off during the period 1st April 2021 to 31st December 2021 amounted to £0.005m. This relates to the loss of income which the Trust was unable to recover and in the majority of cases is based on the advice provided by our credit control partner (CCI) and their current updates on the status of both their "customer" and the resulting likelihood of cost recovery. (**Annexes 2 & 3**).

9. In relation to the one item formally written off here as a result of reported cash lost, before approving this a detailed explanation was sought as to the particular circumstances that existed over the last year, some of which have been pandemic related, that has resulted in this now having to be reported in this way. Assurances have also been sought, and provided, in terms of lessons learnt and measures which have been put in place to ensure this cannot happen again. The more generic risk in relation to this is also reducing as we move to

holding less cash balances across the Trust and replacing them with payment cards.

10. In connection with this area the latest (and final) of the series of deep dives, this time into personal injury claims, will be presented to the Committee alongside this report. Future such reports will be further expanded to highlight any additional areas the Committee may need to consider when receiving future details of losses and special payments made, and any resulting areas of additional scrutiny the Committee may wish to seek in the future.

RECOMMENDED: That the Losses and Special Payments Report for this period be received.

Annexes 1, 2 and 3 attached

Welsh Ambulance Services NHS Trust
Losses and Special Payments

Annex 1

Summary of payments for the ten months to 31st January 2022:

	£
April 2021	161,584.84
May 2021	154,976.08
June 2021	102,494.93
July 2021	- 584,439.92
August 2021	17,140.47
September 2021	15,038.63
October 2021	257,603.45
November 2021	585,381.42
December 2021	23,527.99
January 2022	652,063.06
February 2022	0
March 2022	0
	£1,385,370.95

Losses and Special Payments Breakdown:

Payment Type	April	May		**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
	£	£	£	£	£	£	£	£	£	£	£	£	£	
Claimants Solicitor Costs		77749.6	65172.7	47,454.40	17,113.20	6,000.00	1,208.50	4,434.00	26,056.00	960.00	112,110.00	0.00	0.00	£358,258.40
Counsel fees		7932.5	14885	3,270.16	7,289.59	8,625.00	700.00	2,245.83	19,981.25	1,470.00	19,220.00	0.00	0.00	£85,619.33
CRU		1376	0	9,009.43	3,068.00	0.00	1,376.00	688.00	17,860.22	0.00	86,101.46	0.00	0.00	£119,479.11
Damages		32755	63600	16,985.00	36,732.00	-3,598.20	1,898.80	235,162.00	495,051.26	500.00	408,280.00	0.00	0.00	£1,287,365.86
Defence Costs		3773.2	486.02	3,235.10	2,187.10	918.23	920.58	89.25	1,532.00	46.26	3,700.65	0.00	0.00	£16,888.39
Expert Witness		21795.85	316.8	12,245.00	15,257.40	4,764.50	2,800.00	0.00	9,779.90	10,087.10	10,938.40	0.00	0.00	£87,984.95
Vehicle Repairs		15992.69	14505.56	9,655.84	21,970.54	19,642.94	9,015.10	14,536.67	15,120.79	8,644.63	11,712.55	0.00	0.00	£140,797.31
WRP Refund		210	-3990	640.00	-688,057.75	-10,000.00	-3,956.35	447.70	0.00	0.00	0.00	0.00	0.00	-£704,706.40
Court Refund		0	0	0.00	0.00	-9,212.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-£9,212.00
Property Repairs		0	0	0.00	0.00	0.00	1,076.00	0.00	0.00	1,820.00	0.00	0.00	0.00	£2,896.00
Total		**£161,584.84**	**£154,976.08**	**£102,494.93**	**-£584,439.92**	**£17,140.47**	**£15,038.63**	**£257,603.45**	**£585,381.42**	**£23,527.99**	**£652,063.06**	**£0.00**	**£0.00**	**£1,385,370.95**

