Bundle Audit Committee (Open) 30 November 2023

Agenda attachments

ITEM 0 Agenda Audit Committee Open 30 November 2023

0 09:30 - OPENING ITEMS

1 Chair's welcome; apologies and confirmation of quorum

2 Declarations of Interest
Declarations of Interest

3 Minutes of last meeting: - 14 September 2023

ITEM 3 Audit Committee OPEN Minutes 14 September 2023

4 Action Log and Matters Arising
4.1 Open Actions
4.2 Committee AAA - 14 September 2023

ITEM 4.1 Open Audit Committee Action Log
ITEM 4.2 Audit Committee Highlight Report September 2023

4.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION

5 09:40 - Policy Report

ITEM 5 Executive Summary Policy Report AC 301123
ITEM 5.1 Policy Tracker v2 (14.11.23) New Updated

6 09:50 - Quality and Performance Management Framework Implementation Update - Verbal Update
This item was updated to be received verbally post publication

7 10:10 - Internal Audit
7.1 Head of Internal Audit Update
Internal Audit Reports:
7.2 Senior Paramedic Role
7.3 Records Management
7.4 Estates Assurance: Estate Condition

ITEM 7.1 WAST_2324_Internal Audit Progress Report_November 23
ITEM 7.2 WAST_2324-009_Senior Paramedic Role_Final Internal Audit Report
ITEM 7.3 WAST_2324-13_Records Management_Final Internal Audit Report
ITEM 7.4 WAST-SSU-2324-02 Estates Condition Final Audit Report

8 10:40 - Audit Wales Reports
8.1 Audit Wales Update Report
8.2 Workforce Planning Report
8.2a Workforce Data Briefing

ITEM 8.1 WAST Audit Committee update 301123
ITEM 8.2 WAST Workforce Report final
ITEM 8.2a NHS_Workforce_data_briefing_English_Webvrs

9 11:10 - Risk Management and Board Assurance Framework

ITEM 9 Executive Summary Risk Management Report AC 301123

10 11:25 - Q2 Audit Tracker Update

ITEM 10 AC SBAR on Audit Tracker 2.0 - 30 November 2023
ITEM 10.1 Audit Handbook v.2 - 17 October 2023
ITEM 10.2 Audit Tracker 2.0 July-September 2023
ITEM 10.2.1 Audit Tracker 2.0 July-September 2023 Audit Wales HIW
ITEM 10.3 Audit Tracker 2.0 July-September 2023 - AC Specific Filter for Internal Audits

11 11:30 - Losses and Special Payments

ITEM 11 Executive Summary SBAR Losses and Special Payments M07 2023-24
ITEM 11.1 Annex 1 - Losses Special and Payments 2023-24 M7

12 11:40 - Speaking Up Safely Update (Whistleblowers) - Verbal Update

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

13 Committee Cycle of Business Monitoring Report and Priorities Report

ITEM 13 Audit Committee Priorities and Cycle Monitoring Report
ITEM 13.1 Audit Committee Cycle of Business 2023-24 - Monitoring Report

13.1 11:50 - CLOSING ITEMS

14 Reflections & Summary of Decisions and Actions
15 Key Messages for Board
16 Any Other Business
17 Date and time of next meeting: 1 March 2024 – 09:30

AGENDA

MEETING OF THE OPEN AUDIT COMMITTEE

Held in public on **30 November 2023 from 09:30 to 11:55**
Meeting held virtually via Microsoft Teams

Comfort Break at 11.00am

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.	Declarations of Interest	To State Conflicts	Martin Turner	Verbal	
3.	Minutes of last meeting: – 3.1 14 September 2023	Approval	Martin Turner	Paper	
4.	Action Log and Matters Arising 4.1 Open Actions 4.2 Committee AAA – 14 September 2023	Discussion	Martin Turner	Paper	
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
5.	Policy Report	Assurance	Julie Boalch	Paper	10 mins
6.	Quality and Performance Management Framework Implementation Update	Assurance	Rachel Marsh	Verbal	20 mins
7.	Internal Audit 7.1 Head of Internal Audit Update Internal Audit Reports: 7.2 Senior Paramedic Role 7.3 Records Management 7.4 Estates Assurance: Estate Condition	Assurance	Osian Lloyd Andy Swinburn Jonny Sammut David Butler Chris Turley	Paper	30 mins
8.	8.1 Audit Wales Update Report 8.2 Workforce Planning report 8.2a Workforce Data Briefing	Assurance	Fflur Jones	Paper	30 mins
9.	Risk Management and	Assurance	Julie Boalch	Paper	15 mins

No.	Agenda Item	Purpose	Lead	Format	Time
	Board Assurance Framework				
10.	Q2 Audit Tracker Update	Assurance	Trish Mills	Paper	5 mins
11.	Losses and Special Payments	Approval	Chris Turley	Paper	10 mins
12.	Speaking Up Safely Update (Whistleblowers)	Assurance	Paul Hollard	Verbal	10 mins
CONSENT ITEMS **The items that follow are for information only. Should a member wish to discuss any of these items they are requested to notify the Chair so that time may be allocated to do so.**					
13.	Committee Cycle of Business Monitoring Report and Priorities Report	Information	Trish Mills	Paper	-
CLOSING ITEMS					
14.	Reflections & Summary of Decisions and Actions	Information	Martin Turner	Verbal	5 Mins
15.	Key Messages for Board	Information	Martin Turner	Verbal	
16.	Any Other Business	Discussion	Martin Turner	Verbal	
17.	Date and time of next meeting: 1 March 2024 – 09:30	Information	Martin Turner	Verbal	

Lead Presenters

Name of Lead	Position of Lead
Martin Turner	Non-Executive Director and Committee Chair
Julie Boalch	Head of Risk/Deputy Board Secretary
Paul Hollard	Chair of the People and Culture Committee
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Fflur Jones	Audit Wales
Osian Lloyd	Head of Internal Audit
Trish Mills	Board Secretary
Jonny Sammut	Director of Digital Services
Chris Turley	Executive Director of Finance and Corporate Resources
David Butler	Internal Audit

WELSH AMBULANCE SERVICES NHS TRUST

UNCONFIRMED MINUTES OF THE OPEN MEETING OF THE AUDIT COMMITTEE OF THE WELSH AMBULANCE SERVICES NHS TRUST HELD ON THURSDAY 14 SEPTEMBER 2023 VIA TEAMS

Meeting Commenced at 09:30

PRESENT:

Martin Turner	Non-Executive Director and Committee Chair
Paul Hollard	Non-Executive Director
Ceri Jackson	Non-Executive Director

IN ATTENDANCE:

Julie Boalch	Head of Risk/Deputy Board Secretary
Judith Bryce	Assistant Director of Operations
Fflur Jones	Audit Wales
Navin Kalia	Deputy Director of Finance and Corporate Resources
Olaide Kazeem	Project Accountant Financial Services
Angela Lewis	Director of People and Culture
Osian Lloyd	Head of Internal Audit (left during Item 44/23)
Rachel Marsh	Executive Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Toni-Marie Norman	Deputy Business Manager, Operations Directorate
Steve Owen	Corporate Governance Officer
Alex Payne	Corporate Governance Manager
Duncan Robertson	Assistant Director for Clinical Development
Paul Seppman	Trade Union Partner
Lisa Trounce	Business Manager, Corporate Services
Chris Turley	Executive Director of Finance and Corporate Resources
Liam Williams	Executive Director of Quality and Nursing
Carl Window	Counter Fraud Manager

APOLOGIES:

Lee Brooks	Executive Director of Operations

Joga Singh	Non-Executive Director
Damon Turner	Trade Union Partner

40/23 PROCEDURAL MATTERS

The meeting was initially chaired by Paul Hollard who welcomed all to the meeting and advised that it was being audio recorded.

There were no further declarations of Interest, other than those listed in the Declarations of Interest register.

Martin Turner (Chair of the Audit Committee) joins meeting.

Minutes:

The Minutes of the Audit Committee meeting held on 25 July 2023 were approved.

Action Log

Number 35/23: To provide further clarity on recommendation (b) (Approve the approach to the whistleblowing and near misses elements of the terms of reference such that the whistleblowing process and arrangements for special investigations will come to Audit Committee with regular verbal updates from the Chair of the People and Culture Committee on progress in the interim, and that QUEST will monitor near miss reporting), specifically to indicate the reporting process involved for each Committee and that the mechanism by which near misses – with respect to the criteria for escalation to Audit Committee where there are concerns regarding governance, internal controls, and management of risk - will be further considered and brought back to the Committee for endorsement. Trish Mills advised that the Chairs of the Committees who received any reports of near misses would report this to the Audit Committee. The action was accepted and agreed to close.

RESOLVED: The Committee

(1) Noted the apologies from Lee Brooks, Joga Singh, and Damon Turner;

(2) The Minutes of 25 July 2023 were approved; and

(3) The Action log was considered and the one action, reference number 35/23, was closed.

41/23 INTERNAL AUDIT ITEMS

The Head of Internal Audit (HoIA), Osian Lloyd presented the reports which consisted of his update and two Internal Audit (IA) Reports as listed below.

Good progress was being made against the 2023/24 Internal Audit Plan; of the 20 reviews, two were in draft, seven were in progress, four were in the planning stage and seven had not been started. The Committee noted there were no changes being proposed to the plan.

The following Internal Audit reports were received:

1. Health and Safety: – The Internal Audit (IA) opinion was reasonable; this was based on one high and four medium priority findings. The purpose of the audit was to review the Trust's structures and arrangements for complying with Health and Safety legislation. Several measures have been implemented to ensure compliance one of which was to review and update the Trust's Health and Safety policy. The management team have accepted the findings and IA were satisfied with the responses.

   Liam Williams welcomed the useful and interesting Audit, noting it was important to understand the processes and how they were being implemented. There was good engagement over the management responses, and it had been an excellent Learning experience for the Team.

   Clarity was sought on the timeline for the Health and Safety policy approval date. Liam Williams advised it was at its final stages and was currently out for consultation.

   Following a query in terms of the future of regional health and safety from a TU perspective and whether it should be incorporated as part of local partnership forums, Liam Williams agreed to follow up on this and provide clarity whether a Regional Health Safety Committee should be set up going forward. Judith Bryce updated the Committee on discussions at the recent Senior Leadership Team meeting whereby it was agreed that the local partnership forum would invite the health and safety representative.

2. Follow up Review Audit: – The Internal Audit opinion was reasonable. The follow up review was undertaken on two limited assurance reports (Waste Management and NEPTS Transfer of Operations Benefits Realisation) to assess whether the Trust had implemented the related internal audit recommendations. Furthermore, a review of the Trust's system in place (Audit Tracker) to monitor progress on the implementation of actions was undertaken. It was recognised that the Trust was in the process of improving its tracker and seeking ways to improve efficiency through automation.

Chris Turley provided the Committee with additional assurance in respect of the outstanding actions from the Waste Management review. Considerable progress has been made; noting that a detailed update will be provided to the Finance and Performance Committee on 18 September. Of the four actions remaining open a plan was in place to complete these by January 2024, adding that the Waste Management policy was due for approval by then.

Trish Mills advised that once the tracker was more manageable and more automated process actions would be completed more effectively and efficiently.

Clarity was sought on recommendation four which related to training which stated that responsibility for this action was to transfer to Director of People and Culture. Trish Mills advised it was unlikely to transfer to the Director of People and Culture, the action was on the training analysis which will be updated on the tracker.

RESOLVED: The Internal Audit reports and progress report and Internal Audit Plan as presented were received.

42/23 AUDIT WALES REPORTS

The Committee received the Audit Wales update report from Fflur Jones who presented it as read and highlighted the following for the Committee's attention:

1. Financial Audit – Audit of Accounts has been completed and work on the Charity fund was commencing soon

2. Fieldwork completed for the workforce planning review; noting this was anticipated to be reported at the next meeting.

3. The Structured Assessment core element fieldwork has recently been completed and should be presented at the next meeting.

4. An outline of the planned work was given.

5. Members were directed to other areas in the update which included details of events from the good practice team and NHS related national studies.

Comments:

Chris Turley added that the Charity Committee would receive an update on the Chairty audit plan at their meeting on the on 9 October 2023. He assured the Committee that the filing of the charity accounts was due to be completed on time.

In terms of the current potential £800m overspend in NHS Wales, the consequences and potential impact on WAST was discussed by Members. Chris Turley provided an overview in terms of impacts and consequences and reminded members that the Trust had submitted several proposals, suggestions and options to WG, at their request, in terms of potential further reductions in spend in year and was still awaiting feedback. He added that the Finance and Performance Committee would consider the impact in more depth at its next meeting. He summarised that the Trust, whilst having a balanced financial plan and delivering against it as an organisation, was part of the wider system in this significant financial position and may be asked to make further savings going forward.

Fflur Jones added that as part of the Structured Assessment, Audit Wales would look at the arrangements in place to meet the savings in the plan.

RESOLVED: The Committee received and noted the update.

43/23 AMENDMENTS TO THE STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS – WELSH GOVERNMENT REVIEW

Trish Mills presented the report outlining the amendments following Welsh Government's annual review of the model Standing Orders (SO), Scheme of Reservation and Delegation of Powers, and Standing Financial Instructions in July 2023 which resulted in some amendments being required to the documents.

These related primarily to the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 including the introduction of the duty of quality and duty of candour, and the change from the Community Health Councils to the Citizens Voice Body (Llais). Of note the changes are listed below:

1. The Model SO have incorporated the change from Community Health Councils to the Citizen Voice Body (Llais) and reflected the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

2. The requirement for the Trust to publish Board papers has been changed from ten to seven days.

3. The SO now include the role of the Vice Chair and the additional voting Director introduced in 2022.

Trish Mills added that the changes were to be recommended to the Trust Board for their approval and would be a substantive item on the Trust Board agenda.

Comments:

A point of clarity was raised in respect of the requirement to publish Trust Board papers from ten to seven days. Trish Mills confirmed this was the publication on the Trust's Board

and Committee board pack software ibabs and the Trust's website within seven days of the meeting.

RESOLVED: The Committee endorsed the amendments to the Standing Orders, Scheme of Reservation and Delegation of Powers and Standing Financial Instructions and recommended their approval to the Trust Board.

44/23 REVISED AUDIT PROCESS

The Audit Process and Reporting Handbook report was presented to the Committee by Trish Mills. The handbook had been written to provide context around the internal and external audit work at the Trust and outlined the stages of fieldwork for those that were the subject of an audit.

The Trust was working with Digital Health and Care Wales (DHCW) to transform the audit tracker process to a SharePoint solution with automated processes (Tracker 3.0). In the meantime, the current version of the tracker has recently been streamlined to improve the labour intensified process.

Board Committees will continue to receive the tracker; however, the Audit Committee and the Executive Leadership Team will receive updates focused more on the framework and those audits with higher recommendations or limited audits. This revised approach to reporting will position this Committee to focus on the overall framework and escalations where audit management actions were not met in reasonable timescales.

Comments:

Members recognised the significant amount of work undertaken to improve the overall audit tracker process and recorded a note of thanks for Trish Mills.

The Committee queried if the handbook would be linked into the induction programme for new Board/Committee Members. Trish Mills advised it was.

Following a discussion regarding the handbook it was agreed it would be shared as a best practice product at the appropriate forums going forward. Fflur Jones added that her comments on the handbook would be submitted to Trish Mills after the meeting.

Osian Lloyd leaves meeting at 10:25

The Committee questioned what the correct level of management was to agree the closure of actions. Trish Mills explained that the majority of closures would be evident, and the Assistant Director Leadership Team (ADLT) would challenge these closures through liaison with the Board Secretary. ADLT would escalate if appropriate any actions where there has been no movement to the ELT for their consideration. It was agreed this approach would be reviewed after 12 months.

RESOLVED: The Committee:

(1) Provided feedback on the draft Audit Process and Reporting Handbook; and

(2) Approved the ELT and Audit Committee reporting to inform development of Tracker 3.0.

45/23 RISK MANAGEMENT AND BOARD ASSURANCE FRAMEWORK

Julie Boalch presented the report advising that the Committee was responsible for the review of the risk management framework and was not assigned individual risks for oversight.

The principal risks were presented to the Trust Board on 27 July 2023 and were updated as of 01 September 2023. Each risk has been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3. Focus has been given to the risk ratings, controls, assurances, gaps, and the mitigating actions identified and taken to ensure risks achieve their target score.

The Trust's highest rated Risks 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), scoring 25, remain unchanged despite a series of mitigating actions being in place. These risks continue to be closely monitored by management, Board Committees, and the Trust Board. The Committee were advised that in relation to risk 223, work was being undertaken by the Operations Senior Leadership Team to look at regional modelling.

The Committee were also updated on the Risk Management Transformation Programme and Julie Boalch gave an outline on progress.

Comments:

The Committee noted that risk 160 related to sickness absence has maintained a score of 20 and given the fragility of this area and sickness absence trends, both the People and Culture Committee (PCC) and Executive Leadership Team will continue their close monitoring of this risk. PH assured the Committee it was monitored at every PCC meeting, noting the current trajectory was downward but wanted to keep the score high as sickness may worsen. Angela Lewis reassured the Committee as well as PCC this issue was reviewed through all the relevant governance processes internally.

The Committee discussed the volunteer fundraising risk and how this should be separate from the risks to the charity. Trish Mills explained there was a risk register in the Charity Committee and any developing risks will be separated out, noting this was still maturing.

RESOLVED: The Committee:

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

(2) Noted that there have been no material changes to the risks or scores during this period. And

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

46/23 LOSSES AND SPECIAL PAYMENTS

Chris Turley presented the report for the Committee advising that the total net losses and special payments for the period 1 April 2023 to 31 August 2023 were net payments of £65.5k.

RESOLVED: The Losses and Special Payments Report for this period were received and noted.

47/23 SPEAKING UP SAFELY UPDATE (WHISTLEBLOWERS)

Paul Hollard, Chair of the People and Culture Committee (PCC) updated Members of discussions held at the last PCC meeting concerning the speaking up safely programme. Of note during those discussions the Committee had reflected on the recent BBC Wales on sexual safety and sexism at work, and the work undertaken by the Trust in this area.

Feedback from this had been positive with an increase of staff coming forward. He added that the Trust had the solid basis for staff to speak up safely. Angela Lewis advised the Committee that request for additional information and assurance in light of events at the Countess of Chester Hospital and had received related correspondence from Judith Paget, the Director General for Health and Social Services/Chief Executive for NHS Wales. Angela Lewis assured the Committee she would be responding formally to Judith Paget following her request; noting the Board would be kept updated.

Liam Williams outlined the process involved in terms of the information flow between speaking up safely guardians and staff; ensuring this information was triangulated appropriately with other areas in the Trust that were managing concerns.

RESOLVED: The Committee noted the update.

48/23 BOARD/COMMITTEE INDUCTION PROGRAMME

Trish Mills gave an outline of the report which set out details that an induction programme was in place for new Board members which described the roles and responsibilities of all those who were members of or attended the Board. The Committee noted it would be updated periodically and included a range of essential reading for the new member and a programme of introductory meetings on a three-month timescale.

The Committee were informed that the programme was supplemented with a process for Non-Executive Directors (NEDs) to obtain their IT, email, expenses and ESR access, and badging to allow for an easy transition. The next iteration of this would be a Committee specific induction document which was currently in development.

Comments:

The Committee welcomed the induction programme, particularly for NEDs who were new to the NHS system and also newly appointed Executive Directors.

It was agreed following discussion that a retrospective induction, particularly for TU colleagues be carried out, that Trish Mills would liaise with Paul Seppman to take this forward.

RESOLVED: The Committee received assurance that the Trust has in place an induction programme for new Board members and noted that the next steps were to develop a Committee induction programme for new members and attendees.

49/23 COMMITTEE CYCLE OF BUSINESS MONITORING REPORT, PRIORITIES REPORT AND MEMBERSHIP UPDATE

Trish Mills presented the report which set out progress against the priorities the Committee had set for 2023/24 and progress against the agreed cycles of business.

The Committee noted that one priority had been set at the beginning of the year which was to develop the induction programme for new Board Members; this will now be expanded to be Committee specif.

Members were asked to note that the oversight of the development and effectiveness of the Quality and Performance Management Framework (QPMF) has moved from the QuEST to the Audit Committee. The reporting for this business was also under development.

With respect to the Committee membership and prescribed attendance; it has been agreed with the Executive Director of Operations that his deputy - Judith Bryce (Assistant Director of Operations, National Operations & Support) - would attend the Committee as a prescribed attendee, in his place on a permanent basis. The Committee were content to support this new arrangement.

RESOLVED: The Committee Noted the update, and reviewed and endorsed the change to the prescribed attendance for the Committee to enable an alternative representative of the Operations Directorate to attend in place of the Executive Director of Operations.

50/23 TRUST POLICY REPORT

Julie Boalch provided an update to the Committee on the status of the Trust's Policies and gave assurance that a prioritisation programme had been agreed based on risk assessments for each policy and noted the list of policies due to be revised in 2023/24 and 2024/25.

In terms of headline figures from the report:

1. There were currently 96 Trust policies with 15 of them within their review date.

2. In terms of 22 All Wales policies, four were within their review date.

3. There were 11 Policies which had been identified as new policies for development.

4. It was expected that 27% of policies will be within their review date by March 2024.

5. For non-critical policies a criteria for extension of policies was agreed. A piece of work was underway to implement this.

6. There were a number of policies that could be considered as Standard Operating Procedures, with work also taking place to determine the definitions and the process followed.

7. Regular monitoring updates will be provided to the Executive Leadership Team (ELT) through the Committee's AAA reports with a quarterly report to the Committee.

Comments:

The Committee welcomed the clarity contained within the report recognising there was further work to be completed and were assured that the priortisation of policies had been conducted effectively.

It was queried, in terms of the policy review extension criteria, if there were other risks that could be captured within the six criteria points. Julie Boalch agreed to include this in the criteria list.

In terms of the NHS Wales wide policies, concern was raised that the NHS Wales Equality Impact Assessment (EIA) guidelines policy was last was last issued in 2013. Julie Boalch explained the all Wales policy was the framework for undertaking the EIA; advising that the Trust was developing its own policy and the EQIA procedure.

RESOLVED: The Committee;

(1) Considered the contents of the report and the policy work plans established to mitigate risk and review policies in line with appropriate review dates;

(2) Received assurance on the prioritisation and progress being made to review Policies;

(3) Approved the criteria to extend the review date on appropriate, non-critical policies following professional review;

(4) Noted the policies that have been identified for professional review as potential Standing Operating Procedures; and

(5) Noted the next steps.

51/23 REFLECTIONS & SUMMARY OF DECISIONS AND ACTIONS

Key messages for the Board would be captured in the AAA report.

The Chair thanked the authors for the succinct and easy to read papers presented at the meeting today.

RESOLVED: The above was noted.

Meeting concluded at: 11:08

Date of Next Meeting: 30 November 2023

ACTION LOG

WELSH AMBULANCE SERVICES NHS TRUST - AUDIT COMMITTEE - December 2021

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
48/23	14 September 2023	Board/Committee Induction Programme	To liaise with Paul Seppman to consider retrospective induction particularly for TU partners who are members of the Board and its sub Committees.	Trish Mills	30 November 2023	Update for 30 November 2023 TM wrote to Paul Seppman 210923 Scope for joint chairs and TU member session being developed for Q4. Propose this is extended to February meeting for closure.	Open
50/23	14 September 2023	Policy Report	Policy review extension criteria. Was there any other risk that could be captured within the 6 criteria points, i.e. whether a policy review should be delayed.	Julie Boalch	30 November 2023	Update for 30 November 2023 Complete - this has been included in the criteria list	Complete

AUDIT COMMITTEE
HIGHLIGHT REPORT TO BOARD

This report provides the Board with key escalation and discussion points at the last Committee meeting. A full list of items discussed appears at the end of the report to enable members to raise any questions to the Chair which have not been drawn out in the report.

Trust Board Meeting Date	28 September 2023
Committee Meeting Date	14 September 2023
Chair	Martin Turner

KEY ESCALATION AND DISCUSSION POINTS

ALERT

(Alert the Board to areas of attention)

1. Welsh Government's annual review of the model **Standing Orders**, Scheme of Reservation and Delegation of Powers, and Standing Financial Instructions in July 2023 resulted in some amendments being required to the documents. These relate primarily to the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 including the introduction of the duty of quality and duty of candour, and the change from the Community Health Councils to the Citizens Voice Body (Llais). **The changes are recommended to the Trust Board for their approval** and are a substantive item on the Trust Board agenda.

2. A **change of prescribed Committee attendees** was made with Judith Bryce, Assistant Director of Operations, National Operations and Support, attending in the place of the Executive Director of Operations, Lee Brooks. **The Board is requested to approve the change**.

ADVISE

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

3. The **Audit Process and Reporting Handbook** was presented to the Committee. The handbook provides context around the internal and external audit work at the Trust and sets out the stages of fieldwork for those the subject of an audit. The Committee approved the handbook, which includes the roles and responsibilities for management, this Committee and other Board Committees as they relate to audit reviews. A revised approach to reporting was also approved which will position this Committee to focus on the overall framework and escalations where audit management actions are not met in reasonable timescales.

4. The Audit Committee chair held a **pre-meet** with Internal Audit and Audit Wales before the meeting in line with best practice.

5. Members **reflected** that the papers for the meeting were clear and concise making it easier for members to understand the key issues and recommended actions. The Chair thanks those who wrote papers and presented items and those who attended the meeting as observers.

ASSURE

(Detail here any areas of assurance the Committee has received)

6. The Board received alerts in the AAA reports Committees in July regarding the **Trust policies that were beyond their review dates**. The Audit Committee were assured at this meeting that a prioritisation programme had been agreed based on risk assessments for each policy and noted the list of policies due to be revised in 2023/24 and 2024/25. For non-critical policies a criteria for extension of policies was agreed. The development of a new Policy on Policies was noted, and the inclusion of wider definitions and processes for all forms of written control documents including Standard Operating Procedures was welcomed.

7. There is good progress against the **2023/24 Internal Audit Plan** and two **Internal Audits** (Health and Safety; Follow Up) reviews were completed during the quarter and presented to the Committee, both of which had ratings of reasonable assurance. The Health and Safety Internal Audit was reviewed in detail at the People and Culture Committee in August.

8. The **Audit Wales Update** was received and the Committee noted:

    - Review of unscheduled care part one (flow out of hospital) reports being drafted with Parts two and three – accessing unscheduled care; and national arrangements and leadership structures, to begin shortly.
    - Workforce planning An assessment of workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. The review will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. It is anticipated this will be reported to the Committee in November.
    - Structured assessment 2023. The fieldwork is complete for the core assessment work, and the report will be presented to the Audit Committee in November.

    Planned work including a deep dive into digital to begin in Autumn 2023, and a follow up of the Review of Quality Governance Arrangements will begin in late 2023/24.

9. The **losses and special payments** made during the period 1 April 2023 to 31 August 203 amounted to £66.5K.

10. The Committee was assured that an **induction programme** was in place for new Board members which set out the roles and responsibilities of all those who are members of or attend the Board. This documents is updated periodically and includes a range of essential reading for the new member and a programme of introductory meetings on a three month timescale. It is accompanied by a process for Non-Executive Directors to obtain their IT, email, expenses and ESR access, and badging to allow for a smooth transition. The next iteration of this is a Committee specific induction document which is in development.

11. In **private session** the committee received the counter fraud update 1 June to 31 August 2023, as well as the report on tenders and single tender waiver requests. The Local Counter Fraud Service (LCFS) provided an update on its work including fraud awareness sessions delivered, prevention and deterrence support and guidance. This quarter has seen an increase in dual working fraud risk and the securing of the Counter Fraud Awareness E-Learning as a mandatory training course. There are 20 recorded ongoing investigations by LCFS – an increase of one from last quarter - with a number of potential offences ranging from working whilst sick, to secondary employment.

12. The **2023/24 Committee Priority** (review of Board member induction programme and annex) was

reviewed and is on track with that programme being presented at this meeting. A new priority was added as a transfer from the Finance and Performance Committee, that being the oversight of the development and effectiveness of the Quality and Performance Management Framework.

13. The **Committee's cycle of business** was reviewed and is on track.

RISK MANAGEMENT

The Committee is responsible for the review of the risk management framework and is not assigned individual risks for oversight. The Committee noted that risk 160 related to sickness absence has maintained a score of 20 given the fragility of this area and sickness absence trends. Both the People and Culture Committee and Executive Leadership Team will continue their close monitoring of this risk.

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

COMMITTEE AGENDA FOR MEETING		
Head of Internal Audit Progress Report	Health and Safety Internal Audit	Follow Up Internal Audit
Audit Wales Update	Amendments to Standing Orders and Standing Financial Instructions	Revised audit process
Risk Management and Board Assurance Framework	Losses and Special Payments	Whistleblowing (speaking up safely)
Board Induction Programme	Committee cycle of business, monitoring report, priorities report and membership update	Policy Report

COMMITTEE ATTENDANCE					
Name	**20 April 2023**	**25 July 2023**	**14 Sept 2023**	**30 Nov 2023**	**1 Mar 2023**
Martin Turner					
Paul Hollard					
Joga Singh					
Ceri Jackson					
Chris Turley					
Lee Brooks		Judith Bryce	Judith Bryce		
Liam Williams	Duncan Robertson				
Angie Lewis					
Osian Lloyd (IA rep)					
Audit Wales rep		Andrew Doughton	Fflur Jones		
Paul Seppman					
Damon Turner					
Trish Mills					
Carl Window					

	Attended
	Deputy attended
	Apologies received
	No longer member

AGENDA ITEM No	**5**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**1**

TRUST POLICY REPORT

MEETING	Audit Committee
DATE	30th November 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk/Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide an update to the Committee on the status of the Trust's Policies as outlined on the work plan for the next two years.

2. As reported at the July 2023 meeting of the Audit Committee, the number of Policies within their review date fell below reasonable levels during the Covid-19 pandemic as the policy work plan was largely paused and efforts directed to support the response. This meant that most policies have passed their review date; however, it is important to note that these remain our extant policies, they are in use and have not expired. There will be several policies that will only require minor changes during the review process as they have already been through robust governance.

3. It is, of course, good practice to review, improve and update our policies in a timely manner and a policy prioritisation exercise has been undertaken to fully assess the Trust's position. This has resulted in a priority programme of work being established to bring the organisation's key policies up to date during 2023/24 with a further work plan agreed for 2024/25.

4. The work plans include the extension of several review dates for non-critical policies that have already been through a robust review process and in line with the criteria approved by Audit Committee in September 2023.

5. The work plans are resource intensive and that there needs to be a degree of flexibility, particularly in the winter months, to undertake the policy reviews.

6. The Trust's Policy for Policies is undergoing a 'light touch' review and will be presented to the Executive Leadership Team (ELT) for endorsement in early 2024 and submitted to Audit Committee and Trust Board in March 2024 for approval.

7. Further, the Trust's policy governance process is being refreshed in partnership with Trade Union colleagues which will include the process for other written control documents such as Standard Operating Procedures, Frameworks, Guidelines and Procedures for example to ensure good governance is maintained. Proposals will be drawn up early in 2024/25.

RECOMMENDATION:

8. **Members are asked to:**
   - **a) Note the updates to the policy work plans established to mitigate risk and review policies in line with appropriate review dates.**
   - **b) Receive assurance on the prioritisation and progress being made to review Policies.**
   - **c) Note the next steps.**

KEY ISSUES/IMPLICATIONS
9. The key issues are set out in the Executive Summary above.
REPORT APPROVAL ROUTE
10. The report and associated policy tracker were considered by: • Policy Group – 23rd October 2023 • ELT – 22nd November 2023

REPORT ANNEXES
Annex 1 – Trust Policy List

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)	Yes
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	Yes

SITUATION

1. This paper provides an update to the Committee on the status of Trust Policies as of 22nd November 2023 as outlined on the policy work plan.

BACKGROUND

2. The Policy Group was set up in 2017 to ensure appropriate governance, process and partnership working was applied to the review of existing policies, the development of new policies and to ensure that all policies were dealt with in agreed timelines.

3. Since the Trust's revised policy process was implemented in 2017 there was a significant improvement in the number of policies within their review date. However, the rate of review fell below reasonable levels during the Covid-19 pandemic as policy work was largely paused and efforts directed to support the response. This means that most policies are now past their review date and are overdue for review.

4. Whilst it is not possible to provide assurance that all Trust policies comply with current legislation, or that they discharge the Trust's statutory duties; the Trust can be assured that professionals across the organisation are proactive in identifying legislation or practice changes and updating policies as and when necessary to reflect any significant changes.

ASSESSMENT

5. The Corporate Governance Team continues to maintain a policy tracker, included at Annex 1, which describes the status of all policies. This has been specifically designed to facilitate dynamic reporting dependent on the areas which are of most interest to users, for example reports can be produced by Directorate, type of policy, review date or Policy Lead.

6. As reported at the September 2023 Committee, the Trust holds 96 polices with an additional 22 all Wales NHS Policies that the Trust has adopted from the NHS Employers Unit.

7. The table below describes the status of the All Wales NHS Policies adopted by the Trust.

All Wales Policies

Policy Title	Issue Date	Review Date	Comments
NHS Wales Apprenticeship Policy	New	New	New Policy to be developed
NHS Wales Disclosure and Barring Service	New	New	New Policy to be developed
NHS Wales Pay Progression Policy	01/06/22	01/06/25	Remains extant
NHS Wales Respect and Resolution Policy	01/04/21	01/04/24	Remains extant - Under review

NHS Wales Patient Safety Incident Reporting and Management	01/06/23	31/03/24	Remains extant
NHS Wales Menopause Policy	10/01/19	10/12/21	Remains extant
NHS Wales Managing Attendance at Work	16/10/18	16/10/21	Remains extant - Under review
NMC Revalidation and Registration	04/09/18	04/09/21	All Wales Policy - to be reviewed
NHS Wales ANTT Policy	25/02/20	25/07/21	NHS Wales Policy - to be reviewed
NHS Wales Capability Policy	27/06/18	27/06/21	Remains extant - Under review
NHS Wales Email Use Policy	04/10/19	26/06/20	Remains extant
NHS Wales Disciplinary Policy	27/07/17	01/03/20	Remains extant
NHS Wales Recruitment & Retention Payment Protocol	27/07/17	01/03/20	Remains extant
NHS Wales Organisational Change Policy	10/01/19	01/03/20	Remains extant - Under review
NHS Wales Speaking up Safely Policy	01/09/23	01/09/26	Remains extant
NHS Wales Special Leave Policy	13/03/18	01/01/20	Remains extant
NHS Wales Reserve Forces Training and Mobilisation Policy	07/03/16	01/09/19	Remains extant
NHS Wales Secondment Policy	07/03/16	01/09/19	Remains extant
NHS Wales Employment Break Scheme Policy	27/07/17	01/03/19	Remains extant
NHS Wales Internet Use Policy	24/05/16	01/01/18	Remains extant
NHS Wales Social Media Use Policy	24/05/16	01/01/18	Remains extant
NHS Wales Equality Impact Assessment Guidelines Policy	01/10/10	01/09/13	Remains extant

8. There are 12 new policies which have been identified for development as described in the table below which brings the total number of policies on the tracker to 118.

New Policies Identified for Development

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead
Equality Policy	1	People & Culture	Paula Spiteri
Staff Immunisation Policy	1	People & Culture	TBC
People Development Policy	2	People & Culture	Lynda Bugonovic
Colleague Experience / Wellbeing Policy	3	People & Culture	Lynda Bugonovic
Mental Capacity Policy	3	QS&PE	Mark Jones / Nikki Harvey

Information Sharing Policy	6	Digital	Kelly Holding
Bank Worker Policy	7	People & Culture	Michelle Morse
Forensic / Digital Evidence Policy	7	Digital	Aled Williams / James Rowlands
Patient Clinical Record Policy	7	Medical & Clinical	Kevin Webb
Overpayments Policy	N/A	Finance & Corporate Resources	NWSSP / Jill Gill
Transgender Policy	N/A	People & Culture	Kathryn Cobley
Welsh Language Policy	N/A	Corporate Governance	Melfyn Hughes

Policy Work Plans

9. The table below provides an update in relation to the 2023/24 work plan and those policies identified for priority review. It is important to note the need to be flexible with scheduling given the priority and needs of the service particularly over the winter period.

Workplan 2023/24

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead	Update (20th November 2023)	Current Status
Counter Fraud, Corruption and Bribery Policy	1	Finance & Corporate Resources	Carl Window	Policy Group (December 2023)	On Track
Education Programme Policy (RTW)	1	People Services	Martin Mulholland	Meeting with Policy Lead to agree next steps taking place on 29th November 2023.	Being Progressed
Environmental, Estates and Facilities Policy	1	Finance & Corporate Resources	Susan Woodham	New policy. Awaiting confirmation from policy lead re: timeframe for development.	Being Progressed
Flexible Working Policy	1	People Services	Karen Jones	All Wales Policy in development (see note below). Provisionally listed for Policy Group in December 2023.	On Track
Professional Regulation Policy	1	Medical & Clinical	Greg Lloyd	Policy Group (December 2023)	On Track
Retirement Policy	1	People Services	Sara Williams Hilary Caffrey	All Wales Policy in development (see note below). Provisionally listed for Policy Group in December 2023.	On Track
Risk Management Policy	1	Corporate Governance	Julie Boalch	Policy Group (December 2023)	On Track
Violence & Aggression Policy	1	QS&PE	Nicola White	Policy Group (February 2024)	On Track

10. The work plan for 2024/25 is described in the table below. Members are asked to note that whilst each of these Policies have been listed on the Policy Group forward planner for 2024/25, the order is subject to slight change as the work plan unfolds. Policy Leads are

being contacted to ensure that these Policies are reviewed in accordance with the work plan.

Workplan 2024/25

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead	Update (20th November 2023)	Current Status
CCTV Policy	2	Digital	Kelly Holding	Issued 25/04/2019. Review Due 25/04/2021. Provisionally listed for Policy Group in February 2024.	**Being Progressed**
Data Quality Policy	2	Digital	Jon Hopkins / Sue Brown	Issued 16/07/2019. Review Due 16/07/2022. Provisionally listed for Policy Group in March 2024.	**Being Progressed**
Management of Allegations Policy	2	QS&PE	Nikki Harvey	Issued 27/02/2018. Review Due 27/02/2021. Provisionally listed for Policy Group in February 2024.	**Being Progressed**
Non-Medical Prescribing Policy	2	Medical & Clinical	Kerry Robertshaw	Issued 25/03/2020. Review Due 25/02/2023. Provisionally listed for Policy Group in January 2024.	**Being Progressed**
Occupational Health Policy	2	People Services	Ceri Bryant	Issued 01/01/2024. Review Due 01/01/2014. Provisionally listed for Policy Group in February 2024.	**Being Progressed**
Alternatives to Conveyance Policy	3	Medical & Clinical	Bryn Thomas	Issued 01/11/2010. Review Due 01/11/2011. Provisionally listed for Policy Group in January 2024.	**Being Progressed**
Consent to Examination and Treatment Policy	3	Medical & Clinical	Bryn Thomas	Issued 25/02/2020. Review Due 25/02/2021. Provisionally listed for Policy Group February 2024.	**Being Progressed**
Lone Worker Policy	3	QS&PE	Nicola White	Provisionally listed for Policy Group in March 2024.	**Being Progressed**
Maternity and Adoption Policy	3	People Services	Sophie James	Issued 10/05/2018. Review Due 10/05/2021. Provisionally listed for Policy Group in March 2024.	**Being Progressed**
Paternity Policy	3	People Services	Sophie James	Issued 10/05/2018. Review Due 10/05/2021. Provisionally listed for Policy Group in February 2024.	**Being Progressed**
Safer Handling Policy	3	QS&PE	Graham Stockford	Issued 01/12/2020. Review Due 01/12/2023. Provisionally listed for Policy Group in March 2024.	**Being Progressed**

Shared Parental Leave Policy	3	People Services	Sophie James	Issued 10/05/2018. Review Due 10/05/2021. Provisionally listed for Policy Group in March 2024.	**Being Progressed**

11. Several policies are already at various stages of the review and development process for 2023/24, as described in the list below, and have been or are included on the Policy Group Agenda in recent months.

Policies Currently Under Review

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead	Update (20th November 2023)	Current Status
Charitable Funds Investment Policy	N/A	Finance & Corporate Resources	Jill Gill	Issued 05/07/2023. Review Due 05/07/2026. Approved Charity Committee July 2023	Complete
Clinical Supervision Policy (New)	1	Medical & Clinical	Jonathan Chippendale	Policy Group - November 2023. ELT - December 2023. QuEST - January 2024	On Track
Command Policy	N/A	Operations	Clare Langshaw	Issued 25/04/2023. Review Due 25/04/2026. Approved April 2023	Complete
Data Protection Policy	1	Digital	Aled Williams (DPO)	Consultation period started 15th November 2023. Policy Group – December 2023 / January 2024.	On Track
Dispatch Cross Reference (DCR) Table Policy	4	Medical & Clinical	Grayham McLean	Issued 27/07/2021. Review Due 23/07/24. Policy Group – November 2023	On Track
Driving at Work Policy	1	People Services	Andrew Morgan	Issued 07/09/2021. Review Due 06/09/2024. Under Review – Policy Group in June 2024.	On Track
Health and Safety Policy	1	QS&PE	Nicola White	Approved at People and Culture Committee on 16th November 2023. To be ratified at Trust Board on 23rd November 2023.	On Track
Home Working Policy	1	People Services	Karen Jones	Policy Group October 2023. ELT – November 2023. Chair's Action November 2023 for approval.	On Track
Infection Prevention & Control Policy	1	QS&PE	Louise Colson	Post consultation, Policy Group 23rd October 2023. ELT – 6th December 2023. Chair's Action – December 2023.	On Track
Information Security Policy	1	Digital	James Rowlands	Policy approved by QuEST on 31st October 2023. Published 14th November 2023.	Complete
Management of Controlled Drugs Policy	1	Medical & Clinical	Chris Moore	Issued 27/07/2021. Review Due 27/07/2024. Review commenced – due at Policy Group in February 2024	On Track

Medicines Management Policy	1	Medical & Clinical	Chris Moore	Updated policy approved by QuEST on 31st October 2023. Published 12th November 2023	Complete
Management of High Intensity Service Users Policy	1	Medical & Clinical	Sarah Woods	Issued 04/09/2018. Review Due 04/09/2021. Under review – due at Policy Group in February 2024.	On Track
Management of Medical Devices Policy	1	Medical & Clinical	Jon Wilson	Post consultation, Policy Group on 28th November 2023, ELT in December 2023, QuEST in January 2024.	On Track
Policy for Policies	1	Corporate Governance	Julie Boalch	Under review – to be presented to Policy Group in December 2024.	On Track
Standards of Business Conduct Policy	N/A	Corporate Governance	Trish Mills	Issued 27/07/2023. Review Due 27/07/2025. Approved by Trust Board July 2023	Complete
Waste Management Policy (New)	1	Finance & Corporate Resources	Nicola Stephens	Post consultation, updated policy to be presented to Policy Group on 19th December 2023.	On Track

12. Once these policies have navigated the policy process and been approved this will bring the number of policies within their review date to 34 equating to 32% by 31st March 2024.

13. Work is underway to apply the extension criteria, approved by the Audit Committee in September 2023, to those Policies described in the table below. A short rationale will be submitted to the Policy Group for consideration by the Policy Leads, the extension applied, and the policy tracker updated accordingly.

Policies for Extended Review Dates

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead
Fire Safety Policy	4	Finance & Corporate Resources	Susan Woodham
Domestic Abuse, Gender Based Violence and Sexual Violence "Ask and Act" Policy	5	QS&PE	Rhiannon Thomas
Safeguarding Children and Adults at Risk of Harm Policy. This policy has merged with the Protection of Vulnerable Adults Policy	5	QS&PE	Nikki Harvey
Working Time Regulations Policy	5	People Services	Sara Williams / Emma Morgan
Information Governance Policy	6	Digital	Kelly Holding
Management of Compensation Claims Policy	6	QS&PE	Trish Gaskell
Access to Personal Information Policy	7	Digital	Judith Birkett
Redeployment Policy	7	People Services	Emma Morgan
Access Control Policy	8	Digital	Kelly Holding

Records Management Policy	8	Digital	Judith Birkett
Vehicle Disposal Policy	8	Finance & Corporate Resources	Gavin Lane
Information Classification Policy	9	Digital	Aled Williams
Managing Families and Relatives Working Together Policy	9	People Services	Amanda Jones
Mobile Computing Policy	9	Digital	Aled Williams / James Rowlands
Bursary Scheme Policy	10	People Services	Sarah Davies
Confidentiality and Code of Conduct	10	Digital	Kelly Holding
Information Risk Policy	10	Digital	Kelly Holding
Organisational Learning and Promoting Improvements in Patient Safety Policy and Procedure	TBC	QS&PE	TBC
Intellectual Rights Policy	TBC	Medical & Clinical	Nigel Rees
Business Continuity Management Policy	TBC	Operations	TBC
Children in Special Circumstances Policy & Procedure	TBC	Medical & Clinical	Ed O'Brien
High Risk Record Policy	TBC	Operations	Katie Blackmore
MPDS QA Policy	TBC	Operations	TBC
Quality Assurance Framework for the Clinical Desk	TBC	Operations	TBC
Resourcing Policy	TBC	Operations	TBC
Transfer Policy	TBC	Operations	TBC

Policies identified as potential Standing Operating Procedures

14. The table below contains a suggested list of policies that could be considered as Standing Operating Procedures (SOPs) due to their nature and content. Given the volume of work that is underway to review existing policies and develop new ones, the intention is that these policies will be looked at as they come up for review.

Potential Standing Operating Procedures

Policy Title	Priority Number 1 High 10 Low	Directorate	Policy Lead
Exit Interview Policy	1	People Services	Emma Morgan
HR Starting Salary Policy	1	People Services	Hilary Caffrey / Anna Stein
Recruitment and Selection Policy	1	People Services	Dee Udeze-Chibuzor / Charlie Bosher

Assessment, Failure Referral & Appeals Policy	2	People Services	Martin Mulholland
Infection Prevention & Control: Sharps Policy	2	QS&PE	Louise Coulson
Premises and Vehicle Cleanliness Policy	2	QS&PE	Louise Coulson
Relocation Expenses Policy	2	People Services	Jan Cross
Study Leave Policy	4	People Services	Sara Williams / Emma Morgan
Adverse Weather Conditions Policy	8	People Services	Bethan Davies
Work Experience Policy	8	People Services	Sara Minahan
Fuel Card Policy	9	Finance & Corporate Resources	Gavin Lane
Trust Mobile Phone Policy	9	Digital	Aled Williams / Tony Raine
Tyres and Wheels Policy	10	Finance & Corporate Resources	Gavin Lane
Transfer Policy	TBC	Operations	TBC

Next Steps

15. The Trust's policy governance process is being refreshed in partnership with Trade Union colleagues and includes a light touch review of the Policy on Policies which will be presented to Policy Group in December 2023.

16. This process and Policy on Policies will be further strengthened to include definitions of other written control documents such as Standard Operating Procedures, Frameworks, Guidelines and Procedures for example and the process that will need to be followed to ensure good governance is maintained. It is expected that proposals will be drawn up early 2024/25.

17. This will include consideration of a policy management software solution, for example using Sharepoint, including automatic reminders and collaboration online during the consultation process.

RECOMMENDED

18. **Members are asked to:**
    a) **Note the updates to the policy work plans established to mitigate risk and review policies in line with appropriate review dates.**
    b) **Receive assurance on the prioritisation and progress being made to review Policies.**
    c) **Note the next steps.**

Policy Title	Priority Number 1 High	Directorate	Policy Lead	Policy Type	Issue Date	Review Date	Date Review due to Commence	Comments	Priority for	Status in process	In Progress / Stage	PRF submitted	Policy Number Allocated	Trade Union Lead Allocated	EQIA completed	Checklist part completed	Virtual Policy Group review	Policy Group	Draft Policy Consulted across	Draft Policy Consulted across	Final draft policy received with	Policy Group	Trade Union SLT	ADLT	ELT	Committee	Type	Final PDF and Word version	Published on Trust Policy	Previous Version	Links to Directorate	Additional Comments
Access Control Policy	8	DIGITAL	Kelly Holding	Corporate	25/10/18	25/04/20	25/01/20			Post	Approved	Yes	050																			
Access to Personal Information Policy	7	DIGITAL	Judith Birkett	Corporate	25/04/19	25/04/21	25/01/21			Post	Approved	Yes	051																			
Adverse Incident/Hazard Reporting Policy	N/A	QS&PE	Jane Palin	Clinical	25/04/23	25/04/26	25/01/26	In review date		Pre	Approved	Yes	097					25/04/23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		01/06/23				
Adverse Weather Conditions Policy	8	PEOPLE SERVICES	Bethan Davies	Employment	05/07/18	05/07/21	05/04/21			Post		Yes	039																			
Alternatives to Conveyance Policy	3	MEDICAL & CLINICAL	Bryn Thomas	Clinical	01/11/10	01/11/11	01/08/11			Pre	Registered	Yes	078																			
Assessment, Failure Referral and Appeals Policy	2	PEOPLE SERVICES	Martin Mulholland	Employment	01/02/16	01/02/18	01/11/17			Pre	Not started																					
Bank Worker Policy	7	PEOPLE SERVICES	Michelle Morse	Employment	New	New	New			Post	Development	Yes	059																		Further work around compliance and training to be incorporated 13/08/19	
Bursary Scheme Policy	10	PEOPLE SERVICES	Sarah Davies	Employment	01/08/16	NRS	#VALUE!			Pre	Development	Yes	108																			
Business Continuity Management Policy		OPERATIONS	TBC	Corporate	24/10/19	24/10/22	24/07/22			Post	Approved	Yes	011																			
CCTV Policy	2	DIGITAL	Kelly Holding	Corporate	25/04/19	25/04/21	25/01/21			Post	Development	Yes	017																			
Charitable Funds Investment Policy	N/A	FINANCE & CORPORATE RESOURCES	Jill Gill	Corporate	05/07/23	05/07/26	05/04/26	Approved		Post	Approved	Yes	089					20/06/23														
Children in Special Circumstances Policy & Procedure		MEDICAL & CLINICAL	Ed O'Brien	Clinical	28/11/17	28/11/20	28/08/20			Post	Approved	Yes	012																			
Clinical Supervision Policy	1	MEDICAL & CLINICAL	Jonathan Chippendale	Corporate	New	New	#VALUE!	Coming back to Nov23 PG, ELT in Dec23 & Quest Jan24		Post	Approval due	Yes	104	Hugh Parry	Yes	Yes	Yes	20/06/23	09/07/23	04/08/23	Yes	28/11/23			13/12/23		QSPE					Few changes from Oct23 PG, now coming to Nov23PG
Colleague Experience / Wellbeing Policy	3	PEOPLE SERVICES	Lynda Bugonovic	Employment	New	New	#VALUE!			Post	Development																					
Command Policy	N/A	OPERATIONS	Clare Langshaw	Corporate	25/04/23	25/04/26	25/01/26	Approved		Post	Approved	Yes	084					25/04/23	N/A	N/A	N/A											
Confidentiality and Code of Conduct	10	DIGITAL	Kelly Holding	Corporate	23/02/21	23/02/24	23/11/23			Pre	Approved	Yes	087																			
Consent to Examination and Treatment Policy	3	MEDICAL & CLINICAL	Bryn Thomas	Clinical	25/02/20	25/02/21	25/11/20			Post	Approved	Yes	076																			
Counter Fraud, Corruption and Bribery Policy	1	FINANCE & CORPORATE RESOURCES	Carl Window	Corporate	24/05/18	24/05/21	24/02/21	scheduled within 2023 work plan, planning on coming to Dec23 PG		Post	Approved	Yes	025																			
Data Protection Policy	1	DIGITAL	Kelly Holding	Corporate	15/12/16	15/12/19	15/09/19	Went Out for Consultation on 15/11/23(28Days) then back to Dec23 PG		Pre	Approval due		014	Maldwyn Jones	Yes	Yes		18/07/23	14/11/23	10/12/23		23/10/23										Data protection Policy has gone out to Consulation for 28 days from 14/11/23 and Chairs action end of Dec23/Jan24
Data Quality Policy	2	DIGITAL	Jon Hopkins / Sue Brown	Corporate	16/07/19	16/07/22	16/04/22	Likely to be a recommendation from the 2023 internal audit for data analysis. It doesn't currently include Clinical Data		Post	Approved	Yes	073																			
Decontamination of Medical Devices Policy (SOP)	2	QS&PE	Louise Coulson	Clinical	New	New	New	IPC owned SOP, not Clinical Directorate policy		Post	Registered	Yes	019																			
Dispatch Cross Reference (DCR) Table Policy	4	MEDICAL & CLINICAL	Grayham McLean	Corporate	23/02/21	23/02/24	23/11/23			Post	Approved	Yes	091									28/11/23										
Domestic Abuse, Gender Based Violence and Sexual Violence "Ask and Act" Policy	5	QS&PE	Rhiannon Thomas	Clinical	26/11/19	26/11/21	26/08/21	Integrate into single Safeguarding Policy, further discussion needed with QSPE		Post	Approved	Yes	081																			
Driving at Work Policy	1	PEOPLE SERVICES	Andrew Morgan	Employment	07/09/21	06/09/24	07/05/24	Under review		Post	Under Review	Yes	045	Damon Turner																		
Education Programme Policy (RTW)	1	PEOPLE SERVICES	Martin Mulholland	Employment	19/12/12	02/05/18	19/01/18	touchpoint/update meeting on 29/11/23		Pre	Development																					
Environmental, Estates and Facilities Policy	1	FINANCE & CORPORATE RESOURCES	Susan Woodham	Corporate	16/07/14	16/02/17	16/11/16	17/11/23- LT emailed SW. LM supplied Policy Doc templates. Policy coming to Dec23 PG		Pre	Not started							19/12/23													Includes estates guidance notes	
Equality Policy	1	PEOPLE SERVICES	Paula Spiteri	Employment	New	New	#VALUE!	How does this fit with NHS Wales Policy?																								
Exit Interview Policy	1	PEOPLE SERVICES	Emma Morgan	Employment	01/06/04	01/06/07	01/03/07	Under review		Post	Development	Yes	080																			
Fire Safety Policy	4	FINANCE & CORPORATE RESOURCES	Susan Woodham	Corporate	17/03/22	17/03/25	17/12/24	A fire safety policy exists and is reviewed, however recent changes to ther team does mean elements of the policy need to be updated.		Post	Approved	Yes	018																			
Flexible Working Policy	1	PEOPLE SERVICES	Hillary Caffrey	Employment	10/05/18	10/09/20	10/06/20	All Wales Policy in Development - to come to PG Dec23		Post	Approved	Yes	015						N/A	N/A	N/A	19/12/23										
Forensic / Digital Evidence Policy	7	DIGITAL	Aled Williams / James Rowlands	Corporate	New	New	New	Not yet written - no systems in place yet for forensics		Post	Not started																					
Fuel Card Policy	9	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	25/04/19	25/04/21	25/01/21			Post	Approved	Yes	029																			
Health and Safety Policy	1	QS&PE	Nicola White	Corporate	28/11/17	28/11/20	28/08/20	Approved by PCC on 16/11/23 - Going to trust board 23/11/23. TM advised this policy needs to be ratified by Tr Board before being fully approved.		Post	Approved	Yes	021					20/06/23	09/07/23	04/08/23		29/08/23				16/11/23	PCC		17/11/23			TM advised that it cannot be fully approved until it has been ratified by Tr Board
High Risk Record Policy		OPERATIONS	Katie Blackmore	Corporate	16/07/20	16/07/23	16/04/23			Post	Approved	Yes	010																			
Home Working Policy	1	PEOPLE SERVICES	Karen Jones	Employment	26/03/20	26/03/21	26/12/20	Going to Chairs action - to be approved by end of Nov23		Post	Approval due	Yes	034	Hugh Parry	Yes	Yes	Yes	23/10/23				23/10/23			15/11/23	16/11/23						Going to ELT on 15/11/23 looking to be approved by end of Nov23 JBo to set up a chairs action to get this approved.
HR Starting Salary Policy	1	PEOPLE SERVICES	Hilary Caffrey / Anna Stein	Employment	01/10/09	01/10/10	01/07/10	Under review			Not started																					
Infection Prevention & Control Policy	1	QS&PE	Louise Coulson	Clinical	08/09/20	22/05/21	08/02/21	20/11/23 - Update - PS/DT Advised to take Food paragraph wording out and plan for the IPC policy to go to ELT 6th Dec with a chairs action for approval shortly after. Under review - this will be an overarching Policy for Premises & Vehicle Cleaning Policy and Decontamination of Medical Devices Policy which will be SOPs/Protocols		Post	Approval due	Yes	002	Ian James	Yes	Yes	Yes	25/04/23				23/10/2023			06/12/23	31/10/23	QSPE					Food wording to be taken out - IPC policy to go to ELT 6th Dec23 & chairs action shortly after for approval
Infection Prevention & Control: Sharps Policy	2	QS&PE	Louise Coulson	Clinical	01/12/20	01/12/23	01/09/23	Dealing with principles of IPC to sit under IPC Policy with health and safety elements to sit under Health & Safety Policy (SOP)		Post	Approved	Yes	002																			
Information Classification Policy	9	DIGITAL	Aled Williams	Corporate	No dates	No dates				Pre	Not started	Yes	009																			
Information Governance Policy	6	DIGITAL	Kelly Holding	Corporate	25/10/18	25/10/21	25/07/21			Post	Approved	Yes	055																			
Information Risk Policy	10	DIGITAL	Kelly Holding	Corporate	23/02/21	23/02/24	23/11/23			Post	Approved	Yes	088																			
Information Security Policy	1	DIGITAL	James Rowlands	Corporate	25/04/19	31/10/26	25/07/26	Approved		Post	Approved	Yes	056	Hugh Parry				20/06/23	09/07/23	04/08/23		29/08/23				31/10/23	QSPE		14/11/2023			Policy went to QUEST on 31/10/2023
Information Sharing Policy	6	DIGITAL	Kelly Holding	Corporate	New	New	New			Post	Not started																					
Intellectual Rights Policy	x	MEDICAL & CLINICAL	Nigel Rees	Clinical	01/01/17	01/11/18	01/08/18	Will be superseded by all Wales Policy		Pre	Approved																					
Lone Worker Policy	3	QS&PE	Nicola White	Employment	No dates	No dates		Feed into Health & Safety Committee to progress			Development	Yes	054																			
Management of Allegations Policy: When an allegation or concern is raised about an Employee or Volunteer	2	QS&PE	Nikki Harvey	Corporate	27/02/18	27/02/21	27/11/20	Robust process - All Wales Policy. Will be changes to allegations process within the Wales Safeguarding Procedures so may need to update this Policy.		Post	Approved	Yes	004																			
Management of Compensation Claims Policy	6	QS&PE	Trish Gaskell	Corporate	26/02/19	26/02/21	26/11/20	Timeframe realistically would be early Quarter 4 so extension to March 2024 would be helpful so the review is meaningful		Post	Approved	Yes	033																			
Management of Controlled Drugs Policy	1	MEDICAL & CLINICAL	Chris Moore	Clinical	27/07/21	27/07/24	27/04/24	Approved by PG & then QUEST		Post	Approved	Yes	063	Paul Seamann/Hugh												31/10/23	QSPE		14/11/23			
Management of ~~Frequent Callers~~ High Intensity Users Policy	1	MEDICAL & CLINICAL	Sarah Woods	Clinical	04/09/18	04/09/21	04/06/21	20/11 Greg working through DPIA's Under Review		Post	Approved	Yes	038	Sharon Thorpe				25/04/23														
Management of Medical Devices Policy	1	MEDICAL & CLINICAL	Jon Wilson	Corporate	22/05/18	22/07/18	22/04/18	To be presented to WASPT & ELT and then QUEST in Jan24		Post	Development	Yes	005					28/11/23														
Managing Families and Relatives Working Together Policy	9	PEOPLE SERVICES	Amanda Jones	Employment	10/03/20	10/03/23	10/12/22			Post	Approved	Yes	082																			
Maternity and Adoption Policy	3	PEOPLE SERVICES	Sophie James	Employment	10/05/18	10/05/21	10/02/21			Post	Approved	Yes	032																			
Medicines Management Policy	1	MEDICAL & CLINICAL	Chris Moore	Clinical	25/02/20	31/10/26	25/07/26	Approved		Post	Approved	Yes	083	Hugh Parry				25/04/23	09/07/23	04/08/23		29/08/23				31/10/23	QSPE		14/11/23			Policy Went to QUEST on 31/10/2023
Mental Capacity Policy	3	QS&PE	Mark Jones / Nikki Harvey	Employment	New	New	New	Policy to be written by Mental Health Team & Safeguarding Team. ?National Policy		Post	Registered	Yes	057																			
Mobile Computing Policy	9	DIGITAL	Aled Williams / James Rowlands	Corporate	No dates	No dates		Drafted - but most remote working aspects now covered under Info Security Policy		Pre	Not started																					
MPDS QA Policy		OPERATIONS	TBC	Clinical	10/01/19	10/01/21	10/10/20			Post	Approved	Yes	052																			
NHS Wales ANTT Policy	N/A	QS&PE	Louise Coulson	Employment - All Wales	25/02/20	25/07/21	25/04/21	NHS Wales Policy - to be reviewed.		Post	Approved	Yes	026						N/A	N/A	N/A											
NHS Wales Apprenticeship Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	New	New	#VALUE!			Post	Development								N/A	N/A	N/A											
NHS Wales Capability Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	27/06/18	27/06/21	27/03/21	Remains extant - Under review		Post	Approved	Yes	062						N/A	N/A	N/A											
NHS Wales Disciplinary Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	27/07/17	01/03/20	27/11/19	Remains extant		Post	not started	No	064						N/A	N/A	N/A											
NHS Wales Disclosure and Barring Service	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	New	New	#VALUE!			Post	Development								N/A	N/A	N/A											
NHS Wales Do Not Attempt CPR for Adults in Wales	N/A	MEDICAL & CLINICAL	Dr Paul Buss	Clinical	30/10/18	NRS	Value			Post	Approved								N/A	N/A	N/A											
NHS Wales Email Use Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	04/10/19	26/06/20	04/03/20	Remains extant		Post	Approved	No	065						N/A	N/A	N/A											
NHS Wales Employment Break Scheme Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	27/07/17	01/03/19	27/11/18	Remains extant		Post	not started	No	066						N/A	N/A	N/A											
NHS Wales Equality Impact Assessment Guidelines Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	01/10/10	01/09/13	01/06/13	Remains extant		Pre	Development								N/A	N/A	N/A											
NHS Wales Internet Use Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	24/05/16	01/01/18	24/09/17	Remains extant		Pre	Approved	No	067						N/A	N/A	N/A											
NHS Wales Lease Car Policy	N/A	FINANCE & CORPORATE RESOURCES	Angie Evans	Corporate	30/09/20	30/09/23	30/06/23	New All-Wales policy only recently provided and approved by AC in Nov 22 - would assume no review required for another 3 years or until Shared services advise		Pre	Approved							25/04/23	N/A	N/A	N/A								01/06/23			
NHS Wales Managing Attendance at Work	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	16/10/18	16/10/21	16/07/21	Remains extant - Under review		Post	Approved	No	072						N/A	N/A	N/A											
NHS Wales Menopause Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	10/01/19	10/12/21	10/09/21	Remains extant		Post	Approved	Yes	074						N/A	N/A	N/A											
NHS Wales No PO No Pay (No Purchase Order No Payment) Policy	N/A	FINANCE & CORPORATE RESOURCES	NHS Employers Unit	Corporate	No dates	No dates	Value	All Wales Policy - T&F group set up across Wales to review start of Sept 23		Post	Approved								N/A	N/A	N/A											
NHS Wales Organisational Change Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	10/01/19	01/03/20	10/11/19	Remains extant - Under review		Post	not started	No	068						N/A	N/A	N/A											
NHS Wales Patient Safety Incident Reporting and Management	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	01/06/23	31/03/24	01/12/23	Remains extant										20/06/23	N/A	N/A	N/A					25/07/23	Audit					

NHS Wales Pay Progression Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	01/06/22	01/06/25	01/03/25	Remains extant		Pre	Development								N/A	N/A	N/A													
NHS Wales Raising Concerns Policy - Whistleblowing	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	13/03/18	01/01/20	13/09/19	Remains extant - Under review		Post	Not started	Yes	047						N/A	N/A	N/A													
NHS Wales Recruitment & Retention Payment Protocol	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	27/07/17	01/03/20	27/11/19	Remains extant		Post	Not started	No	069						N/A	N/A	N/A													
NHS Wales Research and Development Policy NHS Wales	N/A	MEDICAL & CLINICAL	Nigel Rees	Corporate	10/05/18	10/05/21	10/02/21			Post	Approved	Yes	036						N/A	N/A	N/A													
NHS Wales Reserve Forces Training and Mobilisation Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	07/03/16	01/09/19	07/05/19	Remains extant		Pre	Approved	Yes	043						N/A	N/A	N/A													
NHS Wales Respect and Resolution Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	01/04/21	01/04/24	01/01/24	Remains extant - Under review		Post	Approved								N/A	N/A	N/A													
NHS Wales Secondment Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	07/03/16	01/09/19	07/05/19	Remains extant		Pre	Approved	Yes	042						N/A	N/A	N/A													
NHS Wales Social Media Use Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	24/05/16	01/01/18	24/09/17	Remains extant		Pre	Approved	No	070						N/A	N/A	N/A													
NHS Wales Speaking Up Safely Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	01/09/23	01/09/26	01/06/26	Remains extant		Post									N/A	N/A	N/A					16/11/23	PCC							
NHS Wales Special Leave Policy	N/A	PEOPLE SERVICES	NHS Employers Unit	Employment - All Wales	13/03/18	01/01/20	13/09/19	Remains extant		Post	Approved	Yes	046						N/A	N/A	N/A													
NMC Revalidation and Registration	N/A	QS&PE	Deborah Armstrong	Employment - All Wales	04/09/18	04/09/21	04/06/21	National Policy adopted which needs updating		Post	Approved	Yes	049						N/A	N/A	N/A													
Non Medical Prescribing Policy	2	MEDICAL & CLINICAL	Kerry Robertshaw	Clinical	25/02/20	25/02/23	25/11/22			Post	Approved	Yes	077																					
Occupational Health Policy	2	PEOPLE SERVICES	Ceri Bryant	Employment	01/01/14	01/01/14	01/10/13			Pre	Development																							
Organisational Learning and Promoting Improvements in Patient Safety Policy and Procedure	TBC	QS&PE	TBC	Clinical	01/11/13	01/11/14	01/08/14	TBC as Jonathan would like to discuss with Senior Team		Pre	Not started																							
Overpayments Policy	N/A	FINANCE & CORPORATE RESOURCES	NWSSP / Jill Gill	Corporate	New	New	New	All Wales Overpayments Policy review group has been set up with a second meeeting taking place																											
Paternity Policy	3	PEOPLE SERVICES	Sophie James	Employment	10/05/18	10/05/21	10/02/21			Post	Approved	Yes	031																					
Patient Clinical Record Policy	7	MEDICAL & CLINICAL	Kevin Webb	Clinical	New	New	New			Post	Registered	Yes	079																					
People Development Policy	2	PEOPLE SERVICES	Lynda Bugonovic	Employment	New	New	#VALUE!			Post	Development																							
Policy for the Development, Review and Approval of Policies	1	CORPORATE GOVERNANCE	Julie Boalch	Corporate	28/03/19	28/03/21	28/12/20	Under review		Post	Development	Yes	001																					
Premises and Vehicle Cleanliness Policy	2	QS&PE	Louise Coulson	Clinical	26/11/19	26/11/21	26/08/21	Query SOP under Health & Safety Policy		Post	Approval due	Yes	061					25/04/23								31/10/23	QSPE							
Professional Regulation Policy	1	MEDICAL & CLINICAL	Greg Lloyd	Employment	10/01/19	10/01/21	10/10/20	Greg emailed 20/11/23 - prioritising this for next PG meeting Dec23		Post	Approved	Yes	048									19/12/23												
Pubic Sector Payment Policy - WG	N/A	FINANCE & CORPORATE RESOURCES	TBC	Corporate	01/01/21	NRS	Value	All Wales Policy - Shared Services Procurement team asked to provide any review dates		Pre	Approved	N/A																							
Purchase Card Policy	10	FINANCE & CORPORATE RESOURCES	Jillian Gill	Corporate	New	New	New	Purchase card process in place on a trial basis which will help to inform the final purchase card policy which has been to the policy group for review previously		Post	Development	Yes	086	Mark Marsden				25/01/22																Jill G has sent over Updated SBAR & Policy (saved in Jan24 PG Folder in readiness for it coming to PG Jan24 onwards)
Putting Things Right Policy	N/A	QS&PE	Jane Palin	Corporate	25/04/23	25/04/26	25/01/26	In review date		Post	Approved	Yes	006					25/04/23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	01/06/23				
Quality Assurance Framework for the Clinical Desk		OPERATIONS	TBC	Clinical	01/06/15	NRS				Pre	Development																							Paused pending the CCC Clinical Review
Records Management Policy	8	DIGITAL	Judith Birkett	Corporate	25/10/18	25/10/21	28/07/21	Needs updating to latest GDPR references		Post	Approved	Yes	008																					
Recruitment and Selection Policy	1	PEOPLE SERVICES	Dee Udeze-Chibuzor/Charlie Bosher	Employment	25/10/18	25/04/20	25/01/20	Under review		Post	Approval due	Yes	058																					
Redeployment Policy	7	PEOPLE SERVICES	Emma Morgan	Employment	25/02/20	25/02/23	25/11/22			Post	Approved	Yes	023																					
Relocation Expenses Policy	2	PEOPLE SERVICES	Jan Cross	Employment	10/01/19	10/01/21	10/10/20			Post	Approved	Yes	060																					
Resourcing Policy *		OPERATIONS	TBC	Employment	01/03/14	01/06/14	01/03/14			Pre	Registered	Yes	094																					
Retirement Policy	1	PEOPLE SERVICES	Sara Williams / Hilary Caffrey	Employment	01/08/14	01/08/15	01/05/15	Changes in legislation, UK, National and Partnership Forum. All Wales policy being developed.		Pre	Development	Yes	030																					16/11/23 - HC emailed All wales Policy is imminent . HC is going to Link in with TFG early Dec23 and update us.
Risk Management Policy	1	CORPORATE GOVERNANCE	Julie Boalch	Corporate	New	New	#VALUE!	Under development		Pre	Development																							
Safeguarding Children and Adults at Risk of Harm Policy This policy has merged with the Protection of Vulnerable Adults Policy	5	QS&PE	Nikki Harvey	Corporate	28/11/17	27/11/20	28/07/20	Integrate into single Safeguarding Policy, further discussion needed with QSPE		Post	Approved	Yes	003																					
Safer Handling Policy	3	QS&PE	Graham Stockford	Employment	01/12/20	01/12/23	01/09/23	To Health & Safety Committee as a planned extension. Additional work to be undertaken once Health & Safety Policy agreed.		Post	Approved	Yes	044																					
Shared Parental Leave Policy	3	PEOPLE SERVICES	Sophie James	Employment	10/05/18	10/05/21	10/02/21			Post	Approved	Yes	037																					
Staff Immunisation Policy	1	PEOPLE SERVICES	Ceri Bryant	Employment	New	New	#VALUE!			Post	Development	Yes	085																					
Standards of Business Conduct Policy	N/A	CORPORATE GOVERNANCE	Trish Mills	Corporate	27/07/23	27/07/25	27/04/25	Approved		Post	Approved	Yes	035					25/04/23				20/06/23												
Study Leave Policy	4	PEOPLE SERVICES	Sara Williams / Emma Morgan	Employment	01/06/15	01/06/16	01/03/16	September 2023 review possibly		Pre	Not started																							
Transfer Policy *		OPERATIONS	TBC	Employment	10/03/20	10/03/23	10/12/22			Post	Approved	Yes	071																					
Transgender Policy	N/A	PEOPLE SERVICES	Kathryn Cobley	Employment	New	New	New																											
Trust Mobile Phone Policy	9	DIGITAL	Aled Williams / Tony Raine	Corporate	01/11/09	01/11/12	01/08/12	Possibly obsolete		Pre	Not started																							Possibly obsolete
Tyres and Wheels Policy	10	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	16/07/19	16/07/20	16/04/20			Post	Approved	Yes	028																					
Vehicle Disposal Policy	8	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	11/03/21	11/03/24	11/12/23			Post	Approved	Yes	022																					
Vehicle Telematics Policy	N/A	FINANCE & CORPORATE RESOURCES	Gavin Lane	Corporate	10/05/18	10/05/21	10/02/21			Post	Approved	Yes	027																					
Violence & Aggression Policy	1	QS&PE	Nicola White	Employment	04/02/21	04/02/24	04/11/23	Will be undertake once Health & Safety Policy agreed		Pre	Approved	Yes	093																					
Waste Management Policy	1	FINANCE & CORPORATE RESOURCES	Nicola Stephens	Corporate	New	New	New	In development - consultation phase			Development							25/04/23	09/07/23	04/08/23		19/12/23											
Welsh Language Policy	N/A	CORPORATE GOVERNANCE	Melfyn Hughes	Corporate	New	New	New																											
Work Experience Policy	8	PEOPLE SERVICES	Sara Minahan	Employment	No dates	No dates	#VALUE!			Pre	Development																							
Working Time Regulations Policy	5	PEOPLE SERVICES	Sara Williams / Emma Morgan	Employment	01/07/04	01/07/07	01/04/07			Post	Development	Yes	040																					

Key
Year 1 (Sept - Mar 2024)
Year 2 (Apr - Mar 2025)
Extend for 18 months with professional review
Review as SOPS with professional review
Yet to be prioritised

Internal Audit Progress Report

Audit Committee

November 2023

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 *3*

2. Progress against the 2023/24 Internal Audit Plan *3*

3. Proposed changes to approved plan *3*

4. Engagement *3*

5. Key Performance Indicators *4*

6. Recommendation *4*

Appendix A: Progress against 2023/24 Internal Audit Plan *5*

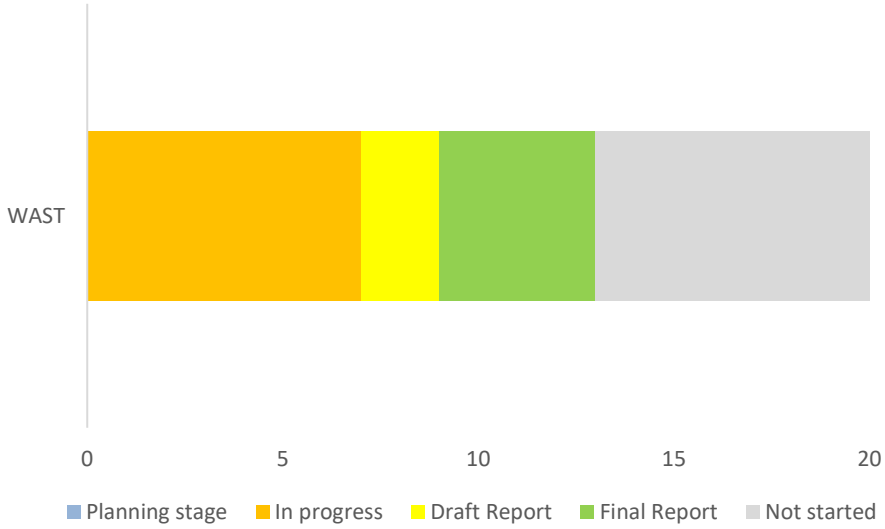
1. Introduction

The purpose of this report is to:

- highlight progress of the 2023/24 Internal Audit Plan to the Audit Committee; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2023/24 Internal Audit Plan

There are 20 reviews in the 2023/24 Internal Audit Plan, and overall progress is shown below.



