Bundle Audit Committee (Open) 15 September 2022

Agenda attachments

ITEM 0 Agenda Audit Committee Open 15 September 2022 TM.docx

0	09:30 - OPENING ITEMS
1	Chair's welcome; apologies and confirmation of quorum
3	Minutes and Action Log
	ITEM 3.1 Audit Committee OPEN Minutes 7 June 2022 CT.doc
	ITEM 3.2 Action Log.docx
3.3	ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION
4	09:40 - Committee cycle of business
	ITEM 4 SBAR for AC on Cycles of Business - Sept 22.docx
	ITEM 4.1 Audit Committee Cycle of Business Template - v.0.1.xlsx
5	09:50 - Internal Audit reports
	5.1. Update Report *5.2. Fleet Maintenance* *5.3. Major Incidents*
	ITEM 5.1 WAST_2223_Internal Audit Progress Report_September 22.pdf
	ITEM 5.2 WAST_2223-005_Fleet Maintenance_Final Internal Audit Report_for Trust issue.pdf
	ITEM 5.3 WAST_2223_06_Major Incidents_Final Internal Audit Report_for Trust issue.pdf
6	10:20 - Audit Wales Reports
	ITEM 6.1 WAST Audit Committee update 092022.pdf
	ITEM 6.2 WAST Review of Quality Governance report (FINAL).pdf
	ITEM 6.3 Unscheduled Care Project Brief.pdf
7	10:40 - Update on Waste Management Actions following Limited review - Verbal update
8	10:50 - Risk Management and Board Assurance Framework
	ITEM 8 Executive Summary Risk Management Report AC 150922.docx
9	11:05 - Losses and Special Payments
	ITEM 9 Executive Summary SBAR Losses and Special Payments - AC 15 Sept 2022.docx
	ITEM 9.1 Annex 1 - Losses Special and Payments 2022-23 M1-5.pdf
10	11:20 - Audit Tracker
	Audit Tracker circulated separately by e mail
	ITEM 10 Executive Summary AC - Internal Audit Report 150922.docx
11	11:30 - Covid-19 Public Inquiry Update
	ITEM 11 AC SBAR 150922 Covid-19 Inquiry Update.docx
12	11:40 - Report from Quality, Patient Experience and Safety Committee re clinical audit
	ITEM 12 Quest Committee Highlight Report August 2022 to Audit Committee.docx
12.1	CONSENT ITEMS
13	11:45 - Committee Priorities Q2
	ITEM 13 Audit Committee Priorities September 22.docx
13.1	11:50 - CLOSING ITEMS
14	Key messages for Board
15	Any other business
16	Date and time of next meeting 1 December, 09:30

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services NHS Trust

AGENDA
MEETING OF THE AUDIT COMMITTEE
Held in public on 15 September 2022 from 09:30 to 11:55
Meeting held virtually via Microsoft Teams

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome; apologies and confirmation of quorum	Information	Martin Turner	Verbal	10 Mins
2.	Minutes of last meeting	Approval	Martin Turner	Paper	
3.	Action Log	Review	Martin Turner	Paper	
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
4.	Committee cycle of business	Approval	Trish Mills	Paper	10 Mins
5.	Internal Audit reports 5.1. Update Report 5.2. Fleet Maintenance 5.3. Major Incidents	Assurance	Osian Lloyd	Paper	30 Mins
6.	Audit Wales Reports 6.1. Update Report 6.2. Quality Governance Update 6.3. Unscheduled Care Update	Assurance Assurance	Fflur Jones Urvisha Perez/Jonathan Turnbull Ross	Paper Paper	20 Mins
7.	Update on Waste Management Actions following Limited review	Assurance	Chris Turley	Verbal	10 Mins
8.	Risk Management and Board Assurance Framework	Assurance	Trish Mills	Paper	15 Mins
9.	Losses and Special Payments – 1 April 2022 to 31 August 2022	Assurance	Chris Turley	Paper	15 Mins
10.	Audit Tracker	Assurance	Julie Boalch	Paper	10 Mins
11.	Covid-19 Public Inquiry Update	Assurance/Information	Trish Mills	Paper	10 Mins
12.	Report from Quality, Patient Experience and Safety Committee re clinical audit	Assurance	Trish Mills	Paper	5 Mins
CONSENT ITEMS					
13.	Committee Priorities Q2	Information	Trish Mills	Paper	5 Mins
CLOSING ITEMS					
14.	Key messages for Board	Information	Martin Turner	Verbal	5 Mins
15.	Any other business	Discussion	Martin Turner	Verbal	
16.	Date and time of next meeting 1 December, 09:30	Information	Martin Turner	Verbal	

Lead Presenters

Name of Lead	Position of Lead
Martin Turner	Non Executive Director
Chris Turley	Director of Finance and Corporate Resources

Osian Lloyd	Internal Audit
Julie Boalch	Head of Risk/Deputy Board Secretary
Trish Mills	Board Secretary
Fflur Jones	Audit Wales
Urvisha Perez	Audit Wales

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN MEETING OF THE AUDIT COMMITTEE OF THE WELSH AMBULANCE SERVICES NHS TRUST HELD ON TUESDAY 7 June 2022 VIA TEAMS

PRESENT :

Martin Turner	Non Executive Director and Chair
Joga Singh	Non Executive Director

IN ATTENDANCE :

Julie Boalch	Head of Risk and Deputy Board Secretary
Lee Brooks	Executive Director of Operations
Judith Bryce	Assistant Director of Operations
David Butler	Audit and Assurance NWSSP
Rhian Davies	Graduate Trainee HEIW
Simon Cookson	Internal Audit NWSSP
Jill Gill	Financial Accountant
Andy Haywood	Director of Digital Services
Estelle Hitchon	Associate Director of Strategic Transformation
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
Paul Seppman	Trade Union Partner
Chris Turley	Executive Director of Finance and Corporate Resources
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Mike Whitely	Audit Wales
Carl Window	Counter Fraud Manager

APOLOGIES:

Wendy Herbert	Interim Executive Director of Quality and Nursing
Paul Hollard	Non Executive Director
Ceri Jackson	Non Executive Director
Fflur Jones	Audit Wales
Damon Turner	Trade Union Partner

27/22 PROCEDURAL MATTERS

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

Declarations of Interest

No declarations of interest were recorded.

Minutes

The Minutes of the open session of the Audit Committee meeting held on 3 March 2022 were confirmed as a correct record subject to adding Paul Seppman to the apologies list.

Action Log

The Committee considered the action log: The one action, 14/22 – Amendment to the Committee's Terms of Reference (amend paragraph 4.6 to read: Chief Executive will be invited to attend annual) was completed and therefore marked as closed.

RESOLVED: That

(1) the Minutes of the meeting held on 3 March 2022 were confirmed as a correct record subject to the above.

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

28/22 ANNUAL ACCOUNTS 2021/22

The audited Annual Accounts for 2021/22 were considered and reviewed by the Committee. Chris Turley gave a PowerPoint presentation and drew Committee members attention to the following areas:

1. The draft accounts had been submitted to Audit Wales and Welsh Government (WG) on 29 April 2022; the Trust had a retained surplus of £0.260m which when adjusted to take into account a donated asset of £0.185m was £0.075m for performance reporting purposes.

2. Income for the year for Patient care activities was £262m, an increase of £29m from the previous year, with the vast majority coming from the Emergency Ambulance Services Committee - £186m. Other operating income was £15m which was an increase of £6m. The total increase in income from the previous year was £35m. In terms of expenditure this consisted of pay costs £192m, and non pay and other costs of £84m.

3. As in previous years, there was an additional 6.3% employers pension cost which equated to £7.8m.

4. .

5. In term of the continuing impact of Covid 19 on the Trust's finances, the funding and further comprehensive details of costs were contained within the report.

6. The Committee noted the uncorrected misstatement which was not material and has arisen due to a very late update received by WG from the District Valuer in March 2022, in relation to property indexation. Given the way this one has arisen, this will be the same across all NHS Wales organisations.

7. The Public Sector Payment Policy, in terms of paying invoices within 30 days had been met every month during the year.

8. The Capital in year spend had been delivered to WG against the Capital Expenditure Limit.

9. In terms of tangible fixed assets, the net book value (NBV) as at 1 April 2021 was £89m, taking into account adjustments throughout the year the NBV as at 31 March 2022 was £96m.

10. The cash and bank balances were broadly consistent with the previous year; creditors had increased by £7m and borrowings had decreased by £1m.

11. In terms of next steps, the accounts, following recommendation from the Committee with any minor amendments today would be presented to the Board on 13 June, with a deadline submission to WG by 15 June 2022.

Audit Wales, Audit of Accounts Report

The draft Audit Wales Audit of Accounts Report (ISA260) was presented by Mike Whitely who apprised the Committee of the following:

1. In respect of payroll testing, further information was still awaited; however no issues were anticipated.

2. With regards to the property, plant and equipment work there were a number of assets still recorded in the asset register with a nil NBV; work was ongoing to determine if these assets were still in use at year end. It was anticipated this work would be completed prior to circulation of the Trust Board agenda papers.

3. It was the intention of the Auditor General for Wales to issue an unqualified certificate and report on the 2021/22 financial statements, citing that they provided a true and fair view of the Trust's finances in the 2021/22 financial year.

4. Audit Wales commended the finance team for providing good quality accounts and working papers and for their timely responses to enquiries.

5. In terms of the unadjusted misstatement as referred to earlier the Committee were advised that further detail was outlined in the Letter of Representation; the reason for not being amended was carried out following the technical guidance from Welsh Government.

6. With regards to the summary of any corrections made, the Committee noted there was no overall impact on the Trust's financial position.

7. There was a recommendation linked to last year's ISA 260 whereby, due to the tagging system (RFID, Radio Frequency ID) not being live, it was an issue identifying the exact location and existence of some defibrillators which were not part of the main maintenance records. Once the tagging system goes live this will resolve the issue.

Comments:

The Committee endorsed the thanks expressed by Audit Wales and recommended the Annual Accounts for approval by the Trust Board at today's meeting, subject to changes, if any, being highlighted at that report.

RESOLVED:

The Committee, subject to there being no material changes to the accounts, and should there be any these will be clearly highlighted for the Board's attention, recommended that the Board approve the accounts

29/22 ANNUAL REPORT

Trish Mills outlined details of the report and drew Committee's attention to the following:

1. Comments from both Audit Wales and Welsh Government have been incorporated into the final Annual Report and were for the Committee to review and endorse.

2. The draft Annual Report was considered by the Executive Management Team on 27 April and circulated to the Audit Committee on 28th April. The Remuneration Committee reviewed the Remuneration Table on 21st April.

3. An Annual report and Accounts highlights document has been prepared into an easy read report for the public and stakeholders.

4. The Annual Report and 'foreword' section of the Financial Accounts was in the process of Welsh language translation, as was the Highlights document and they will be available for the Annual General Meeting on 14 July 2022. The full financial accounts have not been translated. This was due to the complexity of the document where translation of complex excel workbooks poses risk of errors and a significant workload from the finance and audit teams.

Comments:

1. Estelle Hitchon explained that the highlight report was slighter shorter than in previous years and contained several hyperlinks – it would be presented at the AGM along with a presentation.

2. In terms of the average days lost as indicated in the highlight report, Estelle Hitchon agreed to cross reference with the original document to ensure the correct figure was illustrated.

RESOLVED: That the 2021/22 Annual report was recommended for formal approval by the Trust Board

30/22 INTERNAL AUDIT REPORTS

Head of Internal Audit Annual Report and Opinion

Osian Lloyd outlined the report which set out the results of the work performed by internal audit during the year and audit performance. It gave an overall opinion for 2021/22, which was one of reasonable assurance. The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas were under review, were suitably designed and applied effectively. Some matters required management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved. The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed

Internal Audit Reviews

Osian Lloyd presented each of the internal audit reviews as follows:

1. **Risk management & assurance** – Reasonable Assurance; the purpose of the review was to provide assurance that the Trust had a robust risk management and assurance framework in place. It was noted that the corporate arrangements for risk management were firmly embedded and the Trust had identified key priorities within risk management. The Trust was embarking on an ambitious improvement plan linked to its Integrated Medium Term Plan. It was noted that the Board Assurance Framework (BAF) had been assigned a limited assurance; the BAF has been paused to allow for a transitional BAF to develop, and this had already been approved by the Committee. In terms of the findings there was one high priority finding which related to the inconsistencies in the review and management of risks within the operations directorate. There were 2 medium findings which related to arrangements to support the completeness of registers and the other finding was around risk management training and guidance. The findings have been accepted and the Committee noted the ongoing work.

2. **Network and Information Systems (NIS) Directive** – Reasonable assurance, the purpose of the review was to look at the implementation of the directive including the cyber assessment framework improvement plan an overarching governance. There were 3 medium priority findings which related to no retention of supporting information, an improvement action plan was yet to be developed and there was insufficient oversight of security matters by appropriate governance committees. Management have accepted the findings

   Andy Haywood explained this was the first organisation in NHS Wales to carry out this particular audit, the risk has been elevated to the Corporate Riske Register. The Trust continued to work on the Key Performance Indicators and all recommendations were accepted by management.

3. **Respiratory protective equipment** – Reasonable assurance, the purpose of this review was to ensure there was adequate arrangements in place for the provision of such equipment. There was 1 high priority finding and this related to gaps identified

in local records for fit testing and device maintenance. Internal Audit were content with the response from management. Jonathan Turnbull-Ross confirmed that the high priority recommendation had been completed.

4. **Service reconfiguration** – Reasonable assurance, the purpose of the review was to provide assurance that the relationship between the Trust and Commissioner was effective in ensuring expected operational outcomes in its support of health board service changes. The audit focused on the sharing of information and engagement around the Grange University Hospital (GUH) inter-site transport service. There were 4 medium priority findings; it had taken time to finalise and agree the full commission agreement, limited evidence that performance of the inter-site transport activity received sufficient management oversight, GUH inter-site transport journeys should be subjected to spot checks for quality and scrutiny review and the collaborative GUH project meeting documentation should be improved. The response to the recommendations and actions had been accepted by management.

5. David Butler presented the **Waste Management Audit report** - Limited Assurance, the purpose of the review was to assess the Trust's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets. This includes both domestic and clinical waste. There were several issues which gave rise to 5 high priority findings and 2 medium priority findings. Whilst the review found that operational waste management gave rise to substantial assurance, the 5 high priority findings concerned improvements to waste process documentation, there should be an executive lead assigned to clinical waste related matters, arrangements for the transfer of clinical waste required review, and other improvements in overall documentation of waste related matters.

   Chris Turley commented that waste management was a collective responsibility, he provided additional assurance that the Trust had also completed a significantly detailed action plan which supported delivery of the recommendations. The management response was being considered across all directorates and will feed into the Audit Tracker. He added that an update on actions completed would be provided at the September Audit Committee meeting.

   Comments:

   In terms of non-compliance will this lead to any financial penalties? Chris Turley explained that, given the level and type of non-compliance highlighted within this review, the risk of fines were low and should not therefore be of significant financial concern.

6. **Follow up review – Final Internal Audit review –** The purpose of this follow up review was to assess whether the Trust had implemented the internal audit recommendations in relation to: Job evaluation process, fire safety and ICT disaster recovery. A sample of 10 findings were focussed on and the review resulted in a substantial overall rating highlighting that the Trust had effective arrangements in place to track progress in relation to audit and review findings.

7. **Organisational culture – a learning organisation**. This was an advisory review which resulted in a positive report and reflected learning activities in a number of areas. There were several recommendations to strengthen and improve

organisational learning including the recording and progress on staff/patient stories.

Comments:

1. In response to a query, Chris Turley explained that all audit reports were presented at EMT as required.

2. In terms of staff/patient stories it would be useful to document any feedback and messaging that any lessons learned were being implemented

RESOLVED: That the updates were noted.

31/22 AUDIT WALES REPORTS

Mike Whitely updated the Committee on the following:

Audit Wales Update Report

The main highlight to report was that the Charitable Funds Committee had requested a full audit of the Charitable funds accounts from 2021/22. The findings from this will be reported to the next Audit Committee meeting. Other areas to report on included details around the performance audit update, planned work not yet commenced and NHS related national studies.

Emergency Services Collaborative Report

The key areas to note from this report were;

a) The recommendations in the report were for the attention of the Joint Emergency Service Group to respond to.
b) In terms of the future planned work consultation, the Trust's main observation was to receive a follow up report going forward.
c) A self-assessment checklist was included in the report and this had been designed for the strategic collaboration board's attention.
d) The Board will also consider this report at future Board Development Day.

Audit Wales Audit Plan 2022

This had previously been circulated to the Committee following the March Audit Committee meeting. The main issue was the risk in connection with the audit of financial statements; however this had mainly been completed. There were no other risks for the Committee's attention. Other areas of planned work included the structured assessment and the all Wales thematic work. In terms of fees, it was noted this had increased from the previous year.

Comments:

1. In terms of the unscheduled care work the Committee recognised this was a national audit, promulgation of the review was not yet confirmed; an update would be provided at the September Committee meeting.

2. Data sharing, will the upgrades from the Trust be compatible with other health

boards and emergency services? Andy Haywood explained that for example, the replacement of the airwave radio was national and will be interoperable with other blue light services. Further details regarding this and the implications and governance around data sharing was due for discussion at the next Board Development Day.

RESOLVED: That the Committee noted the update:

32/22 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

1. Trish Mills explained that the purpose of the report was to provide an update to the Audit Committee in respect of activity relating to the Trust's Corporate Risks.

2. A review of each Corporate Risk score has been undertaken by mapping each control to related assurances and by identifying any gaps in these as well as any actions that can be taken to further mitigate the risk. As a result of this, 3 scores had increased in score: Risk 160 (High absence rates impacting on patient safety, staff wellbeing and the Trust's ability to provide a safe and effective service), Risk 201, (Damage to Trust reputation following a loss of stakeholder confidence) and Risk 245 (Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations).

3. The Committee were reminded that reporting on the Board Assurance Framework (BAF) had been paused to enable for a transitional BAF to be developed. It was noted that risk reporting continued at Board Committees.

4. The two highest risks with a score of 25 still remain to be 223 (The Trust's inability to reach patients in the community causing patient harm and death) and 224 (Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service)

5. The Committee recognised the significant amount of work being undertaken in developing the BAF and thanked the team for their efforts.

6. A new Risk Matrix, which was being used on all Wales basis had been adopted, and was recommended for approval by the Committee. Trish Mills gave further details of the contents of the matrix; aligned to this was a reporting timetable.

7. Members were updated on the risk transformation programme project plan which would be reported through the Strategic Transformation Board and included as part of the Integrated Medium Term Plan (IMTP) deliverables.

8. The Committee also noted that the risk management and assurance internal report was given a reasonable assurance and thanks were recorded for the internal audit team for their support in the transition to the new reporting system.

Comments:

1. Members welcomed the new reporting system which provided for more relevant information in terms of the result of the risk.

2. Does the Trust benchmark against other ambulance services in terms of the risk scoring matrix, Trish Mills explained that ambulance services followed something similar; and was more around the consequence and likelihood. Furthermore, as the Trust developed its policies and procedures it would also follow best practice and adopt the all Wales approach.

3. Does the Trust share risks with other heath boards on a regular basis? Trish Mills explained that risks on patient harm were shared. Julie Boalch added that the reporting of risks was being standardised as part of the maturity journey going forward.

4. The Committee discussed in detail how the high risk issues, score of 20 and above should be part of routine reporting to the Board. It was suggested that going forward a clear plan and understanding in terms of what the Trust was doing to mitigate the higher scoring risks; perhaps in a closed Board meeting.

5. Clarity was sought on the Executive ownership of risks. Trish Mills explained the new Transformational BAF would be updated to include accountability by each Committee meeting.

6. Trish Mills added that the Risk Transformation Programme project plan report outlined the high level headlines.

RESOLVED: That Members considered and discussed the contents of the report and:

- **a. Received the improved Board Assurance Framework;**
- **b. Approved the adoption of the new nationally agreed Risk Matrix including scoring levels, review schedules and risk descriptors;**
- **c. Noted the Risk Transformation Programme project plan and reporting arrangements; and**
- **d. Agreed the 2022/23 Risk reporting timetable.**

33/22 AUDIT TRACKER

1. Julie Boalch informed the Committee there were a total of 89 current internal audit recommendations on the tracker. There were 6 high priority recommendations currently showing as overdue. They had all been reviewed internally and by EMT prior to the meeting, with the majority due for completion in July.

2. 27 recommendations had been added to the tracker resulting from 5 Internal Audit Reports which were presented to the Audit Committee in March 2022.

3. There were 3 recommendations showing as overdue from 19/20 reports, all of which were of medium priority. One related to the Trust's Risk Appetite Statement from the Risk Management and Assurance review which formed part of the Risk Transformation programme currently underway. This will not be completed until approximately June 2023.

RESOLVED: That the

1. **Members received and discussed the contents of the report and:**
   - **a) Noted the audit activity since the last Audit Committee in March 2022.**

b) Considered the proposals to address each recommendation particularly those that have been further extended beyond agreed deadlines.

34/22 LOSSES AND SPECIAL PAYMENTS – PAYMENTS FOR THE PERIOD 1ST APRIL 2021 TO 31ST MARCH 2022 & 1ST APRIL 2022 TO 30TH APRIL 2022

1. Chris Turley explained that the report updated the Committee of Losses and Special Payments made during the twelve months from 1st April 2021 to 31st March 2022 and one month to 30 April 2022.

2. The total net Losses and Special Payments made during the period 1st April 2021 to 31st March 2022 amounted to £1.849 million and the one month to 30th April 2022 amounted to £0.109m

RESOLVED: That the Committee noted the contents of this report

35/22 KEY MESSAGES FOR BOARD

Trish Mills would draft this report for the Chair's consideration.

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

36/22 ANY OTHER BUSINESS

Date of Next Meeting: 15 September 2022

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
31/22	7 June 2022	Audit Wales reports	Update on national unscheduled care report	Audit Wales	15 September 2022	On Agenda, Item 6	Complete

AGENDA ITEM No	**4**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	1

COMMITTEE CYCLES OF BUSINESS

MEETING	Audit Committee
DATE	15 September 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. Development of the cycle of business for this committee is the final step in the 2021/22 effectiveness reviews that were conducted in Q4.

2. The cycle has been developed with direct correlation to the duties in the terms of reference. The cycle for the Committee is a maturing document which will grow organically over the next 12 months.

RECOMMENDATION:

3. The Committee is asked to review the cycle of business, propose any amendments, and approve it as a first version.

KEY ISSUES/IMPLICATIONS

4. There are some areas of the cycle which remain to be developed, including the whistleblowing process, declaration of interests, gifts and hospitality register, and the policy report.

REPORT APPROVAL ROUTE

N/A

REPORT APPENDICIES

Annex 1 – Cycle of business 2022/23

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

CYCLES OF BUSINESS

SITUATION

1. The purpose of this paper is to provide the Committee with a draft cycle of business as the final step in the 2021/22 effectiveness review process.

2. Cycles of business for each Committee will be taken through their meetings in September, October and November. The People and Culture Committee approved their cycle on 5 September.

BACKGROUND

3. The Committees carried out effectiveness reviews in Quarters 4 2021/22. This included a review of terms of reference, amendments to which were approved by the Trust Board in May 2022.

4. The final step in the effectiveness review process is the development a cycle of business for each Committee and a review of its sub-committee structure.

ASSESSMENT

Cycle of Business

5. A cycle of business provides order and structure and sets a Committee work plan for the year. This, together with the Board Assurance Framework, should drive agenda setting. It also:

    a. allows papers to be planned in advance, giving Directors and report writers the opportunity to plan necessary pre-committee forums and align cycles of business;

    b. schedules compliance related reports according to legislative or regulatory timeframes;

    c. provides focus for reporting and an opportunity to see where there may be duplication, gaps, and interrelationships;

    d. generates commitment to review matters that may sometimes be vulnerable to postponement;

    e. allows for easy tracking of the Committee's adherence to the cycle which is a marker of an effective Committee;

    f. provides for a collective awareness and agreement of the areas where it applies its focus on an annual basis; and

    g. removes the ad hoc elements of agenda setting.

6. Whilst it is inevitable that other items will arise from time to time, the cycle allows them to be prioritised - perhaps coming later on the agenda.

7. The cycle of business at **Annex 1** has been designed to do all the above. It includes further detail on any pre-committee forums, lead presenters, purpose of reports and any relevant and/or helpful commentary.

8. The cycle has been developed to align with the duties for the Committee set out in the terms of reference. Of note, paragraph 3.5 of the terms of reference requires the Committee's programme of work to be designed to provide assurance that:

    a. there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

    b. there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee and ensure all reported fraud concerns and ongoing investigations are notified to the Committee;

    c. there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees;

    d. the work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

    e. the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

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

    g. the results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations' governance arrangements;

    h. progress is monitored against the requirement of the Auditors' Management Letter;

i. the Committee receives and reviews 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; and

j. the Committee reviews the content of the Corporate Risk Register and obtain assurance that control measures are in place to mitigate all identified risks.

9. The cycle for the Committee is a maturing document which will grow organically over the next 12 months. The areas which remain to be developed include:

a. The whistleblowing process: Staff can currently raise concerns through the traditional routes of line management and escalation set out in the All Wales Procedure for Raising Concerns, and through the sensitive issues function in Datix. A new framework is in development and the Raising Concerns Task and Finish Group is charged with this work. An update was provided to the People and Culture Committee on 5 September and regular progress reports will be provided to that Committee. Terms of reference and a work plan has been agreed.

b. The declaration of interests, gifts and hospitality report: This is being developed along with the new policy framework. This area is subject to an internal audit currently, with that report coming to the December Committee meeting. The Committee receives the annual report which details the declarations of interest of Board members.

c. Policy report: Each Committee has included in their cycles of business a report on the policies in their remit and their currency. An overarching report is being developed for this Committee's oversight.

10. No sub-committees have been mapped to the Audit Committee and it is not recommended that any should be formed at this time. The terms of reference provide that the Committee can form sub-committees or task and finish groups should a need arise in the future.

RECOMMENDATION

11. The Committee is asked to review the cycles of business, propose any amendments, and approve it as a first version.

PAPER	PRE C'EE FORUM	FREQUENCY	Q1	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
AUDIT COMMITTEE - CYCLE OF BUSINESS 2022/23									
									Cycled for each meeting / Ad hoc; not regularly cycled; prompt for agenda setting
Annual filings									
Annual accounts planning and emerging issues report	EMT	Annually				■	EDOF	Assurance	
Annual report timetable	EMT	Annually				■	BS	Assurance	
Audited accounts	EMT	Annually	■				EDOF	Endorsement	
Annual report	EMT	Annually	■				BS	Endorsement	
Annual quality statement	QUEST	Annually	■				EDQN	Endorsement	TOR 3.2(a) review… Annual Quality Statement
Head of internal audit report and opinion	N/A	Annually	■				Internal Audit	Assurance	
Audit report on accounts	N/A	Annually	■				Audit Wales	Assurance	Report specific to WAST
Internal Audit									
Audit Plan	N/A	Annually				■	Internal Audit	Approval	
Internal audit reports	N/A	Quarterly	■	■	■	■	Internal Audit	Assurance	Relevant directors to be in attendance for limited assurance reviews
Audit Wales									
Audit Plan	N/A	Annually				■	Audit Wales	Review	SFI 3.4.1 AC must ensure cost efficient external audit service is delivered; SFI 3.4.3 AC to review plan and associated costs
Update report	N/A	As required					Audit Wales	Assurance	
Annual Audit Report	N/A	Annually				■	Audit Wales	Assurance	Audit report for calendar year
Structured Assessment	N/A	Annually			■		Audit Wales	Assurance	May also be presented at other times depending upon audit plan
Losses & Special Payments/Single Tender Waivers									
Quarterly lossess and special payments report	TBC	Quarterly	■	■	■	■	EDOF	Approval	SFI 17.2.9 AC shall approve the writing off of losses or the making of special payments within delgated limits
Tender update report and single tender waiver request	TBC	Quarterly	■	■	■	■	EDOF	Assurance	Closed session
Counter fraud									
Counter fraud update report	N/A	Quarterly	■	■	■	■	EDOF	Assurance	Closed session
Standing Orders & Standing Financial Instructions									
Standing Orders & Standing Financial Instructions	EMT	Ad Hoc					BS	Endorsement	Amendments to standing order, standing financial instructions, scheme of reservation and delegation and associated schedules
Breach of Standing Orders & Standing Fin. Instructions	EMT	Ad Hoc					BS	Discussion/Assurance	
Whistleblower, Declarations, Gifts & Hospitality									
Annual report on declarations of interest	EMT	Annually	■				BS	Assurance	Audit committee to provide report to Board on adequacy of arrangements for DOI annually
Report on gifts and hospitality	EMT	Annually	■				BS	Assurance	
Whistleblower report	TBC	TBC			■		BS	TBC	TORs 3.1(i) AC will comment on anti-fraud policies, whistle-blowing processes and arrangements for special investigations.
Policy									
Policy report	EMT	Annually				■	BS	Approval	Position on policies including those outstanding for review etc.
Policies	Policy Group	Ad Hoc					BS	Approval	Policies within the purview of this Committee in particular standards of business conduct, and risk management, and patient property
Financial procedures	TBC	Ad Hoc					EDOF	Approval	SFI 1.1.3 all financial procedures must be approved by the EDOF and Audit Committee
Risk Management									
Board Assurance Framework	EMT	Each meeting	■	■	■	■	BS	Assurance	
Corporate Risk Register - People	EMT	Each meeting	■	■	■	■	BS	Assurance	
Audit Recommendation Tracker	EMT	Each meeting	■	■	■	■	BS	Assurance	
GOVERNANCE									
Escalations from Board Committees	Board Committee	Ad Hoc					Committee Chair	Various	
Board Committee annual reports	All Committees	Annually	■				Board Sec.	Approval	May require an additional single item meeting for AC in April 2023 to enable full committee reports to go to Board in May
Audit Committee effectiveness review annual report	Audit/Board	Annually	■				Board Sec.	Approval	
Audit Committee Review of Terms of Reference	Audit/Board	Annually				■	Board Sec.	Approval	
Audit Committee Cycle of Business annual refresh	Audit/Board	Annually	■				Board Sec.	Approval	
Audit Committee Review of Annual Priorities	None	Quarterly	■	■	■	■	Chair	Review	
Governance Practice Notes	EMT	Annually as due					BS	Review/Approve	
PROMPTS									
External Reports	n/a	As required					TBC	TBC	

EDOF - Executive Director of Finance and Corporate Resources
EQDN - Executive Director of Quality and Nursing
BS - Board Secretary

Whistleblowing	Staff can currently raise concerns through the traditional routes of line management and escalation set out in the All Wales Procedure for Raising Concerns, and through the sensitive issues function in Datix. A new framework is in development and the Raising Concerns Task and Finish Group is charged with this work. An update was provided to the People and Culture Committee on 5 September and regular progress reports will be provided to that Committee. Terms of reference and a work plan has been agreed
Declarations of interest, gifts and hospitality register	This is being developed along with the new policy framework. This area is subject to an internal audit currently, with that report coming to the December Committee meeting. The Committee receives the annual report which details the declarations of interest of Board members.
Policy report	Each Committee has included in their cycles of business a report on the policies in their remit and their currency. An overarching report is being developed for this Committee's oversight.
Committee annual reports	Timing to be reviewed when setting 23/24 committee dates to ensure alignment with committee effectiveness reviews

Internal Audit Progress Report

Audit Committee

September 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

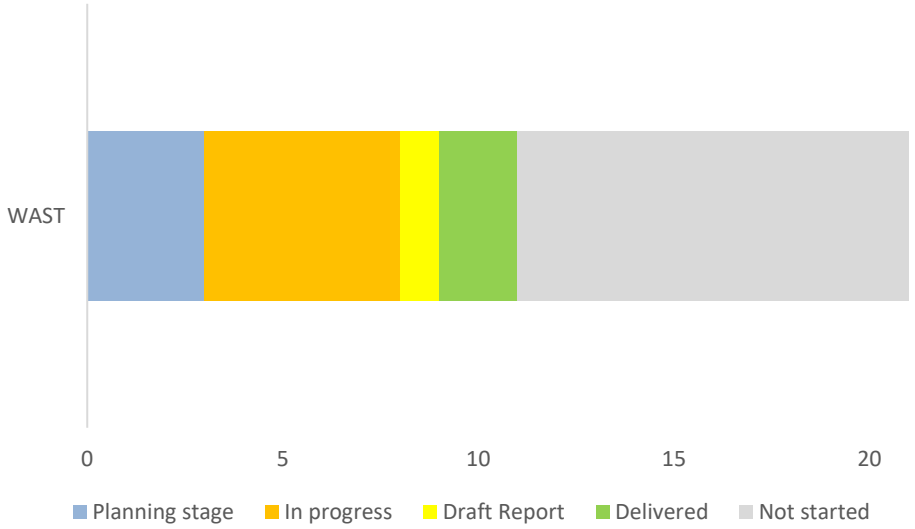
1. Introduction

The purpose of this report is to:

- highlight progress of the 2022/23 Internal Audit Plan to the Audit Committee; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2022/23 Internal Audit Plan

There are 21 reviews in the 2022/23 Internal Audit Plan, and overall progress is shown below.