Welsh Ambulance Services NHS Trust

Losses and Special Payments

Key

MN Medical Negligence

PI Personal Injury

Summary of payments for the ten months to 31st January 2022:	DP	Damage To Property
	£	
PI cases < £1,000	5,445.18	12 CASES
DP cases < £1,000	16,058.45	35 CASES
16RT4MN0009	612,549.07	
17RT4MN0007	539,206.51	
18RT4MN0023	204,850.00	
20RT4MN0010	120,820.00	
19RT4PI0053	80,382.43	
15RT4MN0010	67,418.20	
19RT4PI0029	46,096.60	
22RT4DP0025	24,300.80	
20RT4MN0006	20,432.00	
20RT4PI0014	17,648.00	
20RT4MN0011	16,770.00	
18RT4PI0060	15,505.97	
19RT4PI0023	12,797.70	
20RT4MN0008	12,500.00	
22RT4PI0015	11,114.20	
21RT4PI0034	10,832.00	
21RT4DP0086	9,994.87	
20RT4PI0044	9,896.50	
18RT4MN0012	9,542.50	
22RT4DP0022	9,354.79	
19RT4PI0008	8,775.00	
18RT4MN0005	8,265.00	
19RT4PI0038	7,733.40	
18RT4MN0011	7,000.00	
22RT4DP0049	6,928.65	
22RT4DP0070	6,867.66	
22RT4DP0028	6,801.53	
19RT4PI0044	6,625.00	
19RT4FE0004	6,021.15	
19RT4PI0028	5,955.00	
21RT4PI0024	5,453.00	
22RT4DP0055	5,091.11	
21RT4DP0098	5,027.78	
18RT4MN0015	5,000.00	
22RT4PI0004	4,640.00	
22RT4DP0048	4,582.69	
22RT4DP0040	4,290.00	
21RT4MN0013	4,290.00	
19RT4PI0005	4,252.00	
22RT4DP0019	4,071.28	
22RT4DP0033	3,930.00	
22RT4GN0007	3,670.00	
22RT4DP0011	3,359.68	
22RT4DP0072	3,081.79	
15RT4PI0040	3,006.25	
19RT4EG0005	2,991.67	
21RT4DP0054	2,934.00	
21RT4DP0073	2,774.15	
18RT4MN0016	2,586.75	
21RT4GN0012	2,446.50	
21RT4DP0093	2,428.43	
22RT4DP0015	2,352.42	
19RT4PI0040	2,339.52	
22RT4DP0057	2,300.00	
22RT4DP0009	2,256.86	
22RT4DP0064	2,244.00	
22RT4DP0047	2,227.87	
22RT4DP0052	2,200.00	
21RT4DP0045	2,179.82	
22RT4MN0001	2,145.83	
22RT4DP0051	2,140.26	
22RT4GN0008	2,100.00	
22RT4DP0046	2,058.67	
19RT4PI0051	2,050.00	
22RT4MN0002	2,000.00	
22RT4DP0038	1,990.51	
20RT4PI0034	1,987.70	
22RT4DP0001	1,860.50	
22RT4DP0062	1,820.00	
22RT4DP0007	1,764.15	
21RT4DP0106	1,725.37	
22RT4DP0054	1,639.10	
21RT4DP0104	1,605.00	
22RT4DP0010	1,598.46	
20RT4MN0018	1,590.00	
22RT4DP0050	1,569.54	
22RT4DP0042	1,524.49	
22RT4DP0071	1,511.10	
21RT4DP0075	1,456.02	
22RT4DP0030	1,422.72	
19RT4MN0006	1,375.00	
22RT4DP0061	1,360.68	
21RT4PI0001	1,334.00	
20RT4MN0019	1,300.00	
22RT4MN0010	1,300.00	
21RT4EG0006	1,200.00	
22RT4DP0026	1,136.79	
21RT4GN0016	1,100.00	
20RT4MN0005	1,100.00	
22RT4DP0014	1,076.21	
22RT4DP0044	1,076.00	
22RT4DP0053	1,038.81	
20RT4PI0007	1,000.00	
22RT4MN0012	950.00	
20RT4MN0017	872.00	
21RT4MN0012	646.80	
18RT4MN0001	625.00	
22RT4MN0003	520.00	
22RT4MN0016	72.65	
22RT4MN0011	68.00	
22RT4MN0013	46.26	
22RT4MN0009	36.00	
15RT4MN0010	- 681,645.75	WRP REFUND
20RT4EG0017	- 10,000.00	WRP REFUND
21RT4GN0006	- 5,714.30	WRP REFUND
21RT4GN0001	- 3,200.00	WRP REFUND
15RT4PI0040	- 3,006.35	WRP REFUND
21RT4GN0020	- 500.00	WRP REFUND
21RT4GN0017	- 250.00	WRP REFUND
21RT4GN0010	- 250.00	WRP REFUND
21RT4EG0003	- 250.00	WRP REFUND
21RT4GN0009	- 200.00	WRP REFUND
21RT4GN0003	210.00	WRP REFUND RETURN
15RT4PI0032	100.00	WRP REFUND RETURN
19RT4PI0051	- 9,212.00	COURT REFUND
Total	**1,385,370.95**	