Detailed progress in respect of each of the reviews in the 2023/24 Internal Audit Plan is summarised in Appendix A.

3. Proposed changes to approved plan

No further changes are proposed in respect of the 2023/24 Internal Audit Plan.

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 October 2023

Indicator	Status	Actual	Target
Operational Audit Plan agreed for 2023/24	●	March	By 30 June
Audits reported over planned	●	4	6
Work in progress		8	
Report turnaround: time from fieldwork completion to draft reporting [10 days]	●	3 out of 4	80%
Report turnaround: time taken for management response to draft report [15 days]	●	2 out of 3	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.

Appendix A: Progress against 2023/24 Internal Audit Plan

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Risk management and assurance	Not started			June 2024
Decarbonisation	Draft report	Limited		March 2024
Delivery of Major Change Programmes	Not started			March / June 2024
111 Service Commissioning Arrangements (Advisory)	Draft report	N/A	Clarity over roles and responsibilities within the National Collaboration Agreement; Develop a mechanism to enable post-implementation learning of benefits and impact to service delivery; Enhancements to governance arrangements to strengthen oversight; Opportunities to strengthen reporting of the commissioning arrangements; and Review of risk registers.	March 2024
Integrated Quality Performance and Management Framework	Not started			March / June 2024
Strategy Development	In progress			March 2024
Serious Adverse Incidents Joint Investigation Framework	In progress			March 2024
Clinical Handover	In progress			March 2024
Senior Paramedic Role	Final report	Reasonable	Ensuring Senior Paramedics are appropriately discharging areas of responsibility; The need to address the disparity in the allocation of Paramedics and Technicians, to ensure appropriate level of supervision and support; Monitoring of training compliance and ensuring that the required clinical skill enhancements are provided; Limited reporting evaluating the impact and effectiveness of the role.	November 2023

[1] May be subject to change

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
Clinical Audit	Not started			June 2024
Volunteers Governance	Not started			June 2024
Seatbelt Action Plan	In Progress			March 2024
Records Management	Final report	Reasonable	Reviewing the resource available to the Records Management Team; Defining an improvement plan for the organisation; Ensuring records held with third parties are subject to formal agreement; Identification and assessment of storage sites; Ensuring all records are disposed of according to schedules.	November 2023
Technical Resilience	Final report	Reasonable	Fully recording the contents of the VPH datacentre; Finalising a service catalogue and recording the resilience position; Testing resilience for non-critical services; and fully defining recovery plans for all systems and ensuring resilience position is reflected in these.	November 2023
ICT Contract Management	In progress			March 2024
Retention of Staff	In progress			March 2024
Disciplinary Case Management – Compassionate Leadership	Not started			March 2024
Recommendations tracker	Not started			June 2024
Capital & Estates				
Estates Assurance: Estate Condition	Final report	Limited	Current / forward investment approvals do not presently match the approved plans to eliminate "high" and "significant" risk backlog; The need to confirm appropriate levels of investment and an appropriately resourced maintenance team, to assess and address backlog maintenance; The need to ensure effective monitoring and reporting against targets; An appropriate methodology for the	November 2023

Review	Status	Rating	Key matters arising	Anticipated Audit Committee[1]
			annual update; and accurate performance indicators.	
Capital Assurance: Vehicle Replacement Programme	In progress			June 2024

[1] May be subject to change

Senior Paramedic Role

Final Internal Audit Report

November 2023

Welsh Ambulance Services NHS Trust

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

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

Contents

Executive Summary 3
1. Introduction 4
2. Detailed Audit Findings 4
Appendix A: Management Action Plan 12
Appendix B: Assurance opinion and action plan risk rating 21

Review reference:	WAST-2324-09
Report status:	Final
Fieldwork commencement:	4 August 2023
Fieldwork completion:	20 September 2023
Debrief meeting:	26 September 2023
Draft report issued:	6 October 2023
Management response received:	24 October 2023 & 2 November 2023
Final report issued:	2 November 2023
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Rhian-Lynne Lewis, Principal Auditor
Executive sign-off:	Andy Swinburn, Director of Paramedicine
Distribution:	Greg Lloyd, Assistant Director of Clinical Delivery; Steven Magee, Regional Clinical Lead; Darren Panniers, Head of Service (EMS South East)
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 Chartered Institute of Public Finance & Accountancy in April 2023.

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

Executive Summary

Purpose

To assess the extent Senior Paramedics are achieving their key role objectives. To include a comparison across Wales.

Overview

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

The matters requiring management attention include:

- Ensuring Senior Paramedics are appropriately discharging the three main areas of responsibility;
- The need to address the disparity in the allocation of Paramedics and Technicians, to ensure appropriate level of supervision and support;
- Monitoring of training compliance and ensuring that the required clinical skill enhancements are provided; and
- Limited reporting evaluating the impact and effectiveness of the role.

Other recommendations are within the detail of the report.

Report Opinion

		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]

Objectives		Assurance
1	Roles and Responsibilities	Reasonable
2	Training and Supervision	Reasonable
3	Utilisation of Senior Paramedics	Reasonable
4	Governance Arrangements	Limited

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Achievement of allocation of SP time across the areas of responsibility	1,4	Operation	Medium
2	Disparity in the SP: P&T ratio allocation	1,3,4	Operation	Medium
3	Management and review of training compliance	2	Operation	Medium
4	Review of the Senior Paramedic Group terms of reference	4	Design	Low
5	Evaluation and Lessons Learned	1,2,3,4	Design	Medium

1. Introduction

1.1 In 2021, a three-year programme was introduced to replace the Clinical Team Leader role which had been identified as being inconsistently adopted across Wales. This role was split between an operationally focussed Duty Operations Manager role and a clinically focussed role of Senior Paramedic.

1.2 The Senior Paramedic role aims to enhance clinical leadership by supporting the delivery of a more clinically led and operationally effective service. The role focuses on frontline clinical leadership of Paramedics and Emergency Medical Technicians with the intention of developing and improving practice. Candidates complete a leadership and development programme resulting in a Postgraduate Certificate in Professional Practice (Leadership in Emergency Services).

1.3 The risk considered during the review was the ineffective roll out and allocation of Senior Paramedic resource which in turn does not improve efficiency, patient care, and outcomes.

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	2
Operating Effectiveness	-	3	-	3
Total	-	4	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 for Senior Paramedics have been set out clearly and are consistently adopted across Wales.

2.3 When establishing the Senior Paramedic (SP) role, a presentation was taken to the Executive Management Team in September 2020, which set out:

- the initial proposal of the role
- outline costs
- associated risks; and
- case for change summarising the intended outcomes.

We note that the case for change lacked detail, including to demonstrate how the intended outcomes would be achieved and a baseline position to measure against,

and there has been no assessment undertaken against this initial proposal to establish if these have been achieved (refer also to objective 4). **See MA5**

2.4 The SP job description sets out job summary, duties and responsibilities, person specification, organisational chart, and supplementary job description information. Further to this, during the initial induction (detailed further within audit objective 2) SPs are provided with two modules setting out their roles and responsibilities and the day-to-day expectations of the role.

2.5 The SP role is split into three main responsibility areas:

- Ride-outs (50%): undertaking an analysis of the performance of a designated group of Paramedics and Technicians (Ps and Ts).
- Clinical Governance (25%): undertaking administrative duties of the role and clinical reviews.
- Cymru High Acuity Response Unit (CHARU) (25%): attending higher acuity calls with the use of a rapid response vehicle (RRV).

2.6 A sample of seven SPs was selected, across all localities, and discussions were held with each to confirm consistent understanding and application of the role.

2.7 It was confirmed that SPs are expected to manage their own allocation of shifts in order to ensure the appropriate split of their time, entering their shifts into the Global Rostering System (GRS).

2.8 We were provided with a GRS report which summarised the split of the shifts for each SP over the last 12 months. This is summarised and further analysed within table 1, highlighting that the SPs have not achieved their expected split. **See MA1**

Table 1

Senior Paramedic	Locality	Total shifts after abstractions [1]	EA shifts - ride-outs (Aim 50%)	Clinical Governance shifts (Aim 25%)	Solo response - CHARU shifts (Aim 25%)
1	ABUHB	125	62.4%	7.2%	30.4%
2	BCUHB	134	54.5%	19.8%	26.1%
3	CTMUHB	126	54.8%	17.5%	27.8%
4	CVUHB	125	56.8%	26.4%	16.8%
5	HDUHB	122	35.2%	22.1%	42.6%
6	PTHB	43 [2]	44.2%	18.6%	37.2%
7	SBUHB	123	67.5%	28.5%	4.1%
Average			**54%**	**20%**	**26%**

[1] *Total shifts after abstractions refers to the number of days worked after removing annual leave, sickness absence, training etc.*

[2] *SP 6 has been in post since June 2023 hence the lower number of shifts recorded.*

2.9 In line with the requirement to represent 50% of the shifts, ride-outs are a key aspect of the SP role. Discussion with the Assistant Director of Clinical Delivery

confirmed that the expected ratio of SP to Ps and Ts is 1:30, to allow for two ride-outs per year to be completed. We were advised that ride-outs should ideally be undertaken on single crewed vehicles. From discussions with the SPs, it is noted that significant disparity in the ratio and the challenge of finding single crewed vehicles (see table 2) impacts on their ability to complete the expected number of ride-outs. **See MA2**

Table 2

Senior Paramedic	Number of Ps and Ts	Comments from SP
1	43	On track to complete 2 ride-outs each this year
2	40	On track to complete 2 ride-outs each this year
3	30	On track to complete 2 ride-outs each this year
4	70	Noting the ratio is more than double expectation (1:70) and that the locality is currently one SP short, have been unable to achieve the expectation of 2 ride-outs this year.
5	40	Struggles to find shifts where vehicles are single crewed and so isn't scheduling as many ride-outs as are needed
6	28	Aims to complete ride-outs on single crewed vehicles but does have to schedule some that are double crewed
7	54	Noting the ratio is nearly double expectation and that the locality is currently one SP short, have been unable to achieve the expectation of 2 ride-outs this year.

Conclusion:

2.10 The roles and responsibilities have been clearly established for SPs and are well understood. However, there are inconsistencies in how shifts are tracked to ensure adherence to the recommended split of time between responsibilities; and there are challenges which impacts their ability to provide sufficient supervision to Ps and Ts. As such, a **reasonable** assurance rating is concluded for this objective.

Audit objective 2: Arrangements are in place to ensure staff receive adequate training and supervision, and that it is considered fit for purpose.

2.11 Prior to the commencement of their role, SPs must attend a weeklong internal induction which provides coverage across all aspects of the day-to-day expectations of the role, including:

- Definition of the SP role, which includes the split of 50/25/25 (as per para 2.5);
- Clinical audit;
- Clinical reviews undertaken following a patient safety incident or complaint;
- ISCLE[1] (the tool used to assess performance during ride-outs);
- Datix investigations;
- Airway log; and

[1] The five key areas of practice of ISCLE are I (identify, continuity and ownership), S (systematic approach to care), C (comprehensiveness of care), L (logical care planning and disposition), E (evidence duty of care has been met)

- several clinical elements of the role.

2.12 Discussion with the SPs noted that the induction provided them with the tools necessary to undertake their role. However, it was felt that the course was intense; and, for some, there was still a steep learning curve to undertaking the role day to day.

2.13 To enhance their leadership skills, all SPs are also required to complete at Post Graduate Certification in Clinical Leadership. This qualification was created for the Trust in partnership with the University of Wales Trinity St. David (UWTSD). The course is split in to 2 modules: '*Authenticity and the Role of the Leader*' and '*Leadership and Change*', and includes 28 hours on-line contact time for each module.

2.14 Management advised that the Trust receive updates from the UWTSD on their progress and Locality Managers are kept informed of progress, but that they do not formally record, monitor or report this information.

2.15 The SPs advised that whilst the course allowed them to explore different leadership skills to apply within their role, it was felt an advancement in their clinical skills would have been more beneficial. Also, at the outset of the role, there was an understanding that additional training on cardioversion and pacing would be offered to SPs, but this has yet to happen. We were advised by the Assistant Director of Clinical Delivery that further skill enhancement for SPs is due to commence in the next 6 months. **See MA3**

2.16 Continuing Professional Development (CPD) and mandatory training requirements for SPs are the same as Band 6 Paramedics, but with additional training for drug administration (noting their increased clinical responsibility) and LUCAS device (Lund University Cardiopulmonary Assist System (*Mechanical Chest Compression System*)). These are monitored through their annual performance appraisal (PADR) within the normal development framework within the Trust. However, we note that data on the overall position of the SP training is not collected and is therefore not reported. **See MA3.**

2.17 In addition to their own CPD, discussions with the SPs identified varying contributions to the CPD they provide to Ps and Ts, which could be shared with all localities. **See MA5**.

2.18 The SPs are line managed by Locality Managers, with additional support available from the Health Board Clinical Leads, Regional on Call Clinical Lead and Consultant Paramedics. Every SP interviewed were positive about the support and supervision they receive, and that they feel they can discuss and escalate any concerns with the confidence that it will be appropriately managed and responded to. Periodic Locality meetings are also held and attendance at these meetings include some of the officers listed above and sometimes the Duty Operational Managers. We note that the structure of these meetings is informal, with no minutes/action notes circulated, and that arrangements differ between localities.

Conclusion:

2.19 Appropriate training is made available to SPs to equip them to undertake their role. They are appropriately supported and supervised by management, although we note improvements could be made to formally monitor completion of training. Discussion with the SPs has identified some areas of good practice in relation to training provided to Ps and Ts that should be shared across Wales. However, noting the feedback from the SPs regarding the balance of leadership / clinical training for the PGCert and that expected clinical training has not been delivered, a **reasonable** assurance rating has been determined for this objective.

Audit objective 3: The Trust ensures Senior Paramedics are being utilised in an effective way to support patient care and their designated group of clinicians.

2.20 We were advised by the SPs that they contribute to patient care whilst undertaking supervisions of Ps and Ts during ride-outs, their own attendance at high acuity calls whilst on the CHARU response vehicle and through their contribution to staff learning and CPD. They also undertake clinical reviews of incidents where triggers have been met or issues/feedback has been escalated. We note that there is no formal mechanism to measure the overall effectiveness of SPs contribution to patient care. **See MA5.** Also refer to audit objective 4 for further details of the governance arrangements in place.

2.21 As per para 2.5, ride-outs are undertaken to monitor and supervise Ps and Ts whilst on shift to measure performance and the effectiveness of the standard of patient care being delivered. This is captured within a standardised feedback form on Microsoft Forms, which determines areas for improvement and an action plan (if required) to address issues identified during assessment. Areas covered include referral pathways, clinical indicators, patient assessment and clinical updates.

2.22 A total of 3,250 ride-outs have been undertaken since the inception of the SP role in October 2021. Using a consistent review methodology (ISCLE), 65% of these required no further action, 25% were identified as a low risk (i.e., resolved on the day), 9% required medium improvements (i.e., to be completed by the next ride-out); and 1% showed a formal action plan was required (review timeframe tailored to each plan).

2.23 Noting the expectation to complete two ride-outs for every P and T per annum and the challenges faced by SPs to achieve this are outlined in Table 2, we note that 696 of the 3,250 ride-outs undertaken relate to second ride-outs. **See MA2**

2.24 Following a ride-out, Ps and Ts are able to provide feedback on the SP and the ride-out process / experience. The comments are anonymised and posted to the SP Dashboard on PowerBI. Feedback is primarily positive, however there were some less favourable comments with common themes including:

- SP behaviours and the format and structure of observations;
- Impact of hospital delays on clinical exposure; and
- Late notification of ride-out which, in some cases, impacted performance.

2.25 We also note that the data does not specifically identify the relevant SP therefore preventing appropriate remedial action to be taken, if applicable. In addition, we received specific feedback from SPs in relation to the role and their experiences and shared with management. **See MA5.**

2.26 The delivery of patient care is further enhanced through the CHARU aspect of the SP role. The following additional skills allow SPs to provide additional interventions above those of Ps and Ts, enabling improved patient care outcomes:

- to provide the opportunity to act in a clinical leadership role while attending critical calls such as serious trauma;
- to make decisions in relation to terminating intervention during resuscitation;
- enhanced analgesia and drug formulary; and
- use of the LUCAS device (mechanical chest compression).

2.27 Clinical reviews are instigated when an issue/complaint raises a concern about the clinical practices of a Trust employee. SPs are expected to complete an investigation if/when an issue is raised against one of their allocated Ps or Ts, collating the necessary evidence in relation to the incident (including employee statements, Mobile Data Terminals (MDT) / electronic patient care record (ePCR) data, clinical contact centre records), and reviewing statements made by the patients and family members. We have not tested this process in detail as part of this review.

2.28 The management of clinical reviews helps establish whether or not the Trust's duty of care has been compromised and if any remedial actions are required by the individual or wider Trust practices. The clinical reviews are discussed at Locality meetings (see para. 2.18) and quarterly reports on the number of active clinical reviews are submitted to the Chief Ambulance Service Commissioner.

Conclusion:

2.29 SPs contribute to patient care through a variety of mechanisms, including supervision on ride-outs, attendance at high acuity calls whilst on the CHARU response vehicle and undertaking clinical reviews. We note that each P and T are expected to be observed and supported during two ride-outs per annum, but the numbers achieved falls significantly below this. Further work is also required to ensure feedback on the SPs is reviewed and reported at an appropriate forum. A **reasonable** assurance rating has therefore been determined.

Audit objective 4: Appropriate governance arrangements are in place to ensure there is regular monitoring of Senior Paramedics and their effectiveness, with sufficient and appropriate reporting to the Board of performance and progress to ensure alignment with the IMTP.

2.30 A key priority within the Integrated Medium Term Plan (IMTP) is to *'grow the senior paramedic contingent to maximise the benefit of enhanced clinical leadership'*. The intention following introduction of the SP role was for the full complement to be 51. There are currently 45 and we were advised by the Assistant Director of Clinical

Delivery that the intake for the final tranche has been put on hold due to funding constraints. **See MA2.**

2.31 As per para. 2.3, the proposal to establish the role was presented to the EMT in September 2020. This was followed by an update within the CEO Report in November 2020 to the Trust Board, which stated that the role had been finalised and agreed. We note that we have not seen evidence to support this but were assured that the role was approved, recognising that these transitional arrangements were agreed during the COVID-19 pandemic.

2.32 Following the commencement of the role in October 2021, a report was taken to the Quality, Patient Experience and Safety Committee (QUEST) in November 2021 providing an update on the implementation of the SP role. This indicated that the SP attendance and clinical leadership at cardiac arrests had potentially had a positive impact on Return of Spontaneous Circulation (RoSC) performance. We note that the Committee was advised that updates on the role would be provided at the People and Culture Committee, however, there has been limited reporting on the effectiveness and impact of the role at Board and Committee level. **See MA5.**

2.33 Following a Welsh Government requirement to undertake mortality reviews across Wales, the final report was presented to QUEST in May 2023. This stated *that 'it is known that ROSC rates in Wales have* historically *been lower than the rest of the UK. In stating this, when considering data in relation to patient outcomes from cardiac arrest when a SP attends, this demonstrates ROSC rates comparable to the highest performing UK services*'. This indicates that the introduction of the SP role has had a positive impact on the RoSC rates across Wales, and the report and meeting minutes further ensued that there had been wider improvements to the quality of care, airway logs and completion of documentation as a direct result of SPs undertaking ride-outs. Due to limited reporting, we have been unable to formally verify these benefits. **See MA5**.

2.34 Following the introduction of the SP role in October 2021 and the subsequent change of the RRV element to CHARU in January 2022, the CHARU Task and Finish Group (CTFG) was established to create set codes for CHARU calls (Red – Immediately life-threatening and Amber – Life-threatening or serious) and review the capacity of CHARU response across localities to ensure the effective delivery of the service. The CTFG produces a highlight report which includes:

- Project Status Summary;
- Summary of project objectives;
- Headlines/Main Achievements;
- Key Decisions in Month Benefits Realised in month; and
- Lessons Learned so far.

This is presented to the Operational Transformation Programme Board, which feeds through by exception to the Strategic Transformation Board, EASC and ultimately the Trust Board. However, this reporting is not specific to the SP role and lacks review of the appropriateness and consistency of their utilisation across Wales (**see MA5**).

2.35 In early 2023, following recognition that there was not enough focus on the SP role within the CTFG, a Senior Paramedic Steering Group was established which had a focus '*to provide advice and direction, set timelines, monitor performance and risk, and to define outcomes for the role of the Senior Paramedic*'. The Group has met monthly since February 2023 and has a range of members which include the Assistant Director of Clinical Delivery, Health Board Clinical Lead, Consultant Paramedic and Senior Paramedics. An action log is maintained to keep track of outputs from the meetings, but our review of the Terms of Reference (ToRs) has shown that there is there is no mention of quoracy, the membership does not include a SP representative from each locality, and a high-level review of meeting attendance has that member attendance has been inconsistent. We recognise that this is an operationally focused group, however there is no current reporting through to any forum. **See MA4**

2.36 One of the objectives of the Steering Group is to *'ensure that the allocation of SP 75% operational shifts is carried out fairly and consistently'.* As observed within audit objective 1 and **MA1**, the balance of shifts has not been effectively achieved across the SPs sampled. There is no evidence of escalation of this matter through the SPSG. **See MA4**.

Conclusion:

2.37 There has been insufficient reporting on the development and implementation of SP role and its impact and effectiveness to an appropriate forum. We also note that achievement of the full growth of the role could be impacted by funding pressures, and the Trust is not meeting the objective set to ensure a 75% allocation of operational patient facing time. Therefore, a **limited** assurance rating is determined for this objective.

Appendix A: Management Action Plan

<table>
<tr><th>Matter Arising 1: Allocation of SP time across the areas of responsibility (Operation)</th><th>Impact</th></tr>
<tr><td>We were provided with a GRS report which summarised the split of the shifts for the sample of seven SPs over the last 12 months (See Table 1). This showed that there is disparity between their allocation of shifts across the three areas of responsibility (ride-outs – 50%, clinical governance – 25% and CHARU – 25%).

While the majority achieved the 75% operational element of their time, the expected balance between ride-outs and CHARU was not always achieved, as detailed below:

<table>
<tr><th>Senior Paramedic</th><th>Locality</th><th>EA shifts (ride-outs)</th><th>CHARU</th><th>Total % of operational shifts</th></tr>
<tr><td>1</td><td>ABUHB</td><td>62.4%</td><td>30.4%</td><td>92.8%</td></tr>
<tr><td>2</td><td>BCUHB</td><td>54.5%</td><td>26.1%</td><td>80.6%</td></tr>
<tr><td>3</td><td>CTMUHB</td><td>54.8%</td><td>27.8%</td><td>82.5%</td></tr>
<tr><td>4</td><td>CVUHB</td><td>56.8%</td><td>16.8%</td><td>73.6%</td></tr>
<tr><td>5</td><td>HDUHB</td><td>35.2%</td><td>42.6%</td><td>77.9%</td></tr>
<tr><td>6</td><td>PTHB</td><td>44.2%</td><td>37.2%</td><td>81.4%</td></tr>
<tr><td>7</td><td>SBUHB</td><td>67.5%</td><td>4.1%</td><td>71.5%</td></tr>
</table>
Discussion with management confirmed that there is no assessment undertaken to monitor the accuracy of SPs management of their time.</td><td>Potential risk of:

• SPs not consistently achieving the appropriate the split of shifts.</td></tr>
</table>

Recommendations			Priority
1.1	Periodic analysis of GRS data should be undertaken to ensure all SPs are adhering to the recommended split of their shifts.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	A GRS report will be generated using a randomised sample of the SP group; and this report will be submitted to the SP Steering Group.	January 2024	Assistant Director of Clinical Delivery

Matter Arising 2: Disparity in the SP: P&T ratio allocation (Operation)	Impact
Management advised that the recommended ratio for Ps and Ts allocated to SPs for ride-outs is 1:30. However, discussion with the SPs has established significant disparity in the actual allocations, with 1:28 being the lowest and 1:70 being the highest, therefore impacting on their ability to provide appropriate supervision and support to the Ps and Ts. We acknowledge that the recommended ratio is based on a full cohort of SPs at 51 (currently 45 in post). The final intake of SPs was due to take place within the final quarter of 2023, however we were advised that this has been put on hold due to funding constraints. In the absence of the final cohort, the disparity between ratios will likely worsen due to the expected increase in newly qualified Paramedics later this year.	Potential risk of: • Ps and Ts do not receive appropriate supervision and support; • Additional workload pressures on SPs with higher ratios of Ps and Ts; and • Failure to achieve IMTP priority

Recommendations		Priority
2.1	A review of allocation of Ps and Ts is undertaken to ensure consistency across Wales.	**Medium**
2.2	Arrangements should be put in place for the appropriate escalation of issues with ratios and ensure regular monitoring through an appropriate forum.	
2.3	An assessment should be undertaken to establish and highlight the wider impact of not achieving the full growth of the SP role.	

Agreed Management Action		Target Date	Responsible Officer
2.1	a) The SP shown with the highest ratio was due to a vacancy in the operational area. This post has now been recruited into, so the team size has reduced to 35 each for the two SPs in the area and further SPs have been recruited with induction starting on 13 November (up to the 45 FTE). b) A review of options for reducing variances in the size of SP teams will be presented to the quarterly SP Steering Group.	a) Complete b) January 2024	Assistant Director of Clinical Delivery
2.2	Team sizes and ratios will form part of a report into the quarterly SP Steering Group.	January 2024	Assistant Director of Clinical Delivery
2.3	An analysis on the impact of not achieving the full growth of SPs has been completed and reviewed at internal clinical/operational and financial groups in light of the current financial savings plan.	Complete	Assistant Director of Clinical Delivery

Matter Arising 3: Management and review of training compliance (Operation)			Impact
A requirement of the SP role is the completion of a tailored PGCert in Clinical Leadership. This course includes 28 contact hours via Zoom/Teams for each of the two modules. We were advised that whilst the Trust receives updates on individual SPs progress throughout the course this is not formally recorded, monitored or reported. Further, we understand that there is no ongoing CPD requirements following the completion of the course. At the outset of the role, SPs were advised that additional training that would enhance their clinical skills (including cardioversion and pacing) would be offered. However, at the date of fieldwork these which have yet to take place (noting that some of the SPs have been in post for circa 2 years). Management has advised that there are plans for this training to commence within the next 6 months.			Potential risk of: • Training non-compliance • Training provided is not sufficient to appropriately equip SP to meet their responsibilities
Recommendations			**Priority**
3.1	Training status for all SPs should be collated and captured with regular reporting within an appropriate forum to monitor progress.		**Medium**
3.2	A training plan, and expected timeline for the required clinical skill enhancements should be established.		
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Updated reports on education progress of the SP cohorts to be brought together into a single progress report. This will be presented through the Clinical Directorate Business meeting and the Senior Operations Team.	January 2024	Assistant Director of Clinical Delivery

Agreed Management Action		Target Date	Responsible Officer
3.2	An Extended Skills Working Group has been established to deliver four new areas for skill development during 2024. The first meeting is in November 2023 with two priorities already agreed (sedation for post ROSC patients and the management of ABD). The workplan and draft terms of reference have been shared with Audit for information. These skills will initially be for the SP group only until an assessment and audit is completed for further consideration on safety and efficacy.	December 2023	Regional Clinical Lead

Matter Arising 4: Review of SPSG terms of reference (Design)	Impact
The Senior Paramedic Steering Group (SPSG) was established in early 2023, subsequent to the recognition that the CHARU Task & Finish Group did not provide sufficient focus on the SP role. The SPSG produces minutes and an action log to monitor outputs from the meetings. We note that the SPSG is operationally focused, however there is no formal defined pathway for escalation of issues if required. Member attendance at the meetings has been inconsistent and we noted that there is no mention of expected quoracy in the agreed terms of reference.	Potential risk of: • Forums not operating in a complete and effective manner. • Decisions taken without consideration of all parties.

Recommendations		Priority
4.1	The terms of reference should be reviewed to: • Include a defined pathway for escalation of issues; • Update membership to ensure representation from each locality; and • Define quoracy.	**Low**

Agreed Management Action		Target Date	Responsible Officer
4.1	The SP steering group has changed to a quarterly meeting and the terms of reference are being updated to reflect the audit findings. An Alert/Assure/Advise report will be completed and submitted to the Senior Operations Team	November 2023	Assistant Director of Clinical Delivery Head of Service (EMS South East)

Matter Arising 5: Evaluation and Lessons Learned (Design)	Impact
The initial presentation for the establishment of the SP role, taken to EMT, set out the 'case for change' which included the following areas: • Drive high quality clinical services to our population; • Role model Trust behaviours and professional practice; • Recognise the importance of excellent leaders and managers on operational performance; • Provide aspirational career opportunities across the operational workforce; • Standardise the leadership model across Wales; • Deliver against Civil Contingencies Act obligations; and • Engage workforce through appropriate and realistic ratios. We note that the case for change lacked detail, including to demonstrate how the intended outcomes would be achieved and a baseline position to measure against, and there has been no assessment undertaken to establish if these have been achieved. A report was presented to QUEST (November 2021) outlining the positive early impact of the SP role in relation to attendance at cardiac arrests. The committee was advised that the People and Culture Committee (PCC) would receive update reports on the role, however there has been very limited evidence of reporting on the effectiveness and impact of the role at Board and Committee level. Further, it is recognised that anonymous feedback is provided by the Ps and Ts following ride-outs. Whilst collated on the SP dashboard, there is no evidence of comments and required actions being considered at an appropriate forum. It is considered that the SP Steering Group would be the appropriate forum for such. In addition, discussions held with the sample of SPs during audit fieldwork noted that they are looking to enhance the CPD they deliver to the Ps and Ts. Activities undertaken are detailed below there is an opportunity for these to be shared across all localities for consideration of good practice: • CPD days: monthly guest speakers including Maternity, End of Life Care, Safeguarding, Holistic Therapies; • Case Studies: monthly printout of a clinical case study shared within the station; and • JRCALC (Joint Ambulance Colleges Ambulance Liaison Committee) guidance quiz to test the knowledge of the Ps and Ts.	Potential risk of: • Lack of acknowledgement of the benefits / shortfalls, where applicable, of the SP role; with no appropriate mitigating action taken. • IMTP objective not achieved.

Recommendations		Priority
5.1	The Trust should undertake a lessons learned exercise on the development and evolution of the SP role.	**Medium**
5.2	The Trust should report regularly on the impact and effectiveness of the SP role, including analysis of their utilisation across Wales and the achievement of the wider IMTP objective.	
5.3	Feedback from Paramedics and Technicians should be included as a standing agenda item on the SP Steering Group for consideration / action as appropriate.	

Agreed Management Action		Target Date	Responsible Officer
5.1	A review on the evolution of the role will be completed to highlight any lessons that can be learned for future role development.	February 2024	Assistant Director of Clinical Delivery
5.2	A report including number of rideouts undertaken and the outcomes (action plans/issues resolved during the shift/documentation/CPD/NQP portfolio reviews) will be developed into a regular report into the SP Steering Group on a quarterly basis.	January 2024	Assistant Director of Clinical Delivery
5.3	Feedback through the Power BI reporting process will be included on the SP Steering Group quarterly meeting.	January 2024	Assistant Director of Clinical Delivery

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Records Management

Final Internal Audit Report

October 2023

Welsh Ambulance Service NHS Trust

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

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Welsh Ambulance Services NHS Trust

Contents

Executive Summary 3
1. Introduction 4
2. Detailed Audit Findings 4
Appendix A: Management Action Plan 12
Appendix B: Assurance opinion and action plan risk rating 19

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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 Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

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Executive Summary

Purpose

To review the arrangements and processes in place to enable the effective management of records.

Overview

We have issued a reasonable assurance. on this area.

There is guidance in place that cover the records management lifecycle, and includes retention period for different record types.

The Records Management Department focuses on the provision of records under legislative requirements and is complying with the defined timescales for this. However, we note that due to a lack of resource, there has been no structured assessment of records management across the Trust, and no associated improvement plan.

The majority of records in use, particularly patient records, are in digital form. Records are generally stored appropriately, with recent improvements being made. However, the main storage of physical records is with an external provider, for which no formal agreement exists.

The main points which require management action are:

- Reviewing the resource available to the Records Management Team.
- Defining an improvement plan for the organisation.
- Ensuring records held with third parties are subject to formal agreement.
- Identification and assessment of storage sites.
- Ensuring all records are disposed of according to schedules.

Report Opinion

		Trend
Reasonable. 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	None

Assurance summary[1]

Objectives		Assurance
1	Guidance	Reasonable
2	Capacity and Resilience	Limited
3	Availability	Substantial
4	Storage	Limited
5	Digitisation	Reasonable
6	Disposal	Limited

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Capacity of RSA Team	2	Design	High
3	Records Storage Contract	4	Operation	High
5	Retention and Destruction of Records	6	Operation	High

1. Introduction

1.1 The Information Commissioners Office (ICO) Records Management Code of Practice 2021 (Section 46) provides guidance to public authorities (and any other organisations whose administrative and departmental records are subject to the Public Records Act) on their obligations in relation to good records management, including keeping, managing and destroying records. Following the code of practice will help the Welsh Ambulance NHS Trust (the 'Trust' or 'organisation') to comply with the legislation.

1.2 The risks considered as part of this audit are:

- Inappropriate access to confidential information.
- Inaccessibility of records impacts on patient care; and
- Inefficient processes lead to increased costs.

1.3 We note that this audit did not include an assessment of the quality of the contents of records nor the delivery and completion of Information Governance training across the Trust, as the responsibility for this lies outside of the Records Management Team. As such, the audit does not provide assurance that documentation and records are kept to an appropriate standard.

2. Detailed Audit Findings

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

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

Objective 1: Guidance - appropriate policies, procedures and guidelines are in place for records management that cover the full records lifecycle and ensure standardisation of processes and record content.

2.3 The Welsh Ambulance Services NHS Trust (WAST) recognises the importance of sound records management arrangements, for both clinical and corporate records produced by the Trust. To this end the WAST Record Management Team has a number of policies, procedures and guidelines in place for the organisation, which cover records management and the lifecycle of individual records to ensure a

consistent approach to the standardisation and management of records. These include but not limited to:

- Access to Personal Information Policy (2019);
- Police Records Request Guide V3;
- Call Recording User Guide V3;
- Redacting a Call Recording Guide V2;
- Records Retention Schedule;
- Records-Management-Policy (2018).

2.4 The Trust has a structured process for the creation and approval of Policies. This is managed by the Trust's Corporate Governance Team. Recent Audit Wales and internal audit reports have highlighted a wider issue across the Trust with policy reviews being impacted by the Covid-19 pandemic and the capacity of the Office of the Board Secretary. This meant that most policies, including those highlighted above, whilst remaining extant and in use have passed their review date. A prioritisation exercise has recently been undertaken to fully assess the Trust's position, which has resulted in a programme of work being established to bring key policies up to date. We have not therefore raised a recommendation on this basis.

2.5 Guidance documents produced 'internally' have a version number and are managed by the Records Services and Archives Manager (RSAM), and we note that these documents have recently been updated to incorporate changes in processes. The guidance is available for staff on a shared drive stored on the local server. However, we note that due to the workload for the department which has a small team, the RSAM has not been able to actively disseminate the information throughout the organisation to ensure standardisation.

2.6 As part of our testing, using the Information Asset Register (IAR), a number of information assets were selected and key staff contacted to assess awareness of guidance and records management good practices. All parties contacted were aware of the Records Services & Archives (RSA) Team but only contacted the RSA Team for storage issues or document requests. All the asset owners contacted were aware of the requirements and regulations for records management.

Conclusion:

2.7 There are a number of policies and procedure in place which cover the lifecycle of the records stored within WAST. Although there is no programme for dissemination of these, our discussions with staff noted that staff in charge of information do comply with good practice and legislative requirements. We note that the policies are passed their review date however. Accordingly, we have provided **Reasonable** assurance over this objective.

Objective 2: Capacity - the capacity, resilience and succession planning for the records function is appropriate to ensure continued compliance, recognising the continuing trend of increasing requests for support.

2.8 The RSA Team is a small unit consisting of the manager, one business support officer for 18.75 hours per week and 1.6 WTE information governance officers (of which 1.0 is vacant), with additional help provided by one full time light duties staff member as and when available. We note that there is an advertised vacancy currently in place for the vacant full time role.

2.9 Light duty staff are utilised when available and are provided with basic training in relation to records management. However, there is a regular turnover of light duty staff and providing in depth training for them would be time consuming and would not provide a good return on the time invested. We note however, that there are internal guidelines available for reference thus ensuring compliance with current records management procedures.

2.10 The RSA Team has responsibility for various aspects of records management within the Trust. These include core records management, provision of advice and dealing with requests for information, including in relation to subject access requests (SARs) made under the General Data Protection Regulation (GDPR). The team also assists in the provision of information requested under Freedom of Information (FoI), with that process being managed by the Corporate Governance Team.

2.11 Due to the small size of the Records Management Team, nearly all the working time is taken up dealing with information requests from the police and subject access requests received by the Trust. The timescales for provision of this information are set out under GDPR and as such this is a legislative requirement for the Trust.

2.12 Information gathered through our testing process showed that the RSA Team follow a clear and defined set of processes for handling subject access requests. This involves a high level of scrutiny of the data to ensure that only data requested is passed on to the requesting parties and includes redacting data where necessary. We note that the collation and preparation of the documentation can be time consuming.

2.13 We note that both the number of requests, and the complexity requests have been increasing on a year by year basis, with employee requests in 2022 accounting for 2.5K pages of information, and a total of around 3,500 requests made to the Team. This would equate, for 2.5 WTEs, working 45 weeks a year to more than 30 requests a week each.

2.14 From our testing of the process, from January 2023 to March 2023, the Team processed 1,472 requests of which 1,442 (98%) where completed on time. Currently the RSA Team are complying with the majority of deadlines for provision of information, however as the team only consists of 1.5 full time members of staff, there is a risk that this compliance will drop in the future, particularly if the trend of increasing requests and their complexity continues. We also note that the size

of the team make succession planning difficult and leads to limited resilience in the case of staff absence, with a single point of failure. **Matter Arising 1**

2.15 We note that the activity on access requests is reported as part of the information governance reporting framework, within the highlight report to the Information Governance Steering Group. However, this only provides the compliance KPIs and does not provide any detail on trends of complexity, or time taken to resolve. As such the activity of the RSA department is not fully reported and this may mean that the resourcing risks are not highlighted. **Matter Arising 1**

2.16 Due to the lack of resource, currently there is no wider work on improving records management throughout the organisation, with no records management assessment or improvement plan in place. The RSAM has made attempts to develop this, however the lack of resource available has meant that this has not be possible at present. As such there may be an inconsistent approach to records management across the organisation. **Matter Arising 2**

Conclusion:

2.17 The RSA Team is small, and makes use of staff being rotated in on a temporary basis. The Team is responsible for all areas of records management, including the provision of information to the police, under FOI and for subject access requests under GDPR. Whilst there is compliance with required timescales at present, the number of requests has increased and become more complex, taking longer to process and the small size of the team leads to limited resilience which presents a risk that compliance may drop. The lack of resource also means that there is no capacity to monitor records management throughout the Trust and develop an improvement plan. Accordingly, we have provided **limited** assurance over this objective.

Objective 3: Availability - records are available when and where needed by operational staff and for any disclosure requirements.

2.18 WAST has transitioned to a largely digital based organisation, with all the key patient management systems in use being digital, such as the electronic patient clinical record (ePCR), and the computer aided dispatch (CAD) system. As such records are available to staff within the organisation as needed, and access is controlled to the systems as appropriate. Access is controlled by the IT Department with authorisation from RSAM, although we have not fully tested system access controls as part of this audit.

2.19 There are still some physical records in use, as an example the Pontypool site contains records relating to staff disciplinaries, work related incidents and various HR records.

2.20 As noted under objective 2 above, the RSA Team comply with the procedures and requirements relating to time constraints for disclosure requests. We note that physical records are more of a challenge due the location of some, as these would need to be transported to North Wales where the RSA Team is based, which could lead to delays in fulfilling the request.

2.21 There is a process for tracking of records, which is included within ePCR. In respect of call recordings, the Telecoms Team will investigate if they cannot be located in the first instance. If a record cannot be found, then an incident is logged within DATIX.

2.22 Request for records and documentation can be received from a number of different sources, including the police, health care professionals, the Medical Examiner, the DVLA, patients and professional Councils such as the GMB. The nature and extent of documentation requested can vary and include patient notes, emails and call recordings. We note that call recordings may need to be redacted which is time consuming. Requests are prioritised for time and complexity, with some requests having defined response times:

- Response to Coroner in 24-48 hour turn around.
- Subject Access is 30-day response.
- Access to health is 40-day response.

2.23 There is a robust process in place to enable the RSA Team to track requests for records in order to ensure timescales are met. This process uses multiple spreadsheets which capture key information relating to the requests, such as the date received, regulatory time allowed, target date and escalation dates.

2.24 In order to provide information as requested, the RSA Team has full access to all the digital records used within the organisation.

Conclusion:

2.25 The move to a digital organisation has meant that, in general, records are available as needed throughout the Trust. There are good processes in place within the RSA Team for handling requests for information and this ensures that records are provided within the required timescales. Accordingly, we have provided **substantial** assurance for this objective.

Objective 4: Storage - records storage facilities ensure that records are protected from unauthorised access, destruction or theft, and from accidental damage from environmental hazards.

2.26 Digital records are stored within the WAST architecture and as such are subject to standard protections. Our previous work on cyber security noted reasonable assurance over the processes in place to protect digital systems from unauthorised access or loss.

2.27 The main storage location for physical records is a facility operated by Denbigh County Council (DCC), where more than 1.5 million archived records are being stored. These records, in the main, were produced prior to the introduction of digital records. There is no contract or formal agreement between WAST and DCC regarding the transfer and storage of the records, and nothing that defines the responsibilities of DCC in relation to the management of health records, as such this may be breaching GDPR. **Matter Arising 3.**

2.28 Access to the records at DCC is arranged by the RSAM, who maintains a record of what has been passed for storage, via a contact in DCC. DCC staff will collect the

requested records and provide them to the requesting department within the Trust, who will return them back to DCC to be filed back into storage. The RSAM has visited the DCC location to review the arrangements in place to ensure records are held securely and in a good condition and protected from environmental damage. The RSAM has also given assurance that the transportation of any physical records is done in a secure manner by NHS staff.

2.29 There are additional records storage facilities at the Pontypool ambulance station. This being a small purpose-built room which has been partitioned off from an old maintenance bay on the ground floor. There are live water pipes traversing the area where records are stored and the area is subject to flooding, of which there was recent evidence. All racking is full, and boxes are being stored on the floor of the room. There is no water detection system on the floor, nor is there any fire/smoke detection or suppression in the area.

2.30 Access to the room is via a digital door lock mounted on a not very robust door frame. The unused maintenance bay which has been partitioned off to create a storge room is closed by a roller shutter which is damaged and could be prised open.

2.31 Additional storage has been provisioned at Vantage Point House (VPH) Cwmbran. This is a shared building with South Wales Police. The basement area in VPH has recently been renovated and has several rolling racks to store records. The basement area allocated to WAST will also be used by various NHS departments for their storage, which will also include the relocation of documents currently in the Pontypool Ambulance Station basement noted above. WAST has access to racks 6 to 9 which are currently empty. The renovated basement was completed in March 2023, however as yet no records have been moved. **Matter Arising 4**

2.32 As noted previously, the lack of resources within the RSA Team has meant that there has been no full programme of identification and assessment of all areas where records are held. As such it is likely that there are physical records of which the RSAM is unaware, and no associated plan to ensure that all records are held appropriately. **Matter Arising 5**

Conclusion:

2.33 The majority of records in use, particularly patient records, are in digital form. Archived physical records are stored in an offsite secure location based at DCC. There are additional storage areas within the Trust, and a new, improved area has been recently created. However, no records have yet moved into the new area and the DCC facility lacks any formal agreement or underpinning basis for the transfer and storage of records outside the Trust. Accordingly, we have provided **limited** assurance over this objective.

Objective 5: Digitisation – the records management function has transitioned from enabling a paper-based service to a digital service.

2.34 Whilst paper records still exist, the majority of these are held at DCC as noted above. They are accessed infrequently and therefore are not planned for digitisation at the present time. The majority of the records are now digital and

stored electronically, such as on the CAD system and ePCR. Records, in particular patient records relating to emergency services may be required to be held for a significant time, with some needing to be held for 25 years.

2.35 The procedures for handling digital records in relation to availability and storage follow the same process as paper, with a secure environment and restricted access. The major difference is that digital records are backed up via an IT policy which does not form part of this audit.

2.36 The RSA Team has transitioned into managing the requests from electronic information, with guidelines and procedures for this being updated.

Conclusion:

2.37 The move of the Trust to a digital organisation has led the Records Management Team to amend their processes in order to manage requests for information. The processes have changed, however we note that the updating of procedures is not yet finalised. Accordingly, we have provided **Reasonable** assurance over this objective.

Objective 6: Disposal – an appropriate process is in place to archive and dispose of records appropriately, both physical and digital.

2.38 Guidance in place states that the Trust will only retain records if there is a legal obligation to do so. Unless agreed for extended preservation, all records will be securely destroyed on expiry of minimum retention periods as listed in the retention schedules which have been provided by the RSAM, and which are available to all staff. Our discussions with individual asset owners confirmed that they were aware of the retention policy and requirements for disposal and referred back to RSAM for any additional guidance.

2.39 As noted previously, a large number of physical records are stored by DCC. The RSAM has a comprehensive list of what is stored there and when it should be destroyed. There is a process in operation for disposal of records from this site, with the WAST Record manager contacting DCC via email and providing a 'list' of what can be removed for destruction. DCC has a large secure destruction container which is used for both WAST and DCC records. However, as there is no WAST staff present who can physically verify the correct records are destroyed, there is a heavy reliance on DCC staff to comply with the list provided by the WAST Record manager. We note that DCC provide email confirmation of destruction to the RSA Team.

2.40 The removal of digital records will enable easier deletion going forwards. Digital records are the 'property' of the individual asset owners. The retention schedule relates to all records, including digital records. However, there is no structured process to ensure that digital records are deleted as per the schedule. As noted previously there is no records management improvement plan and so no process to ensure that all records are deleted appropriately. As such the Trust is likely to be holding records for longer than the required period. **Matter Arising 6.**

Conclusion:

2.41 Guidance is in place which sets out the retention periods for records, and staff were aware of this. There is a process for appropriate disposal of physical records which is managed by the RSA. However, there is no structured process to ensure that all records, including digital, are appropriately disposed of throughout the Trust. Accordingly, we have provided **limited** assurance over this objective.

Appendix A: Management Action Plan

Matter Arising 1: RSA Team Resilience (Design)			Impact
The RSA Team only consists of 2.6 full time members of staff of which 1.0 has been vacant since June, and is having to deal with an increasing number of requests for information of increasing complexity. Although the team is complying with required timescales at present there is a risk that this compliance will drop in the future, particularly if the trend of increasing requests continues. We also note that the size of the team make succession planning difficult and leads to limited resilience in the case of staff absence, with a single point of failure. We note that the activity on access requests is reported within the information governance reporting framework. However, this only provides the compliance KPIs and does not provide any detail on trends of complexity, or time take to resolve. As such the activity of the RSA department is not fully reported and this may mean that the resourcing risks are not highlighted.			Potential risk of: • Inadequate records management arrangements, resulting in non-compliance with legislative requirements and potential reputational damage and financial loss.
Recommendations			**Priority**
1.1	Management should ensure that a full review of current resources, how resource is used and time required to complete all legislative duties is undertaken, to identify gaps and risk areas upon which capacity and resilience can be measured.		High
1.2	The IG reports should include a measure of the complexity of requests.		
Agreed Management Action		**Target Date**	Responsible Officer
1.1	Previous time & motion study showed significant variance in the tasks undertaken, and similar pressure is felt across records service community in NHS Wales with increasing complexity. A risk will be captured around legislative duties. Exploration of digital tooling to support better tracking of activity in the RM team	Dec-23 for a risk to be developed and logged	Director of Digital

	is already being taken forward, and the ways of working of the team is under continuous review for improvement.		
1.2a	Coroner requests have been identified as a process possibly suitable for automation. This process will be mapped to see if automation would create additional capacity within the team.	Jan-24 for process mapping	Records Services & Archives Manager
1.2b	Additional metrics will be included in the IG & InfoSec KPI report, representing complexity of and utilisation in legislative duties.	Jan-24 for new metrics	Assistant Director of Digital Services

Matter Arising 2: Records Management Improvement Plan (Design)			Impact
Due to the lack of resource, currently there is no wider work on improving records management throughout the organisation, with no records management assessment or improvement plan in place. The RSAM manager has made attempts to develop this, however the lack of resource available has meant that this has not be possible at present. As such there may be an inconsistent approach to records management across the organisation.			Potential risk of: • Inadequate records management arrangements, resulting in non-compliance with legislative requirements and potential
Recommendations			**Priority**
2.1	A record management improvement plan should be developed, based on a formal assessment of records throughout the Trust.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1a	Additional fixed-term support will be sought to conduct the assessment and craft an improvement plan. The risk of not developing an improvement plan in 2023-24 will be included in the risk being developed as per action 1.1.	Sept-24 (due to current resourcing constraints)	Assistant Director of Digital Services
2.1b	A Digital Notice re records management will be published on the intranet to increase awareness of individual staff responsibility.	Dec-23 for Digital Notice	Records Services & Archives Manager

Matter Arising 3: DCC Records Storage Contract (Operation)			Impact
The main storage location for physical records is a facility operated by Denbigh County Council (DCC), where more than 1.5 million archived records are being stored. There is no contract or formal agreement between WAST and DCC regarding the transfer and storage of the records, and nothing that defines the responsibilities of DCC in relation to the management of health records, as such this may breaching GDPR			Potential risk of: • Non compliance with legislative requirements.
Recommendations			**Priority**
3.1	A formal agreement for storage of records should be developed. This should set out the responsibilities and requirements for management of health records.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1a	Additional temporary resource to be sought (from Jan-24) to conduct review of DCC stored boxes and retention schedules. A forecast of storage requirements at DCC will be created to inform a decision on if/when it will be possible to move these records into WAST-managed storage (e.g. at VPH).	April -24	Records Services & Archives Manager
3.1b	Should [following the review at 3.1a being evaluated] we still need space at Denbigh County Council then we will pursue an agreement with them for those storage, retention and disposal. In the meantime, we will ask for the policies and procedures the Council have in place for their receipt, retention and destruction of records and confirm that this is the way they treat our records. That should provide some assurance on the issues in the matter arising.	September-24	Records Services & Archives Manager

Matter Arising 4: Appropriateness of Records Storage Environment (Operation)			Impact
The records storage facilities at the Pontypool ambulance station is full, with records stored on the floor, evidence of water ingress and no fire/smoke detection or suppression in the area. Additional storage has been provisioned at Vantage Point House (VPH) Cwmbran. This is a shared building with South Wales Police. The renovated basement was completed in March 2023, however as yet no records have been moved.			Potential risk of: • Loss, damage, or inappropriate access to records.
Recommendations			**Priority**
4.1	Records should be moved into the new storage area.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	RSAM to review suitability of the VPH storage facility and access management arrangements. If appropriate, secure transfer of the records from Pontypool to VPH will require budget approval beyond the funds available for Records Services (to be discussed with Corporate Governance & Finance).	Jan-24	Assistant Director of Digital Services

Matter Arising 5: Identification and Assessment of Records Storage Areas (Design)			Impact
As noted previously, the lack of resources within the RSA Team has meant that there has been no full programme of identification and assessment of all areas where records are held. As such it is likely that there are physical records of which the RSAM is unaware, and no associated plan to ensure that all records are held appropriately.			Potential risk of: • Loss, damage, or inappropriate access to records. • Non compliance with legislation.
Recommendations			**Priority**
5.1	The records management improvement plan noted in MA2 should include a programme of identification and assessment of all records storage areas within the Trust.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	The risk of not fully assessing storage areas in 2023-24 will be acknowledged in the risk being developed as per action 1.1. A Trust-wide request will be made to gather intel on what paper records are being stored across the organisation and where. This will inform the improvement plan of how to assure these storage areas.	Sept-24	Records Services & Archives Manager

Matter Arising 6: Retention and Destruction of Records (Operation)			Impact
Digital records are the 'property' of the individual asset owners. The retention schedule relates to all records, including digital records. However, there is no structured process to ensure that digital records are deleted as per the schedule. As noted previously there is no records management improvement plan and so no process to ensure that all records are deleted appropriately. As such the Trust is likely to be holding records for longer than the required period.			Potential risk of: • Inadequate records management arrangements, resulting in non-compliance with legislative requirements and potential reputational damage and financial loss.
Recommendations			**Priority**
6.1	The records management improvement plan noted in MA2 should include an assessment of the disposal of records (both physical and digital) and ensure that records are removed as appropriate.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	Agreement that this is needed, but dependency on the assessments of MA2 and MA5, for which additional fixed-term expert support would be required. There is however an individual staff responsibility and asset owner responsibility to ensure records are disposed of correctly, which will be included in the Digital Notice of action 2.1.	Dec-23 for Digital Notice	Records Services & Archives Manager

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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Contents

Executive Summary 4
1. Introduction 7
2. Detailed Audit Findings 8
Appendix A: Management Action Plan 16
Appendix B: Estates Facilities Performance Management System (EFPMS) 31
Appendix C: Contact Details for Health Board and Trust Designated Persons (extract) 33
Appendix D: Assurance opinion and action plan risk rating 34

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

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

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Executive Summary

Purpose

The NHS in Wales faces unprecedented challenges balancing the management of the current estate condition against other competing priorities and within existing funding constraints – whilst also developing a deliverable estate strategy for the future.

The backlog maintenance figures for NHS Wales recently exceeded £1bn (the substantial element being High and Significant risks) and is likely to increase further due to the aging estate in Wales.

The latest nationally reported data (2021/22) for the Trust confirmed a total backlog maintenance requirement of £10.6m.

The audit sought to evaluate the arrangements put in place by the Trust to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

Overview

Backlog has almost halved since 2017/18 (from circa £13.6m). As of 2022/23, the Trust had an assessed backlog of circa £7.3m. However, "high" and "significant" backlog had increased to circa £4m of this sum (i.e., 54% of the total).

Key to understanding the challenge is the accuracy of the baseline data. A six-facet survey was undertaken in 2021. However, while recognising the simple nature of the estate (with limited need for invasive surveys), the audit identified the need for a targeted programme of surveys to supplement the non-invasive nature of the six-facet survey.

Further issues have been raised on the comparability of the data, given the significantly varied methods of computation by each NHS Wales organisation.

The Trust set out its vision to eliminate backlog maintenance over a 10-year period within its 2017 Estates Strategy. (It is recognised that in the period to date, Covid may subsequently have had some impact on investment plans).

In the short to medium term, the Trust uses a combination of all Wales capital funding, targeted EFAB funding, planned and reactive maintenance,

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary [1]

Assurance objectives		Assurance
1	Governance	Reasonable
2	Baseline information	Reasonable
3	Estates strategy	Limited
4	Funding strategy	Limited
5	Monitoring & reporting	Reasonable
6	Risk management	Limited

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

Key Matters Arising

		Assurance Objective	Priority
1.1	Management should consider the advantages and disadvantages of specialist capital expertise provided by a Non-Executive Director to oversee the capital programme.	*1*	Medium
1.2	The Trust should advise NWSSP: SES that the "designated person" will be re-allocated to an appropriate Board member in accordance with WHEN 07-02.	*1*	Medium
2.1	The adequacy of the existing Capital Development & Estates workforce will be affirmed (in terms of capacity and associated skill sets	*4*	Medium

and discretionary funding to address identified high-priority areas as follows, e.g.:

- All-Wales capital funding (£8m) was secured for a new facility at a site in Pontprennau for a make ready depot. A new workshop facility was also developed in Merthyr, facilitating the return of the Blackweir facility to Cardiff City Council.
- The Trust successfully secured EFAB funding of £2.18m across 2022/23 & 2023/24 to address estate priorities.

Reductions in the backlog maintenance required were to be primarily achieved by disposal and replacement of older sites. However, a refresh of this strategy in 2021 showed that capital requirements had increased from £89m to £107m over a re-based 10-year period.

With the current limitations of available investment, progress has stalled. The approved values of current and forward investments do not presently match the approved plans to eliminate "high" and "significant" risk backlog.

Matters requiring management attention included the need to confirm appropriate levels of investment, with an appropriately resourced maintenance team, to assess and address backlog maintenance. There was also a need to ensure effective monitoring and reporting against targets. This should be supported by effective reporting of "high" and "significant" risks; an appropriate methodology for the annual update; and accurate performance indicators.

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

An overall **limited assurance** has been determined noting that identified estate risks cannot be managed within existing funding. This assurance opinion is in line with that determined across NHS Wales, given the common challenges faced by each organisation.

Whilst not a specific focus of this review, the recently nationally reported Reinforced Autoclaved Aerated Concrete (RAAC) issues have further increased the risk profile of the NHS Wales estate. At the time of reporting the Trust had confirmed to Welsh Government that appropriate RAAC surveys had been undertaken and confirmed the absence of RAAC within the Trust's estate.

	required) based on the current configuration of the estate, and to inform a financial model for required revenue support.		
3	Management should review and confirm the accuracy of published backlog maintenance data by consultation with NWSSP: Specialist Estates Services.	*2*	Medium
4	The Trust should review the risk categorisation within the EFPMS and engage with NWSSP: SES to ensure consistency in approach when applying risk categories to the estate backlog maintenance figures.	*2, 6*	Medium
5.1	The Trust should engage with NWSSP: SES to ensure that the survey approach is appropriate noting the need for a consistent all Wales assessment of the estate.	*2*	Medium
5.2	Planned disposals should be removed from backlog maintenance data in accordance with guidance.	*2*	Medium
6	Management should report progress e.g., annually, against backlog maintenance and estate investment targets to an appropriate forum (e.g., Finance and Performance Committee), including funding variances and forecast variances to targets.	*3,4,5*	Medium
7.1	The Estates Strategy should be updated to provide a funded target solution separately to eliminate "high and significant" and overall backlog maintenance profiled by year.	*4*	High

7.2	Revisions to the Estates Strategy should include performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	*4*	Medium
8	Statutory, "high", and "significant" risk backlog maintenance that remains unaddressed by investment proposals should be appropriately profiled at the corporate risk register and reported to management for acceptance and approval / implementation of mitigating actions.	*6*	Medium
9	Management should confirm to Welsh Government via appropriate surveys the absence or extent of Reinforced Autoclaved Aerated Concrete (RAAC).	*6*	Medium

Future Assurance Matters[2]		Assurance Objective	Priority
2.2	Future estate workforce reviews should acknowledge the refreshed Estates Strategy ensuring that it adequately reflects any delays in the associated investment programmes informing the capacity, skill set and future requirements of the service.	*4*	Medium

[2] Future assurance matters are for management action at future (appropriate) projects. Noting current action cannot be taken, the Audit Committee is requested to exclude from the audit tracker and the matters arising included in this report for management information. They have, however, been taken into consideration when determining the assurance rating at this report.

1. Introduction

1.1 This audit forms a part of the 2023/24 operational plan agreed with the Trust.

1.2 The audit was undertaken to evaluate the processes and procedures put in place by the Trust to support the management, condition, and performance of the estate.

1.3 The effective and efficient management of the NHS Wales estate is essential for the delivery of quality health care services.

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

- The Board may be unaware and/ or may not be adequately informed to effectively assess and manage the risks associated with backlog maintenance (particularly statutory requirements);
- Appropriate funding may not be in place;
- The status and value of backlog maintenance may not be adequately defined, and the probability and impact may not be fully understood;
- Information may not be interrogated to ensure focus is prioritised on the key risks; and
- Performance in addressing identified priorities may not be monitored, potentially impacting organisational objectives.

1.5 The Estates and Facilities Performance Management System (EFPMS) records a range of estates measures including:

- Function and space of assets;
- Age of assets;
- Quality of Buildings; and
- Estates Maintenance.

1.6 Within the Quality of Buildings section, the total estate backlog figures were categorised on a risk basis, based on national guidance i.e. ranging from High, Significant, Moderate to Low risk.

1.7 The EFPMS enables the Trust to submit an annual declaration on key data to Welsh Government. The Trust reported position over the last three years, against NHS Wales averages, was as follows (also showing targets of the Trust Estates Strategy):

Table 1

	Estates Strategy Target	2019/20	2020/21	2021/22	2022/23
Trust Cost to eradicate High Risk Backlog (£)	Eliminate	2,419,647	2,465,575	667,468	283,153
Trust Cost to eradicate Significant Risk Backlog (£)	Eliminate	5,819,905	5,871,468	2,855,208	3,669,780
Trust Total Backlog Cost (£)	Eliminate	12,559,894	12,596,981	10,629,409	7,288,001
NHS Wales average: Total Backlog Cost (£)		78,098,898	97,385,329	113,007,158	
Trust Risk Adjusted Backlog Cost (£)		9,758,028	7,759,073	7,184,233	4,649,810
Trust Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)		17.27	24.91	28.48	
NHS Wales average: Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)		23.86	27.43	28.77	

1.8 The WAST EFPMS Data for 2022/23 had not been fully compiled at the time of the audit, and all Wales figures had yet to be published.

1.9 Additional estate performance data across NHS Wales is presented at **Appendix B,** taken from the NHS Estate Dashboard Report for 2021/22 (published by NWSSP: Specialist Estates Services).

1.10 Our audit work was reliant on the above information. We have not sought to provide assurance over the accuracy of supplied information; however, we have commented within the body of this report on the consistency in approach with other NHS Wales Organisations.

2. Detailed Audit Findings

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

Governance: *To obtain assurance that robust governance arrangements were applied to ensure the organisation stays abreast of matters and associated risks relating to the estates condition.*

2.2 Effective governance was in place, with structures ensuring that the Trust's Executive Board was appropriately informed. This oversight included Non-Executive Directors.

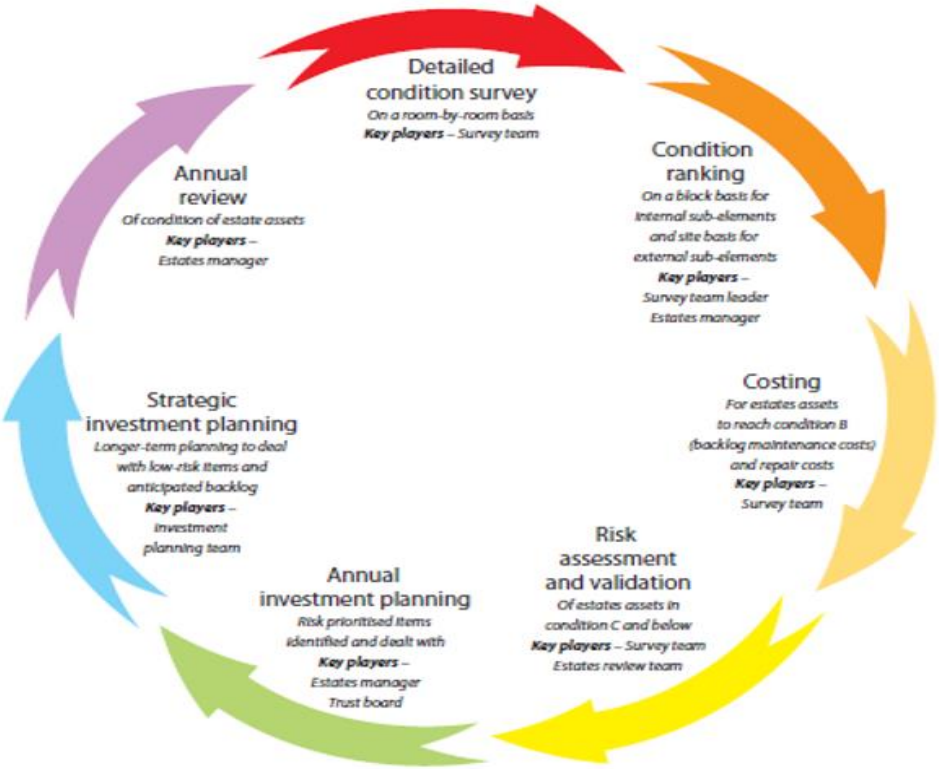
2.3 The Estates Strategy indicated that the Executive Director of Finance & Corporate Services *"will act as formal programme sponsor and will ensure that the programme meets its overall objectives and delivers its expected benefits"*. WHEN 07-02 additionally requires a designated Board lead for technical Estates matters. However, the nominated person as recorded at the NWSSP: SES "Health Board and Trust Designated Persons" list is currently the Assistant Director of Capital & Estates (not a Board attendee) (**MA 1**).

2.4 The allocation of capital/estate responsibilities to an appropriate Non-Executive Director to champion estates issues has additionally been recommended for consideration (**MA 1**).

2.5 Sound decision making is predicated upon the quality of management information and these matters are further considered at subsequent sections of this report. Noting these matters, **reasonable assurance** has been determined in relation to project governance.

Baseline information: *To obtain assurance that the Trust has detailed assessments of the condition of the estate based on a combination of robust condition surveys and risk assessments. The information was managed and retained within robust management systems that are subject to regular review.*

2.6 The extant guidance in relation to assessing backlog maintenance: '*A risk-based methodology for establishing and managing backlog,'* (updated March 2013) describes the steps involved in establishing and managing backlog, as follows:



2.7 In respect of the detailed condition survey, the guidance recommends that[1]:

> *"NHS organisations carry out a detailed survey of their assets on a five-yearly basis[1]."*

2.8 A six-facet survey of the estate was conducted in 2021, in accordance with the above guidance. This provided management with a detailed, risk-assessed picture of the condition of the estate and compliance with statutory / mandatory requirements (e.g., fire safety), along with the indicative costs for undertaking the remedial works.

2.9 The remit and associated caveats for the six-facet survey were not provided, limiting associated assurance as to the robustness of its data. It is understood that the WAST survey was non-invasive, a fact which has significantly limited the robustness of data across Wales. However, it is recognised that the infrastructure at the WAST is less complex than in clinical/acute hospital settings. Management have commented that for WAST there were few access limitations, such as full access to server rooms, clinical contact centres, and roof voids.

2.10 However, some data anomalies were evidenced at EFPMS returns at percentage compliance figures. There was therefore a need to ensure data accuracy (**MA 3**).

2.11 Additionally, noting differences in approach to inflation, surveys, interim updates, and risk categorisation across Wales, this has resulted in inconsistencies in EFPMS figures between different health bodies. To appropriately benchmark and compile consistent data, health bodies would therefore benefit both from peer review and consultation with/advice from NWSSP: Specialist Estates Services (**MA 4**).

2.12 It is important that the baseline of the six-facet survey is kept up to date to enable effective monitoring, reporting, and investment planning. The guidance recommends that:

> *"You should update the findings of your detailed survey on an annual basis. This will inform your investment planning process and ensure your assets are safe and fit for purpose.4*

2.13 While management advised that interim updates were undertaken, a robust methodology for delivering the same was not evidenced (i.e., to demonstrate accordance with NHS guidance). Recent increases in "high and significant" backlog had been attributed to "better intelligence" (**MA 5**).

[1] A risk-based methodology for establishing and managing backlog (publishing.service.gov.uk) (Applies in Wales)

2.14 Whilst recognising the need to confirm accurate data the six-facet survey undertaken in 2021, and the simple nature of the estate, **reasonable assurance** has been determined in relation to the baseline information.

Estates strategy: *To obtain assurance that a tailored estates strategy was in place including linkage to major investment, estates condition, statutory compliance, decarbonisation requirements, service needs etc. The strategy also reflected emerging risks.*

2.15 It is important that long term Estates strategies are re-evaluated for on-going applicability and sustainability.

2.16 Health Building Note 00-08 'Estatecode' (2018) highlights that:

> *"Once a comprehensive analysis of the condition and performance of the existing estate has been completed, the organisation will have the baseline data used when developing an estate strategy.*
>
> *An estate strategy should .. provide the strategic framework for the provision of an efficient, sustainable and fit-for-purpose estate that is both safe and secure... improving efficiency and rationalising occupancy whilst reducing ongoing revenue and capital commitments.*
>
> *The estate strategy should be reviewed annually using EFPMS data and the information from the five-facet survey. The clinical strategy should be the driver of the estate."*

2.17 The Trust's Estates Strategy (a 10-year Strategic Outline Programme - SOP) was endorsed by Welsh Government in 2017 outlining a proposed 10-year capital investment programme.

2.18 This was informed by a Demand & Capacity review, providing a strategic framework for the development of services and associated estate (including backlog maintenance) requirements. This updated an earlier SOP delivered in 2013, and in turn, was further refreshed in 2021 in accordance with good practice (also noting the intervening Covid emergency, and availability of capital, impacting on planning).

2.19 The SOP also contained a backlog target, and an associated ten-year investment plan. Key amongst these was the aim that "*current backlog maintenance will be largely eliminated and there will be a planned preventative maintenance regime to ensure properties are maintained to appropriate standards*". However, the strategy primarily addressed service reconfiguration rather than specifically detailing the resultant backlog reduction.

2.20 The 2017 SOP required £89m investment over 10 years, increasing to £107m at over 10 years at the 2020/21 re-fresh. (Management have stated this to be due to both inflation and an increased footprint in the estate for Covid social distancing).

2.21 It was not evident whether this additional requirement arose from lack of funding in the earlier years, or from additional service needs (**MA 6**).

2.22 However, the total funding received from Welsh Government (against the SOP required investment above) was not reported at SOP updates, as these only reported forward planning. This impeded understanding of the increased capital investment requirements.

2.23 Data published at the Estates and Facilities Performance Management System showed the WAST as the lowest ranked health body for functional suitability & condition of the estate.

2.24 Partly as a result of disposals and capital investment, the WAST had made positive inroads into its estates backlog to 2021/22.

2.25 However, as of 2022/23, while overall backlog has continued to reduce, "high" and "significant" risk backlog maintenance is now increasing, and the effective implementation of the Estates strategy has therefore stalled. This matter is further considered within the Funding Strategy section below.