Detailed progress in respect of each of the reviews in the 2022/23 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 Decarbonisation from quarter 1 to quarter 3, to allow time to review the governance and reporting arrangements currently being put in place.

4. 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.

5. Key Performance Indicators

Correct on 31 August 2022

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2022/23		March	By 30 June
Audits reported over planned		3	4
Work in progress		5	
Report turnaround: time from fieldwork completion to draft reporting [10 days]		3 out of 3	80%
Report turnaround: time taken for management response to draft report [15 days]		1 out of 2	80%
Report turnaround: time from management response to issue of final report [10 days]		2 out of 2	80%

Key:

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

6. Recommendation

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

Appendix A: Progress against 2022/23 Internal Audit Plan

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Risk management and assurance	Not started			June 2023
Health and safety (Deferred from 2021/22)	Not started			June 2023
Infection prevention and control	Planning			December 2022
Savings and efficiencies (Deferred from 2021/22)	Not started			March 2023
Fleet maintenance	Final report	Reasonable	Inconsistencies between the Fleetwave and Oracle authorised signatory lists; Appropriate procurement of suppliers and review of supplier lists; Estimates should be included on job cards and raised before work is undertaken; Lack of formal performance monitoring of suppliers and inhouse workshops; and Undertaking risk-based spot checks on work completed.	September 2022
Major incidents	Final report	Reasonable	Committee oversight of the Incident Response Plan; Exercising is at a low frequency, weighted towards the South East territory, and reliant on multi agency partners; There is a clear process for capturing and monitoring lessons from incidents, but lessons from exercising are not routinely noted; Arrangements to share plans have been outlined, but we noted instances where action cards required updating; Gaps identified in Commander CPD records.	September 2022
Hazardous Area Response Team (HART)	In progress			December 2022
Immediate release requests	In progress			December 2022
Trade union release	Planning			December 2022

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
time				
Attendance management	In progress			December 2022
Clinical handover	Not started			March 2023
Pain management	Not started			March 2023
Strategy development	Not started			June 2023
IMTP delivery	Not started			March 2023
Cyber security	Not started			March 2023
IM&T infrastructure	Not started			June 2023
Data analysis	In progress			December 2022
Standards of business conduct: Declarations	In progress			December 2022
Recommendations tracker	Not started			June 2023
Capital & Estates				
Decarbonisation	Planning			March 2023
Electronic Patient Clinical Record	Draft report	Reasonable		December 2022

[1] May be subject to change

Fleet Maintenance
Final Internal Audit Report

September 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

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Review reference:	WAST-2223-005
Report status:	Final
Fieldwork commencement:	22 June 2022
Fieldwork completion:	18 August 2022
Draft report issued:	24 August 2022 and 26 August 2022
Debrief meeting:	24 August 2022
Management response received:	8 September 2022
Final report issued:	9 September 2022
Auditors:	Osian Lloyd, Head of Internal Audit Johanna Butt, Principal Auditor
Executive sign-off:	Chris Turley, Director of Finance and Corporate Resources
Distribution:	David Holmes, Fleet Manager Andrew Jones, Regional Fleet Manager (North)
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

The review assessed the application of the fleet management system and its impact in improving the coordination of fleet maintenance and cost control.

Overview

We have issued **Reasonable** assurance on this area.

The matters requiring management attention include:

- Inconsistencies between the Fleetwave and Oracle authorised signatory lists;
- Appropriate procurement of suppliers and review of supplier lists;
- Estimates should be included on job cards and raised before work is undertaken;
- Lack of formal monitoring of supplier performance; and
- Undertaking risk based spot checks on work undertaken.

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

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 – first audit in this area

Assurance summary[1]

Assurance objectives		Assurance
1	Fleet maintenance strategy / plan	Reasonable
2	Fleet maintenance effectively planned	Reasonable
3	Contracts in place	Limited
4	Monitoring of fleet maintenance delivery	Reasonable
5	Governance and oversight	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
MA2	Authorised signatory lists	2	Design	High
MA3	Approved suppliers and standing data	3	Operation	High
MA4	Retrospective job cards and estimates	2	Operation	Medium
MA5	Performance monitoring of external suppliers and in-house workshops	4	Design	Medium
MA6	Spot checks	4	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 Current arrangements for the provision of fleet maintenance within Welsh Ambulance Services NHS Trust ('the Trust') includes a combination of an 'in-house' service and a variety of outsourced arrangements. There is an ambition to provide all vehicle maintenance 'in house' and fully embed a robust planned preventative maintenance system on a time-based servicing basis.

1.2 Fleet Management software allows a fleet manager to access relevant information on the performance of their fleet. In effect, it is a database with numerous applications that enables the recording and reporting of the key attributes that can help improve efficiencies and drive down costs. The Trust purchased a new Fleet Management System called Fleetwave II ('Fleetwave' or 'Chevin'). Fleetwave is a bespoke software package designed specifically for the Trust and went live on 1 April 2018.

1.3 The potential risks considered in this review were:

- Current model for delivery of fleet maintenance may not provide value-for-money; and
- Failure to comply with legislation with vehicles not fit for purpose, leading to patients and staff coming to harm.

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	1	1	1	3
Operating Effectiveness	1	2	-	3
Total	2	3	1	6

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

Audit objective 1: There is a strategy / plan in place to embed a robust system to coordinate and manage fleet maintenance, including clear guidance and procedures with roles and responsibilities clearly defined.

2.3 The Trust has a 10 year Fleet Strategic Outline Programme (SOP) in place which has been endorsed by the Welsh Government. The purpose of the Fleet SOP is to detail the vision for the Trust's fleet over a ten-year period commencing from 2018. It describes the proposed future fleet configuration and the approach to

vehicle replacement, together with the strategic approach to the development of integrated, co-ordinated and consistent fleet maintenance and make ready approach across Wales.

2.4 Section 6.5.5 of the Trust's Integrated Medium Term Plan (IMTP) 2019-22 refers to the infrastructure of the fleet. It details how the Fleet SOP articulates the Trust's vision to for the delivery of fleet services up until 2028/29 and focuses on the three key work streams. Under fleet maintenance it details the ambition to provide all vehicle maintenance 'in house', and fully embed a robust Planned Preventative Maintenance (PPM) system on a time-based servicing regime. It also details the key initiatives that will be delivered over the next three years to support implementation of the SOP. These include, but are not limited to, delivering a fleet apprenticeship scheme, purchasing a new combined fleet workshop in the South East to replace Blackwood and Blackweir, piloting a dedicated fleet desk in the South East and develop a plan to progress development of 'in house' maintenance provision across Mid and West Wales (Central and West).

2.5 There is no specific policy in respect Fleet Maintenance. However, there are detailed procedure notes in place for using the Chevin / Fleetwave system, which are available to all staff who use the system. These include procedures on updating standing data, entering defects onto the system, managing job cards, raising purchase orders (POs), uploading the ATS invoice, invoice matching, approval and payment and how to upload onto Oracle. The majority of these were last reviewed in 2018, but the guide for suppliers was updated in 2019 and the defects guide was updated in 2020. In addition, each member of staff has a job description which defines their roles and responsibilities.

2.6 The Trust has four in-house workshops for fleet maintenance, based in Cardiff (Blackweir), Blackwood, Bangor and Wrexham. These undertake the PPM for all vehicles based in South East and North Wales. PPM for vehicles based in Central and West Wales are outsourced to external providers, due to the absence of an in-house workshop servicing the region. At the time of our audit, the Chevin system showed that there are 170 vehicles assigned to the North region, 318 vehicles in the South East region and 318 vehicles in the Central and West region. These include both emergency vehicles, mainly emergency ambulances (EAs) and rapid response vehicles (RRVs), and non-emergency vehicles, mainly the non-emergency patient transport service (NEPTS).

2.7 Key dates for PPM, such as for servicing, MOT and tail-lifts, are included as standing data for each vehicle on the system. This dictates the coordination and management of this type of fleet maintenance.

Conclusion:

2.8 The Fleet SOP is the Trust's fleet strategy and this is referenced in all corporate documents, including the Trust's IMTP. The Trust's IMTP details the initiatives that will contribute to delivery of the Fleet SOP. The Trust has produced Chevin procedure notes, though the majority of these were last reviewed in 2018 and

may need to be updated to reflect the findings of this review. Noting this, we have assessed this objective as **reasonable** assurance.

Audit objective 2: Planned and routine maintenance of the Trust's fleet is effectively planned and scheduled, with appropriate arrangements in place for the provision of any unplanned maintenance.

2.9 The Trust's fleet is serviced on a time-based regime. Broadly all 'blue light' vehicles, mainly EAs and RRVs, are serviced on a six week cycle, with all other vehicles, including the NEPTS vehicles, serviced on a 12 week cycle. Servicing of Hazardous Area response Team (HART) vehicles can either be every six or 12 weeks, at the discretion of the manager. As such, the Trust's vehicles are serviced more regularly than the manufacturers standard mileage service.

2.10 The Chevin / Fleetwave system is used as the Trust's database of all vehicles. Our audit does not include verification work to confirm completeness of that list. For each vehicle listed, the database details the service interval (either six or 12 weeks), MOT date (annual) and, where relevant, the tail lift expiry date (every six months). The system includes reminders, which are RAG (red, amber, green) rated, as each vehicle is approaching any of these deadlines. Whilst the Trust can implement discretion as to when a service is undertaken, there is no discretion for MOTs or the servicing of tail lifts. Where an MOT or tail lift service falls close to the date of a service, there is discretion to delay or bring forward the service of the vehicle to minimise disruption from taking the vehicle out of operation.

2.11 For planned maintenance the vehicle is taken to the appropriate garage according to its maintenance schedule. The contractor calls the Fleet department for a job number. Fleet Administrators raise a job in Fleetwave. Fleetwave prompts the user to check that the job hasn't already been raised by identifying existing open jobs related to that vehicle. The job card number is provided to the contractor.

2.12 For unplanned maintenance the driver logs the defect with the Control Room. The Control Room input the defect to LaunchPad and inform the on call member of the Fleet Department who raise the job on Fleetwave. Fleetwave prompts the user to check this job has not already been raised by identifying existing open jobs related to the vehicle. The on-call member notifies the contractor by phone of the work required and job number. The technical assistants will review and challenge any work and there is constant dialogue between the technical assistants, authorisers and external contractors. Where necessary, the '*Comments*', '*WAST Notes*' or '*Supplier Notes*' section of the job card is used to provide narrative notes.

2.13 For both planned and unplanned maintenance, the contractor logs the completed work onto Fleetwave and uploads a copy of the invoice which is submitted to the Fleet Department for approval. Jobs awaiting authorisation are checked to ensure the work was undertaken as required and agrees to the invoice and no extra work was undertaken without authorisation. Review of job cards confirms that, where applicable, the e-mail trail has been attached showing pre-approval from the Trust for the work carried out within the invoice.

2.14 We reviewed the Chevin vehicle database and found that, for every vehicle listed, the vehicle service interval, the MOT expiry date and where appropriate a tail lift expiry had been entered, which facilitates the PPM for all vehicles. In the North and South East regions, weekly e-mails are sent to in-house workshops which detail the vehicles approaching key maintenance deadlines. This information is used to plan workshop maintenance for the following week. In Central and West region, this is managed by the external supplier who has access to the Chevin system. However, the Fleet Department do not currently run reports to capture when these dates have been breached.

2.15 We selected a sample of 30 vehicles to confirm that they had received the minimum servicing (we did not include MOTs and tail lift servicing given these are legal requirements). This included vehicles across all regions, including both emergency and non-emergency vehicles and services undertaken in-house and externally. We found five vehicles where the minimum number of services had not been carried out: four vehicles had missed one service and one vehicle had missed two services. Explanations had been received for two of these, in that the vehicles had been involved in accidents and had been in the garage for an extended period. The other three instances related to Central and West vehicles where the planned preventative servicing has been outsourced. The reason for the missed service intervals was that multiple vehicles were due for service at same time, which would have had a detrimental impact on the availability of the fleet in that area. This as an achievement given it was during the pandemic, when the Trust was reliant on military staff support and external garages were also impacted. See **MA1 in Appendix A**.

2.16 We selected a sample of 29 job cards for the 15 month period from 1 April 2021 to the end of June 2022. Our sample of job cards again included all regions, in-house and external, planned and unplanned work on both emergency and non-emergency vehicles. Supplier invoices had been received for all job cards raised and these referenced the Chevin job card number.

2.17 Ten of the job cards selected related to servicing. There was evidence of the servicing checklist being completed in all instances. For external suppliers this included the completion of the '*WAST Vehicle Inspection Safety Record'* sheet.

2.18 In-house jobs do not require authorisation. This is due to the majority of in-house work undertaken relates to PPM only. As such, the job card is raised and planned work undertaken and completed on the same day. This was evident from the timeliness of maintenance work undertaken by the in-house workshops included in our sample.

2.19 All job cards had been authorised within the users authorisation limits on Chevin. However, we compared the user authorisation limits for the Fleet Department between the Chevin and Oracle systems and found inconsistencies. We noted some individuals have a higher authorisation limit on Chevin than on Oracle. Additionally, our sample testing identified 14 exceptions: 11 job cards had been authorised by individuals who were requisitioners only on Oracle; two individuals who were not listed on the Oracle hierarchy had authorised job cards with a value

of £2,792.12 and £510.34; and one job card for £12,928.12 was authorised by an individual with an Oracle authorisation limit of £10,000. We also noted that seven job cards had been raised by individuals not included as requisitioners on Oracle. See **MA2 in Appendix A**.

2.20 The Trust works to the NHS Wales agreed 'No PO No Pay' policy. POs are raised after the invoice is received on Chevin before uploading the file to Oracle. The job card is raised on Chevin before the supplier commences work, as such this is the equivalent of the Oracle PO. From our testing we identified four instances of retrospective job cards (which should only occur out of hours), i.e. job cards that were raised after the invoice date. We understand that where there was a 44 day delay to raising the job card, the Trust was aware of this and confirmed it is an anomaly. See **MA4 in Appendix A**.

2.21 The estimated cost had not been completed for 19 of the 29 job cards in our testing sample. We would expect estimates to be made with reference to similar jobs captured on the system and to agreed rates within contracts. We understand that e-mail trails are retained to demonstrate authorisation, and review of job cards confirms that narrative is attached. The absence of these limits the effectiveness when reviewing the appropriateness of invoices and to act as a useful reference point for similar jobs in the future, as well as to compare work being undertaken inhouse and externally. We acknowledge that for unplanned work it is not always feasible to enter an estimate before the diagnostic has been completed by the garage, however the estimate could be recorded once this has been agreed. Of those that included estimates, differences between the estimate and the amount invoiced were noted. **See MA4 in Appendix A.**

Conclusion:

2.22 Key dates are entered against all vehicles on Chevin which facilitates planning and scheduling of PPM, with notifications raised when key dates are approaching. However, we have identified some room for improvement around job cards estimates and inconsistencies between Chevin and Oracle authorisation limits. Noting this, we have assessed this objective as **reasonable** assurance.

Audit objective 3: Contracts are in place with private providers, with agreed rates, and only approved providers are used.

2.23 The Trust's Fleet department works with NHS Wales Shared Services Partnership (NWSSP) Procurement services before entering into contracts with suppliers. There is an approved list of suppliers which is maintained by NWSSP Procurement services. The listing did not include further detail on the specific services they relate to, contract terms, value, length etc. It is worth noting that as detailed on the Procurement Policy, where expenditure is below £5,000 then the only requirement is that there should be evidence of value for money; between £5,000 and less than £25,000 - there should be evidence of three quotations and a simple form of contract; and over £25,001 to the prevailing OJEU threshold - there should be openly advertised call for competition and a formal contract in place.

2.24 The job card report for the 15 month period confirmed that there were a total of 24,414 job cards during the period with £8,792,137 total gross cost. 7,637 (31%) of these job cards were in-house with a total gross cost of £2,113,225.16 (24%). The remainder related to external suppliers. For external suppliers:

Threshold	Total Gross	Total job cards
Less than £5k	£43,293.44	348
Between £5k and £25k	£178,609.85	685
Over £25k	£6,457,008.55	15,744

2.25 Our review of Fleet Management team meetings under audit objective 4 below confirmed that tenders are discussed and this includes when tenders are due for renewal.

2.26 We compared the suppliers used on the Chevin system from 1 April 2021 to 27 June 2022 to the list of approved tenders for fleet services from NWSSP Procurement, which included 16 suppliers. We also noted that the listing did not include further detail on the specific services they relate to, contract terms, value, length etc. This exercise identified 49 suppliers that had been used but were not on the approved contractors list provided. 20 of these had expenditure greater than £5k. Explanations were provided by management for 11 of these, including that they were part of a framework agreement and that the supplier had to be used to maintain the vehicle warranty. Of the remaining items, we identified two instances where it was confirmed that quotations had not been obtained and five instances where there wasn't a tender in place. The total expenditure incurred in relation to these was over £500k and we were informed that approximately £410k of this related to expenditure on garage services that had been previously tendered for relating to the North. However, when these services went out for retender, the award excluded the Northern lots due to a lack of available suppliers, including exceptional circumstances with one supplier (£295k) which went into administration. These have now been added to the NWSSP Procurement services workplan. See **MA3 in Appendix A**.

2.27 The Trust agreed with a recommendation we raised in 2018-19, following the implementation of Fleetwave, to undertake an annual exercise to review the suppliers included on the system and to remove those that have not been used. We reviewed the suppliers used in the last 15 months against the list of suppliers on Chevin and identified 60 suppliers that had not been used over that period. See **MA3 in Appendix A**.

2.28 Where contracts are in place we understand that checks are undertaken by the Fleet Department before invoices are approved, to ensure they are in line with agreed rates and price lists. It was not possible to verify that this manual check is undertaken as it isn't evidenced. We checked one approved supplier invoice from our sample of 29 job cards and were able to confirm that the correct rate had been applied on the invoice for the work undertaken.

Conclusion:

2.29 The Fleet department engages with NWSSP Procurement services for any tenders in place and these are discussed at Fleet Management meetings. We noted a number of instances where contracts are not in place and that these have now been included on NWSSP Procurement Services workplan going forward. Noting this, we have assessed this objective as **limited** assurance.

Audit objective 4: Delivery of the fleet maintenance program is appropriately monitored, including regular monitoring of costs and benefits.

2.30 As noted under objective 2 above, the Chevin system captures key dates in relation to servicing and issues alerts and reminders, which assists with monitoring PPM. This information is available to the user in a dashboard when they log in to the system.

2.31 The Fleet Department runs regular reports on PPM, including weekly servicing schedules for its in-house workshops. In addition to these, daily reports are run which detail the number of invoices and jobs on Chevin awaiting approval; the number of equipment jobs awaiting approval; the number of equipment jobs open 31 days or more; the number of jobs open 31 days or more and the number of rejected jobs. These reports are sent to Fleet managers, assistant managers, supervisors, team leaders, technicians, mechanics, workshops, technical assistants and administrative assistants, to assist prompt resolution of any issues. Open job cards have been discussed at the Fleet Management team meetings. The report could be enhanced to capture items such as when these servicing have been breached, significant or unusual differences between invoice values and job card estimates, job cards without estimates and suppliers with a high number of jobs recalled. See **MA5 in Appendix A**.

2.32 In addition to these, ad-hoc reports have been run to identify potential savings. For example, the fleet manager has used the Chevin system to identify whether an extended warranty should be purchased based on the costs associated with maintenance of out of warranty vehicles.

2.33 The Fleet Management Group meets monthly. Review of the meetings since April 2021 confirms that the group receives updates from finance, which includes analysis on fleet maintenance costs. Review of the Head of Finance monthly reports identified that issues with accident repair costs being raised and highlighted overspends relating to external garages. These meetings also include updates on tenders as a standard agenda item, discussions on open job cards and detailed that workshop staff have received training on the electric vehicles.

2.34 We noted a lack of evidence to demonstrate formal performance monitoring of supplier performance, from a contract management perspective. Arrangements to monitor the performance, effectiveness and quality of the in-house workshops should also be considered, noting the Trust's ambition to provide all vehicle

maintenance 'in house'. Financial reports detail that there are continuous overspends on the fleet maintenance budget and is highlighted as a reason for the Trust's overall overspend on non-pay costs. We were also informed of recent pressures and challenges that have had an impact, including the increased fleet numbers and an ageing fleet following a reduction in capital funding during 2020-21. See **MA5 in Appendix A**.

2.35 One of the Trust's approved suppliers was investigated for a potential fraud during 2021, relating to an allegation of invoicing for work that had not been carried out. Whilst these allegations were proven to be unfounded, the Counter Fraud Team raised recommendations, which included undertaking spot checks to confirm that the work assigned to the supplier had been undertaken. Whilst there was evidence of quality audits being undertaken at two contracted suppliers in the Central and West region, it wasn't evident from these forms that spot checks had been undertaken to verify work on the vehicle had been carried out. We acknowledge that during the COVID-19 pandemic it would not have been possible to visit these sites to undertake spot checks. See **MA6 in Appendix A**.

Conclusion:

2.36 The Fleet Department run regular reports and we have included suggestions to enhance. Analysis of fleet maintenance costs is included as part of the finance agenda item at the Fleet Management Group, where we note issues around accident repair costs and overspends relating to external garages have been highlighted and discussed. However, the reporting around supplier performance could be improved to assist with appropriate contract management. Establishing arrangements to monitor the performance, effectiveness and quality of the in-house workshops would also be sensible, Noting this, we have assessed this objective as **reasonable** assurance.

Audit objective 5: There is appropriate governance and oversight arrangements within the Trust.

2.37 The Board has delegated responsibility for oversight of the development and implementation of the estates and fleet strategies to the Finance Performance Committee (FPC).

2.38 We reviewed the FPC Agendas, minutes and papers since 1 April 2021. This confirmed that the Committee receives updates on the Fleet SOP, as well as the Estates and Decarbonisation SOPs which are closely linked. We also note that the monthly finance performance report presented to the Committee has consistently reported an overspend on fleet maintenance, which has contributed to the Trust's overall overspend on non-pay costs.

2.39 The FPC also receives updates on progress against the delivery of the relevant IMTP activities, which includes deliverables relating to fleet infrastructure. The approval route for the IMTP update paper to FPC is via the Strategic

Transformation Board (STB). The deliverables relating to the Fleet, Estates and Decarbonisation SOPs are reported under the 'Infrastructure' programme.

2.40 Review of the IMTP update paper presented at the March 2022 meeting confirmed that for Q4 the deliverable relating to the Fleet SOP: '*Deliver the vehicle replacement scheme as per the approved Business Justification Case*' was reported as being on track. We also note that deliverables relating to decarbonisation were also on track, specifically, '*Develop an Electric Vehicle Strategy including a charging network*'; and '*Deliver on our commitments to modernise our fleet including the increase in the number of hybrid vehicles and roll out of vehicle solar panels*'. It is important that the maintenance arrangements are considered to reflect the changing nature of the fleet going forward.

2.41 The Fleet SOP Delivery Group is responsible for monitoring progress and delivery of the Fleet SOP. These are formal monthly meetings and papers are embedded into the agendas. Review of the meetings held since April 2021 confirms that these meetings are well attended. Updates on the Vehicle replacement project, which contributes to the Fleet SOP, is included as a standard agenda item. There are regular project updates from the Project Accountant and Project Manager. These updates are used to inform and refresh of the Fleet SOP and any Business Justification Case (BJC), which is the means for requesting the capital money to deliver the Fleet SOP.

Conclusion:

2.42 Governance and oversight of Fleet has been delegated by the Board to the Finance and Performance Committee. The Fleet SOP is referenced throughout the Trust's corporate documents, including the IMTP, and progress updates are provided to the FPC, the Strategic Transformation Board and the Fleet SOP Delivery Group. There are consistent overspends on fleet maintenance and we have suggested enhancements to reporting. Noting this, we have assessed this objective as **reasonable** assurance.

Appendix A: Management Action Plan

Matter arising 1: Servicing interval (Design)	Impact
The Trust's fleet is serviced on a time-based regime. Broadly all 'blue light' vehicles, mainly emergency ambulances (EAs) and rapid response vehicles (RRVs), are serviced on a six week cycle, with all other vehicles, including the Non-Emergency Patient Transport Service (NEPTS), serviced on a 12 week cycle. Servicing of Hazardous Area response Team (HART) vehicles can either be every six or 12 weeks, at the discretion of the manager. The system includes reminders, which are RAG (red, amber, green) rated, as each vehicle is approaching any of these deadlines. We selected a sample of 30 vehicles to confirm that they had received the minimum servicing. We found five vehicles where the minimum number of services had not been carried out: four vehicles had missed one service and one vehicle had missed two services. Explanations had been received for two of these, in that the vehicles had been involved in accidents and had been in the garage for an extended period. The other three instances related to Central and West (C&W) vehicles where the planned preventative servicing has been outsourced. The reason for the missed service interval was that multiple vehicles were due for service at same time which would have had a detrimental impact on the availability of the fleet in that area.	Potential risk of: • Failure to comply with legislation with vehicles not fit for purpose, leading to patients and staff coming to harm; and • Lack of available fleet to respond to patients.

Recommendations	Priority
1.1 The Fleet Manager for Central and West should run regular reports from Chevin to identify any missed services and these should be escalated to the relevant group and used for any supplier performance meetings held. 1.2 The Fleet Manager for Central and West should consider whether the timing of its servicing intervals should be re-profiled to ensure that multiple vehicles are not called for planned maintenance at the same time.	Low

Management response	Target Date	Responsible Officer
1.1 WAST agree with the findings and recommendations. Regular reports will be generated by the Fleet Management team in C&W identifying vehicles that are requiring their planned preventative maintenance (PPM) and any that are overdue. Any compliance concerns will be managed by the Fleet manager and the report data shared with both suppliers and our operations management team to ensure that any overdue services are dealt with swiftly.	November 2022	Regional Fleet Manager Central and West (C&W)

1.2	In coordination with the above response (1.1), the Fleet Management team in C&W will work with the Operations management to realign the fleet servicing programme to ensure that a planned number of vehicles are released when requested by Fleet allowing for PPM to be undertaken when required.	November 2022	Regional Fleet Manager C&W

Matter arising 2: Authorised signatory lists (Design)	Impact
We compared the Fleet Department's authorised signatory lists between the Chevin and Oracle systems and found inconsistencies. We noted some individuals have a higher authorisation limit on Chevin compared to Oracle. There are 23 users on Chevin that have authorisation limits that range from £2,000 to £200,000. Review of the Oracle hierarchy noted that there are currently seven individuals who are authorisers on Oracle and 15 individuals who can raise requisitions. For two of the Oracle authorisers their authorisation limit on Chevin was higher than their authorisation limit on Oracle. These were: **Chevin Authorisation limit** / **Oracle Authorisation Limit** User 1: 200,000 / 80,000 User 2: 15,000 / 10,000 We selected a sample of 29 job cards for the 15-month period from 1 April 2021 to the end of June 2022. Our sample of job cards again included all regions, internal and external, planned and unplanned work on both emergency and non-emergency vehicles. Seven of these had been raised by individuals not included as requisitioners on Oracle. Additionally, our sample testing identified 11 job cards had been authorised by individuals who were requisitioners only on Oracle; two job cards (with values of £2,792.12 and £510.34) were authorised by individuals who were not listed in the Oracle hierarchy, and one job card for £12,928.12 was authorised by an individual with an Oracle authorisation limit of £10,000.	Potential risk of: • Inappropriate commitment and authorisation of expenditure.

Recommendations	Priority
2.1 The Trust should review the appropriateness of the Chevin authorised signatory list, ensuring consistency with the requisitioner and authorisation limits on the Oracle system. 2.2 The Chevin user list and authorisation limits should be subject to regular review.	High

Management response	Target Date	Responsible Officer
2.1 Agreed. Fleet Management and Finance colleagues will work in collaboration to ensure that the limits on both Chevin and Oracle are aligned. Chevin user profiles will be set with the same authority as Oracle i.e. requisitioner/approver.	November 2022	National Fleet Manager

2.2	Agreed. The Fleet systems manager will review the user limits on Chevin and match against Oracle on an annual basis. All new starters will be granted the correct authorisation limits for both Oracle and Chevin.	Immediately and annually	Fleet Systems Manager

Matter arising 3: Approved suppliers and standing data (Operation)	Impact
Competition thresholds are mandated in the Standing Financial Instructions, which form part of the Standing Orders and overall governance arrangements for the organisation. These detail the following for spend: • *Less than £5,000 - there should be evidence of value for money;* • *Between £5,000 and less than £25,000 - there should be evidence of three quotations and a simple form of contract; and* • *Over £25,001 to the prevailing OJEU threshold - there should be openly advertised call for competition and a formal contract in place.* We compared the suppliers used on the Chevin system from 1 April 2021 to 27 June 2022 to the list of approved tenders for fleet services from NWSSP Procurement, which included 16 suppliers. We also noted that the listing did not include further detail on the specific services they relate to, contract terms, value, length etc. The above exercise identified 49 suppliers that had been used but were not on the approved contractors list. 20 of these suppliers had expenditure greater than £5k. Explanations were provided for 11 of these being that there was a Crown Commercial Services Framework Agreement in place; the supplier had to be used as they were a nominated agent / dealer of the original manufacturer to maintain the vehicle warranty; the suppliers were used to undertake MOTs only and these are standard prices; and one where we were informed that the general spend was below £5k after removing COVID spend for bulkhead screens. Of the remaining items, we identified two instances where it was confirmed that quotations had not been obtained and five instances where there wasn't a tender in place. The total expenditure incurred in relation to these was over £500k and we were informed that approximately £410k of this related to expenditure on garage services that had been previously tendered for relating to the North. However, when these services went out for retender, the award excluded the Northern lots due to a lack of available suppliers, including exceptional circumstances with one supplier (£295k) which went into administration. These have now been added to the NWSSP Procurement services workplan. In addition, the Trust agreed with a recommendation we raised in 2018-19, following the implementation of Fleetwave, to undertake an annual exercise to review the suppliers included on the system and to remove those that have not been used. We reviewed the suppliers used in the last 15 months against the list of suppliers on Chevin and identified 60 suppliers that had not been used over that period.	Potential risk of: • non-compliance with procurement requirements; and • The Trust does achieve value for money.