Nov-21

Case Reference	Details	Amount (£)
16RT4MN0009	Expert witness	150.00
16RT4MN0009	Expert witness	651.40
16RT4MN0009	Counsel fees	2,700.00
16RT4MN0009	Expert witness	96.00
16RT4MN0009	Expert witness	500.00
16RT4MN0009	CRU	8,681.48
16RT4MN0009	Expert witness	3,000.00
17RT4MN0007	Expert witness	300.00
17RT4MN0007	Counsel fees	3,712.50
17RT4MN0007	Expert witness	225.00
17RT4MN0007	Counsel fees	2,025.00
17RT4MN0007	Damages	50,000.00
17RT4MN0007	Damages	445,051.26
17RT4MN0007	CRU	4,948.74
17RT4MN0007	Counsel fees	2,268.75
18RT4MN0001	Counsel fees	625.00
18RT4MN0016	Expert witness	297.50
19RT4PI0008	Counsel fees	900.00
19RT4PI0023	CRU	4,230.00
19RT4PI0044	Expert witness	1,500.00
19RT4PI0044	Counsel fees	3,000.00
19RT4PI0044	Expert witness	850.00
19RT4PI0044	Defence costs	275.00
19RT4PI0044	Counsel fees	750.00
19RT4PI0053	Claimants solicitors fees	26,056.00
19RT4PI0061	Counsel fees	600.00
20RT4MN0005	Counsel fees	1,050.00
20RT4MN0011	Expert witness	390.00
20RT4PI0004	Defence costs	159.50
21RT4PI0001	Defence costs	580.00
21RT4PI0001	Defence costs	449.50
22RT4DP0048	Vehicle repairs	2,449.28
22RT4DP0048	Vehicle repairs	2,133.41
22RT4DP0052	Vehicle repairs	2,200.00
22RT4DP0053	Vehicle repairs	1,038.81
22RT4DP0054	Vehicle repairs	1,639.10
22RT4DP0055	Vehicle repairs	5,091.11
22RT4DP0056	Vehicle repairs	569.08
22RT4DP0059	Vehicle repairs	75.00
22RT4DP0059	Vehicle repairs	1,302.05
22RT4DP0059	Vehicle repairs	- 1,377.05
22RT4DP0060	Vehicle repairs	1,166.76
22RT4DP0060	Vehicle repairs	775.00
22RT4DP0060	Vehicle repairs	50.00
22RT4DP0060	Vehicle repairs	7,471.85
22RT4DP0060	Vehicle repairs	- 9,463.61
22RT4MN0003	Expert witness	520.00
22RT4MN0011	Defence costs	68.00
18RT4MN0005	Expert witness	1,300.00
18RT4MN0023	Counsel fees	2,350.00
Total		**585,381.42**