2.26 The Estates Strategy itself represents a comprehensive assessment of targeted service reconfiguration with clear objectives, supported by detailed and dynamic investment / divestment plans. However, noting the need for an associated backlog strategy, supported by accurate data, **limited assurance** has therefore been determined in relation to backlog Estates Strategy.

Funding strategy: *To obtain assurance that there was a co-ordinated approach to the targeting of All-Wales, Estates Funding Advisory Board (EFAB) and Discretionary funding to implement the estates strategy.*

2.27 There has been historical under-investment across Wales in this area, resulting in a deterioration of the NHS estate condition. The cost of the Trust's backlog maintenance was estimated at £13.6m in 2017/18.

2.28 As at ***Table 1***, as of 2022/23, backlog stood at £7,288,001 – almost halved from prior levels.

2.29 The Trust has published detailed funding plans, drawing on both Welsh Government and discretionary finance.

2.30 More recently, this has been supplemented by the availability of EFAB funds, where a range of bids have been approved in the sum of £2.18m (relating to works to address fire safety, infrastructure, and decarbonisation). This evidenced appropriate review and consideration of funding options.

2.31 The 2017 SOP required over £89m investment to maintain an effective estate. As from 2020/21 (year 4) this assessment was refreshed and increased to £107m for the next ten years (including £67.5m reliant on WG discrete approvals of capital business cases, and the remainder from discretionary allocations).

2.32 The endorsement of the SOP, however, is not a commitment to expenditure by Welsh Government, which would be subject to the submission and approval of

individual business cases - assessed against other competing NHS investment priorities across Wales. There remains therefore a material risk that the Estates Strategy and capital investment plan was unaffordable, noting the current financial climate and considering total funding requirements across NHS Wales

2.33 As previously noted, the total funding received from Welsh Government was not reported at SOP updates, as these only reported forward planning (**MA 6**).

2.34 The Trust's total backlog has reduced over the period 2019/20-2022/23 (see **Table 1**). This reduction has primarily been achieved though the disposal and rationalisation of the Trust's older estate i.e., 8 of a potential 28 sites across Wales disposed of during the period – driven by a more efficient hub and spoke service re-configuration; co-location with service partners; and regional centralisation of the non-operational premises.

2.35 The delivery of the Trust's Estates Strategy (including to "*largely eliminate*" backlog maintenance requirements) will require continued capital investment and support from Welsh Government.

2.36 The Estates Strategy currently plans the disposal of a further 20 sites, and over the next three years targeted £67.374m of investment. Excepting annual funding of circa £4m from discretionary allocations, approvals for such spending were not in place. There was therefore a need to match funding against backlog reduction within a revised Estates Strategy. Revisions to the Estates Strategy should also include maintenance targets to avoid future escalation (**MA 7**).

2.37 The Estates and Facilities Performance Management System (EFPMS) is an annual return that the Trust makes to Welsh Government; a part of this return categorises the "Total Building & Engineering Maintenance Cost per Occupied Floor Area" over recent years as highlighted below.

Table 2

Measure	2019/20	2020/21	2021/22
Trust Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	17.27	21.41	28.48
NHS Wales average: Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	23.86	27.43	28.77

2.38 Subject to the accuracy of the above, when compared to 2019/20 reported figures, the Trust's expenditure now aligns with national averages of spend per occupied floor area. However, whilst recognising the simpler WAST estate (e.g., offices, and ambulance depots etc., compared to acute hospital sites), the Welsh average level of investment has been insufficient to prevent a deterioration in the condition of the NHS estate across Wales.

2.39 Local and national resource constraints are a theme across Wales. At the time of the current review, the Trust was carrying vacancies within its Estates staffing establishment. A resource plan was required to provide assurance relating to the future demands of the service (e.g., to effectively identify and address backlog) (**MA2**).

2.40 An appropriate range of funding had been utilised, deriving from an endorsed investment strategy. However, at the most recent data "high and significant" risk backlog had increased, similarly required investment to address the same had increased. There remains a material risk that the Estates Strategy and capital investment plans are unaffordable, and that backlog will again increase. Noting the absence of a funded strategy to reduce / eliminate backlog maintenance, the audit therefore concluded **limited assurance** in respect of the funding strategy.

Monitoring and reporting: *To gain assurance that appropriate management information was presented with regularity on key issues, including the estate condition and progress to implement the estates / funding strategy. Monitoring and reporting included an assessment of the success of the combined strategies in improving estates condition (and reducing risk exposure), and confirmation that expenditure of funding was in line with agreed conditions.*

2.41 The Estates Strategy (Strategic Outline Programme – SOP), was approved by the Trust Board in March 2017, and endorsed by Welsh Government in August 2017.

2.42 An updated SOP was submitted to the Trust Board in March 2021, though the associated approvals / endorsement by the Trust Board and Welsh Government respectively, were not evidenced.

2.43 This provided a prioritised plan to address Estate's needs. Key reporting included a periodic update of the Estates Strategy, with associated updates and approval of a medium-term plan, and annual discretionary programme.

2.44 Formulation of these matters was via the Estates (SOP) Delivery Group, with a review by the Capital Management Board and oversight and approval by the Finance and Performance Committee.

2.45 While the Estates Strategy contained targets, there was a need for variance reporting of associated outcomes. As highlighted previously, there was also a need to report funding variances of prior years within the SOP, in addition to re-calibration of the forward plan (**MA 6**).

2.46 While recognising the reduced need for formal reporting relevant to the size/nature of the organisation, the 2021 SOP update represented the only formal reporting relating to backlog maintenance requirements identified since 2017.

2.47 A key facet within the SOP impacting on backlog has been disposals of older properties. However, the level of backlog maintenance associated with these was

not reported. Similarly, the impact of investments (e.g., whether service enhancements, or replacements of older estate), was not identified.

2.48 However, it is recognised that reporting to the Executive is risk based. Additionally noting that management were well informed of risk backlog via EFPMS data, **reasonable assurance** has been determined in relation to monitoring and reporting.

Risk management: *To obtain assurance that risks were appropriately logged and escalated through the corporate risk reporting arrangements. The risk exposure of the Trust in relation to estates condition was clearly reported.*

2.49 The 2021 survey provided overall totals for each risk priority. Following the categorisation of backlog maintenance requirements into "high", "significant", "moderate" and "low", associated risk scores were utilised as part of a wider risk assessment. This included scoring of strategic fit (e.g., with the Welsh Government approved demand and capacity review), in accordance with best practice. This facilitated the objective assessment of the best organisational investment / divestment choices.

2.50 However, the resultant statutory, "high" and "significant" risk backlog left un-addressed by such decisions was not reported. While the corporate risk register has included certain issues, there was the potential for a further review following a re-appraisal of estates risks. There was also a need to assess the holistic estates backlog maintenance risk position (**MA 8**). Management have commented, that for context, in line with (**MA 4**) above, that following re-appraisal of risk ratings, few or no "high" or "significant" risk items may remain. They also noted that backlog had almost halved since 2019/20, and as such would not have a high corporate profile.

2.51 It is important that management understand both unaddressed statutory maintenance and potential single points of failure (**MA 4** & **8**). As such, it was noted that the WAST included items such as leaking skylights within non-critical areas as "high" risk backlog. In the context of having no in-patient facilities, and comparability of data with Health Boards, it is therefore recommended that the WAST seek guidance and review their risk prioritisation. This could provide scope for further reduction in the "high" and "significant" risk backlog figures (**MA 4**).

2.52 At the time of audit, there was also a need to conclude reporting to confirm initial conclusions that the Trust does not have Reinforced Autoclaved Aerated Concrete (RAAC) (which can cause structural issues over time) (**MA 9**). This matter was addressed subsequent to audit fieldwork.

2.53 The recent reduction in the profile of backlog risks is therefore recognised. However, noting limited reporting of residual risks, including "high" priority (and potentially statutory) issues, **limited assurance** has currently been determined in relation to risk management.

Appendix A: Management Action Plan

Matter Arising 1: Non-executive scrutiny and challenge (Design)	**Impact**
NHS Wales utilises both expert Non-Executive Directors and Board leads as key elements of its governance and scrutiny arrangements. Welsh Health Circular (WHC/2021/002) issued in January 2021 (expiry/review date of March 2023), discontinued the role of the estates board champion. At the time of reporting, there had been no update issued in line with timescales. However, whilst noting the above, in the period since 2021 the profile of the NHS estate has increased significantly at a national level. Through our thematic reviews undertaking throughout NHS Wales, good practice has been evidenced within other organisations; where Non-Executive Directors or Independent Members had been specifically allocated areas of representation associated with capital and estates. Capital Planning was progressed via a Capital Management Board – with assigned responsibility for the implementation of the Estates Strategy. There was onward accountability to the Finance and Performance Committee led by the Executive Director of Finance & Corporate Services (DOF) – with assigned responsibility for delivery of the Estates Strategy. While this committee also included expert scrutiny, it did not include a Non-Executive Director with specialist estates and capital management knowledge (to champion estates matters). All Wales guidance (WHEN 07-02) requires that the lead for technical Estates matters be a designated Board member. However, NWSSP: SES has been notified that this role rests with the Assistant Director of Capital & Estates (as per the "Health Board and Trust Designated Persons" list - see extract at **Appendix C**).	Potential risk that: • The programme is not appropriately scrutinised and challenged.
Recommendations	**Priority**

1.1 Management should consider the advantages and disadvantages of specialist capital expertise provided by a Non-Executive Director to oversee the capital programme.	**Medium**
1.2 The Trust should advise NWSSP:SES that the "designated person" will be re-allocated to an appropriate Board member in accordance with WHEN 07-02.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
1.1 Noted. The capital programme is overseen by the Capital Management Board and reported to the Finance and Performance Committee where both non execs and executive directors attend. Further consideration may be undertaken in relation to a NED champion role on the Board if such an opportunity arises but, noting that this is not a mandatory requirement, and the alternative assurances provided as to the scrutiny and oversight of such matters undertaken at committee and board level, it is not deemed required or indeed feasible at this stage.	Already completed	N/A
1.2 Designated named persons will be updated to appropriate board members.	31st December 2023	Assistant Director of Capital & Estates

Matter Arising 2: Resource (Operation)	**Impact**
In April 2022, the Welsh Government Deputy Director of Estates and Capital Planning, wrote to all Heads of Estates across Welsh Health Bodies to assess the adequacy of Estates resource. This letter particularly referenced a desire to reduce outsourcing, stating: "*The central intention is to keep NHS Wales as a public service and to only outsource contracts and services when there is no in-house alternative or where there is a time limited job that requires specialist input to be completed*". Appropriate staffing levels are required to ensure the on-going assessment and maintenance of the estate (in accordance with WG guidance). The need includes not only the assessment of staffing numbers and grades, but of an adequate range of specialisms to assess and address the various aspects of backlog maintenance (e.g., fire, water, asbestos, and medical gas safety). Any new or refurbished estate is likely to deteriorate in the future without a change in the level of investment. An inadequate internal maintenance resource can contribute to an increasing backlog position i.e., reduced ability to address reactive and planned maintenance. The WAST initiated a re-appraisal of required roles within the Capital Development and Estates departments in March 2021. This identified the need to increase staffing from 11 to 16 whole time equivalent staff e.g., including the need for environmental officers. However, as of April 2023, three roles remained un-filled, including a facilities officer, and an estates compliance officer. The need for a decarbonisation specialist was also subsequently identified but was yet to be appointed. An initial £67m investment was targeted within the first three years of the current Estates Strategy. However, this had not been secured (**MA 7**). Any review of associated maintenance staffing requirements would need to consider the impact of the same.	Potential risk that: • The programme is not appropriately resourced.

The Trust therefore has challenges in recruiting and retaining skilled labour to enable effective estates service provision and meeting the needs and risks of an aging property portfolio (noting restricted investment). Noting these matters, and the dynamic nature of estates management and the regulatory environment, there is therefore an on-going requirement to refresh the assessment of future estates requirements (including skills, qualifications, and in-house versus contracted out provision).		
Recommendations		**Priority**
2.1 The adequacy of the existing Capital Development & Estates workforce will be affirmed (in terms of capacity and associated skill sets required) based on the current configuration of the estate, and to inform a financial model for required revenue support.		**Medium**
Future Assurance 2.2 Future estate workforce reviews should acknowledge the refreshed Estates Strategy ensuring that it adequately reflects any delays in the associated investment programmes informing the capacity, skill set and future requirements of the service.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 Agreed. And due to the completion of a recent OCP, this has already been undertaken	Already completed	N/A
2.2 Agreed	N/A	Assistant Director of Capital & Estates

Matter Arising 3: Data accuracy (Design)	**Impact**
Backlog is defined as the value of the estate falling below category "B". However, several key indicators of the estate, including the percentage below category "B" had not changed in recent years despite considerable reduction in declared backlog (as published at the Estates and Facilities Performance Management System), returned to Welsh Government annually (***Table 1***). These figures also declared that only 48% of the estate was in a compliant physical condition. The remaining 52% of the value of the estate therefore was not compliant. This would indicate that the backlog maintenance figure should be much higher than the £10,629,409 published. Management advised that in the case of this Key Performance Indicator (KPI), a building was recorded as deficient where it contained defects e.g., where £10 - £30k backlog maintenance applied, the entire value of the building was added to the value of the defective estate for purposes of the KPI. While noting there was no guidance for completion of the KPI's, this approach was not replicated across Wales, effectively meaning that EFPMS data was not comparable. There was a need therefore to confirm the accuracy of published data.	Potential risk that: • Data is inaccurate.

Recommendations	**Priority**
3 Management should review and confirm the accuracy of published backlog maintenance data with consultation with NWSSP: Specialist Estates Services.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
3 Agreed, however guidance will need to be sought from NWSSP to ensure accuracy of backlog maintenance for the unique ambulance service estate within NHS Wales. Action will be closed once such guidance is sought.	31st March 2024	Assistant Director of Capital & Estates

Matter Arising 4: Data consistency – All Wales approach (Design)	**Impact**
In 2004, NHS Wales published "*A risk-based methodology for establishing and managing backlog*" (mandatory in Wales) as guidance for the consistent compilation of EFPMS data. The six-facet survey of the estate undertaken in 2021 resulted in a significant change in the percentage of the estate meeting acceptable physical compliance standards, while dropping from 82% to 65% in one year. There was also no consistent approach agreed across Wales relating to the uplift for inflation e.g., some NHS bodies have utilised professional estimates ranging from 3% to over 16%, while others have applied cost indices. Uplifts for fees, overheads and profits have similarly varied. At the WAST, while an uplift to the works costs of 49% was applied, no addition was made for inflation (i.e., inflation was assessed at 0%). Management have advised that they have now secured professional estimates for works inflation at 3%, which would be applied to future data. The approach to risk prioritisation also varied across Wales, with some organisations assessing matters as high risk, where whole asset classes had reached the end of their useful life, while others took account of the ability to safely maintain its condition (in accordance with guidance). Other examples of "high risk" areas across Wales, included, lack of expert staff to undertake assessments, and at the WAST included leaking skylights in non-critical areas. There was also a need for some health bodies (including the WAST) to remove estate areas where there were approved plans for disposal within five years (in accordance with guidance). Additionally, the completion of Key Performance Indicators such as Physical Condition did not seem to be completed on a consistent basis within backlog data. Associated guidance was not available. Current guidance would indicate the prioritisation of single critical points of failure which cannot be readily recovered. It was not evident that any of the identified "high" risk backlog items would present such a risk to continuity of operations. In the event of these being present, they should be included within a business continuity / disaster recovery document.	Potential risk that: • Backlog data is inaccurate. • Backlog figures are not comparable across Wales.

These matters therefore raise questions as to the comparability of figures across Wales. However, it is recognised that the nature of the WAST estate may be simpler, and easier to survey than many of the Health Boards, and that both "high" risk and overall backlog figures may not be materially impacted by these adjustments.		
Recommendations		**Priority**
4 The Trust should review the risk categorisation within the EFPMS and engage with NWSSP: SES to ensure consistency in approach when applying risk categories to the estate backlog maintenance figures.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
4 Agreed, however again guidance will need to be sought from NWSSP to ensure risk categorisation within EFPMS is appropriate for the unique ambulance service estate within NHS Wales. Action will be closed once guidance is sought.	31st March 2024	Assistant Director of Capital & Estates

Matter Arising 5: Annual update (Design)	**Impact**
In 2004 NHS Wales published "*A risk-based methodology for establishing and managing backlog*" (mandatory in Wales). This recommended a six-facet survey every five years, and that "y*ou should update the findings of your detailed survey on an annual basis".* A six-facet survey of the estate was conducted in 2021. However, the remit and associated caveats of this survey were not provided, limiting associated assurance as to the robustness of its data. Across Wales, surveys at some other health bodies have been heavily caveated, notably as to their non-invasive nature, meaning that significant sums relating to e.g., mechanical, electrical, and asbestos issues may not have been assessed. While the infrastructure at the WAST is less complex than in acute hospital settings, it is understood that the WAST survey was also non-invasive, similarly qualifying the resultant data. Management advised that interim updates of the survey (backlog) data by Trust Estate's staff included the removal of estate disposals and the addition of items notified as requiring maintenance (though these systems were not evidenced/tested at this audit). At other health bodies, the approach to interim updates was typically more pro-active and variously included: • the addition of items at the end of their useful life & no longer serviceable; and • rolling surveys of the full estate (typically targeted at older / higher risk estate). However, there was a need to confirm the effective update of surveys (as outlined above and in accordance with NHS guidance). There was also a need to remove redundant Estate from the backlog maintenance data i.e., where there were agreed disposal plans (in accordance with national guidance). However, it is recognised that the 2021 survey did not result in any material amendments to previously published figures.	Potential risk that: • Backlog is not appropriately recognised.

Recommendations		Priority
5.1 The Trust should engage with NWSSP: SES to ensure that the survey approach is appropriate noting the need for a consistent all-Wales assessment of the estate.		**Medium**
5.2 Planned disposals should be removed from backlog maintenance data in accordance with guidance.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
5.1 Agreed, noting that the service followed the six-facet approach to ascertain the condition of the estate, engagement is therefore required with NWSSP to further highlight the unique ambulance estate within NHS Wales. Action will be closed once this is done.	31st March 2024	Assistant Director of Capital & Estates
5.2 Agreed.	Already Completed	N/A

Matter Arising 6: Delivery - reporting (Operation)	**Impact**
A Strategic Outline Estates Programme was submitted to and endorsed by Welsh Government in August 2017. This targeted capital investment of circa £89m over 10 years (with £35m targeted by year 3). This was aimed largely at providing an enhanced service model, but also with the stated intention eliminate backlog maintenance requirements. The endorsement of the programme, however, was not a commitment to expenditure/funding by Welsh Government. Approved funding would be subject to the approval of individual business cases submitted by the Trust and would be assessed against competing NHS priorities across Wales. The updated SOP produced in 2021, included increased capital investment requirements revised to £107m for the next ten years (including £67.5m subject to the submission and approval of capital business cases via Welsh Government, and the remainder from discretionary allocations). The updated SOP did not provide an assessment of the increased investment requirements compared to the original SOP (and / or interim investment received) - variances between budgeted and approved funding were not profiled. Reporting could also usefully include inflationary adjustments, reductions due to direct/indirect investment, benchmarking information, newly discovered backlog maintenance.	Potential risk that: • The programme is not effectively monitored.

Recommendations	**Priority**
6 Management should report progress e.g., annually, against backlog maintenance and estate investment targets to an appropriate forum (e.g., Finance and Performance Committee), including funding variances and forecast variances to targets.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
6 Agreed, backlog maintenance will be reported through the Finance & Performance Committee annually in line with the EFPMS submission.	30th June 2024	Assistant Director of Capital & Estates

Matter Arising 7: Estates Strategy - update (Operation)	**Impact**
The current Estates Strategy (a 10-year Strategic Outline Programme – approved by the Trust Board in March 2021) included plans for circa 20 capital investment schemes requiring additional Welsh Government funding, typically averaging circa £3.4m each. Together with discretionary funding (circa £4m p.a.) this required £107m of investment. The plans included closure of over 20 premises (which would reduce backlog maintenance requirements). Planned funding over the next 3 years was profiled as: **(£'m)** / **2022/23** / **2023/24** / **2024/25** / **Three year total** Total funding / 22.932 / 22.501 / 21.941 / **67.374** Excepting discretionary allocations, the above would require additional funding approvals from Welsh Government of circa £18m p.a. No such approvals were in place for 2022/23 funding, and business cases were not funded or in progress for 2023/24 and 2024/25. The Estates Strategy did not therefore represent a funded programme to address Estate's needs. Revisions to the Strategy could usefully include measures that the Trust would put in place to ensure refurbished buildings are maintained in the future, thus, ensuring that any future backlog maintenance can be managed appropriately.	Potential risk that: • The Estates strategy does not match funding to backlog reduction targets.
Recommendations	**Priority**
7.1 The Estates Strategy should be updated to provide a funded target solution separately to eliminate "high and significant" and overall backlog maintenance profiled by year.	**High**

7.2 Revisions to the Estates Strategy should include performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
7.1 Agreed, a refreshed Strategic Outline Programme is required upon receiving guidance from NWSSP as detailed within recommendation 4.	30th September 2024	Assistant Director of Capital & Estates / Head of Capital Development / Head of Financial Business Intelligence & Capital Planning
7.2 Agreed, noting that this would form part of managing facilities and through pre planned maintenance contracts to ultimately reduce high and significant backlog maintenance.	30th September 2024	Assistant Director of Capital & Estates / Head of Estates and Facilities Management / Head of Financial Business Intelligence & Capital Planning

Matter Arising 8: Risk reporting (Design)	**Impact**
The Trust has a defined Risk Management and Board Assurance Framework which provides guidance on the management of strategic and operational risks within the organisation (as reported to the Board in March 2023). While Estates risks were not included within top Trust risks, this assessment pointed to linkage with the Intermediate Medium-Term Plan and associated Estates Strategy (which in turn was informed by supporting risk assessment from the 2021 Survey of the Estate). Following the categorisation of backlog maintenance into "high", "significant", "moderate", and "low", associated risk scores were utilised as part of a wider risk assessment. This included scoring of strategic fit (e.g., with the demand and capacity review), in accordance with best practice (as part of the approved Estates SOP refresh). This facilitated the objective assessment of the best organisational investment / divestment choices. However, internal reporting did not highlight or summarise the "high" and "significant" risk backlog maintenance not being addressed by these options. The deferment of "high" and "significant" backlog maintenance to future years, should be an objective choice, with associated risks owned by the Board. Similarly, any deviation from the approved SOP Estate's Strategy (targeting the elimination of backlog maintenance across a ten-year period), should be approved in the manner as the original strategy. It is also important that management understand both statutory maintenance that remains un-addressed and potential single points of failure. Key remaining risk issues should be reflected within the corporate risk register. While the corporate risk register has included certain issues, there was potential for review following a re-appraisal of the estate's risks. Management have commented, in line with **MA 4** above, that it is recognised that there are differing views on what constitutes "high" risk, and that more guidance would be welcome. Accordingly, for context, few or no "high" or "significant" risk items respectively may remain following such re-assessment.	Potential risk that: • Management is not sighted on accepted risks. • Annual investment decisions are contrary to approved strategy.

Recommendations		Priority
8 Statutory, "high", and "significant" risk backlog maintenance items that remain unaddressed by investment proposals should be appropriately profiled at the corporate risk register and reported to management for acceptance and approval / implementation of mitigating actions.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
8 As noted at **MA 4**, additional advice will be taken in respect of "high" and "significant" risk classifications, which may largely remove this issue. Further consideration of any residual reporting through the Corporate Risk Register will then be considered.	31st March 2024	Assistant Director of Capital & Estates

Matter Arising 9: RAAC (Operation)	**Impact**
Welsh Government have written to respective NHS Wales Chief Executives requesting confirmation of any issues relating to Reinforced Autoclaved Aerated Concrete (RAAC) at health premises. This type of concrete, common in floor and ceiling panels in prior decades of construction, has been assessed as having the potential to cause structural issues over time, requiring strengthening (e.g., via pillars), or replacement. At the WAST, it was not thought that RAAC was present at any of its properties. At the time of reporting management confirmed that this position had been assessed by a chartered surveyor, but remained subject to formal confirmation by a structural engineer in accordance with revised requirements issued by NHS Wales Shared Services: Specialist Estates Services (NWSSP: SES) on behalf of Welsh Government.	Potential risk that: • the assessment of backlog maintenance is mis-stated.

Recommendations	**Priority**
9 Management should confirm to Welsh Government, via appropriate surveys, the absence or extent of Reinforced Autoclaved Aerated Concrete.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
9 Actioned since audit fieldwork and ahead of the audit being completed A structural surveyor has now affirmed that appropriate surveys has been undertaken & Welsh Government have been advised that RAAC is not present within WAST buildings.	N/A	N/A

Appendix B: Estates Facilities Performance Management System (EFPMS)

NHS ESTATE DASHBOARD REPORT 2021/2022

HEALTH BOARD / TRUST ESTATE PERFORMANCE BREAKDOWN 2021/2022

National Key Performance Indicators

Percentage of the estate which is of reasonable standard and therefore falls within Estatecode category 'B'/'F' or above:

	Physical Condition (%)	Statutory & safety compliance (%)	Fire safety compliance (%)	Functional suitability (%)	Space utilisation (%)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	94	93	85	98	91
BETSI CADWALADR UNIVERSITY HEALTH BOARD	62	74	64	74	93
CARDIFF & VALE UNIVERSITY HEALTH BOARD	78	86	87	66	81
CWM TAF UNIVERSITY HEALTH BOARD	96	89	95	100	97
HYWEL DDA UNIVERSITY HEALTH BOARD	88	89	65	91	99
POWYS TEACHING LHB	67	80	72	71	86
SWANSEA BAY UNIVERSITY HEALTH BOARD	51	47	47	55	97
VELINDRE UNIVERSITY NHS TRUST	65	95	95	88	99
WELSH AMBULANCE SERVICES NHS TRUST	48	90	90	36	99

Backlog Maintenance Costs

...o be agreed

	High Risks (£)	Significant Risks (£)	Moderate Risks (£)	Low Risks (£)	Risk Adjusted Cost (£)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	37,754,428	16,518,352	45,488,017	49,807,323	98,296,321
BETSI CADWALADR UNIVERSITY HEALTH BOARD	91,809,773	142,498,091	68,658,155	45,421,260	239,955,528
CARDIFF & VALE UNIVERSITY HEALTH BOARD	32,033,876	85,487,856	28,777,072	5,537,518	101,262,019
CWM TAF UNIVERSITY HEALTH BOARD	31,261,530	31,963,352	22,345,412	1,519,250	64,046,747
HYWEL DDA UNIVERSITY HEALTH BOARD	0	89,509,339	9,432,673	6,802,904	90,679,218
POWYS TEACHING LHB	5,075,437	23,998,187	12,931,568	10,039,954	30,117,985
SWANSEA BAY UNIVERSITY HEALTH BOARD	9,057,000	46,516,759	41,835,883	4,598,390	56,464,069
VELINDRE UNIVERSITY NHS TRUST	139,220	1,894,312	5,002,211	2,719,910	1,875,521
WELSH AMBULANCE SERVICES NHS TRUST	667,486	2,855,208	3,170,304	3,936,411	7,184,233

The complete dataset upon which this report is based is accessible from the NHS Wales Shared Services Partnership - Specialist Estates Services intranet and internet sites

Appendix C: Contact Details for Health Board and Trust Designated Persons (extract)

CONTACT DETAILS FOR HEALTH BOARD AND TRUST DESIGNATED PERSONS **January 2023**
(AS DEFINED IN WHTM 00 AND REQUESTED IN FSN 12/05)

Health board and Trust Designated Persons are at **board level** with responsibility for one or more of the technical disciplines listed below as specified in the following guidelines:

WHTM 01 – Decontamination

HTM 02 – Medical Gases

HTM 03 – Heating and ventilation systems

W HTM 04 – Water systems

WHTM 05 – Fire safety

HTM 06 – Electrical services

HTM 07 – Environment and sustainability

HTM 08 – Specialist services

Trust	Designated Person	Discipline	Contact details
Welsh Ambulance Services NHS Trust **Vantage Point House** **Vantage Point Business Park** **Ty Coch Way** **Cwmbran** **NP44 7HF**	Mr Richard Davies *Assistant Director of Capital & Estates*	All services except for: *Decontamination* and *Specialist Services*	Richard.Davies16@wales.nhs.uk Tel: 01633 626228

Appendix D: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Archwilio Cymru
Audit Wales

Audit Committee Update – Welsh Ambulance Service NHS Trust

Date issued: November 2023

Document reference: 3765A2023

This document has been prepared for the internal use of the **Welsh Ambulance Service Trust** as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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Contents

Audit Committee update:

About this document 4

Accounts audit update 4

Performance audit update 5

Good Practice events and products 7

NHS-related national studies and related products 8

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
2022-23 Independent Examination of the Charitable Funds' Financial Statements	The Independent Examination of the Charity's annual report and accounts is due to start at the beginning of December with the intention of certifying and filing before the Charity Commission deadline of 31 January.
Audit of the 2022-23 Financial Statements	Audit work is complete, and our closing 'Audit of Accounts Report' has been issued. The accounts were certified by the Auditor General on 28 July 2023, and laid with the Senedd shortly afterwards.

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 or completed

Topic	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care	This work will examine different aspects of the unscheduled care system in three parts: • Part One: Flow out of hospital • Part Two: accessing unscheduled care • Part three: national arrangements and leadership structures.	Blog and data tool published in 2022 Part One: Drafting reports for each region Parts 2 and 3 to begin shortly.
Workforce planning	The review examined how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Complete. Reporting to Audit Committee in November 2023.
Structured Assessment 2023 - core	This work will review the following core areas: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and	Draft report issued to the Trust. Anticipated to be presented to Board in January 2024 and Audit Committee in March 2024.

Topic	Focus of the work	Current status and Audit Committee consideration
	• Corporate financial planning and management arrangements. This work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.	

Exhibit 3 – Planned work not yet started or revised

Topic	Focus of the work	Current status
Structured Assessment – deep dive into financial efficiencies	In addition to the core structured assessment work, we will also undertake "deeper dive" work in a specific area. We had initially identified digital transformation as the deeper dive topic for 2023. However, given the financial challenges facing the NHS at present, we are looking to now focus our deep dive work in health boards on financial savings / cost improvement plans. The focus of this work is currently being developed and further details will be shared in due course.	Not yet started. Fieldwork anticipated to begin in early 2024.
Follow up Review of Quality Governance Arrangements	This work will examine progress made in response to previous audit recommendations during the original review of quality governance arrangements, which was reported to the Audit Committee in September 2022.	Not yet started. Planned to begin in early 2024.

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 four Good Practice Exchange (GPX) events since we last reported to the Committee in September 2023, including on the theme of 'Digital Strategy'. The next events will be on 'Finance for the Future 2023' on 12 December 2023 and 'Active Travel' on 19 March 2024. Further details of future events are available on the GPX website.

NHS-related national studies and related products

6 The Audit Committee may 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 **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
NHS Wales Workforce data briefing	September 2023
Approaches to achieving net Zero across the UK	September 2023
NHS Wales Finances Data Tool	September 2023

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Archwilio Cymru
Audit Wales

Review of Workforce Planning Arrangements – Welsh Ambulance Services NHS Trust

Audit year: 2023

Date issued: November 2023

Document reference: 3819A2023

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and Audit Wales are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

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

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

Contents

Summary report

Introduction 4

Key findings 5

Recommendations 7

Detailed report

Our findings 9

Appendices

Appendix 1 - audit methods 22

Appendix 2 – selected workforce indicators 24

Appendix 3 – organisational response to audit recommendations 30

Summary report

Introduction

1 An effectively planned workforce is fundamental to providing good quality care services. The NHS employs a range of clinical and non-clinical staff who deliver services across primary, secondary and community care, representing one of the largest NHS investments. Over the years there have been well documented concerns about the sustainability of the NHS workforce. And workforce challenges are routinely highlighted to us in our audit reviews and ongoing engagement with health bodies. Despite an overall increase in NHS workers, these concerns remain. The workforce gaps are particularly acute for certain professions such as GPs, nurses, radiologists, paediatricians and ophthalmologists (A Picture of Healthcare, 2021). In nursing alone, the Royal College of Nursing Wales reported 2,900 vacancies in their 2022 Nursing in Numbers analysis. In addition, the social care sector, is also facing its own workforce issues. These challenges have been exacerbated by the pandemic as the health sector looks to recover services.

2 Given the current challenges, robust and innovative workforce planning is more important than ever. Effective workforce planning ensures that both current and future services have the workforce needed to deliver anticipated levels of service effectively and safely. Planning is especially important given the length of time required to train some staff groups, particularly medical staff.

3 National and local workforce plans need to anticipate service demand and staffing levels over a short, medium, and long term. But there are a range of complex factors which impact on planning assumptions, these include:

- workforce age profile, retirement, and pension taxation issues;
- shifts in attitudes towards full and part-time working;
- developing home grown talent and the ability to attract talent from outside the country into Wales; and
- service transformation which can change roles and result in increasing specialisation of roles.

4 The Trust approved its 2023-26 People and Culture Plan in May 2023. The Trust is also developing a strategic workforce plan for the organisation to detail delivery which it is anticipating will be received by the Board in April 2024.

5 The key focus of our review has been on whether the Trust's approach to workforce planning is helping it to effectively address current and future NHS workforce challenges. Specifically, we looked at the Trust's strategic approach to workforce planning, operational action to manage current and future challenges, and monitoring and oversight arrangements. Operational workforce management arrangements, such as staff/nurse rostering, consultant job planning and operational deployment of agency staffing, fall outside the scope of this review.

6 The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

Overall, we found that **the Trust is taking effective steps to mitigate current workforce challenges and clarify its longer-term strategic vision, however medium to longer-term resourcing is a significant and ongoing barrier.**

Key workforce planning challenges

7 The Trust is facing significant workforce challenges. The workforce indicators presented in **Appendix 2** highlight that the Trust's workforce levels and costs have increased between 2017-18 and 2022-23. This included an increase in agency staffing, from £180,000 in 2018-19 to £1.7 million in 2021-22[1] which has since reduced and is significantly lower than Health Board agency spend. While vacancies are comparatively low, the Trust has seen higher than usual turnover and concerningly, for 67% of the staff who left the organisation in 2021-22, their reasons for leaving were stated as either unknown or other. A new process is due to be rolled out which aims to seek further clarity on the reasons for staff leaving. Noting that ambulance services tend to have higher sickness absence levels than other NHS organisations, the Trust has the highest percentage of sickness absence rates in Wales, which stood at 12.1% in January 2022, although this figure reduced to 8.2% in July 2023 levels increased in August 2023 to 9.2%.

Strategic approach to workforce planning

The Trust is strengthening its strategic workforce planning approach to address key risks and is effectively engaging with most stakeholders. However, it needs strengthen how it accesses and analyses workforce intelligence.

8 The Trust's strategic vision and plans focus on strengthening the workforce to overcome key current and future workforce risks. The Trust intends to strengthen its approach further by developing a strategic workforce plan for the organisation which it expects to complete by April 2024. The Trust has access to significant amounts of data which it uses to inform key decisions relating to its workforce. However, there is a need to better integrate IT systems to enable workforce data analysis and ensure its workforce establishment model is routinely updated. While the relationship between the Trust and its trade union partners is sometimes challenging, the Trust effectively engages with its staff, wider stakeholders and commissioners to provide assurance and develop workforce solutions.

[1] The Trust has indicated increased agency costs in 2021/22 to pandemic and system pressure-related factors, such as staffing to cohort patients outside of some Emergency Departments. This complicates spending comparisons with pre-pandemic levels. Agency use has subsequently decreased, with the Trust relying on alternative variable pay aspects, primarily overtime for employed staff, to support its capacity.

Operational action to manage workforce challenges

We found that The Trust is proactively addressing its workforce challenges, based on a strong understanding of risks. However broader workforce transformation is constrained by resource availability.

9 The Trust has invested in its workforce planning capacity and capabilities, such as by recruiting a head of workforce planning and transformation and developing workforce planning training for managers. The Trust will need to ensure that workforce planning training is realising the intended benefits. There is also a need to ensure consistent central support for recruitment activity across the Trust.

10 The Trust demonstrates a relatively strong understanding of the barriers and risks associated with implementing the strategic vision for its workforce. It is adopting a proactive approach to mitigate some longer-term and immediate challenges under its influence. For example, to overcome recruitment challenges. It is looking to introduce home working for nurses and raising the profile or paramedicine within universities.

11 While the Trust has costed its workforce plan through the development of its Integrated Medium-Term Plan (IMTP), it may require significant resource to fully achieve the significant transformation set out in its strategic vision. At the same time, the Trust currently holds substantial inefficiencies in its workforce due to handover delays caused by system pressures. It also finds securing ongoing additional investment from commissioners to build capacity challenging, and additional short term workforce funding can make recruitment and retention more difficult. To address these issues, the Trust will need to continue to work closely with its commissioners and Welsh Government.

Monitoring and oversight of workforce plan/strategy delivery

There is reasonable Board-level oversight of operational workforce challenges, but it is too early to judge the impact of delivering the People and Culture Plan.

12 The People and Culture Committee receive regular and comprehensive reports relating to the workforce. Information to the committee has been increasingly operational, however at the August 2023 committee, the Committee approved metrics and a data dashboard to help monitor the progress of strategic aims within the People and Culture Plan. The Trust will also need to ensure effective arrangements for monitoring progress of its strategic workforce plan, once approved.

13 External oversight by the Emergency Ambulance Services Committee (EASC)[2] ensures the commissioners understand the Trust's service workforce pressures. This helps to align commissioner's expectations, with available finance and workforce resource. The Trust has benchmarked its performance with other ambulance services however, this is not regular nor is it reported broadly within the organisation.

Recommendations

14 **Exhibit 1** details the recommendations arising from this audit. These include timescales and our assessment of priority. The Trust's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations
Terms of Reference R1 We found that the Terms of Reference for both the Integrated Technical Planning Group and the Forecasting and Modelling Group require review. The Trust should review these to ensure they are accurate and up-to-date, particularly to clarify what role they will play in supporting the new People and Culture Plan and developing strategic workforce plan. **(medium priority)**
Workforce information systems R2 We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that: • Systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems interconnect, where possible; **(medium priority)** • Explore ways to resource the management of a system to ensure an up-to-date establishment model. **(medium priority)**

[2] The Emergency Ambulance Services Committee (EASC) is Joint Committee of the seven health boards in Wales with the responsibility for planning and securing sufficient ambulance services for the population.

Recommendations

Evaluating workforce planning training

R3 We found that the Trust is strengthening workforce planning capability through training initiatives, but it will need to evaluate these to ensure they are having the desired impact. The Trust should develop an evaluation framework to measure the success of its training programme. **(medium priority)**

Recruitment support

R4 We found that only the emergency ambulance services department has dedicated support from the central management team for recruitment activity, due to capacity issues. While the central team can provide support on a case-by-case basis, the Trust should review opportunities to increase the corporate support offered to other departments across the organisation. **(medium priority)**

Metrics for Strategic Workforce Plan monitoring

R5 Once the Trust has developed its strategic workforce plan it should also ensure there is appropriate reporting of targets and milestones to enable the People and Culture Committee to monitor its progress. **(medium priority)**

Benchmarking

R6 The Trust does not routinely benchmark its workforce performance metrics with other health bodies in Wales. Its performance benchmarking with other ambulance trusts is infrequent. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice. **(medium priority)**

Detailed report

Our findings

15 The following three tables set out the areas that we have reviewed and our findings. These focus on:

- the Trust's approach to strategic workforce planning (**Exhibit 2**);
- operational action to manage workforce challenges (**Exhibit 3**); and
- monitoring and oversight of workforce plan/strategy delivery (**Exhibit 4**).

Exhibit 2: strategic approach to workforce planning

This section focusses on the Trust's approach to strategic planning. Overall, we found that **the Trust is strengthening its strategic workforce planning approach to addressing key risks and is effectively engaging with most stakeholders. However, it needs strengthen how it accesses and analyses workforce intelligence.**

What we looked at	What we found
We considered whether the Trust's workforce strategy and plans are likely to address the current and future workforce risks. We expected to see a workforce strategy or plan which: • identifies current and future workforce challenges. • has a clear vision and objectives. • is aligned to the organisation's strategic objectives and wider organisational plans. • is aligned to relevant national plans, policies, and legislation. Including the	We found that **the Trust is strengthening its strategic approach for the workforce through recently approved and developing plans which align to its strategic vision** The Trust's strategic vision entitled 'Delivering Excellence: Our Vision for 2030', describes the Trust's aim to become a more clinically-focussed organisation that reduces the need to convey patients to hospital by increasingly providing care closer to home. This overall aim, along with other ambitions within the strategic vision, are based on identified current and future workforce challenges, including staff wellbeing and support, and delays in treating patients due to system pressures. 'Delivering Excellence' appropriately recognises the workforce as a key enabler of this vision and identifies relevant supporting ambitions including transforming the Trust's education and training provision and protecting staff wellbeing. There is clear alignment between this vision and the Trust's

What we looked at	What we found
national workforce strategy for health and social care. • is supported by a clear implementation plan.	recently approved People and Culture Plan 2023-26 (the Plan) and Integrated Medium-Term Plan (IMTP) 2022-23. The Plan also appropriately aligns to key national policies including the national Workforce Strategy for Health and Social Care. The IMTP and People and Culture Plan contain deliverables and measures against the ambitions of Delivering Excellence, with a focus on improving Culture, Capacity and Capability. The Trust intends to review its People and Culture Plan, in addition to its statutory review and refresh of the IMTP, each year. The People and Culture Plan has an initial one-year focus which contains an ambitiously high number of actions (49). Organisational capacity, service pressures and financial constraints are amongst its risks to its delivery of its actions, which it is actively managing. At a service level, the Trust has developed transactional service-specific workforce plans. For example, the plan for the Emergency Medical Service (EMS) details monthly national projections for the emergency medical workforce up to March 2027. The Trust is developing a corporate-level strategic workforce plan to fill the gap between annual iteration of the People and Culture Plan and the longer-term strategic vision of 'Delivering Excellence'. The strategic workforce plan, which is being developed using the HEIW's six step method for workforce planning, will have a medium to long term focus and will be reviewed annually. The Trust's intention is that it will provide a basis for workforce modelling to deliver its strategic ambitions and is aiming for Board-level approval in April 2024.
We considered whether the Trust has a good understanding of current and future service demands. We expected to see: • use of reliable workforce information to determine workforce need and risk in the short and longer term; and	We found that **the Trust understands its current and future service demands, however there is opportunity to better integrate systems to help ensure that capacity and demand information and workforce establishment can be regularly updated** The Trust demonstrates that it seeks to understand its workforce capacity and demand and performance information. Between 2018 and 2022, the Trust commissioned demand and capacity reviews: one for Emergency Medical Services and one Non-Emergency Patient Transport Services,

What we looked at	What we found
• action to improve workforce data quality and address any information gaps.	and an additional capacity review for 111 operations. These reviews focused on understanding the level of resource required to meet expected levels of performance, including which staff groups should be expanded or decreased. The Trust incorporated the findings into its ongoing workforce planning and informed discussions with its commissioners. The Trust has effective approaches for interpreting workforce data. These include a weekly 'Forecasting and Modelling Cell' and a weekly Integrated Technical Planning Group. The former analyses and interprets forecasts for the operations teams and the latter analyses key data relating to workforce, estate, vehicle fleet, rosters, and financial planning. We found these groups provide helpful ongoing information within reports. For example, reports that contain information provided by the Integrated Technical Planning Group demonstrated comprehensive and thorough analysis which helped inform key decisions relating to workforce. However, the Terms of Reference for both these groups require review and update as some arrangements appear to have evolved since they were established **(Recommendation 1).** A review of the terms of reference for these groups would also provide an opportunity to set out their roles in supporting delivery of the newly approved People and Culture Plan and developing strategic workforce plan. While the Trust has not undertaken a skills gap analysis, it has conducted service reviews as part of its financial sustainability programme. These reviews focused on ensuring consistency of job roles to achieve efficiencies where possible. We understand that the Trust intends to use this to inform its understanding of skill mix and need going forward and will be key to discussions on job planning and recruitment. There is also scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. During interviews, we heard how managers within the organisation are not yet consistently providing data to the central team. We also understand that systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems are not effectively connected, therefore requiring resource intensive manual collation. In addition, while the Trust modelled its establishment for operational

What we looked at	What we found
	staff in 2022, the information was prepared at a single point in time and has not been kept up to date. Consequently, the Trust do not currently have up-to-date establishment information to support decisions relating to workforce **(Recommendation 2).**
We considered whether the Trust is working with partners to help resolve current and anticipated future workforce challenges. We expected to see: • effective and timely engagement and working with key internal and external stakeholders to tackle current and future workforce issues; and • shared solutions identified with key stakeholders to help address workforce challenges.	We found that **there are challenges with internal and external stakeholder engagement which the Trust is collaborating with partners to resolve** To inform its development of the People and Culture Plan, the Trust effectively engaged with staff, Trade Union partners, Non-Executive Directors and wider stakeholders, including peer Workforce and Organisational Development, and other UK ambulance services. Specifically in relation to training and qualifications, the Trust engages regularly with Health Education and Improvement Wales (HEIW) to explore opportunities to resolve key workforce challenges and support development. For example, the Trust worked with HEIW to develop apprenticeship schemes. The aim of this is to support career progression or those working in areas with high turnover within the Trust and to provide career opportunities and to develop skills and competencies. The Trust has dedicated forums to engage and inform its Trade Union partners, including through the Welsh Ambulance Services Partnership Team, and the Trade Union representatives that attend the People and Culture Committee and Board. At the time of fieldwork, those we spoke to recognised that relationships had come under strain due to recent industrial action. While we did not find any evidence that this was having adverse effects the time of our fieldwork, strained relationships could still present challenges. Nevertheless, senior leaders within the Trust and trade union representatives expressed eagerness to return to more meaningful engagement. As a commissioned organisation, the Trust engages with its commissioners to communicate key workforce challenges and needs and seeks to identify shared solutions. For example, Advanced Paramedic Practitioners receive the benefit of enhancing their skills through sharing their time between the ambulance service and primary care. Forums such as monthly meetings with the Chief

What we looked at	What we found
	Ambulance Services Commissioner and bi-monthly Emergency Ambulance Services Committee (EASC) meetings provide regular opportunities to engage. Meetings cover workforce issues and challenges including vacancies and sickness absence rates.

Exhibit 3: operational action to manage workforce challenges

This section focusses on the actions the Trust is taking to manage workforce challenges. Overall, **we found that the Trust is proactively addressing its workforce challenges, based on a strong understanding of risks. However broader workforce transformation is constrained by resource availability.**

What we looked at	What we found
We considered whether the Trust has identified sufficient resources to support workforce planning over the short, medium, and long term. We expected to see: • clear roles and responsibilities for workforce planning; • appropriately skilled staff to ensure robust workforce planning; • sufficient workforce capacity across the organisation to plan and deliver the workforce strategy or plan; and • sufficient financial resources to deliver the workforce strategy or plan.	We found that **the Trust is investing in its corporate workforce planning capacity and capability. However financial pressures and inefficiencies may inhibit the extent that the Trust can invest in delivering its strategic ambitions for example staffing community-based, prevention-focussed service models.** There appears to be sufficient capacity to support workforce planning. The People and Culture directorate, led by the People and Culture Director has a clear structure with teams covering education and development, workforce planning and organisational development and culture and wellbeing. In 2021, the Trust invested in corporate workforce planning by recruiting a Head of Workforce Transformation and Planning whose role includes developing the strategic workforce plan and managing the workforce planning team of nine staff and managers which includes the recruitment and Electronic Staff Record (ESR) teams. Service leads and operational management understand their role in workforce planning but that operational pressures do not allow them sufficient time to 'think strategically' to develop solutions. Service managers also felt there was a need to increase skills and confidence to undertake longer-term workforce planning. At the time of fieldwork, the Trust was developing workforce planning training to support managers to address these challenges. Once in place, the Trust should seek to evaluate the success of its training initiatives to ensure it is realising the intended benefits

What we looked at	What we found
	(**Recommendation 3**). Support for recruitment activities is not consistent across the organisation. Emergency Medical Services (EMS) recruitment is co-ordinated centrally through the workforce team, while other teams undertake their own recruitment activity. Recruitment support is available from the central team when requested for those services. Nevertheless, the devolved arrangement, places a strain on service manager capacity, and can lead to inconsistent practices **(Recommendation 4).** Achieving the vision outlined in 'Delivering Excellence' and linked plans may require significant ongoing investment to facilitate the additional staff, training and related costs. Those we spoke to were clear that frequent engagement takes place with commissioners to communicate the Trust's strategic direction which is well-received by partners. However, securing funding in the context of the current significant financial difficulties is a crucial challenge which is extremely difficult to mitigate. It is clear there are growing financial pressures. This will mean that the Trust will need to achieve efficiencies and/or secure additional investment to achieve its strategic ambitions. Delays in handing over patients at emergency departments cause significant inefficiencies for the Trust. For example, in August 2023, 27% of the Trust's ambulance response staff were unable to respond to further calls due to handover delays. In our 2022 Structured Assessment, we reported that handover delays accounted for around £50 million of inefficiencies for that year. That capacity, if released in part, could support the Trust's investment in community-based prevention-focussed service models. The Trust is engaged in ongoing work both independently and in partnership with commissioners to try and reduce the current levels of inefficiency. In terms of securing additional funding, the Trust is working in a challenging financial environment where additional funding is less likely. In the recent past, 'in-year' funding provided as part of winter pressures money in 2022 supported short-term recruitment of an additional 100 frontline staff.

What we looked at	What we found
	However, the short-term nature of such funding to be used for a specific purpose, restricts the extent that the Trust can invest in service transformation. Short-term funding can also make recruitment and retention difficult. The Trust also needs to make financial savings to achieve a breakeven position. It is addressing this in part through increasing its vacancy control target from £907,000 in 2022-23 to £2.6 million in 2023-24. However, vacancy control is a short-term solution, and it can create a strain on existing staff. The newly introduced vacancy control panel, which includes the Director of People and Culture and the Director of Finance, considers the impact of vacancies on the organisation as well as the potential financial savings. The Trust told us it intended to review the effectiveness of this process during Quarter 3 of 2023-24 to identify potential learning and improvement.

What we looked at	What we found
We considered whether the Trust has a good understanding of the short and longer-term risks that might prevent it from delivering its workforce strategy or plan. We expected to see: • a good understanding of the barriers that might prevent delivery of the workforce strategy or plan; • plans to mitigate risks which may prevent the organisation from achieving its workforce ambitions; and • clearly documented workforce risks that are managed at the appropriate level.	We found that **The Trust has a good understanding of the risks to delivery of its strategic workforce ambitions** The Trust demonstrates a good understanding of the shorter and longer-term risks to delivery of its workforce ambitions. These relate to buy-in from staff and stakeholders, financial pressures and staff morale and wellbeing. Corporately, the Trust appropriately manages and reports significant risks through the corporate risk register and Board Assurance Framework. The Trust's corporate risk register highlights high scoring risks related to the workforce, for example sickness absence, maintaining effective partnerships with the trade unions, and staff wellbeing. Each risk has a detailed list of controls, assurances, gaps in controls and actions which are clear and are likely to have a positive impact on mitigating the risk. For example, for reducing sickness absence the actions on the September 2023 risk register included long term sickness absence deep dives and review of top 100 cases by the people and culture team monthly. While sickness absence performance had significantly improved as of August 2023, the risk remains at 20 due to the likelihood of increased absence over the winter period. The People and Culture Committee is responsible for overseeing these risks which the Assistant Director Leadership Team regularly review.

We considered whether the Trust is effectively addressing its current workforce challenges. We expected to see:

- effective reporting and management of staff vacancies;
- action to improve staff retention;
- efficient recruitment practices;
- commissioning of health education and training which is based on true workforce need; and
- evidence that the organisation is modernising its workforce to help meet current and future needs.

We found that **the Trust is taking appropriate steps to address current workforce challenges through a range of recruitment, retention and training and development activities.**

The Trust has a successful track-record of recruiting paramedics, and the organisation had the lowest vacancy rate of NHS Wales bodies, at a rate of less than 1% during May 2023. The Trust is successful in recruiting newly qualified paramedics through recruitment events which focus on achieving a large intake. However, it is experiencing challenges in recruiting to other roles such as nurse advisors in its 111 service and staff in its digital team. The Trust is proactive in finding alternative solutions to some of these challenges. For example, the Trust found difficulties recruiting Ambulance Care Assistants, as some candidates do not have a C1 category driving license (necessary to drive an ambulance). To overcome this issue, the Trust now offers training in-house, provided candidates meet all other recruitment criteria. In response to difficulty recruiting nurses, the Trust is looking at allowing nurses in its call centres to work remotely. If this plan is successful, the Trust will seek to attract overseas nursing candidates who wish to work remotely from their own countries.

Beyond recruitment, the record for completing staff exit interviews has been inconsistent and in some cases poor. This means that it is difficult for the organisation understand the reasons for their departure and to introduce approaches to remove the ‘drivers’ that cause staff to leave. To address this, the Trust is trialling a new 'Moving on Interview' process in place of exit interviews. The new process includes newly designed questions, which staff can complete via MS Forms in their own time, rather than led by the manager. The Trust has designed the approach to provide more meaningful intelligence and support the Trust to develop more effective plans to retain staff. Nevertheless, in line with broader NHS Wales, since the pandemic, the Trust has been experiencing higher levels of turnover within its operations department. The increased turnover was particularly the case with within its 999 and 111 call-answering staff, due to the challenging working environment. The Trust has also seen a general increase in staff leaving within 6-12 months of recruitment. To resolve these challenges, the Trust has been trialling different working patterns and practices to retain staff. This includes shorter shifts and virtual working where possible, increased support for new staff and developing clear career progression routes.

What we looked at	What we found
	The Trust has had historic issues with managing its sickness rates. Pre-pandemic, rates were between 6% and 8% but increased during the pandemic with rates peaking at over 12% during winter 2022. The most recent project plan introduced in April 2022 has been effective in reducing rates from 10.6% in July 2022 to 8.2% in July 2023. The Trust has indicated that training for staff and investment in wellbeing services has been particularly successful. The People and Culture Committee receive regular reports containing analysis of specific pressures. There are higher rates of sickness within the operations department and reports also identify hotspots within local areas with helpful analysis and action plans identified, where appropriate. In relation to modernising its workforce, the Trust's long-term strategic framework details an ambition to significantly increase the number of Advanced Paramedic Practitioner positions. The roles which require eight years of training, necessitating longer-term planning. While there is a need for investment to achieve this vision, the Trust is taking steps, where possible, to make these changes, such as by substituting small numbers of vacant Emergency Medical Technician roles with increases in Advanced Paramedic Practitioner roles. The Trust successfully commissions health and education training of paramedics through HEIW and numbers of placements are based on the Trust's true workforce planning numbers. More recently this commissioning has expanded beyond a single University (Swansea) to also include Glyndwr University in Wrexham.

Exhibit 4: monitoring and oversight of workforce plan/strategy delivery

This section of the report focusses on the robustness of corporate oversight of workforce risks. We found that **there is reasonable Board level oversight of operational workforce challenges, but it is too early to judge the impact of delivering the People and Culture Plan.**

What we looked at	What we found
We considered whether delivery of the Trust's workforce strategy or plan is supported by robust monitoring, oversight, and review. We expected to see: • arrangements in place to monitor the progress of the workforce strategy or plan at management and committee levels; • effective action where progress on elements of the workforce strategy or plan are off-track; • performance reports showing the impact of delivering the workforce strategy or plan; and • the organisation benchmarking its workforce performance with similar organisations.	We found that **there is reasonable committee and management oversight of workforce performance information, and whilst the Trust has developed metrics to monitor its People and Culture Plan, it is too early to judge its effectiveness** The Trust has a clear and consistent focus on workforce performance indicators both operationally and at Board and committee level. A variety of different operational groups within the Trust as well as the People and Culture Committee and Emergency Ambulance Services Committee receive workforce metrics and information. Executive Management Team papers contain useful workforce information, such as analysis from the Integrated Technical Planning Group. This aligns to the Trust's strategic objectives, highlighting any financial and operational implications. It also helps the team effectively link workforce, finance, and operational issues for example, informing decisions on the recruitment of 100 additional frontline staff in the latter half of 2022-23. The Trust's People and Culture Committee receive significant information on workforce at each of its quarterly meetings. Where the committee has concerns about a particular workforce area or performance, it seeks further assurance by undertaking deep dives. Recent examples include deep dives on improving attendance, the Trust's volunteers, wellbeing, and turnover. Our review of papers in recent committee meetings found significant amounts of operational information provided to the committee, which may make it difficult for committee members to focus on strategic issues. However, the recent approval of the People and Culture Plan and work to develop a strategic workforce plan is likely to support the committee to maintain a medium to longer-term focus when considering the Trust's workforce.

What we looked at	What we found
	Following the People and Culture Plan's approval in May 2023, the People and Culture Committee approved metrics to monitor the Plan in August 2023. The metrics link to the themes and strategic objectives in the Plan and IMTP and will receive quarterly oversight. The metrics focus on short-term areas such as turnover and moving on interviews and employee engagement as well as some longer-term aspects including education and development. It will also include information from the Trust's newly purchased pulse survey tool, which should provide an insight into staff opinions, though it is currently too early to comment on the tool's effectiveness. Targets and milestones to deliver the People and Culture Plan are delivered via the Directorate Plan which is managed by the People and Culture leadership team and reported to the Strategic Transformation Board and PCC. The Trust is in the process of preparing a dashboard, which may help to provide this assurance on progress and impact. Once the Trust has developed its strategic workforce plan, it should also ensure there is appropriate reporting of targets and milestones to enable the People and Culture Committee to monitor its progress **(Recommendation 5).** The Committee also receives a comprehensive Monthly Integrated Quality and Performance Report (MIQPR). The Trust has recently revised the metrics covered in this report and now include additional, high-level people and culture indicators, including: • mental health-related sickness absence rates; and • data relating to applicants and shortlisted candidates from underrepresented groups. These additions should further strengthen the performance reports which provide helpful analysis across a multitude of relevant workforce indicators. While the Trust finds it difficult to benchmark performance with other NHS Wales, they benchmark performance with other ambulance services on an informal and irregular basis. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice **(Recommendation 6)**.

Appendix 1

Audit methods

Exhibit 5: audit methods

Exhibit 5: sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

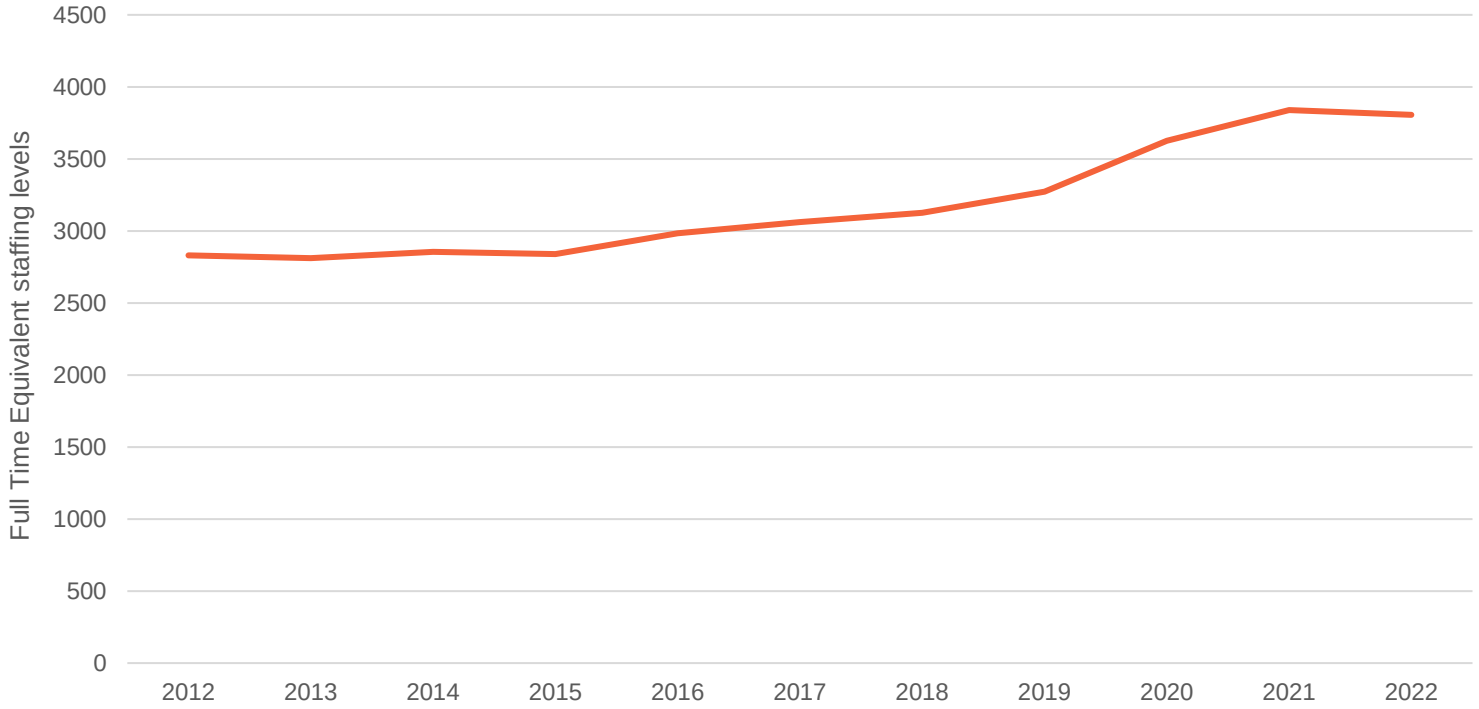
Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Delivering Excellence strategy; • People and Culture Plan; • Integrated Medium Term Plan 2023-6; • Papers to inform workforce section of IMTP 2023-6; • Structure Charts for People and Culture and Programme Governance; • Demand and Capacity Reviews: Emergency Medical Services, Non-Emergency Patient Transport Services, and 111; • Terms of Reference for Forecasting and Modelling Cell and Integrated Technical Planning Group • Document relating to recruitment of addition 100 EMS staff; • EMS Workforce Plan 2023-8; • Evidence of evaluation of workforce strategy and/or associated initiatives; • Structure charts for workforce planning functions; • Corporate risk register; and • Corporate and operational level oversight and monitoring of workforce metric and strategy delivery
Interviews	We interviewed the following:

Element of audit approach	Description
	• Executive Director for Workforce and Organisational Development; • Deputy Director for Workforce and Organisational Development; • Director of Paramedicine; • Head of Workforce Transformation and Planning; • Strategic planning team officers; • Corporate and operational officers responsible for workforce data and intelligence; • Head of Finance; • Head of Workforce Education and Development; • Non-Executive Director with responsibility for Chairing People and Culture Committee; and • Trade Union representatives to the Board
Focus groups	We ran two focus groups with: • a selection of service leads involved in clinical workforce planning; and • a selection of service leads involved in the workforce planning of enabler services.

Appendix 2

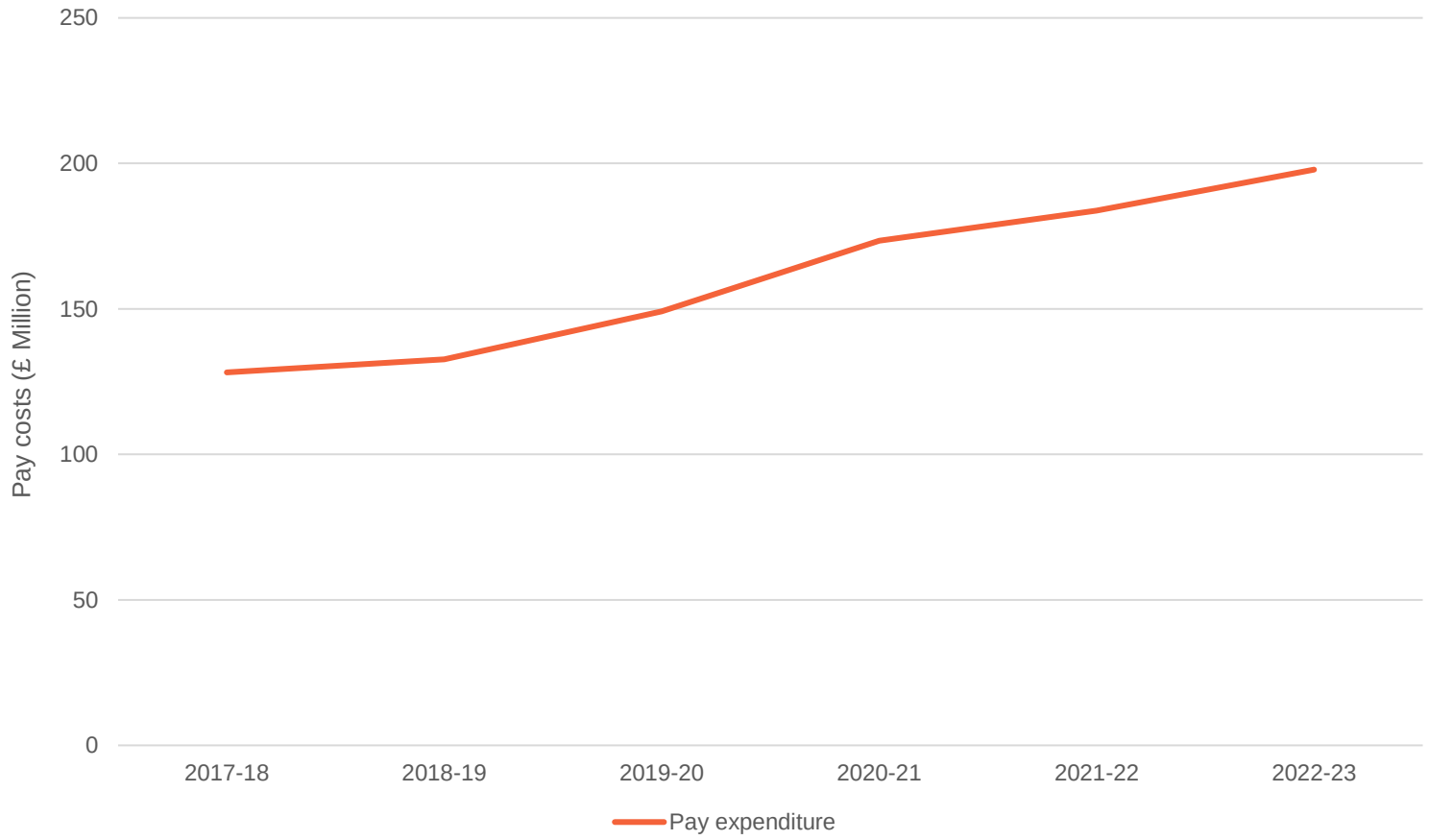
Selected workforce indicators

Exhibit 6: trend in workforce numbers (full time equivalent), Welsh Ambulance Services NHS Trust



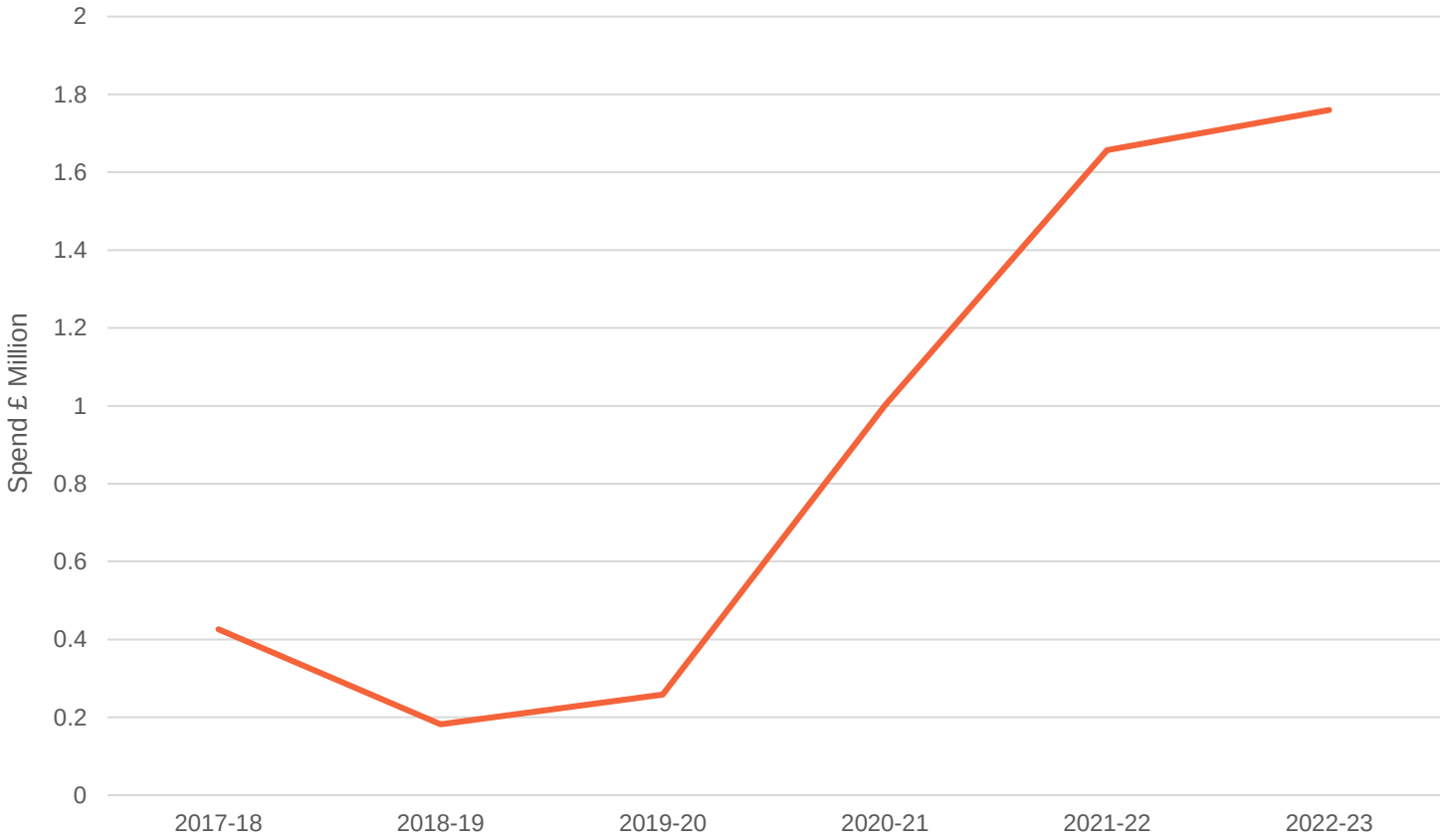
Source: Welsh Government, Stats Wales

Exhibit 7: trend in actual workforce costs, Welsh Ambulance Services NHS Trust



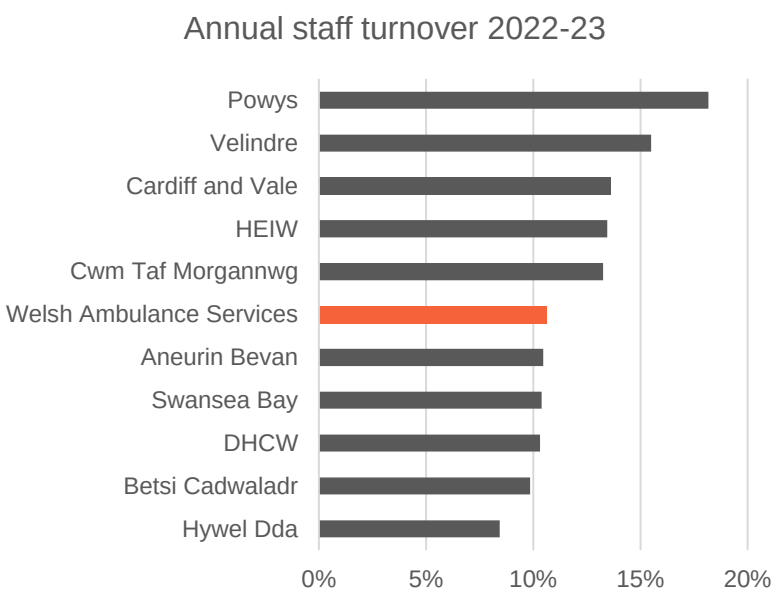
Source: Monthly Monitoring Returns reported to the Welsh Government

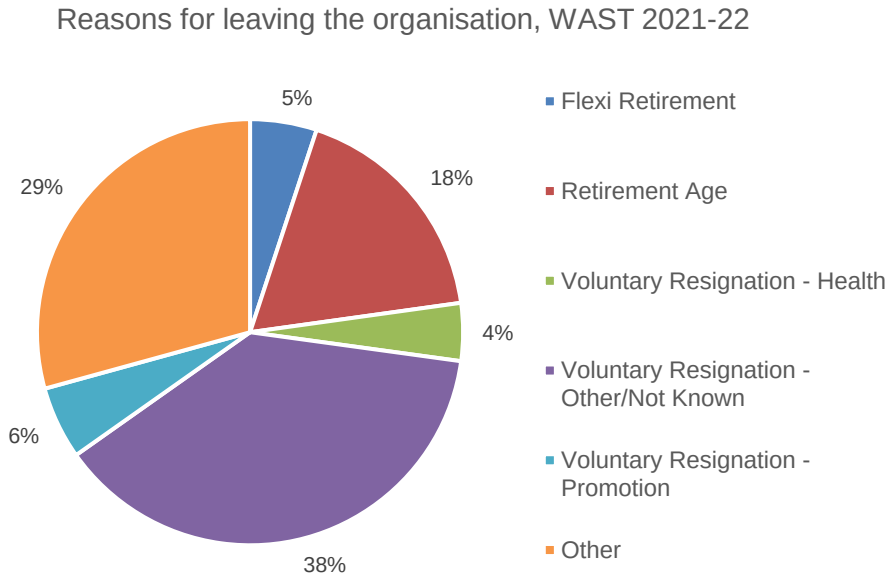
Exhibit 8: trend of expenditure on workforce agency £ million, Welsh Ambulance Services NHS Trust



Source: Monthly Monitoring Returns reported to the Welsh Government

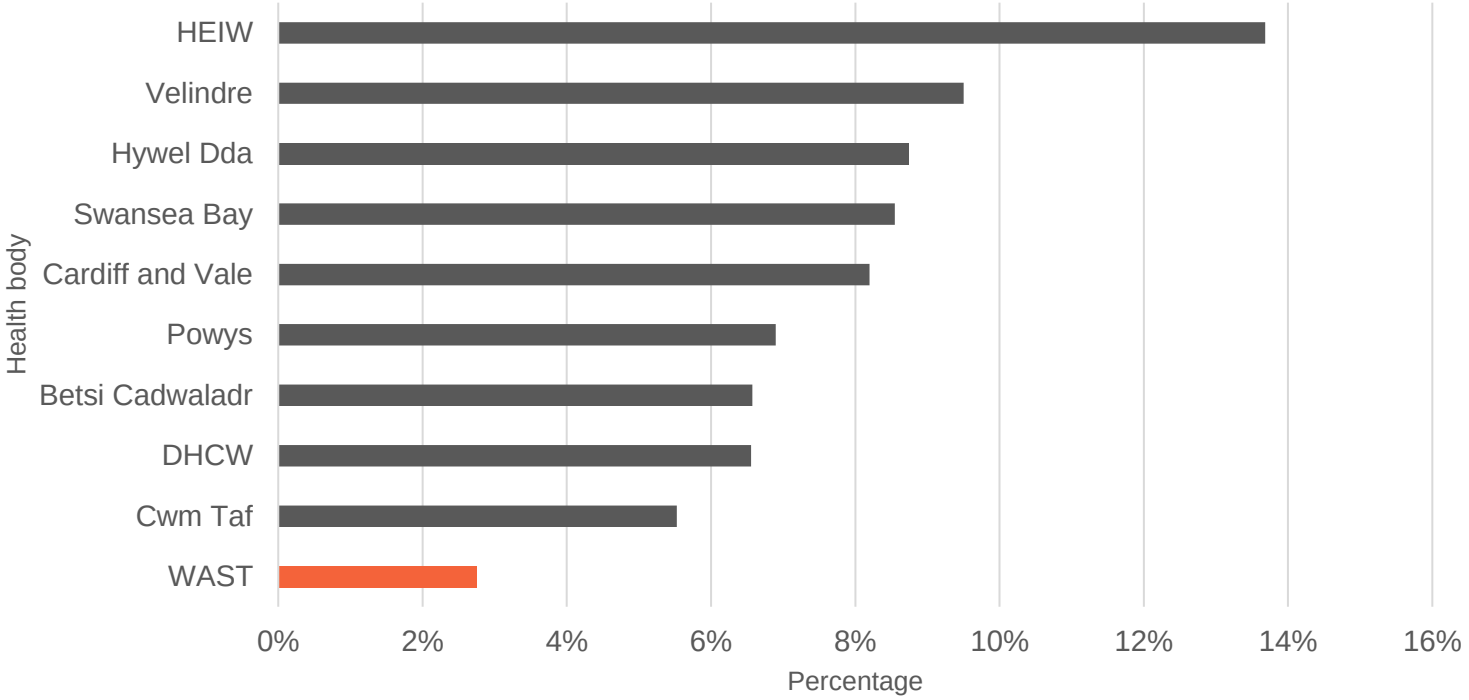
Exhibit 9: annual staff turnover and reason for leaving, 2021-22, Welsh Ambulance Services NHS Trust





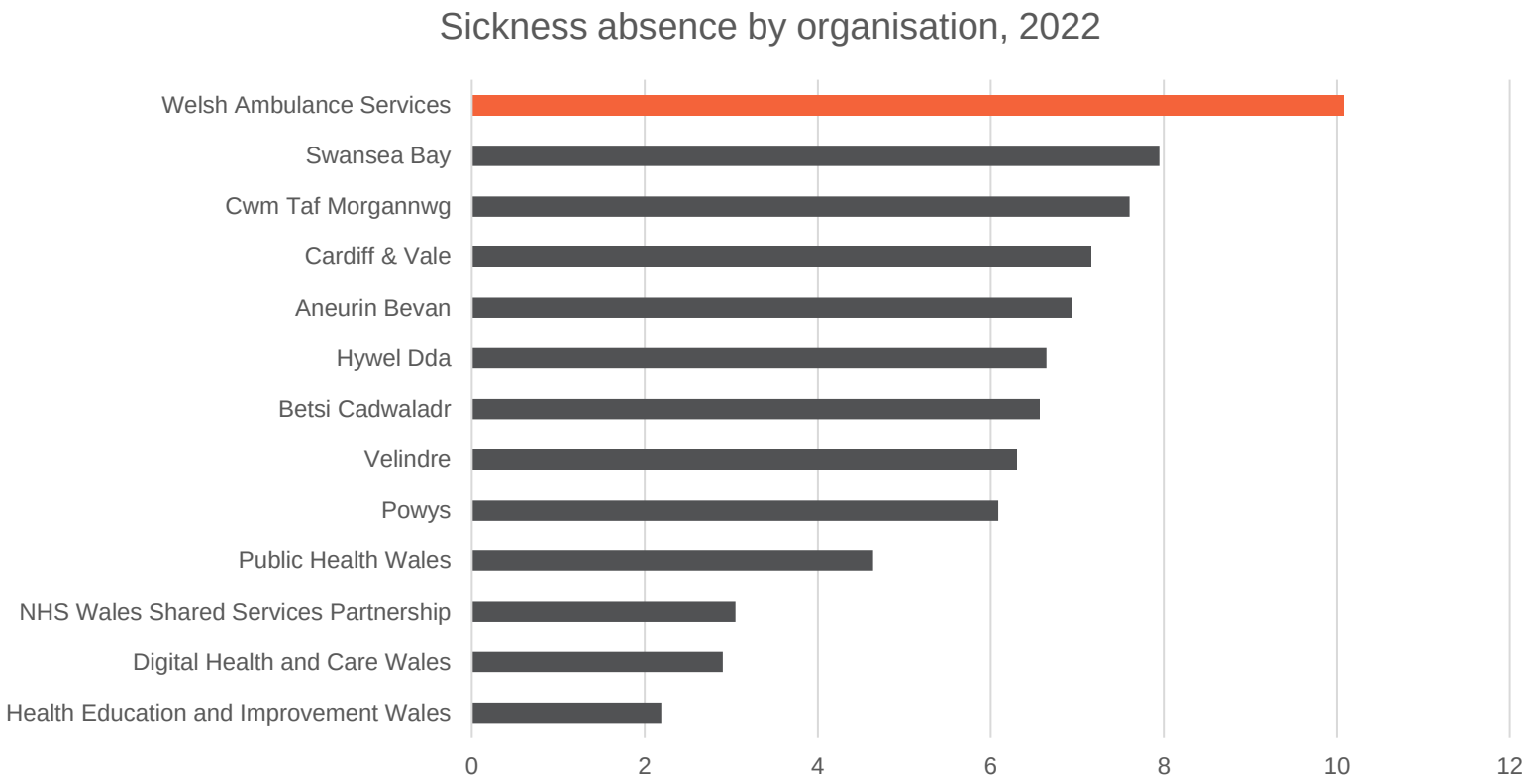
Source: staff turnover data sourced from Health Education and Improvement Wales. Reason for leaving data sourced from health body data request.