Recommendations		Priority
3.1	The Trust should review fleet maintenance expenditure and ensure that the procurement rules have been adhered to.	High
3.2	The supplier list should be enhanced to include further detail on the fleet maintenance contracts in place.	
3.3	The supplier list should be subject to regular review, with support from NWSSP Procurement services, including the removal of those that are not used.	

Management response		Target Date	Responsible Officer
3.1	Agreed. The Fleet Management Team will review all suppliers against fleet maintenance expenditure in partnership with our procurement colleagues in NWSSP. Action arising for the review will be implemented at the earliest opportunity.	November 2022	National Fleet Manager
	All expenditure with suppliers exceeding the financial threshold will be tendered for and/or framework agreements / contracts awarded.	April 2023	National Fleet Manager
3.2	The Fleet systems Manager will enhance the detail held within the Chevin supplier table to provide the status of any contract in place.	November 2022	Fleet Systems Manager
3.3	The Fleet Systems Manager will perform an annual review of suppliers. Suppliers that have not been used for over 12 months will be removed from the active list. This has already been completed with further anniversary dates scheduled.	Completed - Annual review.	Fleet Systems Manager

Matter arising 4: Retrospective job cards and estimates (Operation)	Impact
The Trust works to the NHS Wales agreed 'No PO No Pay' policy. Purchase Orders (POs) are raised after the invoice is received on Chevin before uploading the file to Oracle. The job card is raised on Chevin before the supplier commences work, as such this is the equivalent of the Oracle PO. The estimated cost had not been completed for 19 of the 29 job cards in our testing sample. Of these, 10 were planned jobs and nine were unplanned, with 10 of these being internal jobs and nine external. We would expect estimates to be made with reference to similar jobs captured on the system and to agreed rates within contracts. The absence of these limits the effectiveness when reviewing the appropriateness of invoices and to act as a useful reference point for similar jobs in the future, as well as to compare work being undertaken inhouse and externally. We acknowledge that for unplanned work it is not feasible to enter an estimate before the diagnostic has been completed by the garage, however the estimate could be recorded once this has been agreed. Of those that included estimates, differences between the estimate and the amount invoiced varied from within £300 in five instances, £550 in one instance, two instances between £2,200 and £2,500 and one instance of £7,300. Four of these were overestimated by 20-60%; five were underestimated by 15-44% and one was underestimated by 1477%. Our testing also identified four instances of retrospective job cards, i.e. raised after the invoice date. These were:	Potential risk of: • the Trust does not achieve value for money; and • unauthorised jobs are undertaken by suppliers.

Job Card	Date Job Card raised	Invoice Date	No. of working days
111449	23/05/2022	23/03/2022	44
90007	08/06/2021	31/05/2021	7
98896	29/10/2021	28/10/2021	2
113575	27/06/2022	24/06/2022	2

Recommendations	Priority
4.1 Estimated costs should be populated for all job cards, once the required work has been reviewed and agreed. 4.2 Fleet Managers should ensure job cards are raised prior to the job being undertaken and invoice received.	Medium

4.3	Regular reports should be run from Chevin to identify instances where the job card has been raised after the invoice date.		

Management response		Target Date	Responsible Officer
4.1	Agreed that all job cards from external suppliers should be populated with an estimate and that estimate should be adhered to or amended accordingly as work progresses to completion. The Fleet management team will ensure that suppliers are instructed to do so from immediate effect. With regards to internal job cards, the Fleet management team cannot identify any benefits from our own staff providing estimates on jobs undertaken. The system is live and therefore costs are identified immediately as parts are booked out, there are no reasons to reconcile any labour associated to the job as that is a known cost. We do performance manage our staff against industrial standards for set times.	November 2022 / immediately introduced	Regional Fleet Manager North
4.2	Agreed. Job cards should be raised prior to work being undertaken and it is also agreed that invoices and completed internal jobs should be scrutinised for accuracy. External against estimate and internal against industry standard times. The Fleet team are currently reviewing working practices and re-profiling staffing positions whilst attempting to remain within the current pay budget parameters to ensure the audit recommendations and the recommendations from a previous counter fraud review are achieved. Owing to several influencing factors the remodelling of the department cannot be undertaken instantly and will continue to be work in progress.	April 2023	National Fleet Manager
4.3	A regular report will be produced to identify job cards being raised after the date on the invoice. Reports will be recorded in the Fleet managers' team meeting.	November 2022	Fleet Systems Manager

Matter arising 5: Performance monitoring of external suppliers and in-house workshops (Design)	Impact
The Fleet Department runs regular reports for planned preventative maintenance, including weekly servicing schedules for its internal workshops. In addition to these, daily reports are run which detail the number of invoices and jobs on Chevin awaiting approval; the number of equipment jobs awaiting approval; the number of equipment jobs open 31 days or more; the number of jobs open 31 days or more and the number of rejected jobs. These reports are sent to Fleet managers, assistant managers, supervisors, team leaders, technicians, mechanics, workshops, technical assistants and administrative assistants to assist prompt resolution of any issues. However, we noted a lack of evidence to demonstrate formal performance monitoring of external garages and in-house workshops. Analysis that Fleet Managers should also consider running to assist with this review process include, but not be limited to: • The variance between estimated cost against actual cost by provider; • The length of time taken to undertake a job, by job type and provider – which could indicate the garage / workshop does not have the resources or expertise to undertake the job or is not prioritising the Trust's fleet; • The number of recalls in between services by vehicle and provider - which could indicate poor workmanship or the work not being undertaken in the first place; • An analysis of costs by provider for similar jobs - to satisfy that value for money is received; and • To capture when servicing requirements have not been met.	Potential risk of: • Failure to appropriately monitor performance of inhouse workshops and external suppliers; and • Failure to identify adverse supplier trends.

Recommendations	Priority
5.1 The Fleet Department should run reports to assess supplier / in-house workshop performance. 5.2 Where performance is below expectation, this should be communicated and actions put in place to remediate.	Medium

Management response	Target Date	Responsible Officer
5.1 Agreed. As in response to 1.1, 4.1, 4.2 and 4.3 new reports are to be generated by the Fleet systems manager that will provide data for analysis. The changes implemented as an outcome of 4.2 will enable us to provide these new more accurate reports.	April 2023	National Fleet Manager
5.2 Agreed. Issues arising from the new reports will be manged appropriately by the Fleet management team.	April 2023	Regional Fleet Manager North

Matter arising 6: Spot checks (Operation)	Impact
One of the Trust's suppliers was investigated for a potential fraud during 2021, relating to an allegation of invoicing for work that had not been carried out. Whilst these allegations were proven to be unfounded, the Counter Fraud Team raised recommendations, which included undertaking spot checks to confirm that the work assigned to the supplier had been undertaken. Whilst there was evidence of quality audits being undertaken at two contracted suppliers in the Central and West region, it wasn't evident from review of these forms that spot checks had been undertaken to verify work on the vehicle had been carried out. We acknowledge that during the COVID-19 pandemic it would not have been possible to visit these sites to undertake spot checks.	Potential risk of: • suppliers fraudulently invoicing for work not undertaken.

Recommendations	Priority
6.1 The Fleet Department should use Chevin to identify any adverse supplier trends for all its regions and undertake a sample of risk-based spot checks to confirm that jobs undertaken have actually been carried out.	Medium

Management response	Target Date	Responsible Officer
6.1 Agreed. Vehicles that are being maintained by external contractors are to have follow up spot checks as recommended. As mentioned in the matter arising this is following up from a counter fraud review that the Fleet Management team reported to counter fraud ourselves. Work is underway to implement the recommendations from that report. This recommendation will also be further reviewed alongside 4.2. It is noted and accepted that such checks have been challenging to undertake during much, if not most, of the last couple of years.	Immediately introduced	Regional Fleet Manager C&W

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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Major Incidents
Final Internal Audit Report
September 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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Committee:	Audit Committee

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

Acknowledgement

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

Executive Summary

Purpose

To assess the Trust's approach to prepare for major incidents, including counter terrorism incidents, and how it ensures it learns from such events.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Whilst exercising has taken place it is at a low frequency, reliant on multi agency partners and is weighted towards the South East territory.
- There is a clear process for capturing and monitoring lessons from incidents and externally, but lessons from exercising are not routinely noted.
- Arrangements to share plans have been outlined but there has been gaps in evidence to support this.
- Some gaps in Commander CPD identified.

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

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	Roles and responsibilities	Reasonable
2	Refreshing of plans to incorporate learning	Reasonable
3	Review and testing of plans	Limited
4	Commander training and exercising	Reasonable
5	Partner engagement in planning and response	Reasonable
6	Arrangements to capture learning	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Incident Response Plan oversight and content	1	Design	Medium
2	Testing and exercising frequency and outcomes	3	Design	High
3	Monitoring and reporting of training compliance	4	Design	Medium
4	Monitoring and review of action cards	5	Operation	Medium
5	Organisational SOP escalation arrangements	6	Design	Low

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

1. Introduction

1.1 Over the last few years, the UK has experienced several major incidents, from fire and floods to terrorist activities. As a Category 1 responder, with key emergency response duties under the Civil Contingencies Act (2004), the Welsh Ambulance Services NHS Trust (the 'Trust') is required to ensure it has robust plans in place for emergency preparedness, resilience and response (EPRR).

1.2 The Trust's major Incident Plan was replaced with the Incident Response Plan (IRP) in 2021 This plan aims to provide guidance and support to commanders on a range of incidents that they may be asked to manage, including counter terrorism incidents. Alongside the IRP, a range of related policies and procedures have been introduced. This includes the WAST Command Policy and other procedures related to command and management, whilst responding to the unprecedented scale of the COVID-19 pandemic. The Trust IMTP 2022-25 includes an outline of significant external factors identified by the Emergency Preparedness, Resilience and Response team, which include the impact of the review of the UK Civil Contingencies Act, and review of civil contingencies structures within Wales. This horizon scanning also includes implementing the identified lessons from the UK COVID-19 and Manchester Arena inquiries.

1.3 The risks considered during the review were as follows:

i. Insufficient testing and exercising with wider engagement may impact the effectiveness of plans.

ii. Failure to incorporate lessons learnt into procedures and plans.;

2. Detailed Audit Findings

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

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	1	1	1	3
Operating Effectiveness	0	2	0	2
Total	1	3	1	5

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

Audit objective 1: Roles and responsibilities within the organisation during an incident are clearly defined.

2.3 The Trust is a category one responder under Civil Contingencies Act. As such it has a responsibility to assess, plan and co-ordinate its response to incidents, both internally and with external partners. The Incident Response Plan (IRP) replaced the Trust's previous Major Incident Plan in May 2021, following approval by the Executive Management Team (EMT).

2.4 The IRP was developed to align with guidance issued by the National Ambulance Resilience Unit (NARU), within its '*Command and Control Guidance – version 3 (2019)'* and '*Standards for NHS Ambulance Service Command & Control (2018)'.* The NARU documents outline that they reflect lessons identified from major incidents and '*provide a structured approach to managing major incidents for ambulance services with a particular focus on multi agency responses*.'

2.5 NARU guidance includes information on command structures and roles for the management of incidents. It also contains outline of post incident learning processes, training and CPD requirements related to the key positions of Strategic, Tactical, and Operational commanders.

2.6 The IRP aligns the Trust's incident definitions to those contained in wider national guidance, such as the '*NHS Wales Core Emergency Planning Guidance (2015)'* and '*NHS England EPRR Framework (2015)'.* We note that the definitions have been mapped to a predetermined response matrix (IRP section 9.1.7), which assigns set resource levels according to a scoring matrix determined by number of casualties and anticipated incident duration.

2.7 The IRP also contains detail on a number of set responses, such as mass casualty, marauding terrorist attack (MTA), chemical, biological, radiological, nuclear, and explosive (CBRNe) and hazardous materials (HazMat). It also has detail and refers to other set response plans, such as rail and aircraft/airport.

2.8 We also note the IRP contains CSCATTT (Command and control, Safety, Communication, Assessment, Triage, Treatment, and Transport) principles for responding to an incident, as outlined within NARU guidance. Template documents are also included within the IRP, formatted in line with CSCATTT principles for devising operational and tactical plans, and for the use of IIMARCH (Information, intent, method, administration, risk assessment, communication, humanitarian) headings for conducting site briefings.

2.9 Within '*Section 9.1 Command, Control and Co-ordination',* the IRP outlines command and control roles for the management of an incident. The IRP states that NARU guidance is best practice in this area, and that the Trust's own command structure is aligned accordingly.

2.10 We compared the detail of the roles and responsibilities for Strategic, Tactical, Operational Commanders, confirming that outline and descriptions from within the IPR corresponded with that within the NARU guidance. We note further detail on the roles can be found within the Trust's Command Policy, which was approved

in May 2021 and outlines the accountability, deployment criteria, core role, competence and exercising requirements for each.

2.11 NARU guidance includes outline of functional roles, such as Primary Triage officer, Casualty Clearing Officer and Casualty Loading Officer amongst others, and these roles are to be assigned by the Operational Commander as and if required for the management of an incident. Command support roles, such as the National Interagency Liaison officer, Tactical advisor, and Medical advisor are also outlined. For both functional and support roles, we could identify alignment between those within the IRP and those within NARU guidance for most roles. A small gap was noted against the role of loggist and decontamination officer, and we were informed updated national guidance was being considered by the team for the latter which would need to be reflected within the revised IRP. **See MA1**

2.12 We reviewed the IRP to establish if there is clarity provided on the roles of other responding agencies, and arrangements for engagement. There is detail on the role of the Trust alongside other emergency responders within section 8 of the Plan. Appendix two contains outline of other civil contingency act category one responders. Additionally, the IRP sets out engagement at Operational (locating with other agencies at a Forward Command Post), Tactical (establishment of a Tactical Co-ordination Group to provide multi agency management of an incident), and Strategic levels (Strategic Co-ordination group should an incident have a significant impact or resource implications).

2.13 As noted above, the IRP was approved by EMT in 2021, but we note the Plan does not refer to any Trust governance arrangements nor is there a committee included for oversight. The paper presented to EMT noted that due to the inclusion of official sensitive content, the IRP should not be presented in a public forum.

2.14 The Finance and Performance Committee (FPC) terms of reference was reviewed in March 2022 and includes '*oversight and scrutiny of the Major Incident Plan and assurance that such plans are effective*.' At its July 2022 meeting, the FPC received a copy of the EPRR Document Tracker, which outlines titles and review status of EPRR plans and procedures.

2.15 Review and update of the IRP was underway at the time of fieldwork. We note there could be opportunity for sharing detail of plan content and amendments with the FPC in an appropriate form once the review is complete. **See MA1.**

Conclusion:

2.16 The Trust has developed an Incident Response Plan which aligns with national guidance, and outlines roles and responsibilities for the Trust, Trust Commanders and that of other responding agencies. We note there is opportunity to provide further detail to the FPC as the next version of the IRP is made available. We assign this objective **reasonable** assurance.

Audit objective 2: Incident and business continuity plans have been refreshed to incorporate learning from the pandemic and incidents.

2.17 The Trust has a number of plans which interlink with the IRP and business continuity arrangements. This includes the Resource Escalation Action Plan (REAP), which includes the Joint Emergency service Interoperability Principles (JESIP) and the incident definitions listed within the IRP. Review of REAP action cards identified prompts for declaring incidents when moving to escalation levels 3 and 4. We also reviewed the Clinical Safety Plan (CSP), which provides a framework for responding to increasing demand and resource management. The CSP outlines that any incident will be managed through the IRP, and we note CSP escalation levels align to Tactical and Strategic command roles.

2.18 The Trust has a Clinical Contact Centre Incident Response Standard Operating Procedure (CCC IR SOP), which has been established to support the delivery of the IRP. It provides command and control guidance with reference to the functional and support roles outlined within the IRP. The despatch principles also align with the response matrix and reporting methodology outlined within the IRP.

2.19 The Command Policy introduced alongside the IRP (see 2.10), supports the IRP in outlining the training and knowledge required for Commanders to undertake the Operational, Tactical and Strategic roles within an incident. The Policy refers to the NARU National Standards for Command, and we compared the mandatory and optional competencies listed within the Command Policy to the standards finding they matched.

2.20 Discussion with Operations management outlined that the replacement of the previous Major Incident Plan with the IRP provided an opportunity to ensure it reflected the learning gained from incidents and inquiries elsewhere. In particular, the changes to national guidance relating to the deployment of responders during a Marauding Terrorist Attack (MTA).

2.21 We compared relevant content from the Major Incident Plan and the IRP, noting the IRP allows Commanders to apply discretion in how responders are deployed. This is to be informed by attack methodology and intention to minimise risk to the public through ensuring a prompt medical response is enabled. This is a clear change from the previous guidance, where specialist responders would be required in that situation.

2.22 A Business Continuity Assessment paper to FPC in July 2022 outlined some of the challenges faced throughout the pandemic, such as the rapid processing of legislation and guidance, procurement, management and distribution of PPE, and the need and ability to enhance information sharing with staff, public and partners. We note that the IRP includes reference to business continuity arrangements, an area which the previous Major Incident Plan only briefly referred to. The IRP now includes the need to consider organisational recovery and the impact of an incident on core business, and reference to the establishment, if needed, of a Recovery Cell to assist in this.

2.23 We note the Trust has also taken forward learning identified from COVID-19 debriefs. An example is refreshing the pandemic plan from its previous form as a pandemic flu plan to a more flexible generic pandemic plan following the first wave. The plan has also been updated to reflect the outcomes from further waves.

2.24 The EPRR team maintain a document tracker which contains detail on review dates and owners. As noted within 2.14, this has recently been shared with the FPC and indicates a small number as overdue/requiring review, with the committee being informed of the intention to address these shortly.

2.25 The Trust has an Organisational Learning SOP, which outlines processes for the identification, recording and implementation of learning from internal and external sources. Objective 6 provides further detail on this area at 2.56.

Conclusion:

2.26 The IRP links to and is supported by a number of related policies. Review of these documents confirm the standardisation of incident definitions and adoption of JESIP principles. There remain a small number in need of review and updating. We assign this objective **reasonable** assurance.

Audit objective 3: Plans and processes related to incident response are regularly reviewed and tested, and lessons identified are appropriately communicated and implemented.

2.27 Discussions with Trust management indicated there has been a focus on considering plan development, testing, and readiness in light of themes emanating from the Manchester Arena inquiry, which is due to formally report later this year.

2.28 The IRP contains an outline of required exercising and testing. This includes six monthly communications test, annual tabletop exercise, and a live command post exercise once every three years.

2.29 The communications test is facilitated by the EPRR team and Operational Delivery Unit (ODU) and is a requirement of the NHS Wales Core Emergency Planning Guidance. Major incident alerts are issued to NHS partners on a bi-annual basis (one during standard working hours, and one out of hours), and responses collated. The most recent test was undertaken in March 2022. Review of the associated report identified that responses from health boards varied in completeness, where four sites contacted did not respond, and concerns around the time it takes to contact individual numbers/switchboards within health boards.

2.30 As part of fieldwork, we requested details on exercises undertaken with agency partners to support the testing of plans and processes. This information was not routinely collated by the EPRR team. Submissions were provided for South East (Aneurin Bevan, Cardiff & Vale health boards) and North (Betsi Cadwaladr health board) territories, partial information for South Central (Swansea Bay and Cwm Taf Morgannwg health boards), but details of exercises could not be provided for the Central territory (Hywel Dda and Powys health boards). At the close of

fieldwork arrangements were being made to capture testing information on an ongoing basis.

2.31 We compared the exercise information provided against the plans listed within the EPRR document tracker and the Siren SharePoint site. We note there has been testing of the IRP at live and tabletop exercises, although this is at a low frequency and only in the South East territory. Undertaking exercising will have been difficult noting the operational demands of the COVID-19 pandemic, alongside challenges to coordinate representation from all key partners to make the exercise worthwhile. **See MA2**

2.32 We were informed that the Trust does not maintain a budget for live exercises and so there is limited opportunity with reliance on exercises being undertaken on a multi-agency basis. Whilst this provides best practice circumstances, with each agency undertaking its specific role for the purpose of the exercise, it does limit the ability to set overall scope and objectives of the exercise. The Celtic Consolidation exercise, where there was live testing of the IRP, involved just two Tactical and one Operational Commander from the Trust (although we note wider Trust involvement of around 20 staff in the exercise), working with partners from EMRTS, St John Ambulance Cymru, South Wales Police and South Wales Fire and Rescue. **See MA2**

2.33 The EPRR team has developed a detailed IPR testing checklist, which is mapped against the content of the IRP and its incident management principles in a RAG format. With limited external exercising there has been only two opportunities to use the checklist: exercise Celtic Consolidation and exercise Tonna. **See MA2**

2.34 We were also informed that multi-agency debriefs varied in format and structure. Where a formal debrief has not occurred, for some there may be some bullet point recording of reflections, this would not generate recommendations that could be captured within the organisation's learning spreadsheet. **See MA2**

2.35 We note that the Trust has undertaken some internal exercising through annual seasonal planning which has tested REAP, the Demand Management Plan and the Severe Weather Plan. A number of these plans and procedures are implemented and in use where required as part of Trust service delivery, and we note the debrief processes captures ongoing learning related operational use of these plans, see 2.56 for more detail on that process.

2.36 The Trust is also developing an ICT Business Continuity plan, which is being supported by two internal exercises. The Trust undertook preparatory assessments following cyber-attacks made against the Health Service Executive within the Republic of Ireland. Following identification of key ICT services, senior Operations Directorate managers and the Trust's directorate business continuity leads undertook an exercise to establish ICT dependencies and priorities. The outcome of the first internal exercise has been a draft ICT Business Continuity Plan. This has been tested as part of the second internal exercise and we note formal outcomes were being finalised as fieldwork closed.

2.37 Trust plans are available to Commanders and wider staff through the Siren SharePoint site. Operations Directorate notices are used to communicate updates and amendments to Trust wide plans. We were informed that Commanders and relevant Locality Managers will receive circulation of specific incident plans and were provided with an example of this.

Conclusion:

2.38 The EPRR team has developed a checklist test to support the exercising of the IRP, however the Trust is reliant on LRF and partner agencies to test plans which has limited opportunities to actively use this and led to imbalance in testing across the four territories. We assign this objective **limited** assurance.

Audit objective 4: Training and exercising arrangements for Trust commanders are in place and effective for a single and multiagency response to an incident.

2.39 The introduction of the Command Policy in May 2021 provided the Trust with clear governance relating to Command roles, responsibilities, training, knowledge and Continuous Professional Development (CPD) requirements. It also reflects details on the functional and support roles which could be required as part of response to an incident. As noted within previous objectives we have established this aligns with NARU guidance documents.

2.40 Commanders are required to attend a WAST Foundation Command Course at relevant Operational/Tactical/Strategic level and pass an accompanying competency assessment delivered by the EPRR team. Refresher training is offered on a three-year basis.

2.41 Attendance at an external JESIP course with representatives of other responder agencies follows, again aligned to respective Command level. For Operational and Tactical commanders there is also the requirement to attend a NARU provided Command and Control course. The policy indicates this should be undertaken within two years of the WAST Foundation course, however NARU courses have limited availability (1-2 a month of which 16 places are available to all responder services) which can impact the ability to meet this requirement.

2.42 The policy outlines CPD requirements which align to national standards; year one requiring 65%, year two requiring 75% and by the 3rd year compliance should be at 100%. The policy notes that where the commander is not able to evidence competency to the required level, the EPRR team will review available exercises to assist in meeting target levels.

2.43 Each commander is issued with a National Occupational Standards CPD Evidence record, which allows them to enter a description of the activity (incident, training course, exercise, multi-agency co-ordination group) and the evidence available to support the entry. The commander will assign levels of performance criteria and knowledge/understanding which is mapped against the CPD mandatory and optional competency. Depending on the information entered a progress percentage will be populated for each competency.

2.44 The EPRR team manage training records by territory and established a training spreadsheet in early 2020 to include detail on courses and CPD levels. Records which were previously paper based are now being scanned, and the evidence record, which is excel based, is saved to individual commander records. We note there is no requirement currently for the team to be provided with the evidence referenced within the record itself or undertake any periodic check to confirm they are in place. **See MA3**

2.45 The Policy notes that failure to produce CPD evidence to the required standard will result in the individual not being recognised as a WAST commander. We were informed that where there are gaps in submissions, the EPRR team will highlight this to Operations management. The Policy does not include reference to any process to address non-compliance. **See MA3**

2.46 We selected a sample of 20 CPD records; four Strategic, six Tactical and ten Operational, and reviewed the CPD evidence return against the policy requirements. The following was noted:

- Tactical – three returns did not include evidence to demonstrate that the time related CPD target level had been met for at least one mandatory competency.
- Operational – the record for one return was not present despite the training spreadsheet capturing that it was in place. Issues were also identified for three records, where the time related CPD target level had not been met for between 2 - 4 of the mandatory competencies.

2.47 At present there is no formal reporting on CPD levels or activity from the EPRR team to the wider Operations Directorate. We also note that the Command Policy is a relatively recent addition, and so some initial variation in implementation could be expected. **See MA3**

Conclusion:

2.48 The Trust has introduced a Command Policy which sets out guidance on commander roles and responsibilities that is aligned to national guidance. It also outlines initial and continuing training and development requirements; however our sample test identified some examples of non-compliance. We note there is scope to improve some of the monitoring and reporting which supports this process. We assign this objective **reasonable** assurance.

Audit objective 5: The Trust engages with key partners and organisations to ensure effective and consistent co-ordination during emergency planning and incident response.

2.49 Discussion with the Head of EPRR and Locality Managers outlined the team are engaging with partners across a number of regional, national and UK wide groups. The Local Resilience Forums (LRF) were referred to as key amongst these, as they bring together partners required to co-operate by the Civil Contingencies Act (2004), and a number of other agencies who would respond in emergencies.

2.50 There are four LRFs established across Wales, aligned to the four police force areas. We noted that whilst there are differences relating to their subgroup structures, each has a Strategic group, attended by the Head of EPRR, and training/co-ordination groups which are attended by EPRR Locality Managers. The remaining subject specific subgroups are at the discretion of the LRF itself, and can cover areas such as risk, severe weather, COMAH (Control of Major Accident Hazards). We were informed attendance at these forums would be split by EPRR Locality Manager and supporting Resilience officer.

2.51 We queried if the IRP had been shared with LRF partners, and were informed health boards and Welsh Government were consulted during its development. Trust incident plans are not typically shared with LRF partners, although we were informed there has been occasions where a specific need has prompted sharing of plans with specific partner agencies. For example, the Trust and the Fire Service make joint use of access points for the Severn Tunnel which will impact each other's response plans.

2.52 As LRFs develop or maintain a number of region or site specific plans, and there is variation depending on LRF priorities also (e.g. not all have specific severe weather plans). We were informed that the Trust will access these plans as a reference point in order to develop its own responses, and align with those from other partners. Plan development can vary according to LRF prioritisation, however those for COMAH sites are required by legislation. The Trust has developed a Pan Wales COMAH site plan (currently version 3.2), which contains site specific action cards for 23 COMAH facilities drawn from those plans shared at LRFs.

2.53 We selected two sites and reviewed WAST action card detail. These contained site information, location, response, public information zones, hazards, rendezvous locations, command locations/arrangements and maps. We note one LRF plan had been updated in November 2021 and included information which was not included within the WAST action card. **See MA4**

2.54 We replicated the test above for the WAST Airport Response plan and confirmed consistency with the equivalent LRF plan.

Conclusion:

2.55 There appear to be consistent arrangements to engage with partner agencies, mainly via the four Local Resilience Forums. However, we have noted some gaps in supporting information and a COMAH site plan which had not been reviewed. We assign this objective **reasonable** assurance.

Audit objective 6: Arrangements are in place to capture and incorporate learning from internal and external sources.

2.56 The Trust has developed an Organisational Learning Standard Operating Procedure ('the SOP'), which was approved and issued in January 2022. The purpose of the SOP is to define the processes within the Trust to manage lessons

identified after incidents and translate these into learning. The SOP contains several appendices, including process flowcharts for internal debriefs, training or exercising identified learning. It also outlines arrangements relating to Joint Organisational Learning (JOL) and a process for submitting learning to the JOL online system (a secure UK Government system which supports JESIP principles and provides a facility for sharing lessons between category one and two responders across the UK).

2.57 We discussed the SOP with the EPRR Locality Manager responsible for updating and monitoring the Organisational Learning Spreadsheet (OLSS) which is used to capture internal and external lessons. It was noted that whilst processes have been established for a number of years, the recent formalising of the SOP with accompanying reporting routes to Senior Operational Team (SOT) and Senior Leadership Team (SLT) within the Directorate had seen a positive impact in closing outstanding actions.

2.58 Following an incident, the commander or senior manager can request a formal debrief which will be facilitated by the EPRR team. Questionnaires will be issued to Trust staff to capture feedback on what went well, what did not go well and areas to improve/address. Following this a debrief meeting will be convened. These are currently held virtually and are facilitated by the EPRR team.

2.59 Each report is reviewed and approved by the Head of EPRR and includes recommendations to be taken forward. These recommendations are added to the OLSS and monitored through to completion. Unless specified otherwise, a standard four month deadline is set to address recommendations.

2.60 We selected three incident debrief reports and were able to confirm that the recommendations raised had been captured on the OLSS. Two actions from each report were also sampled and evidence requested to support their closure on the OLSS. Sufficient evidence was provided in relation to four of the six actions, however an absence within the team resulted in a gap in evidence to support the two remaining recommendations.

2.61 The OLSS also contains lessons taken from the national JOL system, which contains multi agency entries. Following notification received from the JOL system the EPRR lead reviews the entries and identifies those deemed relevant for discussion with the wider team. Those recommendations that are supported by the team are added to the OLSS for action.

2.62 We sampled two closed JOL actions from the OLSS and requested evidence to support closure. Review of the evidence provided confirmed that whilst one had been actioned, the second appeared to have been forwarded to the relevant Trust representative for information rather than seeking confirmation that it had been completed.

2.63 We note that appendix four of the SOP includes instructions for the inclusion of lessons gained from exercises or tests undertaken by the Trust. Review of the OLSS identified that lessons from exercises have not been added since 2019. Discussion with the EPRR team outlined that recent multi agency exercises have

not resulted in formal debrief reports, which in turn has meant that actions have not been generated for inclusion on the OLSS. **See MA2**

2.64 At the time of fieldwork, the OLSS recorded 194 closed actions, two in progress and seven outstanding, which were internal. All JOL actions were noted as closed. The Operations Directorate Senior Leadership Team meeting includes representation from across the Trust, which ensures oversight of recommendations that have a wider impact on the organisation. We were informed that should there be a requirement, outstanding actions can be escalated to the Trust's Executive Management Team. **See MA5**

2.65 We note that there is no formal reporting related to the OLSS outside of the Operations Directorate. However, we were provided with an internal case study that was published following an incident involving Palytoxin, a highly toxic substance. The case study outlined information around exposure to the toxin and its effects, alongside outline of steps to be taken by staff if they suspect poisoning.

Conclusion:

2.66 The Trust has clear arrangements to capture, monitor and report lessons learned, although there is a need to consider increasing the recording of outcomes from exercises undertaken There is also an opportunity to capture the escalation arrangements within the SOP. We assign this objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter arising 1: IRP Committee Oversight and content (Design)	Impact
The IRP was approved by the Executive Management Team in April 2021 and is currently undergoing its annual review. We note due to the inclusion of some material from Official-Sensitive sources the plan is not publicly available or has not been presented in a public forum such as a Trust committee. The Finance and Performance Committee terms of reference include that it is responsible for '*oversight and scrutiny of the Major Incident Plan and Business Continuity Plan and assurance that such plans are effective.'* The EPRR team has developed a partner agency version of the IRP which can be shared as the official-sensitive elements have been removed. Additionally, when reviewing the content of the IRP we noted two specific roles listed within NARU guidance were not referenced, Decontamination Officer and Loggist. We were informed that following the issue of new national guidance decontamination procedures within the IRP will need to be updated. Whilst there are trained loggists within the Trust, the IRP does not formally outline their role and responsibilities.	Potential risk of: • Committee unsighted on Trust processes.