Dec-21

Case Reference	Details	Amount (£)
16RT4MN0009	Expert witness	337.10
18RT4MN0016	Counsel fees	600.00
19RT4PI0008	Expert witness	3,000.00
19RT4PI0008	Expert witness	1,500.00
19RT4PI0023	Damages	500.00
20RT4MN0011	Counsel fees	770.00
20RT4MN0019	Expert witness	700.00
20RT4MN0019	Expert witness	600.00
21RT4MN0013	Expert witness	3,000.00
22RT4DP0051	Vehicle repairs	2,140.26
22RT4DP0057	Vehicle repairs	2,300.00
22RT4DP0058	Vehicle repairs	480.00
22RT4DP0061	Vehicle repairs	1,360.68
22RT4DP0062	Damage to property	1,820.00
22RT4DP0063	Vehicle repairs	280.00
22RT4DP0063	Vehicle repairs	159.42
22RT4DP0063	Vehicle repairs	- 439.42
22RT4DP0064	Vehicle repairs	2,244.00
22RT4DP0065	Vehicle repairs	788.75
22RT4DP0065	Vehicle repairs	66.08
22RT4DP0065	Vehicle repairs	- 854.83
22RT4DP0066	Vehicle repairs	119.69
22RT4MN0012	Expert witness	950.00
22RT4MN0013	Defence costs	46.26
22RT4PI0004	Claimants solicitors fees	960.00
18RT4MN0005	Counsel fees	100.00
Total		**23,527.99**

Jan-22

Case Reference	Details	Amount (£)
16RT4MN0009	Expert witness	603.40
16RT4MN0009	Expert witness	375.00
16RT4MN0009	Expert witness	440.00
16RT4MN0009	Counsel fees	11,200.00
16RT4MN0009	Claimants solicitors fees	100,000.00
16RT4MN0009	Damages	402,000.00
16RT4MN0009	CRU	627.00
16RT4MN0009	CRU	52,854.29
17RT4MN0007	CRU	23,880.00
18RT4MN0016	Counsel fees	600.00
18RT4PI0060	CRU	8,740.17
19RT4FE0004	Counsel fees	5,400.00
19RT4PI0037	Claimants solicitors fees	360.00
19RT4PI0037	Defence costs	108.00
19RT4PI0044	Counsel fees	250.00
20RT4MN0006	Expert witness	2,200.00
20RT4MN0008	Claimants solicitors fees	11,750.00
20RT4MN0011	Expert witness	1,920.00
20RT4MN0017	Counsel fees	200.00
20RT4PI0007	Counsel fees	1,000.00
22RT4DP0067	Vehicle repairs	3,631.39
22RT4DP0067	Vehicle repairs	- 3,631.39
22RT4DP0068	Vehicle repairs	252.00
22RT4DP0070	Vehicle repairs	6,867.66
22RT4DP0071	Vehicle repairs	1,511.10
22RT4DP0072	Vehicle repairs	3,081.79
22RT4DP0073	Vehicle repairs	2,057.92
22RT4DP0073	Vehicle repairs	37.44
22RT4DP0073	Vehicle repairs	69.66
22RT4DP0073	Vehicle repairs	- 2,165.02
22RT4GN0007	Defence costs	1,920.00
22RT4GN0007	Damages	1,750.00
22RT4GN0008	Damages	500.00
22RT4GN0008	Defence costs	1,600.00
22RT4GN0017	Damages	350.00
22RT4GN0030	Vehicle repairs	4,717.82
22RT4GN0030	Vehicle repairs	380.00
22RT4GN0030	Vehicle repairs	797.04
22RT4GN0030	Vehicle repairs	37.44
22RT4GN0030	Vehicle repairs	- 5,932.30
22RT4MN0002	Expert witness	2,000.00
22RT4MN0010	Expert witness	1,300.00
22RT4MN0016	Defence costs	72.65
22RT4PI0004	Damages	3,680.00
18RT4MN0005	Counsel fees	120.00
18RT4MN0005	Counsel fees	450.00
18RT4MN0005	Expert witness	2,100.00
Total		**652,063.06**