Exhibit 10: vacancies as a percentage of total establishment, as of March 2022 by organisation



Source: health body data request

Exhibit 11: sickness absence by organisation, 2022



Source: Welsh Government, Stats Wales

Appendix 3

Organisational response to audit recommendations

Exhibit 12: Trust response to our audit recommendations.

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
R1	**Terms of Reference** We found that the Terms of Reference for both the Integrated Technical Planning Group and the Forecasting and Modelling Group require review. The Trust should review these to ensure they are accurate and up-to-date, particularly to clarify what role they will play in supporting the new People and Culture Plan and developing strategic workforce plan **(medium priority).**	Recommendation accepted Chair and Vice Chair of the ITPG and Forecasting and Modelling Group will update the Terms of Reference within the context of the internal governance structures.	End of December 2023	Assistant Director of Commissioning & Performance / Deputy Director, People and Culture

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
R2	**Workforce information systems** We found that there is scope for the Trust to make better use of its workforce information by ensuring data is consistent, joined up and up to date. The Trust should work to ensure that **(medium priority)**: • Systems that hold workforce information including Electronic Staff Record (ESR), Global Rostering System (GRS) and finance systems interconnect, where possible. • Explore ways to resource the management of a system to ensure an up-to-date establishment model.	Use of Power BI reporting feeding into the Integrated Technical Planning Group is in development by the workforce planning team. This will be used for reporting and maintenance of the data. Alongside this we are working on Integrated Planning Nexus via the Planning and Strategy team which enables our understanding of the interconnection between workforce, fleet, estate etc.	Sept 2024 March 2024 (Excel version) Potential PowerBI version (Sept 2024)	Strategic Planning Officer (LP) / Deputy Director, People and Culture Assistant Director of Commissioning & Performance
R3	**Evaluating workforce planning training** We found that the Trust is strengthening workforce planning capability through training initiatives, but it will need to evaluate these to ensure they are having the desired impact. The Trust should develop an evaluation framework to measure the success of its training programme **(medium priority)**.	We will implement an evaluation process to baseline where managers are pre and post training and post 3 months to measure improvement.	June 2024	Head of Workforce Transformation and Planning / Deputy Director for Workforce and Organisational Development

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
R4	**Recruitment support** We found that only the emergency ambulance services department has dedicated support from the central management team for recruitment activity, due to capacity issues. While the central team can provide support on a case-by-case basis, the Trust should review opportunities to increase the corporate support offered to other departments across the organisation **(medium priority).**	The recruitment team focus primarily on EMS but do offer support where needed to other services. This would need to be agreed by ELT and the Directorates as resource would need to be moved into the team from elsewhere. Report to be produced and shared with ELT.	May 2024	Head of Workforce Transformation and Planning; / Deputy Director, People and Culture
R5	**Metrics for People and Culture plan monitoring** The Trust has recently approved the metrics to enable monitoring progress of the People and Culture Plan, however the metrics do not include targets or milestones. The Trust should work to develop targets and milestones to enable the Committee to understand the progress against the Plan **(medium priority)**.	Recommendation Accepted. We will build in appropriate targets and milestones into the plan which will be frequently reviewed for delivery and effectiveness of both the plan and the measures.	May 2024	Head of Workforce Transformation and Planning; / Deputy Director, People and Culture

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
R6	**Benchmarking** The Trust does not routinely benchmark its workforce performance metrics with other health bodies in Wales. Its performance benchmarking with other ambulance trusts is infrequent. The Trust should introduce regular workforce benchmarking with similar organisations and use this to inform relevant groups and committees on its performance and efficiency and to identify and share good practice **(medium priority)**.	Recommendation accepted for high level measures and will be based on what other organisations share / make available. Benchmarks need to be with ambulance sector rather than Health Boards	June 2024	Deputy Director, People and Culture / Assistant Director of Commissioning & Performance

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We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

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NHS Workforce data briefing

September 2023

Report of the Auditor General for Wales

This is an interactive pdf

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Mae’r ddogfen hon hefyd ar gael yn Gymraeg

The NHS workforce is facing a number of significant challenges

Foreword

The Welsh Government's National Workforce Implementation Plan was published in February 2023 in response to the growing workforce pressures being experienced by the NHS in Wales.

The Implementation Plan, which builds on the 10-year Strategy for Health and Social Care Workforce, is an acknowledgement of the need to accelerate action to address the workforce challenges that the NHS in Wales is currently facing.

Whilst the workforce in NHS Wales has seen notable growth in recent years, long standing issues around recruitment and retention have been magnified and added to by the COVID-19 pandemic. Staff who are tired and at risk of burnout are working in a system that is seeing increased demand as services look to recover and deal with backlogs as well as heightened unscheduled care pressures.

My Taking Care of the Carers report described the positive action that was taken to support staff through the pandemic. However, despite these efforts the NHS workforce continues to be stretched with large numbers of vacancies, higher levels of sickness absence, increasing levels of staff turnover and a continued and growing reliance on temporary and agency staff to fill gaps in the workforce.

The Welsh Government's national implementation plan is timely and needs to be complemented by sound workforce planning within individual NHS bodies. Audit Wales are currently examining the approach to workforce planning in each of the 12 NHS bodies in Wales.

This data briefing is designed to help contextualise that work by bringing together a range of metrics and trends that help illustrate the challenges that need to be gripped locally and nationally. Those challenges are significant and are not unique to Wales, however, they must be tackled if the NHS is to remain fit for purpose and a rewarding place to work.

Adrian Crompton
Auditor General for Wales

Key facts

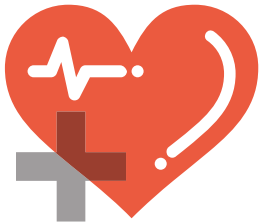
£5.64 billion - Cost of the workforce

£325 million agency spend

1.4 million** working days lost to sickness absence in 2022

Around **6,800** vacancies as at March 2022

9,153 doctors on the GMC register originally trained in Wales of which **3,975** remain in Wales as at February 2023



38,901 nurses educated in Wales of which around **26,500** remain in Wales (Sept 2022)**

27% NHS workforce growth between 2012-13 and 2022-23

91,404 full time equivalent (FTE)* staff - total NHS workforce

Data is for the period 2022-23 unless otherwise stated

*abbreviations and terminology are provided at the back of this briefing

**estimates

Key messages

NHS workforce levels have increased over time, but there is a risk that nursing numbers and the workforce on some medical specialties are not increasing with demand

Workforce costs have grown substantially, because of increasing workforce levels and a shift to a richer staff grade mix

Wales has the joint lowest level of registered doctors relative to population in the UK

Reliance on agency staffing is increasing, it represents around 5.5% (£325 million) of the total workforce costs in NHS Wales

Overall trends show that staff turnover is increasing

There is significant variation in sickness absence but in general, absence levels are high and have grown. The 6.9% sickness absence rate in 2022-23 equates to around 1.4 million working days

NHS Wales is becoming a more flexible and equal employer but there is still more to do

Wales is growing its own workforce, with increased nurses and doctors in training. Despite this, there is still a heavy reliance on medical staff from outside of Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

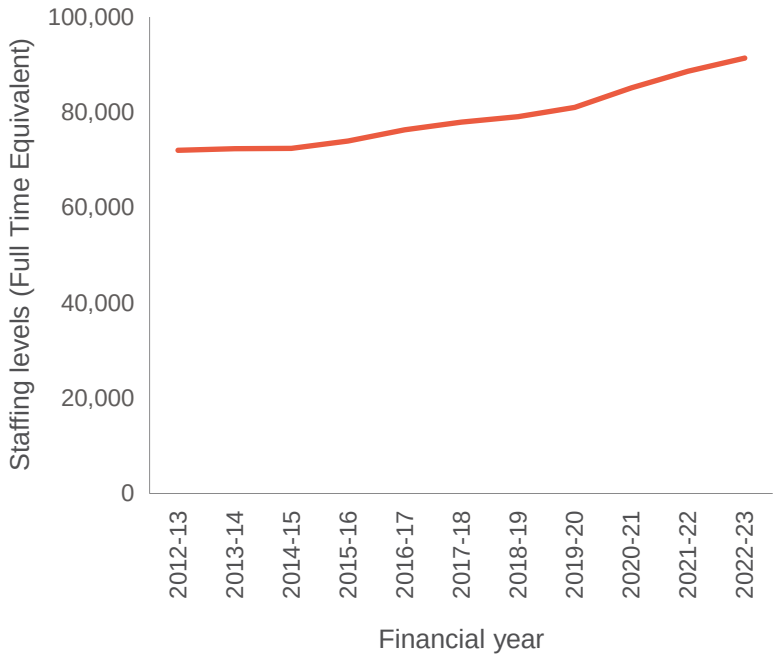
Is NHS Wales growing its own staffing?

Prev Next

01 How is the NHS workforce changing?

All NHS Wales staffing

Exhibit 1: NHS Wales staff levels, 2012 to 2023



Source: Stats Wales

Between 2012-13 and 2022-23, the overall NHS Workforce in Wales increased by around 27%.

But that growth in staffing is not uniform across all staff groups. NHS Wales has seen ambulance staffing and administration and estates staffing grow substantially.

At the same time healthcare assistants and support staffing levels have reduced and nursing has seen some, but limited growth.

Note: There have been some changes to the definitions for staff groups over this timeframe. This will apply to all 'staff group' related data analysis in this briefing.

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

Exhibit 2: NHS Wales percentage change in staff numbers from 2012-13 to 2022-23, by staff group

	2012-13	2022-23	Percentage change
Admin and estates	15039	22731	51.1%
Ambulance staff	1937	2749	41.9%
Scientific, therapeutic and technical	11549	15971	38.3%
Medical and dental	5917	7836	32.4%
Nursing, midwifery and health visiting	31176	36113	15.8%
Other non-medical	124	126	1.8%
Healthcare assistants and other support staff	6259	5878	-6.1%
All staff	**72002**	**91404**	**26.9%**

Source: Stats Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

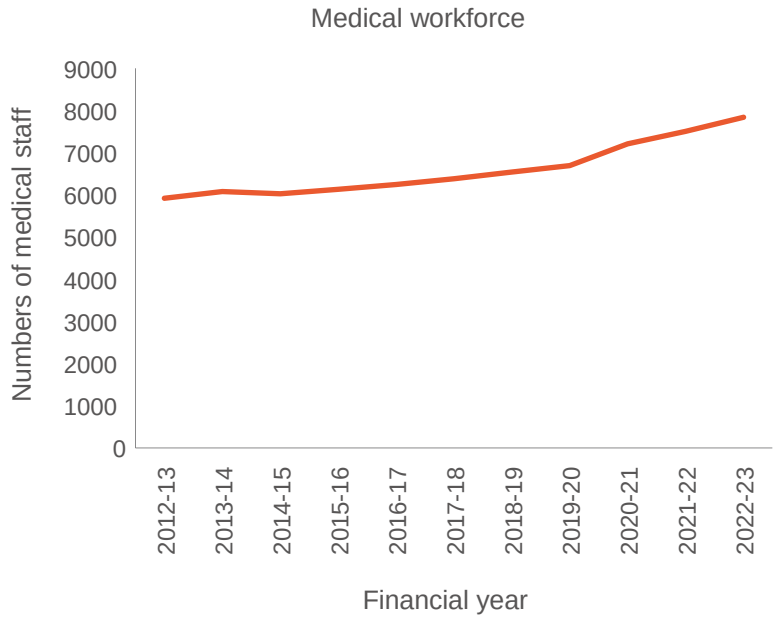
Is NHS Wales growing its own staffing?

Prev Next

Medical workforce

Exhibit 3 shows an increase of around 32% in the medical and dental workforce over the last decade. As a basic comparison, this is broadly in line with the increase in referrals prior to the pandemic.

Exhibit 3: Change in medical and dental workforce between 2012-13 and 2022-23



Source: Stats Wales

Exhibit 4 shows changes in the numbers of referrals and the medical workforce for selected high-volume specialties. For some specialties, this raises questions around capacity and demand.

Exhibit 4: Change in referrals and staffing between 2012-13 and 2022-23

	% change in numbers of referrals	% Change in medical workforce
General surgery	+28%	+12%
Ophthalmology	+56%	-2%
Ear, Nose and Throat	-1%	+21%
Gynaecology	+29%	+9%
Trauma & orthopaedics*	-5%	+17%

Note: *We anticipate reducing orthopaedic referrals is as a result of community-based services which are helping to manage demand in different ways.

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

GP workforce (General Medical Services)

The total numbers of GPs in Wales has remained constant over the last 10 years at around 2,000 (headcount). However, demands on GP services are expected to continue to increase.

This is because the proportion of the population that are elderly is forecast to grow. Linked to this will be an increasing need to manage chronic conditions in the community.

Over the last 10 years the number of the GPs per 10,000 population aged over 65 has reduced by around 14%.

Going forward, we are expecting around a 17% increase in people aged over 65 in the 10 years (Source: Stats Wales).

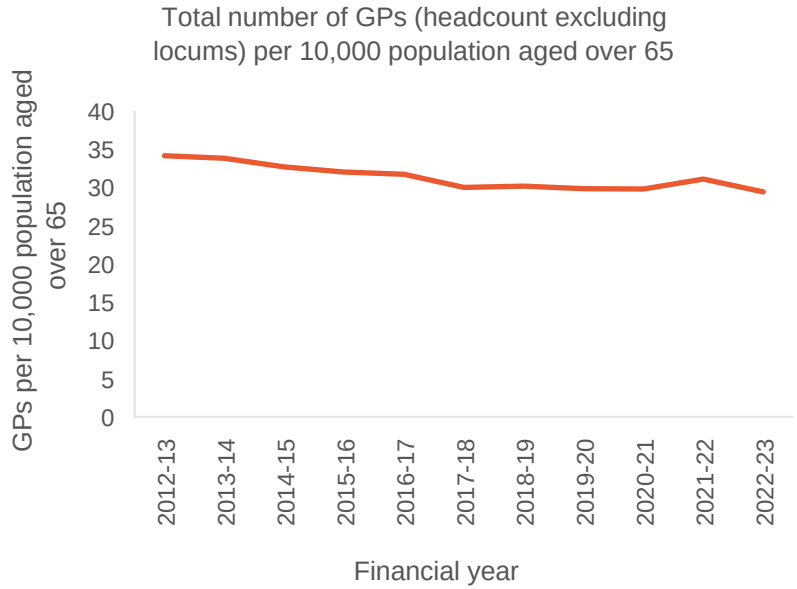
Notes:

A GP (General Practitioner) is doctor who is trained in general medicine and who works in the local community.

GPs are increasingly working part-time which may affect overall capacity in primary care if this continues. As a result, practices are starting to move to multi-disciplinary team models to help meet demand.

Changes to the collection and reporting of GP workforce data may affect comparisons over the 10-year time period.

Exhibit 5: Total number of GPs (headcount) per 10,000 population aged over 65, 2012-2023



Source: Stats Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

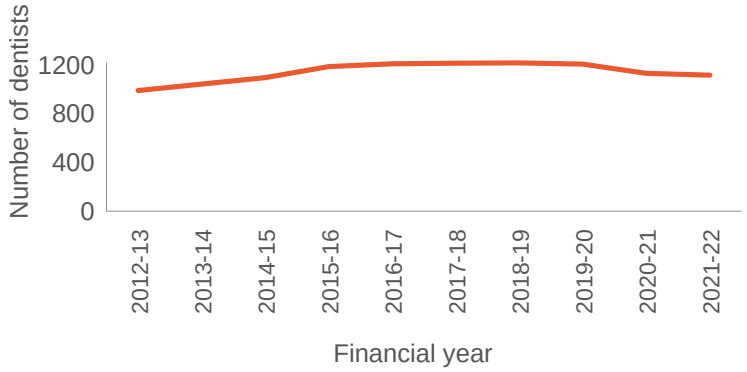
Is NHS Wales growing its own staffing?

Prev Next

Dentist workforce

Exhibit 6 shows around 13% growth in the numbers of dentists between 2012-13 and 2021-22.

Exhibit 6: Dentist numbers in Wales (headcount)



Source: Stats Wales, General Dental Services

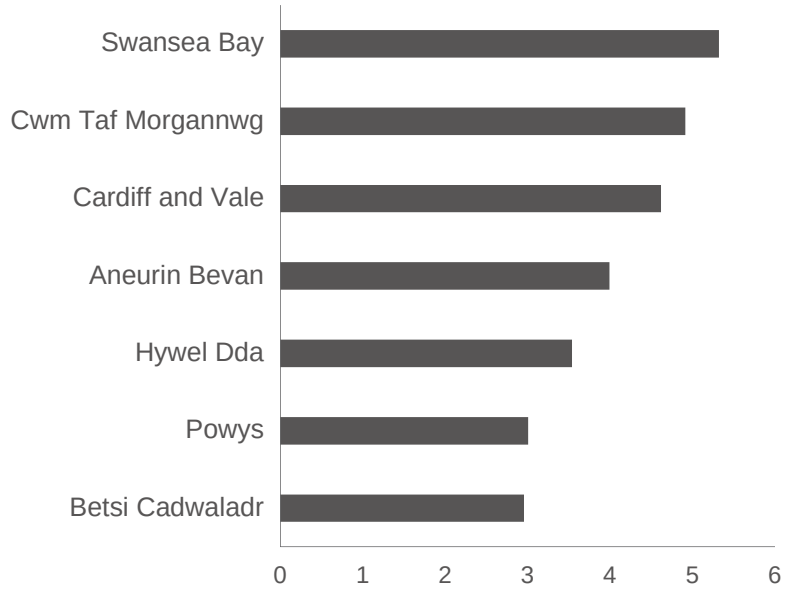
Notes:

Dentist numbers exclude hospital-based dentists. All data relates to 2021-22 with the exception of Scotland, which uses the latest available 2019 data.

The data is presented as 'headcount' and not 'full-time equivalent'. Some dentists will also undertake private work, which limits their capacity for NHS-based community dentistry.

Exhibit 7 shows the variation in registered dentists relative to population in different Health Board areas.

Exhibit 7: Numbers of dentists per 10,000 population (headcount), by health board, 2021-22



Source: Stats Wales, General Dental Services

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

Change in grade mix

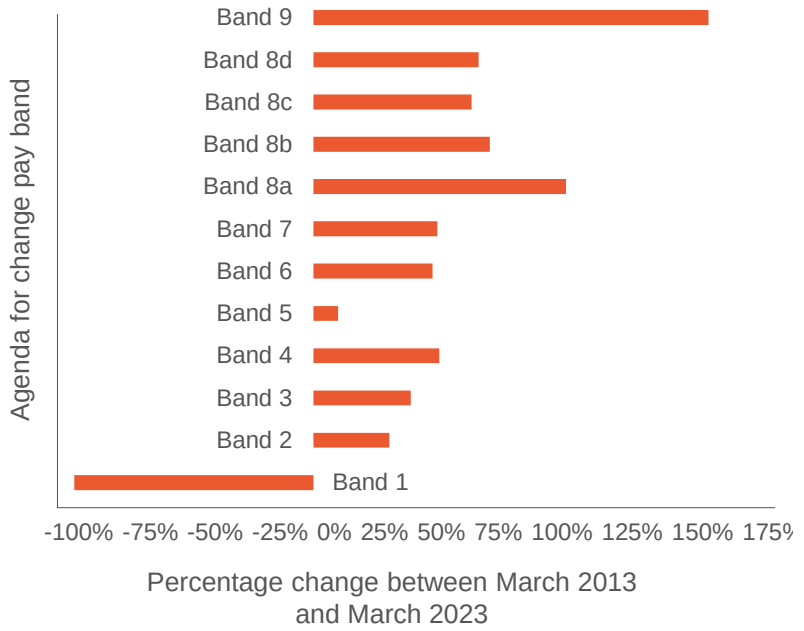
Agenda for Change is the national pay system for the majority of NHS staff.

Agenda for Change pay rates start at around £20,000 for lowest Band 1 and rise to £109,000 once at the top of band 9

Exhibit 8a shows higher pay bands are proportionately increasing at a higher rate. Band 8 and 9 roles are typically senior clinical and management positions. This growth reflects increasing use of advanced practitioners, for example advanced nurse practitioners, who undertake some of the clinical roles previously undertaken by medical staff.

In terms of actual numbers of staff, the greatest increase between 2013 and 2023 is seen at Band 7 and below.

Exhibit 8a: Change in NHS Wales staffing levels between March 2013 and 2023 by 'Agenda for Change' bands 1 to 9



Source: Health Education and Improvement Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

Change in grade mix

Exhibit 8b: Change in NHS Wales staffing levels between March 2013 and 2023 by 'Agenda for Change' bands 1 to 9

AFC band	Staff numbers in 2023	Change in staff numbers between 2013 and 2023
Band 9	219	+132
Band 8d	407	+159
Band 8c	879	+334
Band 8b	1430	+580
Band 8a	3554	+1756
Band 7	10260	+3326
Band 6	15875	+5009
Band 5	16886	+1468
Band 4	9034	+2961
Band 3	12247	+3355
Band 2	16367	+3722
Band 1*	129	-1579

*Note: The substantial decrease in Band 1 staff is a result of the scale being closed to new entry staff

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

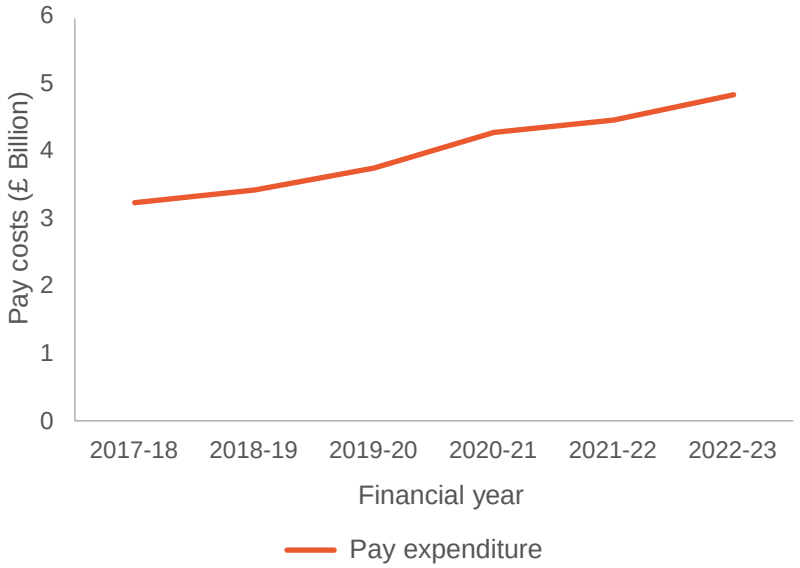
Is NHS Wales growing its own staffing?

Prev Next

02 What is the cost of the NHS workforce?

Exhibit 9 shows the trend in actual total pay costs for Health Boards, with expenditure on pay increasing by 66% between 2017-18 and 2022-23.

Exhibit 9: NHS Wales Annual Health Board total pay costs



Source: Monthly Monitoring Returns reported to Welsh Government

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

Average health board pay costs

Exhibit 10 shows the average Health Board pay costs across Wales. Overall, there is reasonable consistency in pay, although slightly lower pay costs in rural areas.

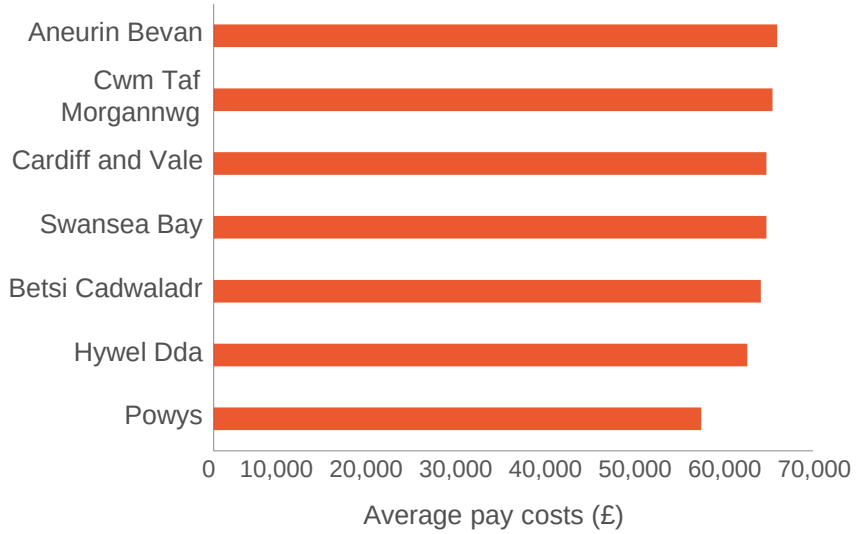
Notes:

Powys Teaching Health Board pay costs will be lower on average, because there is significantly lower medical staffing levels.

Average pay costs do not directly reflect average salary. Total pay costs are higher because they will include employers National Insurance and pension scheme contributions.

The chart shows Health Boards only. We have not analysed the other health bodies in Wales because they provide substantially different functions and would make unfair comparators.

Exhibit 10: Average staff pay, 2022-23



Source: Stats Wales workforce data and Monthly Monitoring Returns reported to Welsh Government

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

03 How do NHS workforce levels in Wales compare to the rest of the UK

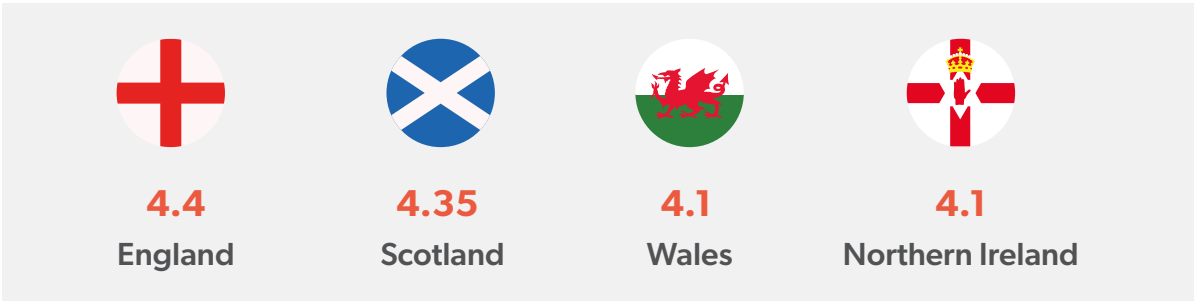
NHS medical and primary care dental staff comparison

Exhibit 11 shows the numbers of General Medical Council registered doctors in Wales, relative to population, is less than in England and Scotland and the same as Northern Ireland.

The data is based on numbers of doctors licenced and registered to practice in each country.

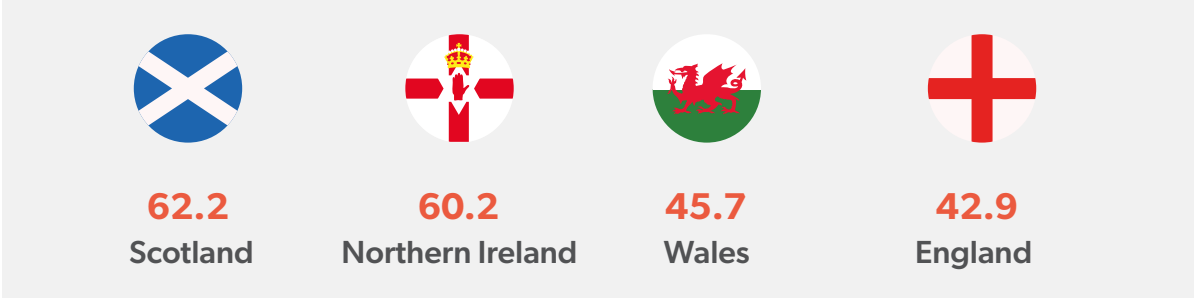
Exhibit 12 shows that comparatively, the numbers of primary care dentists are lower than Scotland and Northern Ireland but higher than England.

Exhibit 11: Number of Doctors (headcount) per 1,000 population, by country, January 2023



Source: Audit Wales analysis of GMC data explorer

Exhibit 12: Number of dentists registered to practice (per 100,000 population), by country, 2021-22



Source: Stats Wales, NHS Scotland, NHS Digital England, Health and Social Care Northern Ireland

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

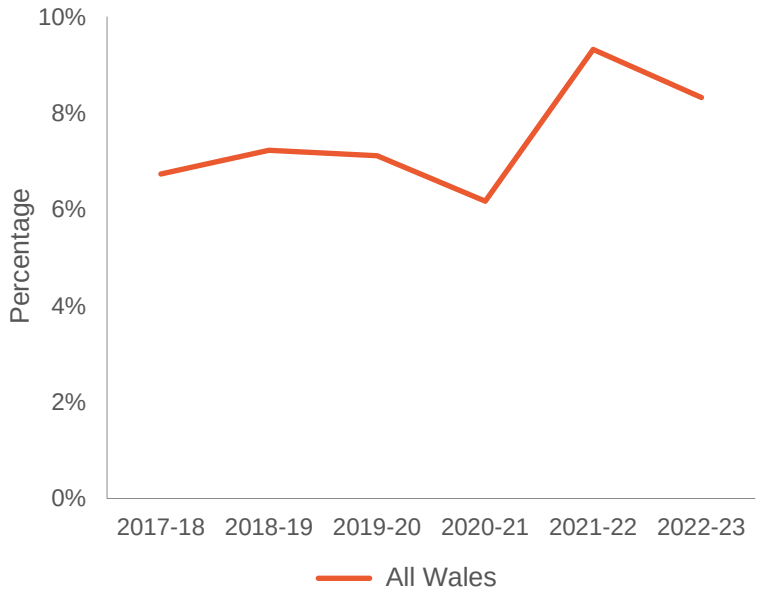
Prev Next

04 What is the recruitment challenge for NHS Wales?

Annual staff turnover

Staff turnover at an all-Wales level has increased in recent years, with a peak in 2021-22 linked in part to staff on short-term contracts employed during the pandemic. In total in 2021-22, over 10,000 FTE staff left NHS bodies in Wales with **Exhibit 14** showing the most common reasons. Highest turnover is seen for registered nursing and midwifery staff groups with over 2,500 leavers whilst **Exhibit 15** shows a variation across NHS bodies. High turnover presents a significant challenge for health bodies in terms of recruitment, induction and associated training costs and it may negatively affect service continuity.

Exhibit 13: All Wales staff turnover as of March of each financial year



Source: Health Education and Improvement Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

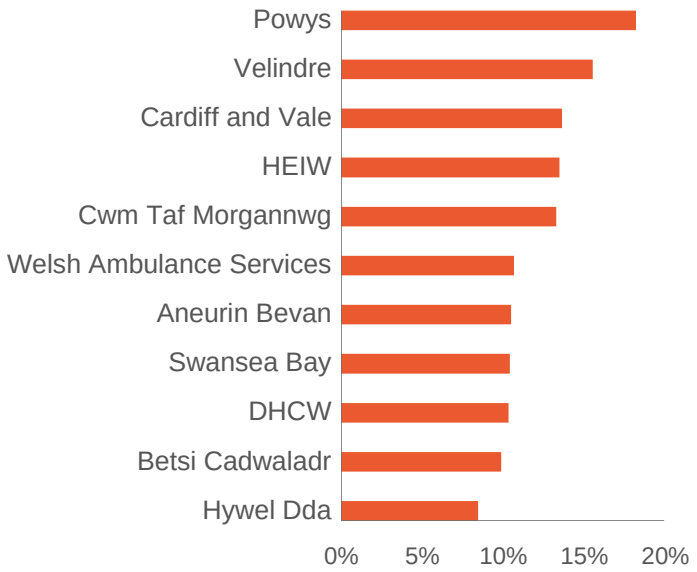
Annual staff turnover

Exhibit 14: 2021-22 staff leavers by reason

Voluntary Resignation - Other/Not Known	30%
Retirement Age	26%
End of Fixed Term Contract	13%
Voluntary Resignation - Relocation	12%
Voluntary Resignation - Work Life Balance	8%

Source: Returns from NHS Wales health bodies

Exhibit 15: Staff turnover by organisation, 2022-23



Source: Health Education and Improvement Wales

Note: individual organisation staff turnover is higher than all Wales because a staff member may move from one organisation in Wales and join another in Wales. This would count as turnover for an individual body. It would not count as turnover at an all-Wales level. All Wales turnover only includes staff leaving NHS Wales completely.

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

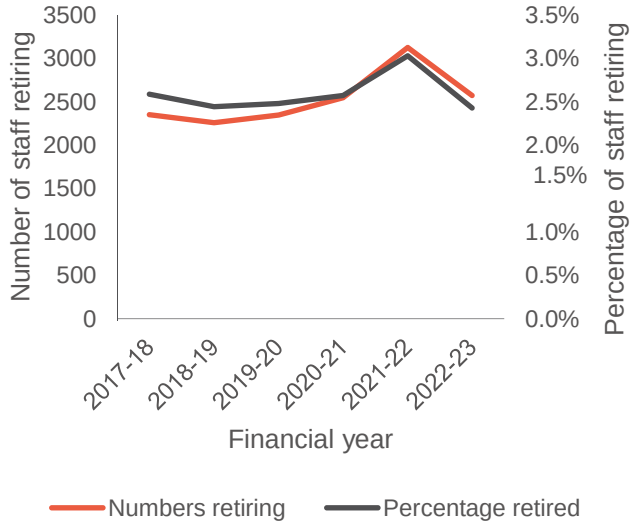
Prev Next

Retirement in NHS Wales

NHS Wales is seeing increasing numbers of staff retiring. While seemingly small compared to the circa 106,000 staff that were employed in 2022-23, it represents a loss of capacity, experience and knowledge.

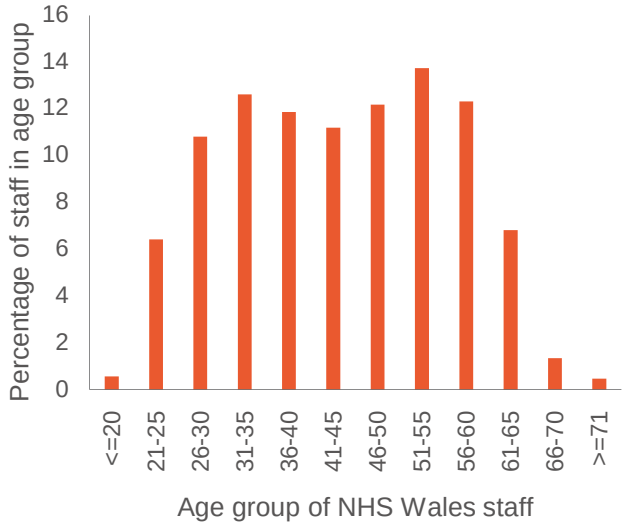
The age profile of the NHS workforce shown in **Exhibit 17** could also present a substantial challenge over the decade. Potentially around 35% of the workforce would reach or be above the current average retirement age of 61.

Exhibit 16: All Wales numbers and Percentage of NHS staff retiring annually, 2017-2023



Source: Health Education and Improvement Wales

Exhibit 17: NHS Wales workforce age profile, September 2022



Source: Stats Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

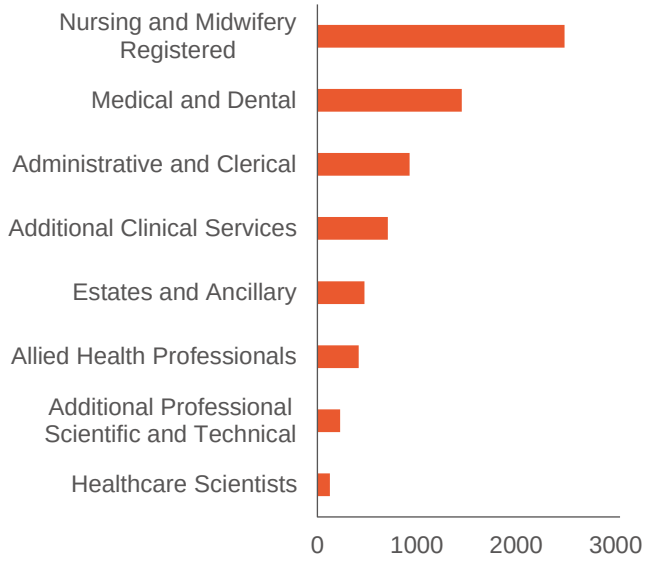
Vacancies in NHS Wales – by staff group

We asked NHS organisations to provide their agreed staffing establishment (agreed number of funded staff positions in an organisation) and the numbers of staff in post. As at March 2022, this indicated around 6,800 FTE equivalent vacancies, of which there were:

- Nearly 2,500 FTE registered nursing and midwifery vacancies
- 1,450 FTE medical and dental vacancies
- Over 900 admin and clerical vacancies.

Whilst some vacancies may only have limited impact on service delivery,the general picture of high service demand combined with high vacancy levels and reliance on temporary staffing will, in some areas, add pressures to the workforce, affect the wellbeing of staff and may compromise the quality of, or access to care.

Exhibit 18: Vacancies by staff group (FTE), March 2022, All NHS Wales (excluding primary care services)



Source: Returns from NHS Wales health bodies

Data quality notes:

- Vacancies has been counted as the gap between establishment and numbers of staff in place. Overstaffing in one staff group has not been counted against understaffing in another i.e. overstaffing by 50 admin and clerical workers does not counteract a shortfall of 50 doctors. We have therefore counted the understaffing against establishment for each staff group only and not offset this with overstaffing in another group.
- The recent Royal College of Nursing Wales 'Nursing in numbers' publication indicate nursing vacancies have increased to over 2,900 in the 2022-23 year.

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

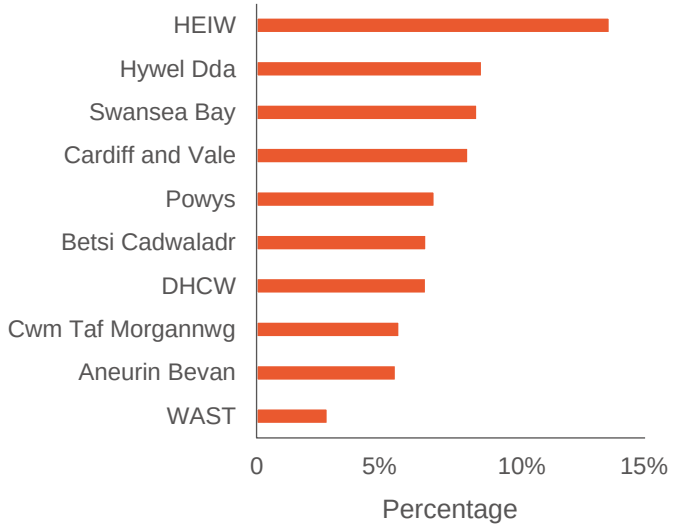
Vacancies in NHS Wales – by organisation

Exhibit 19 shows the percentage of vacancies against the total establishment. It shows that all bodies are operating in an environment where they are having to manage with fewer staff than they currently need.

Variation by health body may be a result of specific organisational challenges recruiting or retaining staff, approaches for calculating establishment, organisational size, and application of vacancy controls.

Note: Please see the previous slide regarding the calculation for vacancy levels.

Exhibit 19: Vacancies as a percentage of total establishment, March 2022



Source: : Returns from NHS Wales health bodies

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

05 To what extent does the NHS in Wales rely on temporary staff?

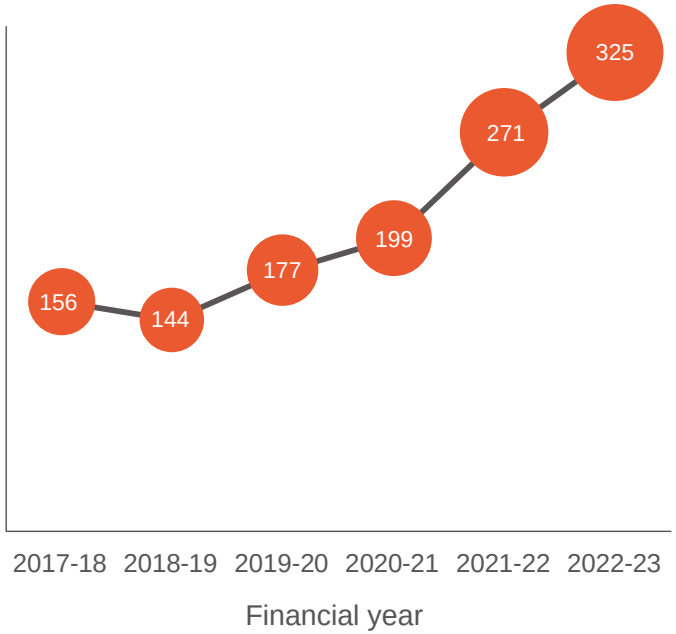
Annual trend in NHS Wales agency staffing use

There is a clear and substantial growth in the use of agency staffing by Welsh health bodies.

The consequences of the pandemic clearly has been a central factor in this increase. However, for 2022-23, agency use is continuing to rise.

Given that Covid-19 is having less of a direct impact than in previous years, it suggests the high agency use may be a feature of NHS workforce supply for some time as services are finding it difficult to recruit while service demand remains high.

Exhibit 20: All NHS Wales agency expenditure 2017-2023, £ million



Source: Monthly Monitoring Returns reported to Welsh Government

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

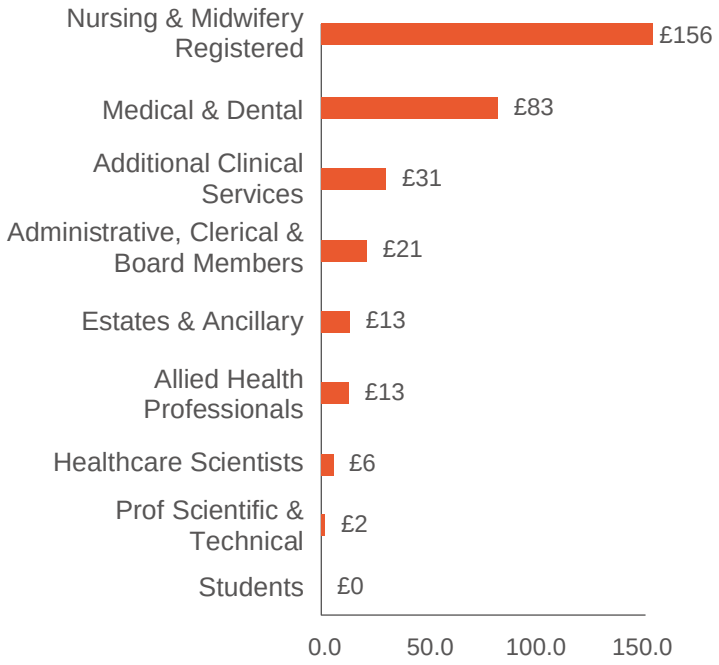
Prev Next

NHS Wales agency staffing use by role and reason

Exhibit 21 shows that the greatest areas of agency spending is on Nursing and Midwifery followed by Medical and Dental staff groups.

Our additional trend analysis indicates that nursing agency spend has more than tripled over the last 6 years from £51 million in 2017-18 to £156 million in 2022-23.

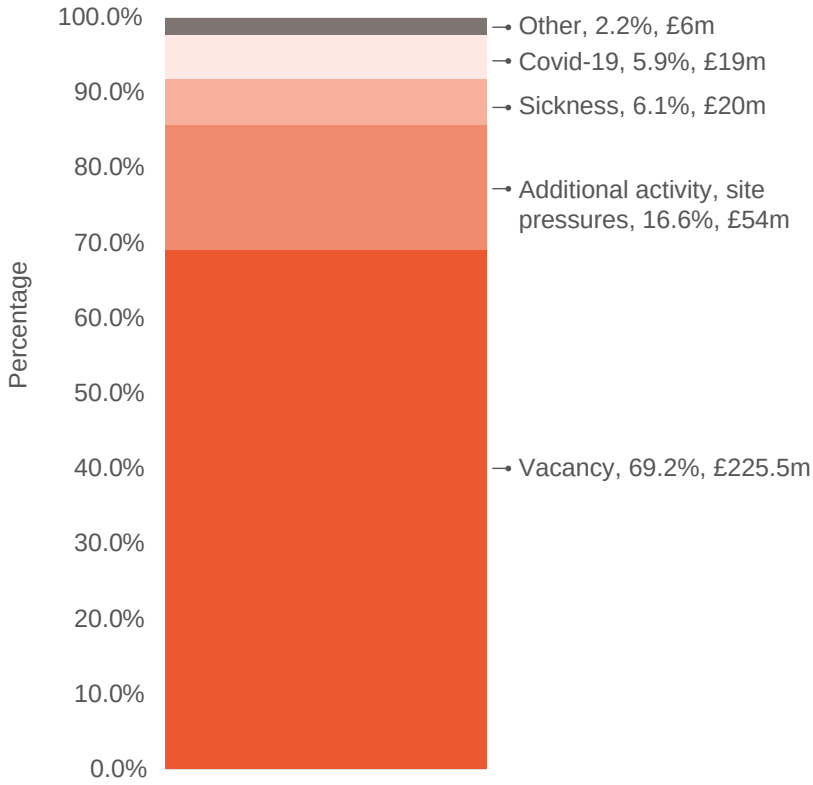
Exhibit 21: All NHS Wales agency spending, 2022-23 £ Million



Source: Monthly Monitoring Returns reported to Welsh Government

Exhibit 22 shows that vacancies are the main factor driving the use of agency staff.

Exhibit 22: NHS agency spend by reason, 2022-23



Source: Monthly Monitoring Returns reported to Welsh Government

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

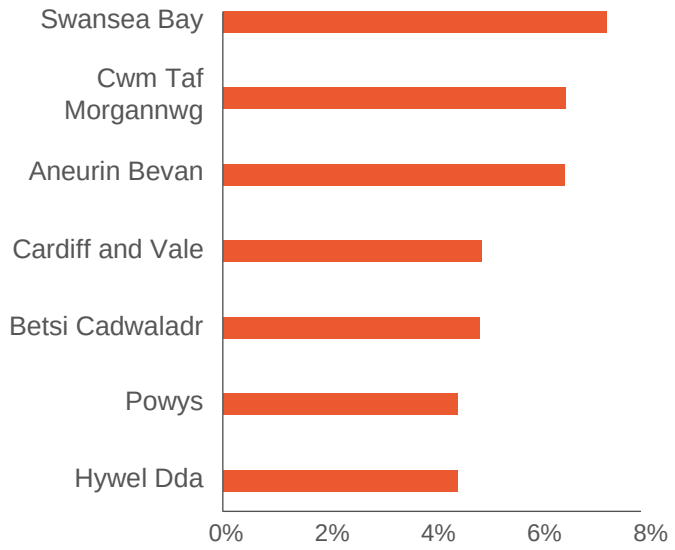
Prev Next

GP locums as a percentage of fully qualified GPs

Exhibit 23 shows the proportion of GP locums in use across Wales employed under the Primary Care General Medical Services contract.

There is clear variation across Wales albeit the overall use of GP locums is proportionately low for all bodies.

Exhibit 23: GP locum use (FTE) as a percentage of all fully qualified GPs, by Health Board, September 2022



Source: Stats Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

06 What is the position on sickness absence?

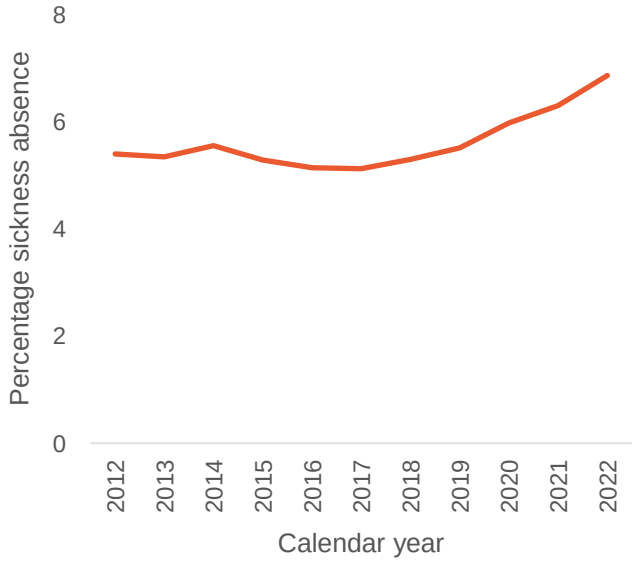
All Wales sickness absence trend

Levels of sickness absence present a substantial challenge for health bodies, particularly when service pressures are so great.

Since 2017, the level of sickness absence has increased, and understandably grew at a greater rate at the onset of the pandemic but has continued to increase since.

While a sickness absence rate of around 6.9% seems proportionately small, the impact is substantial. A loss of 6.9% staff equates to around 6,300 FTE staff lost to sickness absence in 2022-23, equivalent to around 1.4 million working days.

Exhibit 24: All NHS Wales sickness absence, 2012-2022



Source: Stats Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

Reasons for sickness absence

NHS Wales records the reasons for sickness absence on a common system across Wales, the Electronic Staff Record. From 2016-17 onwards, anxiety and stress has been the top reason for staff taking sickness absence, averaging over 27% of cases over the last 7 years.

As would be expected there was a substantial rise in the numbers of staff taking sickness absence because of infectious diseases and a growth of chest and respiratory problems during the pandemic.

Exhibit 25: Sickness absence by reason, top four highest reasons in 2022-23

28%
Anxiety/Stress

8%
Infectious diseases

12%
Other Musculoskeletal

8%
Unknown causes

Source: Health Education and Improvement Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

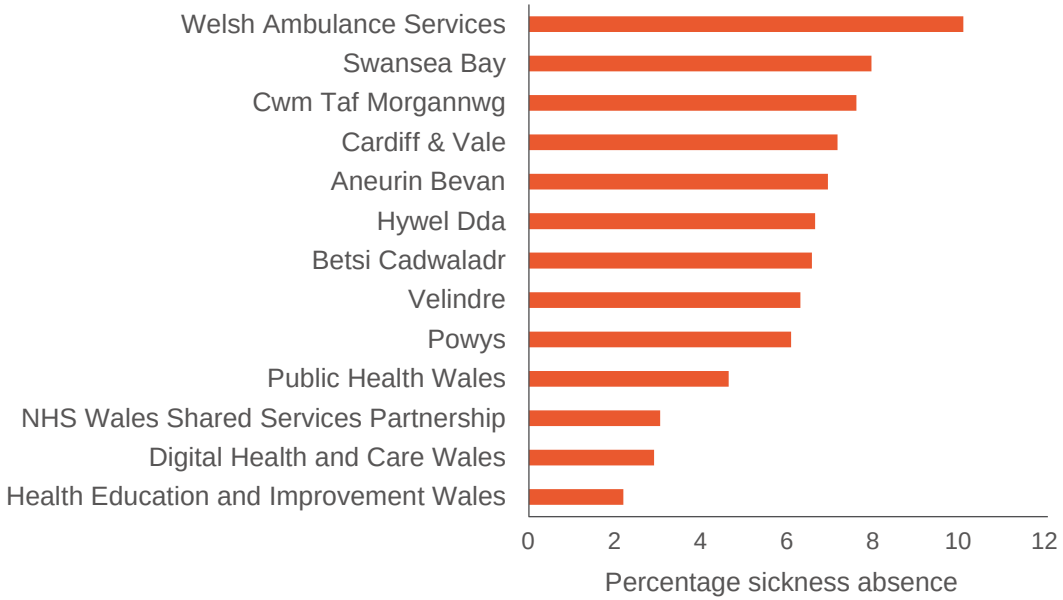
Prev Next

Sickness absence rates by body

Exhibit 26 shows significant sickness absence variation by health body. This may in part relate to differing working environments, service pressures, application of controls and effectiveness of preventative measures and support.

Audit Wales has previously reported on staff wellbeing support in the NHS, in our report on Taking Care of the Carers? The report focusses on wellbeing during the pandemic, but many findings are equally relevant now.

Exhibit 26: Sickness absence percentage by organisation, 2022 (calendar year)



Source: Stats Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

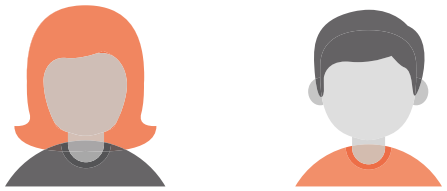
07 Is the NHS a more flexible and equal employer?

Part-time working in NHS Wales – Participation rate

The 'participation rate' is a measure of part-time working across an organisation's workforce. The higher the participation rate the more hours on average, an individual will work each week.

100% participation would mean that all staff are working full working weeks. An 80% participation rate for an organisation would mean that on average their workforce works 4 out of 5 days of a working week.

Exhibit 27: NHS Wales Participation Rate, by gender, March 2023

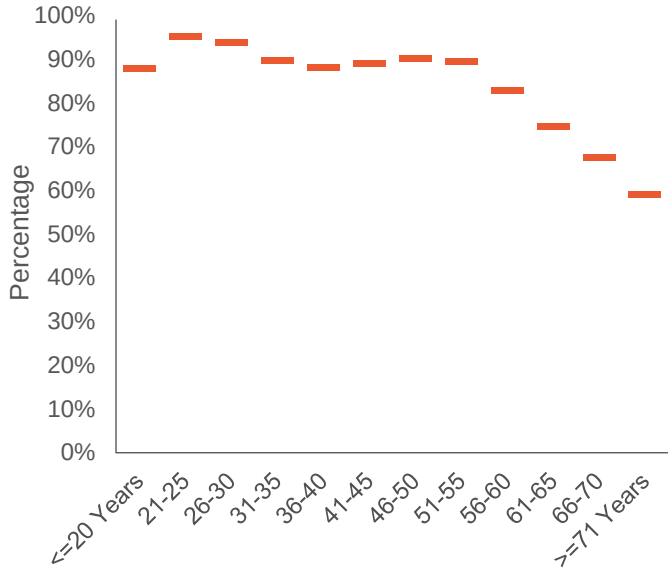


86% female **94% male**

Source: Health Education and Improvement Wales

Exhibit 28: Participation rate (a measure of the extent of part time working), March 2023, by age

The chart shows generally fewer people are working part time up to the age of 30. Between the ages of 30 and 55 part time working is increasing and beyond the age of 56, there is a clear movement to more staff working part time.



Source: Health Education and Improvement Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

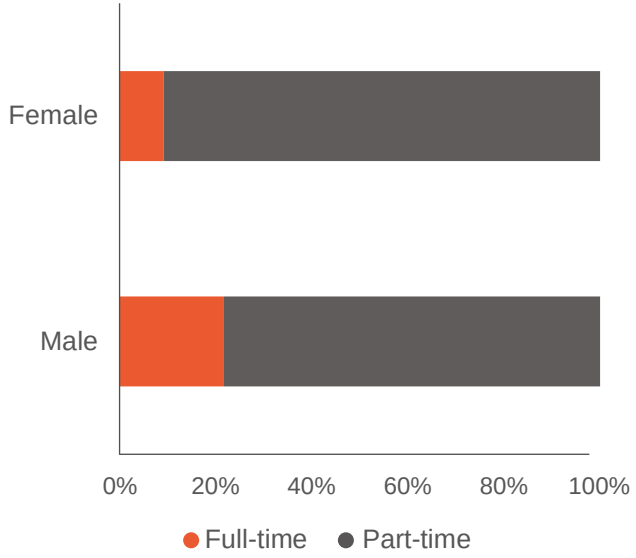
Is NHS Wales growing its own staffing?

Prev Next

GP flexible working and GP gender

A large proportion of fully qualified GPs in primary care are working part-time. In terms of training, we estimate that for every 10 full-time GPs needed in Wales, around 15 people would need to be trained to accommodate current working styles.

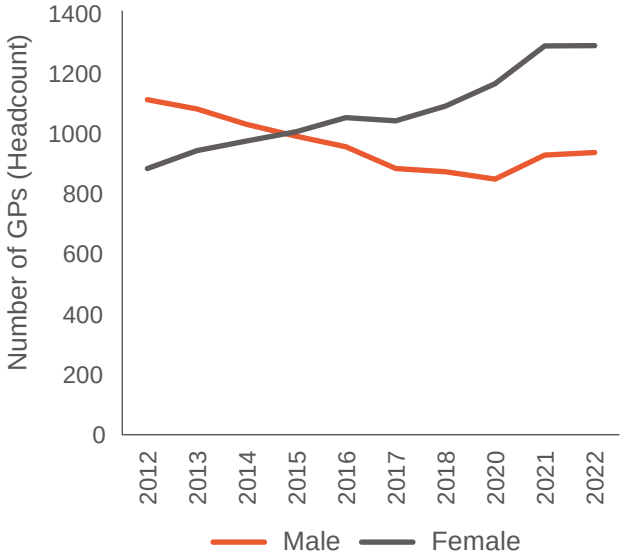
Exhibit 29: Percentage of GPs working full time versus part time by gender, September 2022



Source: Stats Wales

NHS Wales has seen a long-term shift in the gender of GPs working in primary care in Wales. It is difficult to explain the cause of these changes, but it may in part be attributed to the ability to adopt flexible working practices in primary care settings.

Exhibit 30: GPs working in primary care by gender, All Wales, 2012-2022



Source: Stats Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

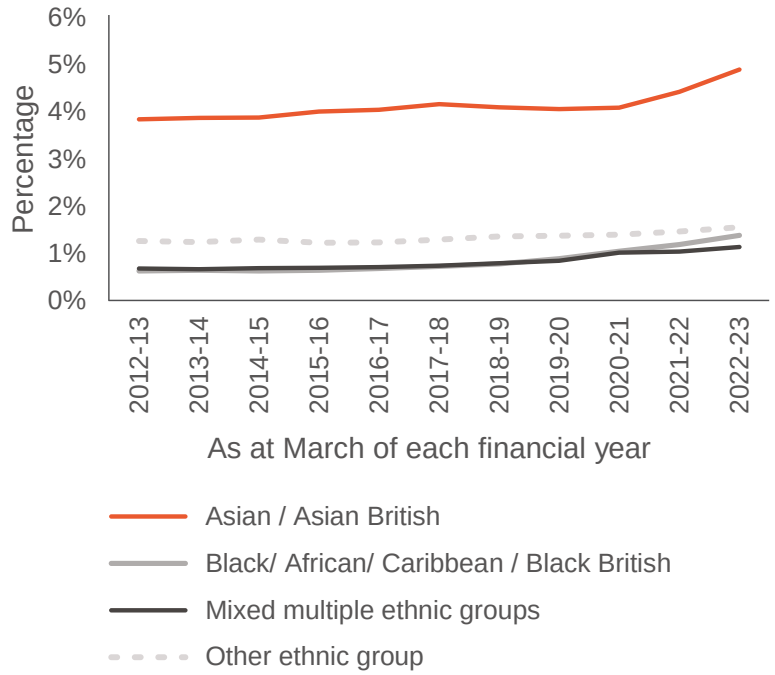
Prev Next

Ethnicity of NHS Wales workforce

NHS data on the ethnicity of the total workforce shows increasing employment of minority ethnic groups.

Note: Ethnicity data is collected by health bodies. More people are completing this data field which is improving reliability over time. In 2022-23, only 3.7% did not provide their ethnicity. Nevertheless, work undertaken by the NHS highlighted that in some cases the accuracy of the ethnicity data should be treated with caution.

Exhibit 31: Proportion of the workforce by ethnicity (excluding white ethnic group)



Source: Health Education and Improvement Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

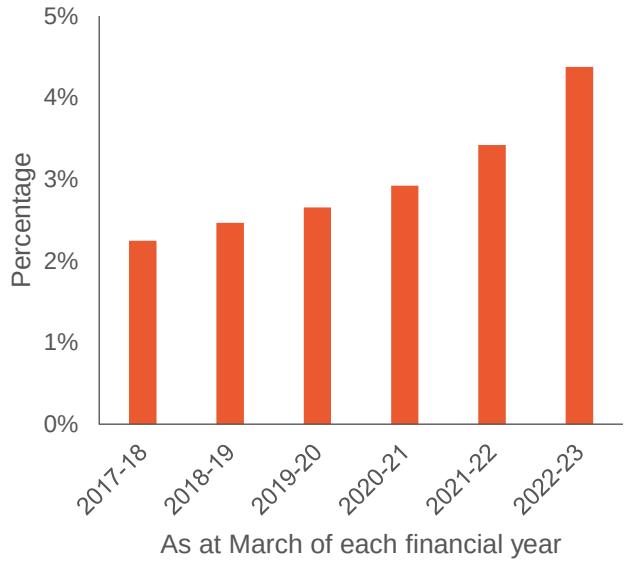
Is NHS Wales growing its own staffing?

Prev Next

Disability in the NHS Wales workforce

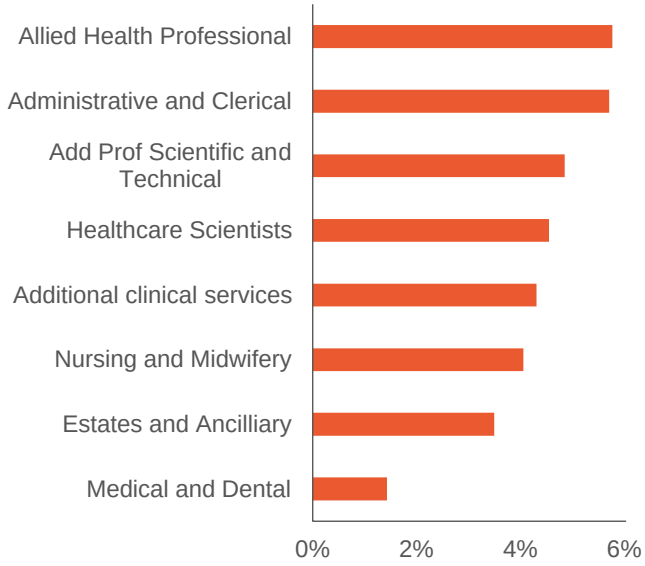
The percentage of staff identifying as disabled has increased over the last 5 years across Wales. The highest proportion of staff identifying as disabled are in Allied Health Professional (4.6%) and Admin and Clerical (4.3%) staff groups.

Exhibit 32: NHS Wales staff identifying themselves as disabled (2017-2023)



Source: Health Education and Improvement Wales

Exhibit 33: Percentage staff declaring as disabled, by staff group, 2022-23



Source: Health Education and Improvement Wales

Note: Disability data is collected by health bodies. The completion rates for this data field is increasing which is improving reliability over time. Nevertheless, the data should be treated with caution.

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

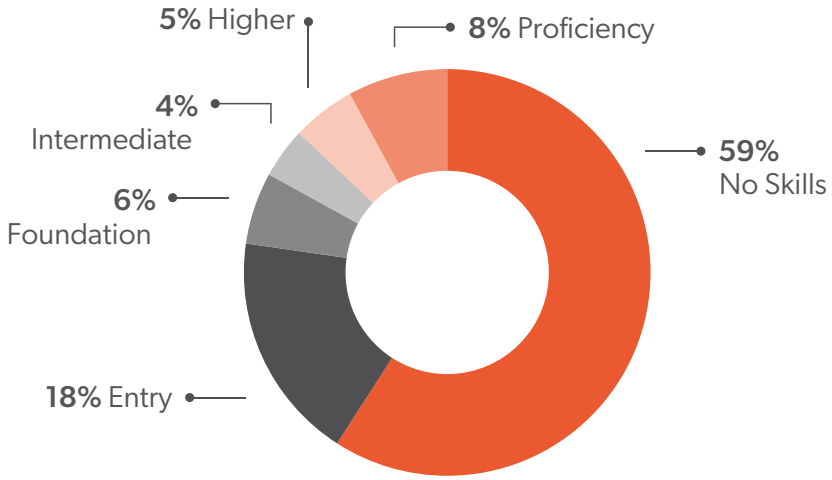
Welsh speaking ability

Around third (30%) of NHS Wales staff have not stated their Welsh language competency in ESR. But of those who have, 59% of staff have indicated that they have no skills and only around 13% have identified that they have higher or proficient Welsh language skills.

For patients who are first language Welsh speakers, it may affect their experience. It may affect their ability to understand their diagnosis, what it might mean for their lifestyle and the treatment options if they cannot communicate in their first language.

There may be further opportunity to encourage those individuals with Welsh language skills to train within Wales to help build a sustainable and thriving Welsh NHS workforce and enhance Welsh language skills.

Exhibit 34: Welsh Speaking Ability, 2022-23*



Source: Health Education and Improvement Wales

Note: NHS Wales records 6 levels of Welsh speaking ability

- No skills
- Entry
- Foundation
- Intermediate
- Higher Level
- Proficient.