Recommendations	Priority
1.1 Following the approval of the annual update to the Incident Response Plan, a summary outline should be provided to the Finance and Performance Committee, or an appropriate version provided at a closed / in-committee session. This should also include consideration of the plan's effectiveness following its first year of use. 1.2 When undertaking the annual update to the Incident Response Plan, the Trust should incorporate the latest national guidance regarding roles and responsibilities required for decontamination and include outline of the role and responsibilities of Trust Loggists.	Medium

Management response	Target Date	Responsible Officer
1.1 The Trust accepts this recommendation. An appropriate update will be supplied to Finance & Performance Committee on completion of the updated IRP.	End November 2022	Judith Bryce, Assistant Director of Operations

1.2	The updated version of the IRP will incorporate relevant changes to national guidance, including an outline of the Loggist and decontamination officer roles.	End November 2022	Judith Bryce, Assistant Director of Operations

Matter arising 2: Testing and exercising frequency and outcomes (Operation)	Impact
We were informed that the Trust does not maintain a budget for live exercises and so there is reliance on exercises undertaken on a multi-agency basis. Whilst this provides best practice circumstances it does limit the ability to set overall scope and objectives of the exercise. Information provided by the IRP team confirms that the IRP has been tested in live and table top multi agency exercises. However, this has been limited to the South East territory and involved a small number of WAST Commanders. We also note that whilst there has been testing (or upcoming scheduled test) of a number of other WAST incident plans (airport, 7 tunnel, casualty dispersion), records show these will be for a single occasion only. We note that undertaking exercising will have been difficult given the operational demands of the COVID-19 pandemic, and co-ordinating representation from key partners would have been challenging. Whilst the team has produced a checklist to support IRP testing, due to the above, there is limited evidence of its use, and currently no comparison of outcomes across exercises undertaken. Recognising this gap in arrangements, the EPRR team were developing a draft template to capture this at time of fieldwork closing.	Potential risk of: • Limited opportunities to test WAST plans. • Imbalance in exercises across the Trust.

Recommendations	Priority
2.1 The Trust should consider options to support more frequent testing of incident plans, this should also consider the location of exercises to ensure equal opportunity for Commanders across the territories. 2.2 The EPRR team should continue to develop a system to capture all exercising undertaken and establish quality measures which can be applied to all incident plans. The system should also capture attendance, exercise type, plan tested and any outcomes/themes from the exercise. If specific recommendations are raised these should be captured within the Organisational Learning Spreadsheet.	**High**

Management response	Target Date	Responsible Officer
2.1 The Trust accepts this recommendation. As the pandemic period closes, the Trust has resumed ongoing work with partner agencies to increase the frequency of plan testing on a multi agency basis. The EPRR team will also develop an internal programme of plan testing, which will be on a Pan Wales basis. Monitoring and reporting will be made through the Senior Operations Team (SOT) and for assurance through to Senior Leadership Team (SLT). Any exercising will be subject to available funding.	March 2023	Clare Langshaw, Head of Service, EPRR

2.2	The EPRR team will work towards a system to capture the quality and effectiveness of exercise testing and plans. Where appropriate, this will interface with the OLLS process. Monitoring and reporting will be made through the Senior Operations Team (SOT) and for assurance through to Senior Leadership Team (SLT).	December 2022	Clare Langshaw, Head of Service, EPRR

Matter arising 3: Monitoring and reporting of training compliance (Design)	Impact
The Command Policy outlines CPD requirements which align to national standards. An evidence return is received from Trust commanders and a spreadsheet updated upon receipt to indicate year of CPD attained. Currently there is no submission of the evidence itself, or requirement for the EPRR team to review this. Where a commander does not submit an evidence return we are informed the EPRR team will flag this with Operations management, however the policy does not include reference to this, or any steps taken to ensure the commander does not undertake a command role operationally. There is currently no scheduled reporting from the EPRR team to the wider Directorate on CPD levels or overall commander status. We reviewed a sample of 20 CPD evidence returns and identified: • Tactical Commanders – three returns did not include evidence to demonstrate that the time related CPD target level had been met for at least one mandatory competency. • Operational Commanders - three returns where the time related CPD target level had not been met for between 2 - 4 of the mandatory competencies. We also identified one Operational commander where a record was not present despite the training spreadsheet indicating it was in place.	Potential risk of: • Noncompliance against policy. • No formal reporting on status to directorate. • No mechanisms for assurance on CPD evidence.

Recommendations	Priority
3.1 A formal process should be developed of actions to address non-compliance with CPD requirements. This should be documented within the policy and notice provided to staff reminding them of their responsibilities. 3.2 Periodic reporting should be established from the EPRR team to the Senior Operations Team on CPD activity levels and any outstanding non-compliance with CPD requirements. Consideration should be given to developing a dashboard which could allow production of a summary compliance rate. 3.3 The EPRR team should undertake periodic sample checks against listed evidence within commander returns. Reference to this should be included within the policy for staff awareness.	Medium

Management response		Target Date	Responsible Officer
3.1	The Trust accepts this recommendation and will incorporate the relevant process into the Command Policy.	November 2022	Judith Bryce, Assistant Director of Operations
3.2	A relevant process of periodic CPD reporting into SOT will be developed by the EPRR team.	November 2022	Clare Langshaw, Head of Service, EPRR
3.3	The EPRR team will undertake sample checks of evidence within commander returns; This process will be referenced within the Command Policy.	November 2022	Clare Langshaw, Head of Service, EPRR

Matter arising 4: Monitoring and review of action cards (Operation)	Impact
As LRFs develop or maintain a number of region or site-specific plans, we were informed that the Trust will access these plans in order to develop their own and align with other partner responses. The Trust has developed a Pan Wales COMAH sites plan (currently version 3.2), which contains site specific action cards for 23 COMAH facilities drawn from those plans shared at LRFs. We selected two sites and reviewed WAST action card detail which contains site information, location, response, public information zones, hazards, rendezvous locations, command locations/arrangements and maps. We note one LRF plan had been updated in November 2021 and included information which was not included within the WAST action card. The Pan Wales COMAH sites plan was last reviewed in November 2021 includes an annual review, but noting the number of action cards it may be beneficial to include an interim check of site plans between review periods.	Potential risk of: • Action cards may contain out of date information.

Recommendations	Priority
4.1 Outside of the COMAH site plan annual review it may be beneficial to include a mid-review check of action cards to ensure WAST references and instructions remain valid.	Medium

Management response	Target Date	Responsible Officer
4.1 The Trust accepts this recommendation and will undertake a periodic review of action cards associated with COMAH sites.	November 2022	Clare Langshaw, Head of Service, EPRR

Matter arising 5: Organisational Learning escalation (Design)	Impact
The Organisational Learning SOP includes clear reporting routes within the Operations Directorate, to both the Senior Operations Team (SOT) for oversight, and Senior Leadership Team (SLT) should there be a need for escalation. Discussion with management indicated that where escalation to SLT does not resolve an issue there would be consideration of highlighting this to the Trust's Executive Management Team (EMT), but we note this is not reflected within the SOP process flowcharts and there are no associated timescales or escalation trigger points to support this escalation.	Potential risk of: • Escalation routes not formally documented.

Recommendations	Priority
5.1 Consideration should be given to including escalation for overdue actions from the Operations SLT to the Trusts EMT formally within the SOP, alongside outline of the criteria or associated timescales where this escalation would occur.	Low

Management response	Target Date	Responsible Officer
5.1 The SOP will be updated to include the process for escalation beyond SLT (to ADLT with assurance to EMT) in order to resolve outstanding recommendations.	November 2022	Clare Langshaw, Head of Service, EPRR

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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Audit Committee Update – Welsh Ambulance Service NHS Trust

Date issued: September 2022

Document reference: 3160A2022

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.

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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.

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
2021-22 Audit of the Financial Statements	Complete Audit of Accounts Report presented to Audit Committee on 7 June 2022, with the final financial statements to considered by Trust Board on 13 June 2022. The Auditor General certified the Performance Report, Accountability Report and Financial Statements on 15 June and they were subsequently laid by the Senedd the following day.
2021-22 Audit of the Charitable Funds' Financial Statements	Planning work is underway. Fieldwork is planned to commence November 2022.

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 considered the structures, information and assurance flows that support quality governance.	Completed Presenting to Audit Committee in September 2022
NHS Structured Assessment 2022	A review of the corporate arrangements in place at the Trust in relation to: • Governance and leadership. • Financial management. • Strategic planning • Use of resources (such as digital resources, estates, and other physical assets).	Drafting report – Anticipated to report to Audit Committee in December 2022
Review of Unscheduled Care	This work will examine various 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	Blog and data tool published in April 2022 Part 1: Fieldwork underway Anticipated to report to Audit Committee in Spring 2023

Topic	Focus of the work	Current status and Audit Committee consideration
	aspects of the unscheduled care system to review in more detail.	

Exhibit 3 – Planned work not yet started or revised

Topic	Focus of the work	Current status
Workforce planning	An assessment of workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. The review will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs	Fieldwork due to begin late Autumn 2022.

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 June 2022. Details of future events are available on the GPX website.

NHS-related national studies and related products

6 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.

7 The Audit Committee might also wish to be sighted of the recently published Audit Wales strategy, **Assure, Explain, Inspire: Our Strategy 2022-27**. This strategy sets out our 5-year vision to drive improvement and support Welsh public Services as they adapt to the challenges and opportunities of a changing world.

8 **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
Public Sector Readiness for Net Zero Carbon by 2030	July 2022
The Welsh Community Care Information System update	July 2022
Assure, Explain, Inspire: Audit Wales Strategy 2022-27	June 2022
Tackling the Planned Care Backlog in Wales	May 2022
NHS waiting times tool	May 2022
Unscheduled Care in Wales: Data Tool and Blog	April 2022
Direct Payments for Adult Social Care	April 2022

9 **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
National report on Quality Governance in NHS Wales	2022
Unscheduled care – a whole system view	2022-23

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Audit Wales

Review of Quality Governance Arrangements – Welsh Ambulance Services NHS Trust

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Contents

Summary report

About this report

1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these 'quality governance' arrangements is to help organisations and their staff both monitor and where necessary improve standards of care.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the Covid-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with Covid-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at the Welsh Ambulance Services NHS Trust (the Trust) carried out in 2021/22.

Key messages

6 The Trust continues to deal with extreme service pressures driven by whole system issues that are resulting in unprecedented ambulance handover delays, and associated difficulties in responding in a timely fashion to calls for an emergency ambulance. Staff are working under significant pressure and sickness absence levels are high. More than ever, therefore, the Trust needs to have robust governance arrangements that allow it to maintain the necessary oversight and scrutiny on the quality and safety of its services.

7 **In overall terms we found that whilst many facets of the Trust's quality governance arrangements are working well, improvements are required in a number of key areas to ensure the Trust is fully informed on issues relating to the quality and safety of its services. The Trust also needs to play its part in the improvements that are required to serious incident reporting across organisational boundaries.**

8 The Trust has renewed its Quality Strategy, is strengthening its risk management arrangements and has invested in quality improvement processes. Lines of accountability for quality governance are clear, and there are good arrangements to listen to and act upon the experiences of patients and staff.

9 The role of Quality Patient Experience and Safety (QuESt) Committee is clearly defined, and its work is supported by a good suite of performance information. The Trust has correctly identified opportunities to rationalise the working groups that support the Committee and must also deliver on commitments in its Quality Strategy to improve its quality management systems.

10 However, the necessary attention given to responding to Covid-19 and wider service pressures have caused delays in pursuing the Trust's quality agenda, constraining its ability to successfully deliver its renewed Quality Strategy. A key area for improvement is the need to address the significant backlog of mortality reviews, and to keep the QuESt Committee adequately sighted of progress in this area. There is also a need to better triangulate information from different sources to ensure there is a full understanding of patient outcomes and avoidable harms associated with long waits for an emergency ambulance.

11 Patient safety walkabouts by Board members need to be reinstated and undertaken on a more systematic basis across the Trust's operations and locations. Action is also needed to ensure clinical audit becomes a recognised and visible source of assurance within the Trust's quality governance framework, beginning with approval of a clinical audit plan for 2022-23.

12 The work that is being done on organisational culture and behaviours needs to understand and address concerns around incident reporting, appraisal rates and to ensure adequate responses to any incidents of bullying and harassment.

13 Whilst the Trust's internal system for managing concerns and serious incidents is sound, the joint escalation framework for managing serious incidents across

organisational boundaries is no longer effective, and the Trust must work with its commissioners and health board partners to improve this.

Recommendations

14 Recommendations arising from this audit are detailed in **Exhibit 1**. The Trust's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations
Quality Strategy delivery R1 We found that delivery of the Trust's renewed Quality Strategy (2021-2024) has been severely hampered by resource pressures caused by the pandemic and a lack of funding to support four senior quality lead posts which are central to delivery. The Trust should update its implementation plan outlining how it will deliver its quality ambitions.
Clinical Audit Plan R2 We found that the clinical audit plan is not approved in a timely manner and the QuESt Committee does not have adequate oversight of progress and delivery. The Trust should ensure that: • the QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year. • the QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan, assurance reports including learning and improvement actions resulting from this work.
Mortality reviews R3 The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: • the number of reviews undertaken, and the numbers of reviews required but not yet complete. • any significant concerns, lessons learned and what changes have been made as a result. • updates on actions to address the mortality review backlog

Recommendations

- updates on progress implementing the all-Wales Learning from Mortality Reviews Framework

R4 The Trust has a significant backlog of mortality review. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee.

Personal Appraisal and Development Reviews (PADR)

R5 The Trust has low PADR compliance rates, for example in June 2022 the Trust's compliance was 59% against the 85% target. As part of embedding its new behaviours, the Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.

Board member walkabouts

R6 Prior to the pandemic, Board members regularly participated in ambulance ride-outs and station visits, but these were ad-hoc in nature and feedback was not collated in a structured way. Now that visits can restart the Trust should develop a standard operating procedure which clarifies the process, frequency of the visits and ensures coverage across the Trust's operations and geographical areas. It should also include a standard template to capture feedback and learning.

Joint Escalation Framework

R7 The joint escalation framework in place with health bodies is no longer effective. The Emergency Services Ambulance Committee is coordinating action to strengthen those arrangements. The Trust must ensure that the recommendations made by the Delivery Unit are effectively responded to in a timely fashion and progress reported regularly to the Board and QuESt Committee.

Quality performance reporting and learning

R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should:

- develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation.

Recommendations

- enhance Covid-19 reporting in the integrated quality and performance report by including information about the harm caused to patients by ongoing service pressures caused by the virus.
- work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits.
- develop patient outcome measures to support its existing quality measures.

Detailed report

Organisational strategy for quality and patient safety

15 Our work considered the extent to which there are clearly defined priorities for quality and patient safety and effective mitigation of the risks to achieving them.

16 We found that **while the Trust has a renewed Quality Strategy and is strengthening its risk management systems, resource constraints threaten the progress of its ambitions.**

Quality and patient safety priorities

17 **Resource issues caused by the Covid-19 pandemic and funding challenges poses a risk to the Trust successfully delivering its renewed Quality Strategy.**

18 The Board approved its 2021-24 Quality Strategy (the Strategy) in May 2021. The Trust had begun work to renew its quality strategy in 2019, which it paused in 2020 to enable it to respond to the Covid-19 pandemic and restarted in 2021. The strategy, developed through engagement with stakeholders including patients and staff, sets out six quality priorities based on the Health and Care Standards. These are:

- **Person-centred Care** – Our services will respond to people's needs and choices. We want people to have a positive experience and value the services and care we provide.
- **Timely Care** – People will have timely access and response to services based on clinical need and will be actively involved in decisions about their care.
- **Efficient Care** – We will ensure that we provide the best quality care through the most efficient use of the resources available.
- **Safe Care** – We will ensure that people using our service are protected from avoidable harm.
- **Effective Care** – The care and treatment we provide will achieve good outcomes and will be based on the best available evidence. We will embrace opportunities to learn, grow and improve.
- **Equitable Care** – We will ensure that the quality of service meets the needs of individuals, taking into account individual characteristics and circumstances.

19 The Strategy includes actions the Trust is taking to comply with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Specifically:

- developing a culture of candour;
- ensuring robust quality management systems; and
- listening and learning from patients and service users.

20 The Strategy is a high-level document which supports the Trust's long-term strategic framework, Delivering Excellence 2030. The long-term strategic framework states the Trust's aim to ensure 'quality is at the heart of everything we do'. The Trust's 2022-25 integrated medium-term plan is aligned to this and includes deliverables to help achieve its wider aim.

21 There was a long gap between Board approval of the strategy and the subsequent approval of the strategy implementation plan. In February 2022, the QuESt Committee received the Quality Strategy implementation plan, following endorsement by the Assistant Director Leadership Team. This is nearly a year after the Board approved the overarching Strategy. The Trust reported that service and resource pressures cause by Covid-19 and wider system pressures delayed the implementation plan. Many actions in the implementation plan are scheduled for 2022-23 but the compressed timetable introduces risks to delivery. Commencement dates for some actions are yet to be confirmed. These generally relate to workshops due to be delivered by Welsh Government on compliance with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Wider progress of strategy implementation in the Trust has also been delayed because of the pandemic.

22 The Trust's Resource Escalation and Action Plan (REAP) arrangements enable it to manage its resources at times of extreme pressure. When the Trust is at its highest level of escalation, REAP 4, all non-essential work is paused, and resources are diverted to aid frontline services. This was the case for most of quarters 3 and 4 of 2021-22. The consequence of this is that the implementation of the 2021 quality strategy has been slow to progress. Given the strategic priority the Board has given to quality, the Trust needs to find a way of delivering its important quality improvement actions alongside managing, what might be, sustained service pressures. To ensure the Strategy delivery progresses, the Trust has convened a cross-discipline Quality Strategy Implementation Working Group, this should help to strengthen the actions taken to deliver the Strategy. The group was established in late 2021, so it is too early to measure the groups impact. However, the Trust reported that operational and staffing pressures have had an impact on the group's effectiveness.

23 The QuESt Committee received regular updates as the Strategy developed, and more recently updates on delivery. The reports routinely highlight resource challenges posed by service pressures. But in May 2022 the update report also highlighted financial challenges. The Trust has plans to recruit four senior quality leads to help deliver the quality strategy. However, the update report stated that the Chief Ambulance Service Commissioner's (CASC) office informed the Trust that it will not fund these posts on a recurrent basis. If the Trust is to successfully deliver its strategy, it will need to revisit its strategy implementation plan (**Recommendation 1**).

Risk management

24 **The Trust is taking steps to strengthen its risk management systems and it clearly articulates quality and patient safety risks. But given the levels of risk the Trust faces and its improvement ambitions, resources for risk management are low.**

25 In December 2021, the Audit Committee endorsed the Trust's risk management and Board Assurance Framework (BAF) transformation programme. Its aims include improving risk management by better defining risks, implementing the once for Wales Datix module, developing risk appetite statements and training staff and board members.

26 While the Trust's risk management strategy and framework expired in 2021, it appropriately covers clinical and non-clinical risks and remains extant. The Trust has decided not to refresh the strategy, instead, it will develop a risk management framework and associated policies, procedures, and training as part of its transformation programme by December 2022.

27 The Trust does not have a dedicated risk management team. In 2020, responsibility for risk management transferred from the health and safety department to the corporate governance team, but resources did not transfer with the responsibility. The previous corporate governance manager, now Head of Risk / Deputy Board Secretary is responsible for risk management. At the time of our fieldwork, risk management capacity only equated to a 0.4 WTE employee. We are aware that the Trust is recruiting to two vacancies within the corporate governance team; a Band 6 Risk Officer and a Corporate Governance Manager, who is joining the Trust in October 2022. At operational levels, there are no risk managers, instead senior leaders are responsible for risk management. Risk registers are reviewed at fortnightly assistant directors' meetings and monthly at executive team meetings. Given the level of risk the Trust carries, along with its ambition to deliver its risk transformation programme, resources for risk management are limited.

28 We reviewed the Trust's updated corporate risk register, reported to the Audit Committee in June 2022, and four of the top risks clearly articulate quality and patient safety risks. The Trust uses a 'if', 'then', 'resulting in' model to describe each risk, this clearly shows the consequence of not taking any mitigating actions. For each risk, the register sets out the controls, assurances mechanisms and actions to reduce gaps in controls and the risk score. However, the risk scores for these risks remain high. The risks, which are assigned to the relevant committees for scrutiny are:

- the Trust's inability to reach patients in the community causing patient harm and death (risk score 25).
- significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service (risk score 25).

- high absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service (risk score 20).
- failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation (risk score 20).

29 In May 2022, the Trust received a reasonable assurance internal audit report on risk management systems. The review made five recommendations, one high priority, two medium and two low. The high priority recommendation related to the operations directorate risk management and escalation arrangements. Internal audit found that whilst risk is a regular agenda item at the newly established Senior Operational Team meeting, this is limited to corporate and directorate level risks and does not include high scoring local risks. It also found unclear escalation processes and inconsistent monitoring and management of Operations Directorate risks. The Trust is responding to these recommendations as part of its risk transformation programme.

Organisational culture and quality improvement

30 NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Trust is promoting a quality and patient-safety-focused culture, including improving compliance with statutory and mandatory training, participating in quality improvement processes that are integral with wider governance structures, listening and acting upon feedback from staff and patients, and learning lessons.

31 We found that **the Trust is investing in operational quality improvement, is taking steps to improve its organisational culture and the Board regularly hears from service users and staff. However, there is a worrying backlog of mortality reviews, which needs greater Board visibility as does delivery of the clinical audit; there is also a need to improve Board member walkabout arrangements.**

Quality improvement

32 **The Trust is investing in quality improvement, however, a recent funding challenge is hindering further investment. Clinical audit needs strengthening and the there is a need to address the substantial backlog of mortality reviews.**

Resources to support quality improvement

33 The Trust's Quality Improvement (QI) Team supports operational staff on quality improvement challenges, projects, and training. The Trust expanded the team of two to seven in 2019 after successfully securing funding through the Healthier

Wales and Regional Improvement and Innovation Coordination Hub funds. The Healthier Wales funding is recurring and specifically to implement a programme for improving the experience of care for older people. Welsh Government awarded Regional Improvement and Innovation Coordination Hub funding has been extended annually, on a fix-term basis, since 2020. The Trust is currently reviewing the QI Team. The Trust had also planned on further expanding quality improvement support by recruiting four senior quality leads by the start of 2022-23. These roles were central to delivering the Trusts quality strategy. However, as highlighted in **paragraph 23** the Trust was unable to secure recurrent funding for these posts, so will need to seek alternative funding and alternative delivery methods.

34 The Trust launched the WAST Improvement and Innovation Network (WIIN) in 2017 to drive consistent quality improvement across the organisation. The cross-directorate network, coordinated by the Quality Improvement Team, supports staff with quality improvement projects, training, and communications. The network is also a key link for improvement bodies and teams across other organisations and health bodies, aiding cross working. In March 2019, the Trust established an online portal for WIIN. Hosted on the Trust's intranet, the portal allows staff to submit suggestions and ideas for improvement proposals. Once ideas are submitted, the WIIN Business Group formally review the ideas using a scoring matrix and categorise into areas of research, audit or clinical improvement. Clinical improvement proposals are generally taken forward by the Clinical Improvement Team. The Trust reports the number of project ideas submitted in its integrated quality and performance report. In June 2022 there were 22 submissions. The Trust reported that the WIIN platform is currently focusing on improving patient handover delays at hospital and rolling out the Electronic Patient Care Record (see paragraph 75). During the height of the pandemic, the Trust redeployed members of the Quality Improvement Team to support core Trust services and paused much of the quality improvement activity, this is now slowly resuming.

35 Improvement in Practice is the national quality improvement training programme for NHS staff in Wales, it replaced Improving Quality Together (IQT) in January 2020. The goal of the programme is to develop quality improvement capability within NHS Wales using a common language for quality improvement. About a fifth of Trust staff (20.5%) completed the bronze IQT training and 1.1% completed silver training. The Trust reported that completion of silver IQT projects was impacted by the pandemic, accounting for the low compliance. As IQT was ending the Trust started offering training delivered by the Scottish Improvement Leader to broaden training opportunities for staff. The Trust has not set a target for staff completing this training, but it is working with Improvement Cymru to understand and maximise training opportunities.

Clinical audit

36 Clinical audit is an important way of providing assurance about the quality and safety of services. The Trust's Clinical Audit Team, employing 12.73 WTE staff, provides training and support to clinical team leaders such as senior paramedics. The type of support provided by the team includes developing audit proposals, preparing and collating data (for example patient clinical records) and writing audit reports. The Trust does not have a clinical audit policy but following an internal audit recommendation has developed a clinical audit guide and audit proposal template to support staff.

37 We found that Board level reporting on the Trust's clinical audit plan is sporadic and not timely. After pausing clinical audit work during the pandemic, the Trust reinstated it by mid-2021. During 2021-22, the QuESt Committee received brief updates on clinical audits through the quality assurance report. However, we have found no evidence of an approved 2021-22 clinical audit plan. Without an approved plan it is difficult to understand the extent of delivery and the level of assurance on the risks faced. A clinical audit plan has been produced for 2022-23 but the timeliness of its approval remains an issue. The Clinical Intelligence Assurance Group and Clinical Quality Governance Group have both reviewed the 2022-23 clinical audit plan in April 2022, but the QuESt Committee did not receive it for formal approval until August 2022.

38 Operational groups and forums consider progress of clinical audit activity, and the Trust provides updates on its intranet for staff to access. However, there is insufficient coverage of clinical audit progress and any risks the work highlights at the QuESt Committee (**Recommendation 2**).

Mortality reviews

39 Mortality review meetings provide a systematic approach for the peer review of patient deaths to reflect, learn and improve patient care. Mortality reviews are conducted when a patient dies whilst in the Trust's care, including whilst waiting for an ambulance to arrive. To aid learning the Trust also reviews cardiac arrests where patients have survived. A Serious Case Incident Forum scrutinises issues identified through mortality reviews.

40 The Trust aims to present mortality reviews and lessons learned to the QuESt Committee quarterly. But our review of QuESt Committee papers shows there is inadequate reporting on mortality reviews (**Recommendation 3**). Whilst mortality reviews feature regularly in QuESt Committee papers, through the quality assurance and, more recently, the integrated quality and performance reports, papers include no substantial detail. Officers periodically report on the backlog of cases, which in August 2022 stood at 800, but reporting does not include the number of reviews conducted or detail lessons learned. This means the committee is not receiving assurances that mortality reviews are taking place or how they are helping to improve quality and patient safety. The committee does, however,

receive details on coroner's activities through the patient safety highlight report. The report details case numbers, outline of hearings and lessons learned for cases where the Trust was an interested person.

41 Since May 2021, the Trust has highlighted challenges in undertaking timely mortality reviews. This is due to several issues, namely the volume of reviews, lack of clinical resources to conduct the reviews when the Trust is working at its highest escalation level (REAP 4), and issues downloading data from the Trust's patient monitoring system (Corpuls). Together these issues have caused a backlog of reviews. The Trust has not reported its mortality review backlog to the QuESt Committee since September 2021, at the time it had grown to 450 cases (**Recommendation 4]**. The Trust reported that it is working with the Corpuls support team and its internal IT team to resolve the data issues.

42 The Trust has recognised that its current mortality review process needs to improve. In March 2022, the Trust held a workshop to review the All-Wales Learning from Mortality Reviews Framework (the Framework) and consider how the Trust could implement it. The Framework recommends mortality reviews follow the Putting Things Right process. While adopting the Framework, the Trust would like to retain an element of their current system to review the care provided to patients who die in their care. Officers presented the outcome of this workshop to the QuESt Committee in August 2022.

Values and behaviour

43 **There are important cultural issues to address around incidents reporting, appraisal rates, and perceptions of bullying and harassment, which the Trust has the opportunity to address through embedding its refreshed organisational behaviours.**

44 Clearly articulated values and behaviours are central to ensuring strong quality and patient-safety-focused culture, promoting continuous improvement, openness, transparency and learning when things go wrong. In March 2021, the Trust commissioned external psychologists to review and refresh its organisational behaviours. The work, supported by a panel of representative staff, included extensive staff engagement through focus groups, interviews and surveys. In November 2021, the People and Culture Committee received the outcome of the review and an action plan for embedding the refreshed behaviours. Officially launched in March 2022, the refreshed behaviours focus on wellbeing, inclusion, belonging and leadership with compassionate conversations. Subsequent committee papers show that the Trust is starting to use the behaviours to improve organisational culture, for example recruitment practices and how it manages sickness management. Nevertheless, sickness absence has been and continues to be a long-standing challenge.

45 All staff have access to and are encouraged to use the Datix system to report incidents and near misses. The Trust's Concerns Team provide operational staff with regular and ad-hoc training on using the Datix system and a variety of other

concerns management skills (for example, undertaking root cause analysis, completing patient clinical records, and taking witness statements). Of the 30 staff who completed our survey[1], most (23 out of 30) agreed or strongly agreed that the organisation encourages staff to report errors, near misses or incidents. However, worryingly, less than half agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation (14 out of 30), that the organisation acts to ensure that errors, near misses or incidents do not happen again (12 out of 30); and that the organisation gives staff feedback about changes made in response to reported errors, near misses and incidents (11 out of 30). This reveals a potentially concerning picture in relation to the culture around reporting errors, near misses or incidents and raising concerns.

46 It is worrying that Trust staff responding to the 2020 NHS Wales staff survey[2] reported high levels of bullying, harassment, or abuse by a member of the public (25.5%), a colleague (19.1%) or line manager (11.3%) over the past year. And fewer than half (46.2%) agreed or strongly agreed that the organisation takes effective action. The Trust recognises that bullying and harassment is an issue, and it is encouraging to see action taken through its work to embed its refreshed organisational behaviours. For example, the Trust's 'With Us, Not Against Us' campaign aims to tackle violence and aggression against staff and initiatives such as the 'Warm WAST Welcome' aim to engender a welcoming and open culture. In addition, the Trust has committed to a harassment and bullying review through its Behaviours Delivery Plan.

47 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. In June 2022, the Trust met the 85% statutory and mandatory training compliance target. While the Trust is progressing with mandatory training, Personal Appraisal and Development Reviews (PADR) needs strengthening. PADR is a two-way discussion which helps staff understand what the Trust expects of them in their role and become more engaged and take responsibility of their own performance and development. The NHS target for PADR compliance is 85%, the Trust consistently falls below this target, compliance in June 2022 was 59%. Between July 2020 and June 2022, the highest compliance rate the Trust achieved was 65% and the lowest 45%. This target is generally unmet across health bodies. To improve compliance the Trust is encouraging staff to engage in their personal development through campaigns promoted on its intranet (#WASTMakeItHappen) and where appropriate increasing access to e-learning. However, given the low

[1] We invited staff working across operational services to take part in our online attitude survey about quality and patient safety arrangements. The Trust publicised the survey on our behalf. Although the findings are unlikely to be representative of the views of all staff across operational services, we have used them to illustrate particular issues.

[2]The NHS Wales staff survey ran for three weeks in November 2020 at the same time as the second surge in Covid-19 transmission and rising numbers of hospital admissions. The survey response rate was 39%.

compliance rates, the Trust should look at whether staff are given enough time for PADR activities and, through its refreshed behaviours, ensure leaders and managers encourage compliance (**Recommendation 5**).