WELSH AMBULANCE SERVICES NHS TRUST

Authorisation for Cancellation/ Write off of Debtor invoices involving loss of income

Invoice Number	Organisation Name	Invoice Date	Value £	Action required	Reason for action
132548	- These have been removed for confidentiality -	12/05/2017	318.37	Write Off	CT agreed 20% discount of £318.37 to settle on 26/7/18, £1320 now repaid so this can be WO as agreed
135531		22/01/2019	61.25	Write Off	Amount too small to pursue - returned from CCI
136088		11/06/2019	102.50	Write Off	Amount to small too pursue - returned from CCI
136683		06/11/2019	63.70	Write Off	Amount too small to pursue
136697		06/11/2019	586.57	Write Off	Debtor in IVA (Individual voluntary arrangement) CCI cannot pursue any further
137816		27/10/2020	79.59	Write Off	Amount too small to pursue
137886		11/11/2020	54.00	Write Off	Amount too small to pursue
137887		12/11/2020	39.84	Write Off	Amount too small to pursue
138125		28/01/2021	69.13	Write Off	Amount too small to pursue
138259		04/03/2021	2,839.50	Write Off	Ex-employee in Prison for 2.5 years following knife assault on partner. CCI have reviewed the details of this case including the Daily Post article and recommend there's no current recovery options for this. In theory we could place the file on hold awaiting his release from prison.However taking into account the notes regarding his mental health, and his future employment prospects the likelihood of recovery is extremely low. Therefore recommend w/o.
138262		04/03/2021	4.91	Write Off	Amount too small to pursue
138318		23/03/2021	54.00	Write Off	Customer has died
138529		21/06/2021	54.00	Write Off	Customer has died
N/A		N/A	12.22	Write Off	Employee died of COVID no invoice raised
		Total	**4,339.58**		

I confirm my approval of the above actions in respect of the amounts stated above.

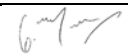
Signature:	
Name:	**CHRIS TURLEY**
Date:	04.10.21

WELSH AMBULANCE SERVICES NHS TRUST

Authorisation for Cancellation/ Write off of Debtor invoices involving loss of income

Invoice Number	Organisation Name	Invoice Date	Value £	Action required	Reason for action
136120	These have been removed for confidentiality -	28-Jun-19	4.95	Write Off	Amount too small to pursue
138089		22-Jan-21	54.00	Write Off	Customer has died
138092		22-Jan-21	54.00	Write Off	Customer has died
138167		04-Feb-21	92.16	Write Off	Customer has died
138520		21-Jun-21	54.00	Write Off	Customer has died
		n/a	50.00	Write Off	Petty Cash lost as per e mail from Chris Sims 7/10/21
		Total	**309.11**		

I confirm my approval of the above actions in respect of the amounts stated above.

Signature:	
Name:	Christopher Turley, Exec Director of Finance & Corporate Resources
Date:	20th January 2022

AGENDA ITEM No	**14.1**
OPEN or CLOSED	**OPEN**
No of ANNEXES ATTACHED	**1**

LOSSES AND SPECIAL PAYMENTS DEEP DIVE INTO PERSONAL INJURY CLAIMS

MEETING	Audit Committee
DATE	3 March 2022
EXECUTIVE	Director of Quality & Nursing
AUTHOR	Assistant Director of Quality & Nursing
CONTACT	Wendy Herbert Wendy.herbert@wales.nhs.uk 01792 315886

EXECUTIVE SUMMARY

Quarterly, the Audit Committee receive a Losses Payments paper in relation to the financial payments that are made by the Trust. This includes the payments made in relation to claims.