See: Learning levels | Learn Welsh for more information

Note: *Analysis of those who have stated their Welsh speaking ability. As identified above 30% of staff have not stated their Welsh language competency.

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

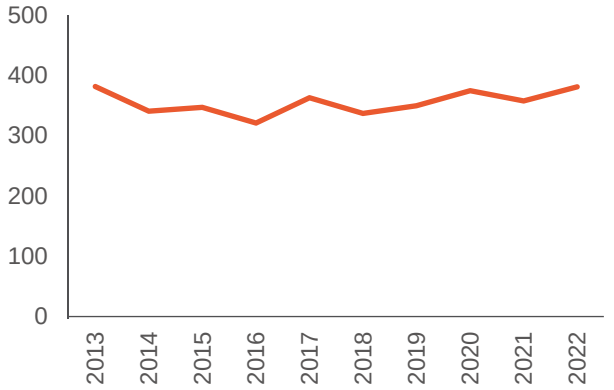
Prev Next

08 Is NHS Wales growing its own staffing?

Medical training in Wales

On average, since 2016, there has been a slight growth in the number of people completing their medical staff training in Wales each year. However, projected growth in demand for care arising from an increasingly elderly population, brings a significant risk that future supply will not meet demand.

Exhibit 35: Numbers of graduates completing their primary medical qualification 2013-2022



Source: Audit Wales analysis of GMC data explorer, Accessed February 2023

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

Many of the doctors that undertook their primary medical qualification in Wales end up practising outside of Wales. Of the 9,153 doctors that undertook their primary medical qualification in Wales and currently registered by the General Medical Council, well over half of them are now practicing elsewhere in the UK.

Exhibit 36: Destination of registered doctors who completed their primary medical qualification in Wales, as of February 2023

9,153 doctors on the GMC register trained in Wales

3,975	doctors remained in Wales
169	doctors are registered in Scotland
4,959	doctors are registered in England
50	doctors are registered in Northern Ireland

Source: Audit Wales analysis of GMC data explorer, Accessed February 2023

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

Medical training in Wales

Exhibit 37 shows the where doctors working in Wales undertook their primary medical training. As of February 2023, 29% of doctors working in Wales undertook their primary medical qualification in Wales. In England, Scotland and Northern Ireland, the corresponding figures were 55%, 63% and 63% respectively. This indicates that in Wales there is a greater reliance on medical staffing from those who originally trained outside of Wales.

Exhibit 37: Percentage of doctors registered to work in Wales by location of their primary medical qualification, as of February 2023

29%	2%	34%	0.4%	6%	29%
trained in Wales	trained in Scotland	trained in England	trained in Northern Ireland	trained in the European Economic Area	trained Internationally

Source: Audit Wales analysis of GMC data explorer, Accessed February 2023

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

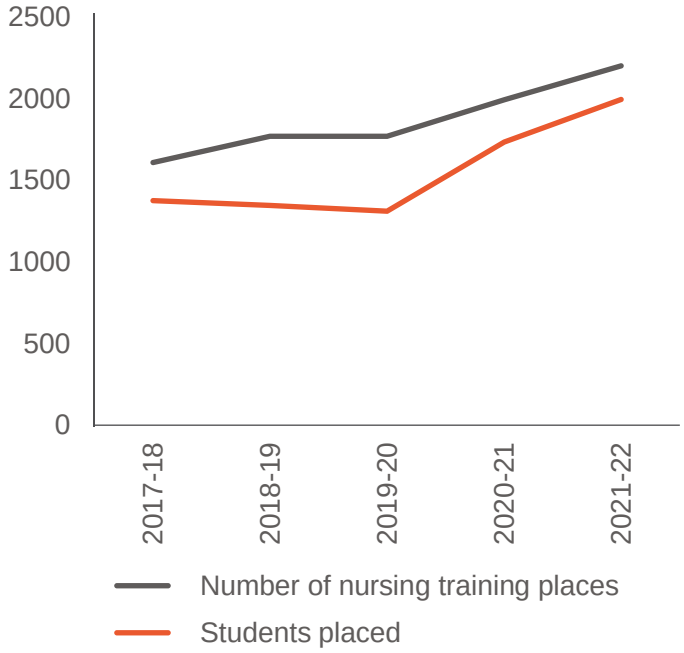
Prev Next

Nursing education in Wales

Exhibit 38 shows a steady growth both in the numbers of nursing education places made available and the numbers of students placed in training. While the growth is positive, not all available places are filled, not all those of those entering training will complete it and some who do will not stay in Wales.

Exhibit 39 shows the 'fill rate'. This is the proportion of education places that are filled, which stood at 91% in 2021-22

Exhibit 38: Numbers of people entering nursing education in Wales



Source: Health Education and Improvement Wales

Exhibit 39: Nursing education fill rate 2021-22

Source: Health Education and Improvement Wales

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

Where do nurses go after receiving nursing education in Wales?

Exhibit 40 shows that most nurses receiving education in Wales, stay in Wales. But a large minority move outside of Wales after completing their education.

*Notes:

The Nursing & Midwifery Council register records location of nurse residence rather than location of employment. Not all nurses in registered in Wales work in Wales. There will be some cross border commuting to work outside of the country of residence. The Nursing and Midwifery Council database does not provide cross-border working breakdown and therefore registration data used for this analysis should be considered an estimate.

Some nurses registered will not be actively working.

Exhibit 40: Destination of nurses educated in Wales, as of September 2022*

31,025 nurses on the NMC register trained in Wales

26,707	remained in Wales
110	nurses are registered in Scotland
4,048	nurses are registered in England
48	nurses are registered in Northern Ireland
112	nurses are registered outside of the UK

Source: Nursing and Midwifery Council register

How is the NHS workforce changing?

What is the cost of the NHS workforce?

How do NHS workforce levels in Wales compare to the rest of the UK

What is the recruitment challenge for NHS Wales?

To what extent does the NHS in Wales rely on temporary staff?

What is the position on sickness absence?

Is the NHS a more flexible and equal employer?

Is NHS Wales growing its own staffing?

Prev Next

Nursing in Wales – where do nurses come from?

As of September 2022, there were 38,901 registered nurses in Wales of which 26,707 (69%) received their nursing education in Wales. Although to a lesser extent than medical staffing, Wales is reliant on a significant number of nurses (around 30 percent) from outside of the country.

Exhibit 41: Percentage of nurses located in Wales by their country/location of nursing education, as of September 2022*

69%	1%	21%	0.1%	1%	8%
trained in Wales	trained in Scotland	trained in England	trained in Northern Ireland	trained in the European Economic Area	trained Internationally

Source: Nursing and Midwifery Council register

Note: *The Nursing & Midwifery Council register records location of nurse residence rather than location of employment. Not all nurses in registered in Wales work in Wales. There will be some cross border commuting to work outside of the country of residence. The Nursing and Midwifery Council database does not provide cross-border working breakdown and therefore registration data used for this analysis should be considered an estimate.

Abbreviations and terminology

Terms used in this report

Term	Explanation
Advanced practitioners	Advanced clinical practitioners come from a range of professional backgrounds such as nursing, pharmacy, paramedics and therapists. They are healthcare professionals with skills and knowledge that enabled them to take on expanded roles and responsibilities when caring for patients.
Agenda for change (A4C)	Agenda for Change refers to a pay and conditions structure for the NHS introduced in 2004.
Agency staffing (NHS)/GP locums	Agency staff are temporary staff members that are not directly contracted by a health body. Health bodies often use commercial agencies to fill short term vacancies and cover sickness absence. Similar to NHS agency staffing, GP locums are staff practising in primary care that do not have a full contract of employment with a GP practice.
Establishment	The agreed number of funded staff positions in an organisation.

Term	Explanation
Full time equivalent or whole time equivalent	Full-Time Equivalent (FTE) is a standardised measure of the workload of an employed person and allows for the total workforce workload to be expressed in an equivalent number of full-time staff. 1.0 FTE equates to full-time work of 37.5 hours per week, an FTE of 0.5 would equate to 18.75 hours per week.
General dental services	General dental services (GDS) contracts came into effect in 2006. General dental services are provided by general dental practitioners who are independent contractors i.e. high street dentists.
General Medical Council	The General Medical Council's remit is defined by the Medical Act 1983 and covers five areas including: Maintaining a medical register, setting standards for doctors, ensuring quality of training, revalidating doctors to ensure they meet standards and provide good care, and investigating concerns of about doctors.
General Medical Services	The General Medical Services (GMS) Contract Wales became effective from 1st April 2004. Is the standard contract between general practice (GPs) and NHS Wales for delivering primary care services to local communities.
Headcount	The actual number of people working in an organisation. Two people working 18.75 hours a week would count as 1 full time equivalent, but have a headcount of 2.

Term	Explanation
Participation rate	The ‘participation rate’ is a measure of part-time working across an organisation’s workforce. It is the average of Full Time Equivalent (FTE) across the workforce. 100% participation would mean that all staff are working full working weeks. An 80% participation rate for an organisation would mean that on average their workforce works 4 out of 5 days of a working week.
Primary medical qualification	Primary medical qualification is the undergraduate medical degree entitling provisional registration to the general medical council.
Registered and Licensed Doctors	Doctors practicing in Wales must be licensed and registered with the General Medical Council.
Staff skill mix/grade mix	The profile of the skill and agenda for change grades working within an organisation or part of it. A guide to the medical register - GMC (gmc-uk.org)
Staff turnover	This is the number or percentage of staff leaving the organisation in a given year.

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AGENDA ITEM No	**9**
OPEN or CLOSED	**Open**
No of ANNEXES ATTACHED	**4**

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Audit Committee
DATE	30th November 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk, Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

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

2. A summary of these risks is set out in Annex 1 with a detailed description contained within the Board Assurance Framework (BAF) in Annex 4.

3. The more detailed description contained within the BAF provides the Committee with an opportunity to review the controls in place against each principal risk and the assurance provided against those controls where applicable. This will assist Members in evaluating current risk ratings supported by the framework in Annex 2.

4. The principal risks are updated as at 15th November 2023 and each of the risks have been reviewed during this reporting period in line with the agreed schedule detailed at Annex 3. Focus has been given to the risk ratings, controls, assurances, gaps and the mitigating actions identified and taken to ensure risks achieve their target score.

5. Updates are highlighted in blue on the BAF which show changes to actions, controls and assurances. There has been one material change made during this period, and this is in relation to the risk rating of **Risk 199** which has achieved its target risk score of 10 (2x5). This is due to the demonstrable work that has been undertaken across the Trust in relation to the Working Safely Programme and Health & Safety. This risk will be de-escalated to the directorate register and monitored by the Executive Director and team on a quarterly basis.

6. Whilst there have been no further material changes made during this period, the BAF includes a commentary for each risk for the Risk Owner to describe the rationale for the risk ratings which is particularly important where ratings have remained static or increased.

7. Notwithstanding, a detailed review, discussion and challenge takes place with the Executive Leadership Team (ELT) and Assistant Director Leadership Team (ADLT) on these risks monthly.

8. The focus for the forthcoming round of reviews will predominantly be in relation to the mitigating actions identified and taken to support risks to achieve their target score and it is foreshadowed that there will be reductions in scores relating to **Risks 139** and **163** during the next scheduled review and which will be reported to the January 2024 Trust Board.

9. **Risk 139** will be considered in conjunction with the level of financial risk detailed in the Trust's financial monitoring returns submitted to Welsh Government. The score will be shown to improve in year as a result, in part due to the Trust being able to resource the remaining cost of the Emergency Medical Service (EMS) staff increase itself in year, whilst further confirmation and assurance has been received from Welsh Government on any pay award funding due. In addition, a recent letter from Welsh Government confirmed that the Trust does not need to contribute anything further to the wider NHS Wales deficit reduction plan or will see any further reduction in its income to do so, providing further confidence that for this financial year, the risk has reduced. It must be noted that even though the level of risk has reduced for this year, in the current challenging financial climate for all public sector organisations the risk will remain elevated as focus turns towards financial planning for the new financial year, for example, recurrent funding will still need to be agreed with Commissioners for 2024/25 for the 100 wte EMS staff.

10. **Risk 163** - The Welsh Government's position on the financial situation across the NHS is now known and it has been confirmed that the Trust is not being asked to find additional savings on top of its original 2023/24 savings target. The Trade Unions are aware of this and have indicated that they are reassured based on this update. Additionally, The Welsh Ambulance Services Partnership Team (WASPT) members are undertaking a development session in November 2023, using the Insights Tools to help understand preferences, communication styles and will be used to continue to build relationships. This will be supplemented with dedicated face to face events between managers and local representatives over the coming months to ensure there is a shared understanding of partnership working and roles across all business areas within the Trust. The Chief Executive Officer and Director of People Services will be attending all these events to position the organisational commitment to effective partnership working. These actions support the rationale to reduce this risk score, whilst acknowledging that the relationship and partnership approach requires significant investment both in terms of time, maintaining strong healthy working relationships and professionally discussing key strategic and people related issues.

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

RECOMMENDATION:

12. Members are asked to consider and discuss the contents of the report and:
    (a) Note the review of each principal risk including ratings and mitigating actions.
    (b) Note the de-escalation of Risk 199 from the Corporate Risk Register to the Directorate Risk Register as this has reached its target score of 10 (2x5).
    (c) Note the update on the Risk Management Policy.
    (d) Note the update on the Risk Management Transformation Programme.

KEY ISSUES/IMPLICATIONS
The key issues and implications are set out in the Executive Summary above.

REPORT APPROVAL ROUTE
Each of the Principal Risks have been or are due to be considered by the following Committees, as relevant to their remit, during the forthcoming reporting period: Quality, Safety & Patient Experience (31 October 2023) EMT (15 November 2023) Finance & Performance Committee (13 November 2023) People & Culture Committee (16 November 2023) Trust Board (23 November 2023)

REPORT ANNEXES
SBAR report. Annex 1 - Summary table describing the Trust's Principal Risks. Annex 2 – Scoring Matrix Annex 3 – Frequency of Risk review Annex 4 - Board Assurance Framework

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

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

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

2. A summary of the Trust's 15 principal risks on the Corporate Risk Register (CRR) is detailed in Annex 1; each of the risks have been fully and formally reviewed in line with the review schedule.

BACKGROUND

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

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

ASSESSMENT

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

4. The ELT has approved the principal risk activity described in this paper and considered the full review of each risk undertaken throughout October and November 2023 by Risk Owners and the ADLT.

<u>Principal Risks</u>

5. The principal risks are updated as at 15th November 2023. Each of the risks have been reviewed during this reporting period in line with the agreed review schedule detailed at Annex 3. Focus has been given to each of the risk ratings and the mitigating actions identified and taken to ensure that risks achieve their target score. This is in addition to the regular review of controls, assurances, and any gaps.

6. Specifically, The Trust's highest rated Risks 223 and 224, scoring 25, remain unchanged because of sustained and extreme pressure across the Welsh NHS

urgent and emergency care system which is negatively impacting on patient flow leading to avoidable patient harm and death. These risks continue to be closely monitored by management, Board Committees, and at the Trust Board meetings.

7. As reported to the September 2023 Trust Board, whilst good progress has been made on the actions that the Trust can control, the extreme pressure continues. As a result, the likelihood is that the levels of avoidable harm will continue. That does not mean that the Trust is not continually seeking additional actions to mitigate these risks and the actions are articulated in the avoidable harm paper that the Board receive at each meeting.

8. Several updates have been made to the controls and assurances in relation to Risk 223 and 224 during this period and these are highlighted on the BAF to address gaps in assurance.

9. A full review of Risk 199 has been undertaken during October 2023 and a reduction in score has been approved by the ELT given the demonstrable work that has been undertaken across the Trust in relation to the Working Safely Programme and Health & Safety. The Trust has moved on significantly in terms of Health & Safety and the corporate risk of failing to embed a positive Health and Safety culture has now been mitigated. This means that the risk has reached its target score of 10 (2x5) and this is due to several factors:

10. An internal audit undertaken during quarter 1 of 2023/24 by NWSSP assessed 6 key areas and reasonable assurance was achieved on each area thus providing a reasonable assurance rating overall. The previous audit undertaken during 2018/19 returned a limited assurance rating which demonstrates the progress made by the Trust over the last 4 years.

11. An assessment was undertaken by the Health & Safety Team including relevant stakeholders across the Trust against the Legislative Register which provided a moderate level of assurance. This score was approved by the Senior Operations Team.

12. The Health and Safety Policy was approved by the People & Culture Committee in November 2023 and this makes reference to a culture of interdependency. The Policy is now being published and rolled out across the Trust.

13. The Working Safely Programme has been incorporated into business-as-usual activities. There are 4 IMTP deliverables monitored by the Strategic Transformation Board and an annual improvement plan, containing 6 additional actions, which is monitored by the Health & Safety Committee.
14. A number of Health and Safety inspections have been completed across the Trust during this year with 87% of Trust premises being assessed as 86% - 100% compliant.

15. A Hazard Register is in place and has been assessed; and is a live document which provides a RAG assurance rating against all known Trust hazards. Any Red/Amber rated hazards are likely to be reduced as further Risk Assessments of Standard Operating Procedures are developed and implemented.

16. The commitment made by the Board and ELT to undertake the IOSH training has been fulfilled and this is being rolled out to ADLT and further across the Trust.

17. The Health & Safety Team has been successfully embedded within and throughout the Trust and partakes in regular and routine discussions with all staff and at relevant business meetings on all matters pertaining to Health & Safety business.

18. A culture survey has been developed and will be rolled out in the next quarter to measure the success of the transformation of the Health & Safety culture change programme.

19. The Health & Safety Team are regular attendees at the formal and informal Operations meetings demonstrating a priority commitment to the subject on the Agendas.

20. A level of external assurance was received from the Coroner in relation to an investigation and who stated that the Health & Safety report produced by the Trust was of a high standard and that the extent of the learning recommended was evident within the paper. There was no determination to issue a Regulation 28 as a result.

21. The next step for this Principal Risk is that it will be de-escalated to the directorate level and this will be monitored by the Executive Director and team on a quarterly basis.

<u>Further Review of Risks</u>

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

    a. IIS, CAS, Symptom Checkers, Website, Clinical Workforce training and funding.
    b. Internal Management Capacity to Delivery the IMTP
    c. Decarbonisation Risk (overarching the programme risks)
    d. Covid-19 Inquiry risks
    e. Charity Risks
    f. Volunteer Fundraising Risk
    g. Technical Planning Risk

Risk Management Policy

23. The Risk Management Policy has been developed and will be navigating Trust governance process in advance of submission to the Audit Committee for approval in March 2023. A procedural document will accompany the Policy to support its delivery.

Risk Management Transformation Programme

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

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

26. The 2024-2025 IMTP will predominantly focus on the design and delivery of a strategic BAF including strategic risks aligned to the long term strategic objectives as well as a series of risk appetite statements.

27. This programme is overseen by the Audit Committee.

RECOMMENDED

28. Members are asked to consider and discuss the contents of the report and:
    (a) Note the review of each high rated principal risk including ratings and mitigating actions.
    (b) Note the de-escalation of Risk 199 from the Corporate Risk Register to the Directorate Risk Register as this has reached its target score of 10 (2x5).
    (c) Note the update on the Risk Management Policy.
    (d) Note the update on the Risk Management Transformation Programme.

Annex 1 – Corporate Risk Register Summary

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

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

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

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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.		
199 PCC **De - escalating from Corporate Risk Register to Directorate Risk Register**	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	**10 (2x5)** ↓ **Reduced from 15 (3x5)**
260 FPC	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	**IF** there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place **THEN** there is a risk of a significant information security incident	Director of Digital Services	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		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		
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 Services	**15 (3x5)** →
558 PCC	Deterioration of staff health and wellbeing in as a consequence of both internal and external system pressures	**IF** significant internal and external system pressures continue **THEN** there is a risk of a significant deterioration in staff health and wellbeing within WAST **RESULTING IN** increased sickness levels, staff burnout, poor staff and patient experience and patient harm	Director of Workforce & Organisational Development	**15 (3x5)** →
594 FPC	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	**IF** a major incident or mass casualty incident is declared **THEN** there is a risk that the Trust cannot provide its pre-determined attendance as set out in the Incident Response Plan and provide an effective,	Director of Operations	**15 (3x5)** →

CORPORATE RISK REGISTER				
RISK ID	**NEW RISK TITLE**	**NEW SUMMARY DESCRIPTION**	**EXECUTIVE OWNER**	**RISK SCORE**
		timely or safe response to patients **RESULTING IN** catastrophic harm (death) and a breach of the Trust's legal obligation as a Category 1 responder under the Civil Contingency Act 2004.		
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)** →
283 FPC	Failure to implement the EMS Operational Transformation Programme	**IF** there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme **THEN** there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters **RESULTING IN** potential patient harm, deterioration in staff wellbeing and reputational damage	Director of Strategy Planning & Performance	**12 (3x4)** →

Annex 2 - Risk Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	oderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	ocal media coverage - short-term reduction in public confidence/trust. hort-term negative social media. ublic expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic

1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Annex 3 - Frequency of Risk Review

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

Risk ID 223	**The Trust's inability to reach patients in the community causing patient harm and death**	**Date of Review:**	**27/10/2023**	**TREND**	**25 (5x5)**
		Date of Next Review:	**27/11/2023**	➡	

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

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

IMTP Deliverable Numbers:

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

Risk Commentary Q2 2023/24

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

In August 2023, over 19,000 hours were lost to hospital handover equivalent to 23% of the Trust's conveying capacity. However, Cardiff & Vale University Health Board is particularly noticeable for its handover hours improvement trend although other Health Boards continue to experience protracted delays. The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes and extended recovery times. Delays across the system continue to be the main focus of patient safety incidents, complaints, Coronial enquires and redress / claims. The effectiveness of our controls in many areas are dependent on external partners acknowledging and having ownership of the risk across the urgent and emergency care system. Key to moving the position is to continue to work in collaboration influencing system partners, being present and engaging in key conversations, whilst continually seeking opportunities internally to swiftly identify and mitigate the risks within our control and share those with relevant system partners that we cannot control. Of note, recent data analysis highlights the increased levels of red activity which has doubled since the pre covid period, plus an average increased on scene time of circa 10 minutes. Both measures are reflective of an increasingly challenged system with WAST crews fully exploring admission avoidance alternatives.

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

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

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

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	27/10/2023	TREND	25 (5x5)
		Date of Next Review:	27/11/2023		

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

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

	months with Welsh Government. NWSSP Information Management Internal Audit report February 2022 (External Assurance). Consult and Close rate has increased from 12% to circa 15% March 2023.
8. Advanced Paramedic Practitioner (APP) deployment model / APP Navigation	8. **WAST has attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.**
9. Clinical Safety Plan	9. Clinical agreement – agreeing escalation to higher levels, ODU dashboard, AACE paper through National Director of Operations group
10. Recruitment and deployment of CFRs	10. Volunteers are another resource for response, Volunteer
11. ETA scripting	11. The ETA Dashboard is a tactic that was signed off by EMT – there is a dashboard that supports scripting analysed by comparing with real time data
12. Clinical Contact Centre (CCC) emergency rule	12. CCC Emergency Rule is policy that has been signed off by Execs.
13. National Risk Huddle	13. This is a tactic contained in REAP ratified through SPT and EPT. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
14.	14.
15. Summer/Winter initiatives	15. Monitoring through SLT and STB
16. CHARU implementation	16. Monitored via the EMS project Board
17. National Transfer & Discharge Model	17.
18. Conveyance Reduction	18. This is part of the weekly performance review and aligned to Care Closer to Home Programme
19. Access to Same Day Emergency Care (SDEC) for paramedic referrals	19. This forms part of the handover improvement plans in place with Health Boards; however assurance is limited given that the acceptance of paramedic referrals is low (less than 1%) and inconsistent.
20. Mental Health Practitioners in cars	20.
21. Roll out of ECNS	21. Reported through QuEST
22. Clinical Model and clinical review of code sets	22. Reported through QuEST
23. Remote Clinical Support Strategy	23. Strategic Transformation Board – IMTP deliverable
24. Trust Board paper (28/07/22) detailing actions being taken to mitigate the risks (see actions section for details of specific work streams being progressed to mitigate this risk)	24. Formally documented action plan – actions captured are contained within and monitored via the Performance Improvement Plan (PIP)
25. Information sharing	25. Information Sharing: Patient Safety Reports, Chief Operating Officer (COO) Data Pack, Immediate Release Declined (IRD) Reports.
26. Completed EMS Roster Review	26. Helps to ensure that we have the maximum available capacity to respond to dispatch to 999 calls received in a timely manner
27. Work underway to reduce the number of multiple attendances dispatched to red calls	27. This will increase vehicle availability generally across the Trust
28. Transfer of Care	28. WAST has clearly articulated to the Health Board COOs the risk associated with delayed handovers. Consequently, work has commenced to withdraw WAST staff from portering duties on hospital premises, cease the practice of ED swaps and cease the use of WAST equipment in EDs across Wales. Please refer to the following documents: i) Letter to COO Handover Delays 30.03.2023 ii) Letter to COO Handover Delays iii) WAST – Transfer of Care Brief

Risk ID 223	The Trust's inability to reach patients in the community causing patient harm and death	Date of Review:	27/10/2023	TREND	25 (5x5)
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IF significant internal and external system pressures continue	THEN there is a risk of an inability and/or a delay in ambulances reaching patients in the community	RESULTING IN patient harm and death		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	5	5	25
			Target	2	5	10

29. New 2023 EMS Demand and Capacity (roster) review	29. To commence in order to ensure we continue to match capacity and demand to our best ability
30. Connected Support Cymru – **is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.**	30. Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform and a Community Welfare Responder model to enhance community resilience. • **Phase 1 delivered through St John Ambulance Cymru** • **Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers.**
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Acknowledgement and acceptance of risk by Health Boards and balancing the risks across the whole system	1. Improvement in handover delays across Cardiff and Vale and more latterly across AB have led to improved handovers at Eds. This has now been sustained for some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in AB, commencing at 4hour tolerance with a plan to reduce over time. In other Health Boards, there remains little or no controls, with variation in both handovers and risk levels across Health Boards. **An extraordinary incident declared by WAST on 22 October 2023 as direct result of system risk associated with handover delays at Morrison hospital has increased focus on handover delays with external partners and across the media. Some plans are in train following a meeting with Swansea Bay COO to include mobile imaging, pathways to bypass ED and a pod solution ahead of winter.**
2. Blockages in system e.g. internal capacity within Health Boards which affect patient flow	
3. Covid capacity streaming	
4. Transition Plan/Inverted Triangle – bid for transition plan has been put in and is now subject to funding	
5. Local delivery units mirroring WAST ODU	
6. Handover delays link to risk 224	
7.	
8. During industrial action days, Health Boards demonstrated compliance with reducing handover delays in order to maximise WAST resources. Despite a reduced volume of conveyance as a result of the industrial action, there is however a demonstration that reduced handover delays are achievable, and this therefore warrants a triangulation of data.	
9. There is an ambition that no handover should exceed 4 hours and for lost hours to handover to be reduced by 25% but given the track record over last 6 months there is a low confidence in attaining this.	
10. Outputs from the NHS System Reset – it is a closer collaboration to address some of the system blockages and reduce system pressures. This is the aspiration	
11.	
12. Handover Improvement Plans agreed between WAST and Health Boards	12. Handover Improvement Plans have been replaced by Integrated Commissioning Action Plans (ICAPS) and are subject to review with EASC; However, it is noted that previous plans did not demonstrate sufficient improvement in reducing handover delays
18. National Transfer & Discharge Model	18. National Transfer & Discharge model is yet to be determined. A task and finish has been established to progress this piece of work
21. Mental Health Practitioners	21. Mental Health Practitioners – not yet implemented but part of the Care Closer to Home workstream
Please note that the gaps listed are not WAST's and are therefore outside of the control of WAST	

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		Date of Next Review:	27/11/2023		

IF	THEN	RESULTING IN
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

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Exploring Rural model options (Paused during Pandemic Response) – subject to funding through IMTP. Now refreshed to wider rural model opportunities to include recruitment of CFRs. Additional funding has been sourced to increase posts within the volunteer function.	Assistant Director of Operations EMS / Assistant Director of Operations – National Operations & Support	Superseded	Rural model superseded by Action 9 below (Recruitment and deployment of CFRs)
2. Leading Change Together (forum to progress workforce related work streams jointly with TUPs)	ADLT Sub-Group	30.09.22 - Superseded	
3. EMS Demand & Capacity i.e. review and implementation of new EMS rosters	Assistant Director of Operations EMS	Complete	Majority of EMS rosters complete and implemented
4. Transition arrangements post pandemic	Executive Pandemic Team / Assistant Director of Strategic Planning (BCRT Chair)	Complete 30/08/22	Transition complete
5. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE (I) [Source: Action Plan presented to Trust Board 28/07/22]	Director of Paramedicine / Director of People & Culture	**Extended to March 2024**	**WAST as attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.**
6. Maximise the opportunity from Consult and Close – stretch to 15% and beyond (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, Integrated Care	31.03.23 Complete	Work undertaken to map influences and progress towards each. Current % of Consult and Close increased from 12% to 15% at March 2023.
7. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support	Complete	System in place and ongoing.
8. Weekly REAP review by senior Operations Directorate team with assessment of action compliance (I) Source: Action Plan presented to Trust Board 28/07/22]	Director of Operations / Operations Senior Leadership Team	Complete	In place and ongoing - Weekly Performance Meetings occur every Tuesday lunchtime to review performance, etc. and determine REAP level.
9. Recruitment and deployment of new CFRs (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Operations, National Operations & Support / National Volunteer Manager	Complete 21.03.23	Additional CFR Trainers and Operations Assistants appointed to support recruitment and training of new CFRs. Volunteer Management Team, supported by the Volunteer Steering Group, now embarking on volunteer recruitment programme and increasing public engagement to raise awareness about volunteering opportunities available within WAST. Volunteer team has recruited and trained 173 additional volunteers between November and March 2023.
10. Transition Plan (I) [Source: Action Plan presented to Trust Board 28/07/22]		Superseded	
11. Overnight Falls Service extension (I) [Source: Action Plan presented to Trust Board 28/07/22]	Assistant Director of Quality & Governance / Head of Quality Improvement	Ended March 2023	The temporary extension of the SJAC contract for overnight provision was evaluated, demonstrating on available evidence a positive performance impact over the period of operation (Jan-April 2023). The evaluation report was presented to EMT on 5 April 2023. The contract extension (as a temporary arrangement) ceased on 5 April 2023. Falls service enhanced day and night provision remains in place and utilisation of resources is reviewed at weekly performance meetings by Operations SLT.

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	24/10/2023	TREND	25 (5x5)
		Date of Next Review:	24/11/2023	➡	

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:

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

Risk Commentary Q2 2023/24

The risk score remains constant at 25 for quarter 2 2023/24 (almost certain & catastrophic). Internal and external assurances remain weak as there remains a daily risk of actual patient harm due to handover of care delays. **There were 1,475 patient handovers in August 2023 which were over 4 hours. The target was originally to have zero by September 2022. In August 2023, over 19,000 hours were lost to hospital handover equivalent to 23% of the Trust's conveying capacity. However, Cardiff & Vale University Health Board is particularly noticeable for its handover hours improvement trend.** The impacts on patients waiting for extended periods of time both in the community and then outside emergency departments is well documented (AACE Delayed Hospital Handovers: Impact assessment of patient harm, 2021) and includes pressure damage, acute kidney injury, deconditioning, poorer outcomes and extended recovery times. Delays across the system continue to be the main focus of patient safety incidents, complaints, coronial enquires and redress / claims. The Trust received **three** Prevention of Future Death Reports (Regulation 28) **during this quarter. Two reports were issued to the Trust, Betsi Cadwaladr University Health Board and the North Wales Local Authorities due to extended community response and handover of care delays.**

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

Improvement actions led by Welsh Government and system partners include:

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

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

Risk ID 224	Significant Handover of Care Delays Outside Accident and Emergency Departments Impacts on Access to Definitive Care Being Delayed and Affects the Trust's Ability to Provide a Safe & Effective Service for Patients	Date of Review:	24/10/2023	TREND	25 (5x5)
		Date of Next Review:	24/11/2023	→	

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

5. Workstreams put in place to meet requirements of *Right care, right place, first time Six Goals for Urgent and Emergency Care A policy handbook 2021–2026.* Goal 4 incorporates the reduction of handover of care delays through collective system partnership. WAST membership at system workshops supported by Commissioners looking at handover of care delays which includes the implementation of the Fit2Sit programme and handover of care checklist pan NHS Wales. Learning from NWAS shared that indicates up to 20% of ambulance arrivals may be suitable for Fit 2 Sit Additionally, the Emergency Ambulance Services Committee (EASC) have stated that no delay should exceed 4 hours.	5. Monthly Integrated Quality and Performance Report
6. Hospital Ambulance Liaison Officer (HALO) (Some Health Boards).	6.
7. Regional Escalation Protocol and Resource Escalation Action Plan (REAP). Proactive and forward-looking weekly review of predicted capacity and forecast demand. Deployment of predetermined actions dependant on assessed level of pressure. Consideration of any bespoke response/actions plans in the light of what is expected in the coming week. WAST has updated the REAP in advance of winter, including revised triggers (higher) for handover lost hours.	7. The Senior Leadership Team convenes every Tuesday as the Weekly Performance Meeting to review performance and demand data, and review/assign REAP Levels as appropriate. Dynamic escalation is via the Strategic Command structure.
8. Staff from WAST, Health Boards and third sector organisations assisting to meet patient's Fundamentals of Care as best they can in the circumstances.	8. Confirmed through Healthcare Inspectorate Wales (HIW) workshops and Health & Care Standards self-assessment process and Putting Things Right Quarterly Reports to Clinical Quality Governance Group and QuESt
9. 24/7 operational oversight by ODU with dynamic CSP review and system escalation as required. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays.	9. Shift reports from ODU & ODU Dashboard received by Executive Management Team (EMT), Senior Operations Team (SOT) and On-Call Team at start/end. Realtime management and escalation of risks and harm with system partners. Triggering and escalation levels within CSP to best manage patient safety in the context of prevailing demand and available response capacity. Monitoring, escalation and reporting of extreme response or handover delays
10. Gold/Strategic, Silver/Tactical and Bronze/Operational 24 hour/ 7 day per week system to manage escalation plans.	10. Shift reports from ODU & ODU Dashboard received by EMT, SOT and On-Call Team at start/end.
11. Escalation forums to discuss reducing and mitigating system pressures.	11. Daily risk huddles are recorded, and documented actions are shared with stakeholders and progress monitored via the ODU.
12. WAST Education and training programmes include deteriorating patient (NEWs), tissue viability and pressure damage prevention, dementia awareness, mental health.	12. Monthly Integrated Quality and Performance Report (**July 2023 overall 75%** - Safeguarding and dementia **awareness remains** over 90%.
13. Clinical audit programme in place.	13. Clinical audit programme in place (dynamic document) with oversight from the Clinical Quality Governance Group and QuEST.
14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover* (undertaken 2021). WAST has senior representation at this meeting. – assurance is that HIW approve and sign off WAST elements and Health Board elements of recommendations.	14. Workshop set up by the Deputy Chief Ambulance Commissioner to respond to the findings in the Health Care Inspectorate Wales (HIW) Report Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (undertaken 2021). WAST has senior representation at this meeting. A collective response from WAST and Health Boards is being overseen by EASC.
15. Escalation of patient safety concerns by Trust Board: featured in provider reports to the Emergency Ambulance Committee (EASC); been the subject of Accountable Officer correspondence to the NHS Wales Chief Executive; numerous escalations to professional peer groups initiated by WAST Directors; and coverage at Joint Executive Meetings with Welsh Government. Evidence submission to Senedd Health and Social Care Committee. Written evidence submitted during Q4 21/22 to the committee to assist their inquiry into Hospital Discharge and its impact on patient flow through hospitals Report published in June 2022 containing 25 recommendations with recommendation six specifically WAST related stating "The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service's statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets."	15. Monthly Integrated Quality and Performance Report, CEO Reports to Trust Board including 'Actions to Mitigate Avoidable Patient Harm Report' (last presented to Trust Board July 2023 and Board sub-committee oversight and escalation through 'Alert, Advise and Assure' reports.

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:	24/10/2023	TREND	25 (5x5)
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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

16. Implementation of Duty of Quality, Duty of Candour and new Quality Standards requirements in April 2023.	16. Welsh Government Road Map in place (soft launch) with milestones for organisations – baseline assessment and monthly updates (RAG ratings) in place with Trust Board oversight. The current internal assessment overall as of July 2023 is 'Implementing and operationalising'. The Trust has representation on the All Wales Duty of Candour Implementation Group and is actively engaged in developing resources.
	External Sources of Assurance Management (1st Line of Assurance)
	1. Monitoring and oversight of the Ambulance Quality Indicators (AQIs) including handover of care timeliness and Commissioning Framework by the Chief Ambulance Services Commissioner (CASC), the Emergency Ambulance Services Committee (EASC) including the Integrated Commissioning Action Plans (ICAPS) and Joint Executive Team (JET) meetings with Welsh Government (I&E).
	2. Healthcare Inspectorate Wales (HIW) 'Review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover' Report and system wide improvement plan with working group in place with WAST senior representation. Oversight by HIW and EASC
	3. Duty of Quality and Duty of Candour readiness returns assessment by Welsh Government.
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Lack of capacity in the Putting Things Right Team to deliver across the functions due to competing priorities resulting from sustained system pressures.	1.
2.	2. Implementation of the revised Joint Investigation process remains in pilot stage with good engagement seen by system partners. A number of overdue patient safety investigations remain presenting a risk to patient safety across the system. The Trust has **38** overdue nationally reportable incident investigations. Shared system learning from the Joint Investigation Framework is currently limited.
3. Lack of implementation and holding to account regarding the NHS Wales of the Handover Guidance v2 and recognition of the patient safety risks pan NHS Wales*.	3. 15-minute handover target is not being achieved pan-Wales consistently and has led to a substantial growth in emergency ambulance handover lost hours. In **August 2023**, **19,000** hours were lost with **1,475 +4 hour** delayed patient handovers.
4. Variation in responsiveness at Emergency Departments to the escalating concerns regarding patients' NEWS*.	4. Strengthening of patient safety reports and audit processes as e PCR system embeds.
5.	5.
6. Variation pan Wales / England as position not implemented across all emergency departments*.	6.
7.	7.
8. Variation pan Wales / England as position not implemented across all emergency departments*.	8. New Quality Management System in development which will include monitoring of the new Quality Standards & Enablers and underpinning governance structure.
9. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	9.
10.	10.
11. Variable response pan Wales / England. WAST have minimal control on this at patient level*.	11.
12.	12.
13. Transition to ePCR impacting on data temporarily	13.
14. National steer required to confirm the accountability arrangements regarding patients in ambulances outside of the emergency departments. The seven Local Health Boards (LHBs) in Wales are responsible for planning and securing delivery of primary, community, secondary care services, and also the specialist services for their areas*.	14. HIW approve and sign off WAST elements of recommendations.
15.	15.
	External Gaps in Assurance 1. Lack of escalation and response to AQIs by the wider urgent care system and regulators

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:	24/10/2023	TREND	25 (5x5)
		Date of Next Review:	24/11/2023	➡	

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Handover checklist implementation – Nationally WAST Quality Improvement (QI) Project	WAST QI Team (QSPE)	• TBC - Paused	• Timeframes awaited via Emergency Department Quality & Delivery Framework (EDQDF).
2. Implement patient safety dashboards (live and look back data) triangulating quality metrics / KPIs and performance data sourcing health informatics resource.	Assistant Director of Quality & Nursing	• Q4 2023/24	• Incremental improvements to quality and safety data and information to enable triangulation / collective intelligence at Trust and system level. • Access to ePCR data (NEWS) now available. Work on-going with Health Informatics regarding patient safety and health board dashboards.
3. Continued Health Board interactions – my next patient (boarding), patient safety team dialogue – proactive conversations with Health Board Directors of Quality & Nursing.	Executive Director of Quality & Nursing	• Monthly and as required.	• Monthly meetings continue to be held and networking through EDoNS.
4. Recruit and train more Advanced Paramedic Practitioners – Value Based Healthcare Fund bid for up to 50 WTE	Director of Paramedicine	• Q4 2023/24	• **WAST as attempted to secure additionality within its APP numbers, as the evidence illustrates a dramatic impact upon ED avoidance with more people being managed within the community. At this stage, no additional funds have been secured. However, it remains the case the prospective APPs are completing their education and could be deployed into the operational setting to mitigate the risk. ELT has therefore agreed to grow the APP numbers further this year, redirecting existing operational spend to bolster APP growth.**
5. Overnight falls service extension	Executive Director of Quality & Nursing	• **31.03.2024**	• **Night Car Scheme extension agreed to 31 March 2024 (2 regional resources)** • **Nighttime falls assistance 64% Utilisation (Apr 2023 -Jun 2023)** • **Nighttime July 2023 – September (14th) 2023 utilisation further improved, currently 67%** • **Continued daytime utilisation improvement: July -August 58%.** • **September currently achieving the utilisation target of 60%.** • **Optima modelling to examine optimal resourcing level in September 2023. WAST are in ongoing negotiations with Regional Partnership Boards for several regions to secure ongoing funding.**
6. Duty of Quality, Duty of Candour and new Quality Standards implementation from April 2023 with development of a Quality Monitoring System supporting monitoring and oversight systems in place and embedded.	Executive Director of Quality & Nursing	• Q3 2023/24	• Monthly updates to progress against actions following the baseline assessment and readiness returns. • RL Datix Dashboards and KPIs under development nationally. • Key policies updated and approved. • Participation in the All Wales Duty of Candour implementation group by Patient Safety Team – monthly. • Quality Management System workshop held 12 June 2023.
7. Connected Support Cymru **is initially designed to utilise NHS and voluntary-sector resources and responders to enable patients to be supported in their own home whilst waiting for an urgent healthcare need to be managed. The service will employ digital health technologies to connect patients, communities and clinicals to achieve better health outcomes. The initiative will improve patient experience and safety, while supporting the healthcare system in directing patients to the right pathway at an appropriate time for their care need. It is expected this will help reduce unnecessary demand upon Emergency Departments.**	Executive Director of Quality & Nursing	• Q3 2023/24	• **Multi phased approach commenced in Dec 2022 with St John Ambulance Cymru virtual ward responder, a digital and telehealth platform and a Community Welfare Responder model to enhance community resilience.** • **Phase 1 delivered through St John Ambulance Cymru** • **Funding also obtained through external grant funding to pilot a volunteer phase. which went live mid October with twelve teams piloting the approach. Early results look promising and the ambition to upscale is being explored with a focus on CSD capacity. Whilst the pilot tests the approach with existing CFRs, the ambition is to introduce a new volunteer role to which we will recruit new volunteers. Service live.** • **SBRI Phase 2 commenced; 12 month delivery phase over 12 months (phase 2a (Sept-October) – process design & project scope; phase 2b – deliver business case development concluding**

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:	24/10/2023	TREND	25 (5x5)
		Date of Next Review:	24/11/2023		

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

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

			(due at project board 21 September 2023). Identified cost pressures include project management, Integrated Care staffing, Clinical specialist engagement requirements, further commissioning of SJAC resources.
8. Organisational change process **(OCP)** of Putting Things Right Team (PTR) to enable increased capacity across all functions to manage increasing complexity and demands.	Executive Director of Quality & Nursing	• Q3 2023/24	• **OCP commenced 25.09.2023.**
9. Connect with All Wales Tissue Viability Network to explore strengthening the current investigations into harm from pressure damage across the whole patient pathway.	Assistant Director Quality & Nursing	• Q4 2023/24	• **Positive meeting held in August 2023 as planned with the Chair of the TVN network. Next steps are for the Patient Safety team to attend a TVN leads meeting to discuss opportunities for collaborative working and data / information sharing.**
10. Audit Wales investigation of Urgent and Emergency Care System: Does NHS Wales and its partners have effective arrangements for unscheduled care to ensure patients have access to the right care at the right time?	CEO	• Q4 2023/24	• Conducted in three phases Audit Wales will independently investigate and report on patient flow out of hospital; access to unscheduled care services and national arrangements (structure, governance, and support) • WAST will proactively support this work and offer best practice examples from other jurisdictions that can support benchmarking and improvement activities. • Expected outcomes in 2023/24.
11. Internal Audit to undertake a review of Serious Adverse Incidents & Joint Investigation Framework	Executive Director of Quality & Nursing	• Q3 2023/24	• **Internal audit in progress.**
Completed Actions	**Action Owner**	**When /Milestone**	**Progress Notes:**
1. HIW Improvement Plan / Workshop – WAST inputs / influencing improvements. Response and improvement actions to Healthcare Inspectorate Wales Inspection report (2021) 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover' which links to Fundamentals of Care.	Assistant Director of Quality & Nursing	Completed	
2. Representation at the Right care, right place, first time Six Goals for Urgent and Emergency Care Delivery Boards and Clinical Advisory Board.	Chief Executive Officer	Completed	• Led by the NHS Wales Deputy Chief Executive this programme seeks to modernise access to and the provision of Urgent and Emergency Care across Wales • WAST will be represented on the Clinical Reference Group by Andy Swinburn with first meeting now held. • The Trust recently reported to EASC that is has further updated how it maps into six goals programmes. The programme structure nationally is being embedded and the Trust now has presence on goals 2, 5 & 6 at delivery board level and on the clinical advisory board.
3. Participation in the CASC led workshop to reform the Framework for the Investigation of Patient Safety Serious Incidents (SIs) V2.2, dated July 2019.	Executive Director of Quality & Nursing	Completed	• Revised joint investigation approach agreed and now formalised.
4. Recruit additional frontline capacity – additional £3m non recurrent 22/23 allocation	Director of People & Culture	Completed	• Strong focus from Executives with detailed updates to EMT every two weeks. • Year-end position is +85 FTEs, with a vacancy factor of just 1%, rather than the often used 5%, which would produce a figure of -88 FTEs rather than the estimated - 15 FTEs. • Further non recurrent funding has been secured for 2023/24
5. Transition Plan	Chief Executive Officer	Completed	• Action complete, but the Trust will continue to undertake strategic and technical workforce planning in support of the Trust's ambition e.g. inverting the triangle etc.
6. Consideration of additional WAST schemes to support overall risk mitigation through winter	Director of Operations	Completed	• Winter ended. Focus now on forecasting and modelling for the summer, but Trust not aiming to produce specific Summer Plan (the Trust did during the pandemic linked to travel restrictions). • The Trust needs to determine whether there is value in producing a specific winter plan, particularly, within the context of the financial constraints NHS Wales is not operating in.

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:	24/10/2023	TREND	25 (5x5)
		Date of Next Review:	24/11/2023	➡	

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

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

7. National 111 awareness campaign	Director of Partnerships and Engagement Director of Digital	Completed	• The national awareness campaign was undertaken as planned and ended in March 2023. An evaluation will be provided to the 111 Board.

Risk ID 160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Date of Review:	24/10/2023	TREND	20 (5x4)
		Date of Next Review:	24/11/2023	➡	

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

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

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

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

Risk Commentary

Sickness absence remains one of the key challenges for the organisation. Whilst there has been a significant reduction in absence levels over the past 18 months, rates remain higher than desired and therefore a continued focus on supporting good attendance at work is needed by both managers and the People and Culture team. Increased pressures on our people like handover delay, missed breaks and cost of living impact on health and wellbeing. As we move into winter, we also see increased absence due to respiratory illness and Covid.

The outcome of this is to maintain the risk at a score of 20 and review the level at the end of Q4 2023/24.

CONTROLS	ASSURANCES
	Internal Management (1st Line of Assurance)
1. Managing Attendance at Work Policy/Procedures in place	1. (a) Policy reviews to ensure policies and procedures are fit for purpose (b) Audits by People Services on sickness
2. Respect and Resolution Policy- recognising issues at work may contribute to sick absence	2. Policy reviews to ensure policies and procedures are fit for purpose in line with agreed time frames and contribute to All Wales forum on this policy
3. Raising Concerns Policy- recognising issues at work may contribute to sick absence	3. Policy reviews to ensure policies and procedures are fit for purpose in line with agreed time frames
4. Health and Wellbeing Strategy – key document that outlines commitment to wellbeing and supportive culture	4. Regular reference to strategy to ensure themes are addressed and linked to wider people and culture plan
5. Operational Workforce Recruitment Plans- provide evidence of sufficient resources and identify any gaps or potential areas of increased workload pressure	5. Local plans link to the wider organisational workforce plan and provide intelligence regarding any particular pinch points in terms of resources
6. Roster Review & Implementation- to support demand and capacity which can have an impact on absence levels	6. Roster Review for EMS completed. Review in 111 underway
7. Return to Work interviews are undertaken - Sharepoint Sway document ensuring accurate reporting of reason for absence and identifying any additional support required	7. Process regularly reviewed and managers provided with relevant training and coaching on process and importance of carrying out return to work interviews promptly
8. Training on all aspects of Managing Attendance – ensures focus is high and understanding of why this is important is maintained	8. Regular bitesize training provided for managers, adapted to reflect feedback and to ensure all aspects of managing attendance is understood
9. Directors receives monthly email with setting out ESR sickness data- ensures ownership and awareness	9. Monthly reporting provided with opportunity for discussion with relevant people services lead and Director
10. Operational managers receive daily sickness absence data via GRS- ensures ownership and awareness	10. Provided daily, with opportunity for discussion with relevant people services lead and operational managers
11. People Services & Occupational Health & Wellbeing support/Employee Assistance Programme- providing professional support	11. Monthly reporting on services provided, volume of referrals and timeframes for accessing support.
12. WAST Keep Talking (mental health portal) additional measures to offer support	12. Quarterly reporting on numbers accessing and regular promotion of service.
13. Suicide first aiders- additional layer of support	13. Quarterly reporting of numbers of trained suicide first aiders and numbers who have accessed.
14. TRiM- additional layer of support	14. Quarterly reporting on access to TRiM and promotion of service
15. Peer Support network- additional level of support	15. Promotion of network and support provided
16. Coaching and mentoring framework- additional level of support	16. Promotion of network and support provided
17. Staff surveys- assess levels of engagement and wellbeing	17. New HIVE survey tool will provide data on overall engagement and wellbeing
18. Stress risk assessments- identify measures that can be taken to address issues	18. Reference to the assessments during attendance management line manager training and to the TUS
19. Sickness statistics are reported to SLT, SOT, People & Culture Committee, Trust Board and the CASC	19. Sickness forms part of Workforce Scorecard to People & Culture Committee

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:	24/10/2023	TREND	20 (5x4)
		Date of Next Review:	24/11/2023	➡	

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

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

20. External agency support e.g. St John Ambulance, Fire and Rescue- if needed at times of increased pressure	20. Standard procedures in place to access additional resource capacity
21. Monthly reviews of colleagues on Alternative duties	21. Action plans arising from meetings with colleagues implemented through monthly diarised meetings
22. Manager guidance on managing Alternative duties	22. Evidence of managers guidance in place and referenced in attendance management training
23. Fortnightly report on absence to EMT and report to every meeting of People & Culture Committee	23. Minuted meetings and action logs for EMT & People & Culture Committee
24. Sickness audits for localities- provides additional level of detail	24. Audits carried out and actions taken forward
25. Additional support for areas with higher than average absence – emphasis is on understanding reasons and developing action plans	25. Dedicated meetings taking place and support from people services for areas with absence with local plans in place to address specific issues
26. Review of top 100 cases -carried out on a monthly basis	26. Provides a focus on cases with a clear focus on support and making sure there are plans attached to each case.
27. Deep dives on specific issues and reasons for absence	27. Enables wider consideration of additional measures that may be adopted and identifies themes and keeps focus on absence management eg – mental health and causes
28 2023 10 point action plan shared with EMT for assurance and RAG rated to track progress quarter	28. Offers assurance to EMT on the activities and measures in place.
	External Management (2nd Line of Assurance)
	1a. All Wales review of All Wales Attendance at Work Policy
	Independent Assurance (3rd Line of Assurance)
	1b. Internal Audits scheduled through Shared Services Partnership (controls 1 - 24)
	2. Audit Wales – Taking Care of the Carers report in October 2021 (controls 1 - 24)
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. (a) Consistency and Application in Managing Attendance at Work Policy	1. There are other factors that impact on sickness which can't be controlled
9 and 10 It is not known what is undertaken with respect to the data covered in assurances 9 and 10 once it is received	9, 10 and 19 Absence data is not updated in a timely manner into ESR by managers
1 – 22 Education and communication with managers about resources available and how to implement it e.g. stress risk assessments	
	External Gaps in Assurance None identified at the present moment

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Implementation of Improving Attendance project	Deputy Director of People & Culture	31.09.23 Completed 2022/23	Underway and ongoing, 2022/23 actions complete or embedded as BAU. May data 7.6%. Trajectory continues to be positive. 10 point plan for 2023/24 agreed by EMT and being implemented.
2. Implementation of Behaviours Refresh Plan	Assistant Director – Inclusion, Culture and Wellbeing	31.10.22 Extended to 31.05.23 CLOSED	Underway and ongoing. Captured in the IMTP for the service. Impacted by IA. New approach adopted from April 2023 to focus on a new behaviour every 6 weeks and continue conversations. Directly linked to people and culture plan. Closed
3. Long term sickness absence deep dive	Deputy Director of People & Culture	31.07.23 **Extend to 31.01.24 based on new plan for 2023/24**	Underway and ongoing. Downward trajectory in levels of long term absence- proposed that this is extended until 31/12/23 to enable more detailed work of reasons, measures being implemented and impact.
4. Develop guidance for line managers to support addressing challenging conversations and change	Deputy Director of People & Culture	31.07.22	Training produced and rolled out. Now BAU

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:	24/10/2023	TREND	20 (5x4)
		Date of Next Review:	24/11/2023	➡	

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

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

		Complete	
5. Roll out platform for raising concerns (in relation to Freedom to Speak Up Arrangements)	Freedom to Speak Up Arrangements Task & Finish Group Ownership moving to DWOD	Extended from 31.07.22 to 31.03.23. Extended to 31.05.23 Extended to 31.08.23 **Completed September 2023 with platform launched and Guardians appointed.**	Extended date in terms of project plans and impact of Industrial Action. 21.3 The task and finish group has completed its work and the project is now going to be handed to DWOD as SRO for the work. 21.06 soft launch of the platform in August with official launch in September in line with Practice Ethically behaviour. 03/08/23 - Soft launch commenced 1 August 2023, full launch moved to October as it is freedom to speak up month.
6. Strengthen Freedom to Speak Up Arrangements policy and advice	Assistant Director of Inclusion, Culture and Wellbeing	31.05.23 Extended to 31/08/23 **Completed**	Deadline extended to coincide with launch of new platform, although Guardians are in place and weekly review meetings taking place. They are receiving the highly confidential Datix and concerns raised through networks and attendance at ER monthly review from July. SharePoint page constructed and comms plan being finalised following refresher demos to key stakeholders. Behaviours reinforced via culture champions group, rotating through behaviours, currently broaden our understanding. Head of Culture and OD in post from August to further this work. 03/08/23 - Share point page published, comms plan in place. complete
7. Create a Manager and Staff training plan for Freedom to Speak Up Arrangements	Assistant Director Inclusion, Culture and Wellbeing	31.05.23 extended to 30/9/23 **Complete as ongoing part of the OD workplan as BAU.**	Ongoing – extended until 30/9/23 to enable soft launch with feedback and policy and advice to be shared. Training plan will be produced with an emphasis on making the platform and use of freedom to speak up as simple and accessible as possible. SharePoint page constructed and comms plan being finalised following refresher demos to key stakeholders. Head of Culture and OD in post from August to further this work. 03/08/23 - Training plan identified. **26/10/2023 ESR module to be available to all staff. Training video available to all for using the platform. Emphasis on creating a psychologically**

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:	24/10/2023	TREND	20 (5x4)
		Date of Next Review:	24/11/2023	➡	

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

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

			safe culture to encourage speaking up as the norm in teams. Culture tool developed.
8. Accountability meetings with senior ops managers	Deputy Director of People & Culture	30.09.22 Complete and ongoing BAU	Underway, conversations re sickness absence well established and continuing
9. Attendance Management training for managers	Deputy Director of People & Culture	31.12.22 Complete and BAU	Underway and ongoing – now BAU 1.11.22
10. PADR review including wellness questions	Assistant Director – Inclusion, Culture and Wellbeing	Complete	Complete. New PADR distributed October 22.
11. Restart the Health and Wellbeing Steering Group	Assistant Director – Inclusion, Culture and Wellbeing	Complete Aug 23 – Paused **26/10/2023 Complete and BAU**	Complete – group started 17.10.22 and will meet quarterly. 03/08/23 - Paused until key vacant posts, i.e. Head of Workplace Wellbeing and OH Manager, are filled **26/10/2023 Head of Workplace Wellbeing in post and OH Manager due to start in December 2023. Group arranged for first week of December.**
12. Review of top 100 cases by the team on a monthly basis	Deputy Director of People & Culture	Commenced and ongoing – review 30.06.23 BAU	Underway and now BAU
13. Actions identified from the Managing Attendance Audit	Deputy Director, People and Culture	Commenced and ongoing. Completion 31.12.23	Delivery of the actions underway and partially complete. All will be completed by 31.12.2023.

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence	Date of Review:	25/10/2023	TREND	20 (4x5)
		Date of Next Review:	25/11/2023	➡	

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

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

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

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

Risk Commentary Q4 2022/23

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

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

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Submit refreshed Board Engagement Framework to Trust Board for approval	Director of Partnerships & Engagement	26.05.22 Complete	Approved July 2022
2. Roll out of the Engagement Framework Delivery Plan	Director of Partnerships & Engagement	**Ongoing**	**Currently being revised in respect of both timelines and specifics to align with further emerging broader strategy work (the move from 'Inverting the Triangle' to transforming**

Risk ID 201	Damage to Trust reputation following a loss of stakeholder confidence	Date of Review:	25/10/2023	TREND	20 (4x5)
		Date of Next Review:	25/11/2023		

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

			care more broadly). Implementation had been delayed by delays to completion of strategy consultancy work. Work has been undertaken to capture engagement on strategy to-date to inform future iterations. BAU stakeholder engagement continues, including with politicians, key influencers and media.
3. Board oversight, scrutiny and challenge of performance, concerns, quality	CEO / Executive Management Team	Ongoing	
4. Monitoring internal Quality and Performance of Trust and raising system issues	Executive Management Team, Finance and Performance Committee Quality, Safety and Patient Experience Committee, People and Culture Committee, Audit Committee	Ongoing	
5. Engaging with internal and external stakeholders to develop confidence	CEO & Director of Partnerships & Engagement	Ongoing BAU	Regular engagement continued with staff, TU partners and a range of external stakeholders such as AMs, MPs, Local Authorities etc. BAU.
6. Monitoring external factors that may affect the Trust	CEO & Director of Partnerships & Engagement	Ongoing BAU	
7. Llais (the new Citizens Voice Body attending October 2023 Board Development	Director of Partnerships & Engagement	October 2023	**Llais attending Board Development session on 26/10**
8. Reputation Audit deep dive on findings to be presented at Board Development	Director of Partnerships & Engagement	**Q1 2024/25**	**Given pressure on agenda and time elapsed, it is proposed that further audit be undertaken (it was always the plan to make this annual), which will allow for comparison of data and analysis with a view to taking through governance structures in Q1 2024/25.**

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	17/10/2023	TREND	16 (4x4)
		Date of Next Review:	17/11/2023		

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

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

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

Risk Commentary

Score remains the same as clarity from Commissioners has still not been provided on £2m of the 100 WTE EMS staff funding which could have a negative impact on the Trusts financial position. Other key item to note is funding for 111, WAST continues dialogue with commissioners of the service and any financial risk is mitigated by operating on a spend and cost recovery basis with commissioners.

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

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation	Date of Review:	17/10/2023	TREND	16 (4x4)
		Date of Next Review:	17/11/2023	→	

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

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

• 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	31/03/24 – Checkpoint Date	22/23 Finances have been agreed as part of year end agreement of balances. Issue currently around the 100 WTE £6m funding and negotiations continue. **In addition discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis.**
2. Embed a transformative savings plan and ensure organisational buy in	ADLT and Savings subgroup	31/03/24 – Checkpoint Date	The Financial Sustainability workstreams that were launched in May 2023 have now been rebranded as the Financial Sustainability Program (FSP) and the work of the program underpins the need of the organisation to deliver transformative savings via the Achieving Efficiencies and Income Generation subgroups.
3. Embed value-based healthcare working through the organisation	Executive Management Team and Value Based Healthcare Group	31/03/24 – Checkpoint Date	Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.
4. WIIN support for procurement, savings and efficiencies	WAST Improvement and Innovation Network group	31/03/24 – Checkpoint Date	WIIN ideas are regularly communicated across to the Achieving Efficiencies subgroup of the FSP.
5. Foundational economy, Decommissioning and procurement to mitigate social and economic wellbeing of Wales	Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/24 – Checkpoint Date	The organisation utilises the NWSSP Shared Services Procurement framework to ensure contracts tendered provide best vfm while ensuring criteria within the tender docs ask bidders to highlight their ability to serve the aims of FE, Decommissioning, Decarbonisation and social as well as the economic wellbeing of Wales.

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	18/10/2023	TREND	16 (4x4)
		Date of Next Review:	18/11/2023	→	

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

	Likelihood	Consequence	Score
Inherent	5	3	15
Current	4	4	16
Target	4	3	12

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

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

Risk Commentary

This risk is regularly reviewed. Work is underway to seek to improve partnership working and an action plan has been created to deliver this. The engagement structures below WASPT are in place and running. The Deputy Director of P&C is currently writing a workshop session with TU partners to deliver to managers are TU reps across the organisation and a second session for senior TUPs and senior managers to improve the understanding of the challenges for both groups.

There is a further prospective risk as discussions on pay commence for 2024/25 which are out of the gift of WAST but may result in further tension and industrial action if an offer made is not accepted by the trade unions. This is in the context of the current financial pressures for Welsh Government who are seeking to make significant savings. At a local level there are challenging issues to be managed such as USH payments for those off sick and EMT 2-3, demand and capacity reviews, industrial injury appeals and changes to the workforce profile by increasing APPs. When there are discussions on one area then there appears to be difficulty disengaging different issues.

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

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

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. Develop an action plan from the recommendations of the ACAS report	Deputy Director of People & Culture	Completed 12/01/23	Action Plan for delivery created and shared with TU Secretary for feedback from TUPs
2. Agree the ToR for refreshed Partnership Forum meeting and move back to a business-as-usual footing	Deputy Director of People & Culture	Completed 12/01/23	WASPT re-established. Third meeting scheduled T&F group undertaking work on the engagement model below WASPT through SLT and SOT is in progress with TU engagement. TU cell stood down.

Risk ID 163	Maintaining Effective & Strong Trade Union Partnerships	Date of Review:	18/10/2023	TREND	16 (4x4)
		Date of Next Review:	18/11/2023		

IF the response to tensions and challenges in the relationships with TU partners is not effectively and swiftly addressed and trust and (early) engagement is not maintained	THEN there is a risk that TU partnership relationships increase in fragility and the ability to effectively deliver change is compromised	RESULTING IN a negative impact on colleague experience and/or services to patients

	Likelihood	Consequence	Score
Inherent	5	3	15
Current	4	4	16
Target	4	3	12

3. Proposed externally facilitated mediation session(s) building on the IPA workshops and specifically to address the thorny issue of what happens when we fail to agree	Deputy Director of People & Culture	Completed 12/01/23	Rearranged date 24.08.22 due to COVID in ACAS facilitators. First ACAS sessions delivered in June. Joint ACAS session with TUPs and Senior Team delivered on 24.08.22. Awaiting report from ACAS advised they are finalising by 23.09 and will forward week of 26th Sept. Draft plan in development to capture actions from the meeting. Actions from the ACAS recommendations will be added on receipt. Report received in October. Action plan developed and shared with TUs. Implementation underway
4. Minutes of formal Partnership Forum should be reported to PCC or Board in future (return to BAU).	Deputy Director of People & Culture	Completed 12/01/23	WASPT feeding into PCC
5. Establish formal meeting structures below WASPT	Deputy Director of People & Culture	30.06.2023 Completed	Structure agreed with TUs. Sign off at next WASPT meeting. Highlight reports to be shared at WASPT. Completed structures for Local Partnership Forums and SOT/ SLT for operations and Partnership Meeting for Corporate Services agreed, ToR for SOT /SLT and LFP agreed.
6. Refresh of engagement programme post Industrial Action and establish work	Deputy Director of People & Culture	30/08/23 **Underway and work ongoing. Plan delivery to be completed by March 2024. However, this will be subject to the national picture.**	**Plan agreed and being monitored via WASPT.** **Draft training development underway in partnership with TUPs** **Principles on engagement being developed (in part from the training) and as a result the partnership statement will be updated.**

Risk ID 424	Resource availability (revenue and capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	30/10/2023	TREND	16 (4x4)
		Date of Next Review:	30/11/2023	➡	

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	4	4	16
Target	1	4	4

IMTP Deliverable Numbers:

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

Risk Commentary

Risk score remains currently at 16 as some outstanding gaps in controls and, linked to risk 458, some continued risk with regards to recurrent funding. There are also currently vacancies in the Transformation team resulting in gaps to support delivery of key workstreams, however these are in the recruitment process.
IMTP planning for 2024-2027 underway to refresh our priorities for the next three years, taking into account the external context in which the Trust is working.
This risk will therefore remain under review as we put further controls in place but also taking account of the new commissioning landscape, financial context and our strategic developments.

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Recruit a Head of Transformation	Assistant Director of Planning	30.09.22 complete	Recruited 02.08.22 in post on 01.11.22
2. Review the PPM	Head of Transformation	Extended from 31.03.23 – To 31.06.23 and then to 30.09.23 in line with milestone for delivery **Extend to 31.12.23 in line with timescales for sign off**	Currently (January 2023) working through delivery structures for 2023-26 which will inform the PPM review – changed checkpoint date to 31.06.23. Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3. Planning Framework approved by STB on 04.07.2023 which sets out the Project Path framework at a high level. **Project Path Framework presented at ISPG on 27.10.23 and is scheduled for approval at STB on 27.11.23**
3. Develop Benefits Realisation plans in line with Quality and Performance Management framework	Assistant Director of Planning/Assistant	Extended from 30.09.22 – to 31.03.23. Further extend to	Reviewed action and extended checkpoint date further as approach being developed for next iteration of IMTP. Work ongoing.

Risk ID 424	Resource availability (revenue and capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)	Date of Review:	30/10/2023	TREND	16 (4x4)
		Date of Next Review:	30/11/2023	➡	

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	4	4	16
Target	1	4	4

	Director, Commissioning & Performance	31.06.23 and then to 30.09.23 in line with milestone for delivery **Extend to 31.12.23 as priorities have taken precedence but there is work ongoing in this space**	Workshop held in Q1 and Q2 to develop new Project Path Framework. Milestone for delivery in Q3 as part of Project Path Framework. **Work continues with the Commissioning and Performance Team to align performance metrics with programme/IMTP deliverables** **An evaluation methodology is being trialled with Swansea University to look at benefits realisation of small, agile projects and PDSA cycles.**
4. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)	Director of Finance	31.12.22 – checkpoint date 31.06.23 and then to 30.09.23 Extend to 31.12.23	Extend checkpoint date to 31.03.2023 on basis of new financial allocations for 2023 to be worked through with Commissioner **A business case panel process has been developed and trialled as part of the development of the project path framework and is factored into the IMTP planning cycle, to give finance colleagues a more timely view of potential developments into the next 3 year cycle.**

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:	17/10/2023	TREND	16 (4x4)
		Date of Next Review:	17/11/2023	→	

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:

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

Risk Commentary

Score remains the same as clarity from Commissioners has still not been provided on £2m of the 100 WTE EMS staff funding which could have a negative impact on the Trusts financial position. Other key item to note is funding for 111, WAST continues dialogue with commissioners of the service and any financial risk is mitigated by operating on a spend and cost recovery basis with commissioners.

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

Actions to reduce risk score or address gaps in controls and assurances	**Action Owner**	**By When/Milestone**	**Progress Notes:**
1. A formal approach to service change to be developed providing secure recurrent funding with commissioners.	Executive Management Team	31.12.23	Update: 22/23 Recurrent & non-recurrent Finances have been agreed as part of year end agreement of balances. Issue currently around the 100 WTE £6m funding and negotiations continue. Recent letter from Commissioners indicates funding will be forthcoming however with conditions**. In addition, discussions continue with commissioners to ensure WAST continue to obtain funds in relation to 111 on a spend and recover basis.**
5. Develop a Value Based Healthcare system approach with commissioners. This would mean that funding would flow more seamlessly between organisations and would go some way to mitigating the risk of not receiving recurrent funding.	Deputy Director of Finance	31.12.23	Update: Work to identify the PROMS & PREMS evaluation criteria for Emergency based services via the Value-Based Healthcare working group continues.

Risk ID 199	Failure to embed an interdependent and mature health and safety culture which could cause harm and a breach in compliance with Health & Safety statutory legislation	Date of Review:	03/11/2023	TREND	10 (2x5)
		Date of Next Review:	03/12/2023	⬇	

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

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

IMTP Deliverable Numbers:

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

Risk Commentary

A full review of Risk 199 has been undertaken during October 2023 and a reduction in score made given the demonstrable work that has been undertaken across the Trust in relation to the Working Safely Programme and Health & Safety. The Trust has moved on significantly in terms of Health & Safety and the corporate risk of failing to embed a positive Health and Safety culture has now been mitigated. This means that the risk has reached its target score of 10 (2x5). This is due to several factors:

29. **An internal audit undertaken during quarter 1 of 2023/24 by NWSSP assessed 6 key areas and reasonable assurance was achieved on each area thus providing a reasonable assurance rating overall. The previous audit undertaken during 2018/19 returned a limited assurance rating which demonstrates the progress made by the Trust over the last 4 years.**
30. **An assessment was undertaken by the Health & Safety Team including relevant stakeholders across the Trust against the Legislative Register which provided a moderate level of assurance. This score was approved by the Senior Operations Team.**
31. **The Health and Safety Policy was approved by the People & Culture Committee in November 2023 and this makes reference to a culture of interdependency. The Policy is now being published and rolled out across the Trust.**
32. **The Working Safely Programme has been incorporated into business-as-usual activities. There are 4 IMTP deliverables monitored by the Strategic Transformation Board and an annual improvement plan, containing 6 additional actions, which is monitored by the Health & Safety Committee.**
33. **A number of Health and Safety inspections have been completed across the Trust during this year with 87% of Trust premises being assessed as 86% - 100% compliant.**
34. **A Hazard Register is in place and has been assessed; and is a live document which provides a RAG assurance rating against all known Trust hazards. Any Red/Amber rated hazards are likely to be reduced as further Risk Assessments of Standard Operating Procedures are developed and implemented.**
35. **The commitment made by the Board and ELT to undertake the IOSH training has been fulfilled and this is being rolled out to ADLT and further across the Trust.**
36. **The Health & Safety Team has been successfully embedded within and throughout the Trust and partakes in regular and routine discussions with all staff and at relevant business meetings on all matters pertaining to Health & Safety business.**
37. **A culture survey has been developed and will be rolled out in the next quarter to measure the success of the transformation of the Health & Safety culture change programme.**
38. **The Health & Safety Team are regular attendees at the formal and informal Operations meetings demonstrating a priority commitment to the subject on the Agendas.**
39. **A level of external assurance was received from the Coroner in relation to an investigation and who stated that the Health & Safety report produced by the Trust was of a high standard and that the extent of the learning recommended was evident within the paper. There was no determination to issue a Regulation 28 as a result.**

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1 Systematic review and assessment of Health and Safety arrangements and Governance (All NHS Wales Health & Safety Management System - HSMS). **Culture Maturity Survey developed.**	1.1 Assessment criteria set for health and safety management system (HSMS) All Wales system). HSMS approved at ADLT in 2022. ADLT members sponsorship for all 11 management principles. 1.2. **H&S Climate Cultural survey developed to determine perception of Trust position against Bradley Curve to be rolled out once political pressures (IA) reduce. Expectation of roll out Q3-Q4 2023.**
2. Health & Safety Governance and reporting arrangements – National Health, Safety and Welfare Committee. Reporting into People and Culture Committee. (PCC)	2.1 Trusts Legislative Compliance Register in place and assessment approved by SOT and ADLT in April 23. Position landed as 1.98/3 providing a Moderate level of Assurance. 2.2 Quarterly H&S performance reports presented at SOT, ADLT and H&S National Health, Safety and Welfare Committee. Reports published on H&S webpage.
3. Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, - Regulation 7 'Health and Safety Assistance'.	3.1 H, **3.1 H&S workplace review fully implemented on 03.19.22. Review introduced new roles to the Trust, namely, Deputy Head of H&S, V&A Manager, H&S Advisor and DSE/MH Advisor.**
4. Health & Safety Policy and Corporate level Procedures.	4.1 H&S Policy approved in 2018. Following landing of business case, Policy review underway Q4 2022-Q1 2023. 4.2 Trust approved Hazard Register in place. Reviewed by ADLT in Q1 2023 approved by SOT and ADLT in April 23. Approved Policies and Procedures in place: Violence and Aggression Policy, Risk Assessment Procedure, Display Screen Equipment Procedure, Workplace Premise Audits Inspection Procedure, Control of Substances Hazardous to Health (COSHH), New and Expectant Mothers Risk Assessment Procedure.