Listening and learning from feedback

48 **The Trust has good arrangements for listening and learning from service users and staff, who the Board hear from regularly, but there is scope to improve Board member walkabouts.**

Patient experience

49 Patient experience is integrated into the Trust's existing strategies and plans. For example, one of the three quality drivers in the Trust's Quality Strategy is 'to ensure a positive patient outcome and experience', through 'embracing the contribution of patients and service users'. To support this approach the Trust uses a continuous engagement model to drive patient and service user engagement.

50 Each quarter, the QuESt Committee receives several reports which highlight aspects of patient experience. At each meeting, the committee receives:

- the patient experience and community involvement report, which highlights the work of the Patient Experience and Involvement Team;
- The patient safety highlight report which updates the committee on key information related to Putting Things Right and patient safety; and
- the integrated quality and performance report that includes some indicators related to patient experience.

51 While each of these reports individually highlights lessons learned, it would be beneficial to triangulate learning themes and improvement priorities across the reports (**recommendation 8a**).

52 The Trust's Patient Experience and Involvement team (11.8 WTE) use a range of techniques to seek patient and user feedback such as the 'have your say' facility on its website, feedback through social media channels, documenting patient stories, running engagement events and patient experience surveys for non-emergency patient transport service users. The Trust also has a People and Community Network, which is a service user panel made up of members of the public, service users, patient group representatives and other interested services and organisations. The network informs service improvement through activities such as commenting on the readability of leaflets, completing surveys, undertaking mystery shopping exercises and attending meetings. As at June 2022, the network had 95 members, which the Trust is continuing to grow.

Patient and staff stories

53 The Board, QuESt Committee, and more recently the People and Culture Committee, routinely receive patient and staff stories. The Trust actively seeks out patient stories, both from its emergency response and 111 services. The Patient Experience and Involvement Team actively contact service users that make a complaint to involve them in patient stories. In some cases, the complainant is offered the opportunity to record their experience for the Board. The Trust alternate patient and staff stories, so the Board and committees also regularly hear staff stories. Recently the Board has heard from a nurse working in the 111 service, a senior paramedic, 999 call-takers and the son of a frequent faller.

54 The Trust uses a driver diagram to ensure the learning and actions from patient stories are making a difference. In addition to summarising the story, the driver diagrams helpfully outline what the Trust aims to do, what this requires, ideas to make this happen, and action points. This is a good process to ensure learning from patient stories, although the Trust explained that some changes can take a long time to action because the issues are complex in nature.

Board member walkabouts

55 As with other health bodies, the Trust suspended its Board member patient safety walkabouts during the pandemic. Prior to this, Board members regularly participated in ambulance ride-outs and station visits. But these were ad-hoc in nature and the Trust did not collate structured feedback. However, the Trust reported that Board member engagement has enhanced since the pandemic. Where restrictions allow, Board members continue to engage with staff, for example through site visits, CEO roadshows and long service awards. Now that restrictions have eased the Trust will be restarting formal patient safety walkabouts. This is a good opportunity for the Trust to develop a standard operating procedure for walkabouts which clarifies the process, frequency of visits and ensures coverage across the Trust's operations and geographical areas. The standard operating procedure should also include a standard template to capture feedback and set out how it will be reported (**Recommendation 6**).

56 The Trust reported that it will adopt the all-Wales principle being drafted for Board level walkabouts and this should be included in the standard operating procedure.

Governance structures and processes

57 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

58 We found that **the Trust has a clear quality governance structure, and it is taking steps to improve the QuESt Committee sub-structures. While the Trust's internal arrangements for managing concerns and serious incidents**

operates well, the interface with other bodies and handling of incidents through the joint escalation framework is not effective.

Organisational design to support effective governance

59 The Trust is commissioned by the Emergency Ambulance Services Committee (EASC). EASC is a joint committee of the seven health boards in Wales. Each health board chief executive is a member of EASC. Collectively, the committee commissions the Trust to deliver safe, quality driven services. Ultimately, EASC is responsible for overseeing the quality and improvement of the services it commissions. The committee has some quality assurance processes in place. For example, in 2016, it introduced ambulance quality indicators[3]. EASC review the quality indicators at each joint committee meeting alongside other performance reports. The committee also receives other ad-hoc quality and safety reports and routinely reviews the EASC risk register.

60 The Quality and Performance Framework states that overall accountability for quality and performance rests at Trust Board level, but everyone in the Trust has a responsibility for quality and performance. At a practical level, the Executive Director of Quality and Nursing is the executive lead for quality and patient safety, but the responsibility is shared with the Executive Medical Director who holds responsibility for clinical effectiveness. Assistant directors and heads of service support the Trust's executive team providing day to day leadership on a range of functions such as quality governance, quality improvement, patient experience, patient safety and concerns and clinical effectiveness.

61 Oversight and assurance on quality and safety matters within the Trust takes place through its QuESt Committee. The Trust is in the early stages of reviewing the number and make-up of the groups which inform the QuESt Committee with the intention of improving the connection to frontline operations, this is a commitment in the Trust's Quality Strategy. Currently, there are six groups which inform the QuESt Committee. These groups feed into the Clinical and Quality Governance Group, which reports up to the Executive Management Team. These groups are:

- Patient Safety Learning and Monitoring
- Serious Case Incident Forum
- Complex Case Management
- Scrutiny Panel
- Health and Safety Committee
- Infection Prevention and Control Steering Group

3 EASC and the Trust jointly developed the Ambulance Quality Indicators to monitor the quality of patient care as well as response times. Indicators are reported along the Five Step Ambulance Care Pathway; help me choose, answer my call, come to see me, give me treatment and take me to hospital.

62 Issues covered and escalated by the groups above inform update reports to the QuESt Committee and the Board. However, the current number and remits of these groups creates a risk of duplication and the current review creates an opportunity to rationalise the structure.

63 The Trust has a straightforward organisational structure. It has one Operations Directorate which houses the majority of clinical contact centre and response team staff. The other directorates perform enabler, support, and research functions, including the Quality, Safety & Patient Experience Directorate. Quality guidance, policy and information is cascaded operationally, however the geographical spread of operational staff and shift patterns can make this difficult.

Handling complaints and incidents

64 The Trust has sufficient capacity for managing complaints and concerns in accordance with the Putting Things Right process. There are 18.4 WTE staff in the Concerns Team, who manage complaints and provide concerns management training to operational staff. The team work closely with the patient safety team to help identify near-misses and adverse events, which feeds into organisation-wide learning. During the pandemic, the Trust deployed members of the Concerns Team to support the Trust's pandemic plan. During this time, the team's activity reduced because volumes of concerns received were lower and coroners' inquests were paused. Now that activity has resumed, the team's workload has increased, stretching its capacity. In June 2021, the Trust received a substantial assurance report from internal audit on its concerns and serious incident management systems.

65 In 2019, the Trust and all trusts and health boards agreed a joint investigation framework for serious patient safety incidents. The framework sets out the process for escalating serious incidents where the main cause is a factor outside of the Trust's control or because of health board hospital handover delays.

66 The Trust identifies cases for escalation through its Serious Case Incident Forum (SCIF). In these cases, the Trust completes an incident referral form (known as an Appendix B form) and sends it to the appropriate health body for investigation, copying in the Welsh Government's Delivery Unit. In May 2022, the Trust received a report from the Delivery Unit outlining findings from their analysis of 'Appendix B' reports. The review found that the framework is no longer effective, given that significant numbers of Appendix B referrals are not investigated properly or reported nationally because of a breakdown in communications between the Trust and health boards. The report made four recommendations:

- to establish a task and finish group to revisit the Framework to ensure the process is fit for purpose and is updated to reflect current national policy regarding patient safety incidents.
- the task and finish group should be coordinated by the EASC, as the body responsible for the delivery of WAST services, and the commissioning arrangements between WAST and health boards and trusts.

- WAST and EASC should update their relevant committee and the Board and consider sharing to nurse directors so they may assess their position.
- the revised policy is endorsed via Nurse and Medical directors and relaunched at the earliest opportunity.

67 The Emergency Services Ambulance Committee is now coordinating action to strengthen arrangements. The Trust must work with its commissioners and partner health bodies to respond to the Delivery Unit's recommendations (**Recommendation 7**). This should ensure strong and effective approaches for quality assurance, escalation, and immediate improvement actions, and wider learning where quality issues cross organisational boundaries.

Arrangements for monitoring and reporting

68 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

69 We found that **the Trust recognises the challenges posed by Covid-19 and is taking steps to improve quality monitoring by improving the data it collates and quality management systems.**

Information for scrutiny and assurance

70 **The Trust has good resources for data analytics and is taking steps to improve the quality, timeliness and integration of data to support quality improvement. However, more needs to be done to ensure that patient outcomes and extent of avoidable harm are fully understood, especially for patients experiencing long waits for ambulance services.**

71 The Trust is clearly committed to assessing how Covid-19 is continuing to affect the service it provides. The quarterly integrated quality and performance report, presented to the Board and its committees, includes a Covid-19 activity dashboard. The metrics included in the dashboard have evolved over the course of the pandemic, with more detail provided during significant waves. It includes information such as cases per 100k population, hospital and ventilated bed occupancy rates and service demand linked to Covid-19. Narrative in performance and assurance reports outline the impact of the pandemic on key performance measures and remedial actions.

72 Whilst there is sufficient information about the effect of Covid-19 on service delivery, there is less about the harm caused to patients by issues such as long ambulance waits or people avoiding accessing emergency services (**Recommendation 8b**). The Delivery Unit report (paragraph 65) highlighted that there is a lack of national data to capture and understand the harm caused by the Trust's inability to respond and treat seriously unwell patients in the community during periods of high handover delays. Much more needs to be done to ensure

quality systems join up, so that the patient outcomes are fully understood particularly when there are service failings such as extensive delays in access to ambulance services (**recommendation 8c**). Linked to this issue, the Trust will need to ensure that it complies with the new Duty of Candour, which requires clear quality standards, underpinned by quality data, that act as a trigger for the duty of candour when services fall short of expected levels.

73 The Trust has good data analytics support. The Health Informatic Team employs 22 WTE staff and supports the organisation by developing daily, weekly and monthly performance reports. The team coordinates live reports through information management systems such as Qliksense, Report Manager and Microsoft Power BI. The Team also supports service delivery and decision making through data analysis, modelling and forecasting.

74 In February 2022, the Trust received a reasonable assurance Internal Audit report on information management. The Internal Audit review focused on 999 calls, specifically 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. The Trust received two medium priority recommendations. These related to making greater use of referral data captured in incident records to improve referral pathways and to reduce the risk of patient harm, extend the sample review of ‘Can’t Send’ call response to include ‘See and Treat’ and ‘Consult and Close’ and ensure learning is routinely reported at an appropriate group.

75 The Trust is improving its system for collating clinical indicators. Until recently, the Trust was using Digi Pen, a semi electronic patient records system. One of the main issues with Digi Pen was limited integration with health board systems. This meant it was difficult to track a patients’ journey and outcome after they have been handed over to an emergency department. The Trust is in the process of rolling out the Electronic Patient Care Record. This new system, which will be fully implemented by March 2023, is fully electronic and integrated with NHS Wales systems such as health board emergency department systems and the Welsh Care Records Service. The Trust is also working with Digital Health and Care Wales on an interface with GP records. The Electronic Patient Care Record provides opportunities for better and more timely data and enables sharing of information between NHS bodies to improve the patient journey. The data from the new system will inform the clinical indicators as part of the ambulance quality indicators[4] and metrics within the Trust’s clinical strategy.

Coverage of quality and patient safety matters

76 **The QuESt Committee is well served with quality information but reporting on mortality reviews and clinical audit needs greater focus. There are**

opportunities to better triangulate data and learning presented in different quality assurance reports and to develop patient outcome measures.

77 The Trust's Integrated Quality and Performance report focuses on key national measures and is broadly aligned to the quadruple aims within A Healthier Wales. The Board and its committees, including QuESt, receive the report at each meeting. One of the four sections in the report called 'our patient' covers quality, safety, and patient experience. It includes measures such as 111 and 999 call handling, stroke, and acute coronary care, over 12 hour waits, nationally reportable incidents and concerns response in 30 days. The report has a clear format with written analysis against each measure, remedial actions and expected performance trajectory. A cover report highlights key issues. Whilst the report gives a good overview of quality and patient safety performance, there is scope to include patient outcome measures and to better triangulate data (**Recommendation 8b**). It is particularly important to understand the outcomes for patients who have waited excessively, outcomes for those who called for an ambulance but cancelled due to long waits, and how outcomes are affected positively or negatively by, for example, implementation of the new Clinical Safety Plan. This will require joining up of systems across organisational boundaries between the Trust and health boards.

78 Aside from the Integrated Quality and Performance report, the QuESt Committee regularly receives other quality and patient safety assurance reports. These include:

- Patient Safety Report
- Quality Highlight Report
- Patients Experience and Community Involvement Highlight Report
- Red review activity
- Operations directorate quarterly report
- Quality Strategy progress report

79 Until September 2021, the QuESt Committee received a Quarterly Quality Assurance report which reported in line with the health and care standards. Since then, as stated on paragraph 76, the integrated performance report has included a section for 'quality, safety and patient experience', whilst this provides a good high-level summary, some of the quality focus and detail in the original Quality Assurance report has been lost. Quality metrics are available separately in the reports listed above but there is merit in the committee receiving a quality assurance report which highlights and triangulates key themes, trends and learning points (**Recommendation 8a**). Also as highlighted in paragraphs 37 and 40, the committee should receive regular and detailed updates on the Trust's clinical audit plan (**Recommendation 2)** and mortality reviews (**Recommendation 3)**.

80 The Trust is in the process of improving its performance reports. Since March 2022, the QuESt Committee highlight report received by the Board uses an 'Alert, Advise and Assure format:

- Alert – alert the Board to areas of escalation.
- Advise – details any areas of on-going monitoring, approvals, or new developments.
- Assure – details any areas of assurance the Committee has received.

81 This format is an improvement on the previous highlight report as it aims to draw Board members to the committee's key concerns. The format is still new, so the Trust is keeping it under review with a view to strengthening it further.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response

Recommendation	Management response	Completion date	Responsible officer
Quality Strategy delivery R1 We found that delivery of the Trust's renewed Quality Strategy (2021-2024) has been severely hampered by resource pressures caused by the pandemic and a lack of funding to support four senior quality lead posts which are central to delivery. The Trust should update its implementation plan outlining how it will deliver its quality ambitions.	Following discussion by the Trust's Quality Committee in August 2022, a revised implementation action plan will be developed.	November 2022	J Turnbull-Ross

Recommendation	Management response	Completion date	Responsible officer
Clinical Audit Plan R2 We found that the clinical audit plan is not approved in a timely manner and the QuESt Committee does not have adequate oversight of progress and delivery. The Trust should ensure that: • the QuESt Committee scrutinises and approves a clinical audit plan ahead of each financial year. • QuESt Committee receives quarterly updates on delivery of the approved clinical audit plan, assurance reports including learning and improvement actions resulting from this work.	The Annual Clinical Audit Programme will be incorporated into the Committee's cycle of business ensuring it is presented to QuESt for scrutiny and approval ahead of each financial year. The Clinical Audit Programme will then be monitored on a quarterly basis by the Clinical Intelligence Assurance Group and updates providing assurance on learning will be submitted to the Clinical and Quality Governance Group. This group will escalate matters for information, assurance, or alert/action to the QuESt Committee.	Q3 2022/23	D. Robertson

Recommendation	Management response	Completion date	Responsible officer
Mortality reviews R3 The QuESt Committee does not receive adequate assurances on mortality reviews. The Trust should ensure the QuESt Committee receives quarterly update reports to include: • the number of reviews undertaken and the numbers of reviews required but not yet complete. • any significant concerns, lessons learned and what changes have been made as a result. • updates on actions to address the mortality review backlog	Monthly oversight of the All Wales Mortality Review Framework now occurs at the Clinical Quality Governance Group (CQGG) via the Alert / Advise / Assure process (Executive led) with onward assurances / updates to QuESt through the CQGG reporting mechanisms. Detailed reporting including organisational and system learning will be included in the Quarterly Patient Safety Report (standing agenda item at QuESt) from Q2 2022/3.	CQGG oversight commenced Q1 2022/23. QuESt reporting from November 2022.	M Jenkins / J Palin

Recommendation	Management response	Completion date	Responsible officer
• updates on progress implementing the all-Wales Learning from Mortality Reviews Framework			
Mortality reviews R4 The Trust has a significant backlog of mortality review. The Trust should develop an action plan to reduce the backlog, reporting progress at each QuESt Committee.	Action will be taken to establish the challenges in this area and implement process improvement to resolve future backlogs. A report will be provided to CQGG on progress.	Q3 2022/23	M Jenkins / J Palin
Personal Appraisal and Development Reviews (PADR) R5 The Trust has low PADR compliance rates, for example in March 2022 the	The Trust acknowledges compliance is below the 85% target. The Trust is currently assessing the current PADR process, with a view to development. Performance is improving, with a positive trajectory.	Q4 2022/23	L Rogers

Recommendation	Management response	Completion date	Responsible officer
Trust's compliance was 51% against the 85% target. As part of embedding its new behaviours, The Trust should ensure that PADR rates are improved and set out the actions it will take to achieve this.	The People and Culture Committee will continue to receive progress reports on a quarterly basis.		
Board member walkabouts R6 Prior to the pandemic, Board members regularly participated in ambulance ride-outs and station visits, but these were ad-hoc in nature and feedback was not collated in a structured way. Now that visits can restart the Trust should develop a standard operating procedure which clarifies the process, frequency of the visits and ensures	The standard operating procedure (SOP) is in development and will include a formal feedback mechanism to facilitate any learning.	March 2023	T Mills

Recommendation	Management response	Completion date	Responsible officer
coverage across the Trust's operations and geographical areas. It should also include a standard template to capture feedback and learning.			
Joint Investigation Framework R7 The joint escalation framework in place with health bodies is no longer effective. The Trust must ensure that the recommendations made by the Delivery Unit are effectively responded to in a timely fashion and progress reported regularly to the Board and QuESt Committee.	The Trust is actively contributing to work with partners across Emergency Services Ambulance Committee regarding the Joint Escalation Framework. Recommendations and/or actions arising on this matter will be reported accordingly to the QuESt Committee.	Q4 2022/23	W Herbert

Recommendation	Management response	Completion date	Responsible officer
Quality performance reporting and learning R8 We found that the QuESt Committee is well served with quality information, but there are opportunities for improvement. The Trust should: • a) Develop a system to triangulate learning themes across its quality assurance reports. This should ensure clarity about what improvement actions have been taken as a result and how learning has been disseminated across the organisation. • b) Enhance Covid-19 reporting in the integrated quality and performance report	• a) The Trust, through the Quality Strategy, is seeking to develop a quality management system. This will improve triangulation of information, clarity of position, and impact of improvement effort. • b) The recommendation will be considered by the MIQPR team, considering the accessibility and accuracy of this data noting the changes to approach due to 'living with covid' context. • c) The Trust will continue to share information and intelligence with partners that detail the consequences of system failures. Whilst particularly evident where experience or outcome is poor and results in complaint or adverse incident. The Trust will pursue patient outcome data through development of the ePCR over 2022/23. • d) The Trust is often limited by data accessibility where the patient journey extends beyond the organisational boundary. The Trust will pursue patient	Q4 2022/23	J Turnbull-Ross W Herbert H Bennett

Recommendation	Management response	Completion date	Responsible officer
by including information about the harm caused to patients by ongoing service pressures caused by the virus. • Work with health bodies so that there are systems to determine the outcomes for patients who have received emergency ambulance services. This should particularly seek to understand the consequence and harm resulting from service failures such as long ambulance waits. • Develop patient outcome measures to support its existing quality measures.	outcome data through development of the ePCR over 2022/23, which will enable 'joining up' of patient records. Furthermore, the Trust will further consider accessibility and governance matters for wider adoption of Patient Reported Outcome Measures, and Patient Reported Experience Measures.		

Appendix 2

Staff survey findings

Exhibit 3: staff survey findings

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
Delivering safe and effective care							
1. Care of patients is my organisation's top priority	11	11	3	4	1	0	30
2. I am satisfied with the quality of care I give to patients	0	12	1	7	7	3	30
3. There are enough staff within my work area/department to support the delivery of safe and effective care	1	1	5	14	8	1	30
4. My working environment supports safe and effective care	2	15	6	3	2	1	30

Attitude statements	Number of staff agreeing or disagreeing with statements						
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	Total respondents
Delivering safe and effective care							
5. I receive regular updates on patient feedback for my work area / department	2	3	4	11	6	4	30
Managing patient and staff concerns							
6. My organisation acts on concerns raised by patients	5	21	1	1	0	2	30
7. My organisation acts on concerns raised by staff	2	10	6	9	1	2	30
8. My organisation encourages staff to report errors, near misses or incidents	3	20	2	3	1	1	30
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	4	10	6	1	4	5	30

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
Managing patient and staff concerns							
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	2	10	12	3	2	2	30
11. We are given feedback about changes made in response to reported errors, near misses and incidents	2	9	4	9	2	4	30
12. I would feel confident raising concerns about unsafe clinical practice	6	15	3	3	2	1	30
13. I am confident that my organisation acts on concerns about unsafe clinical practice	7	9	6	5	1	2	30

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
Working in my organisation							
14. Communication between senior management and staff is effective	2	7	6	7	8	0	30
15. My organisation encourages teamwork	2	13	6	7	1	1	30
16. I have enough time at work to complete any statutory and mandatory training	3	10	6	6	5	0	30
17. Induction arrangements for new and temporary staff (eg agency/locum/bank/re-deployed staff) in my work area/department support safe and effective care	1	11	6	3	4	5	30

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Date issued: July 2022

Review of Unscheduled Care – Project Brief

Background

1 The Auditor General has a statutory requirement to satisfy himself that NHS and local councils have proper arrangements in place to secure economy, efficiency, and effectiveness in the use of their resources as set out in Section 17 and Section 61 of the Public Audit Wales Act 2004.

2 In April 2022, we published a blog 'Unscheduled Care – a system under real pressure' which described the numerous and significant challenges currently being experienced by the unscheduled care system in Wales. The blog considered the impact these pressures are having on patients and staff, the factors contributing to the pressure and what is being done in response. It also set out the Auditor General's intention to undertake a programme of work that will assess the extent to which the system and its leadership structures are responding to the pressures in the unscheduled system.

3 This project brief sets out the main areas of focus for our work on unscheduled care, together with the overall approach and timing of our audit work. Our approach recognises that the unscheduled care system is complex, with many different organisations involved in providing emergency and urgent care and ensuring that the wider system operates effectively and efficiently. Our work comes at a time when the COVID-19 pandemic has had a significant impact on unscheduled care services. While there was an initial easing of pressures on the ambulance service and emergency departments as people stayed home at the beginning of the pandemic, demand has since surpassed the pre-pandemic levels. Pressures within the wider system also means that there are significant challenges discharging patients out of hospital impacting on patient flow, with ambulance handover delays the worst on record and some patients experiencing severe delays in receiving an ambulance response and treatment in emergency departments. More detailed and up-to-date information on how the system is performing across a range of key indicators can be found in the Unscheduled Care Data Tool that accompanied our blog.

Audit approach

4 Our work will allow the Auditor General to answer the overall question: **Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?**

5 Given the complex and interconnecting nature of the issues within the unscheduled care pathway, we will be undertaking the work in three parts:

- **Part 1 – patient flow out of hospital.** This element of our work will seek to address the following question: **Do health and social care bodies have effective arrangements in place to ensure efficient discharge of medically fit patients out of hospital?**
- **Part 2 – access to unscheduled care services.** This element of our work will seek to address the following question**: Are health bodies effectively managing the demand for unscheduled care services to reduce unnecessary pressure on the system?**
- **Part 3 – national arrangements.** This element of our work will seek to address the following question: **Are the national arrangements and leadership structures effectively overseeing, scrutinising, and driving change in the unscheduled care system?**

6 **Exhibit 1** sets out the key lines of enquiry we will consider for the different parts of the work.

Exhibit 1: key lines of enquiry

Level one	Level two
Do health and social care bodies have effective arrangements in place to ensure efficient discharge of medically fit patients out of hospital?	• Do health and social care bodies have effective plans and procedures in place for discharge out of hospital? • Are patients able to flow through the unscheduled care system in a timely and efficient way? • Are health and social care bodies doing enough to review services relating to discharge out of hospital and apply lessons learned to improve further?
Are health bodies effectively managing the demand for unscheduled care services to reduce unnecessary pressure on the system?	• Do health bodies have effective plans in place to manage demand for unscheduled care services? • Are arrangements in place to enable and encourage people to access the right care, in the right place, at the right time, and are these working? • Are health bodies doing enough to review unscheduled care services and apply lessons learned to improve further?

Level one	Level two
Are the national arrangements and leadership structures effectively overseeing, scrutinising and driving change in the unscheduled care system?	• Are the national arrangements (including the national programme boards) clearly set out and working as intended? • Are there realistic and ambitious plans in place to respond to the system challenges? • Are the national arrangements (including the Emergency Ambulance Services Committee) leading to improvements?

7 All three elements of our work will be based on documentation, observations of relevant forums, and structured interviews with the appropriate people in NHS bodies and local councils, and Welsh Government.

8 For our work on patient flow out of hospital, we will also hold workshops with discharge co-ordinators and social care staff, and request and analyse data not already included in the Unscheduled Care Data Tool relating to discharge and social care capacity. Health Boards will also be required to complete a self-assessment against our previous 2017 discharge planning recommendations. Particular attention will be given to the role of the Regional Partnership Boards and the use of additional monies provided by the Welsh Government, for example, the Regional Integration Fund.

9 For our work on access to unscheduled care services, we will also look to gather feedback from ambulance crews through workshops and surveys, and review information available to patients via websites and phonelines. Particular attention will be given to how well 111, 'phone first' and 'same day emergency care (SDEC)' arrangements are working in local areas.

10 At a national level, we will give particular attention to the newly established Six Goals Board, designed to oversee the delivery of the six goals for urgent and emergency care. We will also include a focus on the role played by the Emergency Ambulance Services Committee.

11 We will be undertaking our audit work using a mix of remote and in person working. For any in person work, we will agree this in advance with the relevant contacts and ensure all appropriate risk assessments are undertaken in line with current COVID-19 guidelines.

Timing of our work

12 The indicative timescales for the key stages of the audit work are shown in **Exhibit 2**. Where appropriate, we will give interim feedback if issues of concern arise during our work.

13 We will keep our delivery arrangements and the timescales under close review and adjust them to avoid unnecessary burden on NHS and local government bodies at a time when services are trying to recover from the impact of the COVID-19 pandemic.

Exhibit 2: indicative timescales for the work

	Key stage		
Audit focus	**Set up**	**Fieldwork**	**Reporting**
Patient flow out of hospital	September 2022	September – November 2022	November – December 2022
Access to unscheduled care services	November 2022	November 2022 – January 2023	January – March 2023
National arrangements	June 2022	June – December 2022	January – March 2023

Reporting our findings

14 We will prepare a number of reports as part of this work setting out our findings and any recommendations. With respect to our focus on patient flow out of hospital, we will prepare local reports based on the seven Regional Partnership Board areas reflecting the findings for the respective NHS and local councils. These reports will be supplemented by a short output for individual health boards specifically setting our progress against our previous 2017 discharge planning recommendations, and a summary of key findings for each local council.

15 With respect to access to unscheduled care services, we will prepare local reports for individual health boards and the Welsh Ambulance Services NHS Trust. In line with the Audit Wales arrangements for public reporting, we will publish these reports on our website once they have been formally considered by the relevant Board and Scrutiny committees. Note that as part of our wider work programme, we will also be reporting on how the Welsh Ambulance Services NHS Trust is managing its workforce[1]

16 With respect to our national focus, we will report these in a single national report which may also include a summary of the findings through our local work on patient flow and access to services, where we identify issues of wider relevance to NHS Wales and the 22 local councils. We may consider laying the report before the Senedd in line with the Auditor General's powers set out in Section 145A of the Government of Wales Act 1988.

[1] This work forms part of our all-Wales NHS thematic review of workforce which will be undertaken across all NHS bodies between September 2022 and March 2023.

Other work of note

17 We are aware that commentary on the unscheduled care system is a crowded space in Wales with many interested parties. We have been engaging with relevant stakeholders throughout the scoping of our work, including Age Cymru, Older People's Commissioner for Wales, Healthcare Inspectorate Wales, Care Inspectorate Wales, Improvement Cymru and Welsh Government.

18 We will continue to engage with key stakeholders during the review to avoid duplication and maximise any opportunities to learn from one another where that may benefit and inform the reviews involved.

19 The Auditor General also has a duty under The Well-being of Future Generations (Wales) Act 2015 to carry out examinations of most public bodies that he audits to assess the extent to which they have acted in accordance with the 'sustainable development principle' when setting and taking steps to meet "well-being objectives". Where relevant, we will apply this duty to our review of unscheduled care services. Findings relating to the application of the 'sustainable development principle' will be used to inform the Auditor General's national report that he must produce before each Senedd election.

Audit Wales contacts

20 Further information can be obtained from Anne Beegan, Performance Audit Manager (anne.beegan@audit.wales), Fflur Jones, Performance Audit Lead (fflur.jones@audit.wales) and/or Bethan Hopkins, Performance Audit Lead (bethan.hopkins@audit.wales).

Data Protection

21 Where we process personal data, this is in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulation. Further information is set out in our fair processing notice attached at **Appendix 1**.

Appendix 1 – Fair Processing Notice

This privacy notice tells you about how the Wales Audit Office processes personal data provided by NHS bodies, local authorities, and Welsh Government in connection with our review of unscheduled care services.

Who we are: The Auditor General for Wales examines how public bodies manage and spend public money, and the Wales Audit Office (WAO) provides staff and resources to enable him to carry out his work.

Data Protection Officer (DPO): Our DPO is Martin Peters, who can be contacted by telephone on 029 20320500 or by email at: infoofficer@audit.wales.

The relevant laws (legal basis): We process personal data in accordance with the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR). Our lawful basis for processing is the statutory powers and duties under the Public Audit (Wales) Act 2004, the Government of Wales Act 1998, and Well-being of Future Generations (Wales) Act 2015.

Purpose of processing: We are collecting opinions and information to help us carry out our review of unscheduled care services. Some of this information may be about identifiable individuals, which would make it personal information, even though the purpose of our work is not in itself to collect information about identifiable individuals. The information collected will be used for this work and may also be used in our wider statutory audit work.

Who will see the data? The Auditor General and the WAO audit team will have access to the information provided. We may share some information with senior management at the audited bodies involved, and our published reports may include some information. We may share some data with other regulatory bodies for the purpose of their reviews and such information will be processed in accordance with their respective privacy policies.

How long we keep the data? We will keep the information collected, including personal data, for a period of 6 years following publication of our report, or 25 years if published within a report, and we will hold data securely in accordance with our Information Security Policy.

Your rights: You have rights to ask for a copy of the current personal information held about you or to object to data processing that causes unwarranted and substantial damage and distress. Contact the Information Officer, Wales Audit Office, 24 Cathedral Road, Cardiff, CF11 9LJ or email infoofficer@audit.wales.

Our rights: The Auditor General has rights to information, explanation, and assistance under paragraph 17 of schedule 8 Government of Wales Act 2006 and/or section 52 Public Audit (Wales) Act 2004 and/or section 26 of the Local Government (Wales) Measure 2009. It may be a criminal offence, punishable by a fine, for a person to fail to provide information.

The Information Commissioners Office: If you require further information in relation to your rights under data protection law or are dissatisfied with how we are handling your personal data you may contact the Information Commissioner at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF, or email casework@ico.gsi.gov.uk or telephone 01625 545745.

AGENDA ITEM No	**8**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**2**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit Committee
DATE	15th September 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk, Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide an update in respect of activity relating to the Trust's Corporate Risks.

2. In addition, it provides a progress update in respect of the Risk Transformation Programme as detailed in the Integrated Medium Term Plan (IMTP) (2022/25).