It was felt that the paper should be enhanced to include details surrounding themes and trends, and where appropriate lessons learned. Whilst the Legal Services Team (the Team) can identify themes and trends, as well as learn lessons in relation to the handling of the cases, the wider learning for the Trust is completed by individual Line Manager, the National Training College and Health & Safety Committee. The sharing with the National Training College and Health & Safety Committee will be via this report. In addition, all Welsh Risk Pool Services (WRPS) Learning from Events Reports are presented to the Health & Safety Committee to review learning.

The Trust has adopted a policy of in-house management of personal injury claims since 2008.

RECOMMENDED: That the Committee considers the content of this report

KEY ISSUES/IMPLICATIONS

For assurance only

REPORT APPROVAL ROUTE

Executive Management Team	2 February 2022
Quality, Patient Experience & Safety Committee	17 February 2022

REPORT APPENDICES

Annex 1 - SBAR

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	Yes
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	Yes	TU Partner Consultation	NA

ANNEX 1

SITUATION

1 This report includes details of all personal injury claims, received during 2020 and 2021. This is a total of 38 registered cases.

BACKGROUND

2 Whilst the losses payments paper reports on payments that have been made in the preceding 3 months, those payments will relate to a variety of ongoing cases.

3 Often, by the time that the payments are made, the incident or event, will have occurred many years previously. Therefore, the payments may not relate to current themes and trends but rather be reflective of historic issues.

4 Additionally, the majority of claims will have multiple payments, in complex cases being paid over a number of years.

5 Again, should the themes and trends be drawn from the cases on which payments have been made in the preceding quarter, many cases would be considered multiple times. This in itself would skew the true themes and trends relating to our claims.

6 Therefore, this report is prepared to append to the losses payments paper. This paper focuses on one area of the claims received by the Trust. Looking at themes and trends, in relation to the claims being received, as well as learning in relation to the handling of the claims, with a view to minimising losses.

ASSESSMENT

7 For the purposes of current themes and trends this report includes details of all personal injury claims, received during the last 2 full calendar years (2020 & 2021).

8 For the purpose of the damages paid and learning this report includes details of all personal injury claims closed during the last 2 full calendar years (2020 & 2021).

9 Initially the personal injury data was going to be reported over two papers, one in relation to injuries to staff and one in relation to injuries to patients. However, given the low numbers involved, all personal injury claims have been included in this report.

10 The significant majority of the Trust's personal injury cases are managed by the Trust's own Legal Services Team. This includes the gathering of information and responding to allegations made against the Trust, the provision of pre-action disclosure of evidence and where legal proceedings are issued the legal case management of such cases.

11 As with clinical negligence claims (last report) in the majority of cases a claimant has 3 years from the date of the incident (or the date they became aware of the harm) to raise a claim. This period of time is referred to as limitation. Limitation is suspended whilst any investigation is being undertaken under the Putting Things Right scheme.

12 That being said limitation is a complex matter and the details above are simplistic and apply in the majority of case. There are cases that fall outside of these simple rules.

13 The Legal Services Team uses the Datix computerised system to register claims, and links them to any concerns (complaints or incidents) that have been received. That being said, the Datix system is not a case management system, but rather a reporting system, and as such the Trust currently manages its claims on paper files. The Trust is anticipating the introduction of a legal case management system aligned to that being introduced by Legal & Risk Services (L&RS). L&RS have agreed to create a dedicated Module specifically for the Trust within their new system, with appropriate data privacy and access restrictions. It is hopeful that this will be introduced within 2022-2023.

14 High value and complex cases are reported via different routes and this report is not looking to repeat the content of those papers.