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:	03/11/2023	TREND	10 (2x5)
		Date of Next Review:	03/12/2023	⬇	

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

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

	4.3 Lifting Operations Lifting Equipment (LOLER), Provision and Use of Workplace Equipment (PUWER) under development with an expectation of commencing the approval process approval during Q3-Q4 2023. 4.4 Lone Worker Procedure ongoing - expectation of second draft Q2-Q3 2023. Expectation of ratification Q4 2023.
5. Mandatory Health and Safety training for all staff on ESR. Induction training in place for all new operational staff. **Control of Substances Hazardous to Health (COSHH) training.** **Human Factors (HF) (in risk assessment) training.**	5.1 Quarterly statistics provided by ESR support team and incorporated into Health and Safety Quarterly Performance reports. Induction training compliance held on ESR. **Business as usual activity.** **5.2 H&S training needs analysis incorporated within revised H&S policy (processing through ratification process expectation of approval in November 2023).**
6. Rolling programme of scheduled H&S premise audits.	6.1 Inspections are being undertaken in line with schedule. **All premises inspected during Q3 2-22-Q2 2023. Business as usual activity.**
7. Risk assessments (including local risk assessments, Covid 19, Workplace Risk Assessments, risk assessments covering EMS and NEPTs activities, operations risk assessments).	7.1 Workplace risk assessments schedule for Q3 2023 communicated to SOT in Sept 23 for increased focus to raise compliance. WRA are undertaken by local management teams / TUP and supported by the H&S team and are being monitored via SOT and H&S Quarterly Performance Reports. 7.2 Other Operational risk assessments and SOPs are held on their respective dedicated Share-point areas.
8. Working Safely Strategic Programme Board (STB) to provide oversight of the Working Safely Action plan. Dynamic Delivery Action Group to continue to undertake actions on the Working Safely Action Plan.	8.1 Working Safely Action Plan is being held to account by the Senior Quality Team. IMPT Deliverable Plan developed for 23/24 is being actioned through the Dynamic Delivery Group meeting. Terms of reference for Dynamic Delivery Group are under review for 23/24. **8.2 Annual H&S Improvement Plan also in place for 23/24 in place monitored at the H&S Team meetings.**
9. Rolling programme of IOSH Managing Safely- for Managers- scheduled training programme in place.	9.1 Attendance and competency figures provided in a quarterly report to ADLT, National Health, Safety and Welfare Committee and People and Culture Committee. **Business as usual activity**.
10. IOSH Leading Safely for Directors and Senior Managers training in place.	10.1 Attendance and figures provided in monthly report to ADLT. 10.2 Personal safety commitments are to be monitored on a quarterly basis following discussions to be held with Board Secretary, Executive Director for Quality and Safety and Head of Health & Safety in Q2-3 2023.
11. Board Development Day covering Health & Safety Management and Culture Awareness training undertaken in April 2022.	11.1 Diarised meeting.
12. Health and Safety Management System recognised document approval routes for health and safety documentation.	12.1 Approved and minutes at ADLT meeting in 2022. **HSMS document approval process to be revised in Q2 2023. Expectation of approval of reviewed changes in Q3 2023.**
13. IOSH Leading Safely training delivered to majority of Board and Executive Team on 26 July 2022.	13.1 Compliance metrics held on H&S team database.
14. IOSH Leading Safely additional sessions for new Board /EMT members and ADLT to be scheduled for 2023.	
15. Leading Safely, Safety Positive conversations training to be delivered to Board and EMT to be rescheduled from June 2023.	15.1 Discussions ongoing with Board Secretary and Head of H&S in relation to alternative means of delivery.
	16.1 NWSSP Internal Audit undertaken in Q1- Q2 23/24 (controls 1– 10). Audit position landed as' Reasonable' level of assurance. (External Independent Assurance (3rd Line of Assurance)
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1.	1. Baseline audit for HSMS not to be commenced till Q3 2023 (being addressed in Action 1) **2.** H&S Climate Cultural survey to be rolled out once political pressures (IA) reduce. Expectation of roll out Q3-Q4 2023/24 (being addressed in Action 3).
2. Subgroups of National H&S and Welfare Committee currently under review. (Being addressed in Action 2)	
3.	3.
4. The Health and Safety Policy and some procedures are due to be reviewed by the end of Q4 2022 in Q1 2024 (**being addressed in Action 4).**	1. Review of H&S Policy has been undertaken, and substantial consultation process ceased in August 23. Policy to be presented at EMT in Q2-Q3 20203 for approval before commencing to PCC for final approval. (Being addressed in Action 4)

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:	03/11/2023	TREND	10 (2x5)
		Date of Next Review:	03/12/2023	⬇	

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

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

	2. **Procedures identified via IMTP Deliverable Plan**
5. **Scope of training for volunteers.**	**5.1 New Training needs analysis within revised H&S Policy (2023) includes volunteer population.**
6.	
7.	7.1 (a) Current copies of risk assessments and SOPs are not available at all stations. *(Being addressed as part of Actions 6)* (b) Lack of clarification over many SOPs are required until HSMS baseline audit has been completed. *(Being addressed as part of Actions 1)*
8. Operational pressures and Industrial Action on service impacted on Working Safely Programme delivery **during Pump and Prime Phase**.	
9. Staff availability to attend training **during periods of high levels of operational demand.**	9.1. Work ongoing to determine how many Managers require IOSH Manging Safely. *(Being addressed in Action 8)*. A H&S Training needs analysis has been developed and incorporated into the H&S Policy. 9.2. **Currently, there is no structured monitoring process in place to ensure attendance on the IOSH Leading Safely course. This has been identified as an action on NWSSP's Internal Audit 2023 and is being monitored via audit tracker**
10. Effective learning from events to be documented **and communicated across the Trust.**	10.1 **Incident investigation training to developed and rolled out. Action identified as part of IMTP Deliverable Plan 2023/24. Will incorporate a LFE process.**
11.	4.
12.	5.
13.	6.
14.	7.
15.	8.
16.	9.
17.	10.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Meetings to be scheduled to undertake baseline assessment and feedback to EMT.	Head of Health and Safety	**Q3-Q4 2023**	1.1 **Discussion to be held at SOT in Q3 2023 to agree time scales to undertake baseline assessment.**
2. Meetings to be held with TU partners and AD/Head of H&S to agree arrangements for sub-groups.	Head of Health and Safety	Q1 2023	2.1 23.06.23- H&S proposed to be incorporated into WASTP sub-groups LPF. **For discussion at National H&S committee in Q3 2023 due to rescheduling of Q2 2023 H&S Committee.**
3. Assessment to be undertaken in Q1 2023 of political pressure to determine viability of conducting culture survey	Head of Health and Safety	**Q3-Q4 2023**	3.1 Political pressures likely to be still present. Survey expected to be to be **rolled out Q3 2023**.
4. Revised H&S Policy to achieve ratification	Head of Health and Safety	Q**3** 2023	4.1 Policy to be presented to ELT for approval in Q2-3 2023 and **PCC in Q3 2023**
5. IT solution being investigated to collate data from inspections to enable trending and monitoring of actions generated	Deputy Head of Health and Safety	Q**4** 2023	5.1. The audit proforma has been migrated onto MS Forms to allow for improved data collection. Meeting held with I.T. provider in Q4 2022 provide consideration for the development of utilisation of Power B.I systems. 2.Ongoing. **Meetings ongoing with Estates to determine smarter means of collation and monitoring. Will require engagement and support with Digital Directorate.**
6. H&S advisors will liaise with local management teams to identify risk assessments and SOP's in place and ensure visibility on SharePoint	Deputy Head of Health and safety	Q2-Q3 2023 **Live action.**	6.1 Ongoing live action. Business as usual activity. 6.2 Assessment against the HSMS Principle 3- Compliance Assurance will assist in determining what RA/SOPS are required.

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:	03/11/2023	TREND	10 (2x5)
		Date of Next Review:	03/12/2023		

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

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

7. **Review of number of line managers within the Trust to put in place a suitable schedule to roll out appropriate H&S training as determined within the training needs analysis within the H&S Policy.**	Deputy Head of Health and Safety	Q3-4 2023	**7.1. Interim schedule in place to address known line managers.** **7.2. Further work required with other Directorates to allow for performance metrics to be generated.**
8. **WAST Leading Safely Behavioural Audit training to Exec Team and Board (forms part of WSAP)**	Head of Health and Safety	31.12.22	**8.1 Initially scheduled for BDD - February 2023. Rescheduled to June 2023. Discussions to be held with Board Secretary and Head of H&S in August 23 around alternative delivery style of training.**
8. **Additional legislation to be incorporated into the Legislative Register.**		**Q3-Q4 2023**	**9.1 Further legislation in relation to V&A, Road Safety Traffic Act and the and Civil Contingencies Act to be added and assessed Q3-Q4 2023.**
Completed Actions	**Action Owner**	**When /Milestone**	**Progress Notes:**
1. Delivery of the Working Safely Action Plan (WSAP) (Priority top 25)	Head of Health & Safety	31.09.22 **Partially completed.** Long term action.	1.1 Pump and Prime phase commenced 01.09.21. Closure report for PPP presented to EMT during Q3 2022/23. Working Safely Programme to continue being monitored by STB. Four priorities determined for 2023/24- Violence & Aggression, Culture, Manual Handling and Incident Investigation.
2. IOSH Leading Safely training to be delivered to Exec Team and Board (forms part of WSAP)	Head of Health & Safety	31.12.22 **Complete**	2.1Training delivered to Board and Executive team on 26.07.22. IA and operational pressures impacted on availability to attend during Q4 2022. **2.2 Further sessions to be scheduled as new members commencer with Trust. Business as usual activity.**
3. H&S team workforce review (accompanying Business Case forms part of this) (this forms part of WSAP)	Head of Health & Safety	31.03.22 Completed	Completed- Workforce review fully implemented 03.10.22
4. Culture survey to all members of staff (forms part of WSAP)	Head of Health & Safety	30.09.22 Partially completed	4.1 Survey developed and to be presented at National H&S Committee on 02.11.22 and SOT in December for feedback. Decision made during Q3 2022/23 to postpone survey unit political pressures ease. Expectation of roll out Q4 2023-Q1 2023/24. Political unease impacted on the roll out of the survey roll out. Expectation that survey will be rolled out during Q1-Q2 2023/4
5. A compliance register that describes the requirements of the various Health & Safety legislation that the Trust needs to comply with (part of WSAP)	Deputy Head of H&S	30.06.22 Completed	5.1 Compliance Register framework developed, and assessment approved as providing a moderate level of assurance Q1 2022.
6. An initial assessment will provide assurance on how we are complying with the legislation.	Deputy Head of H&S	Q4 2022 **Complete.** Assurance - 01.06.22 Rolling programme of assessments – 31.12.22	6.1 Assessments undertaken. Some outstanding estates assessments scheduled January 2023. Compliance register presented to ADLT members on 04.04.23. Further legislation in relation to V&A, Road Safety Traffic Act and the and Civil Contingencies Act to be added and assessed Q3-Q4 2023.
7. Quarterly report on training compliance to be presented to ADLT for actioning within respective Directorates	Head of Health and Safety	Q3 2022 - Complete	7.1 Report is a standard section of Quarterly H&S Performance report to ADLT
8. Priority Elements of Working Safely Action Plan to be identified and programme schedule presented to STB to ensure sufficient support from Operational Teams. Migrate into Annual Health and Safety Improvement Plan.	Head of Health and Safety	Q2 2023- Complete	Priority actions for 2023-24 identified as Culture, Manual Handling, Violence and Aggression, Incident investigation training and documented within the IMTP Deliverable Plan for 23/24 05.04.23 An additional Health and Safety Improvement Plan developed Q1 2023 and monitored via Monthly H&S team meetings.

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:	27/10/2023	TREND	15 (3x5)
		Date of Next Review:	27/11/2023		

IF	THEN	RESULTING IN
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	there is a risk of a significant information security incident	a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life

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

IMTP Deliverable Numbers:

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

Risk Commentary

The threat of Cyber attacks remains unchanged with activities of state actors and criminal gangs still high. Whilst the Trust and wider NHS Wales organisations have in place several layers of technology to protect the Trust and its information systems, there is still a risk that users will be fooled by phishing emails which are becoming ever more sophisticated. In an effort to raise user awareness of cyber threats the Trust ICT department run regular phishing exercises as well as short security training packages, reporting the results and uptake through IGSG and into FPC. There was also a specific series of campaign in October as it's cyber awareness month.

CONTROLS	ASSURANCES
	Internal **Management (1st Line of Assurance)**
1. Appropriate policy and procedures in place for Information/Cyber Security	1. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually.
2. Trust Business Continuity Procedure and Incident Response Plan	2. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing
3. IT Disaster Recovery Plan	3. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams.
4. Relevant expertise in Trust with respect to information security	4. Staff undertake relevant training courses e.g. CISSP to increase knowledge and expertise
5. Data Protection Officer in post	5. In job description of Head of ICT
6. Cyber and information security training and awareness	6. Training statistics are available on ESR and from Phish threat module
7. Mandatory Information Governance training which includes GDPR	7. Training statistics reported on by Information Governance department
8. ICT tests and monitoring on networks & servers	8. Any issues would be identified and flagged and actioned
9. Information Governance framework	9. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit.
10. Internal and NHS Wales governance reporting structures in place	10. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings.
11. Checks undertaken on inactive user accounts	11. Software in place to run check on inactive accounts as and when
12. Business Continuity exercises	12. Annual schedule of testing
13. Operational ICT controls e.g. penetration testing, firewalls, patching	13. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when. 04/08/23 – Exploring procurement of additional penetration tests with the aim of annual testing of all critical systems.
14. Security alerts	14. Daily alerts are received. Anti-virus alerts received as and when threat discovered
	External Independent Assurance NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls 1 -,3 – 11, 13 – 14
GAPS IN CONTROLS	**GAPS IN ASSURANCE**

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:	27/10/2023	TREND	15 (3x5)
		Date of Next Review:	27/11/2023		

IF	THEN	RESULTING IN
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	there is a risk of a significant information security incident	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. 04/08/23 – Monthly KPI reports now being generated routinely and fed into the Digital Leadership Group**. Needs to transfer to assurance – no longer gap? - Agree as also now reported through to FPC**
2. Lack of understanding and compliance with policy and procedures by all staff members	**2.** Cyber awareness campaigns could be undertaken more regularly e.g. bi-monthly**.** 04/08/23 – Latest campaign commenced 01/08/23 to raise staff awareness**. Needs to transfer to assurance – no longer gap? - Agree campaigns run regularly along with regular circulation of cyber awareness information**
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	31.03.23 complete	KPI format agreed and will be produced from Q1 2023-24 with a retrospective annual report produced for 2022-23.
2. Discuss how cyber risk is reviewed and frequency of review	Director of Digital Services	28.10.22 Close – now Business as Usual	a. The ongoing cyber threat to the organisation is continually monitored using daily comms feeds and automated alerts from various external sources. b. The corporate cyber risk assessment will be reviewed monthly at the Digital Leadership Group informed by the threat and intelligence monitoring and national strategic trends.
3. Suite of business continuity exercises that departments can undertake to test their plans to be provided.	North Resilience Manager	28.10.22 Complete	The Trust has run two exercise Joshua & Joshua 2 to test departments readiness
4. Exercise template report which shows recommendations to be created	North Resilience Manager	31.12.22 **- Complete**	Exercise reports being drafted.
5. Formalise Cyber Incident Response Plan	Head of ICT	30.06.23 – complete Checkpoint Date 31.12.2023	Cyber Incident Response Plan adopted, and CRU Assessment conducted during May 2023 with report expected by end June 2023. Review of CRU Cyber assessment and development of action plan in response to any recommendations.
6. Implement Meta Compliance Policy Solution	Senior ICT Security Specialist	30.06.23 – **Complete**	Additional learning modules purchased, and both will be rolled out from Q1 2023-24. 04/08/23 – Latest campaign commenced 01/08/23 to raise staff awareness.

Risk ID 543	Major disruptive incident resulting in a loss of critical IT systems	Date of Review:	27/10/2023	TREND	15 (3x5)
		Date of Next Review:	27/11/2023	➡	

IF there is an unexpected or uncontrolled event e.g. flood, fire, security incident, power failure, network failure in WAST, NHS Wales or interdependent systems	**THEN** there is a risk of a loss of critical IT systems	**RESULTING IN** a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	3	5	15
			Target	2	5	10

IMTP Deliverable Numbers: TBC

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

Risk Commentary

The risk remains static as work continue to replace end of life equipment during the previous and current quarters. In addition, controlled cut over of key systems to backup sites was undertaken during this quarter. Maintenance works has been undertaken by estates on power systems supporting key ICT sites which will provide additional assurance for sites in the event of incoming mains disruption. Further desktop exercises are being considered to test both department BCP and ICT recovery plans. Internal audit are also undertaking an audit on ICT system resilience which is due to report shortly

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

GAPS IN CONTROLS	**GAPS IN ASSURANCE**
Non identified	Undertaking Cyber Essentials assessment

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

Risk ID 558	Deterioration of staff health and wellbeing in the face of continued system pressures as a consequence of workplace experiences	Date of Review:	18/10/2023	TREND	15 (3x5)
		Date of Next Review:	18/11/2023	→	

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

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

IMTP Deliverable Numbers: TBC

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

Risk Commentary

The ongoing system challenges remain with long handover delays which are likely to worsen again as we head into winter pressures. Work on reducing shift overruns continues with various pilots being run to test viable options which could be implemented. Front line operations had little respite over the summer months.

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

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:	18/10/2023	TREND	15 (3x5)
		Date of Next Review:	18/11/2023		

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

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

11. Need to increase the education and communication with managers about stress risk assessments. Presentation developed and shared with people services. Delivery dates being agreed in conjunction with Health and Safety.

Lack of awareness about staff wellbeing services

Effects of REAP 4 affecting the ability of staff to engage with staff health and wellbeing services. Important to recognise the consistent reports of the impact of culture on wellbeing.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Restart the Health and Wellbeing Steering Group (link to risk 160)	Assistant Director Inclusion, Culture and Wellbeing	Completed 03.08.23 Group paused due to two key vacancies. **Completed 26/10 /23**	First meeting was on 17/10/2022. This however does not yet bring down the score of the risk as the Steering Group meeting was to re-establish a way forward. Next meeting to be scheduled within 2 months. 03/08/23 - Head of workplace Wellbeing due to be in post in October and OH Manager about to go to advert. No capacity within the team to restart the group. **26/10/23 Head of Workplace Wellbeing in Post, OH Manager starting in December. Steering Group arranged for first week of December.**
2. Increase the education and communication with managers about stress risk assessments	Head of Health & Safety	Completed	This is part of the IOSH Managing Safety Training BAU. OH to undertake workshops with CCC managers – dates to be confirmed this week.
3. Deliver the employee engagement tool into WAST	Deputy Director of People and Culture	**30.09.23** **26/10/23 Complete**	Software has been procured. Planning for rollout is underway. First survey delivery **in October/ November 2023.** 03/08/23 - Working on the timing of launch based on the rollout of the Freedom to Speak up platform. **26/10/23 Questions Finalised and first survey due to be distributed in November**

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	27/10/2023	TREND	15 (3x5)
		Date of Next Review:	28/11/2023	NEW	

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

IMTP Deliverable Numbers: TBC

EXECUTIVE OWNER	Director of Operations	ASSURANCE COMMITTEE	Finance & Performance Committee

Risk Commentary

The challenges across the unscheduled care system continue with 19,000 hours lost to handover delays during August 2023. There is a direct correlation with ambulance availability and high levels of resources unavailable due to protracted waits at hospital EDs. A number of incidents declared have failed to provide sufficient on the ground assurance that vehicles would be released. Health Boards have declined to incorporate testing of vehicle release into a recent mass casualty exercise. Further, a recent workshop undertaken by the EPRR team as part of the Manchester Arena Inquiry assurance process which has tested our ability to fulfil the PDA in North and South Wales, both in and out of hours, has confirmed that we would only meet the PDA in one of these four mass casualty scenarios.

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

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. CEO letter to Health Boards dated 3 Jan 2023, and DOO letter to Chief Operating Officers dated 30 March 2023 to seek assurance on plans	CEO/DOO	3 Jan 2023 Complete	Acknowledgement and acceptance of risk by HBs and balancing the risk across the whole system. Improvement in handovers in C&VHB and ABUHB. This has been sustained form some months across C&V in a phased programme of improvement with no delays in excess of 2 hours. Programme of improvement underway in ABUHB commencing at 4 hour tolerance with a plan to

RISK ID 594	The Trust's inability to provide a civil contingency response in the event of a major incident and maintain business continuity causing patient harm and death	Date of Review:	27/10/2023	TREND	15 (3x5)
		Date of Next Review:	28/11/2023	NEW	

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

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

			reduce over time. In other HBs there remains little or no controls with variation in both handovers and risk levels across HBs.
2. Multi Agency Exercise to be arranged	4 x LRF	Dec 2023	**This exercise has taken place although Health Boards declined to incorporate vehicle release plans**
3. Review of Manchester Arena Inquiry	EPRR Team	Dec 2023	**This work is underway, and a workshop has confirmed that the PDA would be unable to be met in three out of four simulated mass casualty scenarios.**
4. Health boards are asked to provide assurance of existing and tested plans to immediately reduce emergency ambulances on incident declaration	DOO	Feb 2023 Complete	All Health Boards responded with assurance of plans except BCU..
5 Meeting with Welsh Government to outline this risk; WG agreed to write to HBs seeking assurance from EPRR leads in HBs on the ability to clear EDs and release vehicles. WG agreed to incorporate testing into the forthcoming mass casualty exercise, and a timeframe for vehicle release was proposed by WAST with 30% of vehicles released within 10 minutes of an incident declaration, 50% within 20 minutes and 100% within 40 minutes.	**Assistant Director Operations**	**May 2023 Complete**	**WG have confirmed that they have written to HB EPRR leads.**

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:	25/10/2023	TREND	12 (3x4)
		Date of Next Review:	25/01/2023	➡	

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

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

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

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

Risk Commentary

The ambition is appropriate levels of patient safety and good working conditions for our staff. Clearly neither of these are currently being achieved in the emergency ambulance care pathway as evidenced by the long waits, shift overruns and volume of concerns and reportable incidents. The Trust is currently commissioned on the assumption of 6,000 hours of handover lost hours, with current levels being around 20,000. EASC has an ambition to achieve 12,000 handover lost hours by the beginning of quarter four 2023/24, which looks very unlikely, but even if it was achieved, it would still be double what the EMS rosters are predicated on. The Trust is not fully funded on these rosters either. The Trust is not fully funded for the CHARU roster lines, with an identified shortfall of -89.5 FTEs. The Trust has made the decision to transfer staff from emergency ambulance roster lines to CHARU roster lines, which is almost complete, but does not add more staff. Similarly, the Trust has made the decision to recruit another intake of APPs, an additional 16 FTEs, but this is also being funded through internal movements, with a planned reduction in emergency ambulance numbers.

The 2023 EMS Demand & Capacity Review is live with an estimated completion date of Christmas. This strategic review will enable the Trust to articulate the type and level of resource that optimises response and conveyance to deliver appropriate levels of patient safety and good working conditions for our staff i.e. the ambition. Health boards are clearly under substantial financial pressures, so whether EASC can then support the ambition as articulated by the review, remains to be seen. The Trust has largely delivered on its side of the bargain, with the focus clearly shifting to health boards and handover improvement. The one area that the Trust needs to address is abstractions (including sickness), which are materially above the benchmark of 30%.
If further funding is not forthcoming, post the 2023 EMS Demand & Capacity Review, the risk may need to be revise its score upwards.

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

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

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Agree and influence EASC/Health Boards that sufficient funding to be provided to WAST	CEO WAST	02/08/23	30.09.22 Additional £3m provided for +100 FTEs into Response by 23/01/23. 12/01/23 Recurrent funding for the +100 not secure. 02.05.23 Recurrent funding still not secure.

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:	25/10/2023	TREND	12 (3x4)
		Date of Next Review:	25/01/2023		

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

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

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

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	25/10/2023	TREND	12 (3x4)
		Date of Next Review:	25/01/2023		

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

IMTP Deliverable Numbers:

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

Risk Commentary

The EMS Operational Transformation Programme is the Trust's strategic delivery response to the 2019 EMS Demand & Capacity Review. The programme has now largely been delivered e.g. closure of relief gap (recruitment of +300 staff), increase consult & close above the 10.2% benchmark, re-roster EMS, ensure that there was sufficient fleet and estate to support these changes and roll out the new CHARU resource. The main area outstanding is the reconfiguration of EMSC, which was initially delayed by the pandemic and then further delayed by the need to update the data used to ensure the recommended actions were still correct. This update has just been completed, so the focus is now on finishing the EMSC project within this programme.

Whilst the programme has largely delivered on its agreed outputs, it has not delivered the required levels of patient safety and staff working conditions for two main reasons: extreme handover (20,000 lost hours v the 6,000 that the programme was predicated on) and abstractions (37% v the 30% benchmark).

CONTROLS	**ASSURANCES**
	Internal **Management (1st Line of Assurance)**
1. Implementation Programme Board in place – meetings held every 3 weeks with the DASC and TU reps on the membership	1. Minutes and papers of Implementation Programme Board
2. Executive sponsor and Senior Responsible Owner (SRO) for programme in place	2. Project Initiation Document (PID) detailing structure and minutes of Implementation Programme Board
3. Programme Manager and Programme support office in place (for delivery of the programme)	3. Same as 2
4. Programme risk register	4. Highlight reports showing key risks reported to STB every 6 weeks
5. Assurance meetings held with Strategic Transformation Board (STB) every 6 weeks and with CEO every 3 weeks	5. Highlight reports presented to STB every 6 weeks
6. Programme budget in place (including additional £3m funding for 22/23)	6. Programme budget monitoring report is provided to the Implementation Programme Board – every 6 weeks and letter received from CASC on £3m funding for 22/23
7. Programme documentation and reporting is in place to Programme Board every 3 weeks and STB receives highlight report	7. PID and Programme Plan Summary kept up to date**.** PID is presented to the STB if there is a significant change in the programme deliverables. Programme Plan Summary reported to the Implementation Programme Board every 3 weeks.
8. Regular engagement with the Commissioner and Trade Unions and representation	8. Commissioner and TU participation at the Implementation Programme Board
9. Management of external stakeholder and political concerns	9. Communications and Engagement Plan sets out WAST's arrangements for engagement with stakeholders
10. Secured specialist consultancy to support decision making	10. Reports and contractual compliance
	External **Management (1st Line of Assurance)**
	a. Deputy Ambulance Services Commissioner sits on the Implementation Programme Board
	b. Emergency Ambulance Service Committee Management Group receives a highlight report every two months
	c. EASC receives an update every 2 months on the programme as part of the WAST Provider Report
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
1. Current controls on workforce buy in are not sufficient due to changes in working practices	1. Project Initiation Document (PID) needs to be updated to reflect 22/23 budget position. The PID has been updated for 2023/24 and reflects the budget, commissioning intentions and IMTP.

Risk ID 283	Failure to implement the EMS Operational Transformation Programme	Date of Review:	25/10/2023	TREND	12 (3x4)
		Date of Next Review:	25/01/2023	→	

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

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

2. System pressures – patient handover delays at hospitals (link to risks 223 & 224)	2. No prompts from STB for programme PID or risk register updates. The SRO continues to provide the HLR, but the PID needs to be signed off by the Executive Sponsors. This can be done outside of STB.

Actions to reduce risk score or address gaps in controls and assurances	Action Owner	By When/Milestone	Progress Notes:
1. Increase in engagement on the specifics of change through facilitation mechanisms	Assistant Director – Commissioning & Performance	**02.08.23 Checkpoint Date**	30.09.22 Significant engagement through roster review project. 12/01/23 Largely complete. 02.05.23 There remains some minor engagement as the project concludes.
2. More capacity requested (transition plan)	Assistant Director of Planning & Transformation	**02.08.23 – Checkpoint Date**	30.09.22 Transition plan not funded, but +100 FTE agreed. 12/01/23 Recurrent funding not secure. 02.05.23 this has not been **forthcoming,** and handover lost hours are offsetting all of the gains that the Trust has made. **03.08.23 More capacity unlikely within current** financial pressures, but Trust has recently started the next iteration of the strategic EMS Demand & Capacity Review.
3. Engage with key stakeholders to reduce handover delays	CASC	**02.08.23 – Checkpoint Date**	30.09.22 Reduction commitments agreed, but trend is still upwards. 12/01/23 Extreme and upward trend. 02.05.23 handover hours remain extreme**. 28.07.23 Increasing focus through ICAP meetings, with C&V showing notable progress and early signs of progress in some other health boards.**
4. Reduce abstractions in particular sickness absence	Deputy Director of Workforce & OD	**02.08.23 Checkpoint Date**	30.09.22 Sickness absence reducing, but abstractions high linked to sickness, but also training abstraction linked to the +100. 12/01/23 Abstractions have reduced, but still very high. Sickness is reducing and on trend to achieving the 10% Mar-23 target. High abstractions linked to internal movements caused by internal recruitment. 02.05.23 the Trust achieved 7.99% in Feb-23 but levels are higher in Operations. Continued focus into 2023/24 to reach 6% by 31/03/23. **28.07.23 Abstractions, which includes sickness now less than 35% with benchmark to 30%**
5. Engage with Assistant Director of Planning and Transformation on process for PID updates	Assistant Director – Commissioning & Performance	**02.08.23 Checkpoint Date**	30.09.22 HoT recruited and now started. Initial contact made with HoT. PID is up to date. 12/01/23 PID has been further updated but requires sign off by the SRO and STB. 02.05.23 PID has been updated but nees to be signed off by Executive Sponsors. **28.07.23 PID updated and programme aligned to new arrangements required by HoT.**

AGENDA ITEM No	**10**
OPEN or CLOSED	**OPEN**
No of ANNEXES	

Q2 AUDIT TRACKER UPDATE

MEETING	Audit Committee
DATE	30 November 2023
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Trish Mills, Board Secretary
CONTACT	trish.mills@wales.nhs.uk

EXECUTIVE SUMMARY

1. This paper provides the Committee with the current position with respect to management actions for audits overall and within the purview of the Committee, noting that Internal Audit will present internal audit reviews finalised in quarter as a separate agenda item.

2. The Audit Tracker has been fully revised in Quarter 2 with excellent engagement with Directorates. C.30% of all audit recommendations are presented as closed in quarter in this report and there are actions with a change in date proposed (marked in blue), many of which are due to be closed in Quarter 3.

3. Discussions have also taken place on historical actions and those where management actions may need to be amended in view of the current operating context.

4. Good progress is being made with Digital Healthcare Wales (DHCW) on Tracker 3.0 which is a SharePoint solution linked with Power BI reporting for ELT and Audit Committee in particular, and automated reminder functionality for audit points of contact in directorates. It is expected this will be in place by Q1 2024/25 as anticipated.

5. With respect to the Committee's responsibility to scrutinise the impact of actions, members will recall that this was related to opportunities to strengthen challenge raised by Audit Wales in the 2022 Structured Assessment. It is proposed that the most effective way to do this is by identifying actions within audits as audit reports are reviewed by Committees.

6. The current version of the tracker is now open for Directorate review for actions due in October, November and December. This will then be reported in the January and February Committee cycles.

7. Audit Wales have reviewed the Audit Process and Reporting Handbook and make helpful and supportive additions to the document since it was approved in September.

RECOMMENDATION

8. The Committee is requested to:

   (a) Approve the changes to the Audit Process and Reporting Handbook v2.0 (at Annex 1) and agree that non-material changes will be approved by the Executive Leadership Team.
   (b) Receive assurance that the management actions for the audits within the purview of this Committee (at Annex 2), and overall (at Annex 3), are being effectively and appropriately managed and closed off in quarter
   (c) Note the proposal for closer scrutiny of the impact of actions in response to audit recommendations.

KEY ISSUES/IMPLICATIONS
As set out above.
REPORT APPROVAL ROUTE
Tracker presented to ADLT 9th October 2023 Tracker circulated to ELT 13th October 2023 Tracker has been presented in quarter to the following Board Committees: - QUEST – 31 October 2023 - Finance and Performance Committee – 13 November 2023 - People and Culture Committee – 16 November 2023

REPORT APPENDICIES
Annex 1 – Audit Handbook v.2.0 Annex 2 – Tracker 2.0 July-September 2023 (all audit recommendations) Annex 3 – Tracker 2.0 July-September 2023 (Audit Committee specific recommendations)

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

SITUATION

1. This paper provides the Committee with the current position with respect to management actions for audits within the purview of the Committee.

BACKGROUND

2. In September 2023 the Audit Committee approved the Audit Process and Reporting Handbook ('Handbook'). The Handbook has been further revised to include Audit Wales content and version 2.0 is attached at **Annex 1 f**or approval by the Committee. To support agility as the revised audit process embeds, the Committee is asked to confirm it is comfortable for non-material changes to be approved by the Executive Leadership Team (ELT).

3. The Tracker has been fully revised in Quarter 2 and the Corporate Governance Team has been working with DHCW on a SharePoint solution to enable us to move away from the excel spreadsheet. This is continuing at pace and a proof of concept is in place.

ASSESSMENT

Audit Committee Audit Actions

4. The Handbook notes that it is the responsibility of a Board Committee to:

   - Receive audits in their remit
   - Monitor management actions to address recommendations

5. The audit recommendations within the purview of the Audit Committee relate to the Risk Management, Standards of Business Conduct, and Follow Up audits and are listed at **Annex 2**, with 58% of these audit recommendations closed in quarter. The historical 2021/22 risk management actions have now been closed with the support of Internal Audit.

Full Tracker Review

6. As well as monitoring management actions for audits in their purview, the Audit Committee has the responsibility to scrutinise the progress of audits overall, escalating to the Board any issues of concern. To that end, the full audit tracker is attached at **Annex 3**.

7. The Quality, Patient Experience and Safety Committee, Finance and Performance Committee, and the People and Culture Committee have reviewed the management

actions for audits within their purview in the last few weeks. Their AAA reports to Board will note this. Members of those Committees welcomed the revised format, with no escalations to the Board.

8. There has been excellent engagement with Directorates on the revised Tracker 2.0, with the result that c.30% of audit recommendations are presented as closed in quarter in this report. Discussions have also taken place with Internal Audit and audit owners on historical actions and those where management actions may need to be amended in view of the current operating context. There has been some traction with these and discussions will continue into Q3 with a view to closing down or revising as many as possible.

9. The Committee will note that the historical closed items which was a third and fourth tab on Annex 1 have been removed from Tracker 2.0. This is because there is a filter in place under the 'status' column to enable the viewer to see closed items. A copy of the historical closed tabs has been retained separately.

10. Some actions have had a change in date proposed (marked in blue), many of which are due to be closed in Quarter 3.

11. The current version of the tracker is now open for Directorate review for actions due in October, November and December and will be reported in the January and February Committee cycles.

Impact of Closed Management Actions

12. The Handbook also notes that it is the responsibility of a Board Committee to scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

13. The Audit Committee will recall that the Committees' responsibility to scrutinise the *impact of actions* was raised by Audit Wales in the 2022 Structured Assessment. It is proposed that the most effective way to do this is by identifying actions within audits as the audit reports are reviewed by Committees. For example, an internal audit or Audit Wales structured assessment/local review may include an action for roll out of training or for an evaluation. Committees may wish to place closer attention to the impact of such actions by flagging them for follow-up on impact at a particular point in time.

Audit Committee Reporting

14. With the development of Tracker 3.0 with DHCW, reporting which the Audit Committee approved in September is also developing.

15. During the proof of concept stage this reporting is being tested and may be revised as the SharePoint solution and Power BI reporting is piloted. The reporting agreed by the Audit Committee includes the following that will come to this meeting and to ELT for a high level overview of effectiveness of the audit tracker and internal audit processes generally:

    (a) Number of substantial/reasonable/limited/no assurance/advisory audit reports per year.
    Gives a general overview throughout the year and over audit years

    (b) Number of audit reports per committee oversight
    Gives a general overview of the spread of oversight of audit reports and those who may not be monitoring any reports

    (c) Number of high rated recommendations with actions more than 3 months past their original date
    High rated actions should be closed off immediately due to their risk profile. This will allow for escalations.

    (d) Number of actions for limited assurance audit reports more than 3 months past their original date
    Due to the issues that will arise in a limited assurance report they should be closed off asap and before follow-up reviews. This will allow for escalations.

    (e) Number of actions that have 'met' and 'not met' the original due date
    Gives an indication of the realistic nature of the original dates leading to a change in behaviour
    Provides oversight of progress over audit years

    (f) Number of individual actions that have 'not met' revised dates
    Will indicate a potential issue in meeting an action or lack of progress for some other reason. Will need to be sure this is not a double count with some of the other metrics.

RECOMMENDATION

16. The Committee is requested to:

    (d) Approve the changes to the Audit Process and Reporting Handbook v2.0 (at Annex 1) and agree that non-material changes will be approved by the Executive Leadership Team.

(e) Receive assurance that the management actions for the audits within the purview of this Committee (at Annex 2), and overall (at Annex 3), are being effectively and appropriately managed and closed off in quarter

(f) Note the proposal for closer scrutiny of the impact of actions in response to audit recommendations.

Corporate Governance Directorate
Audit Process and Reporting Handbook

This Handbook is intended to equip WAST colleagues with the knowledge you need should you be involved in an audit at the Trust, whether that is an internal audit or external audit. It also sets out roles and responsibilities including those for senior management and the Trust Board Committees.

Internal audit and external audit are both important components of the Trust's financial and operational processes, but they serve different purposes and have distinct characteristics.

All NHS Wales organisations must have an internal audit function and that is provided by NWSSP Audit and Assurance Services (herein referred to as Internal Audit). Internal audit provides independent, objective assurance and advisory activities designed to add value and improve governance and operational efficiency, risk management and control for all NHS Wales bodies.

The Auditor General for Wales is the Trust's external auditor[1] and staff from Audit Wales will deliver an annual programme of statutory audit work that verifies the accuracy, fairness and regularity of the financial statements for the Trust and the WAST Charity. The Auditor General also has a duty to be satisfied that the Trust has proper arrangements in place to use its resources efficiently, effectively and economically, and uses a programme of performance audit work, including an annual Structured Assessment, to discharge this duty.

Both types of audits play crucial roles in ensuring transparency, accountability, and good governance within an organization. The findings from internal audit reviews are taken into account by Audit Wales staff when conducting their audits, and likewise structured assessments and other external audit findings are relied upon by Internal Audit when conducting internal audit reviews.

This Handbook does not include other forms of audit such as clinical or quality audits that are undertaken at the Trust.
It is intended that this Handbook will be reviewed within twelve months of its approval date to reflect any changes in process as a result of revisions to the Audit Tracker including automation, repository and reporting.

[1] *Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions. Audit Wales is not a legal entity and itself does not have any functions

Contents

1. Why audit is important 3
2. Internal Audit 3
   - 2.1 What is an internal audit 3
   - 2.2 Who are Internal Audit and what do they do 4
   - 2.3 Why is the particular audit happening? 4
   - 2.4 The stages of an internal audit 4
   - (a) Planning 5
   - (b) Fieldwork 5
   - (c) The Internal Audit Report (draft to final) 5
   - (d) Follow Up 8
   - 2.5 Review and Monitoring or Internal Audits 8
3. External Audit 8
   - 3.1 Who is the Trust's external auditor & what are their statutory duties and powers? 8
   - 3.2 What work does the Auditor General undertake at the Trust? 9
   - 3.3 How does the Auditor General report their findings? 10
   - 3.4 Data Protection 10
4. The Audit Tracker 11
5. Roles and responsibilities 12
   - 5.1 Director 12
   - 5.3 Audit interviewees 12
   - 5.4 Board Secretary 13
   - 5.5 Audit Committee 13
   - 5.6 Board Committees 13
   - 5.7 Executive Leadership Team 14
   - 5.8 Assistant Directors Leadership Team 14
   - 5.9 Internal Audit 14
   - 5.10 External Audit 14
6. Annexures 15
7. Version History and Document Control 15

1. Why audit is important

Regular audits are an important part of organizational learning and development. They provide valuable assurance to the Board and our key stakeholders on performance. It is important to understand that an audit is not a fault-finding exercise. Internal audits are designed to support you and your teams to identify areas of noncompliance and provide opportunities for improvement. They can be a great celebration of success, particularly where a substantial assurance rating is provided. Also, when a reasonable assurance rating is given to an audit there are often areas of excellent work recognised.

The annual programme of work conducted by the Auditor General provides assurance for the Board and our stakeholders on the regularity of the financial statements and the efficient, effective and economical use of resources by the Trust. Whilst an overall rating is not provided by Audit Wales, key findings are highlighted within their reports.

The insights that audits generate tangible opportunities for improvement. Because they serve as an additional quality control step, you will be able to pinpoint the root causes of any operational or process issues. Knowing this, you will then be able to take your processes to the next level.

By conducting audits on a regular basis, we are demonstrating to our people, our patients and our stakeholders that WAST takes issues of quality, patient safety, health and safety, and regulatory compliance seriously.

Internal audit reports contribute to our end of year Head of Internal Audit Opinion (see section 2.2).

2. Internal Audit

2.1 What is an internal audit

Internal audit is an independent assessment of a system or process through an objective examination of evidence. The aim is to give management and the Audit Committee confidence (assurance) that:

- appropriate mechanisms are in place to manage risk and increase the likelihood that organisational goals and objectives will be achieved; and
- those mechanisms, usually set out in organisational policies, procedures and processes, are being complied with.

We have included an Internal Audit Jargon Buster at **Annex 1** to aid in your interpretation of this Handbook and of any internal audits you may review.

2.2 Who are Internal Audit and what do they do

As set out above, WAST's internal audit services are not carried out 'in house' but by the NWSSP Audit and Assurance Services. They deliver their work primarily through the following:

Annual Audit plan
Annually a plan is developed which sets out a range of internal audit reviews that will be conducted at the Trust that financial year. The plan is aligned to the Trust's principal risks and is developed in conjunction with your Director and the Executive Leadership Team and following consideration of the key documents such as the principal risk register and Integrated Medium Term Plan. In proposing areas to audit, Directorates are encouraged not to focus on areas we feel we have robust processes, but those that we believe can be improved or made more efficient. You can find the list of audits planned for each year here. Where necessary, particularly to address emerging risks in year, the plan may be adjusted. The plan is approved by the Audit Committee.

Individual audits and advisory reviews
Throughout the year Internal Audit undertake audit and consultancy (or advisory) reviews in line with the annual audit plan. Each report aims to provide an assurance opinion (audit report) or advice (consultancy reports) over a specific system or process.

Recommendations are agreed with management before presenting our reports to the Audit Committee.

Head of Internal Audit Opinion
The Head of Internal Audit Opinion (HOIA Opinion) is provided to the Trust annually. It is based on the outcome of audit and consultancy work undertaken during the year and other information available to Internal Audit. The HOIA Opinion contributes to assurances available to the Board to underpin the Board's assessment of the effectiveness of governance and control. It is an integral piece of the Trust's governance framework, providing assurance to inform the annual governance statement and identifying improvement opportunities.

There is more information on Internal Audit 'who we are?' at **Annex 2.**

2.3 Why is the particular audit happening?

You may be wondering why a particular area or process in your Directorate is being audited. You will see above that an annual audit plan is developed so it is likely that this process or area of work was identified during the annual risk-based planning process or has become an emerging risk during the year. It may also have been specifically requested, e.g., by management, the Audit Committee, a third party, etc.

2.4 The stages of an internal audit

There are a number of stages to an internal audit review. Before work starts on your audit be sure to understand the various roles and responsibilities and your part in it (see section 5).

We have set out below the various stages your internal audit will take. You may be involved in all or some of them. The Internal Audit flow chart at **Annex 2** provides more detail on the stages your internal audit will take for additional reference.

(a) Planning

Whilst the area for the audit will have been identified in the annual audit plan, the specifics of what the audit will cover will be agreed with your Director at this first step in the internal audit.

A meeting will take place with internal auditor assigned to the audit and the Director and an audit brief will then be agreed.

You should consider appointing a person as the central point of contact (POC) for the audit in your Directorate. That person should be involved at this planning stage and throughout to ensure Internal Audit have everything they need, and those that need to contribute to the process are fully informed.

(b) Fieldwork

Fieldwork is the process of examining evidence to form an opinion, with respect to the area being audited, systems are designed to mitigate risks identified in the brief, and the mechanisms in place to mitigate those risks are operating effectively.

A kick off meeting will be held with Internal Audit and the Director, and it is advisable to have your POC at that meeting also.

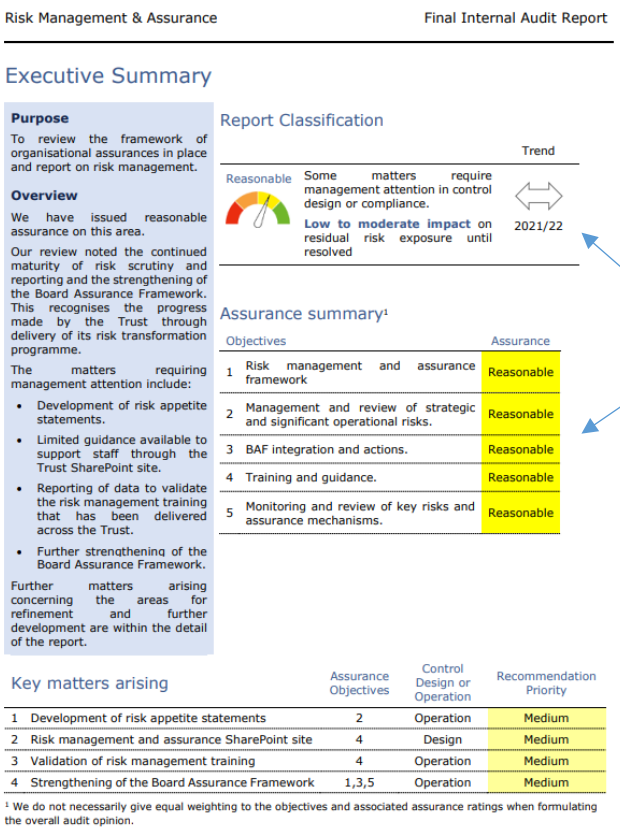
Internal Audit may request a number of documents or interviews with subject matter experts within WAST. Your POC should coordinate these interviews and provide internal audit with all documents they request. The POC should keep a log of documents provided.

Ensure a timeframe for completion of the fieldwork is agreed. The POC will ensure they are aware of that timeframe and the date the draft report is planned to be released.

(c) The Internal Audit Report (draft to final)

At the end of the fieldwork a draft report will be prepared. The Trust has 15 working days to check the accuracy of the report and agree, or otherwise, the recommendations in the report and develop actions to address recommendations.

The report itself will set out the agreed purpose and audit objectives agreed at the planning stage. The executive summary provides a snapshot of the purpose of the audit, an overview of main issues, the overall risk rating, and a breakdown of ratings for the objectives and recommendations. It may look something like this:



Risk Management & Assurance — Final Internal Audit Report

Executive Summary

Purpose

To review the framework of organisational assurances in place and report on risk management.

Overview

We have issued reasonable assurance on this area.

Our review noted the continued maturity of risk scrutiny and reporting and the strengthening of the Board Assurance Framework. This recognises the progress made by the Trust through delivery of its risk transformation programme.

The matters requiring management attention include:

- Development of risk appetite statements.
- Limited guidance available to support staff through the Trust SharePoint site.
- Reporting of data to validate the risk management training that has been delivered across the Trust.
- Further strengthening of the Board Assurance Framework.

Further matters arising concerning the areas for refinement and further development 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	2021/22

Assurance summary[1]

Objectives		Assurance
1	Risk management and assurance framework	Reasonable
2	Management and review of strategic and significant operational risks.	Reasonable
3	BAF integration and actions.	Reasonable
4	Training and guidance.	Reasonable
5	Monitoring and review of key risks and assurance mechanisms.	Reasonable

Annex 3 provides a breakdown of the various assurance ratings

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Development of risk appetite statements	2	Operation	Medium
2	Risk management and assurance SharePoint site	4	Design	Medium
3	Validation of risk management training	4	Operation	Medium
4	Strengthening of the Board Assurance Framework	1,3,5	Operation	Medium

[1] We do not necessarily give equal weighting to the objectives and associated assurance ratings when formulating the overall audit opinion.

Internal Audit will provide a conclusion and separate assurance rating on each of the audit objectives agreed at the planning stage, based on the evidence it has looked at and the interviews it has conducted during the fieldwork?

Recommendations made under each objective are then summarised in the appendix.

Risk Management & Assurance — Final Internal Audit Report Appendix A

Appendix A: Management Action Plan

Matter Arising 1: Development of risk appetite statements (Operation)	Impact
The development of risk appetite statements is a deliverable that is ongoing as part of the Trust's risk management transformation programme. A risk appetite matrix has been developed, where currently risks scoring as high (15-25) are expected to be reviewed monthly, medium risks (8-12) quarterly, and low risks (1-6) every 6 months. The reviews should take place with the risk owners, supported by the risk team. In addition, the Trust's risk appetite is risk averse in two key areas. This means that risks will be eliminated or reduced to the lowest practical level should they impact negatively upon the quality and safety of its patients, workforce, and the public, and compliance with statutory duty, regulatory compliance, or accreditation. We note the progress made in this area with plans in place to scope and develop the risk appetite statements with the Chair.	Potential risk of: • Unintegrated and inconsistent approaches to managing and escalating risks resulting in ineffective and inefficient use of resources.

Recommendations		Priority
1.1	Following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements.	Medium

Agreed Management Action	Target Date	Responsible Officer

Whilst the recommendations from auditors will be based on the evidence provided, it may be necessary to highlight any concerns about the wording, practicality or relevance of audit recommendations. This is particularly the case where the recommendation cannot be completed fully by WAST alone and where the closing of the recommendation would require involvement on and dependency of third parties. Third party actions may cause significant delays in closing an action, seeing an impact in any improvements, and may require escalation to the Audit Committee.

Recommendations are categorised according to their level of priority and the timeframe within which management actions should be completed. The prioritisation table is set out in Annex 4.

Each recommendation must be met with an agreed management action. You will have to respond with a management response within the 15 day window mentioned above.

Management actions are an important consideration and usually the last step in finalising the audit report. Often they will be obvious and likely a plan or action you already have in train or were planning. Sometimes actions will require careful planning and resourcing.

It is important to remember that the actions you promise to deliver and the dates within which you indicate they will be completed by will be monitored closely not only by your Directorate, but also by the Executive Leadership Team and the Audit Committee. This is primarily done via the audit tracker which is regularly reported into those forums. It is therefore crucial that management actions are:

- Approved by the Director and actions assigned to suitably senior members of the team to enable them to close off actions and escalate them

- Framed in a way which broadly meets the requirements of SMART principles:
  - Specific – is there an output or a process that is required to address the recommendation
  - Measurable – what evidence will you be able to provide to demonstrate the action is closed
  - Achievable – are there resourcing or other challenges that may prohibit the action being completed, or is a third party involvement required which may provide challenging
  - Realistic – will the action address the recommendation, does it provide value for money and will it have the desired impact
  - Timebound – do not over promise and underdeliver. Take account of pressures during the winter and annual leave, as well as the required governance routes for the action before suggesting a date by which the action will be closed off

All dates included for completion of actions must be expressed in terms dd/mm/yy.

Recommendations that are rated 'high' must be given priority and should where possible receive a shorter turnaround time to close the recommendation.

Any **differences of opinion** regarding the applicability, relevance, practicality or timeliness of recommendations should be fully discussed between auditors and the Director prior to it being submitted for consideration by the Executive Leadership Team and the Audit and other Board Committees. If an agreed way forward cannot be found, the issue(s) should be referred to the Board Secretary.

Internal audit will aim to provide the final report within ten working days of receipt of the management responses.

(d) Follow Up

Internal Audit conduct a follow up audit annually to verify if agreed actions have been implemented and whether the actions taken have been effective in mitigating risk.

2.5 Review and Monitoring or Internal Audits

Once the internal audit report is finalised it is reviewed and discussed by the Executive Leadership Team and the Audit Committee. Reports relevant to Board Committees are also presented to their next meeting. Section 5 on Roles and Responsibilities goes into more detail on the focus of these various groups.

Audit recommendations and actions are transposed to the Audit Tracker. Further detail on Audit Tracker appears at section 4 below.

3. External Audit

3.1 Who is the Trust's external auditor and what are their statutory duties and powers?

The Auditor General for Wales is the statutory external auditor of most of the Welsh public sector. This means that they audit the accounts of county and county borough councils, police, fire and rescue authorities, national parks and community councils, as well as the Welsh Government, its sponsored and related public bodies, the Senedd Commission and National Health Service bodies. At many of these public bodies, including the Trust, the Auditor General also has a statutory requirement to satisfy themselves that the organisation has proper arrangements in place to secure economy, efficiency, and effectiveness in the use of their resources.

The Auditor General for Wales is a crown appointment and their statutory duties and powers are contained in the following legislation:

- Government of Wales Act 1998
- Government of Wales Act 2006
- Public Audit (Wales) Act 2004
- Public Audit (Wales) Act 2013
- Well-being of Future Generations (Wales) Act 2015[2]

Further information can be found in:

- Access rights of the AGW
- A guide to Welsh public audit legislation

3.2 What work does the Auditor General undertake at the Trust?

To discharge their statutory duties, the Auditor General undertakes an annual programme of audit work at the Trust, which is summarised in the Annual Audit Plan. This plan is developed following assessments of the Trust's principal risks, with a process similar to that described for internal audit above. The Annual Audit Plan will set out the work the Auditor General intends to undertake to audit the Trust's accounts and undertake an independent examination of the charitable funds, as well as a programme of performance (or value for money audit work that will typically include:

- Structured Assessment work; and
- Thematic work which may examine issues specific to the Trust or which is part of a wider examination that is also being taken forward at a number of other bodies.

The Annual Audit Plan, which also sets out the fee the Auditor General must charge for the work, is agreed by the Executive Leadership Team and approved by the Audit Committee.

Audited Financial Accounts

The Auditor General for Wales audits the financial statements of the Trust annually. In addition, Audit Wales staff will undertake an independent examination of the WAST Charity annually. The aim of the audit is to verify that the financial statements are prepared in accordance with relevant accounting standards and to provide reasonable assurance that they are free from material misstatements. These certified financial statements are filed with the Welsh Government (Trust accounts) and Charities Commission (WAST Charity) along with the accompanying respective annual reports.

[2] In line with the Wellbeing of Future Generations (Wales) Act the Auditor General must carry out examinations of each named organisation's well-being objectives and the steps being taken to meet them. This will apply to the Trust when it becomes one of the named bodies (anticipated for April 2024).

The Welsh Government Manual for Accounts guides the preparation of the Trust's financial statements and the Finance and Corporate Resources Directorate oversees their preparation and liaises with Audit Wales throughout.

Structured Assessment
The Structured Assessment takes place annually and primarily examines corporate arrangements relating to governance, systems of assurance, planning, and financial management.

A project brief is agreed with the Executive Leadership Team and the Board and follows similar stages to that of an internal audit above.

The Structured Assessment Report assures the Board, our people, the public and key stakeholder that the Trust has sound corporate governance arrangements and that the necessary action is being taken to deliver high quality, safe and responsive services, and that public money is being spent wisely.

Local performance audit reviews
In addition to the Structured Assessment, the Auditor General may also review certain arrangements at the Trust in more depth. This audit work is determined as part of the local audit planning process and is specific to the risks facing the Trust.

All Wales thematic reviews
The Auditor General may also undertake work at the Trust which is part of a wider thematic review examining a specific issue or service area across all NHS bodies in Wales.

National value for money examinations
In addition to the annual programme of audit work at the Trust, the Auditor General undertakes a number national value for money examinations each year which focus on a range of topical issues, including those relevant to NHS bodies. Depending on the topic under review, national value for money examinations may involve the capture of information from the Trust, and the published outputs from the work may include recommendations for the Trust to respond to.

3.3 How does the Auditor General report their findings?

The findings from the audit of the accounts, the Structured Assessment and any additional performance audit reviews are set out in individual reports which are agreed with management and presented to the Audit Committee and/or the Board. Similar to Internal Audit, management actions will be provided to address any audit recommendations contained in the Audit General's reports and these will be monitored via the Audit Tracker.

3.4 Data Protection

During the course of the Auditor General's audit work, if any personal data is processed, such as during interviews or within Trust documents, it is done so in accordance with data

protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulation.

4. The Audit Tracker

A tracker is maintained by the Corporate Governance Team to provide a central overview on progress against management actions on Internal Audits and Audit Wales reports. From time to time regulator reports may also be included.

Directors and the POC or action owner must ensure the actions are completed by the agreed dates. Of course, it is understandable that sometimes that is not possible and changes to agreed completion dates are warranted. The Audit Tracker enables a Director to propose up to three changes in completion dates. This should not be required if realistic dates are provided in the original audit but where it is needed justification must be provided. The Director should include in the justification the progress to date as well as any risks to a delay in completion of the action.

Directorates should conduct monthly reviews of the Audit Tracker by including a monthly audit update on their Directorate agenda. This agenda item would also include the initial review of any new internal audit reports. The Audit Tracker can then be updated by the POC or action owner ensuring:

- Where an action is proposed for closure evidence demonstrating that is provided or signposted;
- Where a date change is required an update is required the rationale for that including progress made since the date of the last review, obstacles to further progress and confirmation, or otherwise, that the revised date is achievable.
- Early warning of any actions not yet due but which may be at risk of delay

Any changes to dates due must be approved by the Director.

The Board Secretary will undertake a formal quarterly review of the Audit Tracker and will review the evidence provided to support closure of an action. The cycle for review will be as follows:

- 5th working day of the first month in the new quarter (=T) tracker finalised for Committees and sent to IA or AW
- T-9 working days = Assistant Directors Leadership Team (ADLT) review and escalation
- T-13 working days = closure of tracker for ADLT submission
- T-23 working days = send out tracker to POC (or ADLT) and Directors and business partners rep for directorates (however if Directorates are conducting regular monthly reviews the tracker may already be updated)

Where it is no longer possible to complete the action the Board Secretary can support the Directorate to propose amendments to Internal and External Audit.

Where the implementation of a 'high risk' action is delayed beyond 3 months of the originally agreed date the responsible Executive Lead may be invited to attend the next meeting of the Audit Committee to discuss the various issues involved.

Once all recommendations have been implemented to the satisfaction of the Committee they will be classified as closed.

5. Roles and responsibilities

5.1 Director

- Agree the internal audit brief;
- Agree recommendations and develop management responses;
- Ensure all relevant individuals (including any not in your team) are aware the audit is taking place, including sharing the brief with them;
- Support and empower your team to provide all requested audit evidence in a timely manner;
- Agree a directorate process to track management actions;
- Oversee the implementation of agreed actions;
- Attend Audit Committee to provide assurance to members relating to a no or limited assurance internal audit report;
- Lead a discussion of their audit report in the Board Committees where the subject of the audit is in the remit of that Committee; and
- Ensure monthly review of audits as a standard agenda item on directorate meetings.

5.2 Point of Contact (may be action owner or business manager in directorate)

- Communicate any issues to auditors which may impact on the audit, e.g., service pressures, known leave, availability of staff, difficulties around availability of /access to information, etc;
- Provide auditors with the contact details for everyone involved in the system / process being audited, even if from a different team or division; and
- Update the audit tracker monthly.

5.3 Audit interviewees

- Cooperate and be open and honest with the audit team;
- Clearly explain the process and / or system being audited providing any evidence such as meeting minutes etc as may give wider context;
- Provide audit evidence requested and respond to auditor queries throughout the audit in a timely manner;
- Communicate challenges in providing information and / or pressures within the point of contact in your directorate; and

- Answer to the best of your ability – Auditors know that people can be nervous, and sometimes will forget the answer to a question. It is acceptable to say: "I forget that right now, but here is where I can find that information," and then to show the auditor the procedure or other information they need. If an employee doesn't know an answer, it is far worse to make up the answer than to just say, "I don't know, but I can find out."

5.4 Board Secretary

- Ensure there is an adequate provision of internal and external audit services;
- Coordinate the development and approval of the annual audit plan;
- Provide final audit reports to Executive Leadership Team, Audit and other relevant Committees;
- Maintenance of audit tracker;
- Coordinate quarterly review of tracker;
- Review evidence of closed actions;
- Prepare progress and tracker reports to ADLT, Executive Leadership Team, Audit Committee and Board Committees;
- Facilitate escalations from Internal Audit or on tracker; and
- Lodge quarterly Welsh Government return of audits.

5.5 Audit Committee

- Facilitate direct and unrestricted access for the Head of Internal Audit and Auditor General for Wales to the Board;
- Review and recommend Internal Audit Charter for approval by Board;
- Receives the Internal Audit confirmation of independence annually;
- Receives regular reports from Audit Wales and Head of Internal Audit on its activities;
- Agree annual Internal Audit plan;
- Review internal audit reports, Structured Assessments and other Audit Wales reports, and scrutinise of the adequacy of management actions in response to recommendations;
- Scrutinise the progress of audits overall, escalating to the Board any issues of concern; and
- Receive and review Head of Internal Audit Opinion.

5.6 Board Committees

- Receive audits in their remit;
- Monitor management actions to address recommendations; and
- Scrutinise impact of actions in response to audit recommendations in terms of, for example, quality improvement, the provision of more efficient and effective patient care, improved governance, better use of resources etc.

5.7 Executive Leadership Team

- Develop proposal for annual Internal Audit plan;
- Scrutinise the progress of audits overall (dashboard 3.0);
- Review Structured Assessment briefs;
- Receive and review all final Internal Audit reports, Structured Assessment and Audit Wales reports;
- Oversight of the audit framework by way of quarterly dashboard reports; and
- Receive and review Head of Internal Audit Opinion.

5.8 Assistant Directors Leadership Team

- Receive and review audit tracker quarterly;
- Act as a check and challenge forum, agreeing closure of actions; and
- Escalation forum where updates have not been provided by Directorates.

5.9 Internal Audit

- Provide independent assurance that an organisation's risk management, governance and internal control processes are operating effectively;
- Provide annual Head of Internal Audit Opinion to Audit Committee;
- Provide regular reports on progress to Audit Committee;
- Present annual Internal Audit plan;
- Present finalised Internal Audit reports to Audit Committee;
- Review tracker and raise concerns regarding changes to completion dates for actions to Board Secretary and/or Audit Committee; and
- Agree timeframes for the various stages of internal audit work with the Board Secretary.

5.10 External Audit

- Provide independent assurance on the financial statements and the corporate arrangements for securing economy, efficiency and effectiveness in the Trust's use of resource.
- Agree the briefs for audit work with the Board Secretary and/or relevant Director
- Provide regular reports on progress to Audit Committee;
- Present annual Audit plan to Audit Committee;
- Present finalised Audit reports, including the Annual Audit Report to Audit Committee (or other Committees or the Board by agreement);
- Review tracker and raise concerns regarding changes to completion dates for actions to Board Secretary and/or Audit Committee; and
- Agree timeframes for the various stages of performance audit work with the Board Secretary and for the audit of the financial statements with the Executive Director of Finance and Corporate Resources.

6. Annexures

Annex 1 – Internal Audit Jargon
Annex 2 – Internal Audit Guidance Infographic
Annex 3 – Audit Assurance Ratings

7. Version History and Document Control

Version	Date	Author	Summary of changes	Document Status
v.01	TBC	Trish Mills	First version for consultation: Internal Audit: 7 August 2023 Audit Wales: 6 September 2023 ADLT: 14 August 2023 ELT: 30 August 2023	Draft for consultation
v.02	Aug 23	Trish Mills	Audit Handbook for Audit Committee	Draft
v.1	14.9.23	As above	Approval by Audit Committee – Handbook Ref 001	Final
v.2	17.10.23	Fflur Jones	Additions to the role and work of Audit Wales added for completeness. Review of changes by Audit Committee 30.11.23	Final

Annex 1

External Quality Assessment

Our latest EQA, conducted in February-March 2023 by the Chartered Institute of Public Finance and Accountancy, confirmed that our work 'fully conformed' to the requirements of the PSIAS for 2022/23.

Want to know more?

Internet: Audit & Assurance Services - NWSSP

Intranet: Audit & Assurance Services (sharepoint.com)

Key documents / information:

- Public Sector Internal Audit Standards
- Institute of Internal Auditors
- Our Assurance Opinion and Action Plan Risk Ratings
- Our Responsibility Statement

Ask your key contacts for information on:

- Internal Audit Overview
- Our Annual Planning Approach
- Our 2023/24 Internal Audit Plan and Charter

Distilling the jargon

When you know a subject inside-out, it's easy to lose others amongst the jargon. Here's some clarification on some of the audit jargon you might here us using...

Assurance
From an internal audit perspective, this means providing an independent assessment of a system or process through an objective examination of evidence.

Governance
The combination of processes and structures that the Board puts in place to inform, direct, manage and monitor organisational activities and achievement of objectives.

Risk management
A process to identify, assess, manage and control potential events or situations which may hinder achievement of organisational objectives.

Control
Any measures put in place by management, the Board or other parties to manage risk and increase the likelihood that organisational goals and objectives will be achieved.

Control Design recommendation
A recommendation to support improvement in the design of the audited system. Generally, the improvement is needed to improve the mitigation of risks within the system.

Audit Brief
Document that sets out the scope of the audit (i.e., what the audit will cover) and key audit logistics, including the audit team, key contacts and timeframes.

Executive Lead
Individual within the organisation identified as the lead for the audit, usually a director.

Responsibilities include:

- agreeing the audit brief;
- providing management responses to our recommendations; and
- overseeing the implementation of agreed actions.

Audit meetings
Planning meeting: held during the planning phase to identify and agree the audit scope and timing, etc.

Kick-off meeting: usually held at the beginning of the fieldwork phase, we use this meeting to get a detailed understanding of the system under review.

Debrief meeting: at the end of the audit, we will meet with key individuals to debrief on our findings.

Assurance opinion
Our overall view of whether, for the system being audited:

- the controls have been adequately design to mitigate identified risks; and
- the controls are operating effectively (i.e., are being adhered to) in practice.

Our assurance opinions are defined here.

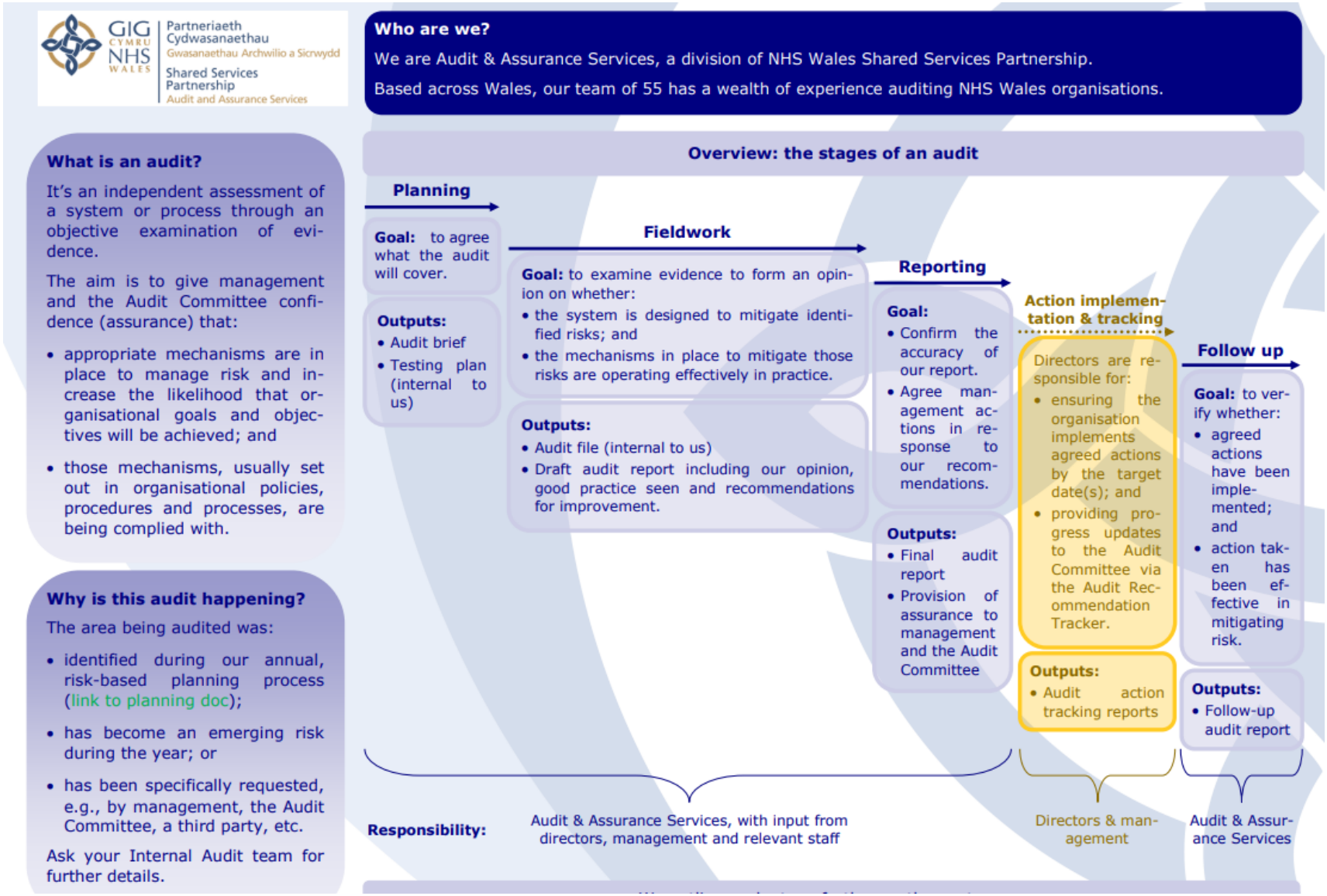
Operating Effectiveness recommendation
These recommendations relate to where we have identified non-compliances within the system, e.g., policies and procedures have not been followed.

Audit Report
Sets out our audit findings, including good practice identified, recommendations for improvement and management responses.

Your key contacts

Head of Internal Audit: Osian Lloyd (osian.lloyd@wales.nhs.uk / Microsoft Teams)
Deputy Head of Internal Audit: Felicity Quance (felicity.quance@wales.nhs.uk / MICROSOFT TEAMS)
Business Manager: Grant Cullen (grant.cullen2@wales.nhs.uk / Chat with me on Microsoft Teams)

Annex 2


GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services
Who are we?
We are Audit & Assurance Services, a division of NHS Wales Shared Services Partnership.
Based across Wales, our team of 55 has a wealth of experience auditing NHS Wales organisations.
What is an audit?
It's an independent assessment of a system or process through an objective examination of evidence.
The aim is to give management and the Audit Committee confidence (assurance) that:
• appropriate mechanisms are in place to manage risk and increase the likelihood that organisational goals and objectives will be achieved; and
• those mechanisms, usually set out in organisational policies, procedures and processes, are being complied with.
Why is this audit happening?
The area being audited was:
• identified during our annual, risk-based planning process (link to planning doc);
• has become an emerging risk during the year; or
• has been specifically requested, e.g., by management, the Audit Committee, a third party, etc.
Ask your Internal Audit team for further details.
Overview: the stages of an audit
Planning
Goal: to agree what the audit will cover.
Outputs:
• Audit brief
• Testing plan (internal to us)
Fieldwork
Goal: to examine evidence to form an opinion on whether:
• the system is designed to mitigate identified risks; and
• the mechanisms in place to mitigate those risks are operating effectively in practice.
Outputs:
• Audit file (internal to us)
• Draft audit report including our opinion, good practice seen and recommendations for improvement.
Reporting
Goal:
• Confirm the accuracy of our report.
• Agree management actions in response to our recommendations.
Outputs:
• Final audit report
• Provision of assurance to management and the Audit Committee
Action implementation & tracking
Directors are responsible for:
• ensuring the organisation implements agreed actions by the target date(s); and
• providing progress updates to the Audit Committee via the Audit Recommendation Tracker.
Outputs:
• Audit action tracking reports
Follow up
Goal: to verify whether:
• agreed actions have been implemented; and
• action taken has been effective in mitigating risk.
Outputs:
• Follow-up audit report
Responsibility:
Audit & Assurance Services, with input from directors, management and relevant staff
Directors & management
Audit & Assurance Services

Why am I being asked lots of questions and / or for various documents?