RECOMMENDATION:

3. **Members are asked to consider and discuss the contents of the report and:**
   - **a. Note that the actions outlined in the avoidable harm paper presented to Trust Board in July 2022 are described as further mitigations against Risks 223 and 224.**
   - **b. Note the closure of Risk 303 from the Corporate Risk Register.**
   - **c. Note the decrease in score of Risk 199 from 20 to 15.**
   - **d. Note the decrease in score of Risk 311 from 16 to 12.**
   - **e. Note the inclusion of the new Risk 543 on the Corporate Risk Register at a score of 15.**
   - **f. Note the inclusion of the new Risk 558 on the Corporate Risk Register at a score of 15.**
   - **g. Review the Board Assurance Framework.**

KEY ISSUES/IMPLICATIONS

4. This paper sets out the key activity in relation to the Trust's Corporate Risks which Members are asked to discuss and note.

5. Reviews continue to be undertaken of each Corporate Risk, described in Annex 1, including the mapping of each control to related assurances and by identifying any gaps in these as well as any actions that could be taken to further mitigate the risk. As a result of this, 2 risk scores have decreased and 1 risk has been closed from the Corporate Risk Register.

6. The Executive Management Team (EMT) received formal, monthly feedback from the Assistant Director Leadership Team (ADLT) on activity relating to the corporate risks for approval.

7. The Trust Board received a paper in July 2022 on actions to mitigate real time avoidable patient harm in the context of extreme and sustained pressure across the urgent and emergency care system which has negatively impacted patient flow through all hospital sites and led to a substantial growth in emergency ambulance handover lost hours and a growing number of cases of avoidable harm or death to patients.

8. This was further to concerns that were escalated to the Trust Board by the Chairs of Quality, Patient Experience and Safety Committee (QUEST), the People and Culture Committee (PCC), and the Finance and Performance Committee (FPC) in relation to the significant impact on staff and patients as a result of system pressures and particularly as a consequence of delays in handover at emergency departments.

9. Actions for the Welsh Ambulance Service and system stakeholders contained in the plan presented to Trust Board in July 2022, further mitigate the Trust's highest scoring Risks 223 and 224 and are reflected in the Board Assurance Framework in Annex 2 of this paper.

10. Furthermore, each of the Corporate Risks were considered by the following Committees, as relevant to their remit, during the reporting period:

    a) **People & Culture Committee** (5th September 2022)
    b) **Quality, Safety & Patient Experience** (11th August 2022)
    c) **Finance & Performance Committee** (18th July 2022)

REPORT APPROVAL ROUTE

11. The report has been considered by:
    - ADLT – 8th August 2022
    - ADLT – 22nd August 2022
    - EMT – 24th August 2022

REPORT ANNEXES

12. SBAR report.

13. Annex 1 - Summary table describing the Trust's Corporate Risks.

14. Annex 2 - Board Assurance Framework

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA

Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The purpose of this report is to provide an activity update in relation to the Trust's Corporate Risks.

2. A summary report describing each of the corporate risks as of 30th August 2022 is detailed in Annex 1.

3. The Board Assurance Framework (BAF) report is included in the paper in Annex 2.

BACKGROUND

4. The Risk Management Transformation Programme was included in the IMTP (2022/2) with the immediate priority to undertake a detailed review of the Trust's 5 highest scoring risks initially with the remaining corporate risks to follow. The programme of work has been completed 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.

5. The Assistant Directors Leadership Team (ADLT) continue to review the risk assessments, which have been approved by the Risk Owner, on all new risks in addition to reviewing any changes to existing risks and mitigating actions, reporting activity to the Executive Management Team (EMT), Board Committees and Trust Board.

ASSESSMENT

6. There are currently 18 Corporate Risks on the register which are described in the summary table in Annex 1. The table sets out the rearticulation of each of the Corporate Risks including new titles and summary descriptions, utilising an '*if, then, resulting in*' approach, the Executive Owner of the Risk and the Risk score with any changes that have occurred during the period.

7. The EMT has approved the rearticulation of each of the Corporate Risks and the activity described in this paper.

Corporate Risks

8. The full detail of each Corporate Risk, including controls, assurances, gaps and mitigating actions form part of the improved Board Assurance Framework (BAF) detailed in Annex 2.

9. Members are asked to note that the inclusion of actions outlined at the last meeting which will mitigate real time, avoidable harm in the context of extreme and sustained pressure across the urgent and emergency care service which seek to further mitigate the Trust's highest scoring risks 223 and 224.

Closure and De-Escalation of Risks

10. One risk has been closed from the CRR and de-escalated to the Medical & Clinical Directorate Register since the last meeting in July 2022.

11. **Risk 303** - *Delayed administration of chest compressions to patients as part of resuscitation*

***IF** there is no universal guidance issued in relation to the level of PPE required when administrating chest compressions and no reduction in infection rates of Covid-19*

***THEN** there is a risk of delayed administration of chest compressions to patients as part of resuscitation due to WAST ambulance crews continuing to wear level 3 PPE*

***RESULTING IN** potential patient harm and damage to the Trust's reputation*

12. The Risk Owner and ADLT recommended the risk be closed from the CRR as all actions have been completed and the score reduced to target. This was approved by the EMT in August 2022.

Transfer of Risks

13. Risk 199 has transferred to the People & Culture Committee for oversight given that the Health & Safety function and programme of work are now included in the Terms of Reference and cycles of business for that Committee.

Changes to Risk Scores

14. There have been two changes to risk scores since the last meeting in July 2022.

15. **Risk 199** – *Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation*.

***IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance*

***THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments*

***RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation*

16. The Risk Owner and ADLT recommended the risk score be reduced from 20 (4x5) to 15 (3x5) having undergone a significant review which was approved by the EMT in August 2022.

17. This reduction in score was a result of the implementation of the Working Safely Programme across the organisation which has had an impact on the application of health and safety.

18. In addition, there has been a significant improvement in the health and safety governance arrangements within the Trust. The Health and Safety Workforce has undergone a review and additional resources allocated to the team.

19. The introduction of the Compliance Register and the ongoing assessment supports the Trust to more effectively map and comply with relevant legislation which supports the mitigation of the risk.

20. Further, the approval of the Health and Safety Management System sets out a process to review health and safely culture within the Trust.

21. **Risk 311** - Inability of the Estate to cope with the increase in FTEs

IF *the cumulative impact on the estate of the EMS Demand & Capacity Review and the NEPTS Review is not adequately managed*

THEN *there is a risk that the Estate will not be able to cope with the increase in FTEs*

RESULTING IN *potential failure to achieve the benefits/outcomes of the programme and reputational damage to the Trust*

22. The Risk Owner and ADLT recommended the risk score be reduced from 16 (4x4) to 12 (3x4) which was approved by the EMT; however, further work will be undertaken in the next cycle of reporting with a view to close this risk relating particularly to the Demand & Capacity review and establish a new Estates capacity risk.

<u>New Corporate Risks</u>

23. Two new risks have been assessed and approved for inclusion on the CRR as follows:

24. **Risk 543** - *Major disruptive incident resulting in a loss of critical IT systems*

IF *there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems*

THEN *there is a risk of a loss of critical IT systems*

RESULTING IN *a partial or total interruption in WAST's effective ability to deliver essential services.*

25. The Risk Owner and ADLT recommended the inclusion of the risk on the CRR at a score of 15 (3x5) which was approved by the EMT.

26. **Risk 558** - *Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences*

IF *significant internal and external system pressures continue*

THEN *there is a risk of a significant deterioration in staff health and wellbeing within WAST*

RESULTING IN *increased sickness levels, staff burnout, poor staff and patient experience and patient harm*

27. The Risk Owner and ADLT recommended the inclusion of the risk on the CRR at a score of 15 (3x5) which was approved by the EMT.

Development of New Risks

28. **Risk 538** - A risk has been developed to reflect the possible consequence of a further delay to the implementation of the new Integrated Information System (Salus); however, due to ongoing commercial discussions and a delay to some delivery milestones, the detail of this risk will need to be reviewed and finalised to capture the emerging position and differentiate it from any realised issues. An update is expected from the Programme team and the supplier mid-September 2022 that will shape the final risk assessment ahead of presentation to Trust Board at the end of September 2022.

29. **Risk 542** - *Failure to deliver the Welsh Government NHS Wales Decarbonisation Strategic Delivery Plan*

This risk has been fully articulated and is navigating Trust risk governance processes. It is expected that this will be included on the CRR during the next reporting cycle.

Further Review of Risks

30. 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*
- *Supply Chain Issues – Digital Equipment*
- *Business Continuity Risks*
- *Securing Stakeholder Support to Deliver the Strategy and IMTP*
- *Capacity to deliver change (IMTP)*
- *Ongoing Impact of CoVID and Increasing Demand for Services (IMTP)*

Board Assurance Framework

31. The BAF is included at annex 2 which focusses the Board on the key risks that are mapped to the IMTP deliverables and that might compromise the achievement of the Trust's strategic objectives. Until such time as the more mature and strategic BAF is developed during 2023/24 as part of the risk transformational programme, these key risks are the corporate risks due to their relationship to the IMTP delivery and their risk ratings.

RECOMMENDED

32. **Members are asked to consider and discuss the contents of the report and:**
    a. **Note that the actions outlined in the avoidable harm paper presented to Trust Board in July 2022 are described as further mitigations against Risks 223 and 224.**
    b. **Note the closure of Risk 303 from the Corporate Risk Register.**
    c. **Note the decrease in score of Risk 199 from 20 to 15.**
    d. **Note the decrease in score of Risk 311 from 16 to 12.**
    e. **Note the inclusion of the new Risk 543 on the Corporate Risk Register at a score of 15.**
    f. **Note the inclusion of the new Risk 558 on the Corporate Risk Register at a score of 15.**
    g. **Review the Board Assurance Framework.**

Annex 1 – Corporate Risk Register Summary

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

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
139 FPC	Failure to Deliver our Statutory Financial Duties in accordance with legislation	**IF** the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458) **THEN** there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs) **RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Director of Finance & Corporate Resources	**16 (4x4)** →
244 FPC	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	**IF** the Trust is unable to increase accommodation capacity **THEN** there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives **RESULTING IN** EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience	Director of Operations	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
245 FPC	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	**IF** CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident **THEN** there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities **RESULTING IN** potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)	Director of Operations	**16 (4x4)** →
458 FPC	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning	**IF** sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis **THEN** there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients. **RESULTING IN** patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage	Director of Finance & Corporate Resources	**16 (4x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
199 PCC	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	**IF** there is a failure to embed an interdependent and mature health and safety culture, effective arrangements and associated governance **THEN** there is a risk of a potential breach in compliance with the requirements of the Health & Safety at Work etc. Act 1974 and associated regulations and other statutory instruments **RESULTING IN** death or serious injury, and punitive actions from multiple enforcement agencies including penalties and adverse publicity leading to damage to reputation	Director of Quality & Nursing	**15 (3x5)** ↓ **New Score Reduced from 20 (4x5)**
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident **RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life	Director of Digital Services	**15 (3x5)** →
NEW 543 **FPC**	Major disruptive incident resulting in a loss of critical IT systems	**IF** there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems **THEN** there is a risk of a loss of critical IT systems **RESULTING IN** a partial or total interruption in WAST's effective ability to deliver essential services	Director of Digital	**15 (3x5)**

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
NEW 558 **PCC**	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences	**IF** significant internal and external system pressures continue **THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST **RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm	Director of Workforce & OD	**15 (3x5)**
100 FPC	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	**IF** WAST fails to persuade EASC/Health Boards about WAST ambitions **THEN** there is a risk of a delay or failure to receive funding and support **RESULTING IN** a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered	Director of Strategy Planning & Performance	**12 (3x4)** →
163 PCC	Maintaining Effective & Strong Trade Union Partnerships	**IF** the response to tensions and challenges in the relationships with Trade Union partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained **THEN** there is a risk that Trade Union partnership relationships increase in fragility and the ability to effectively deliver change is compromised **RESULTING IN** a negative impact on colleague experience and/or services to patients.	Director of Workforce & Organisational Development	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
283 FPC	Failure to implement the EMS Operational Transformation Programme	**IF** there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme **THEN** there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters **RESULTING IN** potential patient harm, deterioration in staff wellbeing and reputational damage	Director of Strategy Planning & Performance	**12 (3x4)** →
311 FPC	Inability of the Estate to cope with the increase in FTEs	**IF** the cumulative impact on the estate of the EMS Demand & Capacity Review and the NEPTS Review is not adequately managed **THEN** there is a risk that the Estate will not be able to cope with the increase in FTEs **RESULTING IN** potential failure to achieve the benefits/outcomes of the programme and reputational damage to the Trust	Director of Finance & Corporate Resources	**12 (3x4)** ↓ **New Score reduced from 16 (4x4)**
424 FPC	Prioritisation or Availability of Resources to Deliver the Trust's IMTP	**IF** resources are not forthcoming within the funding envelope available to WAST (link to risk 139) **THEN** there is a risk that there is insufficient capacity to deliver the IMTP **RESULTING IN** delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing	Director of Strategy Planning and Performance	**12 (3x4)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
303 CLOSED **QuEST**	Delayed administration of chest compressions to patients as part of resuscitation	**IF** there is no universal guidance issued in relation to the level of PPE required when administrating chest compressions and no reduction in infection rates of Covid-19 **THEN** there is a risk of delayed administration of chest compressions to patients as part of resuscitation due to WAST ambulance crews continuing to wear level 3 PPE **RESULTING IN** potential patient harm and damage to the Trust's reputation	Director of Paramedicine	**10 (2x5)** 

Annex 2 – Board Assurance Framework

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	07/09/2022	TREND	25 (5x5)
		Date of Next Review:	06/10/2022	➡	

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

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

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

CONTROLS	ASSURANCES
1. Patient Flow Co-Ordination based in the Grange University Hospital	**Internal** **Management (1st Line of Assurance)** 1. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU
2. Regional Escalation Protocol	2. Daily conference calls to agree RE levels in conjunction with Health Boards
3. Immediate release protocol	3. The Immediate Release Protocol is a Nationally agreed NHS Wales protocol. Refusals by Health Boards are Datixed by WAST and compliance report shared weekly with the Health Board Chief Operating Officers (COOs)
4. Resource Escalation Action Plan (REAP)	4. Weekly review by Senior Operations team with assessment of action compliance. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure.
5. 24/7 Operational Delivery Unit (ODU)	5. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
6. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans	6. Same as 5 - Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Provides operational oversight with dynamic CSP review and system escalation as required.
7. Limited Alternative Care Pathways in place	7. Limited Assurance - Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect, APP development and expansion, and bids for additional prescribing APPs.
8. Consult and Close (previously Hear and Treat)	8. Monitoring CSD rates through AQIs. Consult and Close volumes form part of EMS CCC weekly reports to SLT. Regular reporting of incident volumes to Operational Review Groups. Summary level information about Consult and Close volumes, targets, trends and recontact rates reported to TB and sub-committees. Metrics relating to Ambulance Quality Indicators (AQI) published on a quarterly basis by EASC. Bi-monthly EASC Provider reports. Consult and Close performance reported in Joint Executive Team meeting every 6 months with Welsh Government. NWSSP Information Management Internal Audit report February 2022 (External Assurance)
9. Advanced Paramedic Practitioner (APP) deployment model	9. Qlik sense APP dashboard monitors performance and provides assurance that APPs are flowing patients into alternatives to emergency department. Qlik sense is a national report and can drill down into regional, local and individual performance as required
10. Clinical Safety Plan	10. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group
11. Recruitment and deployment of CFRs	11. Volunteers are another resource for response, Volunteer
12. ETA scripting	12. The ETA Dashboard is a tactic that was signed off by EMT – there is a dashboard that supports scripting analysed by comparing with real time data
13. Clinical Contact Centre (CCC) emergency rule	13. CCC Emergency Rule is policy that has been signed off by Execs.
14. National Risk Huddle	14. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
15. Handover Improvement Plans agreed between Health Boards and WAST	15. Improvement plans are reviewed by EAST
16. Summer/Winter initiatives	16. Monitoring through SLT and STB
17. CHARU implementation	17. Monitored via the EMS project Board
18. National Transfer & Discharge Model	18. Task and Finish Group established

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	07/09/2022	TREND	25 (5x5)
		Date of Next Review:	06/10/2022		

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

19. Conveyance Reduction	19. This is part of the weekly performance review and aligned to Care Closer to Home Programme
20. Access to Same Day Emergency Care (SDEC) for paramedic referrals	20. This forms part of the handover improvement plans in place with Health Boards
21. Mental Health Practitioners in cars	21. Part of the Care Closer to Home workstream
22. Roll out of ECNS	22. Reported through QuEST
23. Clinical Model and clinical review of code sets	23. Reported through QuEST
24. Remote Clinical Support Strategy	24. Strategic Transformation Board – IMTP deliverable
25. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	25. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	None immediately identified but subject to continual review
2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow	
3. Covid capacity streaming	
4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding	
5. Local delivery units mirroring WAST ODU	
6. Handover delays link to risk 224	
7. Tolerance in Health Boards has become the norm. As delays have increased, there appears to be no visible appetite to address these issues	
8. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 6 months there is a low confidence in attaining this.	
9. Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration	
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	31.12.22	
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Paused	
3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters	Assistant Director of Operations EMS	Extended from 30.09.22 to 31.12.22	
4. Transition arrangements post pandemic	Executive Pandemic Team	Complete 30/08/22	
5. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I)	TBA	TBA	

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	07/09/2022	TREND	25 (5x5)
		Date of Next Review:	06/10/2022	➡	

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

[Source: Action Plan presented to Trust Board 28/07/22]			
6. Maximise the opportunity from Consult and Close – stretch to 15% and beyond (I) [Source: Action Plan presented to Trust Board 28/07/22]			
7. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required (I) [Source: Action Plan presented to Trust Board 28/07/22]			
8. Weekly REAP review by senior Operations Directorate team with assessment of action compliance (I) Source: Action Plan presented to Trust Board 28/07/22]			
9. Recruitment and deployment of new CFRs (I) [Source: Action Plan presented to Trust Board 28/07/22]			
10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]			
11. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]			
12. External Controls detailed within the Action Plan presented to Trust Board on 28/07/22: a. Audit Wales's investigation of Urgent and Emergency Care System. Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time? (E) b. Consideration of additional WAST schemes to support risk mitigation through winter (I) c. NHS Wales educes emergency department handover lost hours by 25% (E) d. NHS Wales eradicates all emergency department handover delays in excess of 4 hours (E) e. Alterative capacity equivalent to 1000 beds (E) f. Implement nationwide approach to emergency department 'Fit 2 Sit' (E) g. Implementation of Same Day Emergency Care services in each Health Board (E) h. National Six Goals programme for Urgent and Emergency Car (E)			

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	08/09/2022	TREND	25 (5x5)
		Date of Next Review:	07/10/2022	→	

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

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

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

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. WAST Serious Clinical Incident Forum (SCIF) is in place to discuss patient safety incidents, learning and improvement actions to prevent future harm, working in collaboration with Health Boards / NHS Wales Delivery Unit under the *Framework for the Investigation of Patient Safety Serious Incidents (SIs)* V2.2, dated July 2019.	1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.
2. WAST membership of the working group to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) national investigation framework with system partners. Chaired by the Deputy Chief Ambulance Commissioner and commended in August 2022.	2. Workshop with system partners in place with executive directors of nursing attendance – next meeting 08.09.2002 – plan to finalise revised approach to Appendix B process by November 2022.
3. WAST and system compliance with National Standards - 15-minute handover (NHS Wales Hospital Handover Guidance v2 (May 2016)	3. Monthly Integrated Quality and Performance Report, Health Informatics reports, APP dashboard monitors, reports on app use by Consultant Connect and shared at local and corporate meetings regarding patient safety and handover of care position across NHS Wales and NHS England.
4. WAST Clinical Notice in place - Escalating a clinical concern with a deteriorating patient outside the Emergency Department (11.02.2021). National Early Warning Score (NEWS) trigger of 5 or above for escalation to hospital clinicians. NEWS data available via EPCR (electronic patient care record).	4. NEWS data now available via ePCR and escalation system in place. Learning from incident reporting processes.
5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership. WAST membership at system workshops supported by Commissioners looking at handover of care delays which includes the implementation of the Fit2Sit programme and handover of care checklist pan NHS Wales. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours.	5. Monthly Integrated Quality and Performance Report
6. Hospital Ambulance Liaison Officer (HALO) (Some health Boards).	6. Patient Flow Coordinators (PFCs) are a commissioned service by the Health Board (x2 in ABUHB specifically for GUH) with a bespoke job description, these link directly with the National Delivery Managers in ODU.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP).	7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation via Strategic Command structure.
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process
9. 24/7 Operational Delivery Unit (ODU) escalating handover delays / patient condition to Health Board colleagues.	9. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.	10. Shift reports from ODU & ODU Dashboard received by Exec, SOT and On-Call Team at start/end.
11. Escalation forums to discuss reducing and mitigating system pressures.	11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability, dementia awareness, mental health.	12. Integrated Quality and Performance Report (June 85% target met)

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	08/09/2022	TREND	25 (5x5)
		Date of Next Review:	07/10/2022	→	

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

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

13. Clinical audit programme	13. Clinical audit programme with oversight from the Clinical Quality Governance Group.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board and Board sub-committee oversight and escalation.
	External Sources of Assurance **Management (1st Line of Assurance)**
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC) and Joint Executive Team meeting Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and CASC
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Patient safety reporting and escalation through the Serious Clinical Incident Panel (SCIF), Patient Safety Highlight Reports, Health Board specific reports in place with escalation through WAST governance framework.	1. Strengthen and triangulate patient safety metrics and look back data at ED, service and corporate level for baseline data for improvement projects and WAST reports.
2. Inconsistent review of potentially serious / catastrophic patient safety incidents in line with the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019 (frequently referenced as 'Appendix B' Reports) by Health Boards pan NHS Wales and lack of ownership of system risks. Lack of whole system approach to handling patient safety incidents resulting from system pressures*.	2. Implementation of revised process, engagement and outcome and improvement measures at system level – to be confirmed.
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales*.	3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours from c6000 hours per month at the end of 2018 to in excess of 22000 hours per month during Q4 21/22 and Q1 22/23. This scale of lost emergency ambulance capacity has peaked at 30% per month of the entire emergency ambulance fleet..
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*.	4. Strengthen patient safety reports and audit processes as system embeds.
5. (a) Variation in appetite across the Health Boards to implement Fit2Sit, citing overcrowded emergency department waiting rooms as the reason. Limited confidence in system engagement to address Goal 4 and achieve reduction in handover delays*. 5. (b) Protracted timescales in the Right care, right place, first time Six Goals for Urgent and Emergency Care - A policy handbook 2021–2026. Goal 4 'Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – by the end of April 2025. The number of people waiting over this period for ambulance patient handover will reduce on an annual basis until that point'. No detail on incremental improvements	5. 15-minute handover target is not being achieved pan-Wales consistently.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	08/09/2022	TREND	25 (5x5)
		Date of Next Review:	07/10/2022	➡	

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

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

required at emergency department level or oversight mechanisms. EASC have stated that no delay should exceed 4 hours although WAST is yet to see any demonstrable plans to support this*.	
6. Variation pan Wales / England as position not implemented across all emergency departments*.	6.
7.	7.
8. Variation pan Wales / England as position not implemented across all emergency departments*.	8. Health & Care Standards self – assessment in progress.
9. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	9.
10.	10.
11. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	11.
12.	12.
13. Transition to ePCR impacting on data temporarily	13.
14. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas*.	14. HIW approve and sign off WAST elements of recommendations.
15.	15.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators
	2. Lack of collective system response to HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' Report. Meetings cancelled x 2 in May 2022. WAST has representation on the working group*

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026 – Goal 4: Rapid response in physical or mental health crisis.	CEO	WAST is represented on the Clinical Reference Group by the Director of Paramedicine	Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales
2. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	Review Q4 2022/3	Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF)
3. Implement nationwide approach to emergency department 'Fit 2 Sit'	CMO/CNO	Acceptance at meeting of Chairs and CEOs led by Director General for Health and Social Services and the NHS Wales Chief Executive on 08.06.2022 that a national approach to Fit 2 Sit should be adopted. Chief Medical Officer and Chief Nursing Officer to champion development through peer groups	Emergency Department Quality & Delivery Framework final version drafted for consultation / approval. Q4 2022/23
4. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	Checkpoint Q4 2022/23	Incremental improvements to quality and safety data and information to enable triangulation. Access to ePCR data (NEWS) now available.
5. Continued Health Board interactions – my next patient, patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Director of Quality & Nursing	Monthly	Monthly meetings continue to be held.
6. HIW Improvement Plan / Workshop– WAST inputs / influencing improvements 7. Response and improvement actions to Healthcare Inspectorate Wales Inspection report (2021) 'Review of Patient Safety, Privacy, Dignity and	Assistant Director of Quality & Nursing	• August 2022 in progress • Review outputs Q4 2022/23	

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	08/09/2022	TREND	25 (5x5)
		Date of Next Review:	07/10/2022	→	

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

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

Experience whilst Waiting in Ambulances during Delayed Handover' which links to Fundamentals of Care.			
8. Participation in the CASC led workshop to reform *the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019*.	Assistant Director of Quality & Nursing	• Workshop in progress August 2022	Planned to be concluded by November 2022
9. Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation	Director of Workforce & Organisational Development	• Recruitment decision made at EMT on 15.06.2022 for 100 WTE with offers already made to ACA2s and EMTs on hold list • Courses to commence in Q2 2022/23 with first new deployments in Q3 2022/23 • Offers also made to all 61 NQPs from "Big Bang" event • Correspondence to CASC confirming action taken sent 21.06.2022 with request for recurrent funding source set out	End of Q3 and into Q4 2022/23
10. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Bid to Value Based Healthcare Fund made for up to 50 WTE APPs to commence fulltime education for 12 months from January 2023	Q4 2023/24
11. Senior system influencing	Trust Chair Chief Executive Officer	• Ensure that system safety and avoidable harm remain a live topic of discussion in all relevant fora • Seize opportunities as they emerge that can contribute to mitigating avoidable harm • JESG forum used to raise awareness amongst Emergency Service Chief Officers who have written twice to NHS Wales Chief Executive to convey the impact of our inability to respond to incidents in the community on their core service provision	Ongoing
12. Emergency Department cohorting	Director of Operations	• Provide additional clinical staff and suitable space for patients arriving by ambulance to be held at the emergency department awaiting admission enabling the ambulance to be released • In place at Morriston and The Grange	Ongoing
13. Transition Plan	Chief Executive Officer	• Formally submitted to Commissioners in December 2021 and subsequently subject to a part year funding request of Welsh Government on 24 May 2022 this plan sought to grow our establishment to a further 294 WTE having forecast the challenges currently being seen • Around two thirds of the growth was to deploy additional response capacity (now provided in part by 4 above) whilst the system took action to reduce emergency department handover delays • Around one third of the growth was to accelerate the transition to a new model of service delivery (inverting the triangles) – also now subject to a separate bid as in 5 above	Ongoing
14. Overnight falls service extension	Director of Quality & Nursing	• Review current extension to falls scheme that has temporarily been running on night duty • Benefit derived but further improvement in utilisation and overall volume of work undertake are necessary in the next 3 months • Scheme extension agreed to 31 March 2023	30 June 2022
15. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	Chief Executive Officer	• Conducted in three phases over the next 6 to 9 months Audit Wales will independently investigate and report on patient flow out of hospital; access to unscheduled care services and national arrangements (structure, governance and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities	Q1 2023/2024
16. Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	• Summer performance forecast complete and winter underway imminently • Discussions underway during Q2 to create new/further schemes to support operational delivery through winter	Q3 2022/23
17. National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	• National public awareness campaign funded by Welsh Government to promote appropriate use of services (111 as an alternative to 999/ED where appropriate) • Upgrade to 111 website and symptom checkers also underway	Q3 2022/23

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	08/08/2022	TREND	20 (5x4)
		Date of Next Review:	07/10/2022	➡	

IF there are high levels of absence e.g. sickness and alternative duties	THEN there is a risk that there is reduced resource capacity	RESULTING IN an inability to deliver services which adversely impacts on quality, safety and patient/staff experience		Likelihood	Consequence	Score
			Inherent	4	4	16
			Current	5	4	20
			Target	3	4	12

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

EXECUTIVE OWNER	Director of Workforce & Organisational Development	ASSURANCE COMMITTEE	People and Culture Committee

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Managing Attendance at Work Policy/Procedures in place	1. (a) Policy reviews to ensure policies and procedures are fit for purpose (b) Audits by People Services on sickness
2. Respect and Resolution Policy	2. Policy reviews to ensure policies and procedures are fit for purpose
3. Raising Concerns Policy	3. Policy reviews to ensure policies and procedures are fit for purpose
4. Health and Wellbeing Strategy	4.
5. Operational Workforce Recruitment Plans	5.
6. Roster Review & Implementation	6.
7. Return to Work interviews are undertaken	7.
8. Training	8.
9. Directors receives monthly email with setting out ESR sickness data	9.
10. Operational managers receive daily sickness absence data via GRS	10.
11. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme	11.
12. WAST Keep Talking (mental health portal)	12.
13. Suicide first aiders	13.
14. TRiM	14.
15. Peer Support network	15.
16. Coaching and mentoring framework	16.
17. Staff surveys	17.
18. Stress risk assessments	18.
19. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC	19. Sickness forms part of Workforce Scorecard to People & Culture Committee
20. External agency support e.g. St John Ambulance, Fire and Rescue	20.
21. Strategic Equality Objectives	21.
22. Volunteers	22.
23. Monthly reviews of colleagues on Alternative duties	23. Action plans arising from meetings with colleagues implemented through monthly diarised meetings
24. Manager guidance on managing Alternative duties	24.
25. Fortnightly report on absence to EMT and report to every meeting of People & Culture Committee	25. Minuted meetings and action logs for EMT & People & Culture Committee
	External Management (2nd Line of Assurance)
	1a. All Wales review of All Wales Attendance at Work Policy
	Independent Assurance (3rd Line of Assurance)
	1b. Internal Audits scheduled through Shared Services Partnership (controls 1 - 24)
	2. Audit Wales – Taking Care of the Carers report in October 2021 (controls 1 - 24)
GAPS IN CONTROLS	**GAPS IN ASSURANCE**

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	08/08/2022	TREND	20 (5x4)
		Date of Next Review:	07/10/2022	➡	

IF there are high levels of absence e.g. sickness and alternative duties	THEN there is a risk that there is reduced resource capacity	RESULTING IN an inability to deliver services which adversely impacts on quality, safety and patient/staff experience		Likelihood	Consequence	Score
			Inherent	4	4	16
			Current	5	4	20
			Target	3	4	12

1. (a) Consistency and Application in Managing Attendance at Work Policy (b) Education and communication with managers about resources available and how to implement it e.g. stress risk assessments	1. There are other factors that impact on sickness which can't be controlled
4a. Wellbeing policy currently being produced 4b. There is no steering group for Health and Wellbeing – there are plans to restart the group	8. Reporting on training compliance
9 and 10 It is not known what is undertaken with respect to the data covered in assurances 9 and 10 once it is received	9, 10 and 19 Absence data is not updated in a timely manner into ESR by managers
1 – 22 Education and communication with managers about resources available and how to implement it e.g. stress risk assessments	
	External Gaps in Assurance None identified at the present moment

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Implementation of Improving Attendance project	Deputy Director of Workforce & OD	30.09.23	
2. Implementation of Behaviours Refresh Plan	Assistant Director – Inclusion, Culture and Wellbeing	31.10.22	
3. Long term sickness absence deep dive	Deputy Director of Workforce & OD	31.07.23	Underway and ongoing
4 . Develop guidance for line managers to support addressing challenging conversations and change	Deputy Director of Workforce & OD	31.07.22	Training written rollout underway
5. Roll out platform for raising concerns (in relation to Freedom to Speak Up Arrangements)	Freedom to Speak Up Arrangements Task & Finish Group	Extended from 31.07.22 to 30.11.22	Pushed out date in terms of project plans
6. Strengthen Freedom to Speak Up Arrangements policy and advice	Deputy Director of Workforce and OD	31.05.23	
7. Create a Manager and Staff training plan for Freedom to Speak Up Arrangements	Deputy Director of Workforce and OD	31.05.23	
8. Accountability meetings with senior ops managers	Deputy Director of Workforce & OD	30.09.22	
9. Attendance Management training for managers	Deputy Director of Workforce & OD	31.12.22	
10.PADR review including wellness questions	Assistant Director – Inclusion, Culture and Wellbeing	31.05.22	
11.Restart the Health and Wellbeing Steering Group	Assistant Director – Inclusion, Culture and Wellbeing	Extended from 31.05.22 to 30.05.23	
12. Roll out of meta data compliance policy solution	Senior ICT Security Specialist	31.12.22	

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence	Date of Review:	22/08/2022	TREND	20 (4x5)
		Date of Next Review:	21/09/2022	➡	

IF the stability of the Trust deteriorates to a level where service delivery fails to meet patient safety, national standards and contractual obligations	**THEN** there is a risk of a loss of stakeholder confidence in the Trust	**RESULTING IN** damage to reputation and increased external scrutiny		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	4	5	20
			Target	3	5	15

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

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Regular engagement with senior stakeholders e.g. Ministers, senior Welsh Government officials, commissioners, elected politicians and NHS Wales organisational system leaders	1. Agendas, minutes and documents of engagement events
2. Challenging of media reports to ensure accuracy	2. Programme of daily media engagement
3. Media liaison to ensure relationships developed with key media stakeholders	3. Programme of daily media engagement
4. Engagement Framework approved by the Board July 2022	4. Issues of reputation monitored at EMT via weekly Forward Look item – minuted meetings and action logs.
5. Engagement Framework Delivery Plan	5.
6. Engagement governance and reporting structures are in place	6. Relevant information which impacts on reputation is reported and scrutinised via all internal committees e.g. EMT, FPC, PCC, QuEST & Audit Committee – minuted meetings and action logs
7. Escalation procedure for issues to the Board	7. Minuted meetings, action logs and Board papers

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Inability to control external environment	1.
2. Dependency on Commissioners' decisions	2.
3. Unpredictable external environment affecting the way the Trust operates	3.
4.	4.
5. Engagement Framework Delivery Plan in development and due to be considered by the Board in November 2022	5. Engagement Framework Delivery Plan in development and due to be considered by Board in November 2022
6. Lack of resilience in the function – team is very small so any absences would have an impact on ability to respond	6.