15 The key points that have been considered are:

Current Themes and Trends

16 The table below illustrates the number of cases received.

	2020	**2021**
Total	23	15
Patient	2	3
Staff	21	12

17 From the table above it is possible to see that there has been a marked decrease in claims being received during 2021. By looking further back, the total cases in 2017 was 36, in 2018 was 24 and in 2019 was 31.

18 The 38 cases considered have incident dates ranging from December 2017 until November 2021. Increasingly accumulated effects are being reported, especially in terms of work related stress.

19 This in itself demonstrates the need for the Trust to maintain access to the incidents reported by staff on the existing incident reporting system, when the NHS in Wales moves to the newly introduced RL Datix system. For this reason the Legal Services Team ensure they take an active role in the introduction of the new system and has input in relation to the data retention needs of the old system.

20 All claims made to the Trust by patients relate to non-emergency patients. No personal injury claims have been received from the table below provides details of the allegations received.

	2020	2021
Issues when manoeuvring a patient in a wheelchair	1	1
Securing the patient in the vehicle		1
Injured entering or taking a seat in the ambulance (walking patients)	1	1

21 The number of cases involving staff are higher. The table below illustrates the functions within the Trust.

	2020	2021
Total	21	12
NHS Direct/111	2	1
Emergency Medical Services	12	9
Urgent Care Service	1	0
Non-Emergency Patient Transport Service	6	2

22 From the above table it is possible to see that the decrease in personal injury claims being received is in relation to staff claims. It is also possible to see that more claims are received from emergency staff rather than non-emergency staff. This is probably reflective of the fact that pre-travel risk assessments can be undertaken with non-emergency patients.

23 **Appendix 1** at the foot of this report details the allegations/causes of the claims being raised. Whilst some wider themes can be identified, such as slips/trips and manual handling, the details show that these are often isolated events.

24 Previously there had been multiple claims in relation to trips on charging cables, however there has only been one over the last two years. This is following learning and improvement plans being implemented.

25 The table does indicate that there continues to be multiple needle stick issues. There are also multiple claims in relation to COVID, Stress and assaults.

Closures and Learning

26 During the same period of the calendar years of 2020 and 2021, the Trust closed 31 claims.

Claimant	Damages Paid	No Damages Paid	Percentage Paid	Percentage no payments
Totals	10	21	32	68
Patient	0	3	0	100
Third party*	2	1	66	33
PCS Staff	0	3	0	100
EMS Staff	8	14	36	64
*People who are not patients or staff (family travelling with patients)				

27 The above table indicates that the Trust pays damages in 32 percentage of cases which correlates to a high defend rate. In all cases the Legal Services Team gather all information, investigate the allegations made against the Trust and where necessary instruct an independent expert.

28 The claims are managed in line with the courts Civil Procedure Rules and the Trust utilises Part 36 of those rules, which encourages parties to settle disputes without going to Trial, thus minimising legal costs to the Trust. Part 36 allows the Trust to make a 'without prejudice' offer to settle a matter with no admission of liability, when our investigation identifies weaknesses and/or fault.

29 In the cases where the Trust paid compensation, the table below details the basic reason for the claim and the amount of damages paid.

Type	Details	Amount
3rd party	Stretcher came loss in rear of vehicle	1400.00
	Accumulated traumatic incidents/stress	50000.00
Employee	Needle stick	725.00
	Needle stick	1250.00
	Needle stick	2500.00
	On station -Trip/slip from vehicle	2735.00
	On station - Trip on charging cable	4000.00
	On station - Pothole	3000.00
	Manual handling - Bariatric patient	8000.00
	Whiplash*	4000.00
*This case has been wrongly coded and is a PIRTC		

30 The figures above illustrate that each case is considered on its own merit. The range in the awards in relation to needle stick illustrate the individual level of contamination and the effects on the individual staff member.

31 In each case that the Trust accepts liability and pays damages, the Trust completes a Learning from Events Report for the Welsh Risk Pool. This documents both individual learning and organisational learning on each case.