The Public Sector Internal Audit Standards require that we must identify sufficient, reliable, relevant and useful information to achieve the objectives of the audit. To do this, we:

- require robust audit evidence to be provided in a timely manner; and
- must critically examine this evidence.

We then may need to:

- ask further questions to clarify our understanding or verify the robustness of the evidence; or
- request further evidence to ensure the above requirements are met.

Why is there sometimes a short delay between the fieldwork ending and the issue of the draft report?

Our fieldwork must be clearly documented to evidence our work. This, along with drafting reports, can take time after we have finished speaking with you.

Additionally, all audit fieldwork and draft reports are reviewed by a senior member of our team to ensure our quality standards are met.

Planning stage

What we do for each audit:

- Meet with management to identify and agree the audit scope—this is set out in the audit brief.
- Understand the systems in place, e.g., through review of policies and procedures, understanding relevant laws, regulations and good practice, considering similar audits done at other Welsh health bodies, etc.
- Identify mechanisms in place (a.k.a., controls) that mitigate identified risks and develop a plan to test these.

Fieldwork stage

What we do for each audit:

- Meet with management and operational staff (a.k.a., the kick-off meeting) to verify our understanding and gain further detail on the system under review.
- Consider whether the system is adequately designed to mitigate identified risks.
- Request and critically examine audit evidence to test whether the identified controls are being operated in practice; depending on the audit, this may include reports, meeting agendas and minutes, evidence of approvals, patient or staff records, etc.
- Address queries arising from our examination of the audit evidence through discussions with management / operational staff and / or requesting and examining further audit evidence.
- Discuss our initial findings with management before writing our draft report.

Reporting stage

What we do for each audit:

- Issue our draft report and hold a meeting (a.k.a., the debrief meeting) with directors, management and / or operational staff to formally discuss our findings.
- Confirm the accuracy of our report.
- Agree management actions to address our recommendations (a.k.a., the management response), including responsible individuals and deadlines.
- Issue our final report to management and present this at the next Audit Committee meeting.

Action tracking & implementation

What the organisation must do for all actions:

- Add our recommendations and agreed management actions to the organisation's Recommendation (or Action) Tracker.
- Implement the agreed actions and provide regular progress updates on implementation status to the Audit Committee via the Recommendation Tracker.

Follow-up audits

What we do annually:

- Examine evidence to verify the implementation status of agreed actions and benefits realised for a defined sample of previous reports and / or recommendations.
- Report our follow-up findings to the Audit Committee.

What governs our work?

Public Sector Internal Audit Standards (PSIAS)

Internal Audit Charter—approved by the Audit Committee each year

Quality Manual and Consulting Protocol—our internal procedures setting out how we carry our work and comply with the PSIAS.

Quality assurance

All audit fieldwork and draft reports are reviewed by a senior member of our team to ensure:

- the work has been undertaken to an appropriate standard; and
- the opinion provided is consistent with the audit evidence.

Reports are also reviewed by the Head of Internal Audit to ensure alignment with our understanding of the wider organisation.

Additionally, we have:

- an Annual Quality Assurance and Improvement Programme undertaken by the Director of Audit & Assurance to confirm our compliance with the PSIAS and identify improvements;
- an annual assessment by Audit Wales; and
- a five-yearly External Quality Assessment (EQA) to provide independent assurance over PSIAS compliance.

What to expect and what's expected

What to expect: we will:

- agree clear communication lines / methods;
- be clear in our requests to you;
- agree clear timeframes and deadlines for our work;
- be available to answer any queries or concerns you may have at any point in the audit;
- keep you up to date on our progress and findings throughout the audit; and
- be understanding of your workload, service pressures, team absences, etc.

What's expected of you as an auditee: we need you to:

- cooperate and be open and honest with the audit team;
- clearly explain the process and / or system being audited;
- provide audit evidence requested and respond to auditor queries throughout the audit in a timely manner; and
- communicate challenges in providing information and / or pressures within your team.

What's expected of you as a senior manager (director, head of service, etc) of an area being audited: we need you to:

- ensure all relevant individuals (including any not in your team) are aware the audit is taking place, including sharing the brief with them;
- provide us with the contact details for everyone involved in the system / process being audited, even if from a different team or division
- support and empower your team to provide all requested audit evidence in a timely manner; and
- communicate any issues to us which may impact on the audit, e.g., service pressures, known leave, availability of staff, difficulties around availability of /access to information, etc.

Timelines and key performance indicators

Audit Committee reporting: the Audit Committee we intend to report the audit to is agreed during the audit planning phase and is set out in the Audit Brief.

The timeframe for the audit will revolve around the Audit Committee papers deadline, which is usually **two weeks** before the date of the Audit Committee.

We need to have issued our final report by the Audit Committee papers deadline, considering the three key performance indicators identified to the right.

If necessary, we can agree shorter report turnaround periods with management.

Draft report: we aim to issue our draft report within **10 working days** of completing the fieldwork.

Management response: we ask that management responses to audit recommendations in the draft report are provided within **10 working days** of the draft report being issued.

Final report: we aim to issue our final report within **10 working days** of receipt of the management responses.

Annex 3 – Audit Assurance Ratings

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

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

Annex 4 – Prioritisation of Recommendations

In order to assist management in using internal audit reports, they are categorised 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

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header
When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date
ALL FINAL INTERNAL AUDIT REPORTS CAN BE FOUND HERE [to be added in October]

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
382	20/21	FPC	Clinical Contact Centres - Performance Management	Reasonable	Deborah Armstrong	Liam Williams	Medium		5. Review coaching and training arrangements within NHSDW/111 to ensure mechanisms are in place for all staff to receive regular feedback, coaching and training going forward.		5b. Following recruitment, a review of other aspects of training will be undertaken; It should be noted however that without outsourcing aspects of training and delivery for the new system, an overlap with Salus roll out may delay 'regular' coaching and training until at least Autumn.	Jan-22	Not Met	Nov-23			Open	Last update 30/06/2023 SALUS is now planned for Go Live in November 2023. There has been an improvement in delivery of CPD to more staff but this remains a risk as will be put on hold when Salus needs to be trained to all. External Provider assistance may be required. A risk has been identified previously due to a number of unfunded posts in the training team that may not be made permanent however this risk has recently been reduced for someof the unfunded posts to be funded.
383	20/21	FPC	Clinical Contact Centres - Performance Management	Reasonable	Deborah Armstrong	Liam Williams	Medium		5. Review coaching and training arrangements within NHSDW/111 to ensure mechanisms are in place for all staff to receive regular feedback, coaching and training going forward.		5c. The risk relating to the lack of education, coaching and supervision is currently captured on the QSPE Directorate risk register. This risk will be reviewed and updated and if necessary escalated to the corporate risk register.	Apr-22	Not Met	May 23	Nov-23		Open	Last update 30/06/2023 CPD for 111 operational staff. New CPD year 2023/24 commenced April 2023 and is currently strong however important to note that indicative date for Salus training and implementation (Aug-Nov) will impact on ability to maintain other aspects of education and training.
420	21/22	FPC	Service Management	Reasonable	Aled Williams	Leanne Smith	Medium		WAST should develop their Service Management framework and once complete, the Service Catalogue should be published and communicated to all appropriate stakeholders.		Agreement has been reached to employ consultants to undertake a review of current position and to develop ITIL based procedures covering the whole service management disciplines. This work is expected to commence during September 2021. A deliverable of this work will be a refreshed service catalogue which can then be published and communicated.	Mar-22	Not Met	Dec22	Sep-23	Apr-24	Open	Last Updated: 10/10/23 - There is limited capability to support Service Catalogue in Service point and an attempt was made to develop one in Excel see attached draft. Whilst this could be completed and shared with stakeholders it would not be particularly user friendly. We are now close to procuring a replacement for Service Point where there will be a central service catalogue available to digital staff and the users within the system. Aim is to get new system operational by Mar-24.
462	21/22	Quest	Role of Advanced Paramedic Practitioner	Reasonable	Kerry Robertshaw, Jonathan Chippendale	Andy Swinburn	Medium		Formal structures should be established to ensure APPs are appropriately supported to deliver a high standard of practice. This could include a peer review network, where feedback and themes are reported to the Care Closer to Home Group.		Development of proposed standardised clinical appraisal and supervision model to ensure APPs remain up-to-date and competent within their clinical practice.	Mar-22	Not Met	Dec 22	Mar-24		Open	Last updated: 03.07.2023 APP leadership/clinical supervision rollout not supported at formal SOT in the current financial climate due to concerns around releasing APP leadership (8a) workforce from clinical duties to engage in leadership portfolio work streams. Decision to be revised in Q3. AHP funding bid against installing APP leadership infrastructure within the workforce appears unlikely to be successful. ePortfolio and curriculum development underpinned by clinical supervision framework, unable to progress until review in Q3
463	21/22	Quest	Role of Advanced Paramedic Practitioner	Reasonable	Kerry Robertshaw, Jonathan Chippendale	Andy Swinburn	Medium		The Trust should, through an effective appraisal process, appropriately monitor APPs development in order to achieve all four pillars of advanced practice.		The creation of a 'Principles of Advanced Practice' guidance document to be created which will detail the methodology, application and monitoring of how the four pillars of advanced practice are being addressed within APP practice. Following approval, reporting against this will take place on a 6-monthly basis.	Mar-22	Not Met	Dec 22	Mar-24		Open	Last updated: 03.07.2023 Principles of advanced practice document to be written over Q2 and steered through the Advanced practice Working group (new group created within LDP) and underpinned by the All Wales national advanced and enhanced advanced practice framework.
470	21/22	FPC	Asset Management - RAM System	Reasonable	Jill Gill	Chris Turley	Medium		The Trust should consider the requirement to use the proposed RFID system to validate assets not included in its current processes (e.g. stretchers, defibrillators, suction units, emergency lifting cushions and oxygen delivery systems) against the RAM Asset Management system and review and update its procedures as appropriate.		The Trust has considered the potential of linking RAM and an RFID system, however this would not be practical as RAM is updated on a quarterly basis and the RFID system is a live system with constant streaming updates. These two products would not align in a manner that would deliver a safe and valued output. The proposed solution will be a quarterly download from the RFID system that will be reconciled into RAM and variances investigated. RFID is currently in development, however due to operational pressures the rollout is unlikely to be completed before December 2022.	Mar-23	Not Met	Mar-24			Open	Last updated 25.09.23 This work cannot be taken any further forward until the RFID system is fully implemented and quarterly reports become available to reconcile to RAM, this is as per the management response. The RFID system needs to be implemented at pace by the Trust, work is progressing with Fleet in the North and SE to tag items however currently a separate ICT resource is required in C&W to complete, following the previous update the ICT lead has now left the Trust, in addition ICT currently has circa 10 vacancies and is experiencing difficulties in recruiting to these posts, this is resulting in other schemes having to be prioritised over this scheme to ensure core systems function. The previous completion date of Mar 2023 shows as it is unclear due to the recruitment issues faced by ICT exactly when this action will be completed, Mar 2024 put as estimate by ICT dept.
479	21/22	FPC	Cardiff Make Ready Depot	Reasonable	Richard Davies	Chris Turley	Medium		As appropriate, the Trust should determine whether there are any further actions required noting project team performance issues at this project.		Agreed	Sep-22		Mar-23			Closed	Last updated 13.04.23 This action can be closed as issues highlighted as a result of this project have assisted to ensure tender documentation for the framework design team has incorporated amore robust reporting and data sharing this has been evident by recent project works.Last updatd 17.01.23. Again as above, whilst technically overdue, this is set againat an indicative timeline at the time. This will form part of the project evalution review, when this is able to be completed, as stated previoulsy.Last updatd 24/10/22. Linked to the above - analysis of the project team and their performance will form part of the project evaluation with lessons to be learned.

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480	21/22	Quest	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Brendan Lloyd	Medium		1.1 We recommend that greater use is made of referral data in the incident records to inform further developments of current and future referral pathways, including; production of reports showing more detailed analysis by stop code.		1.1.1 A new report is available with data back to January 2021 which shows the referral pathway presented to the patient once the consultation with CSD is complete. This will be able to be broken down by health board area given the nature of the patient's location information. The Ops team is also reviewing in more detail the calls into CSD and their outcome. A review of this is likely late Q4 2022.	Mar-22	Not Met	Mar-24			Open	Last Updated: 061023: Capacity building in the CSD team will enable this action to be progressed. Currently in IMTP actions for this area for delivery Q3-4 pending team expansion. Recommended removal of example report in Recommendation related to 'detailed analysis by stop code' as this is not relevent. The information is not currently provided in a report as it is live data but a functionality request for referral data to be shown by Health Board on a Power BI dashboard will be raised with Health Informatics and should be achievable by end of Q4. Update 19/10/22 Q4 2022 Update (Q3 2022-23) - Data is now available in a report in Powr BI which shows the volume of telephone triaged calls which were referred to other services and can be broken down by Health Board area. Next steps this quarter is to work with Clinical Services to review the reports and analyse.
480	21/22	Quest	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Brendan Lloyd	Medium		1.2 Coordinated analysis, review and scrutiny of these internally to inform quality improvement.		1.1.2. The review can be shared to inform quality improvement.	Jun-22	Not Met	Sep-24			Open	Last Updated 061023: Further investigation to be undertaken on whether this data would benefit HB partners e.g. could report into SDEC meetings as it is currently unconfirmed whether there is a forum to enable this data to be shared. Management action relevent in 2018 before work undertaken to build on pathways. Info broken down for reporting currently not done by HB level in the usual process by CSD team (see 480 1.1 above). Team to look at possibility of incorporating this filter for reporting if it will be useful to the HBs or whether this is already reported on by Operations. Development of project work (480 1.2 above) may provide more information to accompany the data which HBs may find useful. Updated: 19/10/22 See above, subsequent action.
480	21/22	Quest	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Brendan Lloyd	Medium		1.3 Reporting referral volumes at health board level to assist with their service provision planning		1.1.3. The detail in the new stop codes will allow for the reporting referral volumes through Consult and Close in CSD.	Jun-22	Not Met	Nov 22	Mar-24		Open	Last Updated 061023: Further investigation to be undertaken on whether this data would benefit HB partners e.g. could report into SDEC meetings as it is currently unconfirmed whether there is a forum to enable this data to be shared. Management action relevent in 2018 before work undertaken to build on pathways. Info broken down for reporting currently not done by HB level in the usual process by CSD team (see 480 1.1 above). Team to look at possibility of incorporating this filter for reporting if it will be useful to the HBs or whether this is already reported on by Operations. Development of project work (480 1.2 above) may provide more information to accompany the data which HBs may find useful. Updated: 19/10/22 See above, subsequent action.
483	21/22	Quest	Information Management - Hear and Treat	Reasonable	Paula Jeffery	Liam Williams / Brendan Lloyd	Medium		We recommend that current analysis and sample examination of the 'Can't Send' call responses is extended to include other 'See and Treat' and 'Consult and Close' incident responses. This could be coordinated by theme and pathway type, to inform patient safety and quality improvement and should be routinely analysed and reported into the agenda of an appropriate group in the Trust's governance structure.		With the introduction of a dedicated training and audit team within the CSD more opportunity to analyse and sample Consult and close outcome will be possible. We will ensure it is part of normal audit of the activity in the CSD. Findings can be shared with other groups to ensure quality and enhanced clinical review similar to Can't Send outcomes.	Sep-22	Not Met	Dec 22			Closure Proposed (pending evidence)	Last Updated 061023: Achieved IAED/ACE accreditation in Sept 2023 and a prescribed percentage of audits for every clinician are undertaken every month and reported on compliance by PPeD. Management of staff who are not compliant with audits is stepped out within the quality assurance framework for ECNS. Consult and Close activity is reported on live in Power BI and includes several areas contribution to Consult and Close (CSD, APP NAV, PTAS, and 111 C&C) and is monitored through Operational performance meetings. The monthly audit reports are available and are reported to SLT. Updated: 19/10/22 Now that triage has moved to ENCS and reports and analysis of outcomes and audits are available this activity is more possible. The audit team are working on audit reviews and work closely with the Clinical Services team to produce this analysis. Exepcted Q3 2022-23)
484	21/22	FPC	Digital Governance	Reasonable	Leanne Smith	Leanne Smith	Medium		1.1 The Trust should be explicit and define the intended timescales for the delivery of the Digital Strategy phases.		1.1 WAST is producing a Digital Strategic Outline Case (SOC) for Digital Services that will make these timelines clear.	Sep-22	Not Met	Mar 2023	Jul-23	Sep-23	Closed in Quarter	Last updated: 02/10/23 - The FPC received a paper on 180923 setting out progress against the digital strategy, noting it has this as one of its 2023/24 priorities. The paper demonstrated progress where digital strategy elements were embedded in the IMTP and identified gaps which are being addressed by the new Digital Director, particularly given the fast changing landscape of digital. Digital KPIs have been agreed by FPC and will regularly report there. Given that update and the FPC TOR that says it has oversight and monitoring of the implementation of the Digital Strategy which is embedded in the cycles of business, this is proposed for closure notwithstanding the strategic outline case has been delayed. A refresh of the digital plan will be developed by the new Digital Director.
485	21/22	FPC	Digital Governance	Reasonable	Leanne Smith	Leanne Smith	Medium		2.1 The process of developing a network of digital champions and expanding the role of these should be re-instated.		2.1 Fully support this recommendation. Both EPCR and OCP have user groups with nearly 150 members combined. This was required due to the Trust being at REAP 4, however, as this is de-escalated and capacity increases within the workforce, the role will be broadened and publicised more widely.	Mar-23	Not Met	Ongoing through 2023-24 - milestones tbc			Closed in Quarter	Last updated: 02/10/23 This work continues through 2023-26 and is called out in the IMTP. Focus will be on maximising use of O365 - product specialist secondments now in place, Automation investment case in development, and evolution of ePCR and ECNS continues using feedback gathered from users and existing champions. Additionally, Digital team members are supporting colleagues from across the Trust who are currently enrolled on the 'Digital Transformation for Health & Care Professions' MSc degree. Milestones & 2023-24 outcomes still tba. In view of this closure is proposed.
486	21/22	FPC	Digital Governance	Reasonable	Leanne Smith	Leanne Smith	Medium		3.1 A SOP should be developed that provides a roadmap to delivery of the Digital Strategy and defines the resources required together with a delivery and monitoring structure.		3.1 In progress. Third party support has been engaged and the SOP / SOC is planned in the IMTP for delivery at the end of September '22.	Sep-22	Not Met	Mar 2023	Jul-23	Sep-23	Closed in Quarter	Last updated: 02/10/23 - The FPC received a paper on 180923 setting out progress against the digital strategy, noting it has this as one of its 2023/24 priorities. The paper demonstrated progress where digital strategy elements were embedded in the IMTP and identified gaps which are being addressed by the new Digital Director, particularly given the fast changing landscape of digital. Digital KPIs have been agreed by FPC and will regularly report there. GIven that update and the FPC TOR that says it has oversight and monitoring of the implementation of the Digital Strategy which is embedded in the cycles of business, this is proposed for closure notwithstanding the strategic outline case has been delayed. A refresh of the digital plan will be developed by the new Digital Director.

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494	21/22	PCC	Recruitment Practices – Equality, Diversity and Inclusion	Reasonable	Kat Colbey	Angela Lewis	Medium		2.1 Establish mechanisms to allow the Trust to analyse and capture the effectiveness of initiatives		b) Routinely conduct pulse surveys following a careers event.	May-22	Not Met	Jun-23			Closed in Quarter	Update 101023: The last recruitment event was held in May 2023 and no others are planned in current financial climate. The HIVE pulse survey tool is not appropriate for post event surveys as it is just for staff members. EDI data on general recruitment is reported into P&C directorate on a monthly basis. Update 29.06.23 Pulse tool implementation underway. Go live planned in July.
496	21/22	PCC	Recruitment Practices – Equality, Diversity and Inclusion	Reasonable	Kat Colbey	Angela Lewis	Medium		4.1 a. The Terms of Reference for the EDI Steering Group should be updated to reflect the correct reporting structure.		4.1 a. The Trust accepts this finding and will update the Terms of Reference with support from the Deputy Board Secretary.	Jun-22	Not Met	Jan-23	Dec-23		Open	051023: New date proposed and discussions with Head of EDI planned. 210823 Board Secretary re-opened as TOR not yet approved. Last Updated 11/01/23 COMPLETED - The Terms of reference discussions have been reviewed. Board Secretary to present at next meeting . 250923 Revised ToR shared with Board Secretary
497	21/22	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	High		We recommend the Trust consider the issues identified above regarding risk management occurring outside of Datix and develop guidance to support the operational escalation criteria and processes which can be implemented across the organisation.		Agreed. This will form part of the guidance and procedures that are currently being strengthened as part of the Risk Transformation programme and will include easy read guides, definitions, matrices and escalation and reporting structures.	Sep-22	Not Met	Jun 23	Aug-23		Closed in Quarter	Update 190923: Guidance developed for Directorates regarding Directorate Risks and will be communicated on Siren. Guidance include reference to current escalation criteria and guidance; request to include risk registers on all Directorate meeting agenda; POC for risk support in Corporate Governance Team; foreshadows further work under risk transformation programme Updated: 05/07/23 The development of the guidance forms part of the Risk Transformation Programme supported by Audit Committee and will be addressed in the coming 6 months and progress reported to EMT and STB.
498	21/22	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium		We recommend the Trust consider arrangements to support the consistency and monitor the completeness of directorate registers.		Agreed. This will encompass the training of Risk Champions for each Directorate and a review of escalation and risk management structures is part of the transformation programme local action plan.	Dec-22	Not Met	Dec-23			Closed in Quarter	Update 190923: Guidance developed for Directorates regarding Directorate Risks and will be communicated on Siren. Guidance include reference to current escalation criteria and guidance; request to include risk registers on all Directorate meeting agenda; POC for risk support in Corporate Governance Team; foreshadows further work under risk transformation programme Update 190923: Guidance developed for Directorates regarding Directorate Risks and will be communicated on Siren. Guidance include reference to current escalation criteria and guidance; request to include risk registers on all Directorate meeting agenda; POC for risk support in Corporate Governance Team; foreshadows further work under risk transformation programme Updated: 05/07/23 This work will be undertaken by the Risk Officer who commenced post 03/07/23
499	21/22	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium		We recommend the Trust ensure there is risk management guidance made available to staff in the interim period prior to the roll out of the new risk module within DatixCloud.		Agreed. This will form part of the guidance and procedures that are currently being strengthened as part of the Risk Transformation programme and will include easy read guides.	Sep-22	Not Met	Mar 23	Jun-23	Aug-23	Closed in Quarter	Update 190923: Guidance developed for Directorates regarding Directorate Risks and will be communicated on Siren. Guidance include reference to current escalation criteria and guidance; request to include risk registers on all Directorate meeting agenda; POC for risk support in Corporate Governance Team; foreshadows further work under risk transformation programme Updated: 05/07/23 The development of the guidance forms part of the Risk Transformation Programme supported by Audit Committee and will be addressed in the coming 6 months and progress reported to EMT and STB.
501	21/22	FPC	Waste Management	Limited	Richard Davies / Nicci Stephens	Chris Turley	High		1. The Waste Process document review should be concluded as scheduled, with consideration given to the Policy guidance set out in WHTM 07-01, and with enhanced detail regarding governance structure and training arrangements. The Trust should ensure the Waste Process document, following review and update, is approved at the relevant Board-level Committee as a formal policy, in accordance with WHTM 07-01 requirements.		1. Agreed as the key priority, recommendation and action for immediate further improvement from this review. From which the response and resolution for many of the other actions will naturally follow. To progress many of these, it has been jointly agreed at Exec level that a task and finish group (TFG) will be immediately created with representatives from the following departments: • Estates and Facilities • IPC • Health and Safety • Operations • ICT • Fleet • Corporate Services • Training • Finance • Medical directorate (for drug management issues) • Clinical equipment and logistics • TU rep The TFG will develop a National Waste policy to cover both domestic waste and clinical waste. The policy will identify the management structure for both sections of waste (which will be different) and therefore a reporting structure, including through to Board Committees (likely to be by exception) and therefore Trust Board itself. It will also identify training needs and all compliance and audit obligations.	Sep-22	Not Met	Sep-23	Nov-23		Open	Updatd 180923: Waste management policy is drafted however discussions regarding Director level responsibility for clinical waste are being held. The SOPs that form part of the master list of waste in the policy have been implemented however it is the overarching policy that brings them together with roles, responsibilities and governance structures that is out for consultation. Given the clinical waste ownership discussions, it is proposed that this action be moved to November 2023 for the policy to be presented back to the Policy Group to enable those discussions to be held. The policy will thereafter be approved by the FPC. Last updated 13/07/23 Waste Management Policy out to consulation and due to be approved by FPC in September 2023

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504	21/22	FPC	Waste Management	Limited	Richard Davies / Louise Colson	Chris Turley	Medium		4. Training compliance date will be compiled and reported to an appropriate forum. A formal training needs assessment is required to determine the training requirements across the Trust.		4. Agreed. A formal training needs assessment will be detailed under the TFG work and implemented by the National Training Department. Any remaining IT issues will be further escalated for resolution ASAP.	Nov-22	Not Met	Sep-23	Dec-23		Closed in Quarter	Update 210923: TNA received and agreed with Jo Kelso. Also shared with IA. Propose closure Update 180923: Discussions are ongoing on the development of a training needs analysis (TNA) as that was the action we agreed to. Any training packages will come from that TNA and are unlikely to be put in place now until after April 2024 as new legislation will be introduced then requiring a change in the training. IT issues raised in the audit arose because of the training on ESR was put together by BCUHB so everyone who did it were classed under ESR as a BCU member of staff and it proved impossible to segregate which staff member worked where. WAST has no control over this however the training packages that fall out of the TNA will be WAST training and WAST will be able to report on all levels of compliance. **Propose closure once TNA is completed** Last Updated: 13/07/23 The formal reporting route for waste management training compliance will transfer to the Director of People & Culture.
505	21/22	FPC	Waste Management	Limited	Nicci Stephens	Chris Turley	High		5.1 The Trust should review the arrangements in place for the transfer of clinical waste and seek to gain assurance that the current arrangements as detailed are in keeping with the requirements of WHTM-07-01.		5.1 – The WHTM 07-01 was amended from HTM 07-01 in 2013, this predates the separation of HCS from WAST. Under its current form WAST is not able to comply with this particular section of the document as WAST does not have a direct contract with the current clinical waste contractor. NWSSP FS, the documents authors, have been contacted regarding this point. The WHTM is due for review. However, those confirmed under the TFG as clinical waste lead will produce an annual hazardous waste transfer note for Denbigh Stores and Pontypool Ambulance Station for completion by HCS, therefore compliant with current hazardous waste legislation.	Jun-22	Not Met	Sep-23	Jan-24		Open	Update 180923: WAST does not have a contract with HCS regarding clinical waste. A hazardous waste transfer note was sent to HCS but they have not signed it, stating it was not required. Natural Resources Wales have also confirmed that we have an exemption for transferring clinical waste to HCS and that the only agreements that need to be in place are between HCS and Stericycle (which they are). The only body to whom WAST could have a contract that satisfied WHTM 07-01 is NWSSP (the authors of that WHTM) and they have declined to do so. Propose that this item is closed when a paper is taken to the Finance and Performance Committee setting out the ways in which the risk regarding the absence of a contract for clinical waste for WAST is mitigated. It is proposed that the timing for this is when the Waste Management Policy is taken to FPC (January 2024) so that director responsibilities for clinical risk are clear. Last Updated: 13/07/23 A paper to be prepared and shared at an appropriate forum detailing the current status and the proposals to manage the risk.
505(a 0	21/22	FPC	Waste Management	Limited	Nicci Stephens	Chris Turley	High		6. WAST should contact the respective Health Boards on an annual basis to obtain a duty of care transfer note covering handover of clinical waste from Ambulances at Health Board sites, in keeping with the requirements as stipulated in WHTM 07-01.		6. The WHTM 07-01 was amended from HTM 07-01 in 2013. HTM 07-01 is the English management of waste in healthcare technical note. On amending the HTM to the WHTM this section should have been replaced. As a commissioned service to the health boards clinical waste sits with the patient and therefore the health board. NWSSP FS, the documents authors, have been contacted regarding this point. However, to further add to the assurance of this, it is also now requested that the TFG will propose the production of an annual hazardous waste transfer note for each Health board, therefore compliant with current hazardous waste legislation. This will be included in the national waste management policy.	Sep-22	Not Met	Jan-24			Open	Reopened September 23 followng 22/23 Follow Up Audit. Update: Only two HBs have not returned the duty of care transfer. CVUHB are awaiting the appointment of their waste manager to sign the document. BCUHB did not sign it based on improvements being required on WAST segregation methods. WAST has held fortnightly meetings with local mangers in the HB region, as well as BCUHB management and conducted waste management audits in the area. WAST has identified issues and put in place mitigations and have written to BCUHB indicating as much and seeking their agreement to the duty of care transfer note. It is proposed that this action is closed when the paper which encompasses matter arising 5 and the Waste Management Policy are presented to the FPC in January 2024 Update 02/09/22. WTN have been written and sent.
508	21/22	FPC	Waste Management	Limited	Richard Davies / Louise Colson / Nicci Stephens	Chris Turley	High		7. The Trust will conduct its own Clinical Waste Duty of Care audits and Clinical Waste Pre-Acceptance audits. Infection Prevention and Control Team audits will be reinstated. General waste and recycling compliance audits will be reinstated when safe to do so.		7. Audits will be resumed when safe to do so. This will be reviewed on a quarterly basis by the Clinical waste lead and Domestic Waste lead. Clinical waste audits will be completed as part of general IPC audits not as a specific waste stream audit. General waste audits are completed by Biffa as required under tendered contract. Further overseeing of this will be ensured.	Sep-22	Not Met	Sep-23			Closed in Quarter	Update 180923 - noted in the September 23 Follow Up Audit that this is considered fully implemented and therefore closed. Recognising clincial waste audits are being undertaken, with the intention to eventually incorporate them into the IPC site audits. Updated 12.04.23 Action now with health and safety department: will be picked up during annual site visits and health and safey checks . Also pre audit checks on clinical waste for 2023 have been tasked to operational leads - audit reports have been shared with internal audit.

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512	21/22	FPC	Service Reconfiguration	Reasonable	Mark Harris / Deborah Kingsbury	Rachel Marsh	Medium		1.1 We recommend that the service specification is finalised and reissued for the period beginning June 2022, reflecting any amendments to the model that post-implementation service reviews have indicated. This is particularly significant because of the contribution this project may make to an upcoming all-Wales model to cover similar service reconfigurations. Future service change SLAs must be signed before the renew date.		1.1 The timescale is dependent on commissioners agreeing the longer term commissioning agreement. Meetings with commissioners (ABUHB and NCCU leading) have commenced to take forward the recommendations of the GUH Evaluation and this should include the agreement on the next commissioning agreement. However this may need to be backdated.	Sep-22	Not Met	Apr-23			Open	**REVISED DATE REQUIRED** Update 101023: After initial exchange as noted on 030523 update, Pending receipt of something formally. Informal conversations indicate that based on activity review and remodelling work ABUHB will be looking to reduce peak capacity Currently 10 crews at 1400 hrs daily to 6 Crews. ABUHB will also be redefining the service purpose in the SLA refresh to take out what is believed to be mission creep example Step Across and Discharge activity. WAST will be undertaking its own modelling to corroborate Health Borad modelling and also to ensure there are no unintended consequences or at least the stakeholders are appraised of the risks if any. ABUHB has also indicated that they will be disinvesting from the Paramedic resource it commissioned under this contract and will be looking to increase the Transfer Practitioner resource (TP) instead. The single system project that is looking to move all ACA2 activity under the GUH inter site transfer service on to Cleric CAD system is being progressed with this assumption in agreement with ABUHB 03.05.23 Initial exchange on SLA undertaken, response from WAST considered by ABUHB who are preparing a report to their Execs, advised by NCCU that they will facilitate a further meeting to discuss, likely to be in June. Acknowledged that SLA will not be able to progress until requirements clear from ABUHB. 25.01.23 NCCU proposing a new SLA for April 23. Regular meetings led by the NCCU continue with supporting work to enable the new specification and SLA following the evaluation of the service. The remaining supporting actions are now being prioritised to enable. One key element is the work being undertaken by the health board to review its future clinical needs for transfers as part of the health boards model. Last updated: 02/11/22 Enabling pieces of work are scheduled to be completed for discussion with NCCU and AB in December, NCCU proposing a new SLA for April 23. Regular meetings led by the NCCU continue with supporting work to enable the new specification and SLA following the evaluation no the service. The remaining supporting actions are now being prioritised to enable. One key element is the work being undertaken by the health board to review its future clinical needs for transfers as part of the health boards model.
524	21/22	Quest	Respiratory Protective Equipment	Reasonable	Louise Colson	Liam Williams	Medium		4.1 We recommend the Trust refreshes the above paper in light of the challenges in meeting the requirement to quality assure all Fit testers under its current model. [the paper referred to her was a paper that went to SPT in 2021 estimating the time in hours over a 3 year period that fit testing would be required to comply with HSE legislation]		4.1 A report will be provided to the Clinical & Quality Governance Group on the output of the Quality Assurance programme recently undertaken. Furthermore, it will outline proposal for the emerging risk of sustainable fit testing across the Trust. A crossdirectorate position on a sustainable Fit Testing model will be developed.	Sep-22	Not Met	Jun-23	Dec-23		Open	Update 28.9.23 : An updated Respiratory Protection paper was presented to SOT on 28.04.23 with a recommendation that a multi-disciplinary task and finish group was established to explore a sustainable option of providing respiratory protection for staff. The first meeting took place on 22.06.23 and an options appraisal paper has been submitted to CQGG and SOT on 25.09.23. Further update will be provided once both meetings have taken place. Update 30.06.23 Issue has been discussed in IPC Strategic Group, and escalted issue to CQGG. The matter has also being rasied within Operations Senior Leadership Team, with the management of Fit Testers and associated challenges to be managed through the Senior Operations Team; a T&F group has commence led by IPC to determine a sustainable approach which includes review of PPE/RPE provision. The action related to report generation is complete, and IPC Strategic Group will monitor ongoing performance.
525	21/22	Quest	Respiratory Protective Equipment	Reasonable	Jonathan Turnbull-Ross	Liam Williams	Medium		4.2 Recognising the challenges in delivery of the quality assurance programme due to operational pressures, we recommend that the programme be recommenced with progress updates provided to the Strategic IPC group on a regular basis.		4.2 A regular update on the quality assurance programme will be provided to IPC Strategic Group on a routine basis. This will commence from the next diarised Strategic Group meeting in October 2022.	Oct-22	Not Met	May-23			Closed in Quarter	Update 28.9.23: Proposed for closure. Programme is reported via IPC Group with regular reporting on fit testing via the IPC Management report. As per previous update reporting is completed quarterly. Highlight Report includes updated IPC Workplan; Updated report on FIT Testing; Education & Training via reporting from ESR to support the closure of this action (these element incoporate the quality assurance programme) Update 26.04.23: As above this paper will replace the Q4 Reporting. This action can now be closed as Fit Test reporting is being done quarterly.
500	22/23	FPC	Immediate Release Directions	Reasonable	Kate Blackmore	Lee Brooks/Liam Williams	Medium		1.1 Allocators should be reminded of the requirement to complete the RES screen prior to making an immediate release directive.		The Trust accepts this recommendation and will ensure that communication to allocators on the importance of completing RES prior to making an IRD is actioned	Feb-23	Not Met	Apr 23	Jul-23		Closed in Quarter	Update: 16.08.26 - coaching bulletin drafted and issued 31.07.23 - bulletin supplied Update: 26.06.23 - Training team are drafting a coaching bulletin regarding this for issue in July 2023.
501	22/23	FPC	Immediate Release Directions	Reasonable	Kate Blackmore - **Gill Plemming as of 22/09/2023**	Lee Brooks	High		2.1 Red and Amber 1 declined immediate release directions should be escalated to the ODU to ensure that issues are escalated to the relevant health board site in a timely manner.		The Trust accepts this recommendation and will ensure that communication is issued to emphasise the importance of compliance with the procedure to escalate declined IRDs to the ODU.	Feb-23	Not Met	Apr 23	Jul-23		Closed in Quarter	22.09.2023 - SOP approved in EMSC Business Meeting, SOT and SLT, process is embedded with weekly scrutiny by EMSC Head of Service and Service Managers. Evidence of approval of Deployment SOP approval at SOT via AAA to SLT provided. Update: 16.08.23 - This action forms part of the ongoing changes to the resource deployment SOP. The current review of the resource deployment SOP will step out the additional quality assurance metrics completed by the DCM, Service Manager and Head of Service for EMS Coordination. These measure have been in place since Sept 2022. Ops Notice will go out w/c 21/08/23 to remind staff of the extant processes in place supported by the changes in the new Resource SOP. Closure proposed as acton was for communication - bulletin supplied Update: 26.06.23 - Resource deployment SOP has been reviewed and is expected to go through governance arrangements for approval and issue in July 23

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502	22/23	FPC	Immediate Release Directions	Reasonable	Caroline Miftari	Liam Williams	High		3.1 Datix incidents should be reviewed and closed in a timely manner and any lessons learned should be shared with the relevant parties.		It remains challenging for the Trust to investigate and subsequently close Datix as refusal to comply with an Immediate Release Direction is a Health Board Decision and so any harm that subsequently occurs, requires the Health Board to lead on a joint investigation, with the same principle being expected by the Trust where harm has not explicitly been identified. A new Joint Investigation Process is being piloted under the leadership of the NHS Wales Delivery Unit, which commenced in November and that will run until March 2023. IRD requests that have been declined and where harm has been identified or is considered to have occurred, will form a part of this Pilot and a decision to recommend changes to the process will follow this pilot.Of note the Duty of Candour, that comes into place on 1 April 2023, further regulates the need for openness and transparency with families across the NHS.	Mar-23	Not Met	Apr-23	Dec-23		Open	121023: The SOP developed is a QSPE SOP which relates to the management of records through datix as opposed to the SOP in 504 which is the guidance from EMS Coordination in relation to live management of incidents. The review undertaken by the delivery unit in relation to the joint investigation process did not specifically pick up any additional learning regarding immediate release declines however there is now a 'standing agenda' item in the quarterly PTR report regarding serious incidents linked to declines so that we have a method to capture incidents and identify thematic activity. TBC at next review if this now closes this item. Update: 26.09.23 - Standard Operating Procedure for Datix drafted to step out expectations for managers. Review currently ongoing for how datix is used with proposals to be drafted to more easily identify those IRD records where harm has occurred. Proposed revised date of 31.12.23 to allow datix team to provide analysis and proposols for change. Reason for proposed revised date is due to capacity within team. Senior QUality Governance lead now in place, OCP completed for department but 1 vacancy still remains. Last update: 14.04.23 Delayed due to management capacity and impacts of industrial request for extensiont to end of April 23 - coaching bulletin drafted
503	22/23	FPC	Immediate Release Directions	Reasonable	Caroline Miftari	Liam Williams	High		3.2 Noting the capacity issues above, the Trust should review the requirement to investigate all Amber 1 declined directions and consider introducing a streamlined mechanism of reporting. The Trust's SOP should then be updated accordingly to reflect the outcome of this review.		The Trust will agree a process to record all Amber 1 declined IRDs and report occurrence thematically based on UHB and clinical code sets. Where thematic analysis identifies additional areas of concern, these will be taken forward on a 'task and finish' basis by the Trust with the appropriate UHB and clinical representation.	Feb-23	Not Met	Apr-23	Dec-23		Open	Update 121023: Given that the action is to include the process to record all Amber 1 declined IRDs and report thematically, with TFGs being estabisherd where areas of concern identified, we will close this when the SOP (the SOP is different to that in item 504) has been approved as that will close off the action. The action was not to embed processes. Propose extending to Dec 23 on that basis. All Amber 1 declined IRDs are now recorded through datix. There may be further tweaks to the process as we continue to develop our quality management system. Update 26.09.23: Linked to Ref 502 review now ongoing for how datix is used which will include recommendations on how themeatic anaysis can be provided. Quality Management Group now commencing which will allow for review of thematic analysis to support quality improvement planning and subsequent T&F tasking. Proposed revised date of 31.03.24 to allow recommendations to be approved and QMG to embed processes, pre-requisite for Ref 502 to be completed before this action can be recommended for closure. Reason for delay is due to capacity within team. Senior Quality Governance lead now in place, OCP completed for department but 1 vacancy still remains. Last update: 14.04.23 Delayed due to management capacity and impacts of industrial request for extensiont to end of April 23 - coaching bulletin drafted
504	22/23	FPC	Immediate Release Directions	Reasonable	Kate Blackmore - **Gill Plemming as of 22/09/2023**	Lee Brooks	Medium		4.1 The SOP should be updated to reflect the revised approach to investigate 10% of Amber 1 declined directions, and mechanisms put in place to ensure this requirement is adhered to.		The Trust accepts this recommendation and will update the SOP to reflect the revised approach; Further a mechanism to ensure compliance with the revised approach will be determined	Apr-23	Not Met	Jun-23	Jul-23	Sep-23	Closed in Quarter	22.09.2023 - SOP approved in EMSC Business Meeting, SOT and SLT. Process is embedded with weekly scrutiny by EMSC Head of Service and Service Managers. Addtional measures in place that 10% of the calls are audited for compliance by EMSC staff undertaking the immediate release directions ensuring they are compliant with Standard Operating Procedure. There are weekly reports coming out of those audits, fed back into EMSC service managers for feedback and to improve practice. Proposing Closure for this action. Update: 16.08.23 - Further revised date provided to Sep 23. Resource SOP being finalised and will then be reviewed by SOT before publication. **Anticipated that it'll be reviewed at formal SOT at end of August 2023.** Update: 26.06.23 - Resource deployment SOP has been reviewed and is expected to go through governance arrangements for approval and issue in July 23
506	22/23	Quest	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		1.1 Once the overarching IPC policy is formally approved, the supporting policies/procedures/guidance documents should be reviewed and approved in a timely manner.		1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	Mar-23	Not Met	Sep-23	Dec-23		Open	Update 27.09.23: Both the IPC and Premise and Vehicle cleaning policies are in the policy group process still. Several meetings have been cancelled due to competing priorities involving the public enquiry. Two policies are awating final approval, the next meeting is now the 10th October. I anticiapte approval at this meeting with final approval at QUEST at the December meeting. The 3P project initial outlay is complete and incorporated into annual plan of work and was presented at the IPC strategic meeting on the 26th September. 30.06.23 (as per previous) The IPC policy has now been to the Policy group 24.04.23, a longer delay than anticipated but this was due to circumstances outside of the control of the IPC team. This will now be available for consultation. This will be a new policy which combines the AACE national policy. In the meantime work has been undertaken within the 'IPC 3P' to map out other forms of Standard Operating Procedures and Guidance and where they are aligned to. The RACI framework is being used to aid with identifyng responsibilites, risks and monitoring responsibilities. This along with the audit tracker will be presented at the next IPC strategic meeting in Q2.
507	22/23	Quest	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		1.2 The Trust should clarify arrangements within the Premise and Vehicle Cleaning policy to ensure cleaning instructions, responsibilities and monitoring are comprehensive and align with other related documents.		1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	Mar-23	Not Met	Sep-23	Feb-24		Open	Update 121023: this action will be closed once the IPC and the Premises and Vehicles Polices are approved at Committee . These Policies have been deferred to February Committee due to cancellation of Policy Group Meetings.Update 27.09.23 The Premise and Vehicle cleaning policy is awating approval vai the Policy Group pathway. There is a delay in its progress due to cancelled meetings. The nxt meeting is the 10th October and i anticiapate fianl approval at QUEST December 2023 The trust has a clear vehicle decontamination SOP. The vehilce audit tool has been redesigned, piloted and is good to go.

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508	22/23	Quest	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		1.3 The Trust should map IPC and related policies, responsibilities, ownership, monitoring and governance arrangements to support future review and development of policies and guidance		1.1-1.3 The recommendations are accepted. A project of work 'IPC 3P' will be undertaken to assess policies, procedures, and other 'powers' (including guidance documents, protocols, and activity-based risk assessments). The aim of the project is to 'map' current provision, monitoring arrangements, undertake a gap analysis, and embed a RACI framework to ensure organisational 'buy-in' and accountability. This work will lead to systematic review of departmental and relevant organisational documents.	Mar-23	Not Met	Mar 24			Open	Update 27.09.23: The 3 P project continues, the content of which is now incorporated into the IPC annual plan. This was discussed and shared with the IPC Strategic meeting and is now at a stage for cross directorate working. All IPC related policies within the trust have been identified as the parent document, along with associated guidance, standards, SOPs, audit tools, risk assessments and training. Included is the RACI for each area of responsibility.This document has now started to identify the gaps and the work is at the stage to be shared as there are cross directorate responnsibilites. The progress has also been reported in the IPC Q1 highlight report Update 30.06.23 IPC 3P project to be reported to CQGG in Q2
509	22/23	Quest	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Medium		1.4 Consideration should be given to modifying the IPC handbook to direct users to relevant content, this could also contain the outcome of mapping recommended above		Consideration will be given to modifying the IPC Handbook following the IPC 3P Project. The aim of this action is to ensure staff are able to navigate to relevant and important content, as and when required	Jun-23	Not Met	Jun 23	Sep-23		Closed in Quarter	Update 27.09.23: The IPP Safe Clean Care guidance based on the NIPCM has been published on the 25th August following approval at CQGG. Proposed for Closure The 3P Project details as above will be reported on Q2. Revised guidance dated 1 August 2023 provided and AAA to EMT from CQGG on 060923/ Updated 30.06.23 The IPC Safe Clean Care Guidance, replacement of the IPC Handbook, was present to IPC Strategic Group. Further review and amendment is required, and alignment to the 3P mapping exercise is necessary. The 3P project's output - a mapping of IPC governance/documents - will be presented to IPC Strategic Group and CQGG, with a view to the Safe Clean Care guidance supporting users in navigating IPC policy/SOPs.Project outlay complete will report in Q2 the next steps
517	22/23	Quest	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	Low		The Trust should ensure online resources contain up to date links and guidance		We accept the recommendation, future workplans will detail requirements.	Jan-23	Not Met	Sep-23	Apr-24		Open	Update 27.09.23: Proposed revised date 31.03.24. The prehospital Care ESR taining resources has been updated. The ANTT Training package is in the process of being updated along with the All Wales ANTT policy. We have a plan with training school for ANTT training on the MIST training for 2024/25. This will commence April 2024. A discussion with the training school at the last IPC strategic meeting to transer some of the onclick training to the Learning Launchpad. The priority modules will be PPE, RED Level PPE training, Vehicle Cleaning and Waste management. The other modules via onlick can be incorporated into these modules as they are largely pandemic related training.. Updated 30.6.23 (as per previous 26.04.2023)
519	22/23	Quest	Infection Prevention and Control	Reasonable	Louise Colson	Liam Williams	High		6.2 The Trust should consider longer term mechanisms for compliance which incorporate and map responsibilities of the wider IPC Strategic membership and include outline of compliance monitoring and reporting.		We accept the recommendation to standardise documentation formats. This action will be addressed through the IPC 3P Project (management response 1.1)	Jun-23	Not Met	Mar-24			Open	Update 27.09.23:The 3P project documentation was presented to the IPC strategic group n the September meeting, this will be reflected in the AAA report to CQGG and then in Q2 IPC Highlight report. Update 30.6.23: 3P project outputs to be presented to IPC Strategic Group and CQGG in Q2.
522	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Leanne Smith	Medium		1.1 A report (template) catalogue should be created and maintained. It should list all reports available, their purpose, the data fields they contain, and the parameters that can control the actual report production e.g. period, location etc. This can be supported by the MI on report production; if it has not been produced for over 12 months is it still needed, should it be archived?		A report catalogue is already in development. We will also set up a small selection of report templates to help speed up development, make self-serve easier for consumers, and streamline this report cataloguing effort.	Apr-23	Not Met	Dec-23			Open	Last updated 28/06/23 Capacity in the analytics team means although progress has been made against this action, it is not yet complete. The report catalogue now exists, but cycles of review for the reports contained within it have not yet commenced.
523	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Leanne Smith	Medium		1.2 The process of requesting a new or modified report should be formalised. It should include reference to the catalogue at 1.1 so that specialised analyst time is not wasted reproducing existing reports		The recommendation is welcomed, and we will look to expand on the existing request process with a formalised (potentially guided self-serve) check of existing functionality, and an ability to decline requests if the content already exists in other places, or if not aligned with organisational priorities.	May-23	Not Met	Dec-23			Open	Last updated: 28/06/23 The new report catalogue has been embedded within HI processes: when new requests for intelligence are received a check is made whether a report already exists which could allow the requestor to self-serve the information before the task is actioned. Due to capacity constraints within the team, the request mechanism is still to be amended to ensure alignement with WAST strategic priorities in 2023-24.
524	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Leanne Smith	Medium		1.3 Data on report production and usage should be maintained, and feedback from the requestor obtained. This should be used to maintain and limit the reports available to a manageable number of reports with their usage and priority recorded.		We do already obtain some feedback on service and products, but will look to formalise the collection of this and the embedding of findings within the development cycle process, as well as create management KPIs around these metrics to take through Digital governance routes. However, a dependency here is the management of the HI HelpDesk inbox, and work to converge this with the ICT ServiceDesk inbox.	Jun-23	Not Met	Dec-23			Open	Last updated: 02/10/23 Report usage data is routinely collected and used on an ad-hoc basis, but we don't currently obtain much feedback from requester/users. We are beginning to implement a report review cycle for all reports. Linked to 522.
525	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Leanne Smith	Low		2.1 There should be a series of Entity Relationship Models available covering all of the tables in the data warehouse.		We will develop an ERD library, including meta-data, starting with **EMS CAD.** We will plan out a roadmap for this exercise to expand into the other systems supporting EMS, Ambulance Care, 111 and Corporate teams around the organisation, to build up a full WAST ERD library and meta-data source.	Mar-23	Not Met	Mar-24			Open	Last updated: 28/06/23 The EMS CAD Data diagram is now complete. Deadline for full ERD library is unrealistic, suggest this is reviewed against other priorities. This work will ultimately be used within Digital and not wider Trust stakeholders. There has been a Principal Data Engineer vacancy since Jun-23 and as part of the savings plan, there is no intention to backfil for this post in the short-term.
526	22/23	FPC	Data Analysis	Reasonable	Jon Hopkins	Leanne Smith	Low		2.2 All tables should have a completed meta-data table describing their contents		We will develop an ERD library, including meta-data, starting with EMS CAD. We will plan out a **roadmap** for this exercise to expand into the other systems supporting EMS, Ambulance Care, 111 and Corporate teams around the organisation, to build up a full WAST ERD library and meta-data source.	Jul-23	Not Met	Dec 23			Open	Last Updated: 02/10/23: As per update of item 525. A sequence of design for the ERD library has been agreed within Digital, but timelines for completion are not yet available due vacancies in the team (recruitment is underway). The EMS CAD item is complete, with goal of achieving ePCR diagram by December 2023 (followed by CAS then NEPTS in Spring 2024).

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527	22/23	FPC	Data Analysis	Reasonable	Aled Williams	Leanne	High		3.1 A programme to replace all of the Qlik reports with Power BI equivalents should be scoped and completed. Qlik should then be decommissioned and removed.		**A risk-assessment** will be conducted to understand the exposure to WAST of Qlik Sense being out of vendor support. This platform is not internet facing (i.e. for internal users only, not on a publicly accessible web url), and not believed to present an information security risk, but pending ICT assessment, we will devise a mitigation plan, or an options appraisal for maturity - **due March 23**. In the meantime, there is already a programme of work to migrate reports and dashboards to **PowerBI.** However, this is a lengthy and high-capacity activity, and is not prioritised highly at this current time - due March 24.	Mar-23	Not Met				Closed in Quarter	Last Updated: 02/10/23: Risk assessment completed and in Datix no. 609. A 12-month secondment has been created for a PowerBI specialist to start the work of migration from Qlik before decommissioning. March-24 is likely unrealistic, but a roadmap will be developed once the secondment begins (November-23). Previous update: 27/06/23 Qlik is considered a low IS risk. Work is already ongoing to move reports into powerBI but due to capacity constraints within the team will take most of 2023-24 to complete UPDATE REQUIRED AS TO WHETHER RISK ASSESSMENTS HAVE BEEN COMPLETED AND PROVIDE EVIDENCE
527	22/23	FPC	Data Analysis	Reasonable	Aled Williams	Leanne Smith	High		3.1 A programme to replace all of the Qlik reports with Power BI equivalents should be scoped and completed. Qlik should then be decommissioned and removed.		**A risk-assessment** will be conducted to understand the exposure to WAST of Qlik Sense being out of vendor support. This platform is not internet facing (i.e. for internal users only, not on a publicly accessible web url), and not believed to present an information security risk, but pending ICT assessment, we will devise a mitigation plan, or an options appraisal for maturity - **due March 23**. In the meantime, there is already a programme of work to migrate reports and dashboards to **PowerBI.** However, this is a lengthy and high-capacity activity, and is not prioritised highly at this current time - due March 24.	Mar 24	Not Yet Due				Open	Last Updated: 02/10/23: Risk assessment completed and in Datix. A 12-month secondment has been created for a PowerBI specialist to start the work of migration from Qlik before decommissioning. March-24 is likely unrealistic, but a roadmap will be developed once the secondment begins (November-23). Previous update: 27/06/23 - Qlik is considered a low IS risk. Work is already ongoing to move reports into powerBI but due to capacity constraints within the team will take most of 2023-24 to complete
531	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Leanne Smith	Low		5.1 A defined quality (accuracy) level should be established for all data fields, so that particular focus can be made on those determined as being key, e.g., patient identifiers have to be 100% accurate.		It should be noted that we have only 0.4 WTE capacity in this specialist function and so any activities around data quality management improvements will not be able to be completed quickly. However, we will commit to review our Data Quality Policy, adding in detail regarding the minimum level of acceptable accuracy and error rates for key fields where appropriate.	Aug-23	Not Met	Dec 23			Open	Last Updated: 02/10/23: Data Quality Policy review not yet started - this is agreed to be part of the 2024-25 policy workplan. (Digital are reviewing 3 other higher priority policies in 2023-24.). Date for approval of the Data Quality Policy aimed at November 2024 QUEST.
532	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Leanne Smith	Low		5.2 Acceptable error rate(s) should be agreed and processes put in place or improved, so that Trust data reaches the agreed accuracy levels.		It should be noted that we have only 0.4 WTE capacity in this specialist function and so any activities around data quality management improvements will not be able to be completed quickly. However, we will commit to review our Data Quality Policy, adding in detail regarding the minimum level of acceptable accuracy and error rates for key fields where appropriate.	Aug-23	Not Met	Dec 23			Open	Last Updated: 02/10/23: Data Quality Policy review not yet started - this is agreed to be part of the 2024-25 policy workplan. (Digital are reviewing 3 other higher priority policies in 2023-24.) Date for approval of the Data Quality Policy aimed at November 2024 QUEST
533	22/23	FPC	Major Incidents	Reasonable	Clare Langshaw	Lee Brooks	High		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.		2.1 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.	Mar-23	Not Met	Mar-24			Closure Proposed (pending evidence)	Update 27.09.2023 Developed tracker, annual EPRR report to Welsh Government has been predominantly favourable in the number of excersises we have undertaken, this action has also be superseaded by the Manchester Arena recommendations therefore this action is recommended for closure. Last updated: 26.06.23 - The EPRR team has developed a tracker to record commanders who have undertaking exercising. An exercise plan has been put in place but is limited by available budget and capacity within the EPRR Team so this is currently only available via Teams. Further development is required to enable hybrid table top and live exercises across the Trust to deliver this the EPRR Team requries a dedicated exercise budget and increased capacity within the team.
534	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Leanne Smith	Low		6.1 The data sharing agreements register should be enhanced to capture more detail on each request		We have a very small Data Protection Compliance function, currently with vacancies. We commit to reviewing the data sharing register and including review dates, but note that this is a lower priority recommendation, and will be contingent on building resilience and capacity within this specialist function in the coming months. This action will therefore be managed by the Information Governance Steering Group (IGSG).	Sep-23	Met				Closed in Quarter	Last Updated: 02/10/23: The data sharing register is being systematically reviewed, and process / functionality improvements made to the register as each agreement reviewed. The register has been shared with the Information Governance Steering Group (IGSG) to bring visibility to the log, and so propose that this action is closed, and ongoing monitoring sits with IGSG. The more immediate risk re. resourcing in IG, is being developed through risk management process. Evidence provided.

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536	22/23	FPC	Data Analysis	Reasonable	Leanne Smith	Leanne Smith	Low		6.2 The register should be reviewed regularly to ensure it is up to date.		We have a very small Data Protection Compliance function, currently with vacancies. We commit to reviewing the data sharing register and including review dates, but note that this is a lower priority recommendation, and will be contingent on building resilience and capacity within this specialist function in the coming months. This action will therefore be managed by the Information Governance Steering Group (IGSG).	Sep-23	Met				Closed in Quarter	Last Updated: 02/10/23 Propose that this action is closed as an IG highlight report is now provided monthly at the Information Governance Steering Group (IGSG) which includes update on the position of Data Sharing Agreements and Data Protection Impact Assessments, along with the registers. Evidence provided
541	22/23	AC	Standards of Business Conduct: Declarations	Limited	Liz Rogers	Trish Mills	Medium		2.1 Policies and procedures, including the requirements of the Gifts and Hospitality policy, should be appropriately communicated to all new employees upon appointment, to ensure they are familiar with the requirements.		Staff have access to policy information they need via Siren. We will include the policies in the Learner Handbook for Operational staff who train when joining through the Training and Education Team. These are signed to say they have been read and understood. We will add the policies to the local induction list for new starters.	Jun-23	Not Met	Jul-23			Closed in Quarter	Update 21.08.23: Policy and forms have been communicated on Siren. Learner handbook amended to include a link to all policies includin the gifts and hospitality policy. This will ensure that when changes are made to the policy the handbook remains extant. Learners sign the acknowledgement that they have been made aware of the WAST policies. Propose for closure - links to the policy in induction reviewed Update: 11/07/23 A communications plan has been developed which will begin with the initial announcement on Siren of the revised policy and include regular announcements throughout the year, particularly at festive and religious holidays where the issues with gifts is most prevalent. New staff are signposted to the policy on joining. An infographic has been developed for gifts which will provide clear messaging for stations in particular.
544	22/23	FPC	Major Incidents	Reasonable	Clare Langshaw	Lee Brooks	Low		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.		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.	Nov-22	Not Met	Apr 23			Closed in Quarter	Update 01.08.23 - SOP updated to reflect escalation process - updated SOP provided Update: 11.04.2023 - This action relates to the Organisational Learning SOP, the flow chart for which needed to reflect escalation. CL arranging for updated flow chart outlining the escalation process to be submitted to Operations SLT then ADLT for assurance. This will be completed by end of Apr23.
545	22/23	AC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	Medium		4.1 Management should determine and implement a solution to ensure the completeness and accuracy of declarations of interest, including nil returns.		Initially 'decision makers' will be targeted for completing of declarations of interest and the register of those decision makers will be held centrally by the Board Secretary.	Jun-23	Not Met	Apr 24			Open	Last updated: 11/07/23 Declarations for the decision makers listed in the policy will commence from March 2024 so as not to duplicate efforts given declarations were sought from ADLT in March 2023 as part of the annual review.
547	22/23	AC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	Medium		4.2 Consideration should also be given to introducing a tracking system and reporting the results, including declarations requested but outstanding, to an appropriate forum e.g., Audit Committee.		The 'decision makers' will be a finite known cohort and initially their declarations will be captured via Microsoft Forms to allow for tracking and escalation	Jun-23	Not Met	Apr 24			Open	Last updated: 11/07/23 There will be a known cohort to enable the tracking any outstanding declarations. The PADR form now has a prompt for the line manager to ensure staff have completed their declarations.
554	22/23	FPC	Fleet Maintenance	Reasonable	Dave Holmes	Chris Turley	High		3.1 The Trust should review fleet maintenance expenditure and ensure that the procurement rules have been adhered to.		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. All expenditure with suppliers exceeding the financial threshold will be tendered for and/or framework agreements / contracts awarded.	Nov-22	Not Met	April 23	Jun-23	Aug-23	Open	**REVISED DATE REQUIRED** Last updated 29/06/23: Work continues with our partners in NWSSP. Suppliers/services have been identified as requiring a procurement exercise as follows. MOT services-Tender awarded. Gearbox specialist services awarded. Windscreen services Full tender being advertised and planned to be awarded August 23. Service maintenance repair North Wales is to re added to the next Pan Wales SMR tender as advised by IA at NWSSP.
555	22/23	AC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	High		7.1 Management should remind all staff of the requirements of the Gifts and Hospitality policy, and that completed forms should be submitted to Corporate Governance in a timely manner for review.		Accepted. The standards of business conduct will include a plan of communications on this.	Aug-23	Met				Closed in Quarter	Update 190923: Governance SharePoint site includes dedicated Risk Management page including templages, guidance, points of contact and resources Last updated: 11/07/23 This recommendation is not due until August 2023 and will be incorporated into the communications plan above.
558	22/23	FPC	IMTP Delivery	Reasonable	Heather Holden	Rachel Marsh	Medium		1.1 The PDDs of the sample programmes should be enhanced to include a Quality Management element to assure the quality of the programme and its deliverables.		This recommendation is accepted. We will define the quality standards to be implemented across all projects and programmes as part of the development of the project and programme management framework and will consider how we define quality measures for project deliverables for the delivery of the next iteration of the IMTP. This will commence with a framework workshop by the end of April to determine the actions required to put this in place.	Apr-23	Not Met	Jun-23	Nov-23		Open	20.09.2023 - Since the audit a review of the approach to IMTP delivery has been undertaken and a more agile approach to IMTP and transformation delivery is being developed recognising the complexity and interrelatedness of the programme structures that are currently running. A Project Path Framework is in development (due October/November 2023) to replace the current outdated Project and Programme Management framework along with a standard suite of templates. A first draft of the framework will be presented internally to the SPP team by the end of September and will then be presented to ISPG for feedback and approval. This will include a revised Programme Definition Document that includes a Quality Management section. Following approval, the current programmes will be transitioned to the new templates and the QM sections will be populated. Last Updated: 17.04.23 Workshop with transformation team on 3rd April, outcomes to be written up and next steps agreed.
560	22/23	FPC	IMTP Delivery	Reasonable	Kelsey Rees-Dykes	Rachel Marsh	Medium		2.1 The G2C programme board should implement a programme level deliverables plan to assure the management of dependencies in the event of individual project / workstream slippage or other development; and that this is universally implemented across the transformation programmes of the Trust.		Currently programme level plans are included within the overarching reporting via STB. With specific plans developed at project level. We will therefore develop a detailed G2C Programme Action Plan (Milestone timeline aligned to IMTP deliverables) with project Gantt charts feeding into this timeline.	Mar-23	Not Met	Jun-23	Nov-23		Open	20.09.2023 - Since the audit a review of the approach to IMTP delivery has been undertaken and a more agile approach to IMTP and transformation delivery is being developed recognising the complexity and interrelatedness of the programme structures that are currently running. A Project Path Framework is in development (due October/November 2023) to replace the current outdated Project and Programme Management framework along with a standard suite of templates. A first draft of the framework will be presented internally to the SPP team by the end of September and will then be presented to ISPG for feedback and approval. RAID (Risk, Action, Issues, Decision) logs are part of the standard suite of documentation. Last updated: 17.04.23 Focus of March planning and transformation was landing the IMTP which required additional attention from the team to meet the challenging outlook for 2023/24. Following a review of the governance and reporting into STB we are now re-setting the programme plans in line with the 2023-26 IMTP so this will form part of that work.

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562	22/23	FPC	IMTP Delivery	Reasonable	Heather Holden	Rachel Marsh	Medium		3.1 Programme documentation should incorporate a standard benefit realisation plan that includes the methods to assess the identified benefits, the timing of the benefit realisation work and the criteria that will be applied to measure success.		We would consider there to be a benefits plan in place for EMS Operational Transformation. For other programmes, this has been something that we have intended to do for some time, as we awaited the appointment of a new Head of Transformation. We recognise the need to clearly articulate and plan programme benefits and will review all programmes to determine whether current benefits plans meet the requirement of a benefits realisation plan and will identify dates to hold benefits planning workshops to finalise benefits realisation plans for each programme where this is required.	Apr-23	Not Met	Jun-23	Oct-23		Open	20.09.23 - A Benefits Realisation Plan template has been developed and will be rolled out across the existing programmes. Due October 2023. Will propose closure once action complete Last Update: 17.04.23 Workshop with transformation team on 3rd April, outcomes to be written up and next steps agreed.
566	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		1.1 The Trust should engage with Welsh Government to update the content within the SLA to recognise that HART capabiliilites and include reference, where appropriate to National Standards		The Trust accepts this recommendation, recognising that the SLA is proivded to WAST by Welsh Government who procure the services from WAST. We will therefore seek to agree the content of the SLA	Mar-22	Not Met	Mar 23	Sep-23	Mar-24	Open	Update 27.09.2023 new SLA in draft and agreement with Welsh Governmanet that the new SLA will come into 2024/2025 financial year. Last Updated: 26.06.2023 - Agreement obtained that Welsh Government will review the SLA and the process has commenced. EPRR Team has commenced the review of SLA. Proposed completion date changed from Sep23 to Mar24 as an extensives amount of work needs to be undertaken.
567	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		2.1 The Trust should undertake a self-assessment agains the NARU key lines of enquiry review document. This could support any future "critical friend" review undertaken		The Trust accepts this recommendation and is committed to undertaking a self-assessment aginst the NARU review document	May-23	Not Met	Mar-23	Mar-24		Open	Update 27.09.2023 NARU still unable to support due to capacity limitations. HART uplift currently rolled out in england which is NARU's current focus. To ensure this action is undertaken an internal review will now take place in line with this action. Last Updated: 26.06.2023 NARU has been approached, but they are not able to support this at the moment due to staff shortages. Although they are supportive of the Trust in this. Proposed completion date changed from Mar23 to Mar24.
568	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		3.1 The Trust should establish a single process to collating and maintaining the HART service asset register. NARU guidance indicates this must include any regulatory requirements associated with the equipment		The Trust accepts this recommendation and will ensure that relevant fields are updated and included on Proclus. Regular updating on Proclus will also be maintained.	Apr-22	Not Met	Sep-23			Open	**POTENTIAL REVISED DATE REQUIRED** Update 27.09.2023 process in place to put the asset onto proclus however a waiver needs to be implemented to pay for the licence. Procurement to agree on the single tender waiver. Last Updated: 26.06.2023 - Meeting held with Proclus on 30.03.23 to discuss and agree a plan to progress this matter. This is a significant piece of work but on track for completion by end of Sept23.
569	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		4.1 HART SOPs should be reviewed to ensure they reflect current practice		The Trust accepts this recommendation and will ensure that current SOPS are updated to reflect current practice. Further, we will create a mechanism to monitor the review period of SOPs to ensure consistency	Apr-23	Not Met	Apr 23	Aug-23		Closed in Quarter	Update 27.09.2023 - All SOPs complete, recommend to close this action. Evidence of SOT approval via Minutes and AAA to SLT provided. Last Updated: 26.06.2023 - All 34 SOPs will be complete by end of Aug23, currently 13 completed. Proposed completion date extended from Apr23 to Aug23.
570	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		5.1 The Trust should consider undertaking a periodic review of the CAD codes assigned to prompt specialist response, or establishing a link between the group and HART for its input into ongoing reviews.		The Trust accepts this recommendation and will undertake a review of CAD codes to ensure they are applicable to HART capabilities and also maximise the use of HART deployments. Any changes will be subject to CPAS approval and we will engage with CPAS to reflect this work on their work programme.	Jun-23	Not Met	May-23	Oct-23		Open	Update 27.09.2023 - Specialist ops LM has approached EMSC for support, EMSC unable to support at this time due to thier capacity, unable to move this action forward without EMSC support. Last Updated: 26.06.2023 - EPRR Team linking with EMSC colleagues to progress this audit recommendation.
573	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		8.1 The Trust should make arrangements to update and finalise the MOU with Fire and Rescue services		The Trust accepts this recommendation and will ensure that the MOU with Fire and Rescue Services is updated appropriately	May-23	Not Met	May-23	Dec-23		Open	29.09.2023 - following discussion at SLT, and in line with the update on the 1st August 2023, this recommendation is recommended for closure. The JESG document is in development with JESG and is unconnected with this action. CLOSURE PROPOSED. 27.09.2023 - The action will not be closed untill JESG doc approved 2nd revised date for December 2023. Update: 01.08.23 - SWFRS are unable to locate this document. A review of the need for this document, taking into account the content of the document now being outdated, as it was orginally intended to aid the start up of HART and the length of time this document has been pending with no serious untoward incidents. I recommend this action is closed as it is no longer relevant. On 8/8/23 the SLT approved document 'Requests for Assistance and/or Support MoU between WAST, Police Forces and Fire & Rescue Services'. This document is due to be approved by JESG and establishes support arrangements between services. Update: 11.04.2023 - SWFRS who own the MOU have confirmed that they have the document and are in the process of reviewing it. Response from SWFRS will be progressed during Apr23 in order to aim for completion of this recommendation by end of May23 as planned.

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574	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		9.1 A formal mechanism should be developed for the recording, monitoring and completion of actions related to debriefs and lessons learnt. Periodic reporting within the Directorate should be undertaken to provide assurance that these mechanisms, and the debrief process are operating as expected.		The Trust accepts this recommendation and will develop a formal mechanism to record, monitor and complete actions from debriefs and lessons learnt. This mechanism will include a reporting process to Senior Operations Team (SOT) with relevant assurance to Senior Leadership Team (SLT) where appropriate	May-23	Not Met	May-23			Closed in Quarter	Update 01.08.23 - this action is now complete. Dates have been set for CPD learning days. The HART Dashboard is part of the quarterly reporting into SOT and onto SLT (into which HART debrief are recorded) and Lessons Identified from HART debriefs can be fed into the OLSS through the Specialist Ops LM. - SOT SBAR EPRR and HART Dashboard reviewed Update: 11.04.2023 - CPD development days are being arranged where learning can be shared between watches. These dates will be set by 01.05.23. Debriefs are stored and shared between the Operational Managers via a shared drive and recorded on the Quality Dashboard. The quality Dashbaord is now subitted to SLT on a quartley basis along with the HART KPI. Any lessons identified that need wider Trust support to implement are escalated onto the OLSS. In progress and on track to complete by end of May23 as planned.
575	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		9.2 In progressing the above there could be consideration to aligning the recording of actions and responses to NARU National Safety Notices		The recording of actions and responses to NARU National Safety Notices will be incorporated into the formal reporting mechanism in 9.1	May-23	Not Met	May-23			Closed in Quarter	Update: 01.08.23 - 01/08/23 - this action is now complete. This is incorporated into the HART quality dashboard and any learning is fed back to NARU trough the HART National Operations Group. Update: 11.04.2023 - This is to be incorporated into the HART Quality Dashboard. In train and on track for completion by end of May23 as planned.
577	22/23	PCC	Attendance Management	Reasonable	Liz Rogers	Angie Lewis	Low		1.1 We recommend that the Trust agree a set definition of what constitutes alternative duties. Following this the Trust should continue to investigate methods of gathering information including the measurement of the effectiveness of providing alternative duties for staff to return to work after a sickness absence.		Accepted – we will add to the Managing Attendance action plan and define alternative duties. From the GRS (rostering system) perspective we may have limited capacity to change in the system due to system parameters, therefore manual intervention may be needed	Mar-23	Not Met	Jun 23	Aug-23		Closed in Quarter	Updated 21.08.23 The main recommendation was for the defining of alternative duties. That has now been done and entered as guidance on Siren and included in advice to managers in managing attendance section. The secondary recommendation was to further investigate options of gathering information. There are limitations in terms of system changes in GRS therefore manual manipulations will continue for the EMT report. This does however mean the abstraction figure that used for Ops includes all the abstractions in GRS including for example colleagues who are pregnant, short and long term acting ups etc. Any potential system changes will be considered with the next GRS update on alternative duties, as well as other options for ESR. Propose closure on that basis.
579	22/23	PCC	Attendance Management	Reasonable	Liz Rogers	Angie Lewis	Medium		2.1 We recommend that the Trust review and reinstate the process and compliance toolkit for sickness audits to ensure consistency of approach and reporting.		Accepted - We will review the compliance toolkit to establish fitness of purpose and if it is felt that it will add value to the organisation, managers and teams we will reinstate. There is a caveat on the impact of additional paperwork and processes on managers	Sep-23	Met				Closed in Quarter	Updated September 23: We have reviewed the toolkit and our processes and practice in WAST are now significantly robust and we are comfortable that we do not need to use the compliance toolkit as it stands. We are mindful of the increase administrative burdens on managers, the People and Culture team are offering significant support and together progress on managing attendance continues positively with the policy being followed. In addition we are looking to digitalise our sickness paperwork to speed up processes with the intention that we can also create automatice alerts and triggers to managers to take action.
580	22/23	PCC	Attendance Management	Reasonable	Liz Rogers	Angie Lewis	Medium		2.2 The Trust should of incorporate gaining user or manager feedback on the effectiveness of proactive mechanisms as part of the sickness audit process.		Accepted – manager feedback process is already in place. We will look to replicate for colleagues who are the subject of the process	Sep-23	Met				Closed in Quarter	Managers have been surveyed on the level of support they get from the People and Culture team, views on the implementation of the process etc. There was a very limited response. Feedback is also recieved from TU partners who will raise concerns as and when they come accross them, directly to the Deputy Director and Director and through the Corporate Partnership Forum. The introduction of a new survey tool, Hive, means we can survey the organisation or specific groups of employees on the processes. We will look to accommodate some questions on this in a future survey.
583	22/23	PCC	Attendance Management	Reasonable	Liz Rogers	Angie Lewis	Medium		4.1 We recommend that the Trust investigate means to measure the quality and effectiveness of proactive mechanisms put in place to manage sickness absence. Also, the Trust should consider if management information provided by internal and external providers could be standardised with set key performance indicators for ease of comparisons and collection of data		Accepted – we will investigation options for evaluation of quality and effectiveness	Dec-23	Not Yet Due				Open	
595	22/23	FPC	Hazardous Area Response Team (HART)	Reasonable	Clare Langshaw/Judith Bryce	Lee Brooks	Medium		6.1 HART management should undertake periodic comparison of data extracted from the CAD system to compare against activity reported on PROCLUS to support ongoing efforts to improve data recording on that system		The Trust accepts this recommendation and will undertake a comparison of CAD data to Proclus, with a view to improving the accuracy and system of reporting on Proclus in the future.	May-23	Not Met	May-23	Oct-23		Open	Update 27.09.2023 - Specialist ops LM has approached EMSC for support, EMSC unable to support at this time due to thier capacity, unable to move this action forward without EMSC support. Last Updated: 26.06.2023 - EPRR Team linking with EMSC colleagues to progress this audit recommendation.
596	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	1.1	Following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements	1.1	Accepted. Formal risk appetite statements will be developed in conjunction with the transformational BAF in 23/24; however, the risk consequence matrix is in place and includes risk appetite across a range of categories. The Trust sets out its risk appetite for patient harm in its annual report. This action forms part of the risk management transformation programme monitored at the Strategic Transformation Programme Board. Additionally, a Board Development Session is planned for February 2024.	Jun-24	Not Yet Due				Open	
597	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	2.1	The Trust should develop a SharePoint site to ensure guidance on risk management and assurance arrangements is made available to staff.	2.1	Accepted.	Sep-23	Met				Closed in Quarter	051023: Risk management site on SharePoint where BAF guidance, risk assessment templates and research are available. Further guidance and templates will be added in line with the risk management transformation programme which is part of the IMTP.

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598	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	3.1	Management should continue the rollout of risk management training across the Trust and seek to obtain feedback from attendees, including to capture views on the impact the training has had on their understanding of risk management principles and practice and to identify areas of further training need and improvement.	3.1	Accepted. Risk Management training will continue; however, the level 1 and 2 training packages will not be fully established until late 2024. Bespoke and directorate training will continue to be delivered as requested and a feedback form will be put in place at the next session. Continuous 1:1 support is delivered to Risk Officers to manage their risks.	Sep-24	Not Yet Due				Open	
600	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	4.1	The Trust should continue its work to strengthen the BAF, including to; a) ensure alignment to the broader long-term strategy. b) provide further assurances on	4.1	a) Accepted. This is one element of the Risk Management Transformation Programme included in the IMTP and monitored at the Strategic Transformation Board. b) Accepted. A review of mitigating actions and the impact these have had on current scores forms part of the quarter 2 reports for Trust Board and Committees. This is good practice risk management and is part of each risk review discussion. The impact and effectiveness of controls and mitigating actions will continue to be strengthened and drawn out in the risk reports over the coming year.	Mar-24	Not Yet Due				Open	
601	22/23	Quest	Pain Management	Limited	Chris Moore	Andy Swinburn	High	1.1	Whilst recognised not all PGD's are in relation to analgesia, the current data maintained for compliance for all, should be formally reported to an appropriate forum and action taken to address areas of non-compliance.	1.1	From the July reporting period, we will include compliance for 'Paramedic', 'Advanced Practice' and 'Enhanced Analgesia' PGDs in the monthly Medicines Management Assurance Report (MMAR). These reports are routinely shared with the Ambulance Practice Steering Group (APSG), Senior Operations Team (SOT) and highlights to CQGG via triple A (Advise/Assure/Alert) reports.	Jul-23	Met				Closed in Quarter	Last updated: 06.10.2023 - MMAR included APP and Enhanced analgesia PGD compliance from July. Assurance from Director on Evidence.
602	22/23	Quest	Pain Management	Limited	Chris Moore	Andy Swinburn	High	1.2	The Trust should ensure all PGDs follow the Medicines Management policy, with a review undertaken every three years as a minimum.	1.2 (a)	As an immediate action, with the support of our Pharmacist Advisor, we propose to 'extend' the current expiry dates of our out of date PGDs. This will be a limited time action to allow us time to catch-up with the backlog.	Sep-23	Met				Closed in Quarter	Last updated 06.10.2023 - All out of date PGDs were 'extended' from September (took a while to secure time with pharmacist advisor) to January. Assurance from Director on Evidence.
603	22/23	Quest	Pain Management	Limited	Chris Moore	Andy Swinburn	High	1.2	The Trust should ensure all PGDs follow the Medicines Management policy, with a review undertaken every three years as a minimum.	1.2 (b)	We will prepare and agree a prioritisation plan, to manage the expired status backlog which will be presented to APSG and through to CQGG.	Sep-23	Met				Closed in Quarter	Last updated: 06.10.2023 - Prioritisation plan has been agreed with pharmacist advisor and will begin review of expired PGDs from this month. Assurance from Director on Evidence.
604	22/23	Quest	Pain Management	Limited	Duncan Robertson	Andy Swinburn	High	1.2		1.2 (c)	The PGD development and review process is resource intensive, and pharmacist input is an essential requirement. Pharmacist Advisor availability is currently limited to 4-hours per month and does not currently meet the needs of the organisation, particularly given the uplift in advanced practitioners and extended skills (enhanced analgesia) of the paramedic workforce. We will develop an options appraisal to determine a costed and effective way forward to provide additional Pharmacist Advisor capacity	Mar-24	Not Yet Due				Open	
605	22/23	Quest	Pain Management	Limited	Duncan Robertson	Andy Swinburn	High	2.1	To gain assurances on the completeness of pain management recorded for patients, additional pathways within the ePCR system, should be established to extract the required data; and reported to an appropriate forum with any themes or trends highlighted within the report.	2.1	We propose to set up a task and finish group, to develop/design a pain management framework to support analysis and presentation of pain/analgesia related data. We anticipate this will enable a fuller picture of pain management, across a range of conditions, in addition to STEMI and Fractured Neck of Femur. The framework will be presented to the Clinical Intelligence and Assurance Group by the end of Q3 2023/24 and then through to CQGG and QUEST. There will be a co-dependency on some of the actions on the outcome of Matter Arising 3.	Dec-23	Not Yet Due				Open	Last updated: 13.04.2023 - ePCR Lessons learned event took place 15.03.2023. These have been recorded and will be added to the programme closure bundle. Recommend for closure.

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606	22/23	Quest	Pain Management	Limited	Duncan Robertson	Andy Swinburn	Medium	3.1	The functionality of the ePCR system should be reviewed for the inclusion of a field to track the details of the member of staff who administered the analgesia to the patient.	3.1	The ePCR team will prepare a change request specification and work with our TerraPACE suppliers, to enable the identification of clinicians who have administered analgesia before the end of Q2. The change request will be submitted to the ePCR Clinical Reference Group who report to the CQGG. Note that delivering any change to the ePCR will have a cost associated with it, meaning that it may not be able to be delivered in practice until the funds have been identified.	Sep-23	Met				Closed in Quarter	Last updated: 06.10.2023 The change request has been written up but will not be progressed at this stage due to a lack of funding. Should funding become available, this change request will be considered as a ready to go business case and priority will be reviewed. Closed as to leave it open will mean it will remain open indefinately. Potential issues with funding were identified in the action.
607	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	1.1	In partnership with the trade unions the Trust should revisit the agreement and associated documentation and ensure that there is a consistent, mandated, approach throughout the Trust.	1.1 (a)	Internal conversation on whether full time representative are appointed in WAST [see context narrative that prefaced this action in the report - too large to include]	Mar-24	Not Yet Due				Open	
608	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	1.1	In partnership with the trade unions the Trust should revisit the agreement and associated documentation and ensure that there is a consistent, mandated, approach throughout the Trust.	1.1 (b)	Broader discussion with TU reps regarding maintenance and development of clinical skills whilst undertaking TU duties with the aim of reaching a shared understanding [see context narrativethat prefaced this action in the report - too large to include]	Mar-24	Not Yet Due				Open	
609	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	1.1	In partnership with the trade unions the Trust should revisit the agreement and associated documentation and ensure that there is a consistent, mandated, approach throughout the Trust.	1.1 (c)	Regular discussions with senior TU reps in WAST re time for TU duties, trends and peaks in activity [see context narrativethat prefaced this action in the report - too large to include]	Mar-24	Not Yet Due				Open	Amended the date of 'ongoing' to March 24 and will review the conversations that have taken place at that time.
610	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	2.1	A standardised process to formally request trade union time should be agreed and appropriate monitoring mechanisms put in place to ensure practices are applied and managed consistently. The process should also incorporate the method of approval and payment / TOIL as well as the management of refusals.	2.1 (a)	The comments of audit colleagues are noted and accepted. Whilst there was a template provided, reps were advised that they needed to maintain a personal record but flexibility was given on how this was to be done. The audit feedback will be shared with TU partners for information and clarification. The current spreadsheet can not be completed on an iPad. Also managers are often not able to respond to a request as soon as it is submitted due to shift patterns and operational pressure **Action**: Discussion with TU colleagues on feedback from the audit and the need to record time appropriately [see context narrativethat prefaced this action in the report - too large to include]	Completed	Met				Closed in Quarter	Marked as complete in audit report.
611	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	2.1	A standardised process to formally request trade union time should be agreed and appropriate monitoring mechanisms put in place to ensure practices are applied and managed consistently. The process should also incorporate the method of approval and payment / TOIL as well as the management of refusals.	2.1 (b)	The comments of audit colleagues are noted and accepted. Whilst there was a template provided, reps were advised that they needed to maintain a personal record but flexibility was given on how this was to be done. The audit feedback will be shared with TU partners for information and clarification. The current spreadsheet can not be completed on an iPad. Also managers are often not able to respond to a request as soon as it is submitted due to shift patterns and operational pressure **Action:** Revisit manager's responsibilities in signing off TU time with managers across WAST. [see context narrativethat prefaced this action in the report - too large to include]	Dec-23	Not Yet Due				Open	

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612	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	2.1	A standardised process to formally request trade union time should be agreed and appropriate monitoring mechanisms put in place to ensure practices are applied and managed consistently. The process should also incorporate the method of approval and payment / TOIL as well as the management of refusals.	2.1 (c)	The comments of audit colleagues are noted and accepted. Whilst there was a template provided, reps were advised that they needed to maintain a personal record but flexibility was given on how this was to be done. The audit feedback will be shared with TU partners for information and clarification. The current spreadsheet can not be completed on an iPad. Also managers are often not able to respond to a request as soon as it is submitted due to shift patterns and operational pressure **Action:** Engagement with the senior TU partners will be undertaken with the aim of reaching agreement on implementing a standardised simplified approach (in the context of IA within WAST).	Sep-24	Not Yet Due				Open	
613	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	3.1	A standardised process to formally record facility time, and in sufficient detail, should be agreed and implemented.	3.1 (a)	WAST do not currently have the systems to record this information centrally and to do this manually will take more administrative support which is not good value for money. Most TU reps are based in Operations and are recorded in GRS. Only a handful are working outside of the GRS system. **Action:** We will review whether the information could be held in ESR effectively and what the maintenance of this would be and the ease of collecting it. It needs to be in one place for ease of reporting and management. If this is not a realistic option (in terms of cost), we will explore options for alternative methods of recording total time.	Nov-23	Not Yet Due				Open	
614	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	High	3.1	A standardised process to formally record facility time, and in sufficient detail, should be agreed and implemented.	3.1 (b)	WAST do not currently have the systems to record this information centrally and to do this manually will take more administrative support which is not good value for money. Most TU reps are based in Operations and are recorded in GRS. Only a handful are working outside of the GRS system. **Action:** We will review the recording of time in shift track for 111/ CSD colleagues	Nov-23	Not Yet Due				Open	
615	22/23	PCC	Trade Union Release Time	Limited	Liz Rogers	Angela Lewis	Medium	4.1	Accurate and timely management information detailing the time spent and cost of facility time, both on an individual basis and in total for the Trust should be generated. This information should be reviewed on a regular basis and action taken where necessary.	4.1	This is acknowledged. Our aim is to be able to provide this level of detail. However it is dependant on agreeing a standardised method of recording the time spent that is adopted by all TU's, and identifying a corporate system that will collate this information and produce accurate reports, alongside costs in a meaningful way.	Mar-24	Not Yet Due				Open	
616	22/23	FPC	Cyber Security	Reasonable	James Rowland	Leanne Smith	Medium	1.1	The cyber plan should be approved, with appropriate timescales defined for the actions.	1.1	Cyber improvement plan under development and the Trust has undergone a review of readiness by NHS Wales CRU and any recommendation will also be included in the action plan. Once the plan is approved progress monitored will be monitored and reported via IG Steering Group	Dec-23	Not Yet Due				Open	
617	22/23	FPC	Cyber Security	Reasonable	James Rowland	Leanne Smith	Medium	1.2	The cyber related policies and procedures should be reviewed, updated and any missing items developed and issued.	1.2	Will be included in the plan above [Refers to action 1.1 - *Cyber improvement plan under development and the Trust has undergone a review of readiness by NHS Wales CRU and any recommendation will also be included in the action plan. Once the plan is approved progress monitored will be monitored and reported via IG Steering Group]*	Dec-23	Not Yet Due				Open	
618	22/23	FPC	Cyber Security	Reasonable	James Rowland	Leanne Smith	High	2.1	A formal reporting structure for cyber security should be established. This should include regular monitoring of progress against cyber improvement plans, and reporting on key KPIs that show the security posture of the organisation.	2.1 (a)	An agreed Cyber KPI report will be produced monthly from April 2023. This will be reported into Digital Leadership Group and EMT in parallel with IG Steering Group and Quest Sub-committee.	Close	Met				Closed in Quarter	150923 - Board Secretary has seen Cyber KPI reporting to ELT and Finance and Performance Committee

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619	22/23	FPC	Cyber Security	Reasonable	James Rowland	Leanne Smith	High	2.1	A formal reporting structure for cyber security should be established. This should include regular monitoring of progress against cyber improvement plans, and reporting on key KPIs that show the security posture of the organisation.	2.1 (b)	In due course progress against the agreed Cyber action plan will also be included in the KPI [refers to cyber KPI report (action 2.1(a)]	Dec-23	Not Yet Due				Open	
620	22/23	FPC	Cyber Security	Reasonable	James Rowland	Leanne Smith	High	3.1	Backups should be encrypted.	3.1	The Trust server, storage and backup infrastructure is being refreshed during 2023-2024 and we will look to consider these improvements where practicable and affordable	Mar-24	Not Yet Due				Open	
621	22/23	FPC	Cyber Security	Reasonable	James Rowland	Leanne Smith	High	3.2	Consideration should be given to providing immutable storage for backups.	2.3	The Trust server, storage and backup infrastructure is being refreshed during 2023-2024 and we will look to consider these improvements where practicable and affordable	Mar-24	Not Yet Due				Open	
622	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Leanne Smith	Medium	1.1	WAST should schedule a physical stocktake to ensure the asset register is 100% accurate.	1.1	With the majority of corporate staff remote working since Covid it has been difficult to conduct a physical audit. Also given the range of equipment provided to staff for home working (laptop, dock and monitors) we will have to develop a new way of undertaking a physical audit.	Apr-24	Not Yet Due				Open	
623	22/23	FPC	IM&T Infrastructure	Reasonable	Robert Walker	Leanne Smith	Low	2.1	The contract management SOP should be appropriately reviewed and authorised and communicated to relevant staff.	2.1	The Contract Management SOP has been approved at ICT SMT and will now be presented to Digital Leadership Group for approval, following which it will be communicated to staff across the Trust	Sep-23	Not Met				Open	**UPDATE REQUIRED**
624	22/23	FPC	IM&T Infrastructure	Reasonable	Wyn Morris	Leanne Smith	Medium	3.1	The process for clearing all PRTG/system alerts should be formalised and documented. It would typically include •A shared mailbox, all alerts go to one place •Prioritisation guidelines for all calls. •Scheduled review times for technicians and managers. •Process for storing cleared alerts for periodic analysis to assist with trend /cause identification If there are too many alerts for this to be considered reasonable then the parameters for their production could be reconsidered so that a lower number of what could be considered higher priority alerts is generated.	3.1	Agreed, will look to formalise the process and provide some ownership to the defined process	Dec-23	Not Yet Due				Open	
625	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Leanne Smith	High	4.1	Switches should be identified within the asset register.	4.1	This work was underway prior to the audit but the member of staff is on long term sick. As our switches are configured not to respond to general network sweeps it is a manual task to collate and add this information to the CMDB.	Mar-24	Not Yet Due				Open	
626	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Leanne Smith	High	4.2	A process for patching of unpatched switches or other network components should be established.	4.2	We will look to develop a risk based patching procedure for network switches and devices	Mar-24	Not Yet Due				Open	
627	22/23	FPC	IM&T Infrastructure	Reasonable	Tony Raine	Leanne Smith	High	4.3	A mechanism to deal with/isolate equipment that cannot be brought up to the required security specification should be defined.	4.3	This will be included in the above patching procedure	Mar-24	Not Yet Due				Open	
628	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Leanne Smith	Low	5.1	Consideration should be given to how long the switch to the disaster recovery site will take and if automation is a practical option.	5.1	There are differing requirements for fail over of Trust systems in DR terms with some also only supporting a manual failover process to the DR site. The Trust infrastructure is being refreshed during 2023-2024 and we will look to areas where it can improve failover where practicable or required	Dec-23	Not Yet Due				Open	
629	22/23	FPC	IM&T Infrastructure	Reasonable	Aled Williams	Leanne Smith	Medium	6.1	A review should be undertaken to ensure that the assessment of the criticality of the services is still valid. The backup site capacity should then be reviewed to ensure all the required services can be hosted and what systems have priority and their restoration order.	6.1	The Trust server, storage and backup infrastructure is being refreshed during 2023-2024 and we will look to align capacity and to improve failover where practicable and affordable	Mar-24	Not Yet Due				Open	

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630	22/23	PCC	Health & Safety	Reasonable	Nicola White	Liam Williams	Medium	1.1	Management should ensure that all policies and procedures that relate to health and safety arrangements, are updated as soon as possible.	1.1 (a)	The Trust's Health and Safety Policy is currently undergoing the substantial consultation process. Upon ratification the Health & Policy to be sent for approval from Executive Management Team (EMT) and People & Culture Committee (PCC).	Dec-23	Not Yet Due				Open	
631	22/23	PCC	Health & Safety	Reasonable	Nicola White	Liam Williams	Medium	1.1	Management should ensure that all policies and procedures that relate to health and safety arrangements, are updated as soon as possible.	1.1 (b)	Policies and Procedures will be updated in line with the Health and Safety Management System (HSMS). The HSMS will be reviewed to articulate the timeframe for the review of arrangements.	Sep-23	Not Met	Nov-23			Open	28.09.2023: Proposed revised date Nov-23. HSMS review highlighted approval route changes that have to be agreed before other procedures can be reviewed and approved. HSMS reviewed and propsed edits being considered. The Health & Safety Policy is expected to be presented at People and Culture Committeeon on 16 November 2023 for ratification. The HSMS review is underway. Expectation of seeking approval at ADLT in November 23. The HSMS requries approval before other procedures can be developed/reviewed and approved.
632	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	Medium	1.2	Once approved, policies and procedures should be circulated to all staff.	1.2	Policies and Procedures will be issued via corporate communication platforms.	Mar-24	Not Yet Due				Open	
633	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	Medium	2.1 (a)	All programme documentation should be stored in a centralised location to efficiently measure outcomes and capture ongoing learning	1.2 (a)	Review of documentation sources and centralise on MS 365 platform.	Dec-23	Not Yet Due				Open	
634	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	Medium	2.1 (b)	The Programme plan should be enhanced to provide realistic timescales.	1.2 (b)	Review plan and adjust timescales, and present to the Working Safely Programme Board.	Sep-23	Met				Closed in Quarter	28.9.2023: Propose Closure. Plan has been reviewed with adjusted timescales. Working Safely Programme elements have been incorporated into IMTP plans where applicable and safety annual plan. Evidence provided of safety annual plan.
635	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	Medium	2.1 (c)	The Programme Closure report should be appropriately approved and circulated to assist with the sharing of best practice and lessons learnt.	2.1 (c)	Programme Closure to be rediscussed at Strategic Transformation Board and closure noted in meeting minutes	Sep-23	Not Met	Nov-23			Open	28.9.2023: Working Safely Programme closure report to be presented to Strategic Transformaiton Board to close item. 15.08.23 and cirulated virtually to STB members for approave. Revised plan and timescales now incorporated in IMTP and safety annual plan
636	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	High	3.1	Monitoring of compliance against health and safety legislation and that corrective action is taken promptly, where applicable, should be undertaken. Areas to consider should include: • Ensuring that risk assessments of the required standard are in place across all Trust sites, are periodically reviewed, and appropriately stored; • Wider circulation of inspection reports and a completed action plan to be shared with all action owners; • Determine the follow up process to ensure that corrective action has been taken; • Provide a clear audit trail of where non-compliance has been identified, recording the action that is proposed along with action owners and target dates; and confirmation when the corrective action has been taken; and • Issue of clear, documented guidance clarifying the roles and responsibilities of those involved.	3.1 (a)	Develop performance indicators around sharing inspections outcomes within 10 working days.	Dec-23	Not Yet Due				Open	
637	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	High	3.1	Monitoring of compliance against health and safety legislation and that corrective action is taken promptly, where applicable, should be undertaken. Areas to consider should include: • Ensuring that risk assessments of the required standard are in place across all Trust sites, are periodically reviewed, and appropriately stored; • Wider circulation of inspection reports and a completed action plan to be shared with all action owners; • Determine the follow up process to ensure that corrective action has been taken; • Provide a clear audit trail of where non-compliance has been identified, recording the action that is proposed along with action owners and target dates; and confirmation when the corrective action has been taken; and • Issue of clear, documented guidance clarifying the roles and responsibilities of those involved.	3.1 (b)	Update the Health and Safety Management System to reflect new design.	Dec-23	Not Yet Due				Open	

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638	22/23	PCC	Health & Safety	Reasonable	Leanne Smith	Liam Williams	High	3.1	Monitoring of compliance against health and safety legislation and that corrective action is taken promptly, where applicable, should be undertaken. Areas to consider should include: • Ensuring that risk assessments of the required standard are in place across all Trust sites, are periodically reviewed, and appropriately stored; • Wider circulation of inspection reports and a completed action plan to be shared with all action owners; • Determine the follow up process to ensure that corrective action has been taken; • Provide a clear audit trail of where non-compliance has been identified, recording the action that is proposed along with action owners and target dates; and confirmation when the corrective action has been taken; and • Issue of clear, documented guidance clarifying the roles and responsibilities of those involved.	3.1 (c)	Explore a digital solution to advise relevant managers of their compliance and actions.	Mar-24	Not Yet Due				Open	
639	22/23	PCC	Health & Safety	Reasonable	Nicola White	Liam Williams	Medium	4.1	The Trust should revisit its training needs analysis to consider training frequency, monitoring arrangements and reporting tools to confirm that staff have attended the necessary training.	4.1	Trust's training needs analysis to be amended to include frequencies and mechanism for reporting compliance.	Sep-23	Not Met	Dec-23			Open	19.9.23 TNA within H&S Policy revised to include training frequencies. Action to be closed following ratification of H&S Policy by PCC.
640	22/23	PCC	Health & Safety	Reasonable	Nicola White	Liam Williams	Medium	4.2	The Trust should ensure that all staff complete the statutory health and safety training.	4.2	Statutory and mandatory training for Operational Staff to be communicated at Senior Operations Team. For all other directorates will be supported via an identified H&S Business Partner.	Sep-23	Met				Closed in Quarter	121023: Health & Safety Business Partner allocated to all Directorates since commencemnt of OCP 3 October 2023. Presented at Operational Business Meetings and Assitant Dirctors Leadership Team at time of implentation of new structure (Health & Safety Team Structure and roles paperwork provided as evidence). Quarterly H&S Performance report which includes H&S trainig complaince presented at SOT 29.08.23. Quarterly reports to be presnted at SOT on quarterly basis. Evidence of SOT being presented with report provided.
641	22/23	PCC	Health & Safety	Reasonable	Nicola White	Liam Williams	Medium	4.3	The corporate health and safety team's training matrix should be updated in line with job descriptions and management should ensure that succession planning arrangements have been appropriately considered.	4.3	The training matrix for the Health and Safety functions is a best practice model and exceeds the requirements within each respective job description. This allows the team to able to support other departments (e.g. Estates) by providing advice and undertaking activities that contribute to providing a safe working environment (i.e. lighting assessments). This also contributes to cost savings negating the requirement for external provider in some instances. It also provides a route for succession planning. The function's training matrix will be revised to include; Essential; Desirable and Beneficial to make clear where the minimum standard is being attained.	Dec-23	Not Yet Due				Open	
642	22/23	PCC	Health & Safety	Reasonable	Graham Stockford	Liam Williams	Medium	5.1	Upon finalisation of the review of the governance structure, the terms of reference for the Working Safely Programme Board, Dynamic Delivery Group, the National Health, Safety & Welfare Committee and its sub-groups should be updated accordingly and appropriately approved.	5.1	Terms of reference to be reviewed for Working Safely Programme Board and Dynamic Deliver Groups and reflect changes within HSMS	Sep-23	Met				Closed in Quarter	28.9.2023 - Working Safely Programme has been absorbed into the IMTP and annual safety plan. Dynamic Delivery Group has been disbanded. Approval routes have been reviewed to align with current current organisation structures in place with HSMS to be updated to reflect this change.
643	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	1.1	Guidance should be developed to clearly outline: - Roles and Responsibilities (including assessments, approvals, monitoring and reporting arrangements). - Documentation to be used within the savings process to ensure that key elements are included, e.g. impact, risks, success measures, timescales, etc. - Escalation process to be followed (when, to whom and actions to be taken) where savings are not	1.1	Guidance on roles and responsibilities, documentation and escalation to be developed and shared by Financial Sustainability Programme.	Jul-23	Not Met	Dec-23			Open	Draft Financial Sustainability Programme Delivery Strategy document developed which covers off guidance on roles and responsibilities, documentation and escalation - to be shared with relevant stakeholders over the coming months.
644	22/23	FPC	Savings & Efficiencies	Reasonable	Jason Collins	Chris Turley	Medium	1.2	The guidance should be communicated to all key individuals involved in the process, and subject to a regular review with the date recorded.	1.2	Budget Manual to be updated for 23/24 and then annually reviewed.	Jul-23	Not Met				Closed in Quarter	Budget Manual updated for 23/24 and added to the Finance & Corporate webpage for reference. Also reference will be iincluded in training packs being developed for overall finance training for budget managers. Review of manual will take place on an annual basis and will be included in budget setting timetable which is reviewed and updated annually. Evidence of manual on finance and corporate resources page seen.

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
645	22/23	FPC	Savings & Efficiencies	Reasonable	Jason Collins	Chris Turley	Medium	2.1	A formal programme of financial training should be provided to budget holders to allow them to effectively carry out their role.	2.1	Key objective for WAST FM Team (and wider Finance teams) for 23/24 will be to undertake a series of Finance Training to Board Members, Budget Holders and other non-financial staff. This will be delivered by several methods such as face to face training, TEAMS sessions and induction.	Dec-23	Not Yet Due				Open	
646	22/23	FPC	Savings & Efficiencies	Reasonable	Jason Collins	Chris Turley	Medium	2.2	Training records should be maintained to confirm attendance, which should be monitored to identify non-attendance so this can be followed up.	2.1	Schedule of Training and who has attended to be recorded.	Dec-23	Not Yet Due				Open	
647	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	3.1 (a)	Savings and efficiency plans should be enhanced using SMART criteria to define success and provide realistic timescales.	3.1 (a)	Will be evidenced by project management principles being applied to every individual savings schemes as it is identified and its ongoing monitoring.	Mar-24	Not Yet Due				Open	
648	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	3.1 (b)	Noting the expected future financial challenges, there should be prioritisation and recording of recurring funding against one-off savings to assist with financial sustainability.	3.1 (b)	Impact of Non-recurring schemes in 23/24 will be addressed by FSP and as part of WAST Financial Plan for future financial years.	Mar-24	Not Yet Due				Open	
649	22/23	FPC	Savings & Efficiencies	Reasonable	Navin Kalia	Chris Turley	Medium	3.1 (c)	A log should be implemented to enhance the current process recording changes to the savings programme, during the financial year, from that originally approved.	3.1 (c)	Schedule of 23/24 agreed plans and any additions will be controlled through FSP.	Mar-24	Not Yet Due				Open	
650	22/23	FPC	Savings & Efficiencies	Reasonable	Jason Collins	Chris Turley	Medium	4.1	Management should consider enhancing the Savings and Efficiency Highlight Reporting template to provide more information on progress made, changes, future actions, and risk scoring.	4.1	Review of the current monthly savings report.	Jul-23	Met				Closed in Quarter	Reporting format revised as part of FSW programme and now includes full comparison of actual v plan by theme, scheme and directorate. Each scheme is risk assessed on a monthly basis from discussions with Head of Financial Management and Project Manager. Scheme summaries / for some schemees are taken through FSW workstreams of income generation and efficiency .... RECOMMEND THIS IS NOW CLOSED
651	22/23	AC	Follow Up Audit	Reasonable	Alex Payne	Trish Mills	Medium	1.1	The Trust should look to enhance its tracker so it shows the reason why recommendations are overdue. It could further enhance the tracker to show if progress against the recommendation has been achieved and whether actions have a new proposed completion date.	1.1	The tracker has been enhanced to provide the following narrative next to proposed new dates: Include here reasons why action is overdue and progress made if not yet complete.	Oct-23	Met				Closed in Quarter	150923 - Narrative on Column W on this tracker has been amended to provide for further information from Director/Owner/POC

Points of Contact, Directors and Owners of Audit Actions - Do Not Amend Any Column With a Red Header

When proposing a revised 1st, 2nd or 3rd date, include the rationale for the movement and any progress on the action to date

Tracker Ref No	Audit Wales or HIW Report	Year	Committee Assigned To	Report Title	Responsible Officer	Director	Rec. Ac. in Audit	Recommendation	Response in in Audit	Management Response	Agreed Deadline in Report	Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**	Closure Status	Board Secretary Comments
	Audit Wales	21/22	PCC	Taking Care of the Carers	Catherine Goodwin	Angela Lewis		**Retaining a strong focus on staff wellbeing** NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.		1.2 Implement the health and wellbeing strategy	Nov-22	Not Met	150923 - propose for closure: Within the Directorate Plan (which is the detailed action plan underpinning the People and Culture Plan narrative document), we reference the following: IMTP Deliverable: Create an environment where colleagues have autonomy in their work, feel a sense of belonging, and are confident to make decisions, put forward ideas and raise concerns Under this, we have the following objective: Sustain our focus on improving wellbeing, delivering on the actions articulated within our Wellbeing Strategy and supporting the Working Safely agenda Under this, we have the following high level action: Ensure specific actions that are referenced in the Health and Wellbeing Strategy are delivered Catherine's team tracks delivery of the specific, detailed actions articulated within the Health and Wellbeing Strategy (i.e. the action plan for the strategy); essentially, this is the detail behind the high level action above . So in terms of monitoring, delivery of the Health and Wellbeing Strategy is monitored locally within Catherine's team but also, at Directorate level under the Directorate Plan with that single, high level action Previous update: Request to extend deadline to end of Septemer 2024 - so that the strategy can be delivered in full. Delivery for 2022 and 2023 on track	Closure Proposed	
88		21/22		Taking Care of the Carers?	Catherine Goodwin			**Evaluating the effectiveness and impact of the staff wellbeing offer** NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.		3.2 NHS Staff Survey	Dec-22		CLOSED WAST need to wait along with the wider NHS when it comes to the NHS staff survey and so propose to CLOSE the recommendation on the basis that we will participate as soon as it runs?	Apr-23	
99		22/23		Review of Quality Governance Arrangments	Jonathan Turnbull-Ross			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	Nov-22		Update: 26/09/23: Implementation plan updates shared for Q1 2023. Senior Quality Governance Lead taken post from 4th September 2023. Increased focus remains on the existing implementation plan which will now be monitored through Senior QUality Team work programme following conclusion of departmental OCP and appointment of Quality leads. **Propose Closure** Historic update: The Quality Strategy implementation plan, developed to support the delivery of the Quality Strategy 2021-2024 was reviewed. Whilst progress against the plan has been slow due to resourcing challenges, as was raised in the Committee's last AAA report, there has been accelerated progress in the latter half of 2022/23 in preparation for the Health and Care (Quality and Engagement) (Wales) Act 2020. This remains a priority of QuEST.	May-23	
100		22/23		Review of Quality Governance Arrangments	Duncan Robertson			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.		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.	Dec-22		The Trust's annual Clinical Audit Plan, which allows the planning and prioritisation of clinical audits across the financial year, was approved for 2023/24 by QuEST. It is not always possible to predict all of the topics that require evaluation and therefore this is a dynamic document which will be updated quarterly with oversight by QuEST.	May-23	
101		22/23		Review of Quality Governance Arrangments	Mike Jenkins/Jane Palin			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 updates on progress implementing the all-Wales Learning from Mortality Reviews Framework		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.	Nov-22		This is now included on the QuESt workplan and an AAA report is submitted to CQGG so can be closed. (Evidence available if required).	May-23	
102		22/23		Review of Quality Governance Arrangments	Mike Jenkins/Jane Palin			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	Dec-22		A paper is being present at May 2023 QuESt re the outstanding reviews and next steps so this element can also be closed.	May-23	

106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams		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. 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.		a) 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.	Mar-23	Not Met	Update 121023 I. The Quality Management Group has been set up and is running on a weekly basis chaired by the Senior Quality Governance Lead. The structure of the meeting based around the four quadrants of the Quality Management System System (Quality Control, Quality Assurance, Quality Improvement and Quality Planning) is designed to triangulate information, highlighting areas for improvement, lessons learnt and risk. The structure allows for key stakeholders to attend a rolling programme outside of the core membership group including, EMSC, EMS Response, Integrated Care and Ambulance Care as well as wider corporate services. This is an emerging group that will develop over time to provide assurance to the Executive Team. II.There is also a quality Assurance template in development which will follow the QMS structure in its design in terms of the 4 key elements mentioned above. This will be singed off at Quality and Performance Steering Group in due course. The QA lead will then support EMSC,EMS field Ops, Integrated Care, Ambulance Care to undertake a self-review and collated a gap analysis with the Head of Quality Assurance. This process will act as an embedding tool of theory into practice of the QMS system. Further development will be required over time to embed the QMS into business as usual. III. There is a QMS dashboard is in development to support the group, this is emerging in 3 main parts and will develop over time. •Trust Strategic dashboard based on the MIQPR currently with Health Informatics for development. This will be brought to the QMS meeting for discussion. •Technical specification for all Trust Quality Metrics, this is in its final form. Once ready the HI team will develop into a dashboard for utilisation across business meetings and for the QMS team. •Datix dashboard development, training has been offered by the Once for Wales Team to provide operational leads with the skills and knowledge to search and run reports. In addition, Key leads from Digital, Patient Safety, Health & Safety will be provided training to design their own listing reports. This with enhance the overall management of incidents, mortality reviews, concerns etc. IV. The Quality Performance Management Framework (which is the overarching document to support the Quality Management Systemin WAST) is now being developed and overseen by a Steering Group with cross directorate representation from the Senior Leadership team. This organisational framework will be underpinned by local frameworks acknowledging the complexity and diversity of the organisation. The	Closed	
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams		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. 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.		b) 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.	Mar-23	Not Met	A "Harm Report" is produced for the Trust Board every two months. This includes a clear graphic on the estimated harm caused by system pressures, in particular, long waits. Recognising these long waits were there before the pandemic, so they are not attributable to the pandemic as such more a systematic failure to address handover over a sustained period.	Closed	
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett			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. 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.		c) The MIQPR has evolved in recent months and the quality metrics confirmed with Trust Board. Work is being undertaken to automate more of the reporting into Power BI dashboards with live feed where appropriate to inform of current state. The monthly MIQPR will continue to drive organisational discussion and governance reporting as the key analysis of quality of service delivery across the Trust.	Mar-23	Not Met	Update 121023 The MIQPR continues to be reported to commitees and Trust Board. TB recently approved a revised set of metrics. The Quality & Performance Management Steering Group has agreed that as a pragmatic first step to respond to the "Always On" requirement of the MIQPR will be converted to a live Power BI dashboard. The project group for this has just started, so timescales are to be confirmed dependent on the design brief.	Closed	
106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams		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. 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.		d) 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.	Mar-23	Not Met	**REVISED DATE OF DECEMBER 2023** Update 121023: Work Ongoing and will take a period to complete. Conversations continue with DHCW and the Ambulance Data Set (ADS) lead in England to define the ePCR definitions. Work is also continuing with DHCW to establish data sharing to enable joining up of patient records to report on outcome data. no timeline as yet and meeting with DHCW continue to clarify some of the definitions following discussions with the lead for the ADS in England. Trust Information Governance colleagues are working with DHCW for this. Update 26.09.23: Duty of Quality Implementation plan includes the four quadrants of quality management system as set out in the 'road map'. Quality & Performance Management Steering Group continue to monitor and review the development of 'always on' reporting in line with the requirements of the act. Additional metrics have been approved by Trust Board for inclusion in the MIQPR including PREMS/PROMS, Duty of Candour metrics. New HI post now appointed to support MIQPR move to Power BI dashboard. Proposed Revised date 31.12.23 rationale for extension is to allow BI Dashboard work to commence to allow analysts to identify how best to report 'Patient Reported Experience' measures that add value to decision making. Historic Update: We continue to work with Welsh Government colleagues and NHS Executive in the development of the 'all-Wales' Quality Management System, including how the QMS will 'join up' and detail the impact of ambulance performance on HBs/patient care. The Trust PECI Team have also continued to develop the Civiva patient experience software, alongside HBs, to enable analysis of patient experiences of services.	Open	

106	Audit Wales	22/23	QUEST	Review of Quality Governance Arrangments	Jonathan Turnbull-Ross/ Wendy Herbert/ Hugh Bennett	Liam Williams		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. 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.		e) The Trust is often limited by data accessibility where the patient journey extends beyond the organisational boundary. The Trust will pursue patient 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.	Mar-23	Not Met	REVISED DATE OF MARCH 2024 Update 121023: PREMS live, but in development. PLICS is due to come on stream in Mar-24. PROMS is in development and dependent on DCHW. Business Care Process and Project Management Pathway are relevant considerations.	Open	
111	Audit Wales	22/23	QUEST	Structured Assessment 2022	Liam Williams	Liam Williams		R2 Improve quarterly patient experience reporting to QuESt by ensuring a balance of both positive and negative feedback and providing information on what is being done to address the negative themes arising in the report.		Agreed.	Sep-23	Met	Update 121023: Patient Experience & Community involvement reporting will include qualitiative and quantative data showing positive and negative feedback along with actions being undertaken. Compliments recorded in Datix will present the positive themes to balance the negative themes arising from Putting Things Right and poor experience reporting including patient stories and survey feedback recorded within Civica.	Closed	
119	Audit Wales	22/23	PCC	Structured Assessment 2022	Angela Lewis	Angela Lewis		R5 While the Trust has introduced a programme of services to support staff wellbeing, it is not currently undertaking sufficient evaluation and review to ensure these are meeting the needs of staff. The Trust should introduce a regular process to evaluate its staff wellbeing services, such as via pulse surveys or participant questionnaires. This evaluation should inform long-term investment decisions for such services.		• Follow up surveys will be carried out to identify utilisation of wellbeing services, gaps and impact on a twice-yearly basis.	Jun 23 Dec 23	Not Yet Due	Patient experience & community involvement reports will include both positive and negative feedback. A 'patient tracker' will be presented alongside patient experience stories showing work being undertaken to address negative themes/poor experiences. The Quality Management Group will have oversight of this ensuring a balance in the feedback presented.	Open	
120	HIW	20/21	FPC	EMSCCC Patient Safety Review	Lee Brooks	Lee Brooks		21.1 Complete the North Wales EMS CCC estate strategy and identify opportunities for improvement				Not Met	Note - the entire EMSCCC review actions have not been transferred to the tracker, only the two identified in the 3/8/23 EMT paper. Update 030823: The Bryntirion site for EMSC in the North has been allocated some discretionary capital fundig for this financial year (23/24) to support some progress in this area. It should be noted that WAST have completed and rolled out the estate's strategy in VPH with a view to progress plans with DPP for Llangunnor now to progress with the redevelopment of the ground floor. This is at design stage currently but funding has been allocated from this year's discretionary capital budget to support this)	Open	Report
121	HIW	21/22	FPC	EMSCCC Patient Safety Review	Lee Brooks	Lee Brooks		12.1 Continue with the work of the CAD Phase 3 project to realign workloads within the EMSCCC for more efficient operation				Not Met	Note - the entire EMSCCC review actions have not been transferred to the tracker, only the two identified in the 3/8/23 EMT paper. Update 030823: The EMS Configuration Programme recommended in Q1 2023 following being paused due to Industrial Action and Operational Pressures. Roster Reviewv of call takers is complete. Teh realignment of boundaries aspects of this work, which provides the necessary re-alignment of workloads has commenced and engagement with staff had taken place prior to the pause. This work has re-commenced and is currently waiting on a refresh of the data to finalise discussions with staff and TU partners.	Open	Report

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497	21/22	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	High		We recommend the Trust consider the issues identified above regarding risk management occurring outside of Datix and develop guidance to support the operational escalation criteria and processes which can be implemented across the organisation.		Agreed. This will form part of the guidance and procedures that are currently being strengthened as part of the Risk Transformation programme and will include easy read guides, definitions, matrices and escalation and reporting structures.	Sep-22	Not Met	Jun 23	Aug-23		Closed in Quarter	Update 190923: Guidance developed for Directorates regarding Directorate Risks and will be communicated on Siren. Guidance include reference to current escalation criteria and guidance; request to include risk registers on all Directorate meeting agenda; POC for risk support in Corporate Governance Team; foreshadows further work under risk transformation programme Updated: 05/07/23 The development of the guidance forms part of the Risk Transformation Programme supported by Audit Committee and will be addressed in the coming 6 months and progress reported to EMT and STB.
498	21/22	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium		We recommend the Trust consider arrangements to support the consistency and monitor the completeness of directorate registers.		Agreed. This will encompass the training of Risk Champions for each Directorate and a review of escalation and risk management structures is part of the transformation programme local action plan.	Dec-22	Not Met	Dec-23			Closed in Quarter	Update 190923: Guidance developed for Directorates regarding Directorate Risks and will be communicated on Siren. Guidance include reference to current escalation criteria and guidance; request to include risk registers on all Directorate meeting agenda; POC for risk support in Corporate Governance Team; foreshadows further work under risk transformation programme Update 190923: Guidance developed for Directorates regarding Directorate Risks and will be communicated on Siren. Guidance include reference to current escalation criteria and guidance; request to include risk registers on all Directorate meeting agenda; POC for risk support in Corporate Governance Team; foreshadows further work under risk transformation programme Updated: 05/07/23 This work will be undertaken by the Risk Officer who commenced post 03/07/23
499	21/22	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium		We recommend the Trust ensure there is risk management guidance made available to staff in the interim period prior to the roll out of the new risk module within DatixCloud.		Agreed. This will form part of the guidance and procedures that are currently being strengthened as part of the Risk Transformation programme and will include easy read guides.	Sep-22	Not Met	Mar 23	Jun-23	Aug-23	Closed in Quarter	Update 190923: Guidance developed for Directorates regarding Directorate Risks and will be communicated on Siren. Guidance include reference to current escalation criteria and guidance; request to include risk registers on all Directorate meeting agenda; POC for risk support in Corporate Governance Team; foreshadows further work under risk transformation programme Updated: 05/07/23 The development of the guidance forms part of the Risk Transformation Programme supported by Audit Committee and will be addressed in the coming 6 months and progress reported to EMT and STB.
541	22/23	AC	Standards of Business Conduct: Declarations	Limited	Liz Rogers	Trish Mills	Medium		2.1 Policies and procedures, including the requirements of the Gifts and Hospitality policy, should be appropriately communicated to all new employees upon appointment, to ensure they are familiar with the requirements.		Staff have access to policy information they need via Siren. We will include the policies in the Learner Handbook for Operational staff who train when joining through the Training and Education Team. These are signed to say they have been read and understood. We will add the policies to the local induction list for new starters.	Jun-23	Not Met	Jul-23			Closed in Quarter	Update 21.08.23: Policy and forms have been communicated on Siren. Learner handbook amended to include a link to all policies includin the gifts and hospitality policy. This will ensure that when changes are made to the policy the handbook remains extant. Learners sign the acknowledgement that they have been made aware of the WAST policies. Propose for closure - links to the policy in induction reviewed Update: 11/07/23 A communications plan has been developed which will begin with the initial announcement on Siren of the revised policy and include regular announcements throughout the year, particularly at festive and religious holidays where the issues with gifts is most prevalent. New staff are signposted to the policy on joining. An infographic has been developed for gifts which will provide clear messaging for stations in particular.
545	22/23	AC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	Medium		4.1 Management should determine and implement a solution to ensure the completeness and accuracy of declarations of interest, including nil returns.		Initially 'decision makers' will be targeted for completing of declarations of interest and the register of those decision makers will be held centrally by the Board Secretary.	Jun-23	Not Met	Apr 24			Open	Last updated: 11/07/23 Declarations for the decision makers listed in the policy will commence from March 2024 so as not to duplicate efforts given declarations were sought from ADLT in March 2023 as part of the annual review.
547	22/23	AC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	Medium		4.2 Consideration should also be given to introducing a tracking system and reporting the results, including declarations requested but outstanding, to an appropriate forum e.g., Audit Committee.		The 'decision makers' will be a finite known cohort and initially their declarations will be captured via Microsoft Forms to allow for tracking and escalation	Jun-23	Not Met	Apr 24			Open	Last updated: 11/07/23 There will be a known cohort to enable the tracking any outstanding declarations. The PADR form now has a prompt for the line manager to ensure staff have completed their declarations.
555	22/23	AC	Standards of Business Conduct: Declarations	Limited	Trish Mills	Trish Mills	High		7.1 Management should remind all staff of the requirements of the Gifts and Hospitality policy, and that completed forms should be submitted to Corporate Governance in a timely manner for review.		Accepted. The standards of business conduct will include a plan of communications on this.	Aug-23	Met				Closed in Quarter	Update 190923: Governance SharePoint site includes dedicated Risk Management page including templages, guidance, points of contact and resources Last updated: 11/07/23 This recommendation is not due until August 2023 and will be incorporated into the communications plan above.
596	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	1.1	Following the development of the risk appetite matrix, the Trust should develop and finalise its risk appetite statements	1.1	Accepted. Formal risk appetite statements will be developed in conjunction with the transformational BAF in 23/24; however, the risk consequence matrix is in place and includes risk appetite across a range of categories. The Trust sets out its risk appetite for patient harm in its annual report. This action forms part of the risk management transformation programme monitored at the Strategic Transformation Programme Board. Additionally, a Board Development Session is planned for February 2024.	Jun-24	Not Yet Due				Open	
597	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	2.1	The Trust should develop a SharePoint site to ensure guidance on risk management and assurance arrangements is made available to staff.	2.1	Accepted.	Sep-23	Met				Closed in Quarter	051023: Risk management site on SharePoint where BAF guidance, risk assessment templates and research are available. Further guidance and templates will be added in line with the risk management transformation programme which is part of the IMTP.
598	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	3.1	Management should continue the rollout of risk management training across the Trust and seek to obtain feedback from attendees, including to capture views on the impact the training has had on their understanding of risk management principles and practice and to identify areas of further training need and improvement.	3.1	Accepted. Risk Management training will continue; however, the level 1 and 2 training packages will not be fully established until late 2024. Bespoke and directorate training will continue to be delivered as requested and a feedback form will be put in place at the next session. Continuous 1:1 support is delivered to Risk Officers to manage their risks.	Sep-24	Not Yet Due				Open	

Trust Ref. No.	Year/ Audit Plan	Committee assigned to	Report Title	Assurance Rating	Responsible Officer	Director	Priority Level	Rec. No.in Audit	Recommendation	Response No.in Audit	Management Response	Agreed Deadline in Report	Status - met or not met agreed deadline in report	1st revised date	2nd revised date	3rd revised date	Closure Status	Where a management action has not met the agreed or revised date, Director must inlcude here: 1. Date (of your update) 2. Proposed revised date 3. Reasons why action is overdue and 4. Progress made if not yet complete. **Please add most recent update first**
600	22/23	AC	Risk Management & Assurance	Reasonable	Julie Boalch	Trish Mills	Medium	4.1	The Trust should continue its work to strengthen the BAF, including to; a) ensure alignment to the broader long-term strategy. b) provide further assurances on	4.1	a) Accepted. This is one element of the Risk Management Transformation Programme included in the IMTP and monitored at the Strategic Transformation Board. b) Accepted. A review of mitigating actions and the impact these have had on current scores forms part of the quarter 2 reports for Trust Board and Committees. This is good practice risk management and is part of each risk review discussion. The impact and effectiveness of controls and mitigating actions will continue to be strengthened and drawn out in the risk reports over the coming year.	Mar-24	Not Yet Due				Open	
651	22/23	AC	Follow Up Audit	Reasonable	Alex Payne	Trish Mills	Medium	1.1	The Trust should look to enhance its tracker so it shows the reason why recommendations are overdue. It could further enhance the tracker to show if progress against the recommendation has been achieved and whether actions have a new proposed completion date.	1.1	The tracker has been enhanced to provide the following narrative next to proposed new dates: Include here reasons why action is overdue and progress made if not yet complete.	Oct-23	Met				Closed in Quarter	150923 - Narrative on Column W on this tracker has been amended to provide for further information from Director/Owner/POC

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

LOSSES AND SPECIAL PAYMENTS - PAYMENTS FOR THE PERIOD FROM 1ST APRIL 2023 TO 31st OCTOBER 2023

MEETING	**Audit Committee**
DATE	**30th November 2023**
EXECUTIVE	**Executive Director of Finance and Corporate Resources**
AUTHOR	**Olaide Kazeem – Financial Services Project Accountant**
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 between the months of April and October 2023 (**Annex 1**)

KEY ISSUES/IMPLICATIONS

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

- period 1st April 2023 to 31st October 2023 – £229.4k – Net payments

REPORT APPROVAL ROUTE
Audit Committee 30th November 2023 – no action required for information only under SFIs.

REPORT APPENDICES
Annex 1 – Summary and details of payments made for the seven months to 31st October 2023

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	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 OCTOBER 2023

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 five months from 1st April 2023 to 31st October 2023 (**Annex 1**)

ASSESSMENT

3. Total net Losses and Special Payments made during the period 1st April 2023 to 31st October 2023 amounted to £229.4k of net payments.

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 provision. During the seven months to 31st October 2023 payments made exceeded the reimbursements received by £229.4k.

5. About £168.5k (73%) of the total payments from April to October 2023 were made in the month of September. During September you will note the total damages paid amounted to just £8k and this was for 3 payments.

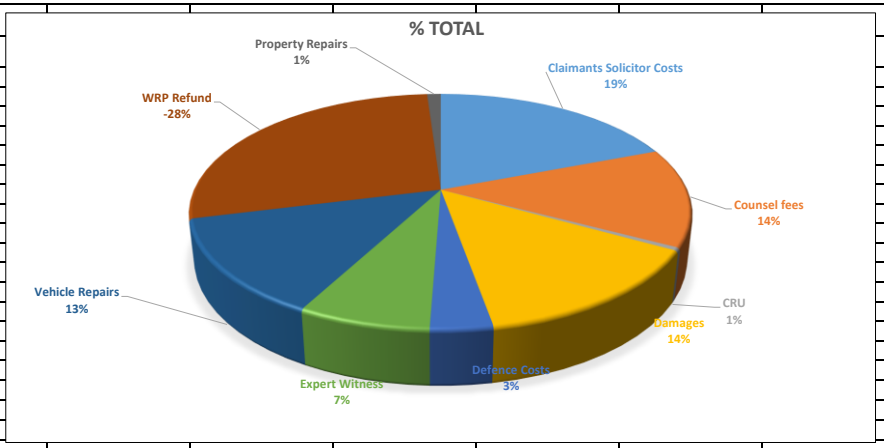
6. During September you will also note the claimants' solicitor cost and counsel fees amounted to £117k for 3 payments and £22.5k for 16 payments respectively.

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

Welsh Ambulance Services NHS Trust

Losses and Special Payments

Annex 1



Summary of payments for the seven month to 31st October 2023:

	£
April 2023	-69261.75
May 2023	28671.21
June 2023	1571.34
July 2023	16364.51
August 2023	89145.51
September 2023	168,450.51
October 2023	-5,493.69
November 2023	0.00
December 2023	0.00
January 2024	0.00
February 2024	0.00
March 2024	0.00
	£229,447.64

Losses and Special Payments Breakdown:

Payment Type	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£	£	£	£	£	£	£	£	£	£	£	£	£
Claimants Solicitor Costs	9,371.50	5,000.00	5,266.00	0.00	10,754.40	117,000.00	-48,212.72	0.00	0.00	0.00	0.00	0.00	£99,179.18
Counsel fees	8,912.79	2,123.91	9,387.22	1,250.00	12,505.84	22,538.33	13,687.50	0.00	0.00	0.00	0.00	0.00	£70,405.59
CRU	0.00	0.00	688.00	0.00	0.00	744.00	688.00	0.00	0.00	0.00	0.00	0.00	£2,120.00
Damages	8,448.00	14,200.45	3,550.00	0.00	36,119.97	8,414.00	2,100.00	0.00	0.00	0.00	0.00	0.00	£72,832.42
Defence Costs	3,713.72	521.58	1,501.84	212.38	854.55	7,878.83	2,905.55	0.00	0.00	0.00	0.00	0.00	£17,588.45
Expert Witness	4,680.00	2,319.00	6,581.50	4,000.00	11,772.26	5,636.67	2,477.61	0.00	0.00	0.00	0.00	0.00	£37,467.04
Vehicle Repairs	3,520.77	4,506.27	16,058.18	10,848.43	5,256.61	6,012.68	22,561.37	0.00	0.00	0.00	0.00	0.00	£68,764.31
WRP Refund	-107,908.53	0.00	-41,461.40	0.00	9,066.88	0.00	-4,000.00	0.00	0.00	0.00	0.00	0.00	-£144,303.05
Property Repairs	0.00	0.00	0.00	53.70	2,815.00	316.00	2,299.00	0.00	0.00	0.00	0.00	0.00	£5,483.70
Court Refund	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	£0.00
Total	**-£69,261.75**	**£28,671.21**	**£1,571.34**	**£16,364.51**	**£89,145.51**	**£168,540.51**	**-£5,493.69**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£0.00**	**£229,537.64**

Welsh Ambulance Services NHS Trust	Key	
Losses and Special Payments	MN	Medical Negligence
	PI	Personal Injury
Summary of payments for the seven months to 31st October 2023:	DP	Damage To Property
	£	
PI cases < £1,000	4,437.22	10 CASES
DP cases < £1,000	8,684.70	47 CASES
23RT4MN0014	5.74	
24RT4MN0001	25.83	
24RT4MN0007	62.96	
21RT4MN0009	190.00	
20RT4MN0008	410.00	
22RT4MN0012	452.50	
22RT4MN0002	870.94	
23RT4GN0037	1,000.00	
24RT4GN0009	1,000.00	
24RT4EG0014	1,000.00	
24RT4DP0037	1,105.00	
24RT4DP0007	1,113.10	
18RT4MN0016	1,137.50	
22RT4GN0034	1,159.87	
23RT4MN0004	1,200.00	
21RT4PI0006	1,200.00	
24RT4DP0008	1,215.00	
24RT4EG0005	1,250.00	
24RT4EG0015	1,250.00	
24RT4EG0016	1,250.00	
24RT4DP0032	1,275.00	
24RT4DP0020	1,285.00	
22RT4MN0018	1,300.00	
24RT4DP0019	1,310.00	
24RT4DP0006	1,320.00	
24RT4DP0001	1,322.35	
24RT4DP0041	1,332.62	
24RT4DP0035	1,404.00	
22RT4MN0013	1,430.00	
24RT4DP0016	1,530.00	
24RT4DP0009	1,573.39	
24RT4DP0023	1,592.90	
22RT4GN0031	1,600.00	
23RT4DP0079	1,627.94	
22RT4DP0085	1,632.84	
23RT4EG0019	1,650.00	
22RT4GN0040	1,650.00	
24RT4DP0034	1,719.76	
24RT4DP0003	1,784.17	
24RT4EG0017	1,800.00	
20RT4PI0037	1,863.60	
23RT4MN0011	1,873.33	
24RT4DP0015	1,919.29	
21RT4PI0023	2,088.20	
23RT4MN0003	2,358.00	
22RT4MN0010	2,365.41	
23RT4PI0035	2,400.00	
21RT4GN0011	2,448.00	
24RT4EG0018	2,475.00	
24RT4DP0026	2,491.60	
24RT4EG0007	2,500.00	
24RT4DP0036	2,513.09	
24RT4DP0013	2,513.69	
24RT4DP0017	2,545.65	
24RT4DP0010	2,555.88	
24RT4PI0001	2,587.95	
20RT4MN0018	2,595.00	
24RT4DP0027	2,956.83	
24RT4DP0043	2,964.80	
22RT4MN0011	2,984.40	
25RT4EG0009	3,000.00	
22RT4DP0094	3,013.14	
24RT4DP0044	3,107.33	
24RT4DP0028	3,109.05	
24RT4DP0012	3,234.28	
24RT4DP0029	3,383.48	
23RT4EG0017	3,575.00	
21RT4GN0023	3,600.00	
24RT4DP0039	3,647.57	
23RT4EG0001	4,100.00	
23RT4PI0013	4,101.00	
22RT4PI0017	4,766.00	
23RT4GN0036	5,000.00	
19RT4MN0008	5,115.73	
20RT4PI0025	5,155.50	
23RT4EG0018	5,175.29	
22RT4MN0003	6,175.00	
23RT4MN0012	6,422.75	
19RT4PI0037	7,875.84	
21RT4PI0017	7,980.00	
22RT4PI0035	8,364.00	
23RT4DP0032	8,576.15	
23RT4PI0003	8,616.00	
20RT4MN0011	8,634.68	
22RT4PI0039	9,256.37	
22RT4PI0023	10,312.00	
22RT4MN0001	23,291.98	
21RT4PI0035	26,550.00	
20RT4PI0008	30,500.00	
21RT4MN0011	39,042.50	
20RT4PI0025	11,316.88	WRP Refund
23RT4GN0010	-200.00	WRP Refund
21RT4PI0034	-249.82	WRP Refund
22RT4GN0021	-250.00	WRP Refund
22RT4GN0019	-300.00	WRP Refund
22RT4GN0027	-400.00	WRP Refund
22RT4GN0020	-500.00	WRP Refund
22RT4GN0015	-600.00	WRP Refund
23RT4GN0025	-1,000.00	WRP Refund
22RT4GN0033	-1,500.00	WRP Refund
23RT4GN0016	-1,500.00	WRP Refund
23RT4GN0032	-2,300.00	WRP Refund
19RT4PI0028	-5,955.00	WRP Refund
21RT4PI0001	-32,956.58	WRP Refund
19RT4PI0008	-107,908.53	WRP Refund
Total	**229,537.64**	

Sep-23

Case Reference	Details	Amount (£)
19RT4MN0008	Counsel Fees	1,820.00
20RT4MN0011	Claimants Solicitor Costs	75,000.00
20RT4PI0008	Claimants Solicitor Costs	15,000.00
21RT4MN0011	Defence Costs	480.00
21RT4MN0011	Claimants Solicitor Costs	27,000.00
21RT4PI0023	Defence Costs	108.00
22RT4GN0034	Defence Costs	25.83
22RT4GN0040	Counsel Fees	1,600.00
22RT4GN0040	Damages	50.00
22RT4MN0001	Expert Witness	400.00
22RT4MN0001	Expert Witness	1,133.34
22RT4MN0001	Expert Witness	720.00
22RT4MN0001	Counsel Fees	1,050.00
22RT4MN0001	Counsel Fees	845.00
22RT4MN0001	Expert Witness	300.00
22RT4MN0001	Expert Witness	600.00
22RT4MN0001	Expert Witness	100.00
22RT4MN0001	Counsel Fees	650.00
22RT4MN0001	Counsel Fees	3,075.00
22RT4MN0001	Expert Witness	833.33
22RT4MN0003	Expert Witness	250.00
22RT4MN0010	Defence Costs	1,285.41
22RT4MN0011	Defence Costs	1,684.40
22RT4PI0023	CRU	744.00
22RT4PI0024	Counsel Fees	600.00
22RT4PI0035	Damages	6,000.00
22RT4PI0035	Damages	2,364.00
23RT4EG0001	Defence Costs	600.00
23RT4EG0001	Counsel Fees	3,500.00
23RT4MN0003	Defence Costs	108.00
23RT4MN0003	Expert Witness	1,300.00
23RT4MN0011	Counsel Fees	573.33
23RT4PI0035	Counsel Fees	300.00
24RT4DP0017	Vehicle Repairs	2,295.65
24RT4DP0022	Property Repairs	120.00
24RT4DP0023	Vehicle Repairs	1,592.90
24RT4DP0024	Property Repairs	196.00
24RT4DP0025	Vehicle Repairs	1,890.00
24RT4DP0026	Vehicle Repairs	2,491.60
24RT4DP0027	Defence Costs	2,956.83
24RT4DP0028	Vehicle Repairs	3,109.05
24RT4DP0029	Vehicle Repairs	3,383.48
24RT4EG0012	Defence Costs	80.36
24RT4EG0013	Counsel Fees	750.00
24RT4EG0014	Counsel Fees	1,000.00
24RT4EG0015	Counsel Fees	1,250.00
24RT4EG0016	Counsel Fees	1,250.00
24RT4EG0017	Counsel Fees	1,800.00
19RT4PI0037	Defence Costs	275.00
21RT4PI0023	Defence Costs	275.00
24RT4DP0025	Vehicle Repairs	- 8,750.00
24RT4EG0018	Counsel Fees	2,475.00
Totals		**168,540.51**

Oct-23

Case Reference	Details	Amount (£)
19RT4MN0008	Counsel Fees	1,662.50
19RT4PI0037	Counsel Fees	2,500.00
19RT4PI0049	CRU	688.00
20RT4MN0008	Counsel Fees	150.00
20RT4MN0011	Claimants Solicitor Costs	8,244.68
20RT4MN0011	Claimants Solicitor Costs	- 75,000.00
20RT4MN0018	Counsel Fees	175.00
20RT4MN0018	Defence Costs	1,500.00
20RT4PI0008	Claimants Solicitor Costs	15,500.00
20RT4PI0037	Defence Costs	1,238.60
21RT4DP0048	Vehicle Repairs	478.50
21RT4PI0023	Defence Costs	55.20
22RT4GN0033	Wrp Refund	- 1,500.00
22RT4GN0034	Claimants Solicitor Costs	1,041.60
22RT4MN0001	Expert Witness	154.17
22RT4MN0002	Expert Witness	412.50
22RT4MN0002	Expert Witness	320.94
22RT4MN0003	Counsel Fees	1,500.00
22RT4MN0010	Counsel Fees	1,050.00
22RT4MN0012	Expert Witness	390.00
22RT4PI0008	Property Repairs	744.00
23RT4DP0051	Property Repairs	280.00
23RT4GN0016	Wrp Refund	- 1,500.00
23RT4GN0025	Wrp Refund	- 1,000.00
23RT4GN0036	Counsel Fees	5,000.00
23RT4MN0003	Counsel Fees	950.00
23RT4MN0004	Expert Witness	300.00
23RT4MN0004	Expert Witness	900.00
23RT4MN0014	Defence Costs	5.74
23RT4PI0013	Claimants Solicitor Costs	2,001.00
23RT4PI0013	Damages	2,100.00
24RT4DP0030	Vehicle Repairs	268.00
24RT4DP0031	Vehicle Repairs	926.25
24RT4DP0032	Property Repairs	1,275.00
24RT4DP0033	Vehicle Repairs	660.00
24RT4DP0034	Vehicle Repairs	1,719.76
24RT4DP0035	Vehicle Repairs	1,404.00
24RT4DP0036	Vehicle Repairs	703.09
24RT4DP0036	Vehicle Repairs	1,810.00
24RT4DP0037	Vehicle Repairs	1,105.00
24RT4DP0038	Vehicle Repairs	250.00
24RT4DP0039	Vehicle Repairs	3,647.57
24RT4DP0040	Vehicle Repairs	120.00
24RT4DP0041	Vehicle Repairs	1,332.62
24RT4DP0042	Vehicle Repairs	378.00
24RT4DP0043	Vehicle Repairs	2,964.80
24RT4DP0044	Vehicle Repairs	3,107.33
24RT4DP0045	Vehicle Repairs	360.00
24RT4DP0046	Vehicle Repairs	926.45
24RT4DP0047	Vehicle Repairs	400.00
24RT4EG0019	Defence Costs	31.57
24RT4EG0020	Counsel Fees	700.00
24RT4MN0007	Defence Costs	62.96
24RT4PI0020	Defence Costs	11.48
Totals		**- 5,493.69**

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

Committee Priorities & Cycle Monitoring Report

MEETING	Audit Committee
DATE	30 November 2023
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 2023/24 and progress against the agreed cycle of business for the Committee. There are no matters to escalate with respect to the Priorities.

2. The priority of oversight of the development of the Quality and Performance Management Framework which has moved from the Finance and Performance Committee is reflected in this update.

RECOMMENDATION: -

3. **The Committee is asked to NOTE the update.**

KEY ISSUES/IMPLICATIONS

No issues to raise.

REPORT APPROVAL ROUTE

Not applicable

REPORT APPENDICES

Annex 1 – Audit Committee Cycle of Business Monitoring Report

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		**Confirm that the issues below have been considered and addressed**	
EQIA (Inc. Welsh language)	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 2023/24 AND CYCLE MONITORING REPORT

SITUATION

4. This report updates the Committee on progress against the priorities it set for 2023/24 and progress against the agreed cycles of business. There are no matters to escalate with respect to the Priorities. The report also seeks approval for a change to the prescribed attendance for the Committee.

BACKGROUND

5. During the course of the effectiveness reviews, it was agreed that it is good practice for Committees to set priorities for the forthcoming year. The Committee's priorities, which are set out below, were agreed by the Trust Board in May 2023 and will be tracked quarterly.

6. The Committee's cycle of business was approved by the Committee in July 2023. The agenda is set with reference to that cycle, together with the forward planner, action log and highest rated principal risks.

7. The monitoring report is at Annex 1. Items in green show they are cycled for a particular meeting. Items in beige indicate they are a prompt at agenda setting as they may be ad hoc items such as business cases or external reports. The blue indicates that the item is either on the agenda as scheduled or is an ad hoc item which was discussed in agenda setting.

ASSESSMENT

8. The Committee priorities, and progress against them is as follows:

Priority	Progress
Review of the Board Member Induction Programme and Annex	• The induction programme and annex documents have been updated for the induction of the new Vice Chair. • An update on the induction programme has been programmed for the September 2023 meeting of the Committee, for assurance. • A scope for a session with Chairs and TU members on their role and mutual expectations is being developed to be delivered in Q4.

Oversight of the development and effectiveness of the Quality & Performance Management Framework	• The Committee will receive an update regarding the implementation of the Quality and Performance Management Framework at its meeting in November.

RECOMMENDATION: -

9. **The Committee is asked to NOTE the update.**

PAPER	PRE or POST C'EE FORUM	FREQUENCY	Q1a	Q1b	Q2	Q3	Q4	LEAD	PURPOSE	COMMENT
AUDIT COMMITTEE - CYCLE OF BUSINESS 2023/24										
For the rationale for this Committee's cycle see Note 8										
MAIN ELEMENTS										
Annual filings										
Annual accounts planning and emerging issues report	EMT	Annually						EDOF	Assurance	
Annual report timetable	EMT	Annually						BS	Assurance	
Audited accounts	EMT and Board	Annually						EDOF	Endorsement	
Annual report	EMT and Board	Annually						BS	Endorsement	
Head of internal audit report and opinion	EMT and Board	Annually						Internal Audit	Assurance	
Audit report on accounts	EMT and Board	Annually						Audit Wales	Assurance	
Internal Audit										
Audit Plan	EMT	Annually						Internal Audit	Approval	
Internal audit reports	EMT and C'ees	Quarterly						Internal Audit	Assurance	
Audit Wales										
Audit Plan	EMT and Board	Annually						Audit Wales	Review	
Update report	N/A	Quartlery						Audit Wales	Assurance	
Annual Audit Report	EMT and Board	Annually						Audit Wales	Assurance	
Structured Assessment	EMT and Board	Annually						Audit Wales	Assurance	
Losses & Special Payments/Single Tender Waivers										
Quarterly lossess and special payments report	N/A	Quarterly						EDOF	Approval	
Tender update report and single tender waiver request	N/A	Quarterly						EDOF	Assurance	
Counter fraud										
Counter fraud update report	N/A	Quarterly						EDOF	Assurance	
Standing Orders & Standing Financial Instructions										
Standing Orders & Standing Financial Instructions	EMT and Board	Annually						BS	Endorsement	
Breach of Standing Orders & Standing Fin. Instructions	EMT	Ad Hoc						BS	Discussion/Assurance	
Governance Practice Notes	EMT	Annually						BS	Approval	
Whistleblower, Declarations, Gifts & Hospitality										
Annual report on declarations of interest	EMT	Annually						BS	Assurance	
Report on gifts and hospitality	EMT	Annually						BS	Assurance	
Whistleblower report	TBC	TBC						BS	TBC	Agreed updates from Paul Hollard
Other										
Near Miss Report	QUEST	Annually						TBC	Assurance	
Quality and Performance Management Framework	QUEST	TBC						EDSPP	Assurance	Included in Q3; reporting to continue to be developed.
Policy										
Policy report	EMT	Quarterly						BS	Assurance	Policy Report added 28.06.2023
Policies	Policy Group	Ad Hoc						BS	Approval	
Financial procedures	TBC	Ad Hoc						EDOF	Approval	
Risk Management										
Review of risk related elements in IMTP	STB	Annually						BS	Assurance	
Board Assurance Framework	EMT	Each meeting						BS	Assurance	
Corporate Risk Register	EMT	Each meeting						BS	Assurance	
Audit Recommendation Tracker	EMT	Each meeting						BS	Assurance	
GOVERNANCE										
Escalations from Board Committees	Board Committee	Ad Hoc						Chairs	Various	
Committee effectiveness reviews and annual reports	All Committees	Annually						BS	Approval	
Audit Committee effectiveness review annual report	Audit/Board	Annually						BS	Approval	
Audit Committee Review of Terms of Reference	Audit/Board	Annually						BS	Approval	
Audit Committee Cycle of Business annual refresh	Audit/Board	Annually						BS	Approval	
Audit Committee Review of Annual Priorities	None	Quarterly						Chair	Review	
Governance Practice Notes	EMT	Annually as due						BS	Review/Approve	
All Wales Audit Committee Chair's Meeting Report	AWACC	Bi-annually						Chair	Review	Added 19.09.23
PROMPTS										
External Reports	n/a	As required						TBC	TBC	

Two Q1 meetings. Q1b is a governance meeting to take the Committee annual reports and other items as noted
EDOF - Executive Director of Finance and Corporate Resources
BS - Board Secretary

Cycled for each meeting
Ad hoc item - prompt for agenda setting
Reporting developing
Presented as cycled/ad hoc item considered at agenda setting
Deferred