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Submit refreshed Board Engagement Framework to Trust Board for approval	Director of Partnerships & Engagement	26.05.22 Complete	Approved July 2022
2. Report progress on Engagement Framework Delivery Plan to the People and Culture Committee	Director of Partnerships & Engagement	30.09.22	Verbal update to be provide to PCC in September 2022 prior to consideration by Board in November 2022
3. Monitoring internal Quality and Performance of Trust	Executive Management Team Finance and Performance Committee Quality, Safety and Patient Experience Committee People and Culture Committee Audit Committee	31.03.23 Checkpoint Date	
4. Engaging with internal and external stakeholders to develop confidence	CEO & Director of Partnerships & Engagement	31.03.23 Checkpoint Date	
5. Monitoring external factors that may affect the Trust	CEO & Director of Partnerships & Engagement	31.03.23 Checkpoint date	

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	15/08/2022	TREND	16 (4x4)
		Date of Next Review:	14/09/2022	➡	

				Likelihood	Consequence	Score
IF the Trust does: • not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)	**THEN** there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	**RESULTING IN** potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage	Inherent	3	4	12
			Current	4	4	16
			Target	2	4	8

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

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

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

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	15/08/2022	TREND	16 (4x4)
		Date of Next Review:	14/09/2022	➡	

IF the Trust does:	THEN there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage		Likelihood	Consequence	Score
• not achieve financial breakeven and/or • does not meet the planning framework requirements and/or • does not work within the EFL and/or • fails to meet the 95% PSPP target and/or • does not receive an agreement with commissioners on funding (linked to 458)			Inherent	3	4	12
			Current	4	4	16
			Target	2	4	8

	8. Bi-monthly Capital CRL meetings with Trust and WG capital leads
	9. Regular P2P meetings diarised (bi-monthly)
	10. Monthly monitoring returns into Welsh Government
	Independent Assurances (3rd Line of Assurance)
	1-10 Internal audit reviews covering
	1-10 External audit reviews

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Continuing negotiations with Commissioners	Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/23 – Checkpoint Date	
2. Embed a transformative savings plan and ensure organisational buy in	ADLT and Savings subgroup	31/03/23 – Checkpoint Date	
3. Embed value-based healthcare working through the organisation	Executive Management Team and Value Based Healthcare Group	31/03/23 – Checkpoint Date	
4. WIIN support for procurement, savings and efficiencies	WAST Improvement and Innovation Network group	31/03/23 – Checkpoint Date	
5. Foundational economy, Decommissioning and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/23 – Checkpoint Date	

Risk ID 244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service	Date of Review:	03/05/2022	TREND	16 (4x4)
		Date of Next Review:	30/05/2022	➡	

IF the Trust is unable to increase accommodation capacity	**THEN** there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives	**RESULTING IN** EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience

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

IMTP Deliverable Numbers: 1,5,9, 10,18, 28, 30, 34

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance and Performance Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Temporary call handling provision in Carmarthen	1. Monitoring of Performance standards for call handling (daily) and dispatch (weekly) to identify impacts on service with further investigation on a monthly basis
2. Maximum use of space at the Bryn Tyrion site	2. All desks have been realigned to 2m physical distancing as part of covid preparations
3. Maximum use of space at the Vantage Point House (VPH) site	3. Review of VPH undertaken – November 2021 Staffing levels are managed according to maximum desk space on each centre. In VPH, because of agile working there is capacity for non-dispatch functions.
4. Prioritisation of space utilisation for each shift by CCC management team and alignment to priorities associated with safe service delivery	4. Business continuity tracker for staffing levels updated daily
	External Not applicable

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. Call handling provision is a short-term solution and not fully resilient	1. Carmarthen solution for call handling is temporary
2. Lack of resilience in temporary accommodation may trigger risk if business continuity plans are invoked	2. Reconfiguration work reviewed by architects during pandemic preparation and earlier have yet to be delivered.
3. Current social distancing plans for EMS CCC do not provide solutions for the dispatch environment in Carmarthen	*3.* Agile working solution would be compromised in an ICT outage and paper-based approach would be used
4. Current social distancing plans for EMS CCC provide limited solutions for call handling and dispatch in Bryn Tyrion	
5. Current social distancing plans for EMS CCC provide limited solutions for dispatch environment in VPH.	
6. Estates Strategy is silent on risk associated with CCC environment	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Review current estate to identify moderate workplans to maximise available capacity within existing estate.	Assistant Director of Operations – Integrated Care	30.09.22 – Checkpoint Date	
2. Develop digital solutions for remote supervision and clinical support to maximise virtual network of CCC reducing capacity required in existing sites.	EMS CCC Area Manager	30.06.22	
3. Option appraisal required to review options for increasing CCC capacity. This should be aligned to the HIW review recommendation for the North CCC estates strategy and expanding this to support the pan-Wales estates position.	Assistant Director – Capital & Estates	31.12.22 – Checkpoint Date	
4. Based on modelling data under D&C review explore any efficiencies that can be gained in CCC estates through revised dispatch models maximising use of digital technology	CCC SE Manager	30.06.22 Checkpoint Date	

Risk ID 245	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	Date of Review:	03/05/2022	TREND	16 (4x4)
		Date of Next Review:	26/05/2022	➡	

IF	THEN	RESULTING IN
CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident	there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities	potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)

	Likelihood	Consequence	Score
Inherent	3	5	15
Current	4	4	16
Target	2	4	8

IMTP Deliverable Numbers: 1, 5, 9

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance and Performance Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Trust Business Continuity Procedure and Incident Response Plan	1. Debrief from significant business continuity incidents which are put into organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years and partial review annually unless there is a major learning point. This is currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
2. National EMS CCC Business Continuity Plan (reviewed in March 2021)	2. Business Continuity Plan is up to date and has been reviewed and is currently waiting sign off. Business continuity exercise undertaken on 9.03.22.
3. Clinical remote working arrangements	3. SOP in place with respect to Clinical Remote Working – this is being reviewed at present moment
4. Single instance CAD allowing virtualisation which enables staff to work anywhere	4. CAD alerts if there are systems issues
5. ITK (Interoperability Toolkit) technology in place which provides connectivity with other UK ambulance Trusts. This is used on a daily basis	5. Monitoring undertaken locally at least weekly
	External Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• If CAD is not functional then any impact of current controls would be negated by need to move physical staff	• Business continuity plan requires increased duties for existing staff as a result of lack of physical accommodation (link to risk 244)

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

Risk ID 458	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding of recurrent costs of commissioning services to deliver the IMTP and/or any additional services	Date of Review:	14/08/2022	TREND	16 (4x4)
		Date of Next Review:	13/09/2022	➡	

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

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

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

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Financial governance and reporting structures in place	1. Risk is reviewed quarterly at F&P and a report is submitted bimonthly to Trust Board
2. Financial policies and procedures in place	2.
3. Setting and agreement of recurrent resources	3.
4. Budget management meetings	4. Diarised dates for budget management meetings. If an area is in financial deficit, the meeting would be at least once a month. If the area is in balance or surplus, the meeting would be quarterly.
5. Budget holder training	5. Diarised dates for budget holder training
6. Annual Financial Plan	6. Submission to Trust Board in March annually
7. Regular financial reporting to EFG & FPC in place	7. Diarised dates for EFG and FPC with full financial reports
8. Regular engagement with commissioners of Trust's services	**External** **Management (1st Line of Assurance)** 1. Accountability Officer letter to Welsh Government e.g. November 2021 3 and 8 EASC management meetings. Monthly meetings with EASC and DAG meetings for NEPTS. Meetings are diarised 9. Monthly monitoring returns
9. Welsh Government reporting on a monthly basis	**Independent Assurance (3rd Line of Assurance)** 2. Internal Audit reviews of financial policies & procedures as part of their audit plan
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Lack of clarity regarding EASC/Welsh Government commitments with respect to recurrent funding	1. Dialogue with EASC and DAG does not always result in recurrent arrangements (outside of WAST control)

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. A formal approach to service change to be developed providing secure recurrent funding with commissioners.	Deputy Director of Finance	31.12.22	
1. Develop a Value Based Healthcare system approach with commissioners. This would mean that funding would flow more seamlessly between organisations and would go some way to mitigating the risk of not receiving recurrent funding.	Deputy Director of Finance	31.12.22	

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	22/08/2022	TREND	15 (3x5)
		Date of Next Review:	21/09/2022	⬇	

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

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

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

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

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Systematic review and assessment of Health and Safety arrangements and Governance (Health & Safety Management system)	1. Assessment criteria set for management system (all Wales system)
2. Health & Safety Governance and reporting arrangements e.g. committees and sub-groups	2. Monthly H&S report to ADLT, quarterly report and annual report to ADLT, H&S committee, EMT, PCC
3. Provision of dedicated health and safety expertise and advice	3. Working Safely team in place until end of September 2022
4. Health & Safety Policy and procedures	4. H&S Policy approved in 2018
5. Mandatory Health and Safety training	5. Quarterly statistics available from ESR and this forms part of Head of Health and Safety's quarterly report
6. Scheduled H&S visits and inspections	6. Head of Health and Safety's monthly report to ADLT
7. Risk assessments (including local risk assessments -Covid 19, workplace risk assessments, risk assessments covering EMS and NEPTs activities, operations risk assessments)	7. Workplace risk assessments are undertaken by local management teams, reviewed by H&S team and monitored by BCRT. Other risk assessments and SOPs are held on Sharepoint and have been submitted
8. Working Safely Programme Board, Dynamic Delivery Action Group & Programme Manager to provide oversight of Working Safely Action Plan	8. Working Safely Action Plan has been agreed and this is being held to account by Strategic Transformation Board. Deliverables are being monitored fortnightly through Dynamic Delivery Group meeting. Terms of reference for Dynamic Delivery Group are approved.
9. IOSH Managing Safely for Managers training in place	9. Attendance and competency figures provided in a monthly report to ADLT and quarterly report to committees and above
10. IOSH Leading Safely for Directors and Senior Managers training in place	10. Attendance and figures provided in monthly report to ADLT. Personal safety commitments are being monitored on a quarterly basis
11. Board development day covering Health & Safety Management and Culture training occurred in April 2022	11. Diarised meeting
12. Health and Safety Management system has been approved. This includes the recognised document approval routes for health and safety documentation.	12. Minuted at ADLT meeting in May 2022
	External **Independent Assurance (3rd Line of Assurance)** 13. Internal Audit to be undertaken in Q4 22/23 (controls 1– 10) 14.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. (a) Baseline audit for (a) not to be commenced till Q1 2022 (***being addressed in Actions 1 & 7)*** (b) Lack of cultural baseline to demonstrate H&S awareness (covering control a) ***(being addressed in Action 5)***	1. Capacity issues in assessing management system
2.	2. Subgroups of H&S committee currently under review
3. 3 live vacancies within H&S department are being advertised. These will need to be filled **(being addressed in Action 4)**	3. After September 2022, uncertainty over capacity to deliver to the Working Safely programme

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	22/08/2022	TREND	15 (3x5)
		Date of Next Review:	21/09/2022	⬇	

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

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

4. The Health and Safety Policy and some procedures are due to be reviewed by the end of Q1 2022 in Q1 2022 (***being addressed in Action 1***)	4. (a) Review of H&S Policy is due at end of Q1 2022 (b) Workforce Transformational change will influence content within H&S policy
5. Poor uptake in statutory and mandatory H&S training ***(being addressed as part of Actions 2 – 3)***	5.
6.	6. Developing schedule for H&S inspections and visits. Once this is undertaken, metrics to be developed
7.	7. (a) Current copies of risk assessments and SOPs are not available at all stations (b) Do not know how many SOPs are required until baseline audit completed
8. Operational pressures on service impacting on Working Safely Programme delivery (covering control h) (being addressed in Action 1)	8.
9. Staff availability to attend training ***(being addressed in Action 4)***	9.
10. Effective learning from events to be documented ***(being addressed in Action 1)***	10. (a) H&S team in discussions with best way of monitoring Personal safety commitments (b) Do not have a schedule of training in place but expecting to complete this in Q1 2022

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Delivery of the Working Safely Action Plan (WSAP) (Priority top 25)	Head of Health & Safety	31.09.22	
2. IOSH Leading Safely training to be delivered to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22	
3. WAST Leading Safely Behavioural Audit training to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22	
4. H&S team workforce review (accompanying Business Case forms part of this) (this forms part of WSAP)	Head of Health & Safety	31.03.22 Completed	Completed H&S Workforce report was presented and discussed at EMT on 6.04.22. Director of Finance and Corporate Resources would be formulating a paper for discussion at the ADLT/EMT meeting on 13.04.22 to discuss the issue of investment in Corporate Services based on the evidence provided in H&S Workforce report.
5. Culture survey to all members of staff (forms part of WSAP)	Head of Health & Safety	30.09.22	
6. A compliance register that describes the requirements of the various Health & Safety legislation that the Trust needs to comply with (part of WSAP)	Working Safely Programme Manager	30.06.22 Completed	
7. An initial assessment will provide assurance on how we are complying with the legislation.	Working Safely Programme Manager	Assurance - 30.06.22 Rolling programme of audits – 31.12.22 (Checkpoint date)	

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Date of Review:	22/08/2022	TREND	15 (3x5)
		Date of Next Review:	21/09/2022	➡	

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

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

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

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Appropriate policy and procedures in place for Information/Cyber Security	1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
2. Trust Business Continuity Procedure and Incident Response Plan	2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
3. IT Disaster Recovery Plan	3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
4. Relevant expertise in Trust with respect to information security	4. Staff undertake relevant training courses e.g. CISSP to increase knowledge and expertise
5. Data Protection Officer in post	5. In job description of Head of ICT
6. Cyber and information security training and awareness	6. Training statistics are available on ESR and from Phish threat module
7. Mandatory Information Governance training which includes GDPR	7. Training statistics reported on by Information Governance department
8. ICT tests and monitoring on networks & servers	8. Any issues would be identified and flagged and actioned
9. Information Governance framework	9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
10. Internal and NHS Wales governance reporting structures in place	10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.
11. Checks undertaken on inactive user accounts	11. Software in place to run check on inactive accounts as and when
12. Business Continuity exercises	12. Annual schedule of testing
13. Operational ICT controls e.g. penetration testing, firewalls, patching	13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when.
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
	External **Independent Assurance** NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14
GAPS IN CONTROLS	**GAPS IN ASSURANCE**

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Date of Review:	22/08/2022	TREND	15 (3x5)
		Date of Next Review:	21/09/2022		

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

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

1. Not all information security procedures are documented	1. No regular Cyber/Info Security KPIs are reported to senior management committees
2. Lack of understanding and compliance with policy and procedures by all staff members	2. Cyber awareness campaigns could be undertaken more regularly e.g. bi-monthly
3. No organisational information security management system in place	
4. IT Disaster Recovery Plan does not include a cyber response	
5. Departments do not communicate in a timely manner with Digital Services around putting in new processes, new projects and procurement and this has a cyber security, information governance and resource impact	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1.Establish Cyber and Information Security KPIs	Director of Digital Services	31.08.22	
2.Discuss how cyber risk is reviewed and frequency of review	Director of Digital Services	31.08.22 – Checkpoint Date	
3.Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	31.12.22	
4.Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22	
5.Formalise Cyber Incident Response Plan	Head of ICT	31.12.22 – Checkpoint Date	
6.Implement Meta Compliance Policy Solution	Senior ICT Security Specialist	31.12.22 – Checkpoint Date	

Risk ID 543	Major disruptive incident resulting in a loss of critical IT systems	Date of Review:	22/08/2022	TREND	15 (3x5)
		Date of Next Review:	21/09/2022		

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

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

IMTP Deliverable Numbers:

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

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

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	31.12.22 Checkpoint date	
2. Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 Checkpoint date	
3. Cyber Essentials assessment to be completed	Head of ICT	31.12.22 Checkpoint date	

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences	Date of Review:	22/08/2022	TREND	15 (3x5)
		Date of Next Review:	21/09/2022	➡	

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

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

IMTP Deliverable Numbers:

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

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

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. There is no steering group for Health and Wellbeing – there are plans to restart the group	4. Reporting on wellbeing training take up
11. Need to increase the education and communication with managers about stress risk assessments	• Lack of awareness about staff wellbeing services

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences	Date of Review:	22/08/2022	TREND	15 (3x5)
		Date of Next Review:	21/09/2022		

IF significant internal and external system pressures continue	THEN there is a risk of a significant deterioration in staff health and wellbeing within WAST	RESULTING IN increased sickness levels, staff burnout, poor staff and patient experience and patient harm		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	3	5	15
			Target	2	5	10

- Effects of REAP 4 affecting the ability of staff to engage with staff health and wellbeing services

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Restart the Health and Wellbeing Steering Group (link to risk 160)	Assistant Director – Inclusion, Culture and Wellbeing	30.09.22 Checkpoint Date	
2. Increase the education and communication with managers about stress risk assessments	Assistant Director – Inclusion, Culture and Wellbeing	31.12.22 Checkpoint Date	

Risk ID 100	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience	Date of Review:	09/08/2022	TREND	12 (3x4)
		Date of Next Review:	08/11/2022	➡	

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

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

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

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

CONTROLS	ASSURANCES
	Internal & External **Management (1st Line of Assurance)**
1. EASC/WAST Forward Plan for EMS and NEPTS in place and monitored at EASC meetings	1. Minutes of meetings and a standard agenda item
2. EASC and its 2 sub-committees established as a forum to discuss WAST's strategy	2. Minutes of meetings and a standard agenda item
3. Weekly catch up between CASC/CEO	3. Meetings are diarised every week
4. Collaboration between EASC and WAST on specific projects e.g. Amber Review, EMS Operational Transformation Programme, Ambulance Care Programme	4. Representatives are co-opted onto meetings and frequency is between 3–6 weeks. Set agendas with NCCU reps co-opted.
5. Monthly CASC Quality and Delivery Meeting established	5. Formal meeting with agendas, minutes and action logs available.
6. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports produced	6. These reports supplied to Director of Quality and Nursing in Health Boards and other senior stakeholders fortnightly
7. Programme structure has been established for 'inverting the triangles' including EASC	7. It exists and has had its first meeting
	External **Management (1st Line of Assurance)** 1. Plans go to every bi-monthly meeting 2. Meet bi-monthly and agendas, minutes and action logs available
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. EASC meetings focus largely on EMS and cursory note of NEPTS	1. Health Boards are not sending Patient Safety Incidents that are National Reportable Incidents to the Delivery Unit (identified within a Delivery Unit audit)
2. Governance coordination between NCCU and WAST to be improved.	2. Identified need for a governance meeting between NCCU and WAST to manage the overall commissioner/provider interface
3.	7. This is a new structure that has been established and is yet to be embedded and tested for assurance
Xx WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility)	
Xx Funding does not flow in a manner to balance demand with capacity (this is outside of WAST's control)	

	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence EASC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	30.09.22 – Checkpoint Date	
2. Agree and influence EASC/Health Board of the need for significant reduction in hospital handover hours	CEO WAST	30.09.22 – Checkpoint Date	
3. Increased understanding of NEPTS by EASC	Director of Strategy Planning and Performance	30.09.22 – Checkpoint Date	
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface	Assistant Director Commissioning & Performance	30.09.22 – Checkpoint Date	
5. Utilising the engagement framework to engage with the stakeholders	Director of Partnerships & Engagement AD Planning & Transformation	30.09.22 Checkpoint date	

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	22/08/2022	TREND	12 (4x3)
		Date of Next Review:	21/11/2022		

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

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

EXECUTIVE OWNER	Director of Workforce and Organisational Development	ASSURANCE COMMITTEE	People & Culture Committee

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Agreed (Refreshed) TU Facilities Agreement developed in partnership	1. Agreed document which states governance arrangements and the criteria for time off for TU activity etc.
2. Go Together Go Far (GTGF) statement and CEO/TU Partners statement	2. Both parties refer to the documents and are signed up/committed to it
3. IPA Workshops	3. Meetings completed with participation from TUs and senior managers. Attendance lists are available
4. Trade Union representation at Trust Board, Committees	4. Committee or Board ask TU representative for feedback or whether they have been consulted. Big issues items progress as planned as a result of TU partner buy in
5. Monthly Informal Lead TU representatives and Chief Executive meetings	5. Diarised meetings
6. Staff representative management in Task & Finish Groups	6. Good attendance and commitment is observed at the meetings. TU partners listed as members in terms of reference
7. Fortnightly TUP Cell meetings	7. Diarised meetings with a formal agenda. Any business needed to be discussed is included in the agenda. Good attendance and commitment observed at meetings.
8. Local Co-Op Forums, and informal monthly meetings between TUs and Senior Operations Team	8. Consistency of invitation and good attendance/commitment observed at meetings. Trade Union representations on SOT meetings
9. Quarterly Report on TU activity to People and Culture Committee	9. Report at every P& C committee meeting regarding activities TUPs involved with which is noted. Whenever Partnerships are discussed, the value of these is formally minuted in the Board and Committee minutes
	External Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Need to move back to business-as-usual footing	None identified
2. Facility to manage situations where there is a failure to agree, to avoid grievance and disputes from occurring	

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Clarify the formal and informal consultation and engagement framework and definitions	Deputy Director of Workforce & Organisational Development	Extended from 31.05.22 to 31.08.22	Rearranged to 31.08.22 as result of range of issues
2. Agree the ToR for refreshed Partnership Forum meeting and move back to a business-as-usual footing	Deputy Director of Workforce & Organisational Development	31.10.22	Underway and good progress now being made
3. Proposed externally facilitated mediation session(s) building on the IPA workshops and specifically to address the thorny issue of what happens when we fail to agree	Deputy Director of Workforce & Organisational Development	31.05.22	Rearranged date 24.08.22 due to COVID in ACAS facilitators
4. Minutes of formal Partnership Forum should be reported to PCC or Board in future (return to BAU).	Deputy Director of Workforce & Organisational Development	Extended from 30.09.22 to 31.10.22	

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	09/08/2022	TREND	12 (3x4)
		Date of Next Review:	08/11/2022	➡	

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

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

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

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

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Current controls on workforce buy in are not sufficient due to changes in working practices	1. Project Initiation Document (PID) needs to be updated to reflect 22/23 budget position
2. System pressures – patient handover delays at hospitals (link to risks 223 & 224)	2. No prompts from STB for programme PID or risk register updates

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Increase in engagement on the specifics of change through facilitation mechanisms	Assistant Director – Commissioning & Performance	31.09.22 – Checkpoint Date	
2. More capacity requested (transition plan)	Assistant Director of Planning & Transformation	31.12.22 – Checkpoint Date	

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	09/08/2022	TREND	12 (3x4)
		Date of Next Review:	08/11/2022		

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

3. Engage with key stakeholders to reduce handover delays	CASC	31.09.22 – Checkpoint Date	Ongoing
4. Reduce abstractions in particular sickness absence	Deputy Director of Workforce & OD	30.08.22 – Checkpoint Date	
5. Engage with Assistant Director of Planning and Transformation on process for PID updates	Assistant Director – Commissioning & Performance	30.09.22 Checkpoint Date	HoT recruited awaiting start date

Risk ID 311	Inability of the Estate to cope with the increase in FTES	Date of Review:	22/08/2022	TREND	12 (3x4)
		Date of Next Review:	21/11/2022	⬇	

IF the cumulative impact on the estate of the EMS Demand & Capacity Review and the NEPTS Review is not adequately managed	**THEN** there is a risk that the Estate will not be able to cope with the increase in FTEs	**RESULTING IN** potential failure to achieve the benefits/outcomes of the programme and reputational damage to the Trust

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	3	9
Target	2	3	6

IMTP Deliverable Numbers: 1,3, 9, 10, 17, 18, 28, 30, 34

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

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Programme governance and reporting structures in place e.g. Estates SOP Delivery Group and EMS Operational Transformation Programme Board, Integrated Strategic Planning Group Technical subgroup	1. Highlight report goes to Estates SOP Delivery Group every other month, report to EMS Operational Transformation Programme Board every 6 weeks, Technical Group meet monthly and there is an agenda, minutes and an action log
2. "Mega" spreadsheet combining all information into total cumulative impact on estate (and fleet) held by Assistant Director, Commissioning and Performance	2. Information is sense checked by AD Commissioning and Performance and reviewed by Integrated Technical Planning Group
3. Programme risk register sits with EMS Programme Board.	3. On agenda of meetings of Board
4. Risk logs held with respect to delivery of aspects of the project	4. Regional meetings are held regularly, and projects are discussed
5. Project Manager in place (for delivery of the solutions identified)	5. This resource is allocated to projects
6. Interim estates solution project	6. Regional meetings are held regularly, and projects are discussed
7. Finance and Corporate Resources directorate delivery plan	7. Reports go every 6 weeks to the Strategic Transformation Board
	External Not applicable
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. NEPTS D&C Review – Ambulance Care Programme Board	**1.** Information is received in an ad hoc and fragmented manner as opposed to a regular method from Operations
2. NEPTS Covid recovery planning	
3. Finance may be a constraint to delivery of solutions when problem is identified	

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
2. NEPTS and EMS – confirmation required from Operations functions about current and future numbers	Senior Management within Operations, Workforce & OD, Strategy Planning & Performance	31.12.22 – Checkpoint Date	
TBC			

Risk ID 424	Resource availability (capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	09/08/2022	TREND	12 (3x4)
		Date of Next Review:	08/11/2022	➡	

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

	Likelihood	Consequence	Score
Inherent	4	4	16
Current	3	4	12
Target	1	4	4

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

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

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Recruit a Head of Transformation	Assistant Director of Planning	30.09.22 – Checkpoint Date	Recruited 02.08.22 awaiting start date
2. Review the PPM	Head of Transformation	31.03.23 – Checkpoint Date	
3. Develop Benefits Realisation plans in line with Quality and Performance Management framework	Assistant Director of Planning/Assistant Director, Commissioning & Performance	30.09.22 – Checkpoint Date	
4. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)	Deputy Director of Finance	31.12.22	

IMTP Deliverable Key

No.	IMTP Deliverable
1	We will recover our systems of working and implement new ways of working developed during the pandemic as we learn to live with COVID-19
2	We will engage with a range of stakeholders, developing genuine Pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum
3	We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles)
4	We will work with partners to promote and expand use of 111 across Wales
5	We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team
6	We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations
7	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
8	We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice
9	We will increase and balance response capacity and capability across urban and rural area of Wales
10	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients
11	We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover
12	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
13	We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand
14	We will develop and implement with partners an-All Wales transfer and discharge service
15	We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery
16	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
17	We will improve resource availability, tackling absence and recruitment challenges to deliver improved performance
18	We will effectively manage risk, governance and compliance to promote and protect colleague and patient safety, and ensure a safe, productive and fair work environment
19	We will purposefully shape our future People and Culture Strategy to equip our people to thrive in a changing environment
20	We will foster a culture of belonging and wellbeing where our people can engage, feel supported and represented
21	We will improve access to, and availability of services via the 111 Wales website and other digital channels (NHS Wales app)
22	Improved signposting to the most appropriate service
23	Improved digital tools and services to empower our teams to do their best
24	We will use modern technology to reduce repeat tasks and improve processes
25	Standardised information architecture and common approach to data and analytics across the organisation

26	We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation
27	Improved resilience, flexibility and interoperability for the 999-call platform
28	We will provide an improved financial plan to support our ambitions
29	Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation
30	We will deliver the Estates Strategic Outline Plan
31	We will implement the Environmental and Sustainability Strategy
32	Deliver the Fleet SOP
33	We will secure and implement Quality Management and control systems
No.	**IMTP Deliverable**
34	We will transform the way we work and engage with people
35	We will revisit and implement the Public Health Plan
36	We will implement the Clinical Strategy to support developments across our service ambitions
37	We will deliver a values-based approach
38	We will deliver strong risk management processes and embed a Trust-wide risk culture that embeds the principles of good governance

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

LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1ST APRIL 2022 TO 31st AUGUST 2022

MEETING	**Audit Committee**
DATE	**15th September 2022**
EXECUTIVE	**Director of Finance and Corporate Resources**
AUTHOR	**Jessica Price**
CONTACT	**Chris Turley 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 five months from 1st April 2022 to 31st August 2022 (**Annex 1**).

KEY ISSUES/IMPLICATIONS

Total net Losses and Special Payments made were as follows:-

- period 1st April 2022 to 31st August 2022 -£0.009m

REPORT APPROVAL ROUTE
Audit Committee 15th September 2022 – no action required for information under SFI's only

REPORT APPENDICES
Annex 1 – Summary and details of payments made for the five months to 31st August 2022

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 - PAYMENTS FOR THE PERIOD FROM 1st APRIL 2022 TO 31st AUGUST 2022

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 twelve months from 1st April 2022 to 31st August 2022 (**Annex 1**).

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2022 to 31st August 2022 amounted to -£0.009 million.

4. 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 five months to 31st August 2022 reimbursements received exceeded payments made by £0.009m.