32 Examples of the learning in relation to the payments made above includes:

- Individual learning in relation to the use of equipment
- Reminder in 2019/20 update training surrounding sharps, Personal Protective Equipment (PPE) and avoiding sharps injuries
- Podcast from Assistant Medical Director covering certain procedures that incur risk of needle stick
- The introduction of quarterly station inspections, with checklist completion
- The introduction of Trauma Risk Management (TRIM), Silvercloud for CBT, Occupational assistance and 24 hour access to assistance (including Face to Face counselling).

Ongoing cases and significant cases the Trust is currently handling

33 The Trust currently has 82 open cases. Of these, 75 relates to staff, 5 relate to patients and 2 to third party claimants.

34 Of the cases 2/3^{rds} relate to Emergency Services, with the majority of the remaining third relating to Non-Emergency Services.

35 This SBAR brings these cases to the attention of the reader. These cases are considered significant because of the quantum involved in each case is potentially £100,000.00, or above.

(i) 5294 - This is a manual handling issue, in that the member of staff fell from the rear of a vehicle and sustained an injury.
(ii) 5318 - This was an incident on station when a member of staff slipped in the rear of an ambulance.
(iii) 5037 - This is a case involving work related stress
(iv) 5219 - This is a claim in relation to Post Traumatic Stress Disorder
(v) 5184 - This is a case involving work related stress

Future

36 Whilst the number of claims being received have reduced what cannot be extrapolated from the current Datix system and these figures are the number of cases which become ligated and the impact of this in both time and costs savings.

37 All cases are investigated and a detailed response and disclosure is provided under the relevant Pre-Action Protocol.

38 However an increasing number of those cases are later the subject of formal legal proceedings.

39 These cases can be litigated on one of three tracks - Small Claims, Fast Track and Multi-track dependent on value and legal complexity. The track determines the extent of legal input required on each case.

40 Of the 82 open cases, 23 are currently on a defended tracks with 6 running on the most complex Multi-track and the remainder on the Fast track or awaiting allocation by the Court.

41 To contextualise this in terms of legal expenses, the average external legal costs paid to external solicitor to defend a Multi-track case was previously @ £45,000 - £50,000 and the Trust's budgeted costs on each of the current defended in-house Multi-track cases are between £50,000 - £60,000. Whilst these Multi-track cases are being managed in-house and this creates a demand on time and resources, it does however create a potential financial saving of £300,000 - £360,000 on 6 cases alone as no external solicitors costs are actually incurred (albeit they are budgeted for by the Court).

42 This indicates that the Trust's model of in-house management of personal injury claims (where possible) does have significant costs savings benefits.

APPENDIX 1

Function	Themes	Detail	2020	2021
NHS Direct/ 111	Equipment (2)	Eye/sight injury (IT use)		1
		Chair arm snapped	1	
		Covid	1	
PCS	Equipment	Vehicle door slammed on limb	1	
	Manual handling (6)	Seating a patient	1	1
		Bariatric patient on a stretcher	1	
		Wheelchair on the ramp		1
		Moving a patient/4 man lift	1	
		Assault	1	
		Stress	1	
UCS	Manual Handling	Bariatric patient	1	
EMS	(4)	Needle stick	3	1
	On station/Slips and trips (8)	Slipped on step		1
		Slipped on ice		1
		Trip due to lack of light	1	
		Trip on hose pipe	1	
		Slipped on wet floor	1	
		Tripped on cable	1	
		Tripped on PPE		1
		Tripped leaving vehicle on restocking		1
	At patient location (5)	Equipment handle on carry chair broke	1	
		Caught response bag in house	1	
		Struggled with weight of response bag outside of house	1	
		Slipped leaving the vehicle on patient drive		1
		Grabbed by patient on Manga elk	1	
		On knees too long		1
		Assault		1
		Stress	1	
		COVID		1