5. During June you will note the Welsh Risk Pool reimbursements amounted to £0.269m. The majority of which, £0.230m, relates to the reimbursement of a finalised personal injury case against the Trust.

6. Also during August you will note the Welsh Risk Pool reimbursements amounted to £0.518m. The majority of which relates to 2 medical negligence cases. £0.221m relates to the reimbursement received for a medical negligence case against the Trust following the death of a patient due to failure to identify the severity of the patients' symptoms. £0.290m relates to the reimbursement received for a medical negligence case against the Trust following the death of a patient due to an ambulance delay.

7. During August you will also note the payments in relation to Claimants Solicitors amounted to £0.233m, of which £0.116m relates to a medical negligence case against the Trust due to patients recovery being effected due to an ambulance delay.

RECOMMENDED: That the Losses and Special Payments Report for this period be received and noted.

Welsh Ambulance Services NHS Trust
Losses and Special Payments

Annex 1

Summary of payments for the five months to 31st August 2022:

	£
April 2021	£109,893.12
May 2021	£141,037.72
June 2021	-£121,785.57
July 2021	£104,081.28
August 2021	-£242,461.55
September 2021	-
October 2021	-
November 2021	-
December 2021	-
January 2022	-
February 2022	-
March 2022	-
	-£9,235.00

Losses and Special Payments Breakdown:

Payment Type	April	May		**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
	£	£	£	£	£	£	£	£	£	£	£	£	£	
Claimants Solicitor Costs		40,455.00	40,731.00	83,866.00	23,200.00	233,182.00	0	0	0	0	0	0	0	£421,434.00
Counsel fees		10,825.00	5,339.00	2,827.50	17,195.63	9,050.00	0	0	0	0	0	0	0	£45,237.13
CRU		0	29,816.83	3,686.00	1,312.00	0	0	0	0	0	0	0	0	£34,814.83
Damages		12,875.00	23,200.00	42,374.31	21,095.87	17,600.00	0	0	0	0	0	0	0	£117,145.18
Defence Costs		4,061.02	2,318.90	2,368.87	4,012.20	221.79	0	0	0	0	0	0	0	£12,982.78
Expert Witness		15,024.00	10,140.75	6,587.50	7,740.00	2,400.00	0	0	0	0	0	0	0	£41,892.25
Vehicle Repairs		12,155.60	29,491.24	5,156.51	29,525.58	6,786.46	0	0	0	0	0	0	0	£83,115.39
WRP Refund		0.00	0	-268,652.26	0	-518,151.70	0	0	0	0	0	0	0	-£786,803.96
Property Repairs		14,497.50	0	0	0	6,449.90	0	0	0	0	0	0	0	£20,947.40
Court Refund		0.00	0	0	0	0	0	0	0	0	0	0	0	£0.00
Total		**£109,893.12**	**£141,037.72**	**-£121,785.57**	**£104,081.28**	**-£242,461.55**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**-£9,235.00**

Welsh Ambulance Services NHS Trust
Losses and Special Payments

Key

MN Medical Negligence
PI Personal Injury
DP Damage To Property

Summary of payments for the five months to 31st August 2022:	£	
PI cases < £1,000	2,346.10	5 Cases
DP cases < £1,000	11,119.09	25 Cases
22RT4MN0018	20.09	
23RT4MN0006	39.42	
23RT4MN0001	80.36	
22RT4MN0013	206.64	
23RT4MN0005	455.69	
22RT4MN0001	465.63	
21RT4PI0035	1,000.00	
21RT4MN0013	1,000.00	
22RT4MN0011	1,050.00	
22RT4DP0097	1,113.36	
20RT4PI0008	1,122.96	
22RT4EG0005	1,200.00	
22RT4DP0091	1,213.84	
23RT4MN0008	1,275.00	
18RT4MN0023	1,287.00	
22RT4DP0042	1,382.04	
22RT4DP0013	1,414.10	
23RT4DP0010	1,449.49	
23RT4GN0016	1,500.00	
22RT4DP0099	1,500.40	
22RT4DP0102	1,520.13	
21RT4GN0014	1,600.00	
23RT4DP0002	1,651.41	
23RT4DP0003	1,659.37	
23RT4DP0007	1,827.40	
22RT4DP0085	1,866.60	
23RT4DP0015	1,907.45	
23RT4DP0011	1,948.86	
22RT4PI0040	2,000.00	
22RT4GN0011	2,020.00	
23RT4DP0008	2,053.80	
23RT4DP0001	2,157.23	
23RT4DP0020	2,315.47	
23RT4DP0017	2,376.89	
22RT4DP0086	2,377.60	
23RT4PI0006	2,510.00	
18RT4MN0016	2,667.50	
23RT4DP0019	2,700.43	
19RT4MN0008	3,021.00	
22RT4DP0090	3,108.94	
22RT4MN0012	3,151.50	
23RT4DP0024	3,263.56	
22RT4GN0014	3,400.00	
23RT4DP0005	3,437.50	
22RT4DP0057	3,522.90	
22RT4PI0036	3,560.00	
22RT4GN0004	3,670.00	
23RT4DP0018	3,898.55	
22RT4DP0101	4,421.27	
16RT4MN0009	5,500.00	
20RT4PI0035	5,920.00	
20RT4PI0028	5,942.00	
21RT4MN0009	6,085.00	
18RT4MN0012	6,140.00	
22RT4PI0038	6,239.29	
20RT4MN0011	6,620.00	
23RT4DP0012	6,665.40	
21RT4GN0011	6,950.00	
23RT4DP0014	7,049.48	
22RT4PI0008	7,207.00	
22RT4MN0002	7,534.48	
23RT4DP0013	8,612.22	
21RT4PI0009	9,132.00	
21RT4DP0086	10,387.33	
19RT4PI0049	12,325.00	
21RT4PI0022	12,991.00	
20RT4PI0042	14,865.00	
22RT4DP0080	20,947.40	
18RT4MN0001	25,035.00	
21RT4PI0001	37,668.00	
20RT4MN0019	40,265.00	
20RT4PI0025	42,980.83	
20RT4MN0010	48,985.20	
17RT4MN0007	68,000.00	
19RT4PI0008	116,321.75	
18RT4MN0005	128,499.00	
20RT4MN0010	-289,685.20	WRP REFUND
18RT4MN0023	-221,366.50	WRP REFUND
18RT4PI0060	-202,886.25	WRP REFUND
19RT4PI0053	-56,834.01	WRP REFUND
20RT4MN0006	-7,682.00	WRP REFUND
23RT4DP0016	-5,154.99	RECOVERY RE LOSS OF USE
21RT4GN0008	-5,000.00	WRP REFUND
22RT4GN0007	-1,750.00	WRP REFUND
21RT4GN0016	-1,250.00	WRP REFUND
22RT4GN0017	-350.00	WRP REFUND
Total	**- 9,235.00**	

May-22

Case Reference	Details	Amount (£)
18RT4MN0001	Claimants Solicitor Costs	25,000.00
18RT4MN0023	Expert Witness	640.00
19RT4MN0008	Counsel fees	1,332.50
19RT4PI0008	Expert Witness	552.00
20RT4MN0011	Counsel fees	992.50
20RT4PI0007	Counsel fees	275.00
20RT4PI0025	Claimants Solicitor Costs	12,343.00
20RT4PI0025	CRU	28,872.83
20RT4PI0028	CRU	944.00
20RT4PI0035	Claimants Solicitor Costs	2,520.00
20RT4PI0035	Damages	3,400.00
21RT4DP0086	Vehicle Repairs	10,387.33
21RT4EG0006	Damages	600.00
21RT4GN0011	Damages	6,950.00
21RT4MN0009	Defence Costs	10.00
21RT4MN0009	Expert Witness	4,950.00
21RT4MN0013	Expert Witness	1,000.00
21RT4PI0001	Damages	12,250.00
21RT4PI0001	Defence Costs	232.00
21RT4PI0035	Defence Costs	1,000.00
22RT4DP0013	Defence Costs	443.30
22RT4DP0042	Vehicle Repairs	1,382.04
22RT4DP0090	Vehicle Repairs	100.00
22RT4DP0095	Vehicle Repairs	906.96
22RT4DP0098	Vehicle Repairs	714.30
22RT4DP0101	Vehicle Repairs	4,421.27
22RT4DP0102	Vehicle Repairs	880.00
22RT4DP0102	Vehicle Repairs	640.13
22RT4DP0103	Vehicle Repairs	274.55
22RT4DP0103	Vehicle Repairs	- 274.55
22RT4EG0005	Counsel fees	1,200.00
22RT4GN0023	Claimants Solicitor Costs	868.00
22RT4MN0001	Expert Witness	225.00
22RT4MN0002	Expert Witness	493.75
22RT4MN0002	Expert Witness	790.00
22RT4MN0002	Expert Witness	990.00
22RT4MN0012	Counsel fees	1,539.00
22RT4MN0012	Expert Witness	500.00
23RT4DP0001	Vehicle Repairs	2,157.23
23RT4DP0002	Vehicle Repairs	1,651.41
23RT4DP0003	Vehicle Repairs	1,659.37
23RT4DP0004	Vehicle Repairs	710.00
23RT4DP0007	Vehicle Repairs	1,827.40
23RT4DP0008	Vehicle Repairs	2,053.80
23RT4PI0001	Defence Costs	633.60
Totals		**141,037.72**

Jun-22

Case Reference	Details	Amount (£)
17RT4MN0007	Claimants Solicitor Costs	35,000.00
17RT4MN0007	Claimants Solicitor Costs	33,000.00
18RT4MN0001	Counsel fees	35.00
18RT4MN0012	Expert Witness	612.50
18RT4MN0012	Expert Witness	1,975.00
18RT4MN0016	Counsel fees	975.00
18RT4PI0060	WRP Refund	- 202,886.25
19RT4MN0008	Counsel fees	192.50
19RT4MN0008	Defence Costs	216.00
19RT4PI0008	Expert Witness	4,000.00
19RT4PI0008	Damages	24,274.31
19RT4PI0053	WRP Refund	- 56,834.01
20RT4MN0006	WRP Refund	- 7,682.00
20RT4MN0010	Claimants Solicitor Costs	10,000.00
20RT4MN0019	Damages	7,500.00
20RT4MN0019	Counsel fees	262.50
20RT4MN0019	Counsel fees	962.50
21RT4DP0055	Counsel fees	400.00
21RT4GN0014	Claimants Solicitor Costs	1,600.00
21RT4GN0016	WRP Refund	- 1,250.00
21RT4PI0001	CRU	2,368.80
21RT4PI0001	CRU	592.20
21RT4PI0009	Damages	2,500.00
21RT4PI0022	Damages	8,000.00
21RT4PI0022	Claimants Solicitor Costs	4,266.00
21RT4PI0022	CRU	725.00
22RT4DP0061	Vehicle Repairs	247.75
22RT4DP0103	Vehicle Repairs	274.58
22RT4DP0103	Vehicle Repairs	- 274.58
22RT4GN0014	Defence Costs	1,800.00
22RT4GN0015	Damages	100.00
23RT4DP0010	Vehicle Repairs	1,449.49
23RT4DP0011	Vehicle Repairs	1,948.86
23RT4DP0012	Vehicle Repairs	6,665.40
23RT4DP0016	Vehicle Repairs	- 5,154.99
23RT4DP0016	Vehicle Repairs	- 7,465.43
23RT4DP0016	Vehicle Repairs	7,465.43
23RT4EG0001	Defence Costs	28.90
23RT4EG0002	Defence Costs	243.61
23RT4MN0001	Defence Costs	80.36
Totals		**- 121,785.57**

Jul-22

Case Reference	Details	Amount (£)
18RT4MN0005	Defence Costs	1,740.00
18RT4MN0016	Counsel fees	1,020.00
18RT4MN0023	CRU	647.00
19RT4MN0008	Counsel fees	717.50
19RT4MN0008	Counsel fees	562.50
19RT4PI0008	Counsel fees	1,850.00
19RT4PI0008	Damages	1,603.37
19RT4PI0008	Damages	1,292.07
19RT4PI0049	Counsel fees	825.00
19RT4PI0049	Damages	11,500.00
19RT4PI0060	Counsel fees	275.00
19RT4PI0061	Counsel fees	412.50
20RT4MN0011	Counsel fees	312.50
20RT4MN0011	Counsel fees	75.00
20RT4MN0011	Expert Witness	1,050.00
20RT4MN0011	Expert Witness	400.00
20RT4MN0011	Counsel fees	1,050.00
20RT4MN0011	Counsel fees	587.50
20RT4MN0011	Counsel fees	600.00
20RT4MN0011	Counsel fees	592.50
20RT4MN0011	Expert Witness	960.00
20RT4PI0008	Defence Costs	22.96
20RT4PI0008	Counsel fees	1,100.00
20RT4PI0025	CRU	665.00
21RT4PI0001	Claimants Solicitor Costs	4,025.00
21RT4PI0001	Claimants Solicitor Costs	4,025.00
21RT4PI0001	Claimants Solicitor Costs	4,025.00
21RT4PI0001	Claimants Solicitor Costs	4,025.00
21RT4PI0009	Counsel fees	1,125.00
22RT4DP0013	Vehicle Repairs	720.00
22RT4DP0013	Defence Costs	250.80
22RT4DP0061	Vehicle Repairs	227.93
22RT4DP0073	Vehicle Repairs	257.76
22RT4DP0073	Vehicle Repairs	- 257.76
22RT4DP0086	Vehicle Repairs	1,425.60
22RT4DP0103	Vehicle Repairs	274.55
22RT4DP0103	Vehicle Repairs	- 274.55
22RT4GN0004	Expert Witness	1,750.00
22RT4GN0004	Claimants Solicitor Costs	1,920.00
22RT4GN0011	Claimants Solicitor Costs	100.00
22RT4GN0011	Claimants Solicitor Costs	1,920.00
22RT4GN0014	Claimants Solicitor Costs	1,600.00
22RT4MN0001	Counsel fees	240.63
22RT4MN0002	Expert Witness	385.00
22RT4MN0002	Expert Witness	1,200.00
22RT4MN0002	Expert Witness	395.00
22RT4MN0002	Counsel fees	1,000.00
22RT4MN0002	Counsel fees	850.00
22RT4MN0011	Expert Witness	1,050.00
22RT4MN0012	Expert Witness	550.00
22RT4MN0012	Counsel fees	562.50
22RT4MN0013	Defence Costs	206.64
22RT4PI0036	Damages	2,000.00
22RT4PI0036	Claimants Solicitor Costs	1,560.00
22RT4PI0038	Defence Costs	1,239.29
22RT4PI0040	Damages	2,000.00
23RT4DP0005	Counsel fees	1,787.50
23RT4DP0005	Counsel fees	1,650.00
23RT4DP0009	Vehicle Repairs	991.99
23RT4DP0013	Vehicle Repairs	1,877.51
23RT4DP0013	Vehicle Repairs	6,734.71
23RT4DP0014	Vehicle Repairs	3,394.92
23RT4DP0014	Vehicle Repairs	3,654.56
23RT4DP0015	Vehicle Repairs	1,907.45
23RT4DP0017	Vehicle Repairs	2,376.89
23RT4DP0018	Vehicle Repairs	3,898.55
23RT4DP0019	Damages	2,700.43
23RT4DP0020	Vehicle Repairs	2,315.47
23RT4DP0023	Vehicle Repairs	104.12
23RT4DP0023	Vehicle Repairs	- 104.12
23RT4EG0002	Defence Costs	14.35
23RT4EG0003	Defence Costs	43.05
23RT4MN0005	Defence Costs	455.69
23RT4MN0006	Defence Costs	39.42
Totals		**104,081.28**

Aug-22

Case Reference	Details	Amount (£)
18RT4MN0005	Claimants Solicitor Costs	116,400.00
19RT4PI0008	Counsel fees	6,750.00
19RT4PI0008	Claimants Solicitor Costs	60,000.00
19RT4PI0008	Claimants Solicitor Costs	15,000.00
20RT4MN0019	Claimants Solicitor Costs	30,000.00
20RT4PI0042	damages	9,250.00
20RT4PI0042	Claimants Solicitor Costs	5,615.00
21RT4MN0009	Expert witness	1,125.00
21RT4PI0009	Claimants Solicitor Costs	5,507.00
22RT4DP0057	Vehicle Repairs	3,522.90
22RT4DP0080	Property Repairs	6,449.90
22RT4GN0024	Counsel fees	300.00
22RT4PI0038	damages	5,000.00
23RT4DP0024	Vehicle Repairs	3,263.56
23RT4EG0004	Defence Costs	17.65
23RT4EG0006	Counsel fees	600.00
23RT4EG0007	Defence Costs	204.14
23RT4GN0015	Counsel fees	600.00
23RT4GN0016	Damages	1,500.00
23RT4GN0017	Counsel fees	800.00
23RT4MN0008	Expert witness	1,275.00
23RT4PI0006	Damages	1,850.00
23RT4PI0006	Claimants Solicitor Costs	660.00
18RT4MN0023	WRP Refund	- 221,366.50
20RT4MN0010	WRP Refund	- 289,685.20
21RT4GN0008	WRP Refund	- 5,000.00
22RT4GN0007	WRP Refund	- 1,750.00
22RT4GN0017	WRP Refund	- 350.00
Totals		**-242,461.55**

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

AUDIT REPORT

MEETING	Audit Committee
DATE	15th September 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 update in respect of internal and external reviews and an update in respect of activity since the las meeting.

2. **Members are asked to receive and discuss the contents of the report and:**
   a) **Note the audit activity since the last Audit Committee in June 2022.**
   b) **Consider the proposals to address each recommendation particularly those that have been further extended beyond agreed deadlines.**

KEY ISSUES/IMPLICATIONS

3. The report provides an update in respect of audit recommendations resulting from Internal Audit and external reviews.

4. Relevant sections of the audit tracker assigned to the following Committees were considered during this period for scrutiny and strategic oversight as follows:

   a. **People & Culture Committee** (5th September 2022)
   b. **Quality, Safety & Patient Experience Committee** (11th August 2022)
   c. **Finance & Performance Committee** (18th July 2022)

REPORT APPROVAL ROUTE

5. The details of the report have been submitted to:
   - ADLT – 6th July 2022
   - ADLT – 31st August 2022

REPORT APPENDICIES
6. The Audit Tracker has been circulated as a separate document – Appendix 1

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
EXECUTIVE MANAGEMENT TEAM
AUDIT REPORT

SITUATION

1. This paper provides an update in respect of audit 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. At the time of issuing the paper, there were a total of 95 current internal audit recommendations on the tracker. 27 recommendations were marked as complete at the June 2022 Audit Committee and removed from the tracker.

5. 33 recommendations were added to the tracker resulting from 7 Internal Audit Reports which were presented to the Audit Committee in June 2022.

6. 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	35	5	27	3
Not yet due*	27	5	21	1
Complete	33	8	19	6
Total	95	18	67	10

* accepting extensions have been applied in line with the agreed pandemic arrangements.

7. The 5 high priority recommendations showing as overdue relate to the following Reasonable Assurance rated reports:

- 20/21 Clinical Contact Centres Performance Management. These are proposed to be completed between September and December 2022.

- 2021/22 Role of Advanced Paramedic Practitioner – Proposed to be completed by March 2023.
- 2021/22 Waste Management – proposed to be completed by December 2022.
- 2021/22 Respiratory Protective Equipment – proposed to be completed by October 2022.

8. 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
2019/20	3	0	3	0
2020/21	15	6	9	0
2021/22	77	27	22	28
Total	95	33	34	28

9. There are 3 recommendations showing as overdue from 19/20 reports, all of which are of medium priority. One 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 June 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 were expected to be completed by the end of March 2022; however, this is now proposed to be extended until the end of September 2022.

11. There are 2 recommendations that are proposed for closure rather than completed from the Clinical Contact Centres – Performance Management Reasonable Review as follows:

12. 379 - While the Trust supports the idea of dedicated auditors a funding request for these positions was subsequently turned down by the Programme Board / Commissioners. The Trust is unable to progress with this as an option without funding.

13. 380 - This action was stepped out in the CCC Reconfiguration model which was approved by EMT, pending funding, in Q3 2021. Due to financial constraints on the organisation for this year and the next 3 years, additional funding has not been successfully sourced and whilst the CCC reconfiguration remains a key deliverable for the organisation it is currently paused as a cost pressure. EMS configurations are continuing to deliver CAD phase 3 objectives within the financial envelope, such as roster review, divisional realignment and broader ways of working but this will now not include formal audit provision for the wider team. Should funding be secured for the CCC reconfiguration model in the future this objective will be reviewed and updated.

14. 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	12	8	4	0
Reasonable	77	10	59	8
Substantial	0	0	0	0
Not Rated	6	0	4	2
Total	95	18	67	10

15. Each of the 95 recommendations were subject to a monthly review by the Assistant Directors Leadership Team since the last Audit Committee in June 2022 to ensure that realistic timescales were proposed where necessary and any new completion dates assigned with a strong narrative and rationale to support this.

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 12 recommendations made as a result of the Taking Care of the Carers external review.

18. These are described in the table below and revised dates are included on the tracker:

Status	Number of Recommendations
Overdue	3
Not yet due	2
Complete during this period	7
Total	12

RECOMMENDED:

19. **Members are asked to receive and discuss the contents of the report and:**
    a) Note the audit activity since the last Audit Committee in June 2022.
    b) Consider the proposals to address each recommendation particularly those that have been further extended beyond agreed deadlines.

AGENDA ITEM No	**11**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**N/A**

COVID-19 PUBLIC INQUIRY UPDATE

MEETING	Audit Committee
DATE	15 September 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. The Covid-19 Public Inquiry has commenced with modules 1-3 which are set out below. Calls for core participant status for module 1 were sought from 21 July to 16 August. This paper updates the Committee on preparation for the Public Inquiry and applications for core participant status.

RECOMMENDATION

2. The Audit Committee is requested to note the update.

KEY ISSUES/IMPLICATIONS

3. Following legal advice and discussion at Executive Management Team, WAST will not be a core participant status for modules 1 or 2, however it is likely that core participant status for module 3 will be pursued given the inclusion of the initial health advice provided by 111 and 999 in the inquiry's terms of reference.

4. A Pandemic Governance Group has been formed in WAST to steer the Public Inquiry preparations. The group which meets monthly, is chaired by the Board Secretary and reports to the Executive Management Team.

REPORT APPROVAL ROUTE

15 August 2022 – Executive Management Team

REPORT APPENDICES

None

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

SITUATION

1. The Covid-19 Public Inquiry has commenced with modules 1-3 which are set out below. Calls for core participant status for module 1 were sought from 21 July to 16 August. This paper updates the Committee on preparation for the Public Inquiry and applications for core participant status.

BACKGROUND

2. Baroness Hallett was appointed as Chair of the Inquiry in December 2021 and its terms of reference were finalised on 28 June 2022. One purpose of the Inquiry is to provide a factual narrative account of what happened across the whole of the UK. Another is to learn lessons to inform preparations for future pandemics in the UK.

3. During public consultation for the terms of reference concerns were heard, particularly from the bereaved, about the capacity of the NHS 111 service to respond to the volume of calls it was receiving, and the suitability of diagnostic advice given both over the telephone and through online 111 services. Respondents also noted concerns about the response time for emergency ambulance services, and apparent inconsistencies in the decision-making process as to whether or not ambulance services would admit someone with Covid-19 symptoms to hospital. As a result of this consultation the terms of reference were expanded to include the initial contact with official healthcare advice services such as 111 and 999 (see 1(b)(ii) in the terms of reference).

4. The Inquiry will be grouped into modules, with teams based across the UK to investigate each one, largely working in parallel. Preliminary hearings for each module are due to take place this year and public hearings will commence in late Spring 2023 for module 1. Core participants will be sought for each module, with those wishing to be considered for module 1 are required to apply by 16 August.

5. NWSSP Legal and Risk have been appointed to act for WAST. Senior and Junior Counsel, Richard Booth QC and Christopher Mellon (junior counsel) have been instructed to act on our behalf.

6. An initial pandemic timeline is being developed and will be complete by the end of October. This will illustrate the response of WAST to government directives/timeline.

7. The Inquiry will conduct a listening exercise later in the year to learn more about the impact of the pandemic on the bereaved, on health and social care staff and carers, on businesses, workers, careers, and livelihoods, on the criminal justice system, on children, on academic achievement and on different communities across the four nations.

8. The Inquiry will announce further modules in 2023, likely to cover both 'system' and 'impact' issues including: vaccines, therapeutics and anti-viral treatment; the care sector; Government procurement and PPE; testing and tracing; Government business and financial responses; health inequalities and the impact of Covid-19; education, children and young persons; and the impact of Covid-19 on public services and on other sectors. The Inquiry has confirmed that it will be looking at the impact of the pandemic on inequalities at every stage of its investigations.

9. A Pandemic Governance Group has been formed in WAST to steer the Public Inquiry preparations. The group which meets monthly, is chaired by the Board Secretary and reports to the Executive Management Team.

ASSESSMENT

Module 1

10. Module 1 opened on 21 July 2022 with the first preliminary hearing due to take place in September 2022 and public hearings in Spring 2023.

11. Module 1 will consider the extent to which the risk of a Coronavirus pandemic was properly identified and planned for and whether the UK was ready for that eventuality. The module will look at the UK's preparedness for whole-system civil emergencies, including resourcing, the system of risk management and pandemic readiness. It will scrutinise government decision-making relating to planning and seek to identify lessons from earlier incidents and simulations and international comparisons.

12. The Module will examine:

    i) The basic characteristics and epidemiology of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) and Coronavirus disease (COVID-19).

    ii) The Government structures and specialist bodies concerned with risk management and civil emergency planning, including devolved administrations and their structures, local authorities and private sector bodies, historical changes to such structures and bodies as well as the structures in place as at January 2020, inter-organisational processes and cooperation.

    iii) The planning for a pandemic, including forecasting, resources, and the learning from past simulation exercises (including coronavirus, new and emerging high-consequence infectious diseases and influenza pandemic/epidemic exercises), the emergency plans that were in place, biosecurity issues relevant to the risk of pandemics/epidemics, international comparisons and the history of, and learning from, past policy-related investigations.

    iv) Public health services, including the structure of public health bodies, their development over time and readiness and preparation in practice; public health capacity, resources and levels of funding, any impact arising from the UK's departure from the European Union, and the way in which relevant bodies monitored and communicated about emerging disease.

    v) Economic planning by relevant Government bodies, including capacity and spending commitments and efficiency and anti-fraud controls, in the context of emergency planning.

    vi) Planning for future pandemics, including (in outline) the state of international preparedness; the risks of new variants of Covid 19, other viruses of concern, and diseases from human contact/viral transmission with animals

13. Given the specificities of this module it was not judged appropriate or beneficial for WAST to apply for core participant status.

Module 2

14. This module will be split with the first part covering the UK and the second part looking at the same issues for each devolved nation. The first part opens in late August with preliminary hearings in Autumn 2022 and the public hearing in Summer 2023. Those parts looking at each devolved nation will begin after the first part.

15. The first part of module 2 will look at core political and administrative governance and decision-making for the UK. It will cover the initial UK response to the Covid-19

pandemic and address central Government decision-making, including political and civil service performance and the effectiveness of relationships with the governments in Scotland, Wales and Northern Ireland, local authority and voluntary/community sectors. It will look at the decision-making for non-pharmaceutical interventions (in other words the lockdowns and all the other restrictions and requirements), as well as the use of scientific expertise, data collection and modelling, government and public health communications, including behavioural science, messaging and the maintenance of confidence and Parliamentary oversight and regulatory control.

16. Core participant submissions have not yet opened for this module, however given its remit WAST does not intend to apply.

Module 3

17. The timetable for Module 3 has not yet been announced. The module will examine the impact of Covid, and of the governmental and societal responses to it, on healthcare systems generally and on patients, hospital and other healthcare workers and staff. Among other issues, it will investigate healthcare systems and governance, hospitals, primary care (including GPs and dentists), the impact on NHS backlogs and non-Covid treatment, the effects on healthcare provision of vaccination programmes and Long-Covid diagnosis and support.

18. Further details of the module are awaited, however it is likely that WAST will apply for core participant status given its remit. Advice is being sought from appointed Solicitors.

Core Participant Status and Criteria

19. The benefits of core participant status include:

- The right to be provided with electronic disclosure of evidence relevant to the particular subject matter of the Inquiry in respect of which they are so designated;
- The right to make opening and closing statements at any hearing;
- The right to suggest lines of questioning to be pursued by Counsel
- The right to apply to the Inquiry to ask questions of witnesses during a hearing.

20. Applicant for core participant status must demonstrate:

- the person played, or may have played, a direct and significant role in relation to the matters to which the inquiry relates;
- the person has a significant interest in an important aspect of the matters to which the inquiry relates; or
- the person may be subject to explicit or significant criticism during the inquiry proceedings or in the report, or in any interim report.

RECOMMENDATION

21. The Audit Committee is requested to note the update.

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE
HIGHLIGHT REPORT TO AUDIT COMMITTEE

This report provides the Audit Committee with key escalation and discussion point at the last Committee meeting.

Audit Committee Meeting Date	15 September 2022
Committee Meeting Date	11 August 2022
Chair	Bethan Evans

KEY ESCALATION AND DISCUSSION POINTS

ALERT
(Alert the Board to areas of escalation)

1. No alerts for the Audit Committee.

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

2. No areas to advise for the Audit Committee.

ASSURE
(Detail here any areas of assurance the Committee has received)

1. The Committee's terms of reference at paragraph 3.15 provides that it will:

   *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.*

2. **Clinical Audit and Outcome Review Plan 2122/23** was received. The criteria for clinical audits included in the National Clinical Audit and Outcome Annual Review Plan do not directly relate to the pre-hospital environment or necessitate the inclusion of WAST clinical data. However, as an example, WAST does contribute indirectly to the Myocardial Ischaemia National Audit Project (MINAP), the Sentinel Stroke National Audit Programme (SSNAP) and the Trauma Audit & Research Network (TARN) as data from Patient Clinical Records is used to inform these. WAST has an annual Clinical Audit Programme updated on a quarterly basis and the Q1 clinical audit plan was approved by the Committee. The Committee will monitor the plan and outcomes on a quarterly basis.

RISKS

N/A

AGENDA ITEM No	**13**
OPEN or CLOSED	**Open**
No of APPENDIX ATTACHED	**0**

Committee Priorities 2022/23

MEETING	Audit Committee
DATE	15 September 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	Trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This report updates the Committee on progress against the priorities it set for 2022/23.

2. Progress is steady across all priorities.

RECOMMENDATION

3. The Committee is asked to note the update.

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable

REPORT APPENDICES

None

REPORT CHECKLIST

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

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

COMMITTEE PRIORITIES FOR 2022/23

SITUATION

4. This report updates the Committee on progress against the priorities it set for 2022/23.

BACKGROUND

5. During the course of the 2021/22 effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year.

6. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2022 and will be tracked quarterly.

ASSESSMENT

7. The Committee priorities, and progress against them is as follows:

Priority	Progress
1. Develop an induction programme for new Audit Committee Members	• The overarching new Board member induction programme is complete other than the roles and responsibilities for trade union representatives. This should be completed by mid-September. • The induction programme is in use for new Board members and includes a scrutiny toolkit, however in collaboration with Audit Wales we are looking to produce Audit Committee specific induction material and checklists. • In addition, a bespoke WAST finance induction for new members is also being developed with the Finance Team.
2. The transformation of risk management and the Board Assurance Framework (BAF).	• The Committee received a progress report on the risk management programme in June 2022. • The programme is part of the IMTP with oversight of the IMTP in Finance and Performance Committee. • The programme includes maturity of risk management and the BAF through 2022/23 and into 2024, and improvements are noted by the Audit Committee with the regular risk management reports. • The risk management policy and procedure will come to this committee for approval as part of that programme.

RECOMMENDATION

8. The Committee is asked to note the